

Independent Investigation
into the
Care and Treatment Provided to Mr. Y
by the
Mersey Care NHS Trust
and
Imagine Independence (Mental Health Charity)

Commissioned by
NHS North West
Strategic Health Authority

Report Prepared by the Health and Social Care Advisory Service
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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. Y was commissioned by NHS North West Strategic Health Authority pursuant to *HSG (94)27*.¹ This Investigation was asked to examine a set of circumstances associated with the deaths of Mr. and Mrs. Y Senior, the parents of Mr. Y, who were killed by Mr. Y on the 19 February 2004 and the 30 March 2010 respectively.

Mr. Y received care and treatment for his mental health condition from the Mersey Care NHS Trust and Imagine Independence (Mental Health Charity).

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank both the Trust's and Imagine Independence's Senior Management Teams who have granted access to facilities and individuals throughout this process. The Senior Management Teams of both the Trust and Imagine have acted at all times in an exceptionally professional manner during the course of this inquiry process and have engaged fully with the root cause analysis ethos of this Investigation.

1. Health Service Guidance (94)27

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2. Condolences to the Family and Friends of Mr. and Mrs. Y Senior

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. and Mrs. Y Senior. It is hoped that this report will provide a narrative to the events that occurred and address any of the outstanding questions that the family may still have.

At the time of writing this report it had not been possible to meet with either the family or friends of the couple.

3. Incident Description and Consequences

Background Information for Mr. Y

Mr. Y was born in Liverpool on the 22 February 1972. Prior to her death in March 2010 Mrs. Y Senior gave a detailed history of her son to the Scott Clinic staff who were caring for him. Mr. Y apparently had a loving relationship with both of his parents. As a child Mr. Y was solitary and did not mix well with other children preferring his own company; his mother said that he was bullied at school and relied upon his elder brother to protect him. As an adult Mr. Y remained a solitary figure who enjoyed history and had a keen interest in keeping fit; he was described as not having a great deal of time for girls as he was shy and felt awkward around them. Mrs. Y Senior described her son as a person who had never been involved in fights, was not aggressive, and who disliked confrontation. Mr. Y spent significant periods of time after leaving school unemployed. Shortly before he became mentally ill for the first time he worked as a taxi driver. Mr. Y remained living at home with his parents.²

On the 7 March 2003 Mr. Y visited his GP because he was feeling shaky and had not been able to work following a road traffic accident the previous year. It was evident at this stage that Mr. Y was having hallucinatory experiences.³ Over the following weeks it became evident that Mr. Y had some kind of psychotic illness for which Risperidone was prescribed and he was referred by his GP to secondary care mental health services. Mr. Y was seen by secondary care services in the Outpatient Clinic on the 28 March 2003 and the provisional diagnosis was “*a psychotic illness, paranoid schizophrenia*”.⁴

Mr. Y was placed on Standard CPA and was allocated a Care Coordinator; he continued to have psychotic symptoms. By November 2003 it was becoming increasingly difficult to keep Mr. Y engaged with secondary care mental health services. Mr. Y's mental health began to deteriorate rapidly and by January 2004 a Mental Health Act (1983) assessment was being considered.⁵ Mr. Y's mental health continued to deteriorate and discussions ensued throughout the first two weeks of February 2004 as to whether or not a Mental Health Act

2. Clinical Records Set 2 PP. 82-83

3. GP Records PP. 14-17

4. GP Record PP. 54-55

5. GP Record P. 24

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(1983) assessment should take place in order to expedite a hospital admission.⁶ On the 17 February Mr. Y was visited at his home by a Social Worker. On this occasion he agreed to an informal admission and the plans for an assessment under the Mental Health Act were abandoned. It was agreed that he would be admitted to hospital with immediate effect, however no bed was available until the 18 February and the admission was ultimately delayed until the 19 February. It was agreed that Mr. Y would be collected from his home at 10.00 hours and admitted to Calder Ward Broadoak Mental Health Resource Unit.⁷

Incident Description of the Death of Mr. Y Senior and the Resulting Consequences

Early on the morning of the 19 February 2004 a Social Worker telephoned Mr. Y to arrange a time to come and collect him and take him into hospital. The telephone was answered by a Police Officer who said that Mr. Y had killed his father and seriously wounded his mother.⁸

Earlier that morning Mr. Y and his father had had a disagreement over money. Although they appeared to have resolved their differences Mr. Y went into the garage and retrieved a “hammer/spanner”. When he returned to the house his mother was upstairs packing bags for his forthcoming hospital visit and his father was downstairs. Mr. Y hit his father around the head until he fell to the ground. Mrs. Y Senior came downstairs at this point, she had been unaware of the attack on her husband, and Mr. Y assaulted her. She sustained injuries to her head, fingers and wrists. Mrs. Y Senior was able to reason with her son who stopped the attack and went upstairs. His mother called for the Police and Mr. Y made no further attempts of either resistance or violence.⁹ Later on the same day Mr. Y was admitted to the Scott Clinic (a forensic medium secure unit) under Section 2 of the Mental Health Act (1983). The Police were of the view that he was mentally ill and required hospitalisation. Mr. Y was remanded on bail.¹⁰

On the 9 August 2004 at the Indictment at Liverpool Crown Court Mr. Y was charged as follows:

“Count 1: murder, contrary to common law.

Particulars of the offence: Mr. Y on the 19 day of February 2004 murdered his father.

6. Mr. Y GP Record PP. 36-37

7. Trust Internal Investigation Report. P. 20

8. Clinical Records Set 2. P. 2

9. Trust Record PP. 56-57

10. Trust Record PP. 76 and 97 and 303

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Count 2: attempted murder.

Particulars of the offence: Mr. Y on the 19 day of February 2004 attempted to murder his mother.

Count 3: causing grievous bodily harm.

Particulars of the offence: Mr. Y on the 19 day of February 2004 caused grievous bodily harm to his mother with intent to do her grievous bodily harm."¹¹

On the 18 October 2004 Mr. Y was convicted of manslaughter and causing grievous bodily harm with intent. On this day Mr. Y was formally discharged from his detention under Section 3 of the Mental Health Act (1983). A Hospital Order was made at Liverpool Crown Court. He was to be detained at the Scott Clinic under Sections 37/41 of the Act. Mr. Y was returned to the Scott Clinic with immediate effect; his given diagnosis was Paranoid Schizophrenia.

Incident Description of the Death of Mrs. Y Senior and the Resulting Consequences

For the next two years and two months Mr. Y remained at the Scott Clinic. On the 15 December 2006 a Mental Health Review Tribunal was convened and it was decided that Mr. Y would be discharged from the Scott Clinic subject to specific conditions. These conditions are set out below. Mr. Y was:

- to reside at 123, Moscow Drive Liverpool (24-hour supported accommodation);
- to provide access to any members of staff caring for him and to have face-to-face contact with staff on a daily basis;
- to comply precisely with all aspects of treatment as directed by the clinical team whether in the form of medication or other therapeutic interventions;
- to attend appointments with his Responsible Medical Officer, (Consultant Psychiatrist 3) his successor, or nominated deputy as required;
- to attend appointments with his Social Supervisor, her successor or nominated deputy as required;
- to attend appointments with his Community Psychiatric Nurse, (Care Coordinator 2), her successor, or nominated deputy as required;
- to notify a member of staff (Imagine) at Moscow Drive of any face-to-face meeting with his mother;

11. Legal Documents PP.2-4

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- not to go within 200 metres of his mother's home;
- to be aware that powers of recall by the Ministry of Justice could be triggered at any time if the conditions were not fulfilled.¹²

On the 20 December 2006 Mr. Y was discharged from the Scott Clinic to live at 123 Moscow Drive, a supported living accommodation, which was managed by an organisation called Imagine Independence (Imagine). It is recorded that during this period Mr. Y settled quickly into the community and was reported to be doing well. Mr. Y had re-established a relationship with his mother prior to his leaving the Scott Clinic and he met with her on a regular basis.

On the 29 September 2009 Mr. Y moved to a self-contained flat at 133 Moscow Drive which was also part of the supported living scheme managed by Imagine.¹³ Mr. Y was apparently very happy to be settled into a more independent living environment. He was reported as being both physically and mentally well at this time.

Four months after this move had taken place plans were put into action to try and move Mr. Y into a flat which would give him even more independence. Mr. Y expressed some concerns about this, however during February and March 2010 planning continued and Mr. Y was taken to view a flat five minutes away from where he lived and offered the opportunity of a long-term lease.¹⁴ Mr. Y continued to be reported as mentally well during this period.

On the 30 March 2010 Mr. Y was reported to have given his television away to another service user. This was a point for concern as giving possessions away had been identified previously as being part of his relapse signature. Mr. Y however appeared to be mentally well. In the morning Imagine staff notified Mr. Y's Social Supervisor who made a visit to his flat. Mr. Y was not there as he was out, the plan having been to have lunch with his mother, which was usual. The Social Supervisor suggested that the Imagine staff contact her again if they identified anything unusual.

At 19.45 hours Mr. Y returned to 133 Moscow Drive. He spent some time with the Imagine staff talking about Scrabble and then went to his flat stating he was going to listen to music.

12. Tribunal Documentation. PP.1-7

13. Imagine Notes. PP. 311-312

14. Imagine Notes. PP.382-383

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At 22.30 hours a neighbour of Mr. Y's mother called Moscow Drive to say that she had not returned home, he subsequently called back to say that her house was on fire. Mr. Y was arrested at the scene of the fire and his mother's body was found subsequently in his flat at Moscow Drive; she had been stabbed to death with a kitchen knife.¹⁵ Immediately after the incident Mr. Y was placed on a Section 3 of the Mental Health Act (1983 & 2007) and placed at the Scott Clinic. On the 7 June 2010 Mr. Y was discharged from his Section 3 and recalled under Sections 37/41 to Ashworth Hospital.¹⁶

On the 28 March 2011 Mr. Y was found guilty of manslaughter and attempted arson. He was sentenced to life imprisonment with a 20 year determination. He was detained at Ashworth High Secure Hospital on a Section 45 of the Mental Health Act (1983 & 2007).¹⁷

On the 19 April 2011, following an appeal by his defence team, Mr. Y's sentence was reduced to a minimum of a fifteen-year determination.¹⁸

15. Trust Record PP. 78-79 and 92-94

16. Trust Record P. 113

17. Trust Record PP. 172-173

18. Liverpool Echo.co.uk 19 April 2011

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

The Health and Social Care Advisory Service was commissioned by NHS North West (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94)4*, issued in 1994 to all commissioners and providers of mental health services. In discussing ‘when things go wrong’ the guidance states:

“in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved”.

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

- i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.
- ii) When it is necessary to comply with the State’s obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.
- iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

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

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

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

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS North West Strategic Health Authority. The Mersey Care NHS Trust and Imagine Independence did not wish to make any additions. The Terms of Reference were as follows:

1. To Examine:

- the care and treatment provided to the service user at the time of the killing of both his father and of his mother (including that from non NHS providers e.g. voluntary/private sector, if appropriate);
- the suitability of that care and treatment in view of the service user's history and assessed health and social care needs;
- the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;
- the adequacy of risk assessments to support care planning and use of the care programme approach in practice;
- the exercise of professional judgement and clinical decision making;
- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical needs;
- the extent of services' engagement with carers; use of carer's assessments and the impact of this upon the incident in question;
- the quality of the internal investigation and review conducted by the Trust.

2. To Identify:

- learning points for improving systems and services;

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- developments in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

3. To Make:

- realistic recommendations for action to address the learning points to improve systems and services.

4. To Report:

- findings and recommendations to the NHS North West Strategic Health Authority Board as required by the SHA.

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of the Mersey Care NHS Trust and Imagine Independence. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Team Leader

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Chair and Report Author
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Investigation Team Members

Dr. David Somekh	Forensic Consultant Psychiatrist Member of the Team
Mr. Alan Watson	Social Worker Member of the Team
Mr. Jon Allen	Nurse Member of the Team
Dr. Len Rowland	Psychologist Member of the Team

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service
Mrs. Fiona Shipley	Stenography Services

Independent Advice to the Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks
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7. Investigation Methodology

On the 18 April 2011 NHS North West (the Strategic Health Authority) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in Section Five of this report. The Investigation Methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. Y and all witnesses to this Investigation.

Communications with the Family of Mr. and Mrs. Y

NHS North West wrote to the family and friends of Mr. and Mrs. Y Senior on the 17 November 2011. It was agreed that one person would act as a liaison for the family as a whole. At the time of writing this report no family member had made contact with either the Strategic Health Authority or the Investigation Team.

Communications with Mr. Y

NHS North West wrote to Mr. Y and his Responsible Medical Officer on the 15 July 2011 to ask for his consent to a full record disclosure to be made to the Independent Investigation Team. Mr. Y signed the consent form for a full disclosure of his health, social care and Criminal Justice System records to be made to the Independent Investigation Team on the 25 July 2011.

A visit was made to Mr. Y on the 24 April 2012 by a member of the Investigation Team and a Senior Officer from NHS North West. The purpose of the visit was to explain the findings of the Investigation and the process for the publication of the report.

Communications with the Mersey Care NHS Trust

On the 14 July 2011 NHS North West wrote to the Mersey Care NHS Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. Y. Following this correspondence the Independent Investigation Team Chair made direct contact with the Trust *via* telephone on the 18 July 2011.

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On the 13 September 2011 the Chair of the Independent Investigation Team met with the Mersey Care NHS Trust Executive Team which included the Chief Executive and the Director of Patient Safety, who was identified as being the Trust Liaison Person for the Investigation. On this occasion the Investigation process was discussed and an invitation was made for a workshop to take place to provide a briefing opportunity for all those who would be involved with the Investigation.

On the 2 August 2011 the Trust received a letter from the Strategic Health Authority requesting formally that Mr. Y's clinical records be released to the Independent Investigation Team.

Workshops were held on the 17 and 18 November 2011 for all those witnesses who had been identified as needing to be called for interviews by the Investigation Team. The workshop provided an opportunity for witnesses to have the process explained to them in full. Advice was given regarding the writing of witness statements and the interview process was discussed in detail.

Between the first meeting stage (held on the 13 September 2011) and the formal witness interviews (held between the 28 November and the 1 December 2011) the Independent Investigation Team Chair worked with the Trust Liaison Person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished.

On the 14 March 2012 the Investigation Chair and the Social Worker Member of the Investigation Team met with the Trust Chief Executive and Executive Team to provide a headline findings session.

The draft report was sent to the Trust for factual accuracy checking on the 18 June 2012 Relevant clinical witnesses were also sent key sections of the report for factual accuracy

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checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

Communications with Imagine Independence (Imagine)

The Independent Investigation Team Chair made direct contact with the Imagine Chief Executive *via* telephone on the 11 October 2011.

Imagine received a copy of Mr. Y's consent form from the Health and Social Care Advisory Service and subsequently released his records to the Investigation Team. Imagine staff joined the Mersey Care NHS Trust staff at the workshops held on the 17 and 18 November in order to receive a briefing regarding the process.

On the morning of the 2 December 2011 the Independent Investigation Team met with the Imagine Top Team. A liaison person had been assigned previously. On the 13 March 2012 the Investigation Chair and the Social Worker Member of the Investigation Team met with the Imagine Chief Executive and Executive Team to provide a headline findings session.

The draft report was sent to Imagine for factual accuracy checking on the 18 June 2012. Relevant clinical witnesses were also sent key sections of the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

Communications with NHS Liverpool, formally the Liverpool Primary Care Trust (PCT)

NHS North West wrote to the Liverpool Primary Care Trust on the 2 August 2011 to explain that an HSG (94) 27 Investigation had been commissioned and to make a formal request for Mr. Y's primary-care based clinical records to be released to the Independent Investigation Team.

The Investigation Chair made contact with the Primary Care Trust *via* telephone on the 7 October 2011 and spoke with a Senior Officer from the organisation. It was agreed that the Investigation Chair would make arrangements to visit the commissioning team towards the

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end of the investigation process in order to ensure that recommendations could be developed jointly between the provider Trust and the commissioning body.

Communications with the Local Authority

On the 13 March 2012 the Independent Investigation Chair and the Social Worker member of the Team met with senior offices from the Local Authority and Supporting People Service to discuss housing and accommodation issues.

Completion of the Process

It was agreed that a formal workshop would be held with the Mersey Care NHS Trust, Imagine and key stakeholders directly prior to the finalisation of this report. The purpose of the workshop would be to complete recommendations and to ensure that a 'learning the lessons' opportunity was given.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon compliant processes. A total of 46 witnesses were interviewed formally.

