VERITA

IMPROVEMENT THROUGH INVESTIGATION

An independent investigation into the care and treatment of Mr B

A report for

NHS South of England

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Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

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1. Introduction

1.1 Mr B stabbed and killed Mr D on 15 February 2010. Mr B pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order without limit of time.

1.2 At the time of the incident Mr D had been receiving mental health services from Sussex Partnership NHS Foundation Trust (the trust).

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

1.4 In 2012 NHS South of England (formerly NHS South East Coast) commissioned Verita to carry out this independent investigation into the care and treatment of Mr B.

1.5 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Tariq Hussain, senior consultant, Dr Mostafa Mohanna, consultant psychiatrist and Emily Ewart, community psychiatric nurse did the work. Their biographies appear at the end of this report.

1.6 Derek Mechen, partner, peer-reviewed this report.

2. Terms of reference

2.1 This independent investigation was commissioned by NHS South of England in accordance with guidance published by the Department of Health in circular HSG (94) 27 (updated in June 2005), *The discharge of mentally disordered people and their continuing care in the community*.

2.2 The aim of the independent investigation is to evaluate the mental health care and treatment provided to Mr B to include:

- a review of the trust's internal investigation to assess its rigor, objectivity and completeness against the investigation's terms of reference including an assessment of the adequacy of its findings, recommendations and action plans
- reviewing the progress made by the trust in implementing the action plan from the internal investigations
- involving Mr B and Mr B's sister
- a chronology of the events to assist in the identification of any care and service delivery problems leading to the incident
- an examination of the mental health services provided to Mr B and a review of the relevant documents
- the extent to which Mr B's care was provided in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies
- the appropriateness and quality of assessments and care planning
- consider the effectiveness of interagency working
- consider other such matters as the public interest may require.

2.3 As well as the matters above the investigation team were asked to review the following themes:

- the effectiveness of the trust community team's architecture, in particular the pathways of care between the various teams
- the availability and use of referral information, assessments information and partner communications when general mental health assessments, risk assessments and MHA assessments are being undertaken

- the availability and involvement of consultant psychiatrists in managing and directing community care plans
- diagnosis and formulation as part of care planning
- the trust's approach to complex care management
- risk assessment and risk management planning.

Approach to the investigation

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

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

2.6 We met Mr B to explain how the investigation was to be conducted and to get his perspective on his care. We also met him to get his comments on the draft report.

2.7 We offered Mr B's sister an opportunity to meet us and/or provide information. Despite a number of phone conversations with her she was not able to offer a date to meet and did not provide any information.

3. Executive summary and recommendations

3.1 Mr B was the driver of a vehicle involved in a fatal accident in 2000 in the north of England. He sustained a serious head injury, which required surgery. He was convicted of dangerous driving and jailed for five years. He moved to Brighton from Manchester after his release. He had not used mental health services before this.

3.2 Mr B was referred by his GP to Brighton East Access Team in March 2008. His GP said that since being released from prison he had marked depression, strong suicidal ideation and periods of elevated mood, during which he ran up thousands of pounds of debt.

3.3 In March 2008, after his first assessment by the east access team he was provisionally diagnosed with post-traumatic stress disorder (PTSD) and offered medication. Later that year the PTSD diagnosis was confirmed and he was placed on a trauma service waiting list. He was discharged back to his GP with advice on medication. His GP referred him again in October 2008 and June 2009. His mental health deteriorated in this period. He had been placed on a community service order because of an argument with railway staff and threatening behaviour to another tenant in his accommodation block, whom he later killed in 2010.

3.4 The Brighton & Hove Housing Department Team reported Mr B to the east access team in early July 2009, describing him as having a complex delusional network around the occult. This included him threatening to burn the tenant in his accommodation block at the stake for being a witch. He attended a crisis appointment with a community psychiatric nurse (CPN 1) from the east access team in July 2009. He was offered appointments with the east access team consultant in September, October and November which he did not attend and was discharged back to the care of his GP.

3.5 Mr B began attending accident and emergency (A&E) departments around the country towards the end of 2009, expressing fears that he was going to die. On 20 November 2009, he spoke about a friend trying to steal his soul and put it into the body of an Asian woman. He was assessed as being of no significant risk to himself or others and was discharged back to the care of the east access team.

3.6 After a visit to Mr B's flat on 20 January 2010 the local housing team contacted the east access team. They found Mr B in a distressed state and flashing a crucifix at the housing team, saying he knew what they wanted. His flat was dirty, with mushrooms growing in the dirt and he had several screwdrivers and scissors lined up in front of him.

3.7 A Mental Health Act (MHA) assessment was discussed with his GP. The assessment started on 29 January 2010 and was completed on 31 January 2010, when he presented at A&E. He had taken an overdose of 60 paracetamol. He was not detained but referred to the crisis resolution and home treatment team (CRHT). He was assessed at home the next day but declined support and he was referred back to the east access team.

3.8 He was seen again in A&E by the mental health liaison team on 3 February 2010, he was discharged with emergency contact numbers. On Monday 15 February he fatally stabbed Mr D. On Thursday 18 February he gave himself up to the police and was subsequently charged with Mr D's murder.

Predictable or preventable

3.9 We conclude that Mr B's care was not effectively managed by the east access team. The team did not effectively assess the risk Mr B posed to the victim and potentially others. We believe that had it done so, it would have assessed Mr B as being a high risk which should have triggered a risk management plan being put in place.

3.10 An effective risk management plan that included options such as admission to hospital for further assessment, referral to the recovery team for the allocation of a care coordinator or allocation of his care to a specified person in the east access team for more assertive support and a more detailed risk assessment may have prevented the homicide.

Findings

F1 The east access team was designed for assessment and brief intervention and as a result was not a suitable service for people like Mr B who were guarded, often disengaged and needed consistent and assertive follow-up by professionals.

F2 The service model for clients in the east access team who needed assessment, formulation and assertive support was not clear and in part contributed to the lack of an overview of Mr B's needs and a failure to respond effectively to his deteriorating mental health.

F3 The risk assessment CPN 1 carried out on 15 July 2009 was inadequate and fell short of professional standards.

F4 The assessments by the mental health liaison team on 20 and 22 November were thorough and the actions appropriate.

F5 The referral back to the GP by the east access team on 25 November 2009, was not an adequate or safe response to Mr B's deteriorating mental health after the urgent referral from the A&E mental health liaison team.

F6 Mr B's risk to himself would have been reason enough to admit him to hospital after the MHA assessment on 31 January 2010. This would also have provided an opportunity for a more thorough assessment of his mental state.

F7 The team who referred Mr B to the CRHT team as opposed to making an order for a hospital admission should have ensured that a contingency plan was in place for his re-assessment if he did not engage with the CRHT team.

F8 The east access team did not carry out risk assessment and risk management processes thoroughly. This failure led to the lack of an effective risk management plan.

Recommendations

3.11 The main focus of this case was how effectively Mr B was cared for by the east access team. This team no longer exists and new team structures were implemented in June 2012. We have therefore considered how recommendations arising from our findings can be made.

3.12 In discussion with the trust we have identified a number of key themes arising from this investigation. We recommend that these themes should be part of a short

independent review but carried out in partnership with the trust. The objective of the review would be to identify how effectively the themes have been embedded within the new team structures and services and what, if any, further action needs to be taken. The trust is supportive of this approach.

3.13 The review process and the evidence needed to support it would be agreed with the trust at the outset. This approach provides external assurance that lessons have been learnt but will also contribute to the trust's own quality and governance processes.

3.14 The themes are:

- How do the new service delivery models address the challenges of difficult-to-engage, risky clients?
- How do the teams liaise and interface with each other in managing risky patients at various contact points?
- What is the quality of the clinicians' risk assessment and management?
- How effectively are MHA assessments carried out?

4. Chronology of care and treatment

First referral from GP

4.1 Mr B first came in contact with mental health services on 27 March 2008 after an urgent referral by his GP. Mr B complained of suicidal thoughts and voices telling him to do foolish things. Mr B was seen by a senior house officer (SHO) in the east access team. The SHO carried out a mental state examination and considered the following provisional diagnosis:

- possible mood disorder
- part substance misuse
- moderate depression with suicidal ideation
- possible post traumatic stress disorder (PTSD).

4.2 The SHO put the following management plans in place:

- an urgent day hospital referral
- referral to the PTSD clinic for counselling
- prescription of a mood stabiliser
- provision of a crisis number.

4.3 Mr B was seen again on 1 April 2008 by the SHO and a consultant psychiatrist who was providing holiday cover for the east access team consultant. Mr B said he did not want to take medication and assured them he felt better. The consultant psychiatrist wrote to the GP suggesting that Mr B would benefit from quetiapine and citalopram. Mr B was advised to keep attending the day hospital and await the appointment for the PTSD clinic.

4.4 Mr B was assessed at the day hospital for anger management on 9 April and six sessions were planned. Mr B contacted services a few days later to decline day hospital services and anger management. He assured staff that he was safe and would wait for the PTSD clinic appointment.

4.5 Despite having called to decline day hospital services, Mr B contacted the consultant psychiatrist on 15 April asking why he had been rejected from the day hospital and for a letter about his diagnosis.

Psychological assessment

4.6 Mr B received a psychological assessment on 15 September 2008 and PTSD symptoms were identified. He was placed on the waiting list for counselling.

Comment

Mr B would present himself for assessment or support and then rapidly disengage. This contradictory behaviour was a major feature of his presentation throughout his contacts with the services.

