Niche
PATIENT SAFETY

An Independent Investigation into the care and treatment of a mental health service user in Kent

October 2013

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1.0 EXECUTIVE SUMMARY

Mr. B was admitted to hospital following three attempts to harm himself during a short period of time. Mr. B had no psychiatric or self-harm history. In December 2005 Mr. B was admitted to a psychiatric ward on a Section 2 of the Mental Health Act. He was expressing beliefs that his neighbours were persecuting and threatening him, his wife, and his home, and that he could hear them talking in the night. His wife stated she had not experienced this.

Following a short spell in hospital and the introduction of anti-psychotic medication Mr. B appeared less agitated and agreed to take to engage with the CMHT and continue to take medication on discharge. Consequently on 4th January 2006 Mr. B was discharged from his Section 2 and from the ward.

On the day of discharge from hospital Mr. B was still having paranoid thoughts about his neighbours but then denied this two days later, on 6th January 2005.

Following discharge from hospital Mr. B was seen consistently in the community by a Community Psychiatric Nurse (CPN) and a Consultant Psychiatrist (CP) and his anti-psychotic medication was reduced slowly over time to a low dose of an anti-psychotic medication.

In April 2007 Mr. B was discharged back to the care of his GP and on the same day, his anti-psychotic medication was stopped.

On 9th August 2007 mental health services were contacted by Kent police and informed them that Mr. B and his wife had been found deceased at home and that the circumstances were unknown and suspicious.

A coroner's inquest deemed Mr. B's death to be suicide and his wife to have been killed unlawfully. Police concluded that there were no other parties involved in the deaths.

As Mr. B and his wife are deceased, and the fact that the independent investigation team have not been able to consult with the relatives in this case, the events directly leading up to the deaths are not known to the independent investigation team, and it is not clear whether a clear deterioration or relapse in Mr. B's mental state occurred in the days or weeks preceding August 2007.

This was Mr. B's first episode of psychiatric care and was largely unremarkable although the independent investigation team are of the view that the care delivered up to the point of Mr. B's discharge from mental health services back to the GP in April 2007, three months prior to his and his wife's death, was of a standard that could have been expected at the time. The independent investigation team were surprised, however, at the severity of Mr. B's self-harm attempts at the commencement of this episode of care and are of the view that more attempts should have been made by the care team to fully understand the pre cursers to this and more importantly, what factors contributed to Mr. B's almost immediate recovery. It is unclear to the independent investigation team whether Mr. B was indeed

recovered or if he became more skilled at ensuring that clinicians were not aware of his possible continuing persecutory beliefs. The independent investigation team, however, acknowledge that Mr. B and his wife were perceived to be very private people and that even if further attempts had been made to do psychological work with him, or them as a couple, this may not have proved fruitful.

The independent investigation team are of the view that given the clinicians uncertainty about what had caused Mr. B's apparent improvement in mental health it was reasonable to assume that him taking a small and regular dose of Olanzapine was contributing to this and that it was therefore unwise to stop his prescription of Olanzapine on the day that he was discharged from the service without any formal monitoring of the effects of this on his mental state, or a formalised risk assessment that took the ceasing of anti-psychotic medication into consideration.

The internal investigation process following this incident did not comply with current national guidance for patient safety investigations in health care although it is acknowledged that the current guidance from the National Patient Safety Agency was not in place at the time and was not published in its current form until a year after this incident. However the independent investigation team are satisfied that there is evidence that considerable developments have taken place in the Trust regarding processes for investigation of incidents and lessons learned and governance in this regard since 2009 when this responsibility was taken over by the current Medical Director, and that these should be audited and tested by the Trust board to ensure compliance with current standards and expectations.

Mr. B had no known history of violence to others so it is the conclusion of the independent investigation team that the unlawful killing of his wife was not predictable and that this was not therefore preventable. However, given his previous severe and impulsive self-harm attempts the independent investigation team are of the view that it remained a continuing possibility that this could re-occur, and that this should have been taken into account when he was discharged from services back to the care of his GP.

This investigation has further identified areas of improvement and the independent investigation team make the following 6 recommendations to improve practice.

1. The Trust should ensure there is guidance in place detailing the responsibility of clinicians to ensure that service users are monitored during changes to psychiatric medication and have process in place to monitor adherence to this on an ongoing basis.

2. The Trust should ensure that formal clinical risk assessments take place on every occasion that service users are transferred between care teams or are discharged from the services of the Trust, as in the Trust policy.

3. The Trust should ensure there are clear standards in place detailing what information should be sent to GP's when a service user is discharged back to their sole care, and should continue to audit ongoing compliance with this.

4. The Trust should ensure that one of the functions of the incident co-ordination group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way. This must extend to retaining contact details for key family members of people involved in Serious Incidents so they can be contacted at a later date if necessary.

5. The Trust should conduct an audit to ensure compliance with National Patient Safety Agency Independent Investigations of Serious Patient Safety Incidents in Mental Health 2008

6. The Trust should undertake a review to examine the efficacy of the processes in place for the learning and sharing of lessons learned to establish their efficacy

2.0 INTRODUCTION

Niche Health & Social Care Consulting was commissioned by NHS South East Coastal, to conduct an independent investigation to examine the care and treatment of a mental health service user who will be referred to for the purposes of this report as Mr B. Under Department of Health guidance[1] Strategic Health Authorities (SHA) are required to undertake an independent investigation:

"*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.*

When it is necessary to comply with the State's obligation 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 for 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.

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."

3.0 PURPOSE AND SCOPE OF INVESTIGATION

Independent investigations should increase public confidence in statutory mental health service providers. The purpose of this investigation is not only to investigate the care and treatment of Mr. B, but to assess the quality of the internal investigation that took place following the incident and the implementation of subsequent learning and to establish whether any lessons can be learned for the future.

4.0 SUMMARY OF INCIDENT

Mr. B was admitted to hospital following three attempts to harm himself during a short period of time. Mr. B had no psychiatric or self harm history. In December 2005 he was admitted to a psychiatric ward on a Section 2 of the Mental Health Act. He was expressing beliefs that his neighbours were persecuting and threatening him, his wife, and his home, and that he could hear them talking in the night. His wife stated she had not experienced this.

Following a short spell in hospital and the introduction of anti-psychotic medication Mr. B appeared less agitated and agreed to engage with the Community Mental Health Team (CMHT) and continue to take medication on discharge. Consequently on 4th January 2006 he was discharged from his Section 2 and from the ward.

[1] Department of Health (1994) *HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care*, amended in 2005 by Department of Health (2005) *Independent Investigation of Adverse Events in Mental Health Services*

On the day of discharge from hospital he was still having paranoid thoughts about his neighbours but then denied this two days later, on 6th January 2005.

Following discharge from hospital Mr. B was seen consistently in the community by a Community Psychiatric Nurse (CPN) and a Consultant Psychiatrist (CP) and his anti-psychotic medication was reduced slowly over time to a lower dose.

In April 2007 he was discharged back to the care of his GP and on the same day, his anti-psychotic medication was stopped.

On 9th August 2008 mental health services were contacted by Kent police and informed them that Mr. B and his wife had been found deceased at home and that the circumstances were unknown and suspicious.

A coroners' inquest deemed Mr. B's death to be suicide and his wife to have been killed unlawfully. Police concluded that there were no other parties involved in the deaths.

5.0 CONDOLENCES TO THE FAMILY OF Mr. B AND HIS WIFE

The Independent Investigation Team would like to offer their deepest sympathies to the family of Mr B and his wife. It is our sincere wish that this report provides no further pain and distress and addresses any outstanding issues and questions raised by relatives regarding the care and treatment of the Mr. B up to the point of the offence.

We would very much have liked to meet with the family but were unable to find contact details for any family members, despite having tried to obtain these through both the Trust and Kent Police on several occasions, including contacting the investigating officer and the family liaison officer, and a thorough search of the notes held by the Trust.

6.0 ACKNOWLEDGEMENT OF PARTICIPANTS

This investigation involved interviews with 4 clinical staff and managers from Kent & Medway NHS and Social Care Partnership Trust (KMPT) and one of the GP's from Mr. B's GP surgery. We would like to acknowledge these very helpful contributions.

In particular we would like to especially thank the Patient Safety Manager, administration staff and the Medical Director from the trust for their valuable and helpful assistance throughout this investigation.

7.0 TERMS OF REFERENCE

The following Terms of Reference were agreed between NHS South East Coastal and Niche Patient Safety:

1. Investigate and review the mental health care and treatment provided by the Trust to Mr. B from his first contact to the time of the offence and suitability of that care in view of the Mr. B's assessed health and clinical diagnosis.

2. Complete a chronology of the events to assist in the identification of any care and service delivery problems leading up to the incident.

3. Examine the extent and adequacy of collaboration and communication between secondary and primary care.

4. Explore and analyse the systems and processes in place for assuring that:
    - Practice is safe, appropriate and meets best practice standards.
    - That appropriate risk assessments are undertaken

5. Ensure that the views and concerns of the families of the victim and the perpetrator are responded to as appropriate and according to their wishes.

6. Consider any other matters that the independent team considers arise out of, or are connected with the findings of this independent investigation.

7. Provide a written report that includes recommendations to the Strategic Health Authority so that the avoidable harm from this episode is reduced in similar future circumstances and that learning is embedded at the trust towards this.

7.1 Approach

The Independent Investigation Team will provide the necessary services to ensure the effective co-ordination and delivery of the independent investigation.