Table One
Witnesses Interviewed by the Independent Investigation Team
(28 November - 2 December 2011)

Date	Witnesses	Interviewers
28 November 2011	Trust Chief Executive Trust Director of Nursing Trust Medical Director Trust Director of Finance Trust Director of Patient Safety Trust Director of Service Development Trust Non-Executive Director ***** Head of Service Governance and Risk Head of Risk and Resilience ***** Forensic Service Director	Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist Investigation Team Social Worker Investigation Team Psychologist In attendance: Stenographer

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	<p>Service Director Liverpool CBU FIRT Team Manager Forensic Service Clinical Director Clinical Director Liverpool ***** Trust Internal Investigation Team x 4</p>	
<p>29 November 2011</p>	<p>Care Coordinator 1 Clinical Psychologist 2 ***** Consultant Psychiatrist 3 ***** Care Coordinator 2 ***** Social Supervisor 1 ***** Care Coordinator 1</p>	<p>Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist Investigation Team Social Worker Investigation Team Psychologist In attendance: Stenographer</p>
<p>30 November 2011</p>	<p>Social Supervisor 2 ***** Consultant Psychiatrist 4 ***** Consultant Psychiatrist 2 ***** Specialist Registrar ***** Named Nurse Scott Clinic Occupational Therapist Scott Clinic Ward Manager Scott Clinic Nurse Therapist Scott Clinic ***** Service Manager (pre- 2011) Clinical Director (pre-2011)</p>	<p>Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist Investigation Team Social Worker Investigation Team Psychologist In attendance: Stenographer</p>
<p>1 December 2011</p>	<p>Scott Clinic CMHT Manager Park Lodge CMHT Manager ***** Care Coordinator 3</p>	<p>Investigation Team Chair Investigation Team Nurse Investigation Team Psychiatrist Investigation Team Social Worker Investigation Team Psychologist In attendance: Stenographer</p>
<p>2 December 2011</p>	<p>Imagine Chief Executive Imagine Director of Operations Imagine Director of Operations and Development Imagine Finance Controller ***** Imagine Team Leader Imagine Bridge Builder Imagine Director of Development Imagine Service Manager</p>	<p>Investigation Team Chair Investigation Team Nurse Investigation Team Social Worker Investigation Team Psychologist In attendance: Stenographer</p>
<p>13 March 2012</p>	<p>Liverpool Local Authority and Supporting People Officers (informal process)</p>	<p>Investigation Team Chair Investigation Team Social Worker</p>

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Salmon and Scott Compliant Procedures

The Independent Investigation Team adopted Salmon compliant procedures during the course of its work. These are set out below.

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:
 - (a) of the terms of reference and the procedure adopted by the Investigation; and
 - (b) of the areas and matters to be covered with them; and
 - (c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and
 - (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and
 - (e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and
 - (f) that it is the witness who will be asked questions and who will be expected to answer; and
 - (g) that their evidence will be recorded and a copy sent to them afterwards to sign; and
 - (h) that they will be given the opportunity to review clinical records prior to and during the interview;
2. Witnesses of fact will be asked to affirm that their evidence is true.
3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

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4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.
5. All sittings of the Investigation will be held in private.
6. The findings of the Investigation and any recommendations will be made public.
7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.
8. Findings of fact will be made on the basis of evidence received by the Investigation.
9. These findings will be based on the comments within the narrative of the Report.
10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general questions that they could expect to be asked.

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The Team Met on the Following Occasions:

12 October 2011. On this occasion the Team examined the timeline based on what could be ascertained from analysing the documentary evidence. The witness list was confirmed and emerging issues were identified prior to the interviews. Using the Terms of Reference and the timeline as guidance, the Team also developed subject headings that required further examination.

28 November and the 2 December 2011. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine the timeline, re-evaluate emerging issues and to discuss additional evidence as it arose.

Between the 3 December 2011 and the 5 January 2012 each Team Member prepared an analytical synopsis of identified subject headings in order to conduct an in-depth Root Cause Analysis process.

6 January 2012. A second meeting took place to discuss further issues raised from the secondary literature and the interview process.

13 February 2012. On this day the Team met to work through each previously identified subject heading utilising the 'Fishbone' process advocated by the National Patient Safety Agency (NPSA). This process was facilitated greatly by each Team Member having already reflected upon the evidence prior to the meeting and being able to present written, referenced briefings to Investigation Team Members. The 'Five Whys' process was also used.

Following this meeting the report was drafted. The Independent Investigation Team Members contributed individually to the report and all Team Members read and made revisions to the final draft.

Other Meetings and Communications

The Independent Investigation Team Chair met on a regular basis with NHS North West throughout the process. Communications were maintained in-between meetings by email, letter and telephone.

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Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

- 1. Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.
- 2. Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
- 3. Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'.
- 4. Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

8. Information and Evidence Gathered (Documents)

During the course of this investigation 3,000 pages of clinical records have been read and some 3,500 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. GP records for Mr. Y
2. Trust clinical records for Mr. Y
3. Imagine records for Mr. Y
4. Ministry of Justice records for Mr. Y
5. Court related documents for Mr. Y
6. Trust Internal Investigation Reports (2004 and 2010)
7. Imagine Internal Investigation Report (2010)
8. Trust assurance and governance documentation
9. Inquest and Pathology documentation
10. Secondary literature review of media documentation reporting the deaths of Mr. and Mrs. Y Senior
11. Secondary literature review of external regulatory bodies pertaining to the Trust
12. Independent Investigation Witness Transcriptions
13. Trust Clinical Risk Clinical Policies, past and present
14. Trust Care programme Approach Policies, past and present
15. Trust and Local Authority Safeguarding and Vulnerable Adult Policies, past and present
16. Trust and Local Authority Operational Policies, past and present
17. Trust Incident Reporting Policies
18. Trust Clinical Supervision Policy
19. Trust Being Open Policy
20. Trust Operational Policies
21. Imagine Policies and Procedures
22. Healthcare Commission/Care Quality Commission Reports for ...Trust services
23. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm*: a protocol for liaison and effective communication

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between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006

- 24.** Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005

9. Profile of the Mersey Care NHS Trust (Past, Present and Transition)

Mersey Care NHS Trust was established on 1 April 2001 to provide specialist mental health and learning disability services for the people of Liverpool, Sefton, and Kirkby. Mersey Care's purpose is to enable people with learning disabilities and mental health difficulties and their carers to optimise their health, life experience and citizenship.

The Trust:

- typically provides care, treatment and support to 28,409 service users a year;
- is dispersed across more than 32 sites;
- has 649 inpatient beds;
- has a combined total of 388,369 outpatient attendances and contacts during the course of a year;
- serves a local population of one million people from Liverpool, Sefton and Kirkby and wider sub regional and national for specialist secure services;
- the Trust also provides medium secure services for Merseyside and Cheshire and high secure services for the North of England and Wales.

*(Statistics based on audited figures for 2010-2011, figures correct as of 31 March 2011)

The Trust accomplishes this by:

- leading a network of services to meet the health and social care needs of individuals and their carers;
- working with other agencies and the community to promote mental well-being and social inclusion;
- championing the rights, needs and aspirations of people with mental health difficulties and learning disabilities, tackling discrimination and stigma.

Mersey Care is one of only three Trusts of its kind in the country providing the entire range of specialist mental health services. Mersey Care has a wider role too, offering medium secure services for Merseyside and Cheshire, and high secure services for England and Wales.

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Services provided by the Trust are managed and delivered through clinical services led by a clinical director and service manager. These have been organised on the basis of service user groups:

- mental health services for adults and older people, primarily community and in-patient services for people either living in Liverpool, or those in Sefton and Kirkby;
- people with learning disabilities;
- people with substance misuse (drugs and alcohol) problems;
- a forensic service with its in-patient unit based at Scott Clinic, Rainhill;
- high secure services based at Ashworth Hospital, Maghull.

Where practicable, Trust services are organised within the boundaries of the Primary Care Trusts for local services, but on a sub-regional basis for forensic services and national basis for high secure services.

The Scott Clinic is a medium secure psychiatric unit located on the outskirts of Rainhill, Merseyside, England. Medium secure services are provided by a range of NHS and independent sector organisations, and are for people who present a significant danger. Many patients will have a history of offending and some will have been transferred from prison or from court to receive inpatient treatment. Typically, patients will remain in treatment between two and five years.

10. Profile of Imagine Independence

Imagine Independence is a mental health charity. Incorporated in the 1970's Imagine has spent the last four decades working to improve the opportunities available for people suffering mental ill health. Committed to the belief that social inclusion is a necessity, as well as a right for all, Imagine specialises in independent living, and inclusion.

In the last year the organisation has expanded. Today more than 1,000 people use Imagine services, in Liverpool, Halton, Lancashire, Sefton, Wirral, London and Greater Manchester. Imagine is fortunate to have the support of many volunteers in addition to over 200 staff members.

The core services include:

- forensic services – follow on accommodation and support;
- high support therapeutic residential community services for women with complex needs;
- personalised accommodation services – dual diagnosis; substance use; learning difficulties;
- employment services;
- social inclusion mainstream;
- befriending;
- Chinese language service;
- day services;
- user-led services;
- pilot personal health budget service(s);
- volunteering.

11. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. Y and on his care and treatment from mental health services.

11.1.1. Background Information for Mr. Y

Prior to her death in March 2010 Mrs. Y Senior gave an account of Mr. Y's history to staff at the Scott Clinic. Mr. Y was born in Liverpool in 1972. His mother described him as an anxious and sensitive child. From an early age Mr. Y disliked being picked up or hugged; if these events took place then he would become rigid and hold his breath. Mr. Y did not communicate well as a child and he did not mix well with other children.

On leaving school Mr. Y took a job in a factory, but he was asked to leave for reasons which Mr. Y never disclosed. Shortly after this Mr. Y went to live at the YMCA but returned to live back at the family home at his mother's insistence. Following this Mr. Y worked as a taxi driver for a period of ten years. Clinical records indicate that Mr. Y may have experienced two road traffic accidents whilst working as a taxi driver. One of these accidents was severe enough to take his car off the road and he was subsequently left unemployed. The first accident appears to have taken place in September 2001. The second appears to have taken place in July 2002.

11.1.2. Account of Events Prior to the Death of Mr. Y Senior (Incident One)

N.B. The only clinical documentation still extant for this period (March 2003 to February 2004) comprise the GP records and a limited E-Pex (electronic) Trust record; these serve as a major source of information to the Independent Investigation. The

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Independent Investigation Team has also included below the findings of the Trust Internal Review Team Report (2004) which had access to the full patient record. Whilst the Independent Investigation Team has no reason to doubt the validity of the internal investigation report it cannot verify that all the recorded events took place. The reader is therefore asked to note the reference source for each entry.

7 March 2003 (a Friday). Mr. Y visited his GP. He was feeling shaky and had not worked since a road traffic accident that had occurred the previous July. He was described as being tense and he described hallucinatory experiences. Mr. Y said he talked to himself and read meanings into what people said to him. He reported that he thought people knew what he was thinking. The GP reached no diagnosis on this occasion but suspected that Mr. Y was bordering on psychosis. The GP asked Mr. Y to write down some of his experiences over the weekend and then return to the surgery.¹⁹

10 March 2003. It was recorded in the GP record “*RX = Risperidone Tablets 1 mg: mental illness referral*”. Mr. Y had written that during the preceding weekend he had felt as though he was being monitored as a taxi driver and felt that people knew him and were influencing his behaviour. The GP also referred Mr. Y for a biochemical test (not specified).²⁰

14 March 2003. Mr. Y was seen by his GP. He was asked if he had found any situations threatening recently and Mr. Y described how being in the library had led him to believe that people were influencing him and that he was being monitored by the taxi office he used to work for. As a consequence he had turned his television and video player to face the wall at his home. Mr. Y was reported to be anxious.²¹

18 and 25 March 2003. On the 18 March Mr. Y was seen once again by his GP. He described himself as feeling “*not too bad*”. Mr. Y was still not sleeping. The plan was to continue the medication. On the 25 March the GP recorded that Mr. Y had an appointment with Moss House (secondary care mental health services) “*on Friday*”.²²

19. GP Record P. 14

20. GP Record PP. 14-15

21. GP Record P. 15

22. GP Record P. 16

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28 March 2003. Mr. Y was seen in Consultant Psychiatrist 1's clinic. The provisional diagnosis made was "*a psychotic illness, paranoid schizophrenia*". There was a reluctance to "*label*" Mr. Y until he had been assessed at the Day Hospital. Mr. Y was not taking his Risperidone as he thought it was affecting his testicles. The plan was to admit him to the Day Hospital; an inpatient admission was not thought to be necessary at this stage.²³

1 and 4 April 2003. On the 1 April it was noted in the GP record that Mr. Y was awaiting Day Hospital placement. Mr. Y reported feeling angry as people "*knew*" him and were trying to influence his behaviour. He admitted to swearing at motorists and passersby.²⁴ On the 4 April Consultant Psychiatrist 1 wrote to the GP to say that it would not be necessary to prescribe antipsychotic medication at this stage until a full assessment had taken place.²⁵

11 April 2003. A referral was received by Arundel House Day Hospital for a period of assessment and observation in order to be able to ascertain whether or not Mr. Y's symptoms were genuine and indicative of a psychiatric illness.²⁶

15 April 2003. It was noted in the GP record that Mr. Y "*has stopped medication, not yet heard re day hospital placement*". It was also recorded that medication had been issued to Mr. Y for stress and anxiety.

25 to 28 April 2003. The Trust Internal Investigation Report stated that Mr. Y's clinical record indicated that he was admitted to the Day Hospital on the 25 April. The plan was to provide:

- support;
- community group participation;
- problem solving;
- leisure group activities;
- creative therapy;
- goal setting;
- individual sessions.

23. GP Record PP. 54-55

24. GP Record P. 16

25. Trust Internal Investigation Report (2004) P. 6

26. Trust Internal Investigation Report (2004) PP. 6-7

Mr. Y Investigation Report

On the 28 April Mr. Y saw Staff Grade Doctor 1 when it was decided to commence him on Olanzapine 10mg. It was noted that Mr. Y's behaviour required ongoing assessment and monitoring.²⁷

May 2003. The Trust Internal Investigation Report provides the following information. Mr. Y commenced his treatment programme on the 2 May. It was noted that he appeared to be responding to hallucinatory experiences. On the 9 May it was recorded that the initial assessment findings were that Mr. Y was psychotic and had paranoid delusions, however this was identified as having improved since the commencement of Olanzapine. As the month progressed it was noted that Mr. Y's attendance at the Day Hospital was sporadic and that he was quiet and subdued in group settings. Towards the end of the month it was recorded that Mr. Y was non-compliant with his medication. Mr. Y was of the belief that the medication was causing him to gain weight. As a consequence of his non compliance it was noted that he was becoming paranoid once again. The plan was to re-start the Olanzapine at 15mg and to also consider antidepressants if Mr. Y remained unmotivated. The diagnosis was still thought to be unclear, however it was thought likely for Mr. Y to have a "*paranoid psychosis within a schizophrenic illness*".²⁸

June 2003. The Trust Internal Investigation Report stated that Mr. Y did not attend the Day Hospital for the first two weeks of June. Day Hospital staff made many attempts to contact Mr. Y by telephone but with no success.

On the 16 June Mr. Y missed his review with Staff Grade Doctor 1. On this occasion it was noted that Mr. Y had not been collecting his medication. Mr. Y did however attend the leisure group at the Day Hospital on this date but he left before the end of the session.

On the 23 June Staff Grade Doctor 1 communicated with the Locum Consultant Psychiatrist (Consultant Psychiatrist 2) who was due to take over Mr. Y's case. It was noted that Mr. Y's attendance at the Day Hospital was sporadic and that it would be necessary to get collateral information from his parents. It was also noted that Mr. Y required a close monitoring of his mental state and that a hospital admission may have to be considered if he continued to disengage with services.

27. Trust Internal Investigation Report (2004) PP.6-7

28. Trust Internal Investigation Report (2004) PP. 7-9

Mr. Y Investigation Report

Mr. Y continued to miss his therapy groups at the Day Hospital for the rest of the month. However he did attend his appointment with Staff Grade Doctor 1 on the 27 June. It was noted that Mr. Y appeared to be very confused and withdrawn and he admitted to taking his Olanzapine only twice a week. Mr. Y said that he was isolating himself in his bedroom in order to avoid contact with his parents. Mr. Y agreed to comply with his medication and it was arranged for him to receive “daily bags”. The plan was once again to talk to Mr. Y’s parents in order to get a collateral history, however Mr. Y refused to give his consent for workers to talk to them. It was agreed that Day Hospital staff would:

- provide Mr. Y with daily medication;
- telephone Mr. Y daily to remind him of appointments;
- discuss with him again the need to talk to his parents.²⁹

July 2003. The Trust Internal Investigation Report stated that Mr. Y’s attendance at the Day Hospital continued to be poor. It was recorded on the 7 July that Mr. Y was not gaining much benefit from the experience. It was also noted that he was not taking his medication regularly. The plan was to discontinue the Olanzapine gradually and to start Risperidone Consta (an antipsychotic administered by injection). The start dose was to be 12.5mg each week initially with the plan to increase it to 25mg every two weeks.

