VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr S

A report for
NHS England

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Authors:
Chris Brougham
Tariq Hussain
Dr Peter Jefferys

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

Verita
53 Frith St
London W1D 4SN

Telephone 020 7494 5670
Fax 020 7734 9325

E-mail enquiries@verita.net
Website www.verita.net

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1 Introduction

Mr S, an 83-year-old man under the care of Somerset Partnership NHS Foundation Trust (the trust), stabbed and killed his landlord[1] (Mr C) on 21 June 2012.

NHS England South commissioned Verita to carry out an independent investigation into his care and treatment. Verita is a consultancy specialising in public sector investigations, reviews and inquiries.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in section two of this report**.**

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation may not identify root causes or find aspects of the provision of healthcare that directly caused an incident but it will often find things that could have been done better.

The chief executive of the trust commissioned an internal investigation into the care and management of Mr S. A consultant psychiatrist and head of service carried out the investigation. They reviewed all Mr S's clinical records and conducted interviews with relevant trust staff. They found areas of practice that needed addressing and made three recommendations.

1.1. Background to incident

Mr S's GP referred Mr S to the older person's community mental health team (CMHT) in Bridgwater in January 2011. He received care and treatment from the CMHT and was discharged in February 2011. His GP referred him to the CMHT again in April 2011.Mr S remained in receipt of services from the CMHT until the time of the incident.

On 21 June 2012 Mr S fatally stabbed Mr C in the neck during an altercation in a car park outside his flat. Mr S was arrested on suspicion of murder. A court case took place but Mr S was not well enough to attend. The Judge ordered Mr S to be detained without limit of time at a secure psychiatric hospital. Mr S has since died.

1.2. Overview of the trust

Somerset Partnership NHS Foundation Trust is a provider of community health, mental health and learning disabilities services in Somerset. The services promote independence and social inclusion for people of all ages.

[1] Mr S was the owner of his leasehold flat. Grason Investments was the owner of the freehold and Mr C owned Grason Investments. We have used landlord in this report only to show that Mr C had some responsibility for the flat but Mr S was not strictly a tenant.

The older person’s multidisciplinary CMHT provides a range of services that include assessing emergency, urgent and routine referrals.

2 Terms of reference

The terms of reference for the independent investigation, set by NHS South of England in consultation with Somerset Partnership NHS Foundation Trust, are as follows.

2.1. Purpose of the investigation

To identify whether there were any aspects of the care which could have been altered or prevented the incident from happening. The investigation process should also identify areas where improvements to services might be required, which could help prevent similar incidents occurring.

The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations for individual, organisational and system learning.

2.2. Main objectives

1. To evaluate the mental health care and treatment including risk assessment and risk management.
2. To identify key issues, lessons learnt, recommendations and actions by all directly involved in providing the care plan.
3. To assess progress made on the delivery of action plans following the internal investigation.
4. To identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies.
5. Identify care or service delivery issues, along with the factors that might have contributed to the incident.

2.3. Terms of reference

- Review the assessment, treatment and care that Mr S received from Somerset Partnership NHS Foundation Trust.
- Review the care planning and risk assessment policy and procedures.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment.
- Review the interagency working between the trust and other agencies and how this influenced the formulation and care plan.
- Review the interagency working between Somerset Partnership NHS Foundation Trust, primary care, police, housing and how this influenced the formulation and care plan.
- Review the documentation and recording of key information.
- Review communication, case management and care delivery.
- Review professional judgement processes and actions and ensure they correspond with statutory obligations, relevant good practice guidance from

the Department of Health, and local operational policies (with particular reference to safeguarding).

- Review the trust's internal investigation of the incident to include timeliness and methodology to:
    - identify if the internal investigation satisfied the terms of reference
    - identify if all key issues and lessons have been identified
    - identify whether recommendations are appropriate and comprehensive and flow from the lessons learnt.
    - review progress made against the action plan
    - review processes in place to embed any lessons learnt
    - conduct a thematic review of the trust's risk assessment, risk management and care planning approaches
    - test out the trust investigation's conclusions/findings
    - seek evidence of the implementation of their recommendations.
- Review any communication and work with families of the perpetrator.
- Establish appropriate contacts and communications with the victim's family to ensure appropriate engagement with the internal investigation process.

Avon and Somerset Constabulary have carried out their own investigation to review the communication between agencies to see what lessons could be learnt. In view of this, we focus our attention on the care and treatment of Mr S from Somerset Partnership NHS Foundation Trust.

A chartered surveyor also carried out an inspection of Mr S's premises following the incident. The report concluded that there was no evidence of rising damp, or persistent or recurring condensation with Mr S's flat.

3 Approach to the independent investigation

The investigation team comprised of Chris Brougham, Tariq Hussain and Dr Peter Jefferys (from now on known as 'we'). Our biographies are at appendix A.

We examined documentary evidence, including the trust's policies and procedures, Mr S's trust and GP clinical records and the trust's internal investigation (see appendix B).

The investigation was commissioned by NHS England as a desktop investigation. We were asked to build on the trust's investigation by using the trust interview transcripts. If these were considered inadequate then further interviews would be carried out. We only needed to carry out one interview. The details of the staff interviewed and the list of transcripts that we used is at appendix C.

Mr S died before this independent investigation was started. We therefore gained permission to access his medical and other records for the purposes of our investigation under the Access to Health Records Act (1990).

A representative from NHS England wrote to the victim's family informing them of the independent investigation.

We met with the victim's wife (Mrs C) at the beginning of the investigation to share the terms of reference with her. We also met with her at the end of the investigation to share our findings and recommendations.

We developed a chronology outlining Mr S's care and treatment. We then analysed all the evidence we received, and drew our findings from this analysis. Our recommendations address these findings.

Derek Mechen, a partner of Verita, peer reviewed for this report.

4 Executive summary and recommendations

NHS England commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service-user Mr S.

4.1. The incident

Mr S, an 83-year-old man, fatally stabbed his landlord (Mr C) in a car park outside his flat on 21 June 2012. Mr S was being provided with care and treatment by the Somerset Partnership NHS Foundation Trust at the time of the incident. The judge ordered Mr S to be detained without limit of time at a secure psychiatric hospital. Mr S has since died.

4.2. Overview of care and treatment

Mr S was first referred by a locum GP (Dr B) to the older person's community mental health team (CMHT) in Bridgwater in January 2011. Dr B highlighted in her referral ongoing disputes between Mr S and his two neighbours concerning damp coming into flat through faulty drainpipes.

An occupational therapist (OT) visited Mr S in January 2011 to assess him. It emerged during this assessment that Mr S had had an ongoing dispute with his landlord, Mr C and not his neighbours. The dispute had previously been heard at a residential property tribunal but Mr S was not satisfied with the outcome.

The OT advised that because his problems were centred on the dampness in his flat he did not require CMHT input. Mr S gave the OT permission to refer him to a social worker to discuss the issue and she discharged him back to his GP.

On 19 April 2011 a GP (Dr D) made an urgent referral to the CMHT. Dr D outlined that Mr S had a history of depression and thoughts of self-harm, was continually thinking about his flat and had suicidal thoughts.

On 21 April the OT telephoned Mr S. She noted that the main focus of his worries were about his flat and the damp. Mr S told the OT that he was experiencing problems with his memory. Mr S was diagnosed with depression and then dementia. He was placed on the care programme approach. The OT was identified as his care coordinator.

A community psychiatric nurse (CPN) assessed Mr S on 27 April 2011. Mr S revealed his forensic history including the non-fatal stabbing of his wife in the 1980's. He received a two-year prison sentence. The CPN told Mr S's GP about this new information. On 28 April 2011 the CPN also alerted the secretary of the trust's safeguarding team about Mr S's situation.

Mr S continued to be supported by the care coordinator and started to attend a day hospital in July 2011.

A care programme approach review meeting was held at the CMHT on 30 January 2012. Mr S attended the meeting. His concerns about his flat and hostility to Mr C, his landlord continued. Mr S said that he *would "do the same as I did to my wife*". Mr S showed no remorse about his previous conviction.

The care coordinator discussed the risk that Mr S posed with her team manager and a psychiatrist. They decided to contact the Avon and Somerset Public Protection Unit (PPU).