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

As well as key staff, the Independent Investigation Team is encouraged to engage actively with the relatives of the victim and Mr. B so as to help ensure that as far as possible, the investigation is informed by a thorough understanding of the incident from the perspective of those directly affected, and will provide appropriate support to relatives throughout the investigation process.

The Independent Investigation Team will follow established good practice in the conduct of interviews, for example offering the opportunity for interviewees to be accompanied and be able to comment of the factual accuracy of their transcript of evidence.

If the Independent Investigation Team identify a serious cause for concern, this will immediately be notified to NHS South East Coastal.

7.2 Publication

The outcome of the investigation will be made public. NHS South East Coastal will determine the nature and form of publication. The decision on publication will take into account the views of the Independent Investigation Team, those directly involved in the incident and other interested parties. The published report will comply with the NHS South East Coastal anonymisation policy.

If the Independent Investigation Team identify a serious cause for concern, this will immediately be notified to NHS South East Coastal.

7.3 Timescales

The independent investigation team will complete its investigation within six months of starting work. The six months will start once the team is in receipt of Mr. B's records and sufficient documents are available to the team for interviews to start. The Investigation Manager will discuss any delay to the timetable with NHS South East Coastal and will also identify and report any difficulties with meeting any of the Terms of Reference to NHS South East Coastal. A bi-monthly progress report will be provided to the SHA along with a bi-monthly detailed update report suitable for all stakeholders.

It is unfortunate that the commissioning of this investigation, and therefore its completion, has been delayed considerably, in large part because of various NHS reconfigurations over the course of the investigation. We have been considerably assured that the new steps taken by NHS England will ensure a much swifter investigation process, closer to the time of the incident, and that this should enable families and staff to feel assured that organisations are fully in a position to learn from, and prevent, future similar incidents.

8.0 THE INDEPENDENT INVESTIGATION TEAM

This investigation was undertaken by the following healthcare professionals who are independent of the healthcare services provided by Kent & Medway NHS and Social Care Partnership Trust:

Nicola Cooper Investigation Manager and Report Author, Registered Mental Health Nurse and Senior Patient Safety Lead of Niche Patient Safety

Dr Gillian Pinner Consultant Psychiatrist Older People's Mental Health

9.0 INVESTIGATION METHODOLOGY

This process for this investigation follows national guidance[2].

9.1 Communication with Family

The independent investigation team have been unable to ascertain the identity of the Mr. B and his wife's extended family. They are not identified in the clinical notes and the police have been unable to furnish the independent investigation team with their names and contact details.

9.2 Consent

Mr. B's clinical records were released by the trust and the Medway Primary Care Trust (PCT) in the public interest as consent for the use of these could not be obtained from Mr. B, his wife, or the extended family.

9.3 Witnesses called by the Independent Investigation Team

The independent investigation team interviewed the staff involved making reference to the National Patient Safety Agency (NPSA) Investigation interview guidance[3]. Niche Patient Safety adheres to the Salmon Principles[4] in all investigations.

Five people who had been involved with the care and treatment of Mr. B or the management and commissioning of services were invited for interview in this investigation.

Four of these were from the mental health trust.

The independent investigation team were unable to interview Mr. B's GP at the time of the homicide as he has retired. However a GP from the practice was interviewed and reviewed Mr. B's clinical records with the independent investigation team.

Every interview was recorded and transcribed and all the interviewees had the opportunity to check the factual accuracy of the transcripts and to add or clarify what they had said.

9.4 Root Cause Analysis

This report was written with reference to the National Patient Safety Agency (NPSA)

[2] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*

[3] National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*

[4] The '*Salmon Process'* is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere.

guidance[5]. The methodology used to analyse the information gathered was by the use of Root Cause Analysis (RCA). Root Cause Analysis is a retrospective multi-disciplinary approach designed to identify the sequence of events that led to an incident. It is a systematic way of conducting an investigation that looks beyond individuals and seeks to understand the underlying system features and the environmental context in which the incident happened[6]. The Fish Bone analysis was used to assist in identifying the influencing factors which led to the incident. This is represented diagrammatically on page 34.

The Trust's Serious Untoward Incident Report was benchmarked against the National Patient Safety Agency's "investigation credibility & thoroughness criteria"[7] and the results analysed.

10.0 SOURCES OF INFORMATION

The independent investigation team considered a diverse range of information during the course of the investigation. This included the Trust's Internal Investigation Report, Mr. B's GP records, CMHT records, Trust policies and procedures and internal performance management information.

A complete reference list and bibliography is provided in the appendices.

11.0 CHRONOLOGY

11.1 Background

Mr. B was one of four brothers and four sisters, and was born in 1935. At the time of contact with mental health services, three of his brothers and one of his sisters were deceased, a brother having committed suicide at the age of 18 years. His father died in the early 60s of prostate cancer and his mother died in 1973 of cardiac problems. Mr. B came out of the Forces in 1956 and worked in the construction industry until 1992. He worked in a factory making flat packed furniture until he retired in 2000.

He married his wife in 1960 and they moved to Northfleet, a little way from his parents. The couple had one son and two daughters. One of his daughters was estranged. His other two children were very close, supportive and visited him regularly.

It was noted that he was able to form and maintain relationships but didn't go out much. In later years most of his friends had either died or moved away and he was reported to have isolated himself more.

[5] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health*
[6] id p38
[7] National Patient Safety Agency (2008) *RCA Investigation: Evaluation, checklist, tracking and learning log* http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60183&type=full&servicetype=Attachment

In 2004, he moved to a new home with his wife. This was a first floor flat in a convenient location; close to the shops, chemist and GP. Mr. B said the neighbours had been a problem "from day one", and he felt, all his problems began from here.

Mr. B reported that he coped very calmly with life events. He did a lot of the chores at home. His wife was able to cope with family support but had arthritis and he reported that his wife couldn't manage without his help.

11.2 Criminal History

The independent investigation team were presented with no evidence that Mr. B had any other forensic history until the offence occurred in August 2007.

11.3 Medical and Psychiatric History

Mr. B had no known past psychiatric history.

He had no significant previous medical problems.

15 December 2005
Mr. B was taken into the Accident and Emergency (A & E) department, at Queen Mary's Hospital, by his daughter in law as he had cut his wrists in an attempt to take his own life.

As the injuries were not life threatening he was discharged from hospital following a psychiatric assessment. He stated that he was not going to attempt suicide again.

Mr. B returned to his own home. At the time of the incident he was staying with his son and daughter in law as a way of reducing stress caused by hearing his neighbours talking whilst at home.

15 December 2005[8]
The psychiatric Senior House Officer (SHO) who was involved in the assessment of Mr. B on 15th December 2005 wrote to the Housing Association from whom Mr. B and his wife rented their home. The letter stated:

This is to intimate you with the fact that the above named individual was seen at the assessment unit this morning. He was referred to us after he presented at the Accident and Emergency department for self harm.

Our assessment revealed that (Mr. B) had been continually harassed by his neighbours leading him to abandon his flat to live with his son's family. The attending frustration and the fact that nothing had been done up to date either by the police or your good self on previous occasions led him to attempt to take his life.

[8] Letter from SHO to Housing Association 15th December 2005

We wonder if something urgent could be done to look into this case with the mind of urgently relocating (Mr. B) and his wife to a friendlier neighbourhood. This will go a long way in removing the major stress that led to the above mentioned incident.

15th December 2005[9]

The SHO wrote to Mr. B's GP to inform him of the day's events. He stated that Mr. B had been referred from the A&E department after self harm attempts. He said that according to Mr. B, his problems started 14 months earlier after moving into a new flat with his wife. He stated that they were harassed and threatened by the neighbours for no reason and that these threats became worse after they reported the matter to the police and the housing association and nothing was done. The letter states that due to this Mr. B's children had arranged for him to live with one of them while his wife stayed back at the flat to prevent it from being vandalised.

The SHO concluded that Mr. B presented no risk self harm or harm to others and did not exhibit any clear features of depression. He stated there were no disordered thoughts noted and that Mr. B denied any perceptual abnormality. Mr. B is reported to have told the SHO that he is unable to concentrate well and he forgets things easily. The SHO noted that this may be 'due to ageing'.

The SHO detailed the plan as follows:

- Mr. B discharged into the care of his children
- Letter sent to the housing association to look into aspects of relocating Mr. B and his wife to a friendlier neighbourhood
- Request made to GP for counselling at primary care level for Mr. B as soon as possible

Comment

There is nothing recorded in the primary care records to suggest that the SHO's suggestion that Mr. B should receive counselling from the primary care service was considered or implemented.

Following the initial self harm attempt and discharge from A&E, a couple of days later Mr. B went to stay in a B&B in Brighton. There he tried to drown himself in the sea. He was picked up by the police, but before he could be assessed he walked out of the hospital and attempted to drown himself again. He was taken to hospital again but discharged himself before he could be assessed. The Police were alerted and located him. They were satisfied that he was no longer actively suicidal, so they put him on a train back to Gravesend and informed local police, social services and psychiatric services.

20th December 2005

Following information being received from Brighton Police about Mr. B attempting to drown himself he was seen by a Community Psychiatric Nurse (CPN) from the Community Mental Health Team (CMHT). The CPN was concerned about Mr. B's presentation and lack of willingness to engage with her or services so she referred him for an assessment under the Mental Health Act stating that she found Mr. B to

[9] Letter from SHO to GP 15th December 2005

be paranoid and very guarded with no insight. She offered him admission to hospital, which he refused and became agitated and hostile.