Second referral from GP

4.7 Mr B's GP referred him again to the east access team on 8 October 2008 for a psychiatric opinion. The referral letter said he was experiencing suicidal thoughts, that he was hearing voices telling him to do things and that he was volatile. Mr B had been in an incident with railway staff since his last contact with the east access team and had received a community service order.

4.8 On 21 October 2008 Mr B was offered an appointment by the east access team for 3 November but he did not attend.

4.9 Mr B's GP was advised by the SHO on 13 November that no further outpatient appointments would be offered. Advice was provided about medication. The GP letter stated the diagnosis could be:

- possible mood disorder
- emotional lability[1] with a moderate depression
- PTSD and history of substance misuse.

[1] Emotional instability

4.10 Mr B met with a psychologist on 13 November 2008 and asked why the initial assessment had been sent to his GP. The psychologist apologised and explained it was normal practice. He requested his assessment letter be removed from the GP notes. He said he did not want any further appointments.

4.11 Mr B was discharged from the east access team back to his GP on 18 February 2009.

Third referral from GP

4.12 A locum GP referred Mr B back to the east access team on 23 June 2009 and detailed Mr B's deteriorating social circumstances. He had been arrested for harassment of a tenant in the building where he lived. He was on police bail and excluded from the housing project because of his behaviour. The GP requested a psychological assessment.

4.13 Mr B turned up at a local outpatient clinic on 24 June in a distressed state after being homeless for the last four or five days. An urgent review took place. Mr B asked to restart psychological therapy. The central access team leader at the outpatient clinic was concerned about Mr B's deterioration. As a result he requested an emergency appointment with the east access team, and wrote a letter to support Mr B's need for emergency accommodation.

4.14 The homeless persons unit contacted the east access team on 1 July and requested further information regarding the risks that Mr B posed. The team held a meeting to discuss Mr B and a request was made for him to be assessed by a psychiatrist. Mr B declined a mental health screening assessment. The case was discussed with the east access team leader. A decision was made by the team to discharge Mr B back to his GP.

Comment

At this point Mr B had been referred three times by his GP since March 2008 and recently by the housing team. His mental state had obviously deteriorated and the manager of the central access team had referred him for an urgent assessment. In light of these factors, a referral back to the GP was inappropriate without further

effort to meet with Mr B and make an assessment. We discuss why this may have occurred in the next section.

Referral by housing

4.15 The housing team contacted the duty person at the east access team on 2 July 2009 to say that Mr B had been temporarily rehoused. The housing team was worried that Mr B might be unwell because he discussed complex delusions and reported that a fellow tenant was a witch and should be burnt at the stake. The housing team also sent a fax to the east access team confirming their concerns. The tenant was Mr D, whom Mr B stabbed and killed on 15 February 2010.

4.16 Mr B was phoned by the duty staff member at the east access team to arrange an appointment. He did not reply so a message was left.

4.17 Mr B attended a crisis appointment on 3 July 2009 at the east access team. He was assessed by CPN 1 and an SHO using the access team assessment documentation. Probation services provided information about his offending behaviour. The assessment concluded that Mr B should remain on the PTSD waiting list.

4.18 On 8 July the housing team requested feedback from the assessment but CPN 1 and the SHO were not available to provide it.

4.19 On 15 July Mr B was seen by CPN 1, who noted that Mr B was suspicious and not complying with medication. Mr B declined a further appointment.

4.20 Mr B was discussed in the east access team multidisciplinary team (MDT) meeting on 11 September 2009. The assessment on 8 July was discussed and it was noted that Mr B was paranoid and psychotic. The following action was agreed:

- a further appointment to be made for Mr B to see a psychiatrist
- CPN 1 to contact Mr B and his GP.

4.21 An appointment was made for Mr B to see a psychiatrist on 30 September but he did not attend. His GP was contacted by the team on the 26 October and it was

established that the last appointment letter had gone to the wrong address so a new one was sent out.

4.22 Mr B was discussed at the east access MDT team meeting on 3 November 2009. It was agreed that CPN 1 would discuss the case with the team consultant psychiatrist. We have seen no evidence that this discussion took place.

Comment

It is clear from the chronology and our interviews that the team psychiatrists were not routinely part of the MDT meeting. Referrals came directly from other team members to the psychiatrist rather than them being involved in the core clinical team assessment process.

4.23 Mr B did not attend a planned outpatient appointment with the psychiatrist on 13 November 2009 but phoned CPN 1 and told her he would contact her if he needed help. The team administrator wrote to CPN 1 asking her to confirm with the administrative team that she was coordinating Mr B's care.

Comment

From our interviews and in light of the administrator's actions we conclude that Mr B had not been specifically allocated to CPN 1 but that she was the most regular team professional in contact with him. We address how cases were allocated or not in the next section of the report.

Attendance at Brighton A&E

4.24 Mr B suffered from heart palpitations so attended A&E on 20 November 2009. He told staff that a friend (Mr D) was involved in the occult and had taken him to graveyards. He said that Mr D was trying to kill him. A&E staff discharged Mr B and told the east access team and the consultant about their concerns.

4.25 Mr B attended A&E again on 22 November, saying he feared he was going to die. Mr B was assessed by the mental health liaison team. The assessment recorded that Mr B was experiencing delusional thoughts, though he was guarded and that there were no violent or homicidal thoughts that might have posed a risk to others. The plan was:

- for an urgent referral to the east access team to be made, with the suggestion that anti psychotic medication should begin
- for 5mg diazepam to be prescribed.

4.26 The duty staff member from the east access team left a message for Mr B on 24 November but he did not return the call.

4.27 Contact was made by the team with Mr B on 25 November but he said he did not need support and that he had improved after taking diazepam. Mr B was discharged from the east access team services and his GP was advised that an MHA assessment should be considered if he went to A&E again.

Comment

Concern about Mr B's deteriorating mental state had been growing among Mr B's GP, housing and the mental health liaison team since July 2009. The east access team should have taken a more assertive approach to managing his care. They should have carried out a home visit or referred his case to the East Brighton Recovery Team, rather than discharging him.

4.28 A housing officer from the housing team and an emergency plumber went to Mr B's home on 20 January 2010 to investigate reports of a water leak. The housing officer knocked several times but no one answered. The repair was urgent and the housing officer had authority to enter so she began to force the door. Mr B ran towards the door shouting *"What do you think you are doing? Go away and leave me alone"*. The officer explained why she had come but Mr B insisted there was no leak and said *"I know why you are here"*. He held a large crucifix up against the window. The police were called and two officers attended. Mr B eventually agreed to let the female police officer and the emergency plumber in but he insisted the other police officer and housing officer stood

well away from the door so he could see them. The police officer told the housing officer that Mr B had several screwdrivers and scissors lined up and that he held the crucifix and did not make any eye contact or engage in conversation while the leak was being fixed.

4.29 The housing officer referred Mr B to the east access team outlining the sequence of events and saying she thought Mr B was *"clearly unwell"*. The team screened the referral on 22 January 2010. They wrote to Mr B asking him to make contact so that an appointment could be made.

4.30 A member of the east access team left a message on Mr B's mobile phone on 25 January.

Mental Health Act assessment

4.31 On 26 January 2010 the duty team contacted Mr B's GP with a view to carrying out an MHA assessment; the GP surgery was closed. Records show that involvement of the crisis resolution home treatment team (CRHT) was discussed but this was not acted on.

4.32 A member of the east access duty team phoned Mr B again on 28 January but there was no reply. The team member also phoned Mr B's GP but he was not available. A message was left asking him to ring the duty team urgently for a case discussion. Mr B's GP phoned the team to pass on information that Mr B had attended A&E departments in other parts of the country. During these visits Mr B told staff that he was concerned he was going to die. Mr B's GP also expressed concerned about Mr B's deteriorating mental state.

4.33 The housing team were also in contact. They told the east access team that the flat was in an unhygienic state and that Mr B did not want to go back to his previous address because the 'witch' (Mr D) lived there. Also that he was frightened, distressed and agitated.

4.34 The GP agreed during the phone call to request an MHA assessment, which he did. He discussed the assessment with one of the Approved Mental Health Act professionals (AMHP) and they agreed that the assessment would not take place that night.

4.35 The eCPA[1] records show that Mr B's consultant psychiatrist had also been informed about the situation. He was keen for the MHA assessment to go ahead.

4.36 The next day Mr B's GP, consultant psychiatrist 1 (not Mr B's consultant), and an approved mental health professional (AMHP) went to Mr B's house[2], but Mr B advised he was just about to go out to sign on at the employment agency. He denied any mental health problems and he left the house before the team could complete the MHA assessment. The team agreed to continue the MHA assessment the following week. Mr B was happy with this decision.

4.37 Mr B attended A&E two days later on 31 January 2010 following an overdose of 60 paracetamol. He was assessed medically and in addition, the adjourned MHA assessment took place.

4.38 The assessment was carried out by consultant psychiatrist 1 and AMHP 1 (not the AMHP who had been involved in the earlier assessment), and a different doctor. Mr B denied any mental health problems. He said that he had called the ambulance after taking some tablets but had spat some out. He attributed the suicide attempt to stress. He appeared well kempt, was appropriately dressed and made good eye contact. He denied any thought disorder but his speech lacked spontaneity. He was observed smiling and laughing to himself but would not elaborate. He admitted attending other hospitals because he felt like he was dying and that his energy had been taken away from him, but again he would not elaborate further. He told the team that he was planning to sign on and get work. They assessed his insight as poor.

4.39 The assessment team concluded that there were no grounds to detain Mr B under the MHA. It considered him to be more of a risk to himself than others.