On the 10 July it was noted that due to a misunderstanding Mr. Y had not kept his appointment with Staff Grade Doctor 1 which had been scheduled on this day in order to discuss the proposed medication changes with him.

On the 14 July Mr. Y failed to attend an arranged support group, although it was recorded that he had attended a coffee group. At the coffee group it was noted that Mr. Y was laughing inappropriately to himself. Mr. Y also attended an appointment with Staff Grade Doctor 1. At this appointment Mr. Y was guarded and suspicious and was observed to smile inappropriately most of the time. He was reported to be showing poverty of thought and thought block. When offered a change of medication in the form of an intramuscular injection he refused. Mr. Y did however agree to take Quetiapine every week day morning by collecting it from the Day Hospital and to gradually stop taking Olanzapine. The plan was to reduce the Olanzapine to 10mg, then to 5mg for one week and then to commence the

29. Trust Internal Investigation Report (2004) PP. 9-10

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Quetiapine 25mg twice daily for the first day, 100mg on the third day, 150mg twice daily on the fourth day and 200mg twice daily on the fifth day.

For the next couple of weeks Mr. Y failed to attend groups on a regular basis at the Day Hospital but he did attend each day for his medication. However on the 22 July Mr. Y told a Doctor at the Day Hospital that he had not been taking his evening dose. Mr. Y was worried that the medication would damage his liver. Mr. Y also said that he thought his neighbours were shining a spotlight into his bedroom and that he was being monitored through his television. He said that he felt better outside of his parent's home.

On the 28 July Mr. Y saw Consultant Psychiatrist 2 and the Staff Grade Doctor. He complained of being monitored at his parent's house, he also said that he believed people had been monitoring him in the past when he had worked as a taxi driver. Mr. Y admitted that he had stopped taking his medication the previous week. During the meeting he became increasingly confused; he finally admitted that his feelings were not healthy and that he had a mental illness. Consultant Psychiatrist 2 advised Mr. Y to take his medication, but Mr. Y expressed his concerns about the side effects. It was agreed at this stage that Mr. Y would be prescribed a Risperidone injection at an initial dose of 12.5mg with the intention of increasing it to 25mg if Mr. Y tolerated it well. However the pharmacy was unable to supply Risperidone Consta as it was not routinely supplied within the Trust. Consultant Psychiatrist 2 was informed that he would have to clear the prescription through the Chief Pharmacist who said that the nursing staff would need specialist training before the drug could be supplied. In the end it was agreed that Mr. Y would continue on the Quetiapine at a dose of 200mg a day. Mr. Y continued to refuse to allow staff to contact his family.

On the 29 July Mrs. Y Senior telephoned the Day Hospital to say that her son was not well and would not be attending that day. However later on that day Mr. Y did attend and said that he was still not taking his medication. It was recorded that he had no insight into his illness and was becoming more paranoid.

On the 30 July Mr. Y had an appointment with the Staff Grade Doctor. He was reported to have been visibly angry as he had been kept waiting for 30 minutes. Mr. Y said he no longer wished to attend the Day Hospital as it was not helping him. The Staff Grade Doctor offered Mr. Y a hospital admission which he refused. Mr. Y was advised that a compulsory

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admission could be arranged. The Staff Grade Doctor concluded that due to Mr. Y's deterioration and continued paranoia a Mental Health Act (1983) assessment should be arranged under Section 2 of the Act. In the event Consultant Psychiatrist 2 did not support this as Mr. Y had not threatened to harm either himself or others. However an urgent domiciliary visit by a Community Psychiatrist Nurse was arranged. The visit took place later on the same day. During this visit Mr. Y denied any problems with his thoughts. He said was a bit fed up and was only in contact with mental health services for anxiety and that he did not need antipsychotic medication.³⁰ This nurse went on to assume the role of Care Coordinator and is referred to as Care Coordinator 1 in this report from this point forward.

1-14 August 2003. The Trust Internal Investigation Report stated that on the 1 August an Effective Care Coordination (ECC) risk assessment was completed by a Day Hospital worker. It was noted that during the assessment Mr. Y's behaviour was often incongruent with his answers. Mr. Y was thought to be experiencing auditory hallucinations and he smirked and laughed inappropriately. The plan was to support Mr. Y in sorting out his finances and to help him find employment. It was agreed that his case would be discussed with Consultant Psychiatrist 2 and the multidisciplinary team.³¹

On the 4 August Mr. Y had a follow up appointment with the Staff Grade Doctor. Mr. Y was observed to be calmer but he was still distressed by what he considered to be plots against him. Mr. Y denied being ill and was ambivalent about continuing to attend the Day Hospital; however he agreed to stay engaged with the service. Mr. Y agreed to take Risperidone and this was prescribed twice daily.

On the 7 August Mr. Y attended the Day Hospital. He continued to be anxious about side effects from his medication. When asked, Mr. Y denied feelings of being monitored.

On the 11 August a review meeting was held with Consultant Psychiatrist 2 and the Staff Grade Doctor in attendance. It was noted that Mr. Y was taking his morning dose of Risperidone, but it was unclear whether or not he was taking the evening dose. Mr. Y was paranoid about the Day Hospital staff and lacked insight into his condition. Following the review Mr. Y was seen by Consultant Psychiatrist 2 and the Staff Grade Doctor. Mr. Y

30. Trust Internal Investigation Report (2004) PP. 10-14

31. Trust Internal Investigation Report (2004) P. 14

Mr. Y Investigation Report

agreed very reluctantly to an increase to his morning Risperidone. Mr. Y was recorded as still not believing that he needed any medication. The Consultant requested once again that Mr. Y allow the team to talk to his family, Mr. Y's response was not recorded. The appointment ended with Consultant Psychiatrist 2 encouraging Mr. Y to maintain his attendance at the Day Hospital.³²

On the 12 August Mrs. Y Senior advised that Mr. Y would no longer be attending the Day Hospital as he felt pressurised by the staff. On the 15 August Mr. Y was discharged from the Day Hospital against medical advice. A letter was written to both Mr. Y and his GP to this effect. It was agreed that the Community Mental Health Team would take over Mr. Y's care.³³

15 August 2003. It was recorded in the GP record that Mr. Y had received a 'Standard Care Plan Medication Review'. It was noted that Mr. Y was to go to Moss House to see Care Coordinator 1 twice a week and attend Consultant Psychiatrist 2's clinic as required. The plan was to clarify the diagnosis and to stabilise his mental state. It was also hoped that Mr. Y's insight would improve and that he would accept antipsychotic medication. The Contingency/Crisis Plan was for Mr. Y or his carer to contact Care Coordinator 1, the Crisis Team, his GP, or the Accident and Emergency Department if in crisis.³⁴

18 August 2003. The GP surgery received a letter to say that Mr. Y had been discharged from the Arundel Day Hospital. The letter stated that Risperidone Caplets 2mg should be prescribed with immediate effect.

A risk assessment was conducted by Care Coordinator 1. It was noted that Mr. Y experienced ideas of reference and persecution. It was also noted that he had paranoid ideas about his neighbours and members of his family. His psychosis was described as being untreated at the time of the assessment and the diagnosis was not clear. Mr. Y was noted to have had some suicidal ideas, but no plans. He also had limited insight into his situation.

It was recorded that Mr. Y had a supportive family and that he was being monitored by Moss House. The summary of the risk assessment was as follows:

32. Trust Internal Investigation Report (2004) P. 16

33. Trust Internal Investigation Report (2004) P. 16

34. GP Record P. 50

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- “Risk of aggression/violence – low
- Risk of suicide – low/moderate
- Risk of self neglect – low/moderate
- Other risks – low”

Mr. Y did not think he had any risk factors and he did not want his mother involved in a care plan. It was recorded “*so opinion not sought*”.³⁵

20-26 August 2003. The Trust Internal Investigation Report stated that on the 20 August Mr. Y telephoned Care Coordinator 1 to cancel his appointment which was due on this day. Care Coordinator 1 had been planning to visit with an approved social worker. The following day Care Coordinator 1 made several telephone calls to Mr. Y but was unable to make contact with him.³⁶

On the 26 August Mr. Y was contacted to remind him about his Outpatient appointment due that day. His mother advised Care Coordinator 1 that Mr. Y had gone to the dentist and then to town, she also intimated that Mr. Y sought to avoid contact with services. A discussion took place between Care Coordinator 1 and Consultant Psychiatrist 2. It was decided that both Mr. Y and his mother needed to be told that when it was suspected that a service user’s mental health was deteriorating services would maintain contact and, if needs be, a Mental Health Act (1983) assessment would be conducted. It was apparently agreed that a social worker opinion would be sought (there was no extant record to indicate that this took place).³⁷

1 September 2003. Care Coordinator 1 recorded that the case was discussed at the multidisciplinary team meeting. A referral was made to the Social Work Department “*for another ASW [Approved Social Worker] assessment*”.³⁸

20-25 September 2003. The Trust Internal Review Report stated that on the 20 September Mr. Y did not attend his Outpatient appointment. On the 25 September Care Coordinator 1 arranged a home visit to Mr. Y. It was noted that Mr. Y refused to comply with his

35. GP Record P. 51

36. CMHT Notes (2003-2004) P. 5

37. Trust Internal Investigation Report (2004) P. 16

38. CMHT Notes (2003-2004) P. 5

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medication and did not want to attend the Outpatient Department. He did however agree to another home appointment for the 2 October 2003.³⁹

29 September 2003. Care Coordinator 1 visited Mr. Y at his home. It was recorded that there was no change in his mental state. It was also recorded that he was refusing to take his medication. Mr. Y agreed to a visit the following week.⁴⁰

2-23 October 2003. The Trust Internal Investigation Report stated that on the 2 October Care Coordinator 1 could not gain access to the house. A home visit did however take place on the 16 and 23 October. During these visits it was noted that Mr. Y's symptoms were continuing although he denied feeling depressed or suicidal. Mr. Y was still not being compliant with his medication, but he did agree to attend his next Outpatient appointment which was due on the 7 November.⁴¹

30 October 2003. It was recorded in the GP record that Mr. Y spent most of his time in his room at home avoiding the television. He thought people could *"make him think and they can hear everything he says"*. Mr. Y was visited by a Nurse and trainee Psychologist on this day but Mr. Y felt sceptical about the support they could offer to him.⁴² His condition was noted to have deteriorated.⁴³ Care Coordinator 1 wrote in the E-Pex record that there were *"no biological symptoms of depression reported, admits to fleeting suicidal ideas but no plans or intent. Will discuss with RMO."*⁴⁴

31 October 2003. It was recorded in both the Trust Internal Review Report and the GP record that Care Coordinator 1 and Consultant Psychiatrist 2 visited Mr. Y at his home. This visit also served as a CPA review. Mr. Y was noted as being on Standard CPA. Those present were:

- Consultant Psychiatrist 2;
- Care Coordinator 1;
- Mr. Y.

39. Trust Internal Investigation Report (2004) P. 16

40. CMHT Notes (2003-2004) P. 6

41. Trust Internal Investigation Report (2004) PP. 16-17

42. GP Record PP. 24-25

43. Trust Internal Investigation Report (2004) P. 17

44. CMHT Notes (2003-2004) P. 7

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Those listed as requiring notification of the outcome were listed as:

- the GP;
- the CMHT Clinical Psychologist;
- the Trainee Clinical Psychologist.

Mr. Y complained that people were “*trying to wind him up*”. He wanted someone to talk to, but did not want medication or a hospital admission. It was the view of the clinical team that Mr. Y needed antipsychotic medication and that his mental state had deteriorated over the past four weeks. It was agreed that urgent talking therapy would be provided to Mr. Y to which he agreed. It was noted that Mr. Y’s care plan did not require revision.

His HoNOS scores were:

Aggressive 0

Self injury 0

Drinking and Drugs 0

Cognitive 0

Relationships 3

Daily living (left blank)

Physical 1

Hallucinations/Delusions 3

Depressed 1

Occupation and Activities (left blank)

Other Mental Behaviour 0

Living Conditions 0

It was noted that Mr. Y was not detainable at that time under the Mental Health Act (1983). Due to Mr. Y being highly paranoid it was advised that he needed to be approached “*very carefully and tactfully to build a rapport with him.*”⁴⁵

Care Coordinator 1 recorded in the E-Pex record that Mr. Y had agreed to attend Moss House for sessions with a Clinical Psychologist.⁴⁶

45. Trust Internal Investigation Report (2004) P. 17 and GP Record PP. 42-43

46. CMHT Notes (2003-2004) P.7

Mr. Y Investigation Report

6-7 November 2003. Care Coordinator 1 visited Mr. Y at his home. There was no change to his mental state. He agreed to a visit from a Clinical Psychologist the following week.⁴⁷ The next day it was noted that Mr. Y failed to attend his Outpatient appointment.

18 November 2003. Consultant Psychiatrist 2 wrote to the GP. Mr. Y had been avoiding engagement with mental health services. He had not attended the Outpatient Clinic on the 25 September and on the 7 November. It was reported that the Community Mental Health Team Psychologist, had tried to visit Mr. Y the previous Thursday but could not get anyone to let him into the house. He planned to visit again the following week. It was thought that Mr. Y was not detainable under the Mental Health Act (1983) at this time. However it was proving difficult to get him to engage with the service. The plan was to continue to try and build a rapport and for Care Coordinator1 to continue to work with Mr. Y.⁴⁸

20-28 November 2003. The Trust Internal Review Report stated that on the 20 November the Psychologist visited Mr. Y at his home in the company of Care Coordinator 1. Mr. Y said that he would consider further sessions (these did not in fact take place). It was recorded that on the 28 November Mr. Y failed to attend his Outpatient appointment. It was also recorded that Care Coordinator 1 was finding it increasingly difficult to gain access to Mr. Y's home. The plan was to discuss Mr. Y's case at the next multidisciplinary meeting.⁴⁹

2 December 2003. It was recorded in the GP record that Consultant Psychiatrist 2 and Care Coordinator 1 visited Mr. Y at his home. Mr. Y was paranoid. The assessment was "*incomplete as poor rapport*". It was also recorded "*CPN: [Care Coordinator 1]. Clin Psychol visiting.*"⁵⁰

11 December 2003. Care Coordinator 1 made a home visit as previously arranged but could not gain access to the house.⁵¹

19 December 2003. Care Coordinator 1 made a home visit as previously arranged but could not gain access to the house.⁵²

47. CMHT Notes (2003-2004) P.8

48. GP Record PP. 44-45

49. Trust Internal Investigation Report (2004) P. 17

50. GP Record P. 24

51. CMHT Notes (2003-2004) P. 9

52. CMHT Notes (2003-2004) P. 10

Mr. Y Investigation Report

2 January 2004. Care Coordinator 1 made a home visit as previously arranged. Mrs. Y Senior opened the door and said that her son was asleep. She said he was “*fine*” and denied that there were any problems. It was agreed that Care Coordinator 1 would visit again the following week.⁵³

7 January 2004. Care Coordinator 1 visited Mr. Y at his home. It was recorded that Mr. Y was “*perplexed*” as to why people were trying to “*wind him up*” when he went out. It was recorded that when Mr. Y listened to the radio he believed that reference was being made to him. Mr. Y continued to refuse his medication. Mrs. Y Senior was present and she said that her son “*explodes if anyone interferes with what he is doing*” she denied that he had been aggressive towards anyone. Mr. Y continued to refuse his medication.⁵⁴

22 January 2004. Care Coordinator 1 made a home visit as previously arranged but could not gain access to the house.⁵⁵

28 January 2004. An entry in the GP record stated that Consultant Psychiatrist 2 telephoned the GP surgery to say that Mr. Y had “*florid psychosis, not taking medication. Not going out as he used to.*” Consultant Psychiatrist 2 thought that the situation could not be allowed to continue and that an assessment under the Mental Health Act (1983) should be considered. The plan was to seek Social Worker involvement and to discuss treatment options.⁵⁶

30 January 2004. The Trust Internal Review Report stated that Consultant Psychiatrist 2 visited Mr. Y’s home with an Approved Social Worker the purpose being to undertake a formal assessment. It would appear that Mr. Y had not been informed of the nature of the visit even though the Psychiatrist had been advised to ensure that this was done.