21 December 2005[10]

Mr. B was assessed by two Section 12[11] approved doctors at his home, under the Mental Health Act (MHA 1983). Mr. B refused to answer any questions asked by the assessing doctors and the Approved Social Worker (ASW). Mr. B said he was concerned that his neighbours would be able to hear the conversation and therefore he was not happy to talk about his problems in the house. They later managed to persuade him to attend Gravesend CMHT so they could interview him properly. There, he was more open about his experiences, reporting that his 3 earlier suicide attempts were made as "impulsive gestures" when he got into a "black mood". He reported that on the day he had cut his wrists, he got up in the morning, looked in the mirror and thought "is it worth it?" and subsequently attempted to take his life.

Mr. B stated that the drowning attempts were decided on the spur of the moment. After he was picked up by police and taken to the hospital, he left without being assessed as he did not feel he needed psychiatric intervention. He said he now felt he would not do anything like that again. However, he could not say what had happened in the meantime to stop him from reacting on impulse again. He said that his problems with his neighbours were the main reasons for his low mood and suicidal attempts. He reported that they started about 2-3 years ago when he got involved in trying to stop a burglary that was being committed in one of his neighbours' house, when he was living in a different part of Gravesend. He said that the person committing the burglary started to "have it in for him" and started to persecute him even after he moved to his current accommodation. Mr. B alleged that his new neighbours whom he was sure were related to his previous neighbours who were also persecuting him. He was sure they were listening in on his and his wife's conversations and deliberately talking all night long to keep him awake. He found it very difficult to fall asleep because of it and felt low as his sleep was continuously disturbed.

After talking to the assessment team for a while, Mr. B became very agitated, saying that he needed to go to his wife as she could not look after herself. He said her arthritis made it impossible for her to do some of her household chores. Also in the last couple of years she had become forgetful and confused. He said it was stressful being the sole carer for his wife and that he did not feel that he couldn't manage the stress. He rejected the suggestion that his experiences with his neighbour could be the result of his mind playing tricks on him and became quite hostile when it was suggested that he could take medication to relieve some of the symptoms. He left abruptly and therefore they could not persuade him to wait while they consulted each other.

The assessment team was very concerned about the impulsive nature of Mr. B's suicide attempts and their seriousness. They did not feel circumstances had changed since his attempt to drown himself. His previous heavy alcohol use combined with his younger brother's suicide and abrupt changes in his mood placed him in the high risk category. Given the intensity of his convictions about being

[10] Report by, Approved Social Worker, Swanley CMHT
[11] Medically qualified doctors who have been recognised under section 12(2) of the Mental Health Act 1983

persecuted, and his experiences of hearing people talk about him, doctors concluded that he was probably suffering from paraphrenia, otherwise termed late onset schizophrenia.

They felt his lack of insight and refusal to consider medication and engagement with psychiatric services left them no option but to detain him under Section 2[12] of the MHA 1983 for further assessment and treatment as appropriate in the interest of his health as well as his safety. They attempted to see Mr. B in his house later in the day but were unsuccessful as he did not respond to his doorbell.

The following day a Section 135[13] warrant was obtained and arrangements were made with the Police to bring Mr. B to hospital as a patient viable to be detained.

The ASW contacted Mr. B by phone to advise him that the police would be arriving and of their visit the previous night. He said he was not aware that they had attempted to see him the night before. He agreed to let the ASW see him later that day but wanted to have time to talk to his wife about it and let her know. However, he was not in when she rang him later and his wife did not seem to be aware of his pending hospital admission. Therefore, she contacted the police who picked him up from the street and took him to Littlebrook Hospital.

Prior to taking him to hospital, the police rang his home, collected his belongings and advised his wife about his detention under the MHA 1983 and gave her all the necessary details of the hospital. Mr. B was subsequently admitted to Birch Ward in Littlebrook Hospital and the application for Section 2 of the MHA 1983 was accepted by the designated nurse.

The ASW advised Mr. B's wife about his legal status under the MHA 1983 and the reasons for the intervention and his right to appeal.

Over the days of the assessment the ASW also remained in close contact with Mr. B's son and daughter, informing them of progress. They confirmed that they would be able to care for their mother during his stay in hospital as at the time of assessment, Mr. B was recorded to be caring for his wife who had arthritis.

The inpatient clinical notes state that it was believed that Mr. B had late onset of paranoid illness possibly associated to stress.

It was noted that Mr. B had no prior contact with psychiatric services and his GP was not available for assessment. It was essential that the assessment was done that day as further delay could have been detrimental to the patient as he was presenting a high risk of suicide. He was refusing to engage further with the services.

Mr. B had to be admitted under section 2 of the Mental Health Act as he refused to be admitted to hospital informally. The core assessment completed at the time states that this was preceded by the police being called after he barricaded himself in the house the previous week. On this occasion he stated he wanted to kill himself, had

[12] Compulsory admission for assessment for up to 28 days
[13] Removal of a person to a place of safety by the police under Section 135 of the Mental Health Act 1983.

cut his wrists and was expressing paranoid ideas. It was noted that he had a drink problem in the past.

The assessment states that Mr. B had retired from work 5 years previously and began having problems with his neighbours 3 years ago. In 2003 it is reported that he got involved with neighbours when a robbery had taken place.

According to the police, Mr. B went to Brighton and was found in the sea in a suicide attempt. The assessment documentation states that on this occasion Mr. B had no intention of killing himself.

In the inpatient assessment report Mr. B was described as clean well dressed and behaving in a passive way. His speech was clear and coherent. His mood was tense. He was guarded and did not reveal much. His memory was intact. He had delusional thoughts and hallucinations.

He had a prostatectomy in April 2003. He had a consultation on 9th Jan 2003 for a hernia. He has no other medical history. He is fully mobile and fully continent. His hearing, sight, and speech were good.

There is an undated clinical risk assessment in Mr. B's records which refer to him being admitted on a section 2 of the Mental Health Act so the independent investigation panel have made the assumption that this was completed on 22nd December 2005[14].

This clinical risk assessment identifies attempted suicide as a current risk for Mr. B and notes that he had made 3 recent attempts including 2 attempts to drown himself and 1 attempt to cut his wrists.

The assessment summary states:

Late onset of psychosis associated with auditory hallucinations. Risk of absconding, unpredictable thoughts and behaviour impulsive

22nd December 2005

The SHO wrote a letter to Mr. B's GP[15] detailing the assessments that had taken place.

It is stated in the SHO's letter to the GP that Mr. B had had trouble with his neighbours since they moved into the area some months prior. This 'trouble' is recorded as including constant harassment and threats from the neighbours to Mr. B and his wife and that this had necessitated police involvement.

Mr. B told the SHO that he had awoken the previous week and decided that life wasn't worth living and had got the sharpest knife he could find and cut both wrists. When it stopped bleeding Mr. B informed the SHO that he realised it wasn't working and asked for help. Mr. B stated that this was an impulsive act and the SHO

[14] Mental Health Risk Assessment, 22/12/05
[15] Letter from SHO to GP 22/12/05

recorded that Mr. B had not written a suicide note or made a will. Mr. B stated that he had mixed feelings about the fact that his attempt had been unsuccessful.

The letter to the GP details that three days later Mr. B went to a seaside town, with no prior planning and booked into a bed and breakfast house. He then walked along the beach and decided on the spur of the moment to drown himself in the sea. Mr. B told the SHO that when this was unsuccessful he called an ambulance that took him to hospital in Brighton where he was assessed and discharged home. Mr. B told that SHO that he also had mixed feelings about the fact that this attempt on his life was unsuccessful.

Mr. B told the SHO that he had no intention of harming himself at the time of the assessment but that he couldn't predict these episodes. He stated that he had always been impulsive.

Mr. B reported that his mood had been low since the harassment from his neighbours commenced and that he was tired as he did not sleep well. He stated that he heard sounds from the flat below, such as TV and radio sounds and talking. He stated that these sounds were loud enough to keep him awake but that his wife slept soundly and that she did not hear the noises.

Mental Health Risk Assessment (Date not recorded)
Mr. B underwent a risk assessment. A present risk of suicide was noted. He had attempted suicide 3 times. Twice by drowning, once by slashing his wrists.

The analysis of the risk assessment stated the following:

- Mr. B was brought in under the Mental Health Act, Section 2.
- He was brought in by the police and two social workers.
- He had slashed his wrists
- He had late onset psychosis
- He was a risk of absconding, unpredictable thoughts and behaviour impulsive.

The immediate action was to be as follows:

- On Level 2 Observations every 15 minutes
- Temporary closure of ward door
- Monitor mood

Mr. B was discussed with the SHO and the ward doors closed temporarily because of Mr. B's potential absconscion from the ward.

28th December 2005
Mr. B was initially managed on the ward without regular medication, but took Lorazepam each night as required. He was then commenced on 10mgs of Olanzapine (an anti-psychotic medication) each day, and a few days later was able to concede that his perception of harassment by his neighbours may not be based in reality but be attributable to mental illness.

29 December 2005[16]
A Mental Health Act Manager wrote to Mr. B to stating that he was being detained for 28 days commencing 22 December 2005.

She also wrote to Mr. B's wife advising her of the situation.[17]

Mr. B appealed against his section the same day.

A tribunal was initially scheduled for 6th January 2006, and then rescheduled to be held 10th January 2006.

4 January 2006[18]
Mr. B was discharged from Section 2 of the Mental Health Act and from hospital. He was recorded to be no longer paranoid or suicidal at this time.