Mr S continued to receive support from the CMHT until June 2012 when the police contacted the trust to say that Mr S was in custody after fatally stabbing Mr C.

4.3. Main findings

4.3.1. The formulation of diagnosis and subsequent management

F1 The diagnostic formulation is consistent with Mr S's history and the findings on examination as recorded at the time. Based on the evidence in Mr S's clinical records this was an appropriate clinical decision. It raises no questions about impaired clinical judgement.

F2 The diagnosis of depressive disorder was appropriately evidenced and reviewed by the consultant psychiatrist throughout the period of Mr S's specialist care.

F3 The consultant psychiatrist's diagnostic formulations were evidenced and well-reasoned.

F4 The consultant psychiatrist appropriately suggested the possibility of an additional diagnosis of delusional disorder in light of Mr S's narrow and fixed beliefs about the landlord's responsibility for the damp flat.

F5 The proposal to treat Mr S with antipsychotic medication in July 2011 was clinically appropriate.

F6 Between February and June 2012 Mr S was managed in the knowledge that his dementia was worsening. During this period his dementia management would not have been significantly different if the diagnosis reached had been vascular dementia rather than Alzheimer's disease because the treatment is the same.

4.3.2. Interagency working and communication

F7 All three communications by Mr S's GP to the CMHT included information relevant to Mr S's risk of harm to himself and to others. This information would have assisted clinical staff in the assessment and management of Mr S's risk.

F8 The risk was documented in Mr S's contemporaneous health record. An appropriate and proportionate discussion with his GP about this risk took place shortly after. Mr S's previous conviction for violence was not known to health professionals at this stage. Direct communication with the police at this stage (January 2011) was not indicated, although consideration was given later when his previous conviction for assault was revealed and the safeguarding lead notified.

F9 The CMHT contacted the police directly when their concern about Mr S's threats against Mr C increased but there was a two week delay before a reply was received from the police. This left the management of risk of harm to Mr C exclusively in the hands of the NHS during these two weeks.

F10 The police decided to leave the CMHT to provide feedback to Mr C that he was the target of threats, after he had contacted them on 15 February 2012.

F11 The police did not share the knowledge and expertise they had to help the CMHT devise a sound risk assessment and risk management plan for Mr S.

F12 Although the trust went beyond the advice given by the police, they had the authority to inform Mr C about Mr S's previous conviction and the risk he posed to him but did not act on this.

F13 There is no evidence that the safeguarding team consulted the police in April 2012. Nor, for that matter did the CMHT chase up or receive any feedback from the safeguarding team about the referral.

F14 A forensic psychiatric opinion about Mr S's risk and management should have been sought, when Mr S made further serious threats to kill Mr C. Although it is unlikely that Mr S would have met the criteria for forensic services, advice about his management might have been helpful.

4.3.3. Risk assessment and risk management

F15 Risk assessments were completed. Safety risks were identified and incorporated into Mr S's recovery care plan. Risk assessments were updated and reviewed regularly.

F16 There is no evidence to show whether or not discussions took place with Mr S from time to time to find out whether he wanted friends or family involved in his care.

4.3.4. Predictability and preventability

F17
Mr S did alert professionals that he might become violent. The trust took his threats seriously as they thought that he might act on them. The trust did not predict that a

homicide would take place but it did predict that a serious incident might take place if preventative measures were not taken.

F18 If Mr C had been informed about Mr S's previous conviction and his lack of remorse about stabbing his wife, this incident may have been prevented.

4.3.5. The trust internal investigation

F19 The trust has demonstrated that the recommendations from its internal investigation report have been implemented. However a more sustainable solution should be put in place to ensure that there is an accurate record of the people present, the discussions and outcomes of clinical reviews.

F20 The trust did not initiate any contact with Mrs C (the victim's wife) until after the court case. The trust advised that this was normal practice as the police liaison service was providing support to Mrs C.

F21 The trust was slow in sending a copy of the internal investigation report to Mrs C. We were advised that the trust did not release the report immediately after the court case as it did not think it would be helpful and that all the information (the police investigation and the trust internal investigation report) would be better channelled through one agency.

F22 The decision to send the information to Mrs C via one channel led to a delay in her receiving the trust investigation report. The approach that the trust took in this respect did not meet the NPSA good practice guidance on being open or the investigation of serious patient safety incidents in mental health services.

4.4. Recommendations

R1 The trust should put steps in place to ensure that all relevant information about a service user is shared (even if consent is not granted) with someone who is a known risk from that service user.

R2 The trust should ensure that there are steps in place so that relevant staff in older person's services are able to gain advice and guidance from forensic services when needed.

R3 The trust should put steps in place to ensure that a discussion with the person using mental health services takes place to find out if they want their family, carers or friends to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once. If consent is refused, advice should be sought as to what action can be taken without releasing confidential information.

R4 The trust should carry out an audit to ensure that accurate records are kept of all clinical reviews including the people present, the discussions and the outcomes of reviews.

R5 The trust should have a clear process in place to ensure that the victims of serious incidents and their families are supported and involved in the trust internal investigation. As a minimum the trust should ensure that the victim's family:

- are provided with and consulted on the terms of reference of the trust internal investigation;
- know how they will be able to contribute to the process of investigation; and
- receive a copy of the trust investigation report in a timely manner without the families having to write to the trust to ask for information.

5 Personal history

Mr S was born and grew up in Somerset. After getting married he moved to Devon and lived in Paignton for many years. He worked as a builder and was married with two daughters. The marriage was unhappy and during an argument over possessions, Mr S stabbed his wife twice in the stomach. He was given a two-year prison sentence. After he served his prison sentence he had no contact with his wife and they subsequently divorced. Although he lost contact with his daughters he tried to make contact with one of them. She told him that she would take out a restraining order if he tried to contact her again.

Mr S retired from work and moved into a ground floor flat in Bridgwater. The clinical records show that Mr S stated that his landlord, Mr C carried out some work in relation to the gutters and since then his flat was constantly damp. The dispute had previously been heard at a leasehold valuation tribunal but Mr S was not satisfied with the outcome. The damp in his flat and his disputes with Mr C remained an issue for Mr S for years.

5.1. The care and treatment of Mr S

5.1.1. First episode of care

A locum GP (Dr B) referred Mr S to the older person's community mental health team (CMHT) in Bridgwater in January 2011. This service is based at Glanville House in Bridgwater near to where Mr S lived. The CMHT provides a range of services that include assessing emergency, urgent and routine referrals to the older people's community services through a single point of access. This process is supervised by a team manager. Assessments take place not only at Glanville House but also in people's homes, hospitals, residential and nursing homes and other community settings.

Dr B highlighted in her referral ongoing disputes between Mr S and Mr C concerning dampness coming into the flat through the drainpipes. The records noted that Mr S had previously taken Mr C to court but was not satisfied with the outcome.

Dr B stated in her referral that Mr S was having angry thoughts about Mr C including thoughts of killing him and then himself.

An occupational therapist (OT) from the CMHT assessed Mr S at his home on 21 January 2011. Mr S's medical records show that on assessment Mr S appeared bright and cheerful, but was experiencing damp in his property that had been a problem for ten years. The OT noted that Mr S was divorced and had two daughters who he had not had contact with for 15 years.

The OT talked to Mr S about the thoughts he had about killing himself and his neighbours. Mr S told her that did not have any plans in place to carry this out. The OT noted that Mr S said that he experienced some memory problems but that this was not evident in the interview with her. She carried out a Geriatric Depression

Scale[1] (GDS) assessment. The score was 7/15, consistent with the presence of a significant depressive illness that required treatment. The OT also carried out a mini–mental state examination[2] (MMSE). She gave Mr S her contact details and agreed to contact him again in two weeks' time. Mr S was placed on the care programme approach (CPA[3]) and the OT was allocated as the care coordinator.

The care coordinator discussed her assessment with Mr S at a CMHT meeting on 27 January 2011. The team agreed that the OT would contact Mr S's regular GP (Dr C) to discuss her opinion of the locum (Dr B's) concerns.

The care coordinator discussed the issue with Dr C on 28 January 2011. Dr C advised that she had known Mr S for a number of years and knew all about the dampness in his flat. She said that Mr S could be a difficult man who could become cross quite easily. She felt that his remarks about killing himself and his neighbours had no intent. Her view was Dr B had taken them seriously because she had not met him before.

