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INVESTIGATIONS – REVIEWS – INQUIRIES

An independent investigation into the care and treatment of RA

A report for
NHS South East Coast
NHS East of England

February 2011

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Contents

Acknowledgements

We would like to thank staff from the Hertfordshire Partnership NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership Trust who gave up time to give information to the investigation and who spoke so freely to us. We would particularly acknowledge the cooperation of Dawn Crump and Penny Lamb whose assistance has been valuable in helping us to complete our task.

1. Introduction

1.1 RA first came into contact with NHS mental health services in 1990 in Hertfordshire. Between 1990 and 2003 she had contact with mental health services in both Hertfordshire and Kent.

1.2 RA killed her ex-partner ND on 26 October 2003 at his home in Cheshunt, Hertfordshire. He was found to have stab wounds to the neck and abdomen. RA was 33 years old at the time of the homicide. RA was found guilty at St Albans Crown Court of murder and sentenced to life imprisonment.

1.3 This independent investigation was commissioned by NHS South East Coast and NHS East of England with the full cooperation of Hertfordshire Partnership NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership Trust. The investigation is commissioned in accordance with guidance published by the department of health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005. The investigation terms of reference are set out in section 2.

1.4 This investigation was conducted by Verita, an independent consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations.

1.5 The Verita team consisted of Malcolm Barnard, senior consultant and lead investigator and Barry Morris, director, who provided a peer-review. Verita used the West Kent Partnership NHS Trust internal clinical practice review as a starting point for the independent investigation.

1.6 This report sets out RA's care and treatment from her initial contact with services until the homicide. It provides a chronological overview of events and evaluates the care and treatment she received. It also covers communication between the organisations involved.

2. Terms of reference, approach and methodology

Terms of reference

Compile a detailed chronology setting out RA's involvement with the relevant agencies following her contact with Hertfordshire and Kent and Medway mental health services from September 1999 until the homicide of ND in October 2003.

Examine the care and treatment of RA, with a particular focus on the:

- appropriateness and quality of the care provided in the light of RA's health and social care needs, and clinical diagnosis
- extent to which RA's prescribed care plans were effectively delivered, complied with and monitored
- adequacy of any risk assessments regarding RA's potential for self harm or to harm others
- extent to which RA's care accorded with the relevant statutory obligations
- adequacy of the collaboration and communication between all the agencies involved, including Kent & Medway Partnership Trust and GP services.

Assess the extent to which the action plan, produced by the (former) West Kent Trust as part of its clinical review was implemented.

Provide a written report with recommendations for NHS South East Coast and NHS East of England.

Approach and methodology

2.1 As agreed with the commissioners the investigation was undertaken by a single investigator supported by a peer reviewer, with access to expert advice. It was conducted in private and took as its starting point the trust's internal investigation supplemented as necessary by source documents and interviews with the trust's current managers.

2.2 The investigation team sought to engage with RA and the relatives of the victim throughout the course of the work. RA chose not to accept an invitation to meet the investigator. The team were unable to trace or make contact with the victim's relatives.

2.3 The evaluation of RA's care and treatment involved a detailed analysis of her medical and other clinical records.

2.4 An expert group was convened with the following membership:

- Dr Mike Dilley, consultant neuropsychiatrist, Central and North West London NHS Foundation Trust
- Emily Ewart, care coordinator, Central and North West London NHS Foundation Trust.

2.5 The group considered an anonymised case study and detailed chronology, identified the issues arising and commented on the changes that could or should have been made in the period since the homicide.

2.6 The investigator met with groups of managers from both trusts to:

- examine key issues identified by the expert group
- discuss progress on action plans and the trusts' current position on how lessons are learned from serious incident investigations
- address points of clarification.

2.7 Those attending the meetings were:

Hertfordshire Partnership NHS Foundation Trust

- Dawn Crump – interim risk manager
- Michelle Jeyaratnam – joint head of community services
- Oliver Shanley – director of quality and safety

Kent and Medway NHS and Social Care Partnership Trust

- Karen Dorey-Rees – Associate director for recovery services

- Penny Lamb – SUI (serious untoward incident) lead

Structure of the remaining sections

2.8 Section 3 provides an executive summary. Section 4 is a chronological overview of RA's care and treatment. Section 5 discusses themes arising from RA's care and treatment. It examines changes and improvements in the trusts' policies, systems and practice since the tragic events in 2003 and sets out our findings and recommendations. Conclusions and recommendations are provided in section 6.

3. Executive summary

3.1 RA killed her ex-partner ND on 26 October 2003 at his home in Cheshunt, Hertfordshire. He was found to have stab wounds to the neck and abdomen. RA was 33 years old at the time of the homicide. RA was found guilty at St Albans Crown Court of murder and sentenced to life imprisonment. The judge told RA that she would have to serve a minimum of 11 years and 152 days in prison before she could be considered for parole.

3.2 RA's first contact with mental health services was in May 1990 when she was 20 years old. There are no records of further contact with mental health services until July 1999.

3.3 On 4 September 1999 RA attended the accident and emergency (A&E) department at the Lister Hospital, Stevenage, having taken an overdose. This was the first of seven suicide attempts between September 1999 and May 2003. There were also two incidents in that period when RA threatened to kill herself.

3.4 Between July 1999 and May 2003 RA was seen by a number of staff from different disciplines in the Hertfordshire secondary mental health services. Her most frequent contacts were with a succession of junior and locum consultant psychiatrists and a number of psychologists.

3.5 Following the last suicide attempt on 8 May 2003 RA was admitted to the Lister Hospital, Stevenage under section 136 of the Mental Health Act 1983. She was detained later that day for assessment under section 2 of the act. Although this suicide attempt took place in Hertfordshire, RA had moved to Kent in October 2002 and she was therefore transferred from the Lister Hospital to Priority House, an inpatient unit in Maidstone in the evening of 8 May 2003.

3.5 She remained at Priority House until 14 May 2003 when she was discharged from her mental health act detention and discharged from hospital. She was subsequently offered three outpatient appointments but did not keep them.

3.6 An assessment of RA was carried out on 12 June 2003 by a community psychiatric nurse (CPN) from the Kingswood community mental health team (CMHT). The CPN's report

noted that she would be discharging RA from the CMHT's caseload and that RA agreed with that decision.

3.7 There was no further contact between RA and CMHT before the homicide on 26 October 2003.

3.8 This independent investigation identified a number of key issues arising from an examination of clinical records and policy documents. These were discussed with senior managers from the Hertfordshire Partnership NHS Foundation Trust and the Kent and Medway NHS and Social Care Partnership Trust.

Findings - Hertfordshire

3.9 The coordination of RA's care and treatment in Hertfordshire was inadequate.

3.10 Changes and improvements in Hertfordshire trust policy and practice since 2003 mean that if similar circumstances occurred today proper care coordination would now be put in place to facilitate and implement a clear care pathway plan.

3.11 Although there is evidence in the notes that RA's risk to herself was identified and discussed, there is no evidence of formal recorded risk assessment.

3.12 Improvements to policy, procedures and practice since 2003 mean that a service user today with similar circumstances and presentation to RA would be subject to formal risk assessment. Risk history would now be readily accessible through the electronic record system.