[1] Electronic mental health records

[2] In most cases a Mental Health Act assessment involves two doctors (at least one of whom should be a section 12 approved psychiatrist under the Act) who consider whether a person is suffering from a mental disorder that would warrant treatment, and an Approved Mental Health Professional (AMHP), who acts as an independent practitioner to ensure that the person's rights and wishes are considered, and decides whether the person should be detained in hospital as a result of their mental health (because they are a risk to their own health and safety or because it is necessary for the protection of others).

4.40 The team made a referral to the CRHT team. On the same day the CRHT team phoned Mr B but his phone appeared off. Later that day they went to his house but there was no reply. A letter was left asking Mr B to contact the CRHT team.

Crisis resolution and home treatment team assessment

4.41 Two staff from the CRHT team went to Mr B's house the next day and carried out a full assessment. Mr B rationalised recent events to the practitioners and told them that it might be easy to accidently kill someone if he became involved in a fight. Mr B was given a contact number. He declined support. The CRHT team told the east access team that Mr B had refused to engage with them so he did not meet their criteria and they were no longer involved.

4.42 The housing team rang the east access team on 1 February, to report that they were concerned about Mr B's mental state.

Attendance at A&E

4.43 Mr B attended A&E again on 2 February 2010 with possible liver damage following the recent overdose of paracetamol. He was admitted to hospital overnight for tests. The A&E mental health liaison team contacted the east access team and were told that he was not under the care of the CRHT team.

4.44 The mental health liaison team was contacted by Mr B's sister on 3 February to check that they were aware that her brother was in hospital following his overdose. She informed them that she believed that he had had transient psychotic episodes in the past and that they might have been linked to substance misuse.

4.45 Mr B was also assessed by the mental health liaison team on 3 February. He again explained what had happened when he took his overdose and that he was now hoping to return to work with the help of an employment agency. He denied that he had any interest in the occult or that he was having experience of dead people communicating with him or that he felt threatened by others. He denied illicit drug use or excessive consumption of alcohol. He was well kempt, had good eye contact and he was calm and

composed. In contrast he appeared quite defensive and guarded, not keen to engage and amused by the proceedings. He grinned defensively but was reactive and spontaneous.

4.46 The assessment noted that he denied any suicidal ideation or intent and that he immediately regretted having taken an overdose. It also noted that Mr B had a history of psychosis but he had enough insight to recognise this as potentially abnormal and he chose not to disclose any details. Mr B was adamant that he did not want any support. The risks were assessed as low for suicide, violence and self-neglect. The plan was:

- for Mr B to consult his GP if he had concerns about his mental health
- to give him emergency contact numbers and tell him he should go to A&E if he felt suicidal so that the mental health liaison team could assess him
- to tell the housing department that Mr B had refused engagement and that he may become unwell again
- that the housing officer should contact the team if there were any further concerns.

Comment

The staff who conducted this assessment were aware of the assessments conducted in the last three days by the MHA team and the CRHT team. We review this assessment later.

4.47 Mr B stabbed and killed Mr D on 15 February 2010. He gave himself up to police on Thursday 18 February and was later charged with murder.

5. Team service design and operational issues

5.1 Before we analyse the themes arising from the chronology we give an overview of how the service was designed and operated. The terms of reference of this investigation include a review of the effectiveness of the trust community team's architecture, in particular the pathways of care between the various teams.

Care overview

5.2 The chronology shows repeated failures to act on serious signs of Mr B's mental health deterioration and risk over a period of almost two years. This was in spite of the involvement of at least two parts of the service - the access team and mental health liaison team – and in spite of the involvement of more than one psychiatrist.

5.3 In a later section of this report we identify a number of themes such as:

- the east access team not using single integrated case records
- the medical and psychological therapies notes not being held on eCPA
- case reviews, risk assessment, action planning and eCPA.

5.4 The trust investigation report also shows that 21 members of the trust saw Mr B. This combination of factors indicates a likelihood of systemic problems in the design and delivery of services from the east access team.

Team service design and operational issues

5.5 Seven integrated community mental health teams (CMHT) across Brighton each served a different geographical area until 5 November 2007. Patients were seen, assessed, followed up and looked after in hospital and after discharge. These teams were reconfigured into access and recovery teams in Sussex in November 2007.

5.6 The principal team working with Mr B was the Brighton East Access Team, a primary care focused mental health team offering a single point of access to mental health services. The service design was different in Brighton from that in other parts of

the trust because it also included a service called Improved Access to Psychological Therapies (IAPT). It was a pilot IAPT site, with government funding for staff training and recruitment and for providing evidence-based psychological interventions, including cognitive behavioural therapy (CBT). The commissioning primary care trust reduced funding if response times to referrals were breached but meeting targets secured further funding.

Comment

Offering a one-stop shop for all mental health referrals from GPs including common and treatable conditions, for example depression and anxiety, was organisationally simpler but prompted a significant increase in GP referrals. We were told in interview by a number of people that the focus on meeting referral targets placed additional pressure on the team.

5.7 We interviewed the east access team consultant psychiatrist, who helped us put the service design and its impact into context:

> *"The Access service was receiving thousands of referrals a year, I think 10,000 across the City so 2,000 or 3,000 in the East. There were very onerous targets and everyone was concerned about these breaches. If you breached the date by which an assessment had to be made there was a financial penalty, so the whole service was geared up – the clinical lead, the team manager – their focus was just on this very high volume turnover."*

5.8 The trust review said one factor predominating in Mr B's care was that he was *"maintained in the Access service whose core function was assessment and brief intervention"*.

5.9 The east access consultant psychiatrist told us that the service design in Brighton was different from that in other parts of the trust. He believed that the previous CMHTs in Brighton were reconfigured into rehabilitation teams while the access team dealt with all acute psychiatry.

5.10 We also spoke with recovery team manager 1. She said the access service was designed to deal with everyday presentational problems rather than those clients who needed assertive follow-up and that this created a gap.

5.11 She went on to say :

> *"I think that service redesign forced us apart, actually." "I think where senior management failed is that they did not make it clear who we are meant to be working with in Recovery; who are our client group? And who bridges this gap between ourselves and the Access primary care service?"*

Comment

The gap the manager of the recovery team was referring to was between low level mental health problems at the primary care level and longer-term recovery work. Mr B had a possible emerging psychosis and was frequently disengaged and guarded in his disclosures. He needed assertive support managed within a coordinated approach.

5.12 We interviewed east access team manager 2. He was the manager from March to November 2009. He told us the east access team was in fact more like a group of teams. It included IAPT staff, cognitive behavioural therapists and a group of staff without a specific title whom he called access practitioners; CPNs, occupational therapists, social workers, medical staff. These provided initial assessments, a single gateway into secondary mental health services and could provide support for individuals for up to 10 sessions.

5.13 East access team manager 1, who had been manager from its beginning until March 2009, told the trust review *"…he felt that the model of service delivery in Access was ill conceived and poorly resourced, increasing risk to others within the care of the team."* In interview with us he told us *"We were offering GPs a very wide range of interventions from a small hub."* He described it as *"a very complex system map"*.

5.14 In her response to the draft report clinical lead 1 told us:

"In my capacity as Clinical Lead, I would frequently be responsible for arranging assessment clinics and for ensuring that we met very tight deadlines on assessment timescales so that we did not breach. Each member of the Access Triage Team (which included CPN 1) would spend a large proportion of their week conducting mental health assessments, on average 4-5 a day. At one point due to high volume of referrals we were asked by Senior Managers to conduct 7-8, 20 minute assessments a day, bearing in mind that a high percentage of these could be highly complex referrals, or referrals considered to be high risk, this was a difficult and challenging amount of assessments to complete (along with high volume of paperwork) in one day.

"As well as our assessment duties, the Access Triage Team delivered a duty service on a daily basis. A designated member of the Triage Team would be office based each day to answer any urgent calls from referrers, to conduct face to face urgent assessments and to provide a duty crisis service to existing clients of all parts of the Service (including Psychology and IAPT)

"This was another busy aspect of our role and it would not be uncommon for duty to be dealing with up to 6 urgent referrals a day, seeing 2 people for emergency assessments and frequently we would be involved in arranging hospital admissions or referrals to the Crisis/Acute Services a process which could take up a whole day and part of the next with the paperwork involved."

Comment

The east access team was a mixture of enhanced primary care support services and an assessment/access signposting team. Demand for these services significantly exceeded the resources available. The team was dealing at the same time both with individuals who had low-level needs and others who may have had a potentially serious mental illness. The design and operation of the access team did not meet the needs of those with a serious mental illness well.

Finding

F1 The east access service was designed for assessment and brief intervention and as a result was not a suitable service for people like Mr B who were guarded, often disengaged and needed consistent and assertive follow-up by professionals.

Model of care

5.15 Access services did not operate within the Care Programme Approach (CPA) framework and did not allocate care coordinators. The trust operational policy states that access teams *"provide short intervention for people who are experiencing common mental health problems (e.g. mild to moderate depression and/or anxiety) and onward referral for people who have more complex presentations"*. The rehabilitation component became the recovery team and they looked after the long-term mentally ill who were in the service.

5.16 The operational policy outlines a need for referral to other teams such as the recovery team providing, *"involvement of multiple agencies, proactive follow-up…*[and] *care-coordination by a mental health team…"*

Comment

When community partners were raising serious concerns about Mr B's deteriorating mental health, it appeared he was suffering from a psychotic illness. He would have met the criteria for recovery team input outlined above and certainly required more proactive follow-up than the east access team could offer.