The care coordinator visited Mr S on 25 February 2011. She carried out an assessment noting that Mr S was complaining of arthritis and that he felt that the damp in his flat was making matters worse. She advised that because his problems were centred on the dampness in his flat he did not require CMHT input. Mr S gave the care coordinator permission to refer him to a social worker to discuss the issue and she discharged him back to his GP.

5.1.2. Second episode of care

On 19 April 2011 a GP (Dr D) made an urgent referral to the CMHT. Dr D outlined that Mr S had a history of depression, thoughts of self-harm and continuous thoughts about his flat.

On 21 April the OT telephoned Mr S. She noted that the main focus of his worries was the damp in his flat. Mr S told the OT that he was also experiencing problems with his memory. Mr S was placed on CPA and the OT was allocated as the care coordinator.

A community psychiatric nurse (CPN) assessed Mr S on 27 April 2011. Mr S revealed a forensic history that included the non-fatal stabbing of his wife in the 1980s for which he received a two-year prison sentence. The CPN told Mr S's GP about this new information. On 20 April 2011 the CPN also alerted the secretary of the trust's safeguarding team. The safeguarding team received no further information.

On 17 May 2011 the care coordinator telephoned the adult social care worker to enquire what input she had had with Mr S. The social worker reported that she had supplied Mr S with contact numbers of people who might be able to help him, but there was nothing more she could do to help so she had closed the case.

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[1] The GDS was designed as a screening tool for depression in elderly people.
[2] A test used to screen for cognitive impairment.
[3] A system of delivering care and treatment to individuals diagnosed with mental illness.

On 24 May the care coordinator telephoned Mr S. He told her that he was not feeling very well so had contacted his GP. The OT noted in the records that he sounded very positive apart from the physical problems he was experiencing.

The following day the care coordinator called Mr S again to check on his wellbeing. She recorded that Mr S was feeling better physically.

On 25 May the care coordinator called Mr C to discuss the damp that Mr S said he was experiencing in his flat. Mr C agreed to send the care coordinator a summary of past events. The care coordinator called Mr S to give him feedback from the conversation. The records show that Mr S was pleased that someone was trying to help him. We have not received any evidence to show that the CMHT received the summary of past events.

The care coordinator telephoned Mr S on 2 June. Mr S advised her that he was feeling better but she noted that he was still focused on the issues in relation to the damp in his flat.

A consultant psychiatrist (in old age psychiatry) assessed Mr S on 8 June 2011. He diagnosed Mr S with a recurrent depressive disorder and long-standing persecutory ideas regarding Mr C. He recorded that Mr S probably had antisocial and paranoid personality traits, noting that Mr S had previously stabbed his wife, expressing no remorse at the time. The consultant psychiatrist also recorded that Mr S had occasional suicidal ideas but no plans to act on them. Mr S told the consultant psychiatrist about the damp in his flat and the problems he was experiencing. Given that the problem had been ongoing for such a long time, the psychiatrist asked Mr S whether it would be better to sell the flat and move somewhere else. Mr S suspected that there was a conspiracy to drive him out of his flat and that Mr C would try and buy it cheaply afterwards as a way of making money so would not sell. He told the psychiatrist that he would consider attacking Mr C and his colleagues if they ever visited. The psychiatrist recorded that this was not likely as Mr C avoided him due to his previous angry verbal outbursts and that Mr S denied he would go looking for them. The psychiatrist repeated the MMSE. The results suggested mild memory impairment. The psychiatrist developed the following management plan:

- stop citalopram[1] 20mg in the morning;
- start venlafaxine[2] XL 75mg in the morning;
- OT to continue to provide support;
- review in clinic on 20 July 2011;
- consider antipsychotic treatment later if delusional ideas persist; and
- further psychometric testing once moods lift to exclude frontal lobe impairment.

The psychiatrist wrote a care plan letter to Mr S's GP. In the letter he wrote that Mr S could become argumentative and physically aggressive with Mr C and that he would talk to the care coordinator to decide on the best way to reduce the risk that Mr S

[1] Medication to treat depression.
[2] Medication to treat depression.

might pose to himself and others. The letter included the management plan that had been put in place.

Mr S continued to be supported by members of the CMHT. He was offered a day hospital placement and started attending on 4 July 2011. Records show that he was pleasant and interacted well with staff and clients.

The consultant psychiatrist reviewed Mr S as planned on 20 July. The psychiatrist developed the following care plan:

- continue on venlafaxine XL 75mg in the morning;
- start olanzapine[1] 2.5 at night for 14 days then increase to 5mg at night (to reduce his obsessional and possibly delusional beliefs about the landlord's "wilful neglect" of his flat);
- continue to attend day hospital;
- care coordinator to continue to support; and
- review in clinic on 21 September 2011.

Mr S continued to attend day hospital throughout July, August and September. Records show that he appeared to enjoy attending and remained in good spirits for the majority of the time. He experienced some drowsiness and increased confusion as a result of his olanzapine medication. Day hospital staff advised the consultant psychiatrist about this.

Mr S did not attend his appointment with the consultant psychiatrist on 21 September. The consultant wrote to him asking if he would like another appointment. He also asked the duty worker to visit Mr S to explain that he should stop his olanzapine and to take the tablets away to avoid him taking further tablets in error. The duty worker made several attempts to contact Mr S but there was no response. This was discussed with the consultant psychiatrist who advised to continue trying.

On 29 September, a CPN from the CMHT visited Mr S. She removed the olanzapine and advised Mr S not to drive whilst he was feeling drowsy. A further follow-up appointment was made with the consultant psychiatrist although Mr S expressed concern that he might not remember to attend. The CPN told Mr S that someone from the CMHT would call him to remind him of the appointment. The CPN updated the consultant psychiatrist of the situation. He wrote a letter to Mr S's GP providing an update.

Mr S continued to attend the day hospital on a regular basis. Records show that Mr S was still driving there despite being advised to stop. Mr S advised day hospital staff that he was concerned about his memory. Staff discussed these issues with the consultant psychiatrist. It was also noted that there was no identified care coordinator for Mr S as the OT who had previously been in this role was on sick leave but the duty team were actively involved in his care.

[1] An antipsychotic medication used to treat delusional symptoms in conditions such as schizophrenia as well as acute manic episodes associated with bipolar disorder.

The consultant psychiatrist reviewed Mr S on 12 October. Mr S presented with low mood and memory problems. He was well orientated to time and place but refused to answer some of the mini-mental state examination questions. He told the psychiatrist that he had not been taking his tablets because he was too forgetful. He claimed he was suicidal but had no plans to harm himself. The consultant psychiatrist noted that Mr S was less drowsy since he had stopped taking his olanzapine. The consultant psychiatrist advised that Mr S would probably need a home care package to start for a few weeks to prompt his tablets and food/fluid intake.

The consultant psychiatrist formulated the following care plan:

- ask duty CMHT worker to review later in the day to check if suicidal ideas have settled and set up bubble pack for medication;
- continue with day hospital; and
- restart venlafaxine daily.

The psychiatrist wrote to Mr S's GP outlining the care plan and advising he would review Mr S again in December and check his cognitive function.

A duty worker from the CMHT visited Mr S on 17 October to discuss a package of care. This package consisted of a visit once a day in the morning to oversee his medication, promote a good diet and help with personal care needs. Mr S agreed to this.

Mr S continued to attend the day hospital and receive his package of home care during October 2011.

On 1 November 2011 Mr S was referred for a CT scan and psychometric testing of his memory function.

The consultant psychiatrist reviewed Mr S on 14 December. Mr S presented with an improved mood as a result of the venlafaxine medication, but his memory was getting worse. He continued to receive some support from home carers who supervised his medication and prompt him with his meals.

Mr S's care coordinator was changed from the OT to a CPN whilst the OT took planned leave.

The OT returned back to work as the care coordinator in January 2012. A care programme approach review meeting was held on 30 January 2012. Mr S attended the meeting. He seemed very positive about the support he was receiving but his concerns about his flat and hostility to Mr C continued. The records state:

> "The damp is still a problem in his flat and [Mr S] feels this is a large factor of his problems. He now feels he can resolve this by not paying his ground rent and maintenance charges and has informed his landlord. He advised that if his landlord and 'accomplice' visit his flat, he plans to 'do the same as I did to my wife'."