3.13 Robust arrangements have been implemented in the trust to monitor compliance with risk assessment and management policy and to ensure that lessons are learned from untoward incidents.

3.14 RA never met her consultant psychiatrist. She was seen by a succession of junior doctors and locum consultants. Communication between the consultant and junior psychiatrists appeared to be poor. The framework for delegation to junior doctors and supervision arrangements now in place should ensure that communication between consultant and junior medical staff is adequate.

3.15 The quantity of medication given to RA in single prescriptions was high in light of her risk history of previous overdoses. There were no recorded medication plans and no link appeared to be made between medication and risk.

3.16 The establishment of the trust's own arrangements for pharmaceutical services has improved the monitoring of prescribing patterns.

3.17 Improved care coordination arrangements and the electronic records system should now ensure that appropriate links are made between medication and risk.

3.18 RA's failure to keep appointments was not well managed. Decisions about appointment intervals appeared to have been taken bureaucratically and without consideration of RA's individual needs.

3.19 The policy and procedural framework for ensuring that service users remain engaged with services is much improved since 2003. Enhanced care coordination arrangements and the work in CMHCs (community mental health centre) to encourage engagement and reduce non attendance should bring further improvements.

3.20 Communication between the inpatient units at the time of RA's transfer was poor.

3.21 The current policy framework in the Hertfordshire Partnership NHS Foundation Trust covering transfers between outpatient units is more robust than in 2003. Improved care coordination arrangements should also have strengthened preparations for discharge and communication between transferring and receiving trusts.

Findings – Kent and Medway

3.22 The policy framework in the Kent and Medway NHS and Social Care Partnership Trust covering transfer of records and communication with other NHS trusts about transfer of patients is now more robust than in 2003.

3.23 No care programme approach (CPA) review was undertaken before RA's discharge from Priority House in May 2003 and no care coordinator was allocated before discharge. Information about RA's discharge was communicated quickly and appropriately to RA's GP

and other agencies. The full discharge summary was not sent to the GP until more than three weeks after the discharge.

3.24 The policy and procedures framework for care pathways (incorporating CPA) is now much more robust than in 2003. Good monitoring arrangements are in place to ensure that policy regarding allocation of care coordinators prior to hospital discharge is complied with.

3.25 Some problems remain in meeting the trust's standard covering timeliness of completing hospital discharge summaries.

3.26 There were weaknesses in the systems to ensure that RA remained engaged with services.

3.27 Policy and systems within the trust for managing patients who do not attend appointments are now much more robust than in 2003.

3.28 We agree with the trust's clinical practice review that the CPN's assessment of RA on 12 June 2003 was of a good standard. However there was a misunderstanding in the assessment report about the circumstances of RA's discharge from her section under the Mental Health Act 1983. There was also an absence in the risk assessment of reference to a large knife found in RA's car at the time of her most recent suicide attempt and a lack of detail of RA's forensic history.

3.29 The reasons for the misunderstanding and omissions are not clear from the records. However it is likely that a major contributory factor was the failure to appoint a care coordinator prior to RA's discharge from hospital and inadequate communication of information between Priority House and the CPN. In the light of an otherwise exemplary assessment it is likely that the weaknesses were systemic rather than the responsibility of the CPN.

3.30 There have been significant improvements in the trust since 2003 in policy and practice relating to:

- appointment of care coordinators on hospital discharge
- communication between inpatient and community services

- the patient records system including recording and summarising risk and forensic history
- clinical supervision, including the process for decision making about discharge from trust services.

Conclusions

3.31 RA's care and treatment in both trusts was poorly coordinated. There were weaknesses in Hertfordshire in the process of risk assessment and in the absence of continuity of care from psychiatrists. In both trusts there was a lack of linkage between decisions about quantity of medication prescribed and the management of risk. Neither trust managed RA's failure to keep appointments proactively. Sharing of information between the trusts at the time of RA's transfer from Hertfordshire to Kent was inadequate.

3.32 There have been significant organisational and structural changes within the trusts since 2003.

3.33 In both trusts, policies and procedures covering care pathways (incorporating CPA) including risk assessment and management, care coordination, clinical supervision and transfers of patients between trusts have been updated and significantly improved. Both trusts now have fully implemented electronic record systems which provide instant access for staff to key information and help to monitor compliance with policy and performance against trust standards.

3.34 The action plan established by the former West Kent NHS and Social Care Partnership Trust following the internal clinical practice review has been implemented.

3.35 In view of the significant improvements in policies and systems in both trusts since the homicide in October 2003 and in the light of the long time elapsed between the homicide and this investigation we make only one recommendation.

Recommendation

R1 The Kent and Medway NHS and Social Care Partnership Trust should include in its programme of clinical audit, a review of the timeliness of completion of hospital discharge

summaries and the sending of them to patients' GPs and, where appropriate, to other agencies.

4. Chronology of key events

1990

4.1 RA's first contact with mental health services was in May 1990 when she was 20 years old. She was referred urgently by her general practitioner (GP) to consultant psychiatrist 1 at the Lister Hospital, Stevenage. RA was experiencing feelings of anger and aggression and depression. She was seen within a week of the referral by SHO1, consultant psychiatrist 1's senior house officer. SHO1 took a full history. According to her medical records RA's symptoms had started about a year earlier. The symptoms were unaffected by her recent pregnancy and the birth of her baby. On examination RA presented as well dressed with good eye contact. Her speech was normal in form and content. Mood was not depressed. Thought was coherent and cognitive function intact.

4.2 Following discussion with consultant psychiatrist 1 it was agreed to refer RA to a consultant psychologist at the Lister Hospital. The referral was made on 11 June 1990. An appointment was made for RA to see the consultant psychologist on 14 August 1990 but RA did not attend. A further appointment was arranged for 2 October 1990 and when RA again failed to attend the consultant psychologist wrote to consultant psychiatrist 1 discharging her back to his care.

1999-2001

4.3 There are no records of further contact with mental health services until July 1999 when RA did not attend an appointment with a psychology therapist at the Lister Hospital. The records do not show who referred RA to the psychology therapist or why she was referred.

4.4 On 4 September 1999 RA attended the accident and emergency (A&E) department at the Lister Hospital having taken an overdose. She was seen by a member of the mental health liaison team (name illegible on the records) before being discharged from hospital. The discharge form noted that RA was requesting counselling and that she would be discussed at the team meeting on 6 September.

4.5 RA attended for an initial assessment by the psychology therapist on 21 September 1999 who noted her concern about RA's recent impulsive suicide attempt. RA reported

having little resilience to stress and said she thought of doing it again when everything gets "*too much*" at home. This was reflected in her Clinical Outcomes in Routine Evaluation (CORE) score of 3.3 (maximum 4) on risk. The psychology therapist referred RA to consultant psychiatrist 2 at the Lister Hospital, for his opinion on whether there was an underlying incipient illness undermining RA's ability to cope.

4.6 On 8 October 1999 RA was seen in the outpatient clinic by the clinical assistant in psychiatry to consultant psychiatrist 2. The clinical assistant took full personal and family histories. He noted that RA had lived with her partner ND for 18 months but they were separated at the moment. Following mental state examination the clinical assistant concluded that RA "*suffers from a mild depressive illness secondary to stress and trauma she is going through with her present boyfriend plus guilt feelings about leaving her children with a childminder*". Prozac 20mgs daily was prescribed and RA was advised to see the psychology therapist again. A follow up appointment was made for three weeks later.