A mental health clinical risk assessment was completed in respect of Mr. B by a SHO, the Consultant Psychiatrist (CP) and CPN.

This states that there are past risks relating to attempted suicide and abuse of alcohol but that there are not any current risks.

The assessment was summarised as follows:

Patient suffered from a delusional disorder, the distress of which made him attempt suicide on two occasions recently. No prior history of suicide. No depressive symptoms. No abuse of alcohol or drugs. Lives with wife and receives support from son and daughter in law. No risk to others. Current risk of suicide moderate but reduced by medication to control symptoms and monitoring by CPN.

The action to manage the clinical risks is cited in the clinical risk assessment to be medication and regular follow up monitoring in the community.

Under 'Substance /alcohol misuse', it was noted that psychiatric risks are seriously exacerbated by abuse of drugs or alcohol. It was also noted that he used to drink heavily 6 years ago.

6th January 2006
A review of Mr. B's care took place at his home. This was attended by Mr. B and the CPN. Mr. B is recorded as being on enhanced level CPA at this time.

In his clinical risk assessment, 'minor self harm without significant risk to life or health' was identified as a present risk.

Summary of his risk assessment was as follows:

[16] Letter to Mr B ,29/12/2009
[17] Letter to Mrs B, 29/12/2009
[18] Mental Health Risk Assessment, 04/01/06

Mr. B was diagnosed with delusional psychosis and detained under the mental health act. He was discharged on 4th January 2006. He remains paranoid about his neighbours but denies any plans of suicide.

The care plan stated action to be taken in order to stabilise mental health and to relieve delusional symptoms, to prevent further suicidal attempts as follows:

- CPN to visit on a weekly basis
- CPN to assess Mr. B's mental health for signs of relapse
- To build a therapeutic relationship with Mr. B and allow him to discuss his fears and concerns.
- CPN to liaise with Consultant Psychiatrist and GP regarding any concerns about Mr. B's mental health.
- To be reviewed by Consultant Psychiatrist within CPA process.
- Medication to be assessed for compliance and effect
- Relapse indicators were: if Mr. B talked about harming himself and became paranoid about his neighbours
- The crisis and contingency plan was to contact Consultant Psychiatrist about interventions regarding his management.

His CPN recorded that he was pleasant and polite but suspicious of the visit. He denied any concerns about harassment from the neighbours and was noted to be taking his medication.

13th January 2006[19]

A discharge summary was completed by the SHO summarising Mr. B's presentation and treatment during his admission to hospital.

Within this it states that Mr. B had stated that his problems began when his neighbours moved in which took the form of them threatening to burn or vandalise the flat if it was left unoccupied. He said his neighbours turned their TV and radio on very loud in order to harass him. He described the sounds as loud enough to keep him awake at night. Mr. B's wife had told the inpatient care team that she never heard the sounds and did not feel threatened in any way and that Mr. B had complained of the same thing in their previous home, which had necessitated their move to their current flat.

The SHO describes that Mr. B was allowed one week of drug free assessment whilst in hospital and that during that time he was pleasant and appropriate and that there was no evidence of abnormal perception although he maintained a firm belief that he was being harassed by his neighbours.

On 28th December he was commenced on 10mgs of Olanzapine (an anti-psychotic medication) and a few days later was able to concede that his perception of

[19] Discharge Summary 13/01/06

harassment by his neighbours may not be based in reality but be attributable to mental illness.

Following this he agreed to take anti-psychotic medication and engage with the CMHT when discharged.

In a ward round on 4th January 2006 he still expressed a belief that he was being harassed by his neighbours but said he regretted suicide attempts and had no intention of doing this again. He was therefore discharged from Section 2 of the Mental Health Act and discharged home.

Mr. B's discharge prescription was noted as follows:

- Olanzapine 10mgs
- Ramiprazole 10mgs daily
- Alverine Citrate 60mgs 3 times each day
- Zopiclone 7.5mgs as required

13th January 2006
Mr. B was visited at home by his CPN. His wife informed the CPN that Mr. B was mentally stable. He denied any concerns about harassment from the neighbours and was noted to be taking his medication.

The CPN noted that she would visit Mr. B again in two weeks time.

25th January 2006
Mr. B was visited at home by his CPN. He denied any concerns about harassment from the neighbours and was noted to be taking his medication. He denied any suicidal ideas. The CPN noted that she would visit Mr. B again on 22nd February 2006.

22nd February 2006
Mr. B was visited at home by his CPN. He denied any concerns about harassment from the neighbours and was noted to be taking his medication. The CPN noted that she would visit Mr. B again in two weeks.

7th March 2006
Mr. B visited at home by his CPN. He stated he was having scans and biopsies in respect of his stomach problems and that the results would be received in May 2006. He reported stable mood and no concerns about the neighbours. The CPN noted that she would visit Mr. B again in two weeks.

16th March 2006
A review of Mr. B's care took place at his home. This was attended by Mr. B, the CPN, and Consultant Psychiatrist. Mr. B is recorded as being on enhanced level CPA at this time.

Mr. B's care plan stated action to be taken in order to stabilise mental health and to relieve delusional symptoms, to prevent further suicidal attempts. Otherwise it remains largely unchanged from the previous plan (see page 16).

26th March 2006[20]
Mr. B went to the local A&E department complaining of a two week history of headaches and shaking. The notes state that he had recently undergone an endoscopy that had showed a polyp to be present. He complained of frontal headache and feeling dizzy, occasional vomiting in the mornings, severe ringing in the ears, pins and needles in the ears and some tingling to his face. Clinicians advised he use painkillers and that the GP arrange a CT scan.

28th March 2006
Mr. B was visited at home by a member of the CMHT. He was found to be mentally stable with no psychotic symptoms. It was suggested to him that he attend the day centre for socialisation and occasional meals. Mr. B agreed to explore this.
It was agreed that the CPN would visit again in three weeks.

Comment
It appears from the notes made by the CPN following her meeting with Mr. B on 28th March 2006, that she was not informed by Mr. B that he had experienced frontal headache and feeling dizzy, occasional vomiting in the mornings, severe ringing in the ears, pins and needles in the ears and some tingling to his face over the previous fortnight, or that he had visited the A&E department in this regard two days earlier. The cause of the symptoms listed within the A&E notes is unknown to the independent investigation panel but could potentially have been linked to his psychiatric illness or medication. As the CMHT were apparently unaware of these issues, they were not explored from a psychiatric perspective.

18th April 2006
Mr. B was visited at home by his CPN. He was found to be mentally stable with no problems. It was agreed that the CPN would visit again in three weeks.

9th May 2006
Mr. B was visited at home by his CPN. Mr. B informed her that his test results had been negative and the polyps in his stomach were benign. He was pleased about this. He was reported to be mentally stable and sleeping well. It was agreed that the CPN would visit again in one month.

6th June 2006
The CPN attempted to visit Mr. B at home but he was not in. It was agreed that the CPN would visit again in one week.

13th June 2006
Mr. B was visited at home by his CPN. He was reported to be well, compliant with medication and eating and sleeping well. It was agreed that the CPN would visit again in one month.

13th July 2006
Mr. B was visited at home by his CPN. Mrs L was also present. He was reported to be mentally stable and sleeping well. It was agreed that the CPN would visit again in one month.

[20] Accident and Emergency department records March 2006

10th August 2006
Mr. B was visited at home by his CPN. He was reported to be mentally stable and sleeping well. He also said that the medication for his stomach was helping him. It was agreed that the CPN would visit again in one month.

7th September 2006
Mr. B was visited at home by his CPN. He was reported to be mentally stable and sleeping well. It was agreed that the CPN would visit again in one month.

19 October 2006[21]
A review of Mr. B's care took place at his home. This was attended by Mr. B, the CPN, and Consultant Psychiatrist. Mr. B is recorded as being on enhanced level CPA at this time.

It was noted that Mr. B remained stable in mood at the time of the review on 19th October 2006. In his clinical risk assessment, there were no risks identified. Summary of his risk assessment was as follows:

Mr. B was diagnosed with delusional psychosis and detained under the Mental Health Act. He was discharged on 4/1/2006. No longer paranoid or suicidal.

His care plan was as follows:

1. Mr. B has remained stable in mood since discharge from Hospital. CPN to visit on a 4 weekly basis
2. CPN to assess Mr. B's mental health for signs of relapse
3. To build a therapeutic relationship with Mr. B and allow him to discuss his fears and concerns
4. CPN to liaise with the Consultant Psychiatrist and GP regarding any concerns about his mental health
5. To be reviewed by Consultant Psychiatrist within the CPA process
6. Medication to be assessed for compliance and effect

The next review was scheduled for 19th April 2007. Following the review the Consultant Psychiatrist wrote to the GP stating that a review had taken place and that Mr. B had done well since being discharged from hospital.
The letter also states:

He is quite a vague man which doesn't lend confidence to those assessing risk of future self harm. However hopefully his erratic risky behaviour that led to a recent admission was a one off.

The Consultant Psychiatrist advised the GP that Mr. B was taking 10mgs Olanzapine which should be reduced to 5mgs and that this should continue for a further 6 months when it may be stopped.

[21] Mental Health Risk Assessment and CPA documentation, 19/10/2006

7th November 2006
Mr. B was visited at home by his CPN. He was reported to be mentally stable and sleeping well. It was agreed that the CPN would visit again in one month.

7th December 2006
Mr. B was visited at home by his CPN. He was reported to be mentally stable and sleeping well. It was agreed that the CPN would visit again in one month.