Records show that Mr S did not seem remorseful about this plan and spent some time describing his previous term of imprisonment which he appeared to have enjoyed. A risk alert was added to Mr S's records concerning potential violence to Mr C.

The care coordinator discussed with her team manager and the psychiatrist the risk that Mr S posed. They made a decision to contact the Avon and Somerset Public Protection Unit (PPU).

On 1 February 2012 the care coordinator sent an email to the PPU saying that Mr S was threatening to harm Mr C. The email included the following information:

> "Mr S owns a ground floor flat. The dispute is over the presence of damp mainly in his bedroom. He constantly has to use a dehumidifier to try and eliminate this problem. Unfortunately Mr S and his landlord do not agree on the cause of this problem which has had a great impact on Mr S's life.
>
> "I reviewed Mr S this week during which time he once again mentioned this problem and once again stated that if he came face to face with his landlord, he would not hesitate to harm him as he did his wife many years ago. Following the end of his marriage, Mr S stabbed his wife for which he served a time in prison. When discussing this with Mr S, his only regret is that he did not kill her and he appears to have really enjoyed his stay in prison. Obviously this has been a concern for some time but as Mr S's landlord lives in Devon, the possibility of them meeting was not likely to happen in the near future. However, Mr S explained that he plans to stop paying his maintenance charge and ground rent until this damp problem is resolved. As a result of this action, it might provoke a visit from his landlord.
>
> "Mr S is now 83 years old and when mobilising uses a walking stick and is experiencing some memory problems. However, I still feel that he would carry out his threats. He is not worried of the outcome which may mean imprisonment. He feels he would be better off in prison than living in his damp conditions.
>
> "After discussing this review with my Team Manager, it was agreed that I should inform yourselves and request that you advise Mr C not to visit Mr S in person.**"**

The care coordinator carried out a risk assessment. She concluded that Mr S represented an acute high risk of violence violence/harm to others, a significant risk of anti-social and offending behaviour, and that his physical health and home safety was at significant risk. She also assessed him as a low risk of suicide, self-harm and falls.

On 13 February 2012, the supervisor from the safeguarding coordination unit from Avon and Somerset PPU contacted the care coordinator and discussed the email. She asked for more information about Mr S. The care coordinator sent further details about Mr S's diagnosis and treatment plan.

On the same day the care coordinator met with Mr S to discuss his care plan and advised him that the police had been informed about his threats to harm Mr C. Records show that Mr S did not seem worried about this.

On 15 February 2012 the supervisor from the safeguarding coordination unit from Avon and Somerset called the care coordinator to say that the trust was responsible for advising Mr C of the potential risk from Mr S. The supervisor subsequently confirmed this advice in an email. It said:

> "…It is for you to disclose to Mr C around his safety on attending the address. I would suggest that Mr C is only advised that he should not attend the address on his own but to take somebody with him…"

Later that day the care coordinator received a phone call from Mr C who had recently spoken with the police and been advised to contact her. During this telephone conversation the care coordinator advised Mr C not to visit Mr S on his own or indeed at all, as he would be at risk.

> "…Mr C was advised that it would be in his best interests if he did not visit Mr S at his flat on his own or indeed at all. Details were not given, just repeated it would be in his best interests and for safety reasons**."**

The consultant psychiatrist reviewed Mr S on 22 February. He noted that Mr S's mood remained stable on venlafaxine 75mg daily. The results of the CT scan showed moderate atrophy (tissue wasting). A mini-mental state examination was carried out. The results suggested a diagnosis of Alzheimer's dementia in its early stages.

On 1 March 2012 the consultant psychiatrist wrote a care plan letter to Mr S's GP. He provided feedback regarding the CT scan and other tests. He also gave clear instructions regarding management:

- venlafaxine 75mg daily;
- chase up the neuropsychological appointment with the CMHT psychologist; and
- possible cognitive test regarding ability to drive.

Mr S continued to be followed up by the CMHT but did not attend his appointment for neuropsychological testing on 27 April 2012. A further appointment was arranged.

The consultant psychiatrist reviewed Mr S on 2 May 2012 in the outpatient department. Mr S continued to drive his car. He continued to have memory lapses, although he denied a persistent low mood or excessive anxiety. He was eating and sleeping normally and taking his medication and appeared to have developed a good routine. He described no suicidal ideation. The consultant psychiatrist started Mr S on a trial of donepezil[1].

[1] Medication used to treat Alzheimer's disease.

Mr S was assessed by a psychologist at the CMHT. The records show that Mr S presented in a confused way and he was disorientated and breathless. The assessment was not completed because of his presentation. The psychologist discussed the situation with the care coordinator. They both felt that Mr S was not safe to drive home so he was sent home by taxi. The psychologist also arranged for Mr S's GP to carry out a home visit later that day.

Mr S also advised the psychologist he had been burgled, but he didn't know when this had taken place. The psychologist contacted the police. They advised that Mr S had called them at 3am and a police community support officer attended Mr S's flat. No crime was found or recorded by the police so the case was closed.

The psychologist made the following plan:

- GP to provide feedback regarding Mr S's physical health;
- if physical health all clear, arrangements to be made for Mr S to pick up car;
- discuss plan with care coordinator to ask to review at home; and
- offer Mr S a further cognitive assessment.

A record of the concerns in relation to Mr S driving was made in his risk history sheet.

A care programme approach review took place on 21 May 2012. Mr S told staff that he would not attack defenceless people but if he was provoked he would defend himself. Mr S did not mention Mr C or any problems with damp in his flat.

On 21 June 2012 the police contacted the trust to inform them that Mr S was in custody after fatally stabbing Mr C, his landlord in a car park outside his flat.

6 Issues arising, analysis and comment

In this section of the report we analyse and comment on the issues we have identified as part of our investigation into the care and treatment of Mr S.

The themes are:

- the formulation of diagnosis and subsequent management;
- interagency working and communication;
- risk assessment and risk management;
- predictability and preventability; and
- the trust internal investigation and action plan.

6.1. The formulation of diagnosis and subsequent management

We examine below how Mr S's diagnosis was reached and whether the management plans that were put in place were adequate.

Records indicate that Mr S was thought to show a significant depressive reaction to his complex home/housing situation as well as possible mild cognitive loss in the first episode of care. We note that during the first episode of care, a formal diagnostic formulation with ICD 10 diagnostic coding[1] was not recorded. This is probably because a psychiatrist (usually responsible for ICD coding) had not seen Mr S.

The care coordinator carried out a competent examination of Mr S. She discussed the case with Mr S's GP. The GP agreed that Mr S was suffering from depression and she prescribed antidepressant medication. The GP who knew Mr S well did not believe that there was a serious risk of him harming himself or others. When Mr S was found to be less depressed at follow-up he was discharged back to his GP.

6.1.1. Finding

F1 The diagnostic formulation is consistent with Mr S's history and the findings on examination as recorded at the time. Based on the evidence in Mr S's clinical records this was an appropriate clinical decision. It raises no questions about impaired clinical judgement.

6.1.2. Diagnosis of depressive disorder

There is ample evidence from Mr S's clinical records to support a diagnosis of recurrent depressive disorder. This fluctuated in severity. Mr S's depression improved in response to antidepressant medication coupled with visits from the OT and weekly day hospital attendance. The consultant psychiatrist regraded Mr S's depressive disorder from "*current episode moderate"* to "*currently in remission"* in

[1] The International Classification of Diseases (ICD) is the standard diagnostic tool used to classify diseases and other health problems.

February 2012. There is no indication in the records to show that Mr S's depression worsened between February and June 2012.

6.1.3. Finding

F2 The diagnosis of depressive disorder was appropriately evidenced and reviewed by the consultant psychiatrist throughout the period of Mr S's specialist care.

6.1.4. Paranoid personality disorder and delusional disorder

Documentary evidence shows that the consultant psychiatrist fully considered Mr S's paranoid symptoms and behaviour at an initial assessment in June 2011. The diagnosis was reviewed at a follow-up appointment in July 2011 when the additional diagnosis of delusional disorder was proposed. The grounds relied on by the consultant to make a diagnosis of paranoid personality disorder are sound, although the only additional history concerning his personality was from his GP. This was not complemented by information from Mr S's cousin or his friends who would have been able to provide additional information about Mr S's personality. We comment further on this issue later in the report.