4.7 RA met the psychology therapist again on 12 October 1999 accompanied by her mother. She did not keep her next appointment on 19 October as she was unwell.

4.8 RA saw the clinical assistant in psychiatry again in outpatients on 29 October.

4.9 The psychology therapist referred RA to an occupational therapist at the mental health unit at the Lister Hospital, for the next anxiety management group.

4.10 On 2 February 2000 RA was reviewed in outpatients by the clinical assistant in psychiatry. RA reported that she still felt low and tended to become aggressive. She reported low frustration tolerance and being unable to relax. The clinical assistant prescribed, in addition to Prozac 20 mgs daily, Stelazine (spansules) 2 mgs for four weeks.

4.11 On 8 February 2000 RA was taken to A&E at the Lister Hospital following an overdose. She was assessed by the duty psychiatrist before discharge.

4.12 At her appointment with the clinical assistant in psychiatry on 16 February RA said she took the overdose the previous week on impulse as she was jealous because her boyfriend, who was in prison, had been receiving letters from another woman. RA's medication was to continue unchanged and a referral was made to a psychotherapist.

4.13 RA saw the clinical assistant in psychiatry again on 1 March 2000. She described the continuing problems with her boyfriend who she felt seemed to be controlling her life from prison. RA had stopped taking Stelazine as it made her feel drowsy. Dosage of Seroxat was increased from 20mgs to 30mgs daily. On 10 March 2000 RA attended another outpatient appointment with the clinical assistant. RA appeared to be making good progress. She was still not taking Stelazine. A prescription was given for Seroxat 40mgs daily.

4.14 RA did not attend appointments booked for 13 March and 20 March 2000 to discuss possible group therapy sessions with an art therapist. She also failed to keep appointments with the clinical assistant in psychiatry on 29 March and 31 May 2000. The clinical assistant wrote to RA's GP on 6 June 2000 to inform him that RA would not be sent a further outpatient clinic appointment but would be seen again if the need arose.

4.15 On 2 April 2001 RA was taken to A&E at the Lister Hospital having taken an overdose. She was seen in A&E by SHO2, locum SHO to consultant psychiatrist 2. SHO2 was the duty psychiatrist in A&E that night. He noted that apart from low mood and a marked reduction in appetite over the last months, there were no other distinct biological symptoms of depression. RA told him that when she was younger, in her early 20s, she had a problem with her food intake. SHO2's assessment was that there was, at that time, no high risk of a repeated suicide attempt. She was discharged from A&E. It was noted that she had an appointment to see SHO3, SHO to consultant psychiatrist 2, on 11 April 2001.

4.16 RA did not attend her appointment with SHO3 on 11 April. SHO3 wrote to RA on 17 April explaining that no further appointment would be offered at present. Advice was given to contact her GP should she wished to be re-referred to the mental health unit.

4.17 RA did not keep an appointment on 24 April 2001 to see the psychology therapist. The psychology therapist wrote to RA offering her the opportunity to make telephone contact if she would like to arrange another appointment.

4.18 On 6 June 2001 RA attended an appointment at the psychology department. The notes indicate that RA was "*ok today*". RA and the psychologist discussed problems in her relationship with her partner.

4.19 RA was admitted on 11 November 2001 to A&E at the Lister Hospital following an overdose of paroxetine, ibuprofen and Neurofen. RA described this to the duty psychiatric SHO as an impulsive overdose after a conversation with her partner. The SHO felt that she was mildly depressed with a reactive affect. RA did not express regret about the overdose. No phobias, fears or anxieties were found and there were no delusions or abnormal perceptions. RA was found to have normal cognition and full insight. The SHO's assessment concluded that there was not at that time a high risk of suicide. She was discharged from A&E with a prescription for a new antidepressant as she had not felt well on paroxetine and Seroxat. She was prescribed venlafaxine 75 mgs once a day. The SHO considered in addition to her mild depression, RA had some "*personality elements which need addressing*". He therefore felt that it would be appropriate for her to be seen by the psychologist for further assessment. The SHO wrote to RA's GP on 15 November 2001 reporting the outcome of his assessment. A copy was sent to the psychology therapist.

4.20 On 18 December 2001 the counselling psychologist at Stevenage Community Mental Health Centre, wrote to RA inviting her to meet a member of the mental health team.

2002-2003

4.21 On the evening of 23 January 2002 RA was taken by ambulance to A&E at the Lister Hospital following an overdose of codeine phosphate possibly taken with a large quantity of vodka. Advice on management was sought from the poisons unit at Guy's Hospital London. RA had written a suicide note. She was seen the following day by the mental health liaison nurse in the medical admissions unit. It was noted that she was medically fit at the time of assessment, having been on a cardiac monitor for the previous 12 hours. RA said that at the time of the overdose she had wanted to die but that she was now relieved that the overdose did not work. RA described emotional turmoil due to problems with her boyfriend and imminent eviction from her council flat. RA said that she now felt positive that things would be sorted out and she would continue with her antidepressant medication. Counselling sessions were to commence on the following Monday and RA would keep an appointment with the psychologist in March. RA agreed to see the mental health liaison nurse for a one-off support session on 26 January. RA stated that she did not (now) feel suicidal and wanted to go home. The mental health liaison nurse discussed and agreed the discharge plan with the duty psychiatric SHO and RA was discharged from hospital.

4.22 RA was seen three days later on 26 January 2002 at 4.30am by the on-call SHO in psychiatry in A&E at the Lister Hospital. She had been brought in by ambulance and the police. RA's mother had called the police who had broken into RA's flat and found her with a bandage around her neck and tied to a banister. She had drunk half a bottle of vodka and had with her a long goodbye letter to her relatives. RA described problems in the relationship with her partner as one of the main causes of her distress. Mental state examination found her mood to be subjectively "*had enough*" and objectively *"rather flat effect, low mood"*. No abnormalities were found in thought or perception. Insight was assessed as limited. RA did not recognise alcohol as her main problem. An impression was formed of deliberate self harm secondary to alcohol abuse. Difficult social circumstances with numerous stresses were noted. The notes on risk assessment stated:

> "*Low to moderate risk of self harm. No true potentially fatal suicide attempt however frequent deliberate self harm. No mental disorder, no illicit drug use. Says she is not suicidal at the moment. However stresses remain. Patent does not wish for admission as she does not want to be surrounded by mentally ill patients. Recognises that hospital admission can't change her current situation."*

4.23 According to the notes, the plan was for RA to be discharged home with a police escort and for her to be seen the following day by the mental health liaison nurse. Counselling would commence on the next Monday and she would keep her appointment with the psychologist in March.

4.24 The next entry in the mental health notes records that on 4 March 2002 RA was seen by a senior charge nurse from the community alcohol team, having been referred by the mental health liaison nurse. RA said that she did not have an alcohol problem. She did not see herself ever giving up alcohol and felt in control of her past alcohol problems. She indicated that her main problem was one of stress related depression. RA felt that her mental state was stable. She had an outpatient appointment with a psychiatrist on 18 March. RA did not want further appointments with the alcohol service. She was advised that if alcohol became a problem in the future she could be re-referred by her GP or the psychiatrist. She was therefore discharged from the care of the community alcohol team.