During this visit Mr. Y was observed to mumble and not speak clearly because he believed people could read his thoughts. It was noted that Mr. Y had no intention of engaging with services. Consultant Psychiatrist 2 gave Mr. Y a letter which set out the concerns that the treating team had regarding his condition and his refusal to engage. The letter also set out the

53. CMHT Notes (2003-2004) P. 10

54. CMHT Notes (2003-2004) P. 10

55. CMHT Notes (2003-2004) P. 11

56. GP Record P. 24

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duty of care of care that the team had, stating that it was the view of the team that he needed an inpatient admission. Mr. Y was asked to respond to the letter by the 2 February.

The plan was to go forward with a Mental Health Act (1983) assessment if Mr. Y did not respond to the letter or engage with services. The Trust Internal Review Report details that when interviewed the Approved Social Worker did not have the same recollection of the meeting as that of Consultant Psychiatrist 2. The Social Worker was of the view that this meeting with Mr. Y was simply to encourage his engagement and was not a formal assessment (under the Act) of his condition.⁵⁷

2 February 2004. The Trust Internal Review Report stated that Consultant Psychiatrist 2 wrote that *“the mental illness is of a degree and severity which can jeopardise his safety in the community (his self neglect) he is getting more withdrawn and not leaving the house as he used to do. To rely on his mother is not practical as she doesn’t see the severity of his symptoms and the stress he is passing through. There is a hx [history] of suicide in the family.”*⁵⁸

5 February 2004. Consultant Psychiatrist 2 wrote to the GP detailing the outcome of recent events and stating that a Mental Health Act (1983) assessment should be arranged.⁵⁹

11 February 2004. A visit to Mr. Y’s home was arranged in order to undertake a Mental Health Act (1983) assessment. Consultant Psychiatrist 2, the GP and the Approved Social Worker visited the home but they could not gain access. It would appear that neither Mr. Y nor his parents had been informed that the visit was due to take place.⁶⁰

16-17 February 2004. Another visit made to Mr. Y at his home by the Approved Social Worker and Consultant Psychiatrist 2. This visit was recorded in the GP record and by the Trust Internal Review Team. The reason for the visit was to discuss with Mr. Y the possibility of an informal admission to hospital.

57.Trust Internal Investigation Report (2004) P. 18

58.Trust Internal Investigation Report (2004) P. 18

59.Trust Internal Investigation Report (2004) P. 19

60.Trust Internal Investigation Report (2004) P. 19

Mr. Y Investigation Report

The meeting had been arranged with Mr. Y's mother and she was present throughout the entire interview. She mentioned that Mr. Y went to the Day Hospital and that it "*made him a hundred times worse*". She also felt that the medication made him like a "*zombie*" and that it was not the answer to his problems. Mr. Y did not mind his mother being present. He said that people were monitoring him and people in the library were winding him up. At this point in the interview Mr. Y's mother appeared to understand the seriousness of his illness and joined with the staff in explaining why a short inpatient admission was necessary.

It was made clear to Mr. Y and his mother that the situation could not continue as it was as his mental health was deteriorating. The Social Worker arranged to visit him again the following day with a view to taking him into hospital. The need for a Mental Health Act (1983) assessment was also discussed if Mr. Y changed his mind and refused to an informal admission.

In the event a hospital bed was not available for Mr. Y on the 17 February. One was however available on the 18 February. On the 17 February Mrs. Y Senior was advised by the Approved Social Worker that she would telephone to make the final arrangements. Mrs. Y Senior told the Approved Social Worker that Mr. Y had been "*fine at home*" and that they had gone out together that afternoon.⁶¹

18 February 2004. In the morning the Approved Social Worker attempted to telephone Mr. Y on two occasions. She was advised that he had left the house and had taken his clothes to give to a charity shop. She was also advised that Mr. Y had agreed to be taken into hospital the following day (the 19 February) and it was arranged that he would be collected at 10.00 hours.⁶²

11.1.3. Account of the Death of Mr. Y Senior

In the days prior to the incident Mr. Y and his parents had been in conflict with each other. Mr. Y had received a sum of £2,000 following a road traffic accident and his parents had

61. Trust Internal Investigation Report (2004) P.20 and GP Record PP. 36-37

62. Trust Internal Investigation Report (2004) P.20

Mr. Y Investigation Report

been looking after this money at Mr. Y's request. Mr. Y then requested that he be given this money, but it appeared that Mrs. Y Senior was reluctant to do this. Eventually she went to the bank and withdrew some of the money and gave it to him.

Mr. Y collected up his clothes and belongings and gave them to charity shops. He took the money he had been given by his mother and went to the house of a person he described as being an ex-girlfriend. Once there he tried to give her the money and asked her to take care of him because he did not want to be sectioned. He was described as being fearful. His 'ex-girlfriend' would not take his money and took him back to his home whereupon his parents took the money from him.⁶³

19 February 2004. At 10.00 hours the Approved Social Worker telephoned Mr. Y to confirm the admission arrangements. A Police Officer answered the telephone to say that Mr. Y had killed his father and injured his mother and that he was in the process of being arrested.⁶⁴

Apparently Mr. Y had argued with his father about the return of the money. Mr. Y had become angry and had smashed some ornaments. Mr. Y Senior told him that he would deduct the cost of the ornaments from the money that was being held. Mr. Y became even more angry, but eventually he broke down and asked his father for forgiveness. His father tried to comfort him and said that he would have to go into hospital and then things would improve.

Mr. Y then went and got either a hammer or a heavy spanner, it is unclear which, and hit his father around the head until he fell to the ground. His mother had been upstairs packing his hospital bags and was unaware of what had happened. When she came downstairs Mr. Y tried to prevent her from seeing his father's body. When she insisted on being allowed to enter the room in which he laid Mr. Y attacked her, fracturing her skull and injuring her wrists and fingers. She was able to appeal to him to stop. He did so and went upstairs and offered no further resistance or acts of violence. Mrs. Y Senior telephoned for the Police.⁶⁵

The Police decided that Mr. Y was mentally ill and should go to hospital following the attack on his parents. It was noted that he had killed his father, hurt his mother, and was considered to be at high risk of suicide if left in a Police cell. Mr. Y was admitted to the Scott Clinic

63. Trust Record PP. 56-57

64. Clinical Records Set 2. P. 2

65. Trust Record P. 57

Mr. Y Investigation Report

under Section 2 of the Mental Health Act (1983) at 21.30 hours. He was remanded on bail. A nursing referral assessment form was completed and it was noted that Mr. Y had “*12 months of untreated psychosis?*” During the assessment it was also noted that Mr. Y was suspicious and had poverty of speech.

Mr. Y was admitted onto Ward 2 under Category A on 1:1 observations and he was commenced on Zopiclone, Olanzapine and prn (as required) Lorazepam.

9 August 2004. At the Indictment at Liverpool Crown Court Mr. Y was charged as follows:

“Count 1: murder, contrary to common law.

Particulars of the offence: Mr. Y on the 19 day of February 2004 murdered his father.

Count 2: attempted murder.

Particulars of the offence: Mr. Y on the 19 day of February 2004 attempted to murder his mother.

Count 3: causing grievous bodily harm.

Particulars of the offence: Mr. Y on the 19 day of February 2004 caused grievous bodily harm to his mother with intent to do her grievous bodily harm.”⁶⁶

18 October 2004. Mr. Y was convicted of manslaughter and causing grievous bodily harm with intent. On this day Mr. Y was formally discharged from his detention under Section 3 of the Mental Health Act (1983). A Hospital Order was made at Liverpool Crown Court. He was to be detained at the Scott Clinic under Sections 37/41 of the Act. Mr. Y was returned to the Scott Clinic with immediate effect; his given diagnosis was Paranoid Schizophrenia.

11.1.4. Account of Events Prior to the Death of Mrs. Y Senior (Incident Two)

20 February 2004. Mr. Y was described as being very quiet and timid. He became tearful at one point. The plan was to reduce to level three observations once reviewed by Consultant Psychiatrist 3 (Mr. Y’ Responsible Medical Officer). He was duly placed on level three observations and commenced on Olanzapine Velotabs 10mg at night.⁶⁷

66. Legal Documents PP.2-4

67. Clinical Records Set 2. PP. 5-7

Mr. Y Investigation Report

21 February 2004. Initially Mr. Y appeared to be settled. He declined his medication and his diet. It was explained to Mr. Y where he was and that he was on a Section of the Mental Health Act (1983); however he still refused his medication.

Mr. Y became agitated later in the day rocking and hitting his head into a wall. His agitation increased and he was restrained, Control and Restraint techniques were used. Lorazepam 2mg was given as an intra-muscular injection as he refused oral medication. As the day progressed Mr. Y asked how his mother was. He was reluctant to eat. He was confused and low in mood. He stayed up late. He was reluctant to interact with staff, but eventually drank some milk and had a banana.⁶⁸

22 February 2004. Mr. Y appeared to be very anxious and disorientated. He refused lunch. As the day progressed he continued to be confused and came out into the day room in his underpants whereupon he stood on the day room table. Once back in his room he tried to remove all of his clothing. He did accept his medication but would not eat or drink. He tried to remove his clothes once more. He said he would “*cut his balls off*”. Mr. Y took some Haloperidol after a great deal of persuasion.⁶⁹

23-29 February 2004. On the 23 and 24 of February Mr. Y did not want to eat or drink. He continued to be “*suspicious and perplexed*” and felt that he should be in prison. Mr. Y was very unhappy about having to take medication⁷⁰ On the 25 February Mr. Y saw his solicitor and was noted to laugh and joke at his humorous remarks. He was also noted to be sullen and difficult to engage with when ward staff approached him. In the early hours of the 26 February Mr. Y was noted to have broken a toothbrush (no explanation for this is recorded in the notes at this stage). The plan was to continue level 3 observations and to increase the Olanzapine to 20mg with Mr. Y’s consent.⁷¹

1 March 2004. Mr. Y had escorted Section 17 leave for a Court appearance. It was noted that he was “*warmer*”. However it was also noted that his interactions were limited.⁷²

68. Clinical Records Set 2. PP. 7-9

69. Clinical Records Set 2. PP. 9-11

70. Clinical Records Set 2. PP. 11-12

71. Clinical Records Set 2. PP. 12-15

72. Section 17 Leave PP. 28-29 and Clinical Records Set 2. P. 15

Mr. Y Investigation Report

15 March 2004. A clinical meeting was held on this day. Mr. Y was commenced on Section 3 of the Mental Health Act (1983). (This was renewed on 14 March 2005). The medication was noted as being:

- Zopiclone 7.5mg prn (maximum at night);
- Haloperidol 5 – 10mg prn (maximum 30mg daily);
- Lorazepam 1 – 2mg prn (maximum 4 mg daily);
- Procyclidine 5 mg prn (maximum 30 mg daily);
- Olanzapine 20 mg at night;
- Senna two tablets prn (maximum at night).

He continued on level three observations.⁷³

16 March 2004. Mr. Y appeared at Liverpool Magistrates Court. He was remanded on bail.⁷⁴

22 March 2004. A Care Programme Approach (CPA) Review was held on this day. The following people were recorded as having attended:

- Consultant Psychiatrist 3 (Scott Clinic);
- Consultant Psychiatrist 2 (Moss House);
- Senior Psychiatric Registrar (Scott Clinic);
- Clinical Psychologist 2 (Scott Clinic);
- the Approved Social Worker;
- Nurse Therapist (Scott Clinic);
- Care Coordinator 1 (Moss House);
- Social Worker 1 (Scott Clinic);
- a Probation Officer.

Mr. Y was on level three observations as he had tried to remove his testicles with a broken toothbrush.⁷⁵

25 March 2004. A letter was sent to the GP. The letter confirmed that Mr. Y had been charged with the homicide of his father and the attempted homicide of his mother. A review

73. Tribunal Documentation P. 10 and Clinical Records Set 2. PP. 23-24

74. Legal Documents P.7

75. Trust Record PP. 495-500 and PP. 502-513

Mr. Y Investigation Report

into Mr. Y's care and treatment was due to take place and copy of his GP records was requested.⁷⁶

1 April 2004. Mr. Y's uncle telephoned the ward as both he and Mrs. Y Senior were worried because Mr. Y had been released on bail. They were worried that he might try and return home.⁷⁷

22 April 2004. A Care Programme Approach (CPA) Review was held. The following people were recorded as having attended:

- Consultant Psychiatrist 3 (Scott Clinic);
- Consultant Psychiatrist 2 (Moss House);
- Senior Psychiatric Registrar (Scott Clinic);
- the Approved Social Worker;
- Care Coordinator 1 (Moss House);
- Social Worker 1 (Scott Clinic);
- a Probation Officer.

Other people noted as requiring notification of outcomes were listed as:

- Staff Nurse (Scott Clinic Ward 2);
- Nurse Therapist (Scott Clinic);
- Clinical Psychologist 2 (Scott Clinic);
- Care Coordinator (not specified how this person differed from Care Coordinator 1).

Mr. Y was present at the review. He said that he wanted to see his mother and he complained about being sedated by his medication. It was noted that Mr. Y's family had yet to be interviewed. At this time Mr. Y was detained under Section 3 of the Mental Health Act (1983) following the murder of his father and the attempted murder of his mother on the 19 February 2004. He had been considered unfit to attend Court on 16 March 2004 and was considered to still be unfit to appear at Court on the 11 May 2004.

Mr. Y was prescribed Olanzapine Velotabs 20mg at night. He was on continuous 1:1 observations. The ward staff were trying to build up a rapport with him; they had noted

76. GP Record P. 32

77. Clinical Records Set 2. P. 33

Mr. Y Investigation Report

sexually inappropriate behaviour. Mr. Y had recently broken a tooth brush which he said he wanted to use to remove his testicles in order to cut off his testosterone supply and thereby his aggression. Further assessments were required and it was decided to split Mr. Y's medication into two doses, one in the morning and one at night.⁷⁸

The GP surgery was sent a copy of Mr. Y's CPA review documentation. Mr. Y was listed as being on Enhanced CPA and eligible for Section 117 aftercare.⁷⁹

11 May 2004. Mr. Y was remanded on bail at Liverpool Magistrates Court to live and sleep at the Scott Clinic.⁸⁰

9 June 2004. Mr. Y appeared at Liverpool Crown Court where he was remanded on bail to the Scott Clinic. He applied for a bail application and bail was granted on condition that he lived and slept each night at the Scott Clinic.⁸¹

14 July 2004. The Social Worker made a visit to Mrs. Y Senior's home. Mrs. Y Senior felt better able to talk on this occasion. She mentioned that Mr. Y had always had a loving relationship with his father, that he liked history and keeping fit. She also said that Mr. Y had never been an aggressive person and had never been in fights. Mr. Y had recently written a letter to his mother. The letter was reported to have been full of love for his mother and regret for killing his father. Mr. Y had requested that his mother visit him. At this stage Mrs. Y Senior felt that she could not visit him, but would consider it for the future. She said her sister would probably visit Mr. Y in the meantime.⁸²

18 July 2004. Mr. Y's uncle and aunt visited him. Mr. Y was reported as being "*warm in response*". There was no physical contact between them. Mr. Y asked if his mother was going to visit, he was told that this would happen soon.⁸³

23 July 2004. A Psychiatric report on Mr. Y was prepared by a Locum Consultant Forensic Psychiatrist. At this stage Mr. Y was charged with the murder of his father and the attempted

78. GP Record PP. 29-30

79. GP Record PP. 29-30

80. Legal Documents P. 7

81. Legal Documents PP.7-9

82. Clinical Records Set 2. PP. 82-83

83. Clinical Records Set 2. P. 85

Mr. Y Investigation Report

murder of his mother. The report noted that it appeared Mr. Y's mental health problems began after his car had been 'rear ended' whilst he sat in traffic when working as a taxi driver. From this time on he was suspicious of people at work and he thought that he was driving with an open microphone and that everyone could hear what he was saying. Mr. Y reported that he was not very sociable and preferred solitary pursuits such as jogging.

The Locum Consultant Psychiatrist had been asked to visit Mr. Y at the Police Station following the offence on the 19 February 2004. On this occasion Mr. Y had appeared to be confused and withdrawn and he had refused to answer questions. The diagnosis was made of Schizophrenic illness. The main concern was of his risk of suicide.

The report noted that Mr. Y had been transferred to the Scott Clinic later on the 19 February under Section 2 of the Mental Health Act (1983). He had been placed on 2:1 observations due to the concerns about his suicide risk. He had possibly been responding to auditory hallucinations. His mood was abnormal and he was extremely distressed. He was commenced on Olanzapine 10mg at night. There was a degree of sexual inappropriateness and on the 26 February he attempted to remove his testicles.

This presentation remained unchanged throughout May and June and Mr. Y's Olanzapine was increased to 20mg at night. Following this there was evidence of a 'warming' of his mood. Mr. Y told the Locum Consultant Psychiatrist that he had been feeling strange the week before the incident and that he had given away a great of money (£7,000 in total) and that he had not been sleeping.