It is often difficult to distinguish between paranoid personality disorder and delusional disorder in older people. Whichever diagnosis is determined, a key issue in clinical management is the recognition of the potential risk of paranoia-driven action against others.

Antipsychotic medication such as olanzapine can benefit some older people with paranoid delusional disorder. This type of medication can sometimes help older people with a paranoid personality disorder although improvement is not guaranteed in either condition. However, even if Mr S had taken it for long enough to see a reduction in his paranoid beliefs, it would not have firmly clarified which of the two paranoid conditions were at play in his case.

6.1.5. Findings

F3 The consultant psychiatrist's diagnostic formulations were evidenced and well-reasoned.

F4 The consultant psychiatrist appropriately suggested the possibility of an additional diagnosis of delusional disorder in light of Mr S's narrow and fixed beliefs about the landlord's responsibility for the damp flat.

F5 The proposal to treat Mr S with antipsychotic medication in July 2011 was clinically appropriate.

6.1.6. The formulation of the diagnosis of dementia

Mr S presented with symptoms of mild memory loss in early 2011. Staff assessed Mr S more fully using a range of standardised cognitive assessment measures. During 2011 Mr S's cognitive loss increased so in December 2011 the consultant psychiatrist initiated further investigations of the possible cause for his dementia.

A CT brain scan was done in January 2012. It was reported as showing "Bilateral patchy low attenuation white matter changes in keeping with mild small vessel ischaemia." Such changes are not necessarily clinically significant. This was the view of the consultant psychiatrist who recorded "no significant ischaemic changes." He concluded that the most likely cause of Mr S's dementia was Alzheimer's dementia "in its early stages."

The consultant psychiatrist noted in an earlier assessment in June 2011 that Mr S had significant history of heart disease including recurrent angina, hypertension and a coronary artery bypass. Mr S was taking several heart medications. This history, combined with the CT result, made it more likely that the underlying cause for Mr S's dementia was vascular dementia rather than Alzheimer's disease, although the two conditions often occur together in older people.

6.1.7. Finding

F6 Between February and June 2012 Mr S was managed in the knowledge that his dementia was worsening. During this period his dementia management would not have been significantly different if the diagnosis reached had been vascular dementia rather than Alzheimer's disease because the treatment is the same.

6.2. Interagency working and communication

In this section of the report we examine whether the different agencies that supported Mr S shared relevant information.

6.2.1. Information from the GP practice to the CMHT

Two GP referral letters were sent and received by the CMHT. The first was written by a locum GP, Dr B, on 20 January 2011. This described Mr S's problems with his memory and mood and added that Mr S had "seriously considered killing two neighbours" and "then taking an overdose himself". Full details of Mr S's medical history and prescribed medication were provided. On return from her leave, Dr C, Mr S's usual GP who knew him well, phoned the service (at its request) to provide additional information. Records dated 28 January 2011 show that Dr C felt the comments made about his neighbours and suicide intentions were remarks with no intent. She had no concerns at all about these issues. She felt he was quite a difficult man who could become cross quite easily. However, she observed that Dr B "had not met him before and had taken his comments seriously."

Dr D referred Mr S to the CMHT on 19 April 2011. She noted concerns about Mr S "still ruminating about the problems with his flat and says again he had suicidal thoughts about a month ago." Mr S was assessed by the CMHT within days.

6.2.2. Information from the CMHT to the GP practice

Clinical staff at the CMHT wrote several letters to Mr S's GP about his clinical condition and the risks related to both his depressed mood (self-harm) and to beliefs about his landlord (threats to harm.) These letters were sent following risk assessments and reviews that staff undertook between February 2011 and May 2012. The CMHT made a decision to share the information about Mr S's past conviction with his GP when this was revealed on 27 April 2011.

Mr S's first consultation with his consultant psychiatrist on 8 June 2011 was followed by a very detailed five-page summary of Mr S's history and examination that included a full discussion of his differential diagnosis, risk issues and advice on further management.

Prompt and detailed GP letters were provided by the consultant after every subsequent outpatient consultation from July 2011 until May 2012. It is not clear whether two crucial CPA Review reports dated 30 January 2012 and 6 June 2012 were sent to the GP. These contained valuable information about developments in Mr S's condition and risk which in effect complement the consultant's letters.

Clinical staff telephoned Mr S's GP on several occasions, both to inform her of clinical developments and to request further information and agree management. In particular the care coordinator discussed her initial assessment with the GP in January 2011. In May 2012 when Mr S's confusion worsened and there were concerns about his physical condition, a senior psychologist phoned the GP. A trainee psychiatrist also phoned the GP the following day to alert her about their concerns.

6.2.3. Findings

F7 All three communications by Mr S's GP to the CMHT included information relevant to Mr S's risk of harm to himself and to others. This information would have assisted clinical staff in the assessment and management of Mr S's risk.

F8 The risk was documented in Mr S's contemporaneous health record. An appropriate and proportionate discussion with his GP about this risk took place shortly after. Mr S's previous conviction for violence was not known to health professionals at this stage. Direct communication with the police at this stage (January 2011) was not indicated, although consideration was given later when his previous conviction for assault was revealed and the safeguarding lead notified.

6.2.4. Information between Avon and Somerset Police Public Protection Unit and the CMHT

On 1 February 2012 the trust contacted the Avon and Somerset Public Protection Unit (PPU) to advise it of the recurring threats that Mr S was making towards his landlord.

Avon and Somerset Police requested more information. The CMHT responded promptly highlighting Mr S's past conviction for a serious assault as well as repeated threats to harm Mr C. Two weeks later the police asked for further clinical information. The CMHT provided this on 15 February. The only police response on record was a brief email on 15 February 2012. This is detailed below:

> "Hi C, We have updated our computer systems with the information you have provided regarding Mr S.
>
> "It is for you to disclose to Mr [landlord] around his safety on attending the address. I would suggest that Mr [landlord] is only advised that he should not attend the address on his own but to take somebody with him. This can be advised around your information sharing protocol.
>
> "Please can I also advise that Mr [landlord] has rung my office this morning wanting to update. Thanks."

There is no record to show that the police provided any further information before the June 2012 incident.

Avon and Somerset Police carried out a review following the incident to see whether any lessons could be learned. They found that there was lack of clarity about who should be responsible for making a disclosure to Mr C.

6.2.5. Findings

F9 The CMHT contacted the police directly when their concern about Mr S's threats against Mr C increased but there was a two week delay before a reply was received from the police. This left the management of risk of harm to Mr C exclusively in the hands of the NHS during these two weeks.

F10 The police decided to leave the CMHT to provide feedback to Mr C that he was the target of threats, after he had contacted them on 15 February 2012.

F11 The police did not share the knowledge and expertise they had to help the CMHT devise a sound risk assessment and risk management plan for Mr S.

We question whether staff at the CMHT should have taken the advice from the police that "Mr S's landlord should only be advised that he should not attend the address on his own but to take somebody with" at face value. The trust policy on sharing information without consent states:

> "The guiding principle is that your information is held in strict confidence, and we would normally ask your consent to share it. However, there are times when information about you may be shared without your consent. These include:
>
> - safeguarding children or vulnerable adults
> - preventing harm or risk to you or others
> - investigation or prevention of crime
> - control of infectious diseases
> - in response to a court order."

The above guidance makes it clear that the trust had the authority to share information about Mr S without his consent to prevent harm to others. The trust did have the authority to tell Mr C about Mr S's previous conviction for stabbing his wife anyway as the information was already in the public domain.

6.2.6. Finding

F12 Although the trust went beyond the advice given by the police, they had the authority to inform Mr C about Mr S's previous conviction and the risk he posed to him but did not act on this.

6.2.7. Recommendation

R1 The trust should put steps in place to ensure that all relevant information about a service user is shared (even if consent is not granted) with someone who is a known risk from that service user.

6.2.8. Information from social services

There are a number of entries in Mr S's records showing that social care staff met with Mr S. However, there are no copies in the records of any systematic social services assessments although a social services referral had been made in early 2011 to which an OT (social services) responded by phone with the advice that Mr S could not be provided with a walking frame because "he does not fit the Fair Access to Care Services eligibility criteria". Mr S's care coordinator contacted adult social care on 12 May 2011 asking about the outcome of a formal referral. She was informed that Mr S had discussed problems with his flat and was given telephone numbers of people to contact*, but* "there was nothing more that Social Services [could] do to help with the situation, so had closed the case."