***The trust report makes clear that the east access team should have referred Mr B to the east recovery team, saying* "Care coordination would ensure information sharing between mental health teams and community partners".**

A referral to and treatment in the recovery service might have provided an opportunity for care-coordination and a better understanding of Mr B's changing clinical picture.

5.17 AMHP 1 told us that one of the shortcomings of access teams in general was:

> *"They will write to somebody offering them an appointment too far ahead in the future and then if they don't turn up or ring in then that's it then. They are passed back to the GP. There is no real effort to engage"*

5.18 CPN 1 from the east access team told us that clients were not on CPA, did not have a care coordinator and that the team did not particularly do assertive outreach unless the GP had identified a clear risk. She said that a client who did not engage with the team would be contacted, usually by phone, and if the team could not get hold of the person they would hand them back to the GP. She told us "*From my point of view I'd say that no-one particularly took ownership of it."*

5.19 The trust's access operational policy document (15 September 2009) states:

> *"Where patients do not respond to the Opt-In letter within the specified time (2 weeks) they are discharged and both they and the GP are informed of this by letter."*

5.20 East access team manager 1 told the trust panel that access was not designed for assertive outreach and there was no capacity in the team for follow-up. We asked him about engagement with clients who needed to be seen over a period to formulate their problem and whether that was possible within the access service. He told us: *"Sometimes it was and sometimes it wasn't."* He told us that team members including himself would go out with the team psychiatrist when they were concerned about risk to children, self or if someone had disengaged in a way that caused concern.

5.21 East access team consultant psychiatrist spoke of how the recovery team "*didn't see themselves responding to anything, which left us with a default position that all the acute psychiatry was being dealt with in the Access service*". The access team was deemed to be a primary care health service but the team consultant psychiatrist disagreed: *"we are looking after people with severe mental illness"*.

5.22 At the trust internal serious untoward incident (SUI) interview, east access team manager 1 described *"demand outstripping capacity with accruing waiting lists and lack of ability to refer to Recovery team"*. His perception was that 20-30 per cent of clients in

the access team had complex psychosocial needs. These individuals should have been supported by the recovery team.

5.23 East access team consultant psychiatrist told us *"we were seeing patients, and I can give you dozens of them, where patients had serious mental illness. We were managing them within the Access service because we couldn't transfer them across"*. He said he raised his concerns with the access team leader, saying *"Look, he needs an allocated worker to co-ordinate his care; he needs to be under the care programme approach"*, and the response he got was "*we don't allocate care-coordinators"*. When the consultant said *"We need to refer him to a service that does"*, which is the recovery service, the response he got was *"But he won't meet their criteria"*.

5.24 Recovery team manager 1 told us in interview about recovery and its workload:

> *"Capacity was always an issue and I think when the services split between Access and Recovery, Recovery lost about 15 care co-ordinators to the Access service and so they had to inherit those caseloads. So Recovery were really squeezed at the time of the configuration, and continued to be so...Generally speaking, yes, they all had caseloads of 35-40 in Recovery and were feeling Access are giving us more and more work and we're not managing to contain this whole workload. So, yes, I think that created a tension and it meant Recovery were probably quite strict in a sense about who they accepted in and who they didn't."*

Comment

The east access team was designed mainly to look after individuals on a single practitioner basis rather than through a team approach. We were told in interview that there was also a difficult relationship between the east access team and the recovery team and that this improved with a change of the access clinical lead.

The recovery team and the east access team both had stretched resources at a time when the referral criteria for the east access team had been widened. This put a strain on both services and added to their difficult relationship.

Finding

F2 The service model for clients in the east access team who needed assessment, formulation and assertive support was not clear and in part contributed to the lack of an overview of Mr B's needs and a failure to respond effectively to his deteriorating mental health.

5.25 When we interviewed AMHP 1 he spoke of Mr B's reluctance to disclose matters, which was fairly persistent:

> *"He was clearly not being open with us. I reckoned that the only way that stood a chance of getting in there and forming a link with him was to have the case allocated, so one person tries to form a relationship with him. He had been bouncing around, as we have said, and I think he needed to form a basis of trust with someone, because each time he is reassessed by new faces I wonder whether that will actually help him. It may help in a crisis in a very short-term way but it won't get to the bottom of the paranoid thinking".*

5.26 In our interview with Mr B he summarised the approach to his care with the statement *"No one knew me"*.

Duty

5.27 Different staff were allocated to duty responsibilities each day, which meant they would cover all referrals that had come in for assessment before their allocation to members of the team. Any work with an individual not completed that day would be left in the duty tray. The next duty worker would do further work on the case and respond to calls about the case the next day. East access clinical lead 2, who took up post after the incident in March 2010, described the duty tray as *"duty hold"* and said that he returned after his summer holiday that year to find paperwork for 80-90 clients sitting in the tray. He said staff told him that dealing with these was his responsibility. As a result of this he abolished the duty tray, ensuring that all cases were allocated.

5.28 East access team manager 1 told us *"…demand on the duty worker was consistent; we were dealing with urgent referrals. You could be seeing someone who was floridly psychotic coming in, so that part of the pathway could place the duty worker in a position where they are having to spend two or three hours dealing with a single case… [also] phone calls, arranging appointments, contacting other services, formulating a treatment pathway for the patient if they had been seen and needed sign-off by a senior clinician or another appointment to be made with a medic."*

Partnership Working

5.29 The east access team needed to coordinate its work with other teams such as the recovery team. The trust review report suggests that Mr B should have been supported by the recovery team because they worked within CPA and he would have been allocated a care coordinator who would have been able to *"hold a comprehensive understanding of his changing clinical picture and the historical psychosocial needs."*

Comment

We agree with this view. We therefore have explored why he was not referred to the recovery team.

5.30 East access team manager 1 told us that he was initially the principal negotiator of cases being referred to the recovery team and that he would talk with recovery team manager 1, with whom he had a good relationship. When clinical lead 1 was appointed he delegated this task to her. She developed a more formal structure using a referrals log and referral record.

5.31 Access team manager 2, east access team manager from March to December 2009, was asked during the trust's internal SUI review about referring someone like Mr B to recovery. He felt there was a poor relationship with that team, saying *"there was an interface problem. It was cultural. The impact was that Access had caseloads including high risk clients"*.

5.32 A number of interviewees told us that east access clinical lead 1's approach was best described as extremely assertive. The east access team consultant told us:

> "[clinical lead 1] *upset I think pretty much everybody, and the pathway that had been set up was that she as the team leader would liaise with the team manager for the Recovery Team, so again there was a disparity in status and position."*

5.33 Access clinical lead 2 told us:

> *"There are two factors involved here: there was a complete breakdown of communication between the Access service and Recovery. That was partly the fault of* [clinical lead 1]*….Part of that was down to the downright confrontational type attitude that* [clinical lead 1]*, under pressure – I have to say that on a different day they could not tolerate coming down to talk to her – it was just a battle."*

5.34 Access team manager 1 had worked with clinical lead 1 in a different trust and had a different view of her management style. He told us:

> *"I would describe her as being assertive, making sure that, if she is concerned about an issue, she takes that issue forward as forcefully as is required to make sure that patient safety is maintained. I would say she is willing to be flexible within the remit of the service that she is providing,"*
>
> *"Again, assertive, direct, patient-focused. I suppose people's perception could be, if they do not know her particularly well, that she is a bit rigid but that rigidity comes from the need to make sure that the job is going to be done."*

5.35 Access clinical lead 1 had left the trust at the time we carried out our investigation. We contacted her to offer her the opportunity to be interviewed. We sent her all extracts from our interviews that related to her work. We offered a number of interview dates but she declined on professional advice to be interviewed. She subsequently sent us a detailed written response to the draft report.

Senior Management oversight of the East Access Team

5.36 We discussed this section of the report with a number of board level managers. They told us that they were aware of some of the difficulties that were affecting the work of the east access team and that they took some short term and longer term remedial actions to support the work of the team. We set out below a summary of the information supplied to us. This sets out key actions that senior managers took from January 2009 until June 2012.

- March 2009 - Change of east access team manager due to reports of team relationship difficulties.
- April to June 2009 - Reviewed and addressed issues of the increase of referrals, waiting times and waiting time targets. Managers accepted that targets would not be met in the fourth quarter of 2009 and penalties would be paid.
- March 2010 - A new screening process introduced to identify whether a more complex assessment was needed.
- May 2010 - Training plan for access service developed.
- July 2010 - Clinical notes audited.
- July 2010 - New pathway between access and recovery developed.
- July 2010 - Brighton urgent response service developed taking away the urgent response targets from the access service.
- January 2011 - Did not attend policy agreed.
- January 2011 to 2012 - Design and implementation of the new model of access and recovery service (this is dealt with in section 8 of this report).

5.37 The information supplied by the trust also shows that during the period February 2009 to February 2010 the east access team had five different team managers/service managers/clinical leads. All the changes bar one occurred as a result of senior staff moving to new jobs.

Comment

We have not included all the detail supplied by the trust but the summary set out above shows that senior managers were aware of the design faults in the way the access service was set up and also some of the operational difficulties.

The large number of changes to team managers in one year would have had an impact on team development and quality improvement. Despite this it is clear to us that senior managers made changes to try and make the service more effective. When it was clear that the service model was flawed senior managers put in place an alternative approach. We discuss the alternative in section 8.

6. Analysis and comment

6.1 The information in this section is based on our review of Mr B's clinical records, our interviews with trust staff and extracts from the trust's internal review. We provide an overview and analysis of Mr B's care divided into three phases:

- early assessment
- crisis period
- MHA and mental health liaison team assessments.