At the time of the report was written Mr. Y was described as presenting with an abnormal affect. He was markedly flattened with little facial expression. He accepted that some of his behaviours were abnormal. It was noted that Mr. Y suffered from Paranoid Schizophrenia. It was thought that he would be likely to relapse if he was not in hospital and receiving treatment.

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Mr. Y's Social Worker made a visit to his mother's home to collect some of his belongings. Mr. Y's aunt and her twelve-year old granddaughter were present. Mr. Y's mother said that she was still trying to come to terms with events.⁸⁴

2 August 2004. At a ward clinical meeting it was noted that Mr. Y was still not engaging with staff or patients. He did not appear to be distressed. His medication was Olanzapine 20mg at night.⁸⁵

9 August 2004. At the Indictment at the Crown Court in Liverpool Mr. Y was charged as follows:

Count 1: murder, contrary to common law.

Particulars of the offence: Mr. Y on the 19 day of February 2004 murdered his father.

Count 2: attempted murder.

Particulars of the offence: Mr. Y on the 19 day of February 2004 attempted to murder his mother.

Count 3: causing grievous bodily harm.

Particulars of the offence: Mr. Y on the 19 day of February 2004 caused grievous bodily harm to his mother with intent to do her grievous bodily harm.⁸⁶ The preliminary hearing date was set for the 18 August 2004.

24 August 2004. A renewal of authority for detention was made. Consultant Psychiatrist 3 stated that the patient (Mr. Y) was suffering from a mental illness and that it was appropriate for him to receive his treatment in hospital and that such treatment was likely to alleviate his condition. It was recorded that Mr. Y remained guarded and withdrawn and that he was charged with serious violence in the context of his mental illness and that he required further treatment and rehabilitation.⁸⁷

31 August 2004. Mr. Y attended Liverpool Crown Court for a review of his case. He remained calm and fully cooperative throughout.⁸⁸

84. Ministry of Justice Documentation PP. 39-50 and Clinical Records Set 2. PP. 71-72

85. Clinical Records Set 2. P. 92

86. Legal Documents PP.2-4

87. Legal Documents P. 12

88. Clinical Records Set 2. P. 104

Mr. Y Investigation Report

6 September 2004. A Social Work Report for the Effective Care Coordination Review was prepared. It was recorded that Mr. Y was a “*little warmer*” and more settled and that he still had a tendency to isolate himself from others.

It was noted that apart from the index offence there was no history of violence towards others. According to his mother Mr. Y had always avoided confrontation. Mr. Y understood that he had a mental illness and recognised certain symptoms and behaviours that were evident prior to admission, e.g. giving away his possessions.

The carer perspective was recorded as being that Mr. Y’s mother was grieving for her husband, but at the same time felt she had lost her son for whom she could not grieve. She felt it would have been better if her son had killed her as well. She could not feel sorry for her son, nor sympathise, as she was still trying to come to terms with what had happened. Mrs. Y Senior said that she had not been informed about her son’s mental illness in the past or about what signs and symptoms to be aware of. Any perceived non-compliance on her part in the past was “*done in complete ignorance.*”⁸⁹

September 2004 (date uncertain). Mr. Y was referred to Clinical Psychologist 2, by his treating team. The Psychologist met with Mr. Y (and with his mother separately) on two occasions. She also met with the treating team. Mr. Y was described as quietly spoken with a flattened affect.

Mr. Y’s mother told the Psychologist that as a young child Mr. Y periodically held his breath until he went blue in order to get his way. Upon starting school she described him as anxious not wanting to be separated from herself or travel on the school bus. Mr. Y had expressed feelings of jealousy about his brother. Mr. Y said that he had a close relationship with his mother; however he described her as being an anxious woman who was “*interfering, controlling and critical.*” He said that her intrusiveness had undermined his confidence. As a consequence he withdrew and bottled up his feelings. Shortly after leaving school he had left home, but his mother had “*ordered him to return*”.

Mr. Y had become unemployed a year prior to the index offence. This had led to arguments between him and his father. Mr. Y expressed remorse for killing his father and hurting his

89. Trust Record PP. 489-491

Mr. Y Investigation Report

mother, although authentic evidence for this could not be discerned by the Psychologist during the assessment. Mr. Y suggested that eventually he would return to live at home with his mother without realising how inappropriate this would be. It was noted that both Mr. Y and his mother were “*poor self-reporters of their own history*”. The Psychological opinion debated:

- were Mr. Y’s presentation and psychological difficulties defences in order to cope?
- had there been any neurological damage as a result of anoxia (from the breath holding as a child)?
- did his presentation warrant a diagnosis of Asperger’s Disorder?

The recommendations were:

- to share the information about diagnosis with Mr. Y;
- to refer him to the Asperger’s Team;
- to commence neurological testing.⁹⁰

15 September 2004. A Psychiatric Report was prepared by Consultant Psychiatrist 3. This had been requested by the Crown Prosecution Service Merseyside. The report was similar in content to that prepared on the 23 July 2004. The additions included the fact that at the time of the offence Mr. Y was thought to be suffering from Paranoid Schizophrenia which “*could be considered to be an abnormality of mind*”. It was the view of Consultant Psychiatrist 3 that Mr. Y suffered from an abnormality of mind and he respectfully suggested that if convicted of manslaughter then the Court should consider disposal by way of a Section 37 Hospital Order under the Mental Health Act (1983). It was confirmed that a bed was available at the Scott Clinic with immediate effect.⁹¹

20 September 2004. A psychiatric report was written by Consultant Psychiatrist 3. It was recorded that Mr. Y had been detained on a Section 3 of the Mental Health Act (1983) and that he was residing on Hawthorn Ward at the Scott Clinic. It was noted that Mr. Y had been admitted to the Clinic from the Belle Vale Police Station on the 19 February 2004 where he had been seen by the Medical Examiner and believed to be psychotic. On examination he had appeared to be perplexed and anxious, paranoid and guarded.

90. Trust Record PP. 52-61

91. Ministry of Justice Documentation

Mr. Y Investigation Report

A review of the clinical notes showed that Mr. Y's mental condition had appeared to deteriorate over the past 12 months prior to the killing of his father. The diagnosis of Paranoid Schizophrenia had been made and Mr. Y had been commenced on antipsychotic medication. It was noted that Mr. Y had not always attended appointments or been compliant with medication in the past when living in the community.

Consultant Psychiatrist 3 concluded that the homicide of Mr. Y's father had resulted as the culmination of an argument between them initiated by financial disagreements. Mr. Y recalled going into the garage to find a "*hammer/spanner*" in order to kill his father. Mr. Y had intended to kill his father outright so that he would not suffer and hit him a few times on the head.

As his mother came down the stairs he hugged her so she would not see her husband on the floor and then hit her over the head. He denied being angry towards his mother, although he agreed he had meant to kill her. He had no explanation why he stopped himself from killing her.

Mr. Y's mother had said that on the morning of the 19, when he was due to be admitted into hospital, he had begun to go on about money. He "*went mad and started shouting*" which was unlike him. His father wrote him a cheque but Mr. Y thought it was for the wrong amount and said he wanted cash. He started to smash ornaments. He then appeared to calm down. Mr. Y's mother had gone upstairs to pack his hospital bag. When she came downstairs Mr. Y hugged her and asked her to go upstairs with him, when she declined he started to hit her over the head with the hammer. He eventually stopped the attack.

At the time the report was written Mr. Y remained compliant with his oral medication and continued to be detained under Section 3 of the Act. It was thought that the introduction of antipsychotic medication had improved his condition. It was noted that he remained isolative and did not engage with the other patients on the ward. The opinion was that Mr. Y suffered from Paranoid Schizophrenia. It was also noted that Mr. Y was due to stand trial in November 2004 and whilst there had been some improvement his condition merited continuing detention in hospital.⁹²

92. Legal Documents PP. 18-26

Mr. Y Investigation Report

29 September 2004. A nursing report was written. It was recorded that Mr. Y's trial was due to commence on the 1 November 2004. This was identified as increasing his potential stressors. His behaviour was described as isolative. Mr. Y was engaging in a psychology assessment. He displayed no particular distress or psychotic symptoms. He was on Olanzapine Velotabs 20mg daily. It was the opinion of the nurse that Mr. Y required further assessment.⁹³

4 October 2004. An Effective Care Coordination (ECC) Review was held. Those present were recorded as being:

- Consultant Psychiatrist 3;
- the Deputy Ward Manager;
- Social Worker 1;
- the Named Nurse;
- Clinical Psychologist 2;
- Occupational Therapist 1;
- Care Coordinator 1 (Moss House);
- Mr. Y.

It was noted:

- **Mental State:** Mr. Y remained generally isolative. No obvious psychotic symptoms were observed. Level one observations were required. Mr. Y was not expressing suicidal thoughts. He was compliant with medication.
- **Assessment:** HoNOS - 7. HoNOS Secure - 15. Lunsers completed.
- **Medication:** Olanzapine 20mg at night.
- **Outside Agencies:** it was noted that Mr. Y was due to attend Court on 18 October 2004, a recommendation for Section 37 and a Restriction Order was considered likely.
- **Therapeutic Interventions:** psychological assessment was ongoing; Social Worker 1 continued to liaise with Mr. Y's mother and aunt.
- **Risk Management:** *"Secure environment. Graded exposure to risk areas. Medication. Psychological input. SPECT scan of brain normal."*

93. Legal Documents PP. 32-37

Mr. Y Investigation Report

- **Carer Issues:** the Social Worker and Psychologist had visited Mr. Y's mother in order to further his assessment. At this stage she did not wish to visit or contact her son.
- **Current Situation:** Mr. Y's mental state was stable. He was still very withdrawn and isolative. He undertook a moderate engagement in activities and was compliant with medication and psychological input.
- **Mental State Examination:** on admission Mr. Y had been confused, suspicious, paranoid, with *"bizarre monologues on wars and unusual behaviour similar to standing on table, on bed, hitting head on wall (briefly)."* He was currently described as *"warmer"* although his engagement was limited. He reported no anxiety, depression or delusional beliefs.

Issues were raised regarding ongoing family dynamics and Mr. Y's unpredictable behaviour. It was also noted that Mr. Y was due to attend Court on the 18 October 2004, *"recommendation for Section 37, likely restriction order."*⁹⁴

5 October 2004. A Review by the Hospital Managers took place. The documentation recorded that Mr. Y was on a Section 37 and that it was due to expire on the 14 September 2004. It was noted as being an Uncontested Renewal Hearing.⁹⁵

18 October 2004. A Hospital Order was made at the Liverpool Crown Court. Documentation stated that Mr. Y had been convicted of manslaughter and causing grievous bodily harm with intent. His diagnosis was given as Paranoid Schizophrenia. He was to be detained at the Scott Clinic under Section 41 of the Mental Health Act (1983). On this day Mr. Y was formally discharged from his detention under Section 3 and was commenced on Sections 37/41 of the Mental Health Act (1983). Mr. Y was returned to the Scott Clinic

Mr. Y was anxious in Court, but flattened in affect afterwards. He said he felt like crying, *"yet he did not appear to be tearful"*.⁹⁶

22 October 2004. A Social Circumstances Report was prepared for the Hospital Managers Review. It was recorded that Social Worker 1 had spoken to Mr. Y's mother and two aunts

94. Trust Record PP. 62-65 and PP.458-482

95. Legal Documents PP. 13-17

96. Trust Record P. 105 and Legal Documents P. 11 and Tribunal Documentation P. 10 and Ministry of Justice Documentation P. 62 and Clinical Records Set 2. PP. 123-124

Mr. Y Investigation Report

on several occasions. Mr. Y's mother described him as a quiet person who was not outgoing. She was devastated by what had happened and was not yet ready to meet with her son. She made it clear she would not be able to support Mr. Y at home in the future.

The conclusions and recommendations pointed out that Mr. Y had been in the Scott Clinic for six months and that he had made progress. However it was felt that he required further assessments and treatment. It was thought that he did not pose a risk to others, but that he might continue to be a risk to himself. The recommendation was that Mr. Y required continued detention under the Mental Health Act (1983) for his own health and safety.⁹⁷

22 November 2004. Mr. Y was granted escorted Section 17 leave in the grounds for half an hour each day. This escorted leave was initially to be with two members of staff. The plan was to reduce this down to a single escort by December 2004. Issues regarding absconding and harm to others were considered pertinent for highlighting as part of the risk assessment.⁹⁸

30 November 2004. The Social Worker spoke to Mr. Y's mother who was happy about the Section 17 arrangements. She planned to visit Mr. Y before Christmas with his aunt as they had bought presents for him. Mr. Y was pleased with this information.⁹⁹

18 December 2004. Mr. Y was visited on the ward by his mother, aunt and uncle. The visit went well. After the visit staff reported that Mr. Y became tearful.¹⁰⁰

28 December 2004. Consultant Psychiatrist 3 wrote to the Home Office to propose that Mr. Y could have escorted leave in the local area. The purpose was to support Mr. Y's rehabilitation. Mr. Y's mental state appeared to be stable. The risks to his mother appeared to be low as he had met with her on the ward on two occasions without incident. No concerns were thought to be present regarding her safety at this time.¹⁰¹

7 March 2005. A Routine Effective Care Coordination Review took place. Those present were recorded as being:

- Consultant Psychiatrist 3;

97. Legal Documents PP. 27-31

98. Section 17 Leave PP. 24-25

99. Clinical Records Set 2. P. 155

100. Clinical Records Set 2. P. 166

101. Ministry of Justice Documentation PP. 33-35

Mr. Y Investigation Report

- a Ward Nurse;
- a Specialist Registrar;
- Social Worker 1;
- Clinical Psychologist 2;
- Care Coordinator 1 (Moss Clinic);
- Mr. Y's mother and aunt.

Therapeutic interventions were noted to have been provided through psychological assessment with one-to-one work with both Mr. Y and his family (who were seen separately). Neurological and theory of mind assessment followed. It was concluded that Mr. Y's insight was limited.

At this stage Mr. Y was having escorted leave for periods of two hours three times a week in the hospital grounds. The plan was to increase this to full unescorted ground leave. Mr. Y wanted to be able to pursue running in the grounds as this was a major coping strategy of his.

The discharge planning, which had been commenced at this stage, identified that Mr. Y required a small group home with staff experienced in autistic spectrum disorder.

Actions that were required included Clinical Psychologist 2 meeting with Mr. Y's mother and aunt, and for the Occupational Therapist to provide sessions around "*expression and emotion*" and to reduce his isolation.

Few carer issues were identified. Mr. Y's mother and aunt attended the review. They expressed no specific concerns, but requested clarification regarding Mr. Y's progress. "*His mother is clear she would not wish for him to return to live with her*".¹⁰²

13 April 2005. The Specialist Registrar wrote a referral letter to the Asperger's Team. Mr. Y's psychological report was enclosed. It was noted that whilst Mr. Y continued to have reduced interactions with people at the Scott Clinic this had improved since admission. Mr. Y was willing to be seen by the Asperger's Team. Mr. Y had expressed concerns that his mother would not provide objective information about his early childhood and suggested one

102. Trust Record PP. 417-424, 450

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of his aunts be contacted. Mr. Y thought that he had a normal childhood developing friendships and playing football. The Asperger Team was asked to read the full psychological report written in September 2004.¹⁰³

13 May 2005. Mr. Y was to have escorted leave in the local area for up to two hours three times a week and escorted leave in the grounds at the discretion of ward staff. The conditions of leave were identified as requiring Mr. Y to “*comply with escorting staff*”. His risks in all areas were deemed to be low.¹⁰⁴

17 May 2005. Mr. Y was formally referred to the Asperger’s Team. It was noted on the referral form that Mr. Y had developed a psychotic illness and killed his father and seriously injured his mother. It was also noted that following Mr. Y’s admission to the Scott Clinic it had become apparent that he had problems with social functioning and interpersonal skills. The Psychologist thought that he might have Asperger’s Syndrome. (The Asperger’s Team were ultimately to find Mr. Y not eligible for their service although there is no record of this communication).¹⁰⁵

4 July 2005. Mr. Y continued to have escorted leave in the grounds at the discretion of the ward staff and to also have escorted leave in the local area for up to two hours three times a week. His risks in all areas were deemed to be low.¹⁰⁶

25 July 2005. Consultant Psychiatrist 3 wrote to the Home Office to report the outcome of Mr. Y’s escorted leave in the grounds. It was noted that Mr. Y continued to do well with his leave. His mental state was described as settled.¹⁰⁷

8 August 2005. A neuropsychological assessment report was written following a referral from the treating team. The referral had been made because of Mr. Y’s presentation and psychological difficulties. The main concern prompting the referral was Mr. Y’s breath-holding activities as a child and the concern that this may have caused neurological damage. It was noted that Mr. Y had not presented with any management problems since being in the

103. Trust Record PP. 40-41

104. Section 17 Leave PP. 22-23

105. Trust Record PP. 36-39

106. Section 17 Leave PP.18-19

107. Ministry of Justice Documentation PP. 30-31

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Scott Clinic, however he did isolate himself and spent most of his unstructured time in his bedroom.