It appears that a social services reassessment took place at a later stage as Mr S was receiving home care service in October 2011. The only reference to this is a note in his health records of a discussion with a care agency about the frequency of home care.

6.2.9. Sharing of information with the trust's safeguarding vulnerable adults lead

On 27 April 2011 Mr S told his care coordinator about a previous conviction for a non-fatal stabbing of his wife for which he received a custodial sentence. CMHT staff decided to inform the safeguarding vulnerable adults lead (based within the trust and not social services). The outline referral details were promptly phoned through to the safeguarding lead's secretary.

The trust's safeguarding policy states that an initial step following a referral is for the safeguarding team to consult with the police regarding any previous convictions.

6.2.10.Finding

F13 There is no evidence that the safeguarding team consulted the police in April 2011. Nor, for that matter did the CMHT chase up or receive any feedback from the safeguarding team about the referral.

6.2.11.Multi Agency Public Protection Arrangements (MAPPA)

The MAPPA arrangements manage the risk posed by the most serious sexual and violent offenders. The police, probation and prison services and other agencies are brought together to share information so that risk assessments and risk management plans can be put in place.

In this case, the CMHT staff did not have a discussion with the trust's safeguarding team to discuss whether Mr S should have been referred to MAPPA.

A discussion with the trust's safeguarding team to discuss whether Mr S should have been referred to MAPPA would have been helpful. It is unlikely that Mr S would have met the criteria for MAPPA but the MAPPA team may have been able to provide some management advice.

We endorse the opinion of the trust's internal investigation that there was a failure at this point in its safeguarding arrangements.

The trust has since introduced a short training programme for staff in older person's services about the MAPPA process and how to access MAPPA via the trust safeguarding team. We have received evidence to show that staff from the CMHT have attended the course. We have not made a recommendation regarding MAPPA given this improvement.

6.2.12.Referral to forensic services

The CMHT did not make a referral or seek advice from a forensic psychiatry service about Mr S at any stage from April 2011 onwards when they first learned of Mr S's previous conviction for violent assault. Threats to kill are uncommon in people in their 80s, and even rarer in men over 80 with a past conviction for violence. Despite the rareness of such events they are not unknown and therefore good practice is generally to seek advice from experts.

6.2.13.Comment

Mr S's presentation to the Older People's Service was an unusual one. Mr S's case might also have presented the forensic psychiatry service lead with some difficulty, as dealing with risks of this order in a man who is 83 years old would be unfamiliar territory for them. However, they should have been asked for their assistance on Mr S's risk management.

6.2.14.Finding

F14 A forensic psychiatric opinion about Mr S's risk and management should have been sought, when Mr S made further serious threats to kill Mr C. Although it is unlikely that Mr S would have met the criteria for forensic services, advice about his management might have been helpful.

6.2.15.Recommendation

R2 The trust should ensure that there are steps in place so that relevant staff in older person's services are able to gain advice and guidance from forensic services when needed.

6.2.16.Did the professional judgements and actions taken by the staff within the CMHT correspond with statutory obligations, established good practice guidance and local operational procedures?

Clinical records show there was good compliance with NICE guidance on the management of depressive illness and on the assessment and management of dementia as well as the trust's operational policies on risk assessment. GP communication was to a high standard and details of Mr S's diagnosis, care plan and treatment were clearly described with appropriate adjustments as clinical developments occurred.

Written communications to the GP about Mr S's diagnosis and care plan were clear and consistent with clinical developments.

The failure to consider a forensic psychiatry referral in April 2011 or January 2012, when Mr S's threats to kill were prominent in the context of a paranoid disorder, represent weakness in clinical judgement rather than failure to comply with established local or national policies.

An appropriate referral was made to the trust's safeguarding lead in April 2011. Regrettably the latter did not act on this. In the absence of feedback the service should have followed up the referral. This is irrespective of any shortcomings by the safeguarding lead.

The risk to Mr C was thought to have increased when discussed at a care programme approach meeting on 30 January 2012. The service made direct contact with the police. They probably should have re-referred Mr S to the safeguarding lead

as well. Such a referral should have facilitated the creation of a more robust safeguarding plan in response to the risks Mr S posed.

The failure to seek or obtain a reliable history about Mr S's previous convictions from the police was an error of clinical judgement. It was compounded by an acceptance of the police advice to let the service manage the risk to Mr C without them in February 2012.

6.3. Risk assessment and risk management

National policy outlines that risk assessment and risk management should be at the heart of effective mental health practice. Trust policy says that all service users should have a risk assessment completed as part of the assessment. Any risks or issues around safety identified should be incorporated into the service user's care plan and reviewed as appropriate within a maximum of 12 months.

There is good documentary evidence that staff assessed Mr S's risks in a timely way. The care coordinator developed a risk management plan. She recorded information about Mr S attempting to kill his wife and the threats that Mr S had made towards Mr C. The risk plan also recorded that the care coordinator had reported the issue to the Avon and Somerset PPU. The PPU risk profile was updated on a regular basis.

A clinical risk management tool developed by the Sainsbury Centre in 2000 advised NHS trusts that in order to assess risk accurately, information must be gathered from relevant parties to build up an accurate picture including:

- the patient;
- carers, friends;
- relatives;
- other team members/other teams;
- other statutory or voluntary sector mental health agencies; and
- police, probation, courts.

Mr S was estranged from his wife and daughters. His main friend was a 93 year old lady living in Axbridge. Records show that Mr S was always seen alone. It would have been useful if the care coordinator had discussed with Mr S if and how he wanted other family or friends to be involved in his care. Such discussions should have taken place at intervals to take account of any changes in circumstances, and should not happen only once. It would have been helpful to obtain collateral information from his cousin and his friend to build up a fuller picture of Mr S. We recognise that Mr S may not have wanted anyone else involved in his care. We make this point because there is no evidence that he was regularly consulted about this. It is possible to seek collateral information from others without breaching confidentiality as the purpose is to glean information not disclose confidential information.

6.3.1. Findings

F15 Risk assessments were completed. Safety risks were identified and were incorporated into Mr S's recovery care plan. Risk assessments were updated and reviewed regularly.

F16 There is no evidence to show whether or not discussions took place with Mr S from time to time to find out whether he wanted friends or family involved in his care.

6.3.2. Recommendation

R3 The trust should put steps in place to ensure that a discussion with the person using mental health services takes place to find out if they want their family, carers or friends to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once. If consent is refused, advice should be sought as to what action can be taken without releasing confidential information.

6.4. Predictability and preventability

The terms of reference for this investigation set out the need to determine whether there were any aspects of the care which could have been altered, thereby preventing the incident from happening.

6.4.1. Verita uses the following definition of predictability:

> We consider that the homicide would have been predictable if there had been evidence from Mr S's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

Mr S attended a review meeting at the CMHT on 30 January 2012. He seemed very positive about the support he was receiving, but his concerns about his flat and his hostility to his landlord continued. His records state:

> "Mr S advised that if his landlord and 'accomplice' visit his flat, he plans to 'do the same as I did to my wife'."

There is documentary evidence that Mr S told staff that he could become violent. Furthermore, staff were aware that he had previously wounded his wife by stabbing and subsequently showed no remorse for having done so. On 1 February 2012 the trust contacted the Avon and Somerset PPU to advise it that Mr S was threatening Mr C.

Finding

F17 Mr S did alert professionals that he might become violent. The trust took his threats seriously as they thought that he might act on them. The trust did not predict that a homicide would take place but it did predict that a serious incident might take place if preventative measures were not taken.

The terms of reference for this investigation to us

> To identify whether there were any aspects of the care which could have been altered or prevented the incident from happening. The investigation process should also identify areas where improvements to services might be required, which could help prevent similar incidents occurring.
>
> The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations for individual, organisational and system learning.

6.4.2. Verita uses the following definition of preventability:

> "We consider that the homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy."

We considered what actions CMHT staff should have taken to prevent this tragic incident. We examined whether a Mental Health Act assessment should have taken place to admit Mr S to hospital under the Mental Health Act[1].