6.2 We also give particular attention to these themes:

- suitability of treatment and care
- risk assessment and risk management.

Early assessment

6.3 Mr B's first contact with trust services was on 27 March 2008 when he was referred by his GP. He was initially assessed by an east access team SHO and five days later by the SHO and a consultant psychiatrist covering for the team consultant.

6.4 The assessment by the SHO contained much of the relevant information. The SHO considered whether Mr B had a mood disorder, for example depression, whether on its own or as part of a bipolar illness. She considered a possible role for substance misuse (though she does not pursue this any further). At the end of the assessment she sought to formulate a differential diagnosis[1].

6.5 One aspect not covered in the initial assessment was the possibility that Mr B's clinical presentation was a result of damage to his brain caused by the accident in 2000. Brain damage can result in a class of mental disorders that include 'organic depressive disorder' and 'organic delusional [schizophrenia-like] disorders'. These disorders can take years to develop. Some studies have found a median[2] time of six or seven years from the time of the trauma. In this case, the period between the accident and the development

[1] A systematic comparison of similar symptoms to determine a diagnosis
[2] The middle value in a frequency distribution

of the mental disorder was seven or eight years. Mr B's sister told the mental health liaison team that her brother had suffered from psychosis before arriving in Sussex.

Comment

If the possibility of Mr B's symptoms being the result of his brain damage had been considered, this should have led to his being kept under close medical supervision. Despite this we make no causal connection between this aspect of the assessment and the homicide two years later.

6.6 Mr B was given a provisional diagnosis of PTSD after these assessments, prescribed medication, referred for day hospital support, PTSD assessment and given a crisis contact number.

Comment

The possible PTSD diagnosis appears to have been maintained as a formal diagnosis throughout Mr B's care and had an impact on his continuing management. This may have influenced the perception of his risk to others as most of the risk assessments carried out focused on Mr B's risk to himself.

6.7 Mr B's GP referred him back to the east access team on 8 October 2008. The GP reported that he was *"quite volatile",* in low mood, was having nightmares and suicidal and delusional thoughts. He was also doing community service after an incident with a railway employee.

Comment

With the possibility of an organic condition in mind, some of the points in the GP's referral could have suggested beginnings of a paranoid condition, possibly psychotic in nature. Therefore a diagnosis and treatment for psychosis should have been considered in addition to Mr B's remaining on the waiting list for PTSD.

Case allocation

6.8 It is unclear in the records whether Mr B was allocated to a particular professional. CPN 1 told us she did not recall him being allocated to her: *"I just know that I saw him for the initial assessment, and then offered him the follow-up just to complete an assessment"*.

6.9 An entry in the records from the administrative team dated 13 November 2009 asks CPN 1 if she could confirm if she was coordinating Mr B. We asked access team manager 1 whether he knew if Mr B was allocated to CPN 1. He assumed she was, though her name did not appear on a list of clients allocated to her.

6.10 In summary Mr B had been referred three times to the east access team between March 2008 and June 2009. He was assessed and placed on the waiting list for PTSD. He was referred for day service support and anger management training and his GP was given advice about his medication. He was arrested and bailed for threatening behaviour towards his future victim. He was also on a community service order after an incident with a railway employee. He was homeless, having been evicted from the housing project because of his threatening behaviour. He was discharged back to the care of his GP after the first two referrals. After the third, no assertive action was taken to assess the risk and urgency of need.

Comment

Mr B needed someone from the east access team to take a lead role in his care and that did not happen. His care was a series of reactive responses to particular events.

Crisis period

6.11 The housing team contacted the east access team on 2 July 2009 to say Mr B had been charged with harassment and evicted from his property. They said he had been accusing a fellow tenant of being a witch; of stealing his brush and saying he should be burned at the stake. The tenant was the victim in this case. The housing officer called the east access team duty later that day to say she had seen Mr B and was concerned

about paranoid ideation and felt he was unwell. Mr B had given explanations regarding complex delusional thoughts, networks around the occult and his threats to burn the previous tenant at the stake for being a witch. The duty staff member called Mr B and booked a crisis appointment for the following morning.

6.12 CPN 1 and an SHO reviewed Mr B the next day and talked with him about problems with his former fellow tenant and his recent eviction. Mr B showed signs of paranoid ideation, had threatened to kill his neighbour and his mood was very changeable. Their plan was to offer a follow-up appointment and to keep him on the PTSD waiting list. The assessing CPN and SHO did not alert the team consultant psychiatrist about the presented risks.

Comment

As a result of the vivid concerns the housing team raised, either CPN 1 or the SHO should have discussed the possibility of an emerging paranoid psychosis with the team consultant.

6.13 Mr B was seen again 12 days later on 15 July 2009 by CPN 1. He was assessed by her as being more suspicious and non-compliant with medication and he declined a further appointment.

6.14 CPN 1 told the trust's internal review panel that she knew Mr B had made threats to kill his neighbour and that was why he had been evicted. Despite this, she had no concerns that he would harm others and had no sense that he required more assertive outreach because he had no history of self-harm. She could not recall seeing the patient's notes on eCPA before she carried out her assessment.

Comment

This assessment 12 days after the previous one did not identify the extent of Mr B's mental health deterioration and action taken as result was inadequate. We

understand from the trust that CPN 1's practice was reviewed by the trust following the trust investigation.

6.15 Despite the concerns the housing department raised that Mr B was threatening to kill his neighbour, there was no further contact with him until 13 November 2009. He was sent outpatient appointments for September and October but did not attend. He contacted the team in November to say he did not want to see a psychiatrist and would ring CPN 1 if he needed help.

6.16 Towards the end of 2009 Mr B began attending A&E departments around the country, expressing fears that he was going to die. He went to Brighton A&E on 20 November 2009, complaining of palpitations. He was also assessed by the mental health liaison team. He told them a fellow tenant (Mr D) was involved in the occult and was trying to steal his soul and put it into the body of an Asian woman. Mr B was assessed as being of no significant risk to himself or others and was discharged back to the care of the East Access team.

6.17 He went to Brighton A&E again on 22 November 2009, fearing he was going to die and was assessed again by the mental health liaison team. He made references to black magic, that he had died before and that he had broken a set of rules but would not elaborate.

6.18 The assessing nurse carried out a thorough assessment of Mr B's mental state and also discussed her findings with the SHO on call and with the A&E consultant. The plan was for Mr B to be referred to the east access team for review by a psychiatrist in the morning, with a view to him starting on antipsychotic medication. Mr B was prescribed 5mg diazepam BD to reduce anxiety and help him sleep.

6.19 The east access team phoned Mr B on 25 November 2009. He said he did not want support and was settled on his diazepam. He was consequently discharged back to the care of his GP that day. The team discharge letter to the GP suggested that if Mr B came to the GP practice or A&E *"it may be useful to consider a Mental Health Act assessment"*.

6.20 No further contact was planned or made with Mr B until the housing department contacted the service in January 2010.

Comment

Mr B disclosed abnormal thoughts when he went to A&E departments. He also presented in conflicting ways; on the one hand refusing appointments and failing to turn up and, on the other, making contact again and again. This is an unusual pattern and required professionals to follow him up assertively to understand the meaning of this pattern of engagement and disengagement and risks to Mr B and others.

Findings

F4 The assessments of the mental health liaison team on 20 and 22 November 2009 were thorough and the actions taken appropriate.

F5 The referral back to the GP by the east access team on 25 November 2009, was not an adequate or safe response to Mr B's deteriorating mental health after the urgent referral from the A&E mental health liaison team.

Resources and workload

6.21 East access team manager 1 described the types of clients and the level of need that the east access team faced:

> *"Most of the patients in the East Brighton area, which has a high level of deprivation and is high on the Needs Index for severe and enduring mental health problems, came with an alcohol or substance misuse problem and depression, or an anxiety disorder plus some previous PTSD, or sexual abuse, personality issues, depression, self-harm."*.

6.22 The team faced resource difficulties. East access team manager 1 told us he raised this with his seniors and that more bank nurses and an occupational therapist were added as a result.

Comment

The large number of referrals and the wide range of clients needs put the team under great pressure.

6.23 East access clinical lead 2 told us:

> *"Complexity was the biggest problem of the East. Secondly, was the actual ratio of practitioners. We had six Cognitive Behavioural Therapists, six different types [therapy], but in the East we had the higher proportion of referrals and between 65% to 70% and probably more were going to nurse practitioners as opposed to the other team [CBT]. By contrast in West, a higher ratio was going to CBT, Psychological Wellbeing Practitioners and the risk ratio was lower."*

Supervision and team relationships

6.24 CPN 1 told the trust's internal review panel that she had a poor relationship with her managers and was avoiding having supervision at that time. She described her working relationship with clinical lead 1 and access team manager 1 as undermining and bullying:

> *"I ended up getting into quite a bad way actually, really depressed, anxious and quite chaotic. I'd be going to work in body but not in mind. It was an absolutely horrible period of my life. My practice just went completely down the drain at that point."*

6.25 Following their review of the draft report both access team manager 1 and clinical lead 1 told us that CPN 1 had performance issues prior to working in the access team and that they sought to address these with her.

6.26 Access clinical lead 2 told us that clinical lead 1 was directive and autocratic in her management style and that she was working with limited resources, was under great pressure and ignored by senior management.

6.27 Access team manager 1 told us:

> *"On balance, there are some similarities in the way in which I was managing the service on an operational level and the way in which* [clinical lead 1] *was managing the service more clinically. We are both very direct people and we were both giving the staff very direct instructions as to how we expected the service to be delivered."*

6.28 Recovery team manager 1 told us she sometimes spoke to clinical lead 1 about how she approached colleagues and said she could be quite antagonistic. She also said that the working relationship improved when the clinical lead changed and the teams then worked better together.