11th January 2007
Mr. B was visited at home by his CPN. His wife was also present. He was reported to be feeling well, having enjoyed Christmas but that he was not sleeping as well as he had. He agreed he would talk to his GP about this. It was agreed that the CPN would visit again in one month.

13th February 2007
Mr. B was visited at home by his CPN. He was reported to be mentally stable and sleeping well. It was agreed that the CPN would visit again in one month.

13th March 2007
Mr. B was visited at home by his CPN. He was reported to be well and stable in mood with no thought disorder. He reported that he'd gained weight since he'd stopped drinking. MR. B reported that he was sleeping and eating well.

20th April 2007[22]
The Consultant Psychiatrist wrote to the GP informing him that a discharge CPA review had taken place for Mr. B the previous day and that both himself, the CPN and Mr. B and his wife, had been present.

This letter states that Mr. B was on enhanced level CPA. It says:

> *He has been in remission for some time from what was seemingly a one off psychotic episode and can now be safely discharged back to primary care.*
>
> *Olanzapine is not normally associated with akathiesia but I noticed it today. It is possible that it is idiopathic or even secondary to Lansoprazole but in all likelihood it is due to Olanzapine. This drug should be stopped and he should take his current supply back to the pharmacy.*
>
> *They have our contact numbers and I don't think his wife will be shy in coming forward should he show signs of relapse.*

9th August 2007
Mental health services were contacted by Kent police who informed them that Mr. B and his wife had been found deceased at home and that the circumstances were unknown and suspicious. Mr. B's clinical notes were passed to the police to assist with this process.

The CPN was interviewed by the police.

[22] Letter from Consultant Psychiatrist to GP 20/04/07

No contact was made with Mr. B's relatives at this time as dictated by the police, as they were undertaking their investigation.

The incident reported as a SUI (Serious Untoward Incident) through the Trust's reporting process. Further investigation by the Trust was not possible at this stage due to the police's request for them not to contact Mr. B's relatives and Mr. B's clinical notes being held by the police.

14th August 2007
A debrief was offered to involved staff.

12.0 REVIEW OF CARE AND TREATMENT OFFERED TO Mr B BY THE MENTAL HEALTH TRUST

12.1 Inpatient care

The CMHT responded to information received from Brighton police about Mr. B's suicide attempts by sending the CPN to see him. The CPN was concerned about him when she met him and a MHA 1983 assessment was initiated which resulted in Mr. B being admitted to hospital on a Section 2 of the MHA 1983 on 22nd December 2005.

Comment

It is the view of the independent investigation team that the CPN responded appropriately after seeing Mr. B for the first time and that the decision to admit him to hospital on a Section 2 of the MHA 1983 was correct given his suicide attempts, paranoia and unwillingness to engage with services, or accept assistance.

On 28th December 2005 Mr. B was commenced on 10mgs of Olanzapine (an anti-psychotic medication) each day, and a few days later was able to concede that his perception of harassment by his neighbours may not be based in reality but be attributable to mental illness. He appealed against his detention under the MHA 1983 but before the hearing was able to take place, on 4th January 2006, he was deemed well enough to be discharged from the MHA 1983 and allowed to go home. The risk assessment completed at the time stated:

Mr. B was diagnosed with delusional psychosis and detained under the mental health act. He was discharged on 4th January 2006. He remains paranoid about his neighbours but denies any plans of suicide.

However by 6th January 2006 Mr. B was reported to be denying any paranoid thoughts about his neighbours.

Comment

Mr. B seemed to recover very quickly from his paranoid thoughts and agitation following his admission to hospital. The reason for this is unclear. It is the view of the independent investigation team that this may have been due to the commencement of anti-psychotic medication, respite from being away from his flat where his delusional beliefs were centred, or that he ceased telling others about his concerns.

The independent investigation team note that on the day of discharge from hospital Mr. B was still having paranoid thoughts about his neighbours but then denied this two days later, on 6th January 2005.

At interview the Consultant Psychiatrist told the independent investigation team that Mr. B's detention under the MHA 1983 was lifted due to his willingness to engage and compliance with medication. He also stated that he did not think more could be learnt about the risk presented by Mr. B by keeping him on another week on the ward. He stated *''you couldn't trust him, but you probably never would trust him and so I didn't think I was going to learn anything much by another week on the ward''.*

12.2 Care Programme Approach (CPA)

Following his discharge from hospital, Mr. B was placed on enhanced level of CPA within the community. This is normal practice for service users who have just been discharged from hospital following high risk behaviours.

The Trusts CPA Policy[23] at the time of the incident described the criteria for enhanced level CPA as follows:

- *Have multiple care needs including housing, employment etc requiring inter agency co-ordination*
- *Be willing to co-operate with only one professional or agency but they have multiple care needs*
- *Be in contact with a number of agencies including the Criminal Justice System*
- *Require more frequent and intensive interventions, perhaps with medication management*
- *Have mental health problems co-existing with other problems such as substance misuse*
- *Be at risk of harming themselves or others*
- *To disengage with services*

Comment

It is the view of the independent investigation team that it was appropriate for Mr B to be on enhanced level of CPA following his discharge from hospital and for a few subsequent months due to the risk of suicide that he had presented at the commencement of his span of care. This could, however, have been reduced to standard level after he had been in the community for some time, presenting as settled. The independent investigation team were consistently told by interviewees from KMPT that it is not unusual in the Trust for service users to remain on enhanced level of CPA and then be discharged to the care of their GP without a period of time on standard level CPA beforehand.

The policy requires that CPA reviews take place at least annually and within 7 days of discharge from hospital. Both these stipulations were met in Mr. B's case.

12.3 Treatment in the community

Mr. B appeared to respond well to treatment in the community and remained well for the entire period between his discharge from hospital in January 2006 and his discharge from the CMT, back to his GP, in April 2007. During this time he was consistently prescribed Olanzapine although it was gradually reduced to 2.5mgs.

Comment

The independent investigation team are of the view that the medication prescribed for Mr. B whilst he was being treated by the CMHT in the community was appropriate and appeared to meet his needs at that time.

[23] Kent & Medway NHS and Social Care Partnership Trust "Care Programme Approach Policy" V1 December 2006

Mr. B was taken off his anti-psychotic medication on the day that he was discharged from the service, back to his GP. The clinicians involved told the independent investigation team at interview that this was because Mr. B requested this. However this request is not reflected in the clinical records. Indeed the independent investigation team were told in interviews with clinicians that Mr. B regularly requested that his medication be stopped and that he be discharged from the service but again, the independent investigation team have not found references to these requests in the records.

The Trusts internal case review pertaining to this case refers to Mr. B having been prescribed Olanzapine as prophylaxis. The independent investigation team were also told this by clinicians during the interview process, and we have noted the letter to the GP of 19th April 2007 which described a tapering off of the dose of Olanzapine to 5mgs for 6 months before stopping.

Comment
Given that Mr. B responded so quickly to treatment as an inpatient, which included taking Olanzapine, the independent investigation team are of the view that is likely that part of the improvement in Mr. B's mental state was attributable to his medication.

Recognising that the clinicians' stated that Mr. B wished to stop taking his medication, and that he had not had any adverse effects when the dosage was previously reduced, the independent investigation team feel that the decision to stop Mr. B's prescription for Olanzapine was reasonable. However, it is the view of the independent investigation team that the CMHT should have continued to see Mr. B for a period of time following the medication being stopped rather than discharging from the service on the same day.

Recommendation 1.
The Trust should ensure there is guidance in place detailing the responsibility of clinicians to ensure that service users are monitored during changes to psychiatric medication and have process in place to monitor adherence to this on an ongoing basis.

12.4 Clinical risk assessment

Clinical risk assessments were completed reasonable regularly for Mr B up until October 2006 but no formal risk assessment is recorded to have taken place prior to his discharge from the service in April 2007.

The transition of a person with mental health problems from one care or treatment environment to another is known to increase risk of harm to self or other people. This is one of the key areas of practice frequently cited as requiring further action following independent investigations of homicides committed by people in receipt of mental health services. The Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[24] showed that 15% of suicides occurred in the first week of discharge, and 22% occurred before the first follow up

[24] University of Manchester "*Avoidable Deaths: The Five Yea Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*", 2006

appointment. With regard to transition to the community it makes the following recommendations:

- regular assessment of risk during the period of discharge planning and trial leave
- agreed plans to address stressors that will be encountered on leave and on discharge
- the patient to have ways of contacting services if a crisis occurs during leave or after discharge
- early follow-up on discharge, including telephone calls immediately after discharge for high risk patients and face-to-face contact within a week of discharge for anyone receiving "enhanced" care under the CPA
- support arrangements for people who discharge themselves from wards.

Similarly a high proportion of the 'most preventable' suicides (39%) and homicides (53%) were not subject to enhanced CPA despite a combination of severe mental illness and previous self-harm or previous violence, or previous admission under the Mental Health Act, and makes the following recommendations:

- aligning CPA and risk management more closely, ensuring comprehensive assessment of risk at CPA review
- ensuring that enhanced CPA is used for high risk groups, including people with severe mental illness who are in the early stages of their illness
- jointly reviewing the management of the most high-risk patients with other clinical teams, through local clinical governance.

Comment
It is the view of the independent investigation team that clinical risk assessments were appropriately completed for Mr B up until the last one was completed in October 2006.