Mr. Y's mother had stated he had displayed some unusual behaviour from an early age. He did not like being held or hugged and would sometimes hold his breath until he turned blue on these occasions. Previous tests administered included:

- Rivermead Behavioural memory test, and subtests from the Wechsler Adult Intelligence Scale (March 2005);
- Reading the Mind in the Eyes Test, Benton Verbal Fluency Test, Hayling subsection from the Hayling and Brixton Task (March 2005);
- Theory of Mind Assessment: the picture sequencing task (May 2005);
- Theory of Mind Assessment: verbal stories (May 2005)

The neurological assessment utilised the tests set out below with the following results:

- Rivermead Behavioural Test (this test is difficult for subjects with acquired brain damage): Mr. Y's scores which suggested he had a poor memory range.
- Similarities, Picture Arrangements and Comprehension Subtests from WAIS III (this tool assesses cognitive functions): Mr. Y scored within the normal range.
- Informal Orientation and Memory Questions: Mr. Y performed well.
- Test of Comprehension and Divided Attention: Mr. Y performed well.
- Benton Verbal Fluency Test: Mr. Y's results were within normal ranges.
- The Hayling Brixton Test (designed to test damage to frontal lobes of the brain): Mr. Y's results were in the 'moderate/average' range.
- The Reading the Mind in the Eyes Test: the results suggested that Mr. Y may have difficulties in feeling/recognising compassion for example.
- The Picture Sequencing Task: Mr. Y performed well.

The conclusion was that it was unlikely Mr. Y had incurred any neurological damage due to breath holding as a child. However it was noted that he had a long-standing deficit in theory of mind functioning. It was noted that Mr. Y had difficulties with social functioning and that this could cause difficulties in the future if he was to feel under threat as he had limited coping strategies. It was recorded that Mr. Y had "*severe difficulties in stepping outside of his own perspective and feelings in order to consider and understand how and why other people might behave in social situations.*"

Mr. Y Investigation Report

The recommendation was that Mr. Y learnt basic theory of mind skills in order to recognise his own emotions in both himself and in others, and that he develop coping strategies. It was also noted that Mr. Y's future accommodation needs would be best met in a small group home with a structured and predictable environment.¹⁰⁸

5 September 2005. A Routine Effective Care Coordination Review took place. Those present were recorded as being:

- Consultant Psychiatrist 3;
- the Deputy Ward Manager;
- Occupational Therapist 1;
- Social Worker 1;
- Clinical Psychologist 2;
- Mr. Y's mother and aunt.

It was noted that Mr. Y had been mentally stable for 12 months in terms of his acute psychosis. He was being nursed on a low-dependency ward on level one observations utilising unescorted leave in the grounds. Mr. Y was also having escorted leave in the local area for two hours three times a week. The Multidisciplinary Assessment described Mr. Y's behaviour as "*very settled*". He continued to have minimal contact with his family members.

Discharge planning identified Mr. Y's need for a small group home with a predictable environment with staff experienced in autistic spectrum disorder. Planned actions were for the treating team to meet with Mr. Y's mother and aunt and for "*Occupational Therapy sessions around expression and emotions.*"

Carer issues were identified. Mr. Y's mother wanted to understand the progress he was making. She was clear that she did not want him to return and live with her again.

A Risk Assessment was conducted. The factors listed as contributing to the index offence were listed as being:

- acute psychosis with marked persecutory delusions;

108. Tribunal Documentation PP. 46-55

Mr. Y Investigation Report

- heightened arousal and fear;
- disengagement with psychiatric services;
- difficulty in complying with medication;
- relationship issues with parents;
- issues regarding money following unemployment;
- difficulty in anticipating the emotions of others;
- suppression of anger and the difficulty in recognising the emotions of others;
- deterioration in social functioning;
- lack of routine and increasing isolation;
- personality issues/developmental disorder;
- expressed needs through avoidance or defiance;
- misreading the behaviour of others when under threat, which could escalate his risk of violence.

Long-term management problems were identified as being: family dynamics; personality issues; psychotic illness; psychological input and neurological assessment. The summary was:

- *“Concerns re: unpredictability and of violence to others although less so with stabilisation of mental state*
- *Risk of harm to self should also be considered low*
- *Risk of absconding - low*
- *Risk of self neglect - low”*

The main risk was deemed to be that to his mother. It was noted that Mr. Y did not want to talk about the death of his father and displayed limited discernable remorse. It was also noted that future offending/relapse indicators could be precipitated by non-compliance with medication, the use of alcohol or drugs, relationship difficulties and personality issues.

A Mental State Examination was recorded. A KGV (Kavannagh–Goldberg–Vaughan Scale) assessment was completed on the 11 August 2005. Mr. Y scored 0 in all areas. Mr. Y denied any psychotic symptoms but had been heard laughing in his room. He was described as being ‘warm’ on approach. No problems had been identified regarding his cognition. His behaviour

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was described as “*very settled*”. It was noted that although Mr. Y joined in ward activities he remained isolative.¹⁰⁹

19 September 2005. Consultant Psychiatrist 3 wrote to the Home Office to request escorted Section 17 leave for Mr. Y three to four times a week in the community. It was proposed that he would be able to use the bus. It was noted that his mental state was stable and that he used regular unescorted leave in the ground with no problems apparent. He had never tried to abscond.¹¹⁰

10 October 2005. Mr. Y’s medication was reduced to Olanzapine 10mg at night.¹¹¹

26 October 2005. The Home Office wrote to Consultant Psychiatrist 3. Mr. Y was to be allowed escorted Section 17 leave in the community at the Responsible Medical Officer’s discretion. He would not be allowed to use this leave to visit his mother or to go to the place where she lived. A report was required within three months. The leave was not to place either Mr. Y or others at risk and if he failed to return to the hospital then both the Police and the Home Office were to be notified.¹¹²

3 January 2006. Consultant Psychiatrist 3 wrote to the Home Office to request unescorted leave for Mr. Y. It was recorded that the focus was to begin to consider move-on plans for Mr. Y. Unescorted leave was planned in order to further his rehabilitation and improve his physical fitness. Mr. Y’s mental state was described as being stable. It was thought that he presented a low risk to others. He had expressed remorse for killing his father and saw his mother regularly. Previous escorted leave in the community had taken place without incident. The request was supported by all members of the clinical team.¹¹³

6 February 2006. A Routine Effective Care Coordination Review took place. Those present were recorded as being:

- Consultant Psychiatrist 3;
- a Specialist Registrar;
- the Deputy Ward Manager;

109. Trust Record PP. 377-382, 388-399, 400-411

110. Ministry of Justice Documentation PP. 25-27

111. Clinical Records Set 2. P. 227

112. Section 17 Leave P. 13

113. Ministry of Justice Documentation PP. 21-23

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- Occupational Therapist 1;
- Social Worker 1;
- Clinical Psychologist 2;
- Care Coordinator 1 (Moss House);
- an Advocate representing Mr. Y (Mr. Y did not wish to attend);
- Mr. Y's mother and aunt.

It was noted that Mr. Y was on level one observations and continued to deny symptoms of psychosis. Mr. Y utilised his leave well and used exercise as a coping mechanism. Mr. Y was noted to be engaging well on the ward. His behaviour was described as being settled. His family stated that they were happy with his progress. Mr. Y had a care plan to support the increase to his unescorted leave. Overall it was thought that Mr. Y was managing well.

A risk assessment was conducted. It was recorded that prior to the homicide of his father Mr. Y had given all of his possessions away and had marked persecutory ideas, he had also disengaged from the service and was not compliant with medication. Mr. Y was noted to suppress his emotions and to have difficulty in expressing his feelings. He also misread the behaviour of others when he felt under threat which was thought to escalate his risk of violence.

Mr. Y was currently compliant with his medication and was on level one observations. He had been able to build up therapeutic relationships with staff and was developing coping strategies.

Long-term risk management was thought to depend upon the outcome of neurological assessment. *"Poor theory of mind issues ongoing"* was also recorded. It was thought that Mr. Y would need nursing staffed accommodation which was able to provide support and monitoring in the future.

The risk assessment summary included:

- *"Concerns re: unpredictability and of violence to others although less so with stabilisation of mental state"*
- *Risk of harm to self should also be considered low*
- *Risk of absconding - low*

Mr. Y Investigation Report

- *Risk of self neglect - low*"

Risk was thought to be confined largely to the dynamic that Mr. Y had with his parents. Future work was to focus on helping Mr. Y recognise his own emotions and those of the people around him and to develop coping strategies. Relapse indicators were identified as being: persecutory beliefs; withdrawal; non-compliance; relationship issues; physical violence. Mr. Y wanted a copy of his care plan. In summary he was happy with his treatment and ultimately hoped to be discharged.¹¹⁴ It would appear he did not sign the documentation until the 6 May 2006.

27 February 2006. A request was made to the Home Office for full unescorted Section 17 in the grounds and full escorted day leave outside of the grounds. Mr. Y was to be allowed to visit the pub and drink a maximum of one pint. He would not be allowed to visit his mother or visit where she lived. His level of risk was deemed to be low in all areas.¹¹⁵

29 March 2006. Consultant Psychiatrist 3 wrote to the Home Office with the annual statutory report for Mr. Y. It was noted that Mr. Y's mental state had stabilised over the past 12 months.¹¹⁶

19 May 2006. The Home Office wrote to Consultant Psychiatrist 3 giving permission for Mr. Y to have unescorted Section 17 leave on the condition that he did not visit his mother or visit where she lived. A full report was required within two months. The leave was sanctioned provided that the patient did not present a risk to either himself or to others. The Home Office required notification if the patient failed to return to hospital from leave.¹¹⁷ On the 24 May Mr. Y was granted unescorted leave in the locality for up to three hours, three times a week.¹¹⁸

5 June 2006. Mr. Y was granted unescorted leave in the locality for up to half a day in the Prescott and St. Helens areas on a daily basis. The condition was that he did not visit his mother.¹¹⁹

114. Trust Record PP. 327-344, 346-357, 60, 74

115. Section 17 Leave P. 9

116. Ministry of Justice Documentation PP. 17-18

117. Section 17 Leave P. 8

118. Section 17 Leave P. 6

119. Section 17 Leave P.6

Mr. Y Investigation Report

24 July 2006. A Routine Effective Care Coordination Review took place. Those present were recorded as being:

- Consultant Psychiatrist 3;
- a Ward Nurse;
- a Community Practitioner;
- Occupational Therapist 1;
- Social Worker 1;
- Clinical Psychologist 2;
- Mr. Y's mother and aunt. Mr. Y did not attend.

Mr. Y was on level one observations and being nursed on a low-dependency ward. He was increasingly able to articulate his needs/emotions and was mentally stable with no suicidal ideation. Early warning signs work was ongoing with his Named Nurse to develop a relapse plan. Mr. Y was on Olanzapine 10mg at night. He was taking regular unescorted day leave from the ward. Mr. Y's physical health was good and planning was underway to identify a staffed placement at Moscow Drive in the community. The date of the next review was set for the 22 January 2007. The care plan was for a Mental Health Review Tribunal to be pursued and for Social Worker 1 to arrange a visit to Moscow Drive. Mr. Y's mother and aunt were recorded as being happy with the plan and the progress that he was making.

The Multidisciplinary Assessment summarised priorities as being:

- *“To continue with the relapse and prevention work*
- *To continue emotional work with Occupational Therapy*
- *To engage in self-catering and budgeting whilst on Olive Ward*
- *Progress regarding future accommodation”*

The Risk Assessment Summary was as follows:

- *“Concerns re: unpredictability and of violence to others although less so with stabilisation of mental state*
- *Risk of harm to self should also be considered low*
- *Risk of absconding - low*
- *Risk of self neglect - low”*

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Concerns regarding “*his personality and theory of mind difficulties*” were noted. It was also noted that Mr. Y may misread social situations and could react impulsively if he considered there to be a threat against him. Previous coping strategies were to be used e.g. jogging, and one-to-one work was to focus upon Mr. Y recognising both his emotions and those of others and developing coping strategies.

Mr. Y’s potential for violence was thought to be specific to the relationship he had with his parents. Mr. Y’s relapse indicators were identified as being: persecutory ideas; withdrawal; non-compliance; relationship issues; and physical violence.

The risk management strategy involved:

- *“Review his mental state*
- *Unescorted leave in community*
- *Medication*
- *Engage in gym and other activities*
- *Psychological assessment*
- *Build therapeutic relationship*
- *Occupational Therapy input”*¹²⁰

24 August 2006. Mr. Y visited Moscow Drive with Social Worker 1. Mr. Y liked the accommodation and said that he would like to live there when he was discharged.¹²¹

11 September 2006. Section 17 day leave was arranged. The condition was that he would not visit his mother. The Consultant Psychiatrist 3 wrote to the Home Office to state that Mr. Y was being monitored whilst on leave and that he had shown no evidence of any physical or verbal aggression since very early on in his admission to hospital. It was stated that Mr. Y was no longer considered to be a risk to others, either people in general, or to his mother in particular. It was noted that Mr. Y had taken unescorted leave for some time without incident.¹²²

120. Trust Record PP. 275-311

121. Clinical Records Set 2. P. 311

122. Section 17 Leave P. 4 and Ministry of Justice Documentation PP. 10-11

Mr. Y Investigation Report

28 September 2006. Social Worker 1 visited Mr. Y's mother. She was confused about the forthcoming Tribunal and what it would mean. Moscow Drive was not far away from her home and she did not feel she could bear Mr. Y coming back into the house; her feelings were described as still being "raw". It was clear that members of the extended family had very strong, negative feelings about Mr. Y. They were angry with Mrs. Y Senior for accepting her son and felt that she should have "locked him up and thrown away the key".¹²³

30 September 2006. Social Worker 1 wrote a Social Circumstances Report. It was noted that the City of Liverpool would be responsible for the Section 117 arrangements. It was noted that Mr. Y had improved "on many levels" and that he had been on the pre-discharge ward for 16 months and had continued to progress towards discharge. It was recorded that following Mr. Y's discharge he would be allocated a Community Psychiatric Nurse/Care Coordinator from the Moss House Community Mental Health Team and that he would continue to receive support from the Scott Clinic Outpatient Service. Social Worker 1 was to continue as his Social Supervisor and she noted that she was confident that Mr. Y should be recommended for discharge.¹²⁴

11 October 2006. Consultant Psychiatrist 3 wrote a report for the Mental Health Tribunal. It was recorded that Mr. Y had been detained in the interests of the safety of both himself and of others. However his insight and condition had now improved with Olanzapine 10mg medication and had no psychotic symptoms. It was noted that there was an ongoing risk of violence to others given his theory of mind issues, although some improvement had been noted. The proposed ongoing management was to ensure a regular review of his mental state, to ensure compliance with his medication, to ensure Mr. Y engaged in activities and to ensure he lived in a supervised environment. It was recommended that Mr. Y received a conditional discharge to live in the community.

Concerns remained about the unpredictable nature of Mr. Y's risk of harm to others, especially if his mental state began to deteriorate. All other risks were considered to be low, especially in his current environment.¹²⁵

123. Clinical Records Set 2. P. 330

124. Tribunal Documentation P. 38

125. Tribunal Documentation PP. 9-37

Mr. Y Investigation Report

23-24 October 2006. Section 17 day leave was arranged. The condition was that he would not visit his mother.¹²⁶ The statement from the Home Secretary for the consideration of the Tribunal said that whilst he was pleased to note Mr. Y's progress he would not be prepared to support his discharge at this time and that he needed to stay in hospital in order to receive treatment for both his own health and safety and for the protection of others. The Home Secretary made it clear that whilst he was happy to note Mr. Y's progress he felt that more "testing" was required before conditional discharge was considered.¹²⁷

7 November 2006. The Social Worker visited Mr. Y's mother to explain about his pending discharge. His mother was happy for him and said she would visit him at Moscow Drive. She needed to understand the conditions of the Section 41.¹²⁸

9 November 2006. The Home Office Mental Health Unit wrote to Consultant Psychiatrist 3 to say that under Section 41 of the Mental Health Act (1983) Mr. Y was to be granted overnight leave to 123 Moscow Road on the condition that he did not visit his mother or go to where she lived.¹²⁹

27 November 2006. An Effective Care Coordination Pre Discharge Review was held. Those present were:

- Consultant Psychiatrist 3;
- the Ward Manager;
- a Staff Nurse;
- Social Worker 1;
- Mr. Y's mother and aunt. Mr. Y also attended.