6.29 Clinical lead 1 responded to these views of her work in her written response to the draft report. To ensure fairness we set out below her response regards her working style.

> *"In my Clinical Supervision I frequently talked through with which ever Manager, the day to day difficulties and challenges of working in this Service, and also my own performance objectives and development needs. Again I do not have a recollection of any performance issues regarding my communication skills or manner being raised with me (with the Access Team or any other Team) so was unaware of any issues in this respect. I was also never spoken to in my own supervision about any direct links my Supervision or communication style were having on CPN 1's emotional health and well-being or professional practice.*
>
> *"I am aware that CPN 1 was experiencing difficulties in her clinical role, and that she was experiencing low mood and anxiety problems. I was never informed that these issues were in any way connected to her relationship with me or any issues she had with my clinical leadership."*

Mental Health Act assessment and mental health liaison team

6.30 No further contact by the east access team was planned or made with Mr B during December 2009 or early January 2010. The housing team contacted the east access team on 20 January 2010 detailing Mr B's recent distress and behaviour which they felt was

consistent with psychosis. During a visit that day he had several screwdrivers and scissors lined up in front of him and flashed a crucifix at staff.

6.31 Clinical lead 1 discussed concerns with Mr B's GP on 28 January 2010. The GP said she had been concerned for several months about his mental state and felt he had untreated psychosis.

6.32 A MHA assessment was started on 29 January 2010 by an AMHP, consultant psychiatrist 1 and Mr B's GP. They could not talk to Mr B in depth about their concerns because he was rushing out, but he attributed his problem to stress. They assessed the risks as relatively low and contained and agreed with Mr B to continue the MHA assessment the next week when his GP was available.

Comment

The east access team had advised Mr B's GP two months earlier to consider a MHA assessment. This assessment was taking place more than a week after the referral from the housing department who were concerned about Mr B and his distressed demeanour. Mr B had a well documented history of guarded disclosure, and avoiding close supervision or assessment from the mental health team, therefore the decision to defer the assessment to the next week was inappropriate and an earlier date should have been arranged.

6.33 Mr B was admitted to A&E on 31 January 2010 after an overdose of 60 paracetamol. He was medically cleared but his attendance at A&E enabled the MHA assessment to be completed. It was carried out by AMHP 1, consultant psychiatrist 1 and an independent doctor.

6.34 AMHP 1 told us he had read Mr B's electronic care notes before the assessment. He completed a report after the assessment and said that Mr B was *"extremely guarded"* and *"attempted to minimise all the concerns we put to him"*. AMHP 1 wrote in the assessment form section on 'Risks to Client and Others':

"Given that [Mr B's] *account appears guarded and unreliable, there is a risk that he may be considering a further attempt on his life. However, admission would not diminish the risks, and in his current presentation he would not be considered for one-to-one nursing."*

6.35 Mr B was not placed on a MHA section and admitted to hospital but was referred to the CRHT team.

Comment

The assessment report does not make clear how much attention was given to assessing Mr B's risk to others, as required by the MHA. The decision not to detain Mr B might have been different if more weight had been placed on risk to others and supporting information.

6.36 Consultant psychiatrist 1 was present at both assessments. He told us the AMHP at the first assessment showed him papers about Mr B and he had reviewed the letter from the housing department sent after the emergency visit to Mr B's flat on 20 January. AMHP 1 again told consultant psychiatrist 1 about previous care details at the second assessment.

6.37 AMHP 1 had reviewed Mr B's history and knew of his marked tendency to be guarded and that a relationship needed to be formed with him so that a more accurate assessment could be made.

6.38 The MHA assessment did not detail the medical opinion influencing the decision not to detain. Consultant psychiatrist 1 told us that if everyone agrees then only the AMHP writes the outcome in the report. We asked him what led him and the team to decide not to detain Mr B. He told us:

"We looked at it and we found that he had been in many hospitals before. It was like going to A&E was an attempt but it wasn't serious, so from that he was willing to engage with the Crisis Resolution Team. The discussion was 'Shall we admit him, or is it better to have somebody who can make a relationship with him in the

community, if there is a way?' *We tried to evaluate the risk, and we felt that if he called the ambulance himself that was an indication that he wasn't serious about killing himself."*

"At that point with the guardedness meant that we thought he might be psychotic, or that there was some level of psychosis. Even if it was minor we didn't see it at that point, but we assumed that he might be psychotic."

6.39 AMHP 1 told us:

"In terms of risk to himself he had been presenting at A&E departments around the country, but not with an actual overdose. The first time he took an overdose was on the occasion when we saw him in the Royal Sussex."

6.40 We asked consultant psychiatrist 1 and AMHP 1 what account they took of the letter from the housing team which had vividly described Mr B's demeanour.

6.41 AMHP 1 told us:

"… from my memory it was felt that even though they knew that he had these screwdrivers and scissors, the thinking was that was for his own protection rather than with any overt violent intent."

"…speaking away from this case very often things are reported about people, and if you take them at face value they are alarming, but then you scratch the surface and you discover that it is hearsay, Chinese Whispers, and what really happened was this. You only come to that often by having dialogue with the person concerned, the patient."

6.42 Consultant psychiatrist 1 told us:

"Frankly from our experience, sometimes the Housing Officer or somebody gives you a picture, and when you go there you might see a different picture, as a psychiatrist. It happens. Every day people do Mental Health Act assessments and the number who are detained are much less. We took all that into account, we got there and we tried to see if there were screwdrivers laid around, if he did hold a cross or something

similar as described by the Housing Officer or at least that he showed any odd behaviour but he did not disclose any psychotic features or showed any abnormal behaviour. It was a very short assessment, [The first assessment he was involved in] *a few minutes, but we didn't see any of that, and at the same time we felt his plan to do something for the future was to some extent reassuring, together with his willingness to be seen again."*

Comment

The letter from the housing team had been sent after its representatives went to Mr B's house and needed help from police to gain access. The housing team had previously raised concerns and therefore the housing officer's description of Mr B's demeanour should have carried more weight in the assessment.

6.43 Mr B was referred to the CRHT team but the referral did not contain a contingency plan detailing what should happen if he did not engage with them. Consultant psychiatrist 1 told us:

"When they [CRHT team] *assess a patient they have to bear in mind that it is a mental health act assessment referred to them and not to access. Then it is not a matter of engagement, it is a matter of the risk at that point of time, and if they feel that the risk is still there and it is 'Let us refer him to Crisis', they should admit him or refer him to the AMHPs."*

6.44 We asked AMHP 1 about contingency planning. He told us "*We don't do that as a matter of course but there are examples of that, yes."*

Comment

Consultant psychiatrist 1 told us that Mr B's failure to engage with the crisis team should have led to either an informal admission to hospital or another MHA assessment to determine whether he should be detained. The CRHT team was not told what the MHA assessment team expected to happen if Mr B did not engage.

***The MHA assessment team's decision that there were* "no grounds for detention or admission" *was taken in the face of Mr B having just taken a large overdose and his recent risk history that was known to both practitioners*.**

Expert advice

6.45 Our expert adviser reviewed all the records related to Mr B's care and we summarise his opinion below. The rest of the investigation team endorses the advice from our expert.

6.46 Our expert adviser says the letter from the housing officer dated 20 January 2010 and addressed to the 'duty worker CMHT' is perhaps the most critical piece of evidence. Its description of the patient's presentation and the state of the flat was enough to allow a firm diagnosis of a paranoid psychotic illness. If this patient had never presented to the services before this report from the housing officer, and no past psychiatric history was known, the housing officer's letter of concern would have been more than enough for the services to act immediately by assessing him under the MHA. However, the patient was already known to the services.

6.47 The electronic records show that Mr B had suffered a severe head injury, that he had appeared at first depressed but subsequently was showing signs of being paranoid and harbouring persecutory beliefs that may have been delusional.

6.48 The records note Mr B's forensic history, including his imprisonment for dangerous driving, previous arrests and imprisonment for various criminal offences. They also record that he had used illicit substances. Our expert adviser therefore concluded that "*all this adds up to as dangerous a scenario as could present to any mental health services*".

6.49 It appears from the record of the assessment that the focus of the assessment team was on Mr B's risk of harm to himself rather than to others. The records clearly show that Mr B had not engaged well with the east access team and was therefore unlikely to do so with the CRHT team.

6.50 A draft of this section of the report was sent to AMHP 1 and consultant psychiatrist 1 for comment. AMHP 1 had no comments to make to our draft. Consultant psychiatrist 1 told us:

> *"…we considered the history and we did not dispute that Mr B was possibly suffering from a mental illness of psychotic nature. We were also aware of the number of tablets taken as an overdose; however, we also took into consideration the actual intention of Mr B to end his life as that was the first time he had taken an overdose and he called the ambulance worried that the overdose might kill him. We agreed that he needed thorough assessment and treatment which could be through admission under the MHA or by the CRHTT. As already explained, we decided after careful consideration, to go for the least restrictive option initially, especially because the involvement of CRHTT would start on the very next day, and the patient had agreed to this plan and was likely to engage better from home."*

Comment

The medical involvement in a MHA assessment is first to assess whether a patient is mentally ill and if so the nature of the illness. It appears from the record of this assessment and our interview that consultant psychiatrist 1 and the other attending doctor did not sufficiently assess Mr B's history to determine the nature of his illness, if he had one. It also appears that in assessing his risk of self-harm, little account was taken of the number of tablets he took and too much emphasis was placed on the fact that he called an ambulance. Referring him to the CRHT team when he was guarded and had a history of non-engagement was likely to fail.