4.25 RA did not attend her appoint on 18 March 2002 with the counselling psychologist or her appointment on the same date with consultant psychiatrist 3, locum consultant

psychiatrist. RA also cancelled a rearranged appointment with the counselling psychologist on 18 April 2002.

4.26 RA was reviewed in outpatients on 18 April 2002 by consultant psychiatrist 3. He noted that RA was due to attend court on 17 June having been charged with disturbance of public order. Consultant psychiatrist 3 considered that she had a long standing personality disorder with depressive episodes. He referred her for a psychological assessment and noted he would see her again in six weeks.

4.27 RA cancelled her rearranged appointment with the counselling psychologist on 29 April 2002.

4.28 On 30 April 2002 RA was seen at the medical assessment unit at the Lister Hospital by the mental health liaison nurse following another impulsive overdose under the influence of alcohol. It was noted that she no longer felt suicidal. Future appointments with consultant psychiatrist 3 and the counselling psychologist in May were noted. She was discharged from the medical assessment unit with no further input planned from the liaison team.

4.29 RA attended her rearranged appointment with the counselling psychologist on 30 May 2002. They discussed her impulsive overdoses, her relationship with her partner and her drinking. A further appointment was made for 11 July.

4.30 RA did not attend her appointment with consultant psychiatrist 3 on 1 July 2002.

4.31 On 2 July 2002 RA was taken by the police to A&E at the Lister Hospital. She had telephoned her sister to tell her she was going to kill herself. RA was seen by a mental health liaison nurse, and SHO4, the duty SHO in psychiatry. They found no evidence of mental illness. She had not taken an overdose but had drunk a minimum of half a bottle of vodka. Admission to hospital was not considered appropriate. RA was discharged with advice to keep her appointments and to contact the alcohol team.

4.32 RA met the counselling psychologist again on 11 July 2002.They discussed support from the children and families (social services) team concerning her daughter, relationships, drinking and her recent attendance at A&E. A further appointment was made for 7 October 2002.

4.33 RA had an appointment to see consultant psychiatrist 4, locum consultant psychiatrist, on 25 July 2002 but there is no record of her attendance. She did not keep a further appointment with consultant psychiatrist 4 on 29 August.

4.34 The appointment with the counselling psychologist on 7 October was cancelled by the psychology department due to unforeseen circumstances and RA failed to attend an appointment with consultant psychiatrist 4 on 17 October.

4.35 When RA failed to keep an appointment on 18 November 2002, the counselling psychologist wrote to her asking if she required further appointments.

4.36 On 2 December 2002 a social worker from the (children and families) referral and assessment team advised the counselling psychologist that RA had moved to Kent at the end of October. On the same date RA telephoned the psychology department to inform them that she was moving to Devon and no longer required their service. She was therefore discharged from the care of the psychology department.

4.37 There is no record of any further contact with mental health services until May 2003.

Admission to the Lister Hospital

4.38 RA was admitted to a mental health ward at the Lister Hospital on 8 May 2003. She had been brought in by the police under section 136 of the Mental Health Act 1983. RA had been reported missing from her home in Maidstone, Kent, by members of her family. The police had found her in her car behind a public house with a hose attached to the exhaust and fed into the car. The engine was running. There was a large knife on the back seat. RA was assessed by a consultant psychiatrist, a second medical practitioner and an approved social worker (ASW). The medical practitioner noted that there had been five previous suicide attempts in the past four years. RA was still "*suicidally ideated*" and was unhappy and resistant to staying in hospital. She was detained at 6.30pm for assessment under section 2 of the Mental Health Act 1983. The ASW subsequently spoke to a social worker in Kent who informed her that RA's two children were on the Child Protection Register.

4.39 On arrival at the mental health ward RA was placed on 15 minute nursing observations. Nursing staff arranged for RA to be transferred to inpatient mental health services at Priority House in Maidstone but it was noted that RA was "*not keen*" on the transfer. Following further assessment by a member of the psychiatric medical team (the designation of the doctor is not clear from the notes) later that day, RA was placed on continuous nursing observation and moved to a side room.

4.40 A discharge checklist was completed at 8.15pm on 8 May 2003 and RA was transferred to James Huxley Unit, Priority House in Maidstone.

Transfer to Priority House

4.41 The nursing notes indicate that RA appeared well settled on admission to Priority House. The notes refer to ongoing problems with RA's partner. He was no longer allowed to contact RA as he was subject to an injunction. RA was on a probation order and needed to attend court the following day. There was no explanation in the notes at this point as to the reason for the court appearance.

4.42 A mental health risk assessment was undertaken at Priority House on 8 May 2003. It noted RA's history of self harm or attempted suicide and made reference to the knife found in the back of her car at the time of the most recent suicide attempt. At the time of the risk assessment she was denying any suicidal thoughts but this attempt was not regretted. The assessment noted: *"Use of cocaine from her ex boyfriend - occasional. Was drinking prior to suicide attempt but says she is not a regular drinker."* The plan was to:

- continue her medication (venlafaxine 150mg XL daily; sodium valporate 300mg daily and temazepam 10mg nocte)
- undertake 10 minute (level 3) nursing observations; No leave to be granted
- undertake routine blood tests.

4.43 RA was assessed the following day by SHO5, SHO to consultant psychiatrist 5. He noted that RA was impulsive and had difficulty controlling her anger. This had resulted in a probation order for 18 months. RA's partner ND was constantly harassing her and her family. The police had warned ND to leave them alone. The notes refer to RA as using cocaine occasionally – "*had it last weekend*".

4.44 Nursing notes taken at Priority House on 10, 11 and 12 May 2003 were written on Lister Hospital headed patient notepaper.

4.45 On 12 May 2003 RA was assessed by Dr A (designation not given in the notes). RA said she was feeling much better. Her ex-partner was subject to an injunction requiring him not to contact her. She did not have any suicidal ideas or plans. RA was missing her job and wanted to arrange school for her children. She was happy to remain on the unit informally and to take medication. The plan was to:

- discharge from section 2
- chase up her primary care counselling
- plan for her discharge.

4.46 Following Dr A's assessment level 3 observations were lifted and discharge was planned for 14 May.

4.47 On 13 May 2003 a social worker from the children and families team telephoned and was informed that RA would be discharged on 14 or 15 May.

4.48 RA was seen on 14 May 2003 by SHO5. It was noted that there was no evidence of acute mental illness, no features of depression and that there were no suicidal ideas or plans. RA agreed to follow up and aftercare. She was keen to have counselling as soon as possible. Her probation officer had been contacted. SHO5 contacted the GP's surgery about counselling and the GP agreed to call back.