A gradual transition to community accommodation was planned "*in terms of Theory of Mind difficulties*". Liaison with the family was also required. Mr. Y was due to move to Moscow Drive supported living accommodation. He was due to commence overnight leave in advance of "MHRT". Early warning signs of relapse were identified as thinking people were talking about him coupled with a lack of energy and feeling tired. Mr. Y's mental state was assessed

126. Section 17 Leave P. 4

127. Tribunal Documentation PP. 59-60

128. Clinical Records Set 2. P. 351

129. Ministry of Justice Documentation P. 4

Mr. Y Investigation Report

as being stable. The new Key Worker was to be liaised with. Mr. Y's medication was Olanzapine 10mg at night. The HoNOS summary was - 2. The HoNOS Secure - 2.

A Post Discharge Effective Care Coordination Review was to be held if Mr. Y achieved Conditional Discharge. The Care Plan stated that overnight leave was to be pursued. Liaison was to take place between the new Key Worker (unspecified) and a Social Supervisor (who was to be allocated). Mr. Y's family were recorded as being happy with the prospect of Conditional Discharge. There was a plan for a Mental Health Review Tribunal on the 15 December 2006.

A Risk assessment was conducted. The summary was as follows:

- *“Risk of harm to self - low*
- *Risk of absconding - low*
- *Risk of self neglect - low*
- *Risk of suicide - low”*

Concerns remained regarding Mr. Y's personality and theory of mind difficulties in that he misinterpreted situations and could act impulsively when he perceived a threat against him. He needed to be able to recognise both his emotions and those of others and to develop coping skills. It was recorded that Mr. Y's potential risk of violence *“appeared to be very specific to the interaction and the dynamics in his relationship with his parents.”* Future risk factors were identified as being:

- *“Medication non compliance*
- *Acute illness*
- *Alcohol/drugs*
- *Relationship issues*
- *Misinterpretation of social situations and of threat towards him”*

“Observable indicators of repetition” were recorded as being: persecutory beliefs; withdrawal; non compliance; relationship issues; and physical violence. The plan was to monitor Mr. Y and to provide support and restrict his visiting and access to his mother's

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address. Long-term risk as recorded as requiring nursing-staffed accommodation which would be able to support and monitor Mr. Y.¹³⁰

28-29 November 2006. Mr. Y went on day leave to Moscow Drive. There were no problems and Mr. Y enjoyed himself. Because Mr. Y was not yet signed up as a tenant he could not stay for the night.¹³¹

2 December 2006. It was agreed that Mr. Y would have Section 17 leave from 9.00 hours until 18.00 hours on the 3 December 2006. The conditions of the leave were that Mr. Y would not visit his mother or attend the close in which she lived. The relapse indicators were noted as being a lack of energy and having feelings that he is talked about. His risks in all categories were noted to be low.¹³²

15 December 2006. Mr. Y was to be discharged subject to the conditions below.

1. to reside at 123, Moscow Drive Liverpool (24-hour supported accommodation);
2. to provide access to any members of staff caring for him and to have face-to-face contact with staff on a daily basis;
3. to comply precisely with all aspects of treatment as directed by the clinical team whether in the form of medication or other therapeutic interventions;
4. to attend appointments with his Responsible Medical Officer (Consultant psychiatrist 3) , his successor or nominated deputy as required;
5. to attend appointments with his Social Supervisor, her successor or nominated deputy as required;
6. to attend appointments with his Community Psychiatric Nurse (Care Coordinator 2), her successor or nominated deputy as required;
7. to notify a member of staff (Imagine) at Moscow Drive of any face-to-face meeting with his mother;
8. not to go within 200 metres of his mother's home;
9. to be aware that powers of recall by the Ministry of Justice could be triggered at any time if the conditions were not fulfilled.

130. Trust Record PP. 221-229, 232-250

131. Clinical Records Set 2. P. 366

132. Section 17 Leave PP. 2-3

Mr. Y Investigation Report

The Tribunal did not reclassify Mr. Y. The reasons the Tribunal gave for the discharge was that Mr. Y had responded to medication since being at the Scott Clinic, he had enjoyed extensive unescorted leave and had not experienced psychotic symptoms. It was thought that Mr. Y was compliant with his medication and had a genuine insight into his condition. It was noted that he still had “*personality difficulties*” but that these pre-dated, and were quite distinct from, his mental illness.

An identified area of risk was that presented to his mother. Mr. Y had been seeing her regularly; however she expressed concerns about his visiting her at home. It was to be a condition of his discharge that he did not go within 200 metres of her house. The Tribunal was confident that Mr. Y would comply with the conditions of his discharge. It was noted that Consultant Psychiatrist 3 and the treating team were unanimous in the decision that Mr. Y no longer required detention in “*conditions of security*” and that he could be safely treated in the community subject to the conditions imposed.¹³³

18 December 2006. Consultant Psychiatrist 3 wrote to Imagine (the supported housing provider for 123 Moscow Drive). It was noted that Mr. Y was on Section 37/41 and had been conditionally discharged at a Mental Health Tribunal. He was to be followed up by Consultant Psychiatrist 3, Social Supervisor 1 and Care Coordinator 2. In addition Mr. Y was to have access to the Crisis Intervention Team. The letter set out some of the conditions of discharge. Mr. Y was to reside at 123 Moscow Drive. It was stipulated that he was not to go within 200 metres of his mother’s home, and that any meeting with his mother was to be notified to the Imagine care staff. A brief history of Mr. Y was given. The plan was to review him at Outpatients on the 11 January 2007. Mr. Y was effectively discharged from the Scott Clinic on this day.¹³⁴

19 December 2006. Care Coordinator 2 visited Mr. Y at Moscow Drive. She noted that Mr. Y was “*understandably quiet as we have not been previously introduced*”. Mr. Y had been discharged with only one day’s medication and his finances had not been sorted out. It was noted that the staff at Imagine would help Mr. Y open a bank account.¹³⁵

133. Tribunal Documentation PP.1-7

134. Imagine Notes PP. 72-73 and Clinical Records Set 2. PP. 380-381

135. CMHT Notes Post Discharge P.1

Mr. Y Investigation Report

20 December 2006. Mr. Y was formally discharged from the Scott Clinic to 123 Moscow Drive.¹³⁶ Care Coordinator 2 took two weeks of medication for Mr. Y to the staff at Moscow Drive.¹³⁷

N.B. the reader is asked to note that from this stage there are regular visits from both Care Coordinators and Social Supervisors, only visits of significance are cited in full.

22 December 2006. Care Coordinator 2 went to visit Mr. Y at Moscow Drive and he remained settled. It was noted that he had been able to get some money from 'finance' at the Scott Clinic to 'tide him over' until his financial affairs could be sorted out properly.¹³⁸

28 December 2006. Care Coordinator 2 visited Mr. Y at Moscow Drive accompanied by the Senior Occupational Therapist from the Scott Clinic. During this visit time was spent with the Imagine staff to provide a transfer of information that included the work Mr. Y had undertaken in relation to his Theory of Mind difficulties. Workers were encouraged to look at Mr. Y's work book and to spend time with him in the future to go through its contents.¹³⁹

4 January 2007. Care Coordinator 2 visited Mr. Y at Moscow Drive. He appeared to be settled but it was noted that he was spending a great deal of time in his room. She provided staff with another two weeks of mediation for Mr. Y.¹⁴⁰

10 January 2007. It was recorded that Mr. Y had been registered with a GP and that from this time on his prescription would be provided from the surgery. It was noted that Mr. Y was not going to be able to get a sick note post-dated to his discharge date as he had only registered with the GP that morning. It was recorded that Mr. Y was spending most of his time in his room.¹⁴¹

11 January 2007. The Home Office Mental Health Unit wrote to Consultant Psychiatrist 3 to say that they had used their powers under Section 73(2)/74(2) of the Mental Health Act (1983). The conditions were those set out above under the 15 December 2006 entry. Powers

136. Demography Records P. 1

137. CMHT Notes Post Discharge P. 1

138. CMHT Notes Post Discharge P. 1

139. CMHT Notes Post Discharge PP. 1-2

140. CMHT Notes Post Discharge P. 2

141. CMHT Notes Post Discharge PP. 2-3

Mr. Y Investigation Report

of recall were set if required. Mr. Y was written to in order to inform him of his conditions of discharge. It was confirmed that the power to recall the patient rested with the Home Secretary.¹⁴²

A Post Discharge Effective Care Coordination Review and Risk Assessment was held and signed off by Consultant Psychiatrist 3 on the 21 February 2007. Those present were:

- Consultant Psychiatrist 3;
- Care Coordinator 2;
- Social Supervisor 1;
- a Worker from Imagine;
- Mr. Y.

It was noted that Mr. Y was living in supported accommodation in the community at 123 Moscow Drive. Signs of relapse were noted as feeling as though he was being talked about and feeling tired with a lack of energy. The crisis plan consisted of an early review by the Care Coordinator and Responsible Medical Officer, to increase support, review medication and provide access to crisis intervention services. The contingency plan was to admit to the Scott Clinic. At this stage Mr. Y's mental state was considered to be stable. Mr. Y was to see his Care Coordinator weekly and his Social Supervisor two-three weekly. His medication was Olanzapine 10mg at night.

The risk assessment noted that prior to the index offence Mr. Y had an acute psychosis with marked persecutory delusions. He had given away all of his personal belongings and had heightened arousal and was fearful. There had been issues with disengagement from services, compliance with medication, and relationship issues with his parents.

Mr. Y was recorded as having difficulty in anticipating and recognising emotions in others, and that he suppressed his anger and could not express his feelings. Deterioration in his social functioning had been observed. It was recorded that Mr. Y could be at risk of being violent when he felt under threat because he was prone to misread the behaviour of others. This escalated his risk. It was also noted that Mr. Y had previously been a heavy drinker and had

142. Ministry of Justice Documentation PP. 1-3

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admitted to using cocaine in the past. He was currently compliant with his medication, had a stable mental state and therapeutic relationships with staff.

Long-term management options were identified as:

- *“Poor theory of mind issues ongoing. Staffed accommodation which is able to provide support and monitoring. Monitoring and support through Conditional Discharge.”*

Summary of risk assessment:

- *“Concerns re: unpredictability and of violence to others although less so with stabilisation of mental state*
- *Risk of harm to self should also be considered to be low*
- *Risk of self neglect - low*
- *Risk of suicide - low”*

The plan was to help Mr. Y recognise his emotions, the emotions of others, and develop coping strategies. In summary the risk of his behaviour reoccurring (in the context of the current risk management strategy) was deemed to be low.

The Plan was for Mr. Y to be monitored especially when major changes to his environment were made. It was noted that a stable and supportive placement would be required in the community in the long term. His mother was to be liaised with to ensure her continued safety. The likelihood of violence was considered to be low, but it would depend upon his continuing mental stability.¹⁴³

It was recorded in the Community Metal Health Team (CMHT) record that Mr. Y visited the drop in centre.¹⁴⁴

20 February 2007. Care Coordinator 2 visited Mr. Y at Moscow Drive. It was noted that he appeared to be settled but had no motivation for any kind of activity.¹⁴⁵

143. Trust Record PP. 178-200

144. CMHT Notes Post Discharge P. 3

145. CMHT Notes Post Discharge P. 4

Mr. Y Investigation Report

22 February 2007. The Scott Clinic CMHT Manager wrote to the Park Lodge CMHT Manager, with a formal request for Mr. Y to be accepted onto the caseload. It was noted that Mr. Y had been referred to the Scott Clinic three years previously following the homicide of his father and the attempted homicide of his mother. Mr. Y had been stabilised on medication and had made good progress at the Scott Clinic under the care of Consultant Psychiatrist 3.

The plan was for the Scott Clinic to work jointly with a community team with a view to handing over the case at a later date. Whilst Mr. Y was at the Scott Clinic he had been visited by a Care Coordinator from Moss House until she left the service. It was thought that Mr. Y would eventually need continuing support from the local CMHT.¹⁴⁶

8 March 2007. Mr. Y was reviewed at the Outpatient Clinic by Consultant Psychiatrist 3 who noted that he appeared to have settled well.¹⁴⁷

13 March 2007. The Park Lodge CMHT Manager wrote to the Scott Clinic CMHT Manager. It had been decided that Mr. Y would be transferred to the Park Lodge CMHT once the Scott Clinic was ready to discharge him.¹⁴⁸

Also on this day Social Supervisor 1 visited Mr. Y at 10.20 hours to find that he was still in bed. Mr. Y had not been going out or socialising, preferring to stay in his room. Mr. Y explained that he was not motivated to do anything. This had been a consistent feature since the time of his discharge. Social Supervisor 1 wrote that she felt uneasy about his isolation and that *“I feel he still presents a risk in keeping things to himself and letting them build up until it’s too late.”*¹⁴⁹

3 April 2007. Care Coordinator 2 wrote that Mr. Y continued to remain isolated in his room and that he *“does talk a little to one member of staff in the evening but continues to spend most of his time in his room.”*¹⁵⁰

10 April 2007. Care Coordinator 2 visited Mr. Y and was told that he was currently visiting town, but that he had only been out once over the weekend.¹⁵¹

146.Trust Record PP. 10-11

147.CMHT Notes Post Discharge PP.5-6

148.Trust Record P. 9

149.CMHT Notes Post Discharge P. 5

150.CMHT Notes Post Discharge P. 6

Mr. Y Investigation Report

19 April 2007. An Effective Care Coordination review took place. Mr. Y attended the review, no family members were present. Mr. Y did not express any concerns and was happy with his current placement at Moscow Drive supported by Imagine. His mental state was noted to have remained stable, however he had developed a routine which was isolative and he was spending a lot of time on his own. The decision was for Mr. Y's plan to remain with no changes made.¹⁵²

3 May 2007. Care Coordinator 2 visited Mr. Y who told her that he was going out three times a week.¹⁵³

15 May 2007. Care Coordinator 2 visited Mr. Y. Imagine staff were not expressing any concerns and stated that Mr. Y was always pleasant on approach.¹⁵⁴

30 May 2007. Care Coordinator 2 visited Mr. Y who unusually initiated the conversation by telling her that he had started jogging again.¹⁵⁵

7 June 2007. Mr. Y appeared to be doing well and was continuing to go jogging. Imagine staff expressed no concerns about him.¹⁵⁶

5 July 2007. Care Coordinator 2 took Mr. Y to the Old Swan area of Liverpool and had a coffee. Mr. Y was still jogging and was considering joining a running club.¹⁵⁷

12 July 2007. It was recorded that Mr. Y attended the drop in centre.¹⁵⁸ Mr. Y was reviewed at the Outpatient Clinic by Consultant Psychiatrist 3; Care Coordinator 2 was also present. It was noted that Mr. Y appeared to be more relaxed and that he had developed some kind of routine and renewed interest in running. Mr. Y denied having any ongoing symptoms of mental illness. It was noted that he continued to have contact with his mother, aunt and uncle who visited him at his flat and that he spoke to his mother fairly frequently on the telephone.¹⁵⁹

151. CMHT Notes Post Discharge P.6
152. Trust Record PP. 209-212 and 219
153. CMHT Notes Post Discharge P. 7
154. CMHT Notes Post Discharge P. 7
155. CMHT Notes Post Discharge P. 8
156. CMHT Notes Post Discharge P. 8
157. CMHT Notes Post Discharge P. 8
158. CMHT Notes Post Discharge P. 9
159. CMHT Notes Post Discharge P. 9

Mr. Y Investigation Report

17 July 2007. Social Supervisor 1 met with Mr. Y. She had not been visiting for a while due to a combination of sickness and annual leave. Mr. Y asked if could move to an independent flat, he was told that this would be too soon and that such a decision would have to made collaboratively with Care Coordinator 2 and Consultant Psychiatrist 3.¹⁶⁰

August - October 2007. Care Coordinator 2 visited Mr. Y on several occasions and it was noted that he was running regularly and was now cooking for himself. He still tended to isolate himself but said that he liked living at Moscow Drive. There were no issues recorded about his medication regimen. Imagine staff expressed no concerns.¹⁶¹ During this period most of the visits took place at Old Swan (an area in Liverpool).

1 November 2007. Mr. Y attended for his routine Effective Care Coordination review with Consultant Psychiatrist 3. A worker from Imagine and Care Coordinator 2 were present. It was recorded that Care Coordinator 2 had been visiting Mr. Y on a weekly/two weekly basis and that his mother (accompanied by his aunt and uncle) visited him every six weeks at Moscow Drive. Mr. Y was also being seen by his Social Supervisor for arranged appointments.