The Mental Health Act code of practice makes it clear that several factors should be considered in deciding whether patients should be detained for their own health and safety. Two of these factors are:

- "Evidence suggesting that patients are at risk of suicide, self-harm, self-neglect or being unable to look after their own health and safety or jeopardising their own health and safety accidentally or unintentionally; or that their mental disorder is otherwise putting their health and safety at risk; and
- Whether other methods of managing the risk are available".

Mr S was receiving a comprehensive package of care from the CMHT. Overall, Mr S engaged with services and he appeared to enjoy going to the day hospital. He complied with treatment and had support to manage his condition. Therefore we do not think that Mr S would have met the criteria for admission to hospital under the Mental Health Act.

[1] Detention under the Mental Health Act for assessment or treatment must be either in the interests of the person's own health or to protect other people.

Earlier in this report we raised the issue about Mr S not having been referred to the forensic services. Whilst this is an omission (recognised already by the trust internal investigation), we do not think that a referral to forensic services would have prevented this incident. It is likely that Mr S would not have met the criteria for forensic services but advice from the team may have been helpful.

6.5. Summary chronology of disclosed threats to harm Mr C

In this section of the report we review from the chronology what was known by trust staff about Mr S's threats towards Mr C and what the trust could and should have disclosed to Mr C about those threats.

Mr S had previously told a CPN about his criminal history – including his non-fatal stabbing of his wife in the 1980s, for which he received a two-year prison sentence – when he was assessed on 27 April 2011.

The CPN told Mr S's GP about this new information. On 28 April 2011 the CPN also alerted the secretary of the trust's safeguarding team about Mr S's situation.

On 30 January 2012 Mr S attended a CPA review meeting. He disclosed his concerns about his flat and his hostility to Mr C. He said that he would "do the same as I did to my wife". Mr S showed no remorse about his previous conviction.

A locum GP referred Mr S to CMHT in January 2011 because Mr S was having angry thoughts about Mr C, including thoughts of killing him and then himself.

An OT from the CMHT assessed Mr S at his home on 21 January 2011. Mr S told the OT that did not have any plans to kill himself or his neighbour.

The care coordinator discussed the issue with Dr C, Mr S's regular GP, on 28 January 2011. Dr C advised that she had known Mr S for several years and knew all about the dampness in his flat. She said that Mr S could be a difficult man who could become cross quite easily. She felt that his remarks about killing himself and his neighbours had no serious intent. Her view was that Dr B had taken them seriously because she had not met him before.

A consultant psychiatrist assessed Mr S on 8 June 2011. He diagnosed Mr S with a recurrent depressive disorder and long-standing persecutory ideas regarding Mr C. He recorded that Mr S probably had antisocial and paranoid personality traits, noting that Mr S had previously stabbed his wife and expressing no remorse.

Mr S told the psychiatrist that he would consider attacking Mr C and his colleagues if they ever visited him. The psychiatrist recorded that this was not likely as Mr C avoided Mr S due to his previous angry verbal outbursts and that Mr S denied he would go looking for them.

The psychiatrist wrote in a care plan letter to Mr S's GP that Mr S could become argumentative and physically aggressive with Mr C and that he would talk to the care

coordinator to decide on the best way to reduce the risk that Mr S might pose to himself and others.

The consultant psychiatrist reviewed Mr S as planned on 20 July. Part of the plan was for Mr S to start olanzapine[1] 2.5mg at night for 14 days then increase to 5mg at night (to reduce his obsessional and possibly delusional beliefs about the landlord's "wilful neglect" of his flat).

The consultant psychiatrist reviewed Mr S again on 12 October. Mr S reported that he had not been taking his tablets because he was too forgetful. He claimed he was suicidal but had no plans to harm himself. The consultant psychiatrist noted that Mr S was less drowsy since he had stopped taking his olanzapine.

Mr S attended a CPA review meeting on 30 January 2012. He seemed very positive about the support he was receiving but his concerns about his flat and his hostility to Mr C continued. The records state:

> "The damp is still a problem in his flat and [Mr S] feels this is a large factor of his problems. He now feels he can resolve this by not paying his ground rent and maintenance charges and has informed his landlord. He advised that if his landlord and 'accomplice' visit his flat, he plans to 'do the same as I did to my wife'".

Mr S did not seem remorseful about this plan and spent some time describing his previous term of imprisonment, which he appeared to have enjoyed. A risk alert was added to Mr S's records concerning potential violence to Mr C.

At a care programme approach review on 21 May 2012, Mr S told staff that he would not attack defenceless people but if he was provoked he would defend himself. He did not on this occasion mention Mr C or any problems with damp in his flat.

6.5.1. Comment

It can be seen from this summary chronology that Mr S had continuing thoughts of harming Mr C right up to 30 January 2012. These thoughts do not appear to have reduced. There were times when he said he had no plans, but he also said that if Mr C came to the flat he would do the same as he did to his wife.

6.6. Contact with the police

On 1 February 2012 the care coordinator sent an email to Avon and Somerset Public Protection Unit (PPU). A key part of that email is set out below:

> "I reviewed Mr S this week during which time he once again mentioned this problem and once again stated that if he came face to face with his landlord, he would not hesitate to harm him as he did his wife many years ago.

[1] An antipsychotic medication used to treat delusional symptoms in conditions such as schizophrenia as well as acute manic episodes associated with bipolar disorder.

> Following the end of his marriage, Mr S stabbed his wife for which he served a time in prison. When discussing this with Mr S, his only regret is that he did not kill her and he appears to have really enjoyed his stay in prison. Obviously this has been a concern for some time but as Mr S's landlord lives in Devon, the possibility of them meeting was not likely to happen in the near future. However, Mr S explained that he plans to stop paying his maintenance charge and ground rent until this damp problem is resolved. As a result of this action, it might provoke a visit from his landlord.
>
> "Mr S is now 83 years old and when mobilising uses a walking stick and is experiencing some memory problems. However, I still feel that he would carry out his threats. He is not worried of the outcome which may mean imprisonment. He feels he would be better off in prison than living in his damp conditions."

On 13 February 2012, the supervisor from the safeguarding coordination unit from Avon and Somerset PPU contacted the care coordinator and discussed the email. She asked for more information about Mr S. The care coordinator sent further details about Mr S's diagnosis and treatment plan.

On the same day the care coordinator met with Mr S to discuss his care plan and advised him that the police had been informed about his threats to harm Mr C. Records show that Mr S did not seem worried about this.

On 15 February 2012 the supervisor from the safeguarding coordination unit from Avon and Somerset Police called the care coordinator to say that the trust was responsible for advising Mr C of the potential risk from Mr S. The supervisor subsequently confirmed this advice in an email:

> "… It is for you to disclose to Mr C around his safety on attending the address. I would suggest that Mr C is only advised that he should not attend the address on his own but to take somebody with him…"

Later that day the care coordinator received a phone call from Mr C who had recently spoken with the police and been advised to contact her. During this telephone conversation the care coordinator advised Mr C not to visit Mr S on his own or indeed at all, as he would be at risk.

> "…Mr C was advised that it would be in his best interests if he did not visit Mr S at his flat on his own or indeed at all. Details were not given, just repeated it would be in his best interests and for safety reasons**."**

6.6.1. Comment

The email to the police was a succinct summary of the assessment of risk that the NHS staff felt that Mr S posed to Mr C.

Avon and Somerset Police carried out a review following the incident to see whether any lessons could be learned. They found that there was lack of clarity about who should be responsible for making a disclosure to Mr C.

The advice that the police gave the trust about how much information should be disclosed to Mr C was in our opinion inadequate. Despite this the trust did go beyond the advice and told Mr C that he should not visit for safety reasons.

6.7. Disclosure

The trust policy on sharing confidential patient information without consent states that it can be shared among other reasons if it is to:

- prevent harm or risk to the patient or others; and
- assist in the investigation or prevention of crime

We acknowledge that disclosure without consent is always a balancing decision and that the staff had a difficult judgement to make on what could be disclosed. The staff carried out a balancing act as they are required to do. Nevertheless we believe the decision to make only a partial disclosure did not fully reflect Mr C's right to relevant information upon which he could decide what actions he could take to protect himself. The information withheld from Mr C was not confidential health information and was in the public domain but as far as we are aware not known to Mr C.