4.49 The GP called back at 1pm on the same day and agreed to expedite counselling.

4.50 RA was discharged from Priority House on 14 May 2003. A hospital discharge statement was completed by SHO5 and copied to RA's GP. A diagnosis of acute stress reaction and emotionally unstable personality disorder was recorded. Arrangements were made for follow up by the Kingswood Community Mental Health Team (CMHT). A care programme approach (CPA) care plan summary details (part 1) form CPA3 was partially completed. It included contact details for a community psychiatric nurse (CPN) and RA and completed sections on crisis and contingency plans and action to be taken in the event of a relapse. It was not signed or dated but referred to an interim action plan.

4.51 The interim action plan was recorded on form CPA/2a by a staff nurse and dated 14 May 2003. It did not include any recording of current mental health needs, risks or contingency plans. Desired outcomes were not noted. The actions recorded were:

> *"1. S Worker (Children's) to be informed of* RA's *discharge + probation officer.*
> *2. OPA 2/52.*
> *3. Dr to speak to GP re being put on priority list for counselling*
> *4. TTO's supplied for 2/52. Discharge."*

4.52 An outpatient appointment was arranged for 5 June 2003 but RA did not attend.

Follow up after discharge from Priority House

4.53 A follow up assessment was undertaken at the Kingswood Community Mental Health Centre (CMHC) on 12 June 2003 by the CPN. She wrote to RA's GP on 20 June providing a detailed report of the assessment. In the section on 'Mental Health Problems/Risks' the CPN stated that RA was in James Huxley Ward for one week "*and won her appeal*" and was discharged. (The notes make no reference to any appeal to a mental health tribunal and this appears to be an error in the assessment report.)

4.54 A full and detailed mental health assessment was carried out. It included reference to RA feeling that things had improved. RA felt more focused and was now back at work full time. RA's history of overdoses was summarised. Reference was made to RA's volatile relationship with her ex-partner. Harassment by ND was reported by RA in the form of his contacting her boss, texting members of her family and disclosing private conversations. She had finished the relationship. RA was reported as feeling that she was sexually abused by her ex-partner. The report indicates that RA categorically denied any intent or plan to attempt suicide at the present time. RA was clear that she wanted to attend for counselling. No psychotic features were elicited or admitted to. RA said that her mood had improved since her admission to hospital. Her concentration was described as normal and her cognition was intact.

4.55 The CPN discussed the possibility of psychotherapy with RA. However, as RA was already on the waiting list for primary care counselling, it was decided that the CPN would not act on the psychotherapy referral. In the summary the CPN highlighted RA's self harm related to intoxication and impulsive actions. She stated that RA's previous difficult

relationship had now ended. RA was described as having good insight into her difficulties and being keen to engage in primary care counselling. The CPN reported that she would be discharging RA from the intake team at Kingswood and that RA agreed with that decision. RA had a list of emergency contact numbers including the CMHC duty system should a crisis occur or if she began to fell mentally unwell. RA had an outpatient appointment with consultant psychiatrist 5's team on 14 July 2003.

4.56 The CPN also completed a risk assessment on 12 June 2003 and recorded it on the mental health risk assessment form CPA4. It noted that *"risk* [of attempted suicide] *occurs when intoxicated and is impulsive"*. Under the heading 'Risk of Harm to Others' RA's past forensic history was noted:

> *"Fighting in pubs and assaulting police – breach of the peace – never in prison - 6 convictions – currently has a probation officer – one year to run."*

4.57 No further details of convictions or sentences were included in the notes. Risks associated with substance/alcohol misuse were noted in the present and past.

4.58 RA did not attend her outpatient appointment on 14 July. A further appointment was made for 13 October 2003 but RA did not attend.

The homicide

4.59 On 26 October 2003 RA was arrested and later charged with the murder of her ex-partner.

5. Key issues from RA's care and treatment

Introduction

5.1 The investigator and the expert group (see paragraph 2.4) identified the following key issues from examination of case notes and the chronology:

Care and treatment in Hertfordshire

- Coordination of care and treatment
- Risk assessment
- Clinical management
- Non-attendance at appointments and managing engagement
- Transfer of patients to other NHS mental health trusts

Care and treatment in Kent

- Transfer of records from other NHS mental health trusts
- CPA on discharge from hospital
- Medication on discharge from hospital
- Non-attendance and gaps between appointments
- CMHT assessment and discharge

5.2 These issues provided a framework for discussions between the investigator and current senior managers from the two NHS trusts. In view of the time elapsed since the homicide the discussions focussed on how services had changed and developed since 2003 and how services would respond to similar circumstances and presentation today.

Care and treatment in Hertfordshire

Coordination of care and treatment

5.3 The chronology and clinical records showed RA's care and treatment to have been fragmented between disciplines. For example there was little evidence of communication between psychiatry and psychology and vice versa and in April 2001 RA was medically discharged but remained open to psychology.

5.4 RA was not allocated to a care coordinator other than a clinical assistant in psychiatry (October 1999 to May 2000), an SHO (April 2001) and a locum consultant psychiatrist (April 2002). In the period between September 1999 and May 2003 RA made multiple suicide attempts. Her care and treatment was reactive rather than proactive.

5.5 There is little evidence from the clinical records of long or short term goals having been set and agreed with RA. There was no plan in place for managing her self-harming behaviour. She was referred to alcohol services but there was little reinforcement of her need to engage with them and therefore no proper exploration of the degree of her alcohol problem. Although there is reference in the notes (in 1990 and 1999) to her children, there appeared to be no contact with safeguarding (child protection) services until they made contact with the trust in 2002 to advise that RA had moved to Kent.

5.6 The clinical records show that RA discussed her relationship with ND with five different mental health professionals in Hertfordshire on eight occasions between October 1999 and July 2002. During this period RA described her feelings of jealousy about contact between another woman and ND while he was in prison and her view that ND was controlling her from prison. The records refer to reports by RA of an injunction against ND to prevent him contacting her in the light of ND's harassment of RA and her family. RA's relationship problems with ND were identified as one of a number of factors causing her distress.

5.7 The current trust managers agreed that coordination had been inadequate. If the same situation presented in 2010 a care coordinator would be allocated from the CMHC and a responsible medical officer (RMO) would be allocated. In present services a clear care pathway would be established and recorded. This would include referral regarding potential safeguarding issues in respect of RA's children. It may also include referral to

specialist personality disorder services (although it is accepted that RA's personality problems emerged gradually during her care and treatment and were not diagnosed as a personality disorder until her admission to Priority House in Maidstone in May 2003). The care coordinator would be responsible for supporting and reinforcing the need for engagement with alcohol services. This would now normally include a joint meeting attended by the care coordinator and a member of the community drug and alcohol team (CDAT). The care coordinator would also be responsible for developing a crisis plan in agreement with the service user.

5.8 The trust's crisis and assessment teams (CATs) now have an operational policy which refers to the National Institute for Clinical Excellence (NICE) guidelines (July 2004) for self harm. The policy requires the guidelines to be followed. The A&E mental health liaison teams now form part of the CATs. This has improved liaison between A&E and mental health services. The trust's electronic clinical records systems is now fully implemented and CAT staff, including those working in A&E departments, have access to mental health records.

5.9 The trust has led the establishment of a county wide multi-agency suicide prevention group which has considered compliance with the NICE guidelines. The director of quality and safety has been asked to coordinate work on training for acute heath services staff on key mental heath issues.