At this meeting Mr. Y said he did not wish for a more independent kind of living arrangement. He was noted as being currently stable in the community. Mr. Y was compliant with his medication and was to continue with his supported living and Care Coordinator support. If required he was to access 24-hour crisis intervention. The main points of the review were listed as being:

- *“To continue living at Moscow Drive 24hr supported housing.*
- *To see CPN for arranged appointments.*
- *To see Social Supervisor for arranged appointments.*
- *Access to 24hr crisis intervention.”*

No changes were required to the care plan and the GP was informed of the outcome of this meeting in writing.¹⁶² The date of the next CPA review was set for the 3 April 2008.

160. CMHT Notes Post Discharge P. 9

161. CMHT Notes Post Discharge P. 61

162. GP Record P. 101 and Trust Record PP. 206-207

Mr. Y Investigation Report

21 November 2007. Social Supervisor 1 visited Mr. Y at Moscow Drive he appeared to be progressing as usual. She however recorded that *“I still worry that if he was experiencing any symptoms he would not discuss them with anyone. This to me is part of the ongoing risk with ... [Mr. Y].”*¹⁶³

21 November – 5 February 2008. Visits continued between these two dates and Mr. Y’s presentation remained the same. Many of the visits took place at Old Swan.

6 February 2008. Social Supervisor 2 took over the case and met with Mr. Y for the first time.¹⁶⁴

7 February 2008. Consultant Psychiatrist 3 reviewed Mr. Y at an Outpatient appointment. Mr. Y was still living at Moscow Drive and was seeing his Care Coordinator on a weekly basis. His Social Supervisor was due to leave her employment with the Trust and a replacement was being sought. It was recorded that Mr. Y was compliant with his medication and no concerns were identified. The GP was written to and updated of Mr. Y’s progress.¹⁶⁵

11 February 2008. Care Coordinator 2 visited Mr. Y at Moscow Drive. Imagine staff said that Mr. Y was becoming more isolative and they would attempt to address this with Mr. Y and try to negotiate specified times when he would spend time with staff and other residents.¹⁶⁶

3 April 2008. Mr. Y attended for his routine Effective Care Coordination review with Consultant Psychiatrist 3. It was recorded that Mr. Y was visiting his mother every six weeks and was commencing self medication. The new Social Supervisor (Social Supervisor 2) met with him every fortnight. A Health of the Nation Outcome Scores (HoNOS) assessment was completed during the meeting. No concerns had been expressed by the staff at Moscow Drive. It was recorded that Care Coordinator 2 was now visiting Mr. Y on alternate weeks to those of Social Supervisor 2.

The Care Plan was reviewed. The care plan noted the following:

163. CMHT Notes Post Discharge P. 59

164. CMHT Notes Post Discharge P. 57

165. GP Record P. 98

166. CMHT Notes Post Discharge PP. 56-57

Mr. Y Investigation Report

1. Signs of relapse: feeling that he is being talked about, being irritated by those around him, and feeling tired.
2. Crisis Plan: this would comprise an early review by the Care Coordinator/Social Supervisor and Consultant Psychiatrist 3. A crisis situation would also require increased support and a review of medication.
3. Contingency Plan: this was to admit to the Scott Clinic.
4. Summary of Risk Intervention: Mr. Y's mental state was recorded as being stable. It was also recorded that Mr. Y was living in 24-hour supported accommodation and that he was receiving weekly support and monitoring of his mental state from the Scott Clinic.
5. Medication: Mr. Y was taking Olanzapine 10mg at night which was being prescribed by his GP.
6. Plan: Mr. Y was to see Care Coordinator 2 fortnightly and Social Supervisor 2 fortnightly on alternate weeks. Mr. Y was to continue to see Consultant Psychiatrist 3 every three months and for his case to be reviewed on a six-monthly basis.

The GP was written to advising him of Mr. Y's progress.¹⁶⁷

15 July 2008. Consultant Psychiatrist 3 wrote to the GP following a review of Mr. Y. Prior to the meeting the Consultant had discussed the case with Social Supervisor 2. They were in agreement that Mr. Y was engaging well, continued to have contact with his mother and was compliant with his medication.¹⁶⁸

26 August 2008. An Imagine Support Plan was developed. It was noted that Mr. Y was a very private person and that he needed support to interact with people. Mr. Y wanted to engage with his Keyworker to develop his fitness. He was to be encouraged to implement his Occupational Therapy plan and to engage with others. Mr. Y was working positively to gain more independence. He liked to visit the library and cook his own meals.¹⁶⁹

1 September 2008. An Essential Lifestyle Plan assessment was conducted by the Imagine service. It was recorded that Mr. Y must have privacy and that people must knock on his door prior to gaining access to his room. Mr. Y was also described as needing to run at around 7.30 in the morning and that he liked to have 1:1 time with his Keyworker. It was recorded

167. GP Record PP. 93-97

168. GP Record P. 92

169. Imagine Notes. PP. 93-96

Mr. Y Investigation Report

that Mr. Y must have contact with his uncle, aunt and mother at least once a fortnight. Mr. Y was recorded as being self medicating and that he had been compliant with this for six months. He was described as liking to keep himself clean and presentable. Mr. Y still preferred to keep to himself, was pleasant and polite and felt that he was ready to move into a flat on his own.¹⁷⁰

12 September 2008. Care Coordinator 2 recorded that Mr. Y was taking part in cooking and shopping activities for the house and that he appeared to be well. He remained reticent in initiating conversation but he did “*volunteer some of the conversation*”.¹⁷¹

18 September 2008. Consultant Forensic Psychiatrist 3 reviewed Mr. Y at an Effective Care Coordination meeting. This meeting was attended by Care Coordinator 2 and Social Supervisor 2. It was noted that Mr. Y appeared to be well. The plan was that he be followed up in Outpatients on the 12 March 2009.

The Effective Care Coordination review paperwork was completed. It was noted that Mr. Y was not on a supervision register, that it had been considered, but not thought necessary. It was noted that he was on a Section 41. Mr. Y continued to be monitored for paranoid thoughts. Both the Care Coordinator and the Social Supervisor were to continue to work with Mr. Y and liaise with Imagine staff. Early signs of relapse were identified as Mr. Y feeling tired and thinking people were watching him and talking about him. More serious indicators included Mr. Y being irritable, preoccupied, withdrawn and giving his belongings away. It was noted that his mental state was stable and his risk was low.

The risk statement for this period noted the condition placed on Mr. Y not to go to his mother’s address.

An Effective CPA Care Plan was developed. It was recorded that Mr. Y remained eligible for Section 117 aftercare arrangements. The focus of the plan was to monitor Mr. Y for paranoid thoughts and to support him. Mr. Y was to remain in 24-hour supported accommodation and to remain on his Olanzapine 10mg at night. Care Coordinator 2 was to continue to make two-weekly visits and to liaise with Imagine. The Imagine workers were to contact the Forensic

170. Imagine Notes. PP. 97-100

171. CMHT Notes Post Discharge P. 50

Mr. Y Investigation Report

Team at the Scott Clinic if they had any concerns. Mr. Y was to access the 24-hour Crisis Service if the need arose.

It was noted that Mr. Y's current mental state was stable. His risk of self harm was deemed to be low. There were some concerns regarding his lack of predictability. It was noted that the risk of violence was "*specific to the interaction and the dynamics in his relationship with his parents*". There was an ongoing risk of violence towards others. It was noted however that he had been able to utilise coping strategies since his discharge.¹⁷²

14 October 2008. Social Supervisor 2 visited Mrs. Y Senior at her home. The visit was described in the clinical record as "*lengthy*" and focused upon the issues leading up to Mr. Y's admission to the Scott Clinic. Mrs. Y Senior was advised that she should contact Social Supervisor 2 if she needed any input that may help her.¹⁷³

1 November 2008. An Imagine risk assessment was conducted. It was noted that Mr. Y was at risk of isolation. The only person thought to be at risk from Mr. Y was himself (it was unspecified exactly what this risk was deemed to be). His general overall risk status fell into the "*medium*" category. Workers were to make contact with him twice each day and he was to be encouraged to join in home activities.¹⁷⁴

3 November 2008. Mr. Y enrolled at the local gym.¹⁷⁵

30 November 2008. An Imagine Support Plan was developed. It was noted that Mr. Y was a very private person who need a structured programme to broaden his social skills. It was also noted that Mr. Y had spent the past three months increasing his fitness, that he went on runs with his Support Worker and had joined the Leisure Centre. Workers were to carry through the Occupational Therapy Support Plan. Mr. Y had identified the goal to run a marathon and Imagine workers were supporting him to do this.

Mr. Y had mentioned during the assessment that in the long term he would like to return to his previous occupation as a taxi driver. Mr. Y also said that he would like to work towards

172. GP Record PP. 84-90 and Imagine Notes. PP. 13-18 and 68

173. CMHT Notes Post Discharge P. 48

174. Imagine Notes. PP. 42-47

175. CMHT Notes Post Discharge P. 47

Mr. Y Investigation Report

having his own flat. Mr. Y had been at Moscow Drive for 18 months at this stage and he had been working towards his independence, he was positive and assessed to be working in the right direction.¹⁷⁶

18 December 2008. Consultant Psychiatrist 3 reviewed Mr. Y at an Outpatient appointment. It was noted that Mr. Y continued to do well. He was in regular contact with both his Care Coordinator and his Social Supervisor. Mr. Y had met up with his mother since the last Outpatient meeting and was compliant with his Olanzapine 10mg at night. There were no specific concerns identified and the plan was to review Mr. Y again in three-months time.¹⁷⁷

18 December 2008 – 11 February 2009. Regular visits continued to take place.

11 February 2009. A worker from Imagine emailed the Scott Clinic to say that Imagine had been requesting Mr. Y's up-to-date Trust risk assessments and Effective Care Coordination documentation for a period of some months. It was noted that some of the paperwork was seriously overdue, some being at least six months in arrears. The response was that CPA and risk reviews were not always conducted six monthly and that these were sometimes done on an annual basis and therefore Mr. Y's information was not in arrears. However Imagine were notified that they should have copies of reviews, especially if they attended the meetings and that the Scott Clinic would "*sort something out*".¹⁷⁸

2 April 2009. Mr. Y attended for a routine Care Programme Approach (CPA) review with:

- Consultant Psychiatrist 3;
- a worker from Imagine;
- Care Coordinator 2;
- a Community Psychiatric Nurse who was due to take over the role of Care Coordinator in a couple of week's time.

The Social Supervisor sent her apologies. Mr. Y was assessed as being well and compliant with his Olanzapine, which he self-medicated. At this stage Mr. Y was considering pursuing his GCSEs. His next CPA review was set for six-months time and he was scheduled to be

176. Imagine Notes. PP. 86-91

177. GP Record P. 83

178. Imagine Notes.

Mr. Y Investigation Report

followed up by Consultant Psychiatrist 3 in three-months time. The GP was written to notifying him of Mr. Y's progress.¹⁷⁹ Mr. Y's Care Coordination was handed over to Care Coordinator 3 at this stage.¹⁸⁰

22 April 2009. Social Supervisor 2 visited Mr. Y it was recorded that he was looking forward to his move to a flat on Moscow Drive.¹⁸¹

29 May 2009. Social Supervisor 2 visited Mrs. Y Senior at her home and it was recorded that she was pleased with her son's progress.¹⁸²

1 June 2009. A Support Costings Summary was completed. It was noted that Mr. Y was receiving funding from Supporting People Housing Benefit and from the Primary Care Trust.¹⁸³

2 July 2009. Mr. Y attended for his routine Outpatient appointment with Consultant Psychiatrist 3. Mr. Y was observed to be well kempt and relaxed. Mr. Y had been talking to his solicitor about an Absolute Discharge. The Consultant said it may be a little early to discuss this. Mr. Y seemed "*content*" with the discussion. The plan was to review him again in six-months time.¹⁸⁴

July – September 2009. Mr. Y was visited on a regular basis during this period and reported to be progressing well. Support was being given to him in preparation for his move to new accommodation.

24 September 2009. Mr. Y was seen for a routine Effective Care Coordination Review. Consultant Psychiatrist 3, a Worker from Imagine, Social Supervisor 2 and the new Care Coordinator (Care Coordinator 3) were present. Mr. Y was due to move into a flat (at 133 Moscow Drive) that was managed by Imagine. He was assessed as continuing to be well. The Consultant planned to see him again on the 10 December 2009.¹⁸⁵

179. GP Record PP. 3-5

180. CMHT Notes Post Discharge P. 43

181. CMHT Notes Post Discharge P. 42

182. CMHT Notes Post Discharge P. 41

183. Imagine Notes. P. 4

184. GP Record P. 102

185. GP Record PP. 65-66

Mr. Y Investigation Report

28-29 September 2009. Mr. Y moved into his new flat. He appeared to settle in well and was reported to be relaxed. He was reminded that he was expected to spend at least an hour a day with the staff.¹⁸⁶ Mr. Y initially received a minimum 1:1 intervention of one hour each day. It was noted that Mr. Y continued to be stable.¹⁸⁷

1-7 October 2009. The Imagine records noted that Mr. Y appeared to have settled in well to his new home and was socialising with one of the other residents well.¹⁸⁸

8-9 October 2009. The Imagine records stated that Mr. Y was reported to be in his flat with his mother. His uncle was observed to be checking in on them. Everything was assessed as being “OK” (presumably this referred to the risk to Mr. Y’s mother).¹⁸⁹

1 November 2009. A risk assessment was prepared by Imagine following Mr. Y’s move to his new flat. The required activities/tasks identified as part of the risk management plan were listed as being:

- staff must ensure daily contact;
- staff must ensure tenant was safe to use all equipment;
- staff must ensure tenant was storing medication correctly;
- staff must ensure tenant understood the importance of turning everything off at night;
- staff must ensure tenant checked foodstuffs were kept in date.

The key potential hazards were noted as being the accidental setting of a fire and self neglect. Mr. Y’s risk rating was classified as “*medium*”. The risk assessment gave no review date.¹⁹⁰

During the rest of November 2009 it was recorded that Mr. Y enjoyed buying things for his flat and was settling in well.¹⁹¹

10 December 2009. Consultant Psychiatrist 3 reviewed Mr. Y at his usual three-monthly Outpatient appointment. Mr. Y appeared to be physically and mentally well. It was noted that Mr. Y had recently moved into a self-contained flat with staff support throughout the day. Mr. Y was apparently compliant with his Olanzapine medication. He was being seen

186. Imagine Notes. PP. 311-312

187. CMHT Notes Post Discharge P. 37

188. Imagine Notes. PP. 312-316

189. Imagine Notes. P. 316

190. Imagine Notes. PP. 7-12

191. CMHT Notes Post Discharge P. 35

Mr. Y Investigation Report

regularly by both Care Coordinator 3 and Social Supervisor 2 from the Forensic Integrated Resource Team. No concerns had been raised. The Consultant planned to continue to follow Mr. Y up on a three-monthly basis.¹⁹²

It was recorded that Mr. Y enjoyed the rest of December and celebrated Christmas with the other residents.

12 January 2010. Care Coordinator 3 visited Mr. Y at his home and it was reported that he continued to be well. He appeared to be “chatty” and no problems were reported by the Imagine staff.¹⁹³

27 January 2010. Social Supervisor 2 met with Mr. Y and took him shopping to Ikea.¹⁹⁴

7 February 2010. It was recorded in the Imagine notes that Mr. Y was “coming around” to the idea of moving out of Moscow Drive. An Outreach Worker was due to come and talk to him about a long-term tenancy elsewhere within the Imagine scheme later on in the afternoon but the meeting did not take place as Mr. Y went out. The Outreach Worker re-scheduled to visit Mr. Y the following day.¹⁹⁵

11 February 2010. Social Supervisor 2 met with Mr. Y in Liverpool for lunch. It was recorded that “... [Mr. Y] unsure about the potential move especially since he has bought furniture. I will discuss this further with ... [Mr. Y] when I visit his flat next week.”¹⁹⁶

15 February 2010. Care Coordinator 3 visited Mr. Y, it was noted that he remained mentally well. A discussion took place about the move from his flat. Mr. Y stated that he did not want to move at the present time. Care Coordinator 3 discussed this with the Imagine staff who said that Mr. Y had told them he was fine with the plan.¹⁹⁷

192. GP Record P. 64

193. CMHT Notes Post Discharge P. 33

194. CMHT Notes Post Discharge P. 33

195. Imagine Notes P. 366-367

196. CMHT Notes Post Discharge P. 33

197. CMHT Notes Post Discharge P.P. 32-33

Mr. Y Investigation Report

23 February 2010. Mr. Y expressed his concerns to his Imagine Keyworker about a potential move to a new flat; he was particularly worried about having anti-social neighbours when he moved. He was reassured that this would