Key risk factors in transition are the move to new services where the patient is less well known, and that dynamic risk factors and mitigation may be less well understood. There is also a risk that vital records and communication can be lost during this transfer. All of which heighten the need for tight procedures regarding risk assessment, documentation, and communication. Recent Coroners Rule 43 letters have highlighted similar requirements for ensuring adequate communication between teams, and risk assessment prior to discharge all take place[25], and it is a frequent recommendation following independent investigations into the care and treatment of individuals when there has been a homicide committed by a mental health service user. The basic principles in managing risk and ensuring safe discharge have changed little since the introduction of CPA, and the "*Guidance on the discharge of mentally disordered people and their continuing care in the community*"[26] which stresses the need for communication between all concerned (including the patient and their carers/ families and other services) and for risk assessment on admission to services, on discharge from services, and at key junctures during a person's care, or when their care needs have changed (including

[25] Ministry of Justice "*Summary of Reports and Responses under Rule 43 of the Coroners Rules" May 2012* http://www.justice.gov.uk/downloads/publications/policy/moj/summary-rule-43.pdf
[26] Health Service Guidelines HSG (94)27) "*Guidance on the discharge of mentally disordered people and their continuing care n the community"* 1994

prior to transfer to another service). The most recent guidance on managing risk in mental health services builds upon this with a 16 best practice points that includes:

- The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis
- Where suitable tools are available, risk management should be based on assessment using the structured clinical judgment approach.
- Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

And:

- Risk management plans should be developed by multidisciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice.
- All staff involved in risk management should receive relevant training, which should be updated at least every three years.
- A risk management plan is only as good as the time and effort put into communicating its findings to others.

Managing risk is clearly a central function of statutory mental health services, since the Mental Health Act 1983 tries to manage the balance between the management of risks presented by service users to themselves or others and their rights. However, safe and proper management of risk is not only a function of mental health services; it is a duty of care for all organisations.

A clinical risk assessment took place at Mr. B's CPA review on 19th October 2006. No risks were identified at this time. However, there is no evidence in the clinical records to suggest that a further risk assessment was undertaken at Mr. B's pre discharge CPA review, before he was discharged from the service to the care of his GP, in April 2007. It appears, however, that a general view was formed by the CPN and the CP that Mr. B did not present any clinical risks. This was alluded to in the discharge letter written by the Consultant Psychiatrist to the GP:

He has been in remission for some time from what was seemingly a one off psychotic episode and can now be safely discharged back to primary care.

An audit[27] of CPA practice in Recovery services and CMHT's for older persons was carried out in the Trust in November 2012, in relation to clinical risk assessment, states:

Clinical Risk Management training stipulates that all service users under CPA (enhanced) must have their risk assessment updated after a CPA review, in the majority of cases this did not occur. This message must be reinforced to staff through the new revised CPA Policy.

[27] Kent & Medway NHS and Social Care Partnership Trust "Service Evaluation of CPA Reviews for Service Users under CPA Within the Recovery and Speciality service Lines", November 2012

Comment
The independent investigation team are of the view that it was poor practice, and not compliant with Trust policy at the time, to discharge a SU back to the care of his GP without the completion of a formalised clinical risk assessment. This was particularly pertinent on this occasion as Mr. B's anti-psychotic medication was ceased on the same day and his response to this, and the effect of this, could not be known on the day of discharge from the service.

Recommendation 2.
The Trust should ensure that formal clinical risk assessments take place on every occasion that service users are transferred between care teams or are discharged from the services of the Trust, as in the Trust policy.

13.0 COMMUNICATION WITH GP

With regard to discharge from the service the Trust CPA Policy at the time of the incident states:

When a service user has recovered, or their needs have lessened to the extent that they no longer need secondary mental health service and in compliance with the Mental Health Act, they should be discharged. The decision to discharge the service user should take place within the CPA review process and must take into account the views of the service user, and where relevant, carers.

Upon discharge a report should be provided for the originating referrer that should summarise progress, how the service user might be re referred, and any outstanding problems or risk factors that are present. This report will be copied to the service user and carer where appropriate.

The independent investigation team spoke to a GP in the practice where Mr. B received primary care. He stated that communications with the CMHT's are variable and that some contain very scant detail and some are over detailed making it difficult for GP's to elicit the salient points. He stated that any requirements of the GP in terms of monitoring the service user concerned need to be very specific to ensure clarity of understanding.

Comment
It is the view of the independent investigation team that the letter sent by the Consultant Psychiatrist to the GP detailing the decision to discharge Mr. B to primary care did not meet the stipulations for the content of reports that should be provided to GP's when service users are discharged that was outlined in the Trust's CPA policy at the time.

Recommendation 3.
The Trust should ensure there are clear standards in place detailing what information should be sent to GP's when a service user is discharged back to their sole care, and should continue to audit ongoing compliance with this.

14.0 ADHERANCE TO NICE GUIDANCE FOR SCHIZOPHRENIA

National guidance[28] published by the National Institute for Clinical Excellence (NICE) states that mental health services providing care to those with psychotic illnesses should;

'Offer family intervention to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings'.

National guidance on the treatment of psychosis[29] also states that mental health services should:

- *Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase 2 or later, including in inpatient settings.*
- *Offer family intervention to all families of people with schizophrenia who live with or*
- *are in close contact with the service user. This can be started either during the acute phase or later, including inpatient settings.*

In a paper[30] written in the Trust in 2009 an evaluation of the Trust's compliance with the NICE Schizophrenia Guideline was undertaken and stated:

The results of the audit indicate there is variable adherence with the guidelines. Standards such as provision of regular health checks and medication reviews achieved very good adherence, which may reflect the strong biological tradition of local services. In contrast, the standards relating to psychosocial interventions, family interventions, advanced directives and occupational/vocational assessment showed poor adherence.

Comment
The national guidance for the care and treatment of those with psychosis published by NICE in 2002 and revised in 2009 is very clear that it does not apply to those whose psychosis onsets after the age of 60, which was the case for Mr B.

However, given the caring responsibilities that he and his wife had for each other, and his wife's view that Mr. B had experienced paranoia about his neighbours in the previous home that they lived in, they may have benefited from some family intervention from the Trust to assist them in dealing with this.

[28] National Institute for Health and Clinical Excellence (2002) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care* [CG1] replaced in 2009 by National Institute for Health and Clinical Excellence (2009) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care* [CG82]
[29] National Institute for Health and Clinical Excellence (2009) *Schizophrenia: Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.* (CG82)
[30] Kent & Medway NHS and Social Care Partnership Trust "Service Evaluation Research Report Older Adult Service Provision in a mental health Trust: Is it meeting the NICE Schizophrenia Guideline", July 2009

Additionally, an increased focus on psychological issues and talking therapies in respect of Mr. B may have enabled him to potentially explore his concerns about the neighbours and the response that he had to these thoughts.

The independent investigation team note the view expressed by a clinician at interview that Mr. B would not have accepted psychological therapy due to the privacy of his nature but are of the view that this should have been explored with him, as a possibility.

15.0 INTERNAL SERIOUS INCIDENT INVESTIGATION PROCESS

The Trust's Adverse Incident Policy that was in place at the time of this incident [31] states:

All level 4 and 5 incidents are reviewed by SUI Core Team at regular weekly meetings, comprising of Medical Director, Service Director, Director of Performance and Risk Manager. Where required further in depth reports are commissioned based on managers' immediate investigation reports using Root Cause Analysis methodology. A process of monitoring, reviewing and learning from these incidents is in place via the Directorate Management Team and Risk Management Group.

This incident constitutes a level 5 incident according to the Trust's incident grading criteria. This policy states there are no exceptions to it.

Kent police informed KMPT of the deaths, and their suspicious nature, on 9th August 2007.

A note was made on the Trusts action plan, dated 10th August 2007, with regard to this case stating:

Attempts made by Service Manager and Team Leader to enquire as to the police investigation progress proved unsuccessful, stating they were unable to disclose the information.

On 14th August 2007 the Service Manager completed an initial report form detailing the incident. This states that Mr. B's clinical records were unavailable as the police had requested them and that the CPN had been inteviewed by the police with regard to the case. The report also states that no contact was to be made with Mr. B's relatives as dictated by police officers who were investigating the deaths.

Comment
It is the view of the independent investigation team that the police's requirements for copies of clinical records following a serious incident should not inhibit Trusts from reviewing the care provided due to unavailability of the clinical records.

However, the Trust now has an electronic patient record system (RiO) which means

[31] Kent & Medway NHS and Social Care Partnership Trust "Adverse Incident Policy" V1 December 2006

that records are can be accessed 24 hours a day via the internet by Trust staff and are available for any authorised body if requested.
The Service Manager who completed the initial report concluded as follows:

For consideration as an root cause analysis investigation, However at time of incident, Police dealing with the incident instructed team not to make contact with family or others involved, whilst they carry out the investigation.

This case was discussed at the Serious Untoward Incident (SUI) Core Team meeting on 3rd September 2007. At that point it was agreed that this case should be investigated by the Trust under Serious Incident investigation procedure, and that the police should be contacted to ascertain their progress.

The Service Manager involved told the independent investigation team at interview that she did escalate the need for discussions with the police at a higher level following her initial report in 2007 but did not receive further instruction until 2009.

Comment
It is unclear what action was taken to establish the progress of the police investigation or consider how the Trust's internal investigation should be progressed at this point.

In 2006 a Memorandum of Understanding[32] was agreed by the Association of Chief Police Officers, Health and Safety Executive and Department of Health laying out multi-agency procedures to be followed in the event of patient safety incidents that cause death or serious harm.