5.10 The trust's current managers explained that in similar circumstances today, in the light of the service user's vulnerability, the care coordinator would make an assessment under the trust's safeguarding adults policy and procedures. A safeguarding meeting would be called. Protection and action plans would be agreed. In RA's circumstances the safeguarding meeting would now prompt a referral to the trust's lead nurse for safeguarding children and to contact with colleagues in the local authority children's services. Documentation in the trust's CPA records system would also prompt such referrals. In the past year, a child risk form in the electronic records system has become a mandatory field for completion. (This means that the recorder cannot move on to the next stage of recording before making an entry about child risk factors).

Findings

5.11 The coordination of RA's care and treatment was inadequate.

5.12 The clinical notes do not indicate any in-depth exploration of RA's relationship problems with ND. It is not clear from the records whether this was because the mental health professionals were not provided with sufficient information by RA to warrant further exploration or whether the lack of further investigation was an omission on their part. Had better care coordination of RA's care and treatment been in place, it is possible that the need for further consideration of the relationship problem may have been identified. However, it has not been possible to reach any conclusions on this matter in the absence of interviews with the staff involved or with RA.

5.13 There is evidence (from examination of policy documents and our meeting with trust managers) of changes and improvements in policy and practice since 2003. This should mean that in similar circumstances today proper care coordination would be put in place to facilitate and implement a clear care pathway and plan.

Risk assessment

5.14 There was an absence in RA's clinical notes of formal risk assessment documentation. Where risk was mentioned it focussed on RA's risk to herself.

5.15 Current trust managers confirmed that trust policy now requires a more formalised approach to risk assessment and management. Mandatory training in risk assessment was now in place and additional expert training was implemented for CAT teams. The electronic records system has a separate compartment to show the service user's risk history.

5.16 The trust now monitors compliance with its risk assessment and management policies through clinical supervision and via clinical audit programmes. In addition a process for learning from untoward incidents is in place using practice governance forums and patient safety groups. A trust wide learning lessons and clinical risk group now pulls together clinical risk issues at a strategic level. A learning database has been established to track learning identified from internal and external investigations.

Findings

5.17 Although there is evidence in the notes that RA's risk to herself was identified and discussed, there is no evidence of formal recorded risk assessment.

5.18 Improvements to policy, procedures and practice since 2003 mean that a service user with similar circumstances and presentation to RA would today be subject to formal risk assessment. Risk history would now be readily accessible through the electronic record system.

5.19 Robust arrangements have been implemented in the trust to monitor compliance with risk assessment and management policy and to ensure that lessons are learned from untoward incidents.

Clinical management

5.20 RA was under the care of a consultant psychiatrist but there is no evidence that he ever met her. She was seen by a clinical assistant, an SHO and two locum consultant psychiatrists. There is no evidence in the records of discussion between the junior psychiatrists, locums and the consultant about RA's care and treatment.

5.21 The trust's current managers reported that there would now be a clear expectation of discussion between junior medical staff and consultant psychiatrists through junior doctor supervision. This is set out in a framework for delegation to junior doctors. They added that there was now strong clinical leadership within the trust. In each directorate there are now joint heads of service in place. Under these arrangements a senior manager and a senior clinician work together on how services are managed and operated and to ensure that policies are implemented and compliance is monitored.

5.22 RA's diagnosis was never clearly formulated. The expert panel accepted however that this may well have been because the complexity of her symptoms and presentation made it difficult to do so.

5.23 The expert panel considered the medication provided for RA. They felt that the use of anti-depressants seemed entirely reasonable but questioned the quantity of supply in single prescriptions given RA's risk history of overdoses. RA was also prescribed antipsychotics, probably to try to manage mood difficulties and anxiety. The panel noted that these are not recommended in the NICE guidelines for patients with personality disorders. However it was also recognised that RA was not formally diagnosed as having a personality disorder until May 2003 – after her move to Kent. There was a lack of a clear

medication plan in the notes and an absence of formal reviews (although it is accepted that medication was reviewed at outpatient appointments). There was also an absence of a link between medication and risk assessment.

5.24 The trust's current managers reported that there is now a clear expectation that a medication plan forms part of the service user's overall care plan and that copies are always sent to the service user's GP. Prescribing patterns and individual prescriptions are now subject to much greater scrutiny by pharmacists. In 2003 the trust was reliant on the neighbouring acute NHS trust for pharmaceutical services. This is now the responsibility of a designated chief pharmacist within the trust. Prescribing patterns are monitored by the trust's drugs and therapeutics committee. The trust has recently participated in national audits on prescribing to gain wider intelligence on prescribing patterns.

5.25 Risk is now reviewed at each presentation and junior doctors are prompted to record this via the electronic record system. It is the responsibility of the care coordinator to regularly review recording of risk assessments and the updated risk history.

Findings

5.26 RA never met her consultant psychiatrist. She was seen by a succession of junior doctors and locum consultants. Communication between the consultant and junior psychiatrists appeared to be poor.

5.27 Given the time elapsed since the homicide it was difficult to establish the extent to which the apparent inadequacy of clinical leadership in RA's management was systemic or individual. It would in any case have been a reasonable expectation for the consultant psychiatrist to have met RA and to have exercised clinical oversight of her care and treatment. There is no evidence from the records that this happened.

5.28 The evidence from our meeting with current trust managers in Hertfordshire is that a care coordinator and a responsible medical officer (RMO) would now be allocated in such a case.

5.29 The quantity of medication given to RA in single prescriptions was high given her risk history of overdoses. There were no recorded medication plans and no link appears to be made between medication and risk.

5.30 The framework for delegation to junior doctors and supervision arrangements now in place should ensure that communication between consultant and junior medical staff is adequate.

5.31 The evidence from our meeting with current trust managers is that the establishment of the trust's own arrangements for pharmaceutical services has improved the monitoring of prescribing patterns.

5.32 Improved care coordination arrangements and the electronic records system should now ensure that appropriate links are made between medication and risk.

Non-attendance and gaps between appointments and managing engagement

5.33 RA failed to attend many of her appointments with psychiatrists and psychologists.

5.34 The current trust managers explained that an outpatient steering group, chaired by the associate medical director, had been set up to consider and develop an approach to managing the engagement of service users who do not keep appointments. Pilot schemes to improve attendance have been rolled out in CMHC's. Decision making about discharge of patients following non attendances is now much more robust than in 2003.

5.35 There were some examples of long gaps between RA's appointments. They were not all to do with her non-attendances. For example, there was a gap of six weeks between her psychology counselling appointments at a time when she had recently made two suicide attempts.

5.36 The trust's current managers commented that decisions about intervals between appointments are now centred on the service user's needs, in accordance with the care pathway and care plan and monitored by the care coordinator.

Findings

5.37 RA's failure to keep appointments was not well managed. Decisions about appointment intervals appeared to have been taken bureaucratically and without consideration of RA's individual needs.

5.38 The policy and procedural framework for ensuring that service users remain engaged with services is much improved since 2003. The evidence from our meeting with trust managers is that improved care coordination arrangements together with the work in CMHCs to encourage engagement and reduce non attendances, should bring further improvements.

Transfer of patients to other NHS mental health trusts

5.39 RA was transferred in May 2003 from the Lister Hospital to Priority House in Maidstone. The notes provide no evidence of adequate communication with services in Kent, other than a completed discharge summary.