AMHP 1 told us he had reviewed Mr B's electronic care notes before the assessment. Either that review was inadequate or the decisions of the assessment team did not properly take account of his history.

We understand and accept that reviewing records can provide a different perspective on risk than a face-to-face interview with a patient. Our expert adviser was nonetheless clear that when all the information available to those involved in the MHA assessment was weighed up, the decision not to section Mr B was wrong and that the failure in this regard was a failure by the whole team.

Finding

F6 Mr B's risk to himself would have been reason enough to admit him to hospital after the MHA assessment on 31 January 2010. This would also have provided an opportunity for a more thorough assessment of his mental state.

F7 The team who referred Mr B to the CRHT team as opposed to making an order for a hospital admission should have ensured that a contingency plan was in place for his re-assessment if he did not engage with the CRHT team.

Recording of medical opinions

6.51 We asked consultant psychiatrist 1 why there was no record of the medical opinion. He told us that if the team agree then only the AMHP writes the report. Trust managers have told us that since this incident, doctors should always record their own part of the MHA assessment report.

Approved mental health practitioner service

6.52 The AMHP service consists of a small number of dedicated staff in a stand-alone team. This team is supplemented by other AMHPs on a rota. AMHP 1 told us:

> *"One of the reasons that Brighton has a dedicated AMHPs team is for one thing it has the highest Section 136 rate in the country, so we are a very busy area. Experience has shown that to have a core group of dedicated AMHPs provides a better service, there is more continuity, you don't have a succession of different people coming in and having a crack at a piece of work that might be going on for several days. We work out-of-hours as well, so there is more continuity in that sense.*
>
> *"In terms of our relationship to other teams including Access, we are there to discuss any potential referrals, so it is not just a case of other teams deciding 'Yes, this is a Mental Health Act assessment', and bunging it our way. We are*

open to dialogue about that and discussing other potential ways of handling the situation."

6.53 AMHPs are part of community teams in some services. A possible advantage to the approach taken in Brighton is that the opinion of the AMHP at an MHA assessment remains independent. However, a possible disadvantage is that the AMHP is not involved in the work of the community teams early enough.

Comment

We have not examined the advantages or disadvantages of locating an AMHP team separately from other community teams but in light of the way this assessment was carried out, we would suggest that the trust carries out a review of the different approaches.

Crisis resolution and home treatment team assessment

6.54 The CRHT team completed an assessment at Mr B's home on 1 February 2010. The outcome was that he declined support and was referred back to east access team.

6.55 We interviewed senior social worker 1, one of the members of the team who carried out the assessment. She told us that when they visited him his house was orderly and tidy. Mr B had been ironing shirts ready for a job interview. He told them his sleep and appetite were alright.

6.56 The trust panel had interviewed the other team member. She told them:

"He did not appear uncomfortable but gave short answers and was guarded. Rather than ask questions, we chatted with him to try and engage. But he was clear he did not want follow-up involvement from the Crisis Team."

6.57 Senior social worker 1 told us she was aware of Mr B's history and record of disengaging with services. Her colleague had reviewed the notes. Senior social worker 1

was also an AMHP, so we asked her what she would have done as a result of the report from the housing officer. She told us:

> *"I would still have referred him to the Crisis Team... I can't speak for another AMHP, but I would have said to Mr B 'you haven't agreed to what was agreed to and decided, you have not engaged with the Crisis Team'."*

She then told us that she would speak again with the doctors who had been involved with the Mental Health Act assessment and that:

> *"They could have done a recommendation without seeing him again. I would have liaised with them, I think, and asked them what we should do"*

Comment

The view of senior social worker 1 was that the referral to the crisis team might have been a reasonable option if it had been accompanied by a contingency plan. The plan should have contained the possibility that Mr B would be re-assessed and if eligible detained under a section of the MHA 1983 if he failed to engage. We agree.

Assessment at A&E

6.58 On 2 February 2010 Mr B was again assessed at A&E. He presented with potential liver damage as a result of his overdose and was admitted overnight. Mr B was medically cleared for discharge on 3 February and was referred to the mental health liaison team for assessment.

6.59 RMN 1 documented details of her assessment in the case notes. She wrote:

> *"Quite guarded and evasive during mental state examination, but has history of psychotic presentations and may be experiencing some symptoms of psychosis which he has enough insight to recognise as potentially abnormal, and chooses not to disclose."*

6.60 Mr B was adamant that he did not wish to engage with mental health services. The risks were assessed as low for suicide, violence and self-neglect. The team decided that he should be referred back to the care of his GP and given emergency contact numbers.

6.61 RMN 1 was the last professional to assess Mr B. We therefore quote extensively from her interview with us:

> *"I saw him on the ward and we normally took people to interview rooms but in his case, because I knew of his history, and he presented as quite odd really, I decided not to take him to an interview room and decided to see him in an open area on the ward. He certainly wasn't aggressive in any way towards me but he grinned a lot. There was no sign that he was responding to any hallucinations or any unseen stimuli. I felt that, as other people had said, he was vague, he was a bit guarded, he seemed a bit suspicious but he denied, although I questioned him at length about symptoms, he denied that there was any problem. He stated very firmly that he felt he was okay and didn't need any help from mental health services, but at the same time he was grinning incongruently so I knew that there was something going on."*
>
> *"He'd had the Mental Health Act assessment within three days of my seeing him and he'd also been seen by the Team Leader of the Crisis Team as well. They thought there were no grounds for sectioning and if he didn't want to engage with mental health services, although there were concerns, so I was using their assessments and their opinion to form my judgment as well."*

6.62 Mr B's sister called while he was in hospital. RMN 1 spoke to her. She told us that his sister:

> *"…was raising her concerns…She said he was quite odd sometimes, not always, but sometimes he was quite odd. She said she didn't know if he was using drugs or if that had something to do with it; she wasn't sure. She didn't see much of him. She said she lived in Manchester. She had contact by telephone with him and didn't see that much of him."*

6.63 She summarised her assessment as:

> *"The main reason that I was asked to see him was because of the paracetamol overdose. He came back in because he was having problems because he hadn't had sufficient treatment and it was really just to make sure that he was safe. In my opinion he came back to hospital of his own accord, he accepted all the treatment, made no attempt to leave, was all right to see me, wouldn't say happy but cooperative to see me. He did everything that he was asked to do."*

Comment

According to RMN 1, the fact that Mr B had been assessed under the MHA only three days earlier and since then by the CRHT team had influenced her judgement.

She told us her main focus was assessing whether anything had changed over this brief period rather than looking at the overall picture. We agree that nothing in Mr B's presentation on the day of her assessment should have led her to take a different view from the earlier assessments.

7. Risk assessment and risk management

7.1 The trust policy and procedure for clinical risk assessment and management dated 4 December 2008 says: *"All service users in Sussex Partnership NHS Trust will have a Brief Screening or Level 1 and/or Level 2 risk assessments completed as required and updated at least every six months, or earlier if there is a change in circumstances relevant to risk".* Risk management plans will include accessing support during crisis and out-of-hours periods. A risk management plan should be updated by reviewing critical and other relevant risk factors on a regular basis. Change in risk factors in any area should prompt a revision of the relevant risk formulation.

7.2 The trust policy glossary of terms describes risk formulation as:

> *"the outcome of a process whereby a single practitioner or care team working together examine all the risk and protective factors relevant to the service user being assessed in order to produce a coherent explanation in a narrative form of how and why the most relevant risk factors interact with one another over time to bring about changes in risk."*

7.3 When the east access team assessed Mr B on 28 March 2008, an initial risk assessment form was filled out but the 'Statement of Risk' and 'Interim Management Plan' sections were left blank. The form appears to have been completed by the assessing SHO but not signed.

7.4 When CPN 1 reviewed Mr B on 3 July 2009 she completed an access risk screening tool. Several questions were left blank, including *"Do you believe the person has an intention to cause harm to others?"* This was in spite of her having reported in the assessment document that another tenant had called the police saying that Mr B had made threats to kill him. The records that CPN 1 had available to her about Mr B showed that he had been charged with harassment and had two previous convictions for harassment. She did not reflect this in her risk assessment.

Comment

The east access team failed to follow the clinical risk policy and to respond accordingly to Mr B's presentation and supporting information. Initial and continuing risk assessments were inconsistent and based at times on self-report without due consideration of supporting information.

The emphasis in the assessments was repeatedly on risk to self. Staff were not alerted to the changing risk picture and their assessments did not reflect the nature of Mr B's behaviour and actions that community partners had seen. Assessment documentation contained no clear narrative explanation of risk factors over time and therefore no risk formulation.

Assessments were not consistently translated into risk management or care plans. If the recovery team had managed Mr B's care frameworks such as the CPA and care-coordination might have made this process better easier.

Finding

F8 The east access team did not carry out risk assessment and risk management processes thoroughly. This failure led to the lack of an effective risk management plan.

Predictable or preventable

7.5 In the last part of this section we analyse whether the homicide was predictable or preventable.

Was there any known history of violence or threats of violence?	**Yes.** Mr B's paranoia about his fellow tenant was specific and the team knew about the threat he felt from the tenant. There had been an incident with railway staff leading to a community service order and his threats to kill his fellow tenant had led to his eviction. His presentation in his new flat was vivid and of serious concern.
Was there history of actual violence?	Possible as he had been convicted in relation to the railway incident.
Was the history recent?	**Yes.**
Was the potential violence risk assessed?	**No effective risk assessments took place.** The risk assessment in the east access team focused on his risk to self and did not effectively assess his risk to others. The MHA assessment should have led to his admission to hospital and the failure of this assessment impacted on the subsequent crisis team and A&E mental health liaison assessments.