The protocol specifies that in the event of a serious incident that will require police, health service and potentially Health and Safety Executive investigation, an Incident Co-ordination Group should be set up that incorporates the appropriate bodies to provide strategic oversight and investigation co-ordination. The protocol specifies that the group should be attended by senior representatives from each organisation and each meeting be formally be minuted.

The need for the establishment of an Incident Co-ordination Group and the responsibility for health service managers to initiate this within five days of the incident was not made clear in the Trusts Incident Investigation Policy at the time.

The current Trust policy pertaining to serious incident investigation[33] does however allude to the need for liaison with the police and adherence to the Memorandum of Understanding following serious incidents. It does not, however, make it clear that it is the responsibility of senior NHS managers to initiate this within five days of an incident occurring.

Since this incident we are aware that the Trust has fully implemented the Memorandum of Understanding and has a constructive working relationship with Kent Police.

[32] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*
[33] KMPT Investigation of serious incidents, incidents, complaints and claims V3 October 2011

On 13th November 2009, over two years after the deaths, a management case review was completed by the Service Manager at the request of the Medical Director who had recently commenced in post and had taken responsibility for the management of serious incident investigation on behalf of the trust board.

The Medical Director concerned told the independent investigation team that on commencement of her new role she was concerned that this incident had not been investigated in full so requested a review of the records to ascertain if there was any learning that the Trust needed to implement as a result of this incidnet.

This report provides a chronology of the key events that occurred during Mr. B's span of care.

With regard to Mr. B's discharge on from the service in April 2007 the management case review states:

At a review at his home address we proceeded to stop Olanzapine. His psychotic episode had been first onset and transient. He had accepted propholaxis for 16 months. There was little evidential argument we could offer to counter (Mr. B's) preferred choice not to accept a longer maintenance period of Olanzapine. (Mr. B and his wife) were both confident about prognosis and did not see a role for secondary mental health services. He was therefore discharged from our service back to primary care with our emergency contact numbers in the event he should show signs of relapse.

15.1 Quality of the Trust's internal investigation report

The Trust's Internal Investigation Report was benchmarked using the National Patient Safety Agency's "*Investigation credibility and thoroughness criteria"*[34]. The Trust Internal Report scored very low. The main reason for this was that the investigation was limited in its scope as it was a documentary management review and no objective analysis of the information found in the clinical records took place.

The care and service delivery problems, contributory factors, root causes, lessons learnt, a summary of the recommendations and the arrangements for shared learning are not specifically identified and there is no evidence that a systematic Root Cause Analysis or other equitable method of analysis was used. The main body of the report did not have the usual subheadings that one would expect. The chronology, although limited, was clear and was of a good standard.

The report made one recommendation as follows:

To ensure service users are fully aware of how to re-engage and access mental health services after discharge, and information leaflet is to be given to all service users highlightng the path to re-engaging the service should the need arise

However it was not clear how it linked to the issues identified within the report, particularly as it states in the report that Mr. B and his wife were informed of how to

[34] National Patient Safety Agency (2008) "RCA Investigation: Evaluation, checklist, tracking and learning log"

re-access the service should they need to.

Additionally, there was no identifiable action plan attached to the report or any comment on the implementation, monitoring and evaluation arrangements in the report.

Comment
The Trust conducted their internal investigation prior to the publication of the National Patient Safety Agency *Independent Investigations of Serious Patient Safety Incidents in Mental Health,* which was published in 2008. It is therefore acknowledged by the independent investigation team that they cannot have been expected, at that time, to meet all the standards set out within the document.

However, for the purposes of learning lessons for future care and service delivery, the independent investigation team have nonetheless used the standards within the guidance as a benchmark.

The investigation team also accept that the Trust has since made significant changes to its processes for managing Serious Incidents and cascading learning from these events which fully complies with NPSA best practice guidance.

15.2 Liaison with families

Despite the requirement for appropriate liaison to take place with families and victims and perpetrators of homicides being well documented in national guidance such as the Being Open framework[35] the families involved in this case were not contacted by the Trust.

Because of the time lapse since this incident, the Investigation team were unable to obtain contact details for the family since the Police were unable to provide them and Mr.B's wife is listed as his next of kin, and so have not been able to meet with them. It would have been helpful for the familes contact details to have been retained by the Trust as part of the internal investigation process.

It is acknowledged that this is challenging when the Trust internal investigation runs concurrently with the police investigation. However, in most circumstance this should not prevent identified persons within the Trust contacting families to offer support and inform them of the processes in place and the agreements that have been made by the Trust or multi agency incident co-ordination group.

Recommendation 4.
The Trust should ensure that one of the functions of the incident co-ordination group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way. This must extend to retaining contact details for key family members of people involved in Serious Incidents so they can be contacted at a later date if necessary.

[35] National Patient Safety Agency (2004) "Being Open" (Updated Nov 2009)

15.3 Current governance arrangements in relation to learning from serious incidents

Considerable changes have taken place within KMPT with regard to governance in relation to the investigation of, and learning from, serious incidents.

The current medical Director took up post in 2007 and took on responsibility on behalf of the Trust board for the investigation of serious incidents, the management of learning lessons and the implementation of guidance issued by the National Patient Safety Agency in 2009.

Since then extensive training in root cause analysis techniques has taken place for incident investigators within the Trust has taken place and a governance and accountability process has been developed.

The current governance process for SUI's outlined in current Trust policy[36] are that the Trust board are responsible for ensuring that systems and processes are in place to undertake suitable and sufficient investigations to ensure that learning and implementation can be demonstrated.

In order to do this the Trust board receive assurance from the Trust's Governance and Risk Committee through summary and exception reporting, and Trust governance structures continue to evolve

The Trust's Governance and Risk Committee review incident reports and ensure the procedure is suitable to identify any learning. They also have responsibility to ensure that lessons are shared and learned across the organisation and are implemented.

The Trust policy states that the Trust's Governance and Risk Committee will:

Receive assurance that underpins that change has been systemic and embedded throughout the trust where it is appropriate to the learning.

And that:
They will provide leadership and support to Service line Directors in undertaking their programme in continuous learning, review, implementing and sustaining change and then evaluating outcomes.

Additionally a Root Cause Analysis (RCA) Action Group is responsible for reviewing all completed investigation reports and ensuring that evidence is available to demonstrate the learning and to monitor and support local teams, managers and clinicians to implement arising action plans.

The RCA Action Group are also responsible for ensuring that learning is disseminated across the Trust in the form of a newsletter.

[36] Kent & Medway NHS and Social Care Partnership Trust "Investigation of Serious Incidents, Incidents, Complaints and Claims" V3 October 2011

Each clinical service line have groups in place who ensure that local learning and action plan implementation has taken place and put any necessary arising risk reduction strategies in place.

The Medical Director is the designated executive lead for patient safety within the Trust.

Comment
The independent investigation team are satisfied that governance processes in relation to the investigation and learning from serious incidents has developed considerably since 2009. The Trust have developed a clear accountability framework and policies, which if followed, will ensure that robust processes for investigation and the identification and dissemination of learning takes place.

It is the view of the independent investigation team that it would be prudent for the Trust board to be able to formally assure themselves of the effectiveness of these mechanisms.

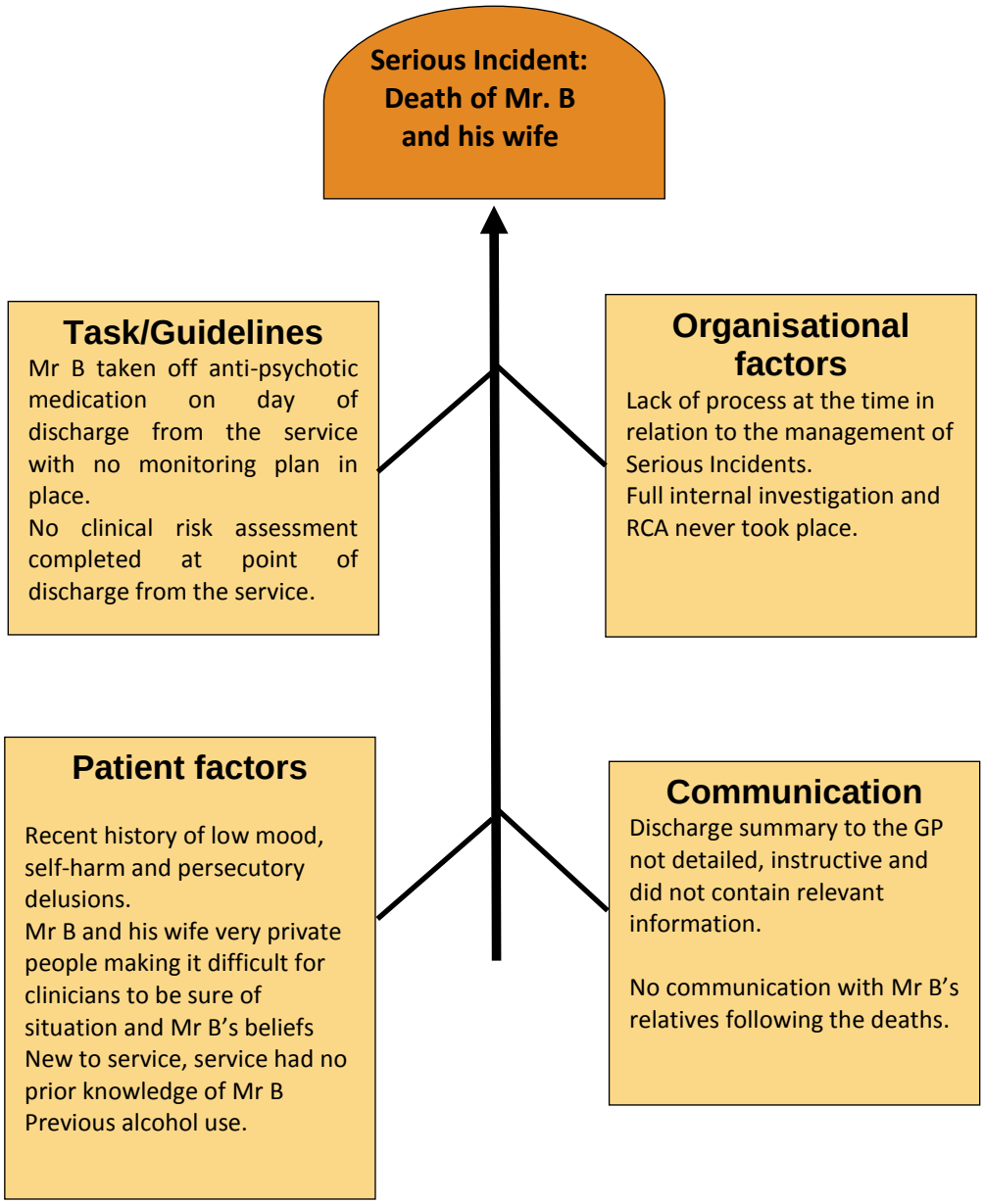
Recommendation 5.