5.40 The trust's current managers explained that there was now a clear expectation in the current policies and procedures covering transfer that as much information as possible will be shared. In case of urgent transfer (such as RA's) this should be done by secure fax. It would also be expected that one to one discussions would take place between doctors and between the respective ward managers. The absence of a care coordinator in RA's case resulted in the lack of a CPA transfer meeting. In the same circumstances today it would be expected that the care coordinator would be involved in the transfer decision and in convening a pre-discharge CPA meeting. The current individual care plan, including the most recent (pre-discharge) risk assessment would be sent to the receiving service before or at the time of transfer.

Findings

5.41 Communication between the inpatient units at the time of RA's transfer was poor. (See also paragraph 5.43 below).

5.42 The current policy framework in the Hertfordshire Partnership NHS Foundation Trust covering transfers between outpatient units is more robust than in 2003. Improved care coordination arrangements should also have strengthened preparations for discharge and communication between transferring and receiving trusts.

Care and treatment in Kent

Transfer of records from other NHS mental health trusts

5.43 At the time of RA's transfer in May 2003 from the Lister Hospital in Stevenage to Priority House in Maidstone there was a lack of adequate information and communication between the trusts.

5.44 The current Kent and Medway Partnership NHS Trust managers confirmed that the expectation would now be for the transferring trust to provide adequate records before or on transfer, if necessary by secure fax. This should include history and care plans including risk history. There were however still some issues nationally about adequacy of information in cases of urgent transfer. It would now also be an expectation now for a CPA review to take place wherever possible before such a transfer and for this to involve appropriate staff from the receiving trust.

Findings

5.45 Communications between the inpatient units in Hertfordshire and Kent at the time of RA's transfer in May 2003 were poor.

5.46 The policy framework covering transfer of records and communication with other NHS trusts about transfer of patients is now more robust than in 2003.

CPA on discharge from hospital

5.47 When RA was discharged from Priority House on 14 May 2003 there was good liaison by telephone from ward staff to RA's GP, children's social services and the probation service. All were appropriately informed of the discharge. Arrangements were made for follow up by the Kingswood CMHT. However there was no pre-discharge CPA review and the CPA documentation on discharge was only partially completed.

5.48 The trust's current managers confirmed that it was now a clear requirement of care pathways policy (incorporating CPA policy) for all documentation to be completed. The policy now includes reference to the role of crisis teams. Compliance with these policy requirements is monitored through supervision. A standard CPA supervision tool is in

use across the trust. Current practice is to review two cases at each supervision meeting. In addition as soon as a referral is received (including transfers from other trusts) a care coordinator is now allocated. The electronic record system allows scrutiny of care coordinator allocation, frequency of reviews and completion of documentation. A mandatory field in the system requires the completion of all documentation. The scrutiny feeds through to the trust's key performance indicators. Team managers receive regular reports on performance of their teams.

5.49 The trust managers explained that assessments and decisions about discharge of patients with a history of self harm are now in accordance with NICE guidelines. Operational policies are in place for mental health liaison services in each A&E department.

5.50 The former West Kent NHS and Social Care Trust's clinical practice review completed in March 2004 investigated events leading up to the homicide and made 13 recommendations. An action plan updated in October 2004 showed progress on implementation of agreed actions.

5.51 Discussion with current trust managers focussed on five recommendations of the clinical practice review:

- Recommendation 6: "*When a patient not open to the CMHT is admitted as an inpatient the Intake Team should be informed as soon as possible to enable them to establish contact with the patient to avoid duplicating assessments.*"

- Recommendation 7: "*A care coordinator must always be identified prior to discharge from hospital unless the patient is being discharged from West Kent NHS and Social Care trust.*"

- Recommendation 8: "*Whenever possible all other agencies involved in the care of a patient must be given appropriate notice prior to a CPA review.*"

- Recommendation 9: "*Trust approved CPA documentation must be used consistently across the Trust to standardise documentation.*"

- Recommendation 10: "*Hospital discharge summaries need to be completed within an agreed time frame.*"

5.52 Recommendation 6: Current trust managers explained that a named worker from the intake team is now allocated to each inpatient ward. Details of all new admissions are faxed to the intake team and the home treatment team is involved whenever appropriate.

5.53 Recommendation 7: Allocation of a care coordinator prior to discharge from hospital is now a policy requirement and now happens in practice.

5.54 Recommendation 8 has been implemented. For planned discharges, CPA reviews are now arranged with adequate notice to partners in providing care and treatment. When discharges happen quickly in the best interests of the patient, the trust's crisis team takes responsibility for organising the CPA review post discharge and for involving partner agencies in accordance with the current care pathways policy.

5.55 Recommendation 9: Current trust managers confirmed that a care coordinator is now appointed prior to the discharge of the patient from hospital. This is now a requirement in the electronic record system and is monitored across the trust.

5.56 Recommendation 10: A trust standard to complete hospital discharge summaries within two weeks is now in place. Information about discharge is now sent immediately to GPs. However, full discharge summaries are still sometimes delayed beyond the two week standard due mainly to rotation of junior doctors. The trust is continuing to work towards fully achieving this standard.

Findings

5.57 No CPA review was undertaken before RA's discharge from Priority House in May 2003 and no care coordinator was allocated before discharge. Information about RA's discharge was communicated quickly and appropriately to RA's GP and other agencies. The full discharge summary was not sent to the GP until more than three weeks after the discharge.

5.58 The policy and procedures framework for care pathways (incorporating CPA) is now much more robust than in 2003. There is evidence from our meeting with trust managers

in Kent that good monitoring arrangements are now in place to ensure compliance with policy on allocation of care coordinators prior to hospital discharge.

5.59 Some problems still remain in meeting the trust's standard covering timeliness of completing hospital discharge summaries.

Recommendation

R1 The Kent and Medway NHS and Social Care Partnership Trust should include in its programme of clinical audit a review of the timeliness of completion of hospital discharge summaries and sending them to patients' GPs and, where appropriate, to other agencies.

Medication on discharge from hospital

5.60 On discharge from Priority House, RA was prescribed "*TTO's for 2/52*" – (to take out for two weeks) venlafaxine XL 150 mg and Epilim Chrono MR 300mg. The prescription of an anti-depressant and a drug to stabilise mood was appropriate. However in view of RA's history of overdoses there may have been some risk in prescribing a two week supply of the drugs.

5.61 The current trust managers commented that prescriptions for two weeks of medication on discharge from hospital remain standard practice. However in cases where there is a high risk of overdose a smaller supply would be prescribed. The decision on quantity would be linked to a risk assessment and a risk management plan on discharge.

Non-attendance and gaps between appointments

5.62 When RA did not attend her outpatient appointment on 5 June 2003 she was sent another appointment for 14 July which again she did not attend. She was then sent another appointment for 13 October 2003 which she also failed to attend. The consequence was that RA was not seen between 12 June and 13 October - when the homicide was committed.