Comment

We conclude that Mr B's care was not effectively managed by the east access team. The team did not effectively assess the risk Mr B posed to the victim and potentially others. We believe that had it done so, it would have assessed Mr B as being a high risk which should have triggered a risk management plan being put in place.

An effective risk management plan that included options such as admission to hospital for further assessment, referral to the recovery team for the allocation of a care coordinator or allocation of his care to a specified person in the east access team for more assertive support and a more detailed risk assessment may have prevented the homicide.

8. Service reconfiguration

8.1 Access teams in the trust have been restructured since 1 June 2012. At primary care level there are 47 GP surgeries in six hubs with practitioners in GP surgeries where possible. This now forms the Brighton and Hove Wellbeing service. This service provides assessment and time-limited evidence-based interventions for patients experiencing mild to moderate mental health problems. This service has CPNs and occupational therapists in GP surgeries. IAPT (CBT practitioners/counsellors) and psychological wellbeing practitioners employed by Turning Point, a national third-sector partner, who also receive referrals from primary care.

8.2 Trust secondary care[1] teams have been remodelled with two large hubs providing ageless secondary care services (recovery and older adults) and an assessment and treatment service providing a triage[2] service. These services are currently at the interim stage of operations.

8.3 The assessment and treatment service assesses individuals and provides a broad range of evidence-based interventions for service users experiencing moderate and severe mental health problems. The main function of the recovery and older adult services is to coordinate the care of service-users with more complex mental health presentations, such as those with higher levels of need and risk. All service-users are supported through CPA.

Change management

8.4 As part of the organisational change process the trust has published a change programme and a risk management plan.

Allocations

8.5 Brighton and Hove Wellbeing service clients are allocated to a named person for assessment. Clients may be referred to talking therapies and each professional group holds a caseload for discussion with their team leader.

[1] Teams that accept referrals from primary care i.e. from GPs.
[2] A process of determining priority for referrals.

8.6 Lead practitioners will bring cases to MDT meetings for triage and seek further information from referrers. The service follows up clients that refuse to engage rather than automatically discharging them back to the referrer.

Care planning

8.7 Depending on their need, clients in the primary care services can be offered group work, short-term interventions for 6-12 weeks or a move to care coordination and CPA in the secondary service. A long-term service user can be seen within seven days if primary care re-refers them in crisis after discharge. Priority assessments usually take place within five days and there is a 28-day response time.

Team working

8.8 The relationship between the east access team and the recovery team was difficult, although it has improved over time. The relationship between primary care practitioners and assessment and treatment service is central to client care.

8.9 The assessment and treatment service work with other teams, for example joint assessments with a psychologist and a practitioner from the recovery team. A wellbeing and triage meeting takes place twice daily.

Demand on services

8.10 Demand in the east access team greatly exceeded resources, with between 600-800 referrals a month. These clients had to be seen even if the GP did not refer appropriately.

8.11 Capacity issues remain the same under the new structure. There are staff shortages within secondary services as they have lost staff to primary care. There are no more resources and the need remains the same.

The future

8.12 We interviewed a group of 13 clinical staff and managers across a range of services in Brighton and Hove to find out their view of the reconfigured services. They told us that the major change was that the wellbeing service or triage could now ensure that the client is referred or sign posted to the right service.

8.13 Our group meeting ended on a note of cautious optimism. The team hopes that the new structure will bring positive change but has a sense of realism. They understood that what happens over the first three to six months is crucial. The group acknowledged that the trust had encouraged clinicians and managers to talk more effectively together about the reality of service delivery and how beneficial this had been.

9. Trust internal investigation

9.1 Our terms of reference asked us to review the trust's internal investigation and assess its rigour, objectivity and completeness and the adequacy of its findings, recommendations and action plan.

9.2 We were provided with a copy of a serious untoward incident final incident report dated 13 May 2010. The strategic director of therapies conducted the investigation and wrote the report.

Terms of reference

9.3 The investigation had adequate terms of reference. These covered Mr B's care as well as liaison with other agencies.

Report themes

9.4 The report provides a detailed chronology of the care and treatment of Mr B from his first referral in March 2008. The following issues were highlighted in the report:

- no robust formulation of diagnosis
- ongoing risk assessment was not consistent and did not reflect his complexity
- not all records and risk assessments were kept on the electronic CPA system
- medical and psychology records were kept separately
- no evidence of capacity management
- Mr B's deteriorating mental health not recognised
- absence of a consultant psychiatrist opinion
- Mr B was seen by more than 20 different staff from different teams
- no supervision for CPN.

Comment

We agree with the key themes identified in the trust report. The report's main focus is on the practice of the professionals involved with Mr B but it does not examine in detail any systemic or organisational issues that may have affected professional practice.

10. Progress on action plan

10.1 Actions and recommendations from the trust internal SUI investigation were published in an updated action plan in June 2012. It contained 12 findings:

- *"Review of SUI investigation and action plan*
- *Chief Executive Strategic group established*
- *Review East Access Team operational and management processes*
- *Interface between services in adult care pathway (including crisis and recovery)*
- *Individual issues*
- *Lack of documented case review, action planning and follow-up articulated in eCPA (East Access Team)*
- *Case formulation*
- *Transition between services*
- *Inconsistency in adherence to clinical risk policy-including assessment and risk management plans (East access, Crisis and A&E)*
- *Mental health Act assessments*
- *Case supervision and appraisal*
- *Information Governance"*

10.2 Each of the findings is accompanied by a number of recommendations. All show they were completed in 2010. The services changed significantly in June 2012 so it was not possible to review the implementation of the recommendations as the systems and processes are different. We met trust managers and held a group meeting with clinical and team managers to discuss the changes to services.

10.3 We were told by senior managers that partly as a result of this investigation the east access team operational and management processes were reviewed and used to inform the development of the new service model. An access development group was established with the primary care team and a number of Brighton GPs in August 2010.

10.4 An audit of risk recording was completed across Brighton Access Services and a new risk screening form was put in place. Action from the audit led to new risk assessment and management training that was introduced to all access staff. The possibility of having single electronic integrated case records is being explored. According to the action plan:

"Clear standards around assessment and recording have been set and these are monitored on an ongoing basis by the Brighton Integrated Governance Forum."

10.5 An update report, *Review of Team, Supervision and Case Review Processes in the East Access Team* was published in September 2010. The trust carried out an internal review of supervision processes to ensure that all staff had clear supervision arrangements and line management arrangements in place. The structure of the East Brighton Access Team meeting was also reviewed. According to the update report:

"Through individual supervision, staff are being encouraged to use the latter two parts of the team meeting to review case material causing difficulties or concerns. This review is conducted by the team and enables the team to take responsibility for shared decision making. These discussions are documented in the case notes by the person bringing the case."

10.6 None of the staff interviewed as part of the trust investigation had been shown a copy of the trust investigation report. Managers told us that feedback is now given to teams about SUI investigations. The integrated governance strategy ensures information is fed back to clinicians. Report writers now also give feedback to teams.

Appendix A

Interviewee list

- Service director for adult mental health services
- Three team managers
- Three members of the east access team
- Three A&E mental health liaison nurses
- Senior social worker
- MHA approved mental health professional
- Consultant psychiatrist-involved in the MHA assessment
- Group meeting with 13 clinical and managerial staff
- Meeting with senior board level managers to discuss draft report

Appendix B

Documents reviewed

Internal reports

- SUI final incident report
- Transcripts of internal interviews
- Untoward incident document

Medical records

- Mr B's integrated case notes

Policies

- Royal Sussex County hospital operational policy, 2008
- Sussex Partnership access operational policy, 2009
- Acute home treatment team guidance for clinicians
- Sussex Partnership care programme approach policy
- East Sussex locality care programme approach protocol and operational guidelines 2007
- West Sussex locality care programme approach: policy and practice guidelines for effective care co-ordination
- Brighton and Hove locality care programme approach protocol and operational guidelines 2007
- Sussex Partnership policy and procedure for clinical risk and assessment and management, 2007

Other documents

- Copy of correspondence from east access team
  consultant psychiatrist to the medical director and others.

Updated action plan (June 2012) and supporting documents

- *The role of doctors in access – review of the East Access medical role*
- *The role of the psychiatrist in Access teams*
- *Review of team, supervision and case review process in the East Access team*
- Sussex Partnership NHS Foundation Trust, *Blueprint for the Under One Roof Service Model,* 23 November 2010
- Sussex Partnership NHS Foundation Trust, *Operational Policy – Adult Community Mental Health Services,* 9 June 2011
- Sussex Partnership NHS Foundation Trust, *Operational Policy – Access Services,* 24 November 2009
- Sussex Partnership NHS Foundation Trust, *Access Services (Brighton and Hove) Clinical Notes Audit,* July 2010
- Draft report for audit of access service caseload

Appendix C
Team biographies

Tariq Hussain

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

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

Emily Ewart

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

Dr Mostafa Mohanna

After graduating from medical school with an MB, BCh, Mostafa went on to get his basic training in psychiatry at Leicester and subsequently, after gaining membership of the Royal College of Psychiatrists (MRCPsych), became a lecturer with the Leicester Medical School. From there he went on to become a senior registrar in the Cambridge rotation. Mostafa then took up a consultant post in Lincoln in 1990 and has been in that position

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