We have balanced the right of Mr S to confidentiality against the right of members of the public to be advised not only of what actions they should take to keep themselves safe, but also of the reasons for so doing. We have considered if the circumstances described above were sufficiently strong to justify a fuller disclosure of the threats that Mr S had made. We conclude that the combination of a historical risk factor – Mr S's stabbing of his ex-wife – and his continuing and unabated threats to Mr C were justifiable reasons to breach Mr S's right to patient confidentiality. In this case, the threats were specific to an individual and not a generalised threat to neighbours. Therefore a targeted disclosure to the individual at risk was justified.

6.7.1. Conclusion

We acknowledge that the staff who contacted the police and informed Mr C of the threats to him had a difficult judgement to make in deciding how much information they should share with Mr C. They made a full referral to the police with clear information about the level of risk they felt that Mr S posed. They then received what we judge to be inadequate advice from the police. Despite this, they made a disclosure that went beyond this advice. Nevertheless the disclosure that was made to Mr C was still insufficient.

We believe that the trust should have gone further than it did in its disclosure and told Mr C that Mr S had a previous conviction of a non-fatal stabbing of his wife and that he had threatened to kill Mr C. Whilst the information about the stabbing of Mr S's wife was in the public domain, it is not likely that Mr C had knowledge of this. Mr C had a right to know this information so that he could make an informed choice

about whether or not to visit the block of flats. We also believe that the trust should have reminded Mr C of this risk from time to time as Mr S had a long-term and persistent grudge against him. Mr C's wife has emailed us and said that that "if health professionals (or the police) had advised her husband that Mr S had threatened to stab him, as he had his wife, then he may still be alive today".

Staff at the CMHT had the knowledge: they knew about Mr S's previous conviction, his lack of remorse and threats to kill Mr C. The CMHT chose to take police advice about the amount of information to share with Mr C, but they were able to share more information about Mr S with Mr C whilst working within trust policy and procedure. They would not have been working outside the law if they had done this as there was a real and immediate risk to Mr C if he visited the flat.

Staff at the CMHT had the opportunity to stop the violent incident from occurring because if they had shared all the information they knew about Mr S with Mr C (the threat to kill him, Mr S's previous conviction and his lack of remorse), there is a reasonable degree of probability that Mr C would not have gone to the block of flats/vicinity where Mr C lived or that he may have sought advice from the police before attending the property.

6.7.2. Finding

F18 If Mr C had been informed about Mr S's previous conviction and his lack of remorse about stabbing his wife, this incident may have been prevented.

7 The trust internal investigation

In this section we examine the trust's serious incident investigation policy and whether the investigation into the care and treatment of Mr S met its requirements.

The trust's policy states that an investigation should take place when there has been a serious incident.

7.1. The trust's internal investigation and progress made against the recommendations

The NPSA's good practice guidance (February 2008) states that in the event of a homicide the trust must carry out an investigation to establish a chronology and identify underlying causes and any further action that needs to be taken.

The trust did carry out its own investigation immediately after the incident.

The trust's investigation was carried out by a head of service and a consultant psychiatrist. There were clear terms of reference for the investigation.

The investigators obtained statements from staff, held individual meetings and carried out telephone interviews with officers from the Avon and Somerset Constabulary.

The report identified several areas that needed improvement and made three recommendations.

1. The trust should consider a short training programme to ensure that staff of the older person's service understand and feel confident in accessing the MAPPA process through the trust's safeguarding team.

2. The trust's safeguarding team should in both face-to-face presentations and Intranet information continue to emphasise a low threshold of case discussion with the safeguarding team where staff are uncertain about MAPPA eligibility or its role.

3. Records of review meetings should contain information about those present and the issues discussed and agreed, and should be attended by all those involved in an individuals' care wherever possible.

We asked the trust to provide evidence to demonstrate that it had implemented the recommendations from the trust investigation. We received a copy of a memo outlining the eligibility criteria for MAPPA. This document was sent to all team leaders within the trust to remind them of the need to check whether any patients were eligible for MAPPA. The trust also set up MAPPA training sessions for staff to understand the categories and levels for MAPPA and multi-agency risk management. We have also received copies of the training register showing which staff attended the training. In addition the trust has amended information on the staff

intranet about MAPPA. The staff intranet now provides information about MAPPA and contact details of who to go to within the trust to get advice.

The trust, in its internal investigation, found that while Mr S's care was clearly reviewed on a number of occasions there was no evidence in his clinical record of a review taking place where all those involved in his care were able to have a face-to-face discussion. The trust therefore sent a memo out to team leaders reminding them of the need to make sure that a record is made of all those present at a clinical review.

7.1.1. Finding

F19 The trust has demonstrated that the recommendations from its internal investigation report have been implemented. However a more sustainable solution should be put in place to ensure that there is an accurate record of the people present, the discussions and outcomes of clinical reviews.

7.1.2. Recommendation

R4 The trust should carry out an audit to ensure that accurate records are kept of all clinical reviews including the people present, the discussions and the outcomes of reviews.

7.2. Supporting and involving the victim's relatives

The NPSA good practice guidance *The investigation of serious patient safety incidents in mental health services* (2008) states that an opportunity should be provided for the victim and their family to meet senior, appropriately experienced staff from the trust. At this meeting their involvement in the investigation process can be discussed. The guidance also states that families should be consulted on the terms of reference for both internal and independent investigations, be provided with the terms of reference, know how they will be able to contribute to the process of investigation, for example by giving evidence. Subsequently, the findings of the internal investigation and the actions to be taken should be discussed with them.

The NPSA *Being open guidance: communicating patient safety incidents with patients, their families and carers* (2009) states that being open about what happened and discussing incidents promptly, fully and compassionately can help families to cope better with the after effects.

7.2.1. Findings

F20 The trust did not initiate any contact with Mrs C (the victim's wife) until after the court case. The trust advised that this was normal practice as the police liaison service was providing support to Mrs C.

F21 The trust was slow in sending a copy of the internal investigation report to Mrs C. We were advised that the trust did not release the report immediately after the

court case as it did not think it would be helpful and that all the information (the police investigation and the trust internal investigation report) would be better channelled through one agency.

F22 The decision to send the information to Mrs C via one channel led to a delay in her receiving the trust investigation report. The approach that the trust took in this respect did not meet the NPSA good practice guidance on being open or the investigation of serious patient safety incidents in mental health services.

7.2.2. Recommendation

R5 The trust should have a clear process in place to ensure that the victims of serious incidents and their families are supported and involved in the trust internal investigation. As a minimum the trust should ensure that the victim's family:

- are provided with and consulted on the terms of reference of the trust internal investigation;
- know how they will be able to contribute to the process of investigation; and
- receive a copy of the trust investigation report in a timely manner without the families having to write to the trust to ask for information.

Appendix A

Team biographies

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, she regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. As Verita's head of training, Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people. Chris heads up Verita's office in Leeds.

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, grievance and abuse inquiries.

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.

Dr Peter Jefferys

Peter is an experienced consultant psychiatrist specialising in old age and former trust medical director. He is a non-executive director for Norfolk & Suffolk NHS Foundation Trust. He has investigated unexpected mental health deaths for health authorities, the Mental Health Act Commission and CQC as well as conducting extensive suicide audits. He is a former advisor to the Parliamentary and Health Services Ombudsman, chairs MPTS (GMC) Fitness to Practice Panels and serves on mental health review tribunals.

Appendix B

Documents reviewed

Medical records

- Mr S's medical and nursing records

Policies and procedures

- *Clinical assessment and management of risk of harm to self and others policy*, December 2010
- *Clinical record keeping policy*, September 2010
- *Recovery care programme approach policy*, September 2010
- *Safeguarding vulnerable adults policy and process*, September 2010
- *Serious untoward event policy and procedure*, March 2011
- *Older persons CMHT operational protocol*, October 2009

Internal report

- SUI review report, November 2012
- Action plan

Avon and Somerset Constabulary

- Operation Grant (the review undertaken by the police into the communication between agencies regarding Mr S' threats
- Correspondence with victim's family

Other

- MAPPA information and training details
- Inspection report on Mr S's residence
- *The investigation of serious patient safety incidents in mental health services* (2008). NPSA.
- *Being open guidance: communicating patient safety incidents with patients, their families and carers* (2009). NPSA.

Appendix C

Interview list

- Trust internal investigation lead

Transcript list

- Consultant psychiatrist
- Care coordinator