5.63 Current trust managers explained that such gaps between appointments were unlikely to happen today. The trust is changing its services to remove traditional outpatient clinics. Consultant psychiatrists are now part of access teams and all referrals

are allocated to a member of the access team. The current trust protocol for the management of non-attendance (DNA) for clinical appointments, implemented in April 2007 and reviewed in 2009, makes clear the requirements and responsibilities for contact with patients and timescales for such contact. Discharges from hospital are now all followed up by telephone contact after 48-hours and by personal contact with the allocated community team member after seven days. The DNA protocol now requires decisions about frequency of appointments to be recorded. Data is used to monitor performance against trust key performance indicators about attendance and managing patient engagement with services.

Findings

5.64 There were weaknesses in the systems to ensure that RA remained engaged with services.

5.65 Policy and systems within the trust for managing patients who do not attend appointments are now much more robust than in 2003.

CMHT assessment and discharge

5.66 The trust's clinical practice review in March 2004 found the CPN's assessment on 12 June 2003 to be "*good and comprehensive*" and to "*include a thorough risk assessment*".

5.67 However, the CPN's assessment report which was completed almost a month after discharge, showed that she believed that RA had "won *her appeal*" prior to discharge, although there is no evidence in the records of any mental health tribunal hearing. The records show that RA was discharged from section 2 of the Mental Health Act 1983 by a psychiatrist at Priority House. Whilst this misunderstanding was a consequence of the absence of a CPA review discharge planning meeting and the failure to allocate a care coordinator to RA prior to discharge, it had no bearing on the quality of an otherwise thorough assessment.

5.68 Improvements since 2003 in pre-discharge review arrangements and in the appointment of care coordinators prior to discharge are described in paragraphs 5.47 to 5.59 above.

5.69 The CPN's risk assessment was thorough but it made no reference to the knife found in RA's car at the time of her most recent suicide attempt in May 2003, despite this being recorded in the notes of her admission to Priority House. It is not clear what detail of information the CPN had at the time of the assessment.

5.70 The current trust managers confirmed that information was now transferred electronically from inpatient to community services at the time of discharge from hospital. This would now ensure that information, such as the possession of a knife, would be immediately available to care coordinators. In addition safeguards are now in place via the electronic records system to ensure that all key risk history is recorded and summarised for ease of reference.

5.71 Although reference was made in the CPN's assessment report to RA's six previous convictions there was no detail recorded of this forensic history.

5.72 The current trust managers explained that there is now a field in the electronic record system which requires recording of known forensic history and that this is linked to the section on risk assessment and management.

5.73 The CPN and RA agreed that RA would be discharged from the CMHT and that was communicated to the GP on 20 June 2003. The decision to discharge was taken in the knowledge that RA had an outpatient appointment on 14 July 2003 (which she did not keep). The records do not show whether the CPN took the decision to discharge alone or in consultation with other team members.

5.74 The current trust managers confirmed that in accordance with current policy all discharges from CMHT's are now signed off in supervision or, for complex cases, following a CPA review.

Findings

5.75 This independent review agrees with the trust's clinical practice review that the CPN's overall assessment of RA on 12 June 2003 was of a good standard. However there was a misunderstanding in the assessment report about the circumstances of RA's discharge from her section under the Mental Health Act 1983. There was also an absence

in the risk assessment of reference to a large knife found in RA's car at the time of her most recent suicide attempt and a lack of detail of RA's forensic history.

5.76 The reasons for the misunderstanding and omissions are not clear from the records. However it is likely that a major contributory factor was the failure to appoint a care coordinator prior to RA's discharge from hospital and inadequate communication of information between Priority House and the CPN. In the light of an otherwise exemplary assessment it is likely that the weaknesses were systemic rather than the responsibility of the CPN.

5.77 There is evidence (from examination of policy documents and our meeting with current trust managers) of significant improvement in policy and practice in the trust since 2003 relating to:

- appointment of care coordinators on hospital discharge
- communication between inpatient and community services
- the patient records system including recording and summarising risk and forensic history
- clinical supervision, including the process for decision making about discharge from trust services.

6. Conclusions and recommendations

Conclusions

6.1 RA's care and treatment in both trusts was poorly coordinated. There were weaknesses in Hertfordshire in the process of risk assessment and in the absence of continuity of care from psychiatrists. In both trusts there was a lack of linkage between decisions about quantity of medication prescribed and the management of risk. The management in both trusts of RA's failure to keep appointments was not proactive. Sharing of information between the trusts at the time of RA's transfer from Hertfordshire to Kent was inadequate.

6.2 There have been significant organisational and structural changes within the trusts since 2003.

6.3 In both trusts policies and procedures covering care pathways (CPA) including risk assessment and management, care coordination, clinical supervision and transfers of patients between trusts have been updated and significantly improved. Both trusts now fully operate electronic record systems which provide instant access for staff to key information and help to monitor compliance with policy and performance against trust standards.

6.4 The action plan established by the former West Kent NHS and Social Care Partnership Trust following the internal clinical practice review has been implemented.

6.5 In view of the significant improvements in policies and systems in both trusts since the homicide in October 2003 and in the light of the long time elapsed between the homicide and this investigation we make only one recommendation.

Recommendation

R1 The Kent and Medway NHS and Social Care Partnership Trust should include in its programme of clinical audit a review of the timeliness of completion of hospital discharge summaries and sending them to patients' GPs and, where appropriate, to other agencies.

Appendix A

Documents reviewed

National policy and guidelines

- HSG 94(27) - *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-36, Department of Health, 1994/2005
- Guideline – Self harm, National Institute for Health and Clinical Excellence (NICE), 2004
- Clinical Guideline 78 – Borderline personality disorder, NICE, 2009

Internal investigation reports

- Clinical practice review, West Kent NHS and Social Care Trust, May 2004

Clinical records

- RA's clinical records – Hertfordshire, 1990-2003
- RA's clinical records – Kent, 2003
- RA's primary care records

Hertfordshire Partnership NHS Foundation Trust policies and procedures

- Policy on clinical risk assessment and management, April 2002
- Clinical risk assessment and management, June 2008
- Discharge policy, September 2002
- Discharge/transfer within the care planning process, February 2010
- Inpatient nursing care plan policy and procedure, 2003
- Care coordination policy (Incorporating the Care Programme Approach), October 2008
- Role and function of the named nurse/associate nurse in developing care and treatment plans, January 2009
- Crisis assessment and treatment teams operational policy, February 2006
- Policy procedure and guidance on the management of care records, August 2002
- Care records management policy, April 2010

- Supervision policy, July 2008
- Policy and procedure for managing the risks associated with safeguarding children and child protection, July 2010
- Safeguarding adults from abuse policy and procedures, April 2010

Kent and Medway NHS and Social Care Partnership Trust policies and procedures

- Medicines policy (West Kent Trust), July 2003
- Medicines management policy, October 2009
- Policy on clinical risk management training (West Kent Trust), January 2006
- Discharge policy (West Kent Trust), September 2002
- Care Programme Approach policy and procedures, September 2002
- Authorised risk assessment tools (West Kent Trust), April 2002
- Clinical risk assessment and management, April 2010
- Care pathways policy (incorporating Care Programme Approach), April 2010
- Protocol for the management of non attendance at clinical appointments (West Kent Trust), November 2005
- Protocol for the management of non attendance at clinical appointments, April 2007