The Trust should conduct an audit to ensure compliance with National Patient Safety Agency Independent Investigations of Serious Patient Safety Incidents in Mental Health 2008

Recommendation 6.

The Trust should undertake a review to examine the efficacy of the processes in place for the learning and sharing of lessons learned to establish their efficacy

ROOT CAUSE ANALYSIS DIAGRAM



16.0 CONCLUSIONS

Mr. B was admitted to hospital following three attempts to harm himself during a short period of time. Mr. B had no psychiatric or self harm history. In December 2005 Mr. B was admitted to a psychiatric ward on a Section 2 of the Mental Health Act. He was expressing beliefs that his neighbours were persecuting and threatening him, his wife, and his home, and that he could hear them talking in the night. His wife stated she had not experienced this.

Following a short spell in hospital and the introduction of anti-psychotic medication Mr. B appeared less agitated and agreed to take to engage with the CMHT and continue to take medication on discharge. Consequently on 4th January 2006 Mr. B was discharged from his Section 2 and from the ward.

On the day of discharge from hospital Mr. B was still having paranoid thoughts about his neighbours but then denied this two days later, on 6th January 2005.

Following discharge from hospital Mr. B was seen consistently in the community by a Community Psychiatric Nurse (CPN) and a Consultant Psychiatrist and his anti-psychotic medication was reduced slowly over time to a low dose of an anti-psychotic medication.

In April 2007 Mr. B was discharged back to the care of his GP and on the same day, his anti-psychotic medication was stopped.

On 9th August 2008 mental health services were contacted by Kent police and informed them that Mr. B and his wife had been found deceased at home and that the circumstances were unknown and suspicious.

A coroner's inquest deemed Mr. B's death to be suicide and his wife to have been killed unlawfully. Police concluded that there were no other parties involved in the deaths.

As Mr. B and his wife are deceased, and the fact that the independent investigation team have not been able to consult with the relatives in this case, the events directly leading up to the deaths are not known to the independent investigation team, and it is not clear whether a clear deterioration or relapse in Mr. B's mental state occurred in the days or weeks preceding August 2007 although the independent investigation team believe that it is reasonable to assume that this was the case.

This was Mr. B's first episode of psychiatric care and was largely unremarkable although the independent investigation team are of the view that the care delivered up to the point of Mr. B's discharge from mental health services back to the GP in April 2007, three months prior to his and his wife's death, was of a standard that could have been expected at the time. The independent investigation team were surprised, however, at the severity of Mr. B's self-harm attempts at the commencement of this episode of care and are of the view that more attempts should have been made by the care team to fully understand the precursors to this and more importantly, what factors contributed to Mr. B's almost immediate recovery. The independent investigation team, however, acknowledge that Mr. B and his wife were perceived to be very private people and that even if further attempts had been made

to do psychological work with him, or them as a couple, that this may not have proved fruitful.

The independent investigation team are of the view that given the clinicians uncertainty about what had caused Mr. B's apparent improvement in mental health it was reasonable to assume that him taking a small and regular dose of Olanzapine was contributing to this and that it was therefore unwise to stop his prescription of Olanzapine on the day that he was discharged from the service without any formal monitoring of the effects of this on his mental state, or a formalised risk assessment that took the ceasing of anti-psychotic medication into consideration.

The internal investigation process following this incident did not comply with current national guidance for patient safety investigations in health care although it is acknowledged that the current guidance from the National Patient Safety Agency was not in place at the time and was not published in its current form until a year after this incident. However the independent investigation team are satisfied that there is evidence that considerable developments have taken place in the Trust regarding processes for investigation of incidents and lessons learned and governance in this regard since 2009 when this responsibility was taken over by the current Medical Director, and that these should be audited and tested by the Trust board to ensure compliance with current standards and expectations.

Mr. B had no known history of violence to others so it is the conclusion of the independent investigation team that the it was not predictable that he would cause harm to his wife and that this was not therefore preventable. However, given his previous severe and impulsive self harm attempts the independent investigation team are of the view that it remained a continuing possibility that this could re-occur, and that this should have been taken into account when he was discharged from services back to the care of his GP.

APPENDIX A: TABLE OF RECOMMENDATIONS

	Recommendation
1.	The Trust should ensure there is guidance in place detailing the responsibility of clinicians to ensure that service users are monitored during changes to psychiatric medication and have process in place to monitor adherence to this on an ongoing basis.
2.	The Trust should ensure there are clear standards in place detailing what information should be sent to GP's when a service user is discharged back to their sole care, and ensure there are processes in place to ensure ongoing compliance with this.
3.	The Trust should ensure there are clear standards in place detailing what information should be sent to GP's when a service user is discharged back to their sole care, and ensure there are processes in place to ensure ongoing compliance with this.
4.	The Trust should ensure that one of the functions of the incident co-ordination group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.
5.	The Trust should conduct an audit to ensure compliance with National Patient Safety Agency Independent Investigations of Serious Patient Safety Incidents in Mental Health 2008
6.	The Trust should undertake a review to examine the efficacy of the processes in place for the learning and sharing of lessons learned to establish their efficacy

APPENDIX B: LIST OF STAFF TITLES – INTERVIEWS

Consultant Psychiatrist
General Practitioner
Community Psychiatric Nurse
Medical Director
Service Manager

APPENDIX C: GLOSSARY

A&E	Accident and Emergency
Bibliography	A list of source materials that are used or consulted in the preparation of this report
Chronology	A sequence of events
CMHT	Community Mental Health Team
Coroner	An officer, as of a county or municipality, whose chief function is to investigate by inquest, as before ajury, any death not clearly resulting from natural causes
CPA	Care Program Approach – the overall framework within which mental health care is delivered
GP	General Practitioner
Homicide	A killing by a person who is or has been under care of a mental health service
NICE	National Institution of Clinical Excellence
NPSA	National Patient Safety Agency
PCT	Primary Care Trust
Perpetrator	A person who has committed an act
PRN	As and when required - in relation to the times medication should be taken
RCA	Root Cause Analysis
Risk Assessment	Assessment of risk which is then documented
Rule 43	Rule 43 of the Coroners Rules 1984 (as amended) provides coroners with the power to make reports to a person or organisation where the coroner believes that action should be taken to prevent future deaths.
SHA	Strategic Health Authority
SU/Service User	The person/patient/client who accesses the service
Trust	A health service organisation created to provide health services

APPENDIX D: REFERENCES and BIBLIOGRAPHY

Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended in 2005 by Department of Health (2005) Independent Investigation of Adverse Events in Mental Health Services

National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health

National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: Investigation interview guidance

The 'Salmon Process' is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere.

National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health

National Patient Safety Agency (2008) RCA Investigation: Evaluation, checklist, tracking and learning log

Letter from SHO to GP 15th December 2005

Report by: Approved Social Worker, Swanley CMHT

Medically qualified doctors who have been recognised under section 12(2) of the Mental Health Act

Compulsory admission for assessment for up to 28 days

Removal of a person to a place of safety by the police

Mental Health Risk Assessment, 22/12/05

Letter from SHO to GP 22/12/05

Letter to Mr. B: 29/12/2009

Letter to Mrs B: 29/12/2009

Mental Health Risk Assessment, 04/01/06

Discharge Summary 13/01/06

Accident and Emergency department records March 2006
Mental Health Risk Assessment and CPA documentation 19/10/2006

Letter from Consultant Psychiatrist to GP 20/04/07

Kent & Medway NHS and Social Care Partnership Trust "Care Programme Approach Policy" V1 December 2006

University of Manchester "Avoidable Deaths: The Five Yea Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness", 2006

Ministry of Justice "Summary of Reports and Responses under Rule 43 of the Coroners Rules" May 2012 http://www.justice.gov.uk/downloads/publications/policy/moj/summary-rule-43.pdf

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Kent & Medway NHS and Social Care Partnership Trust "Service Evaluation Research Report Older Adult Service Provision in a mental health Trust: Is it meeting the NICE Schizophrenia Guideline", July 2009

Kent & Medway NHS and Social Care Partnership Trust "Adverse Incident Policy V1" December 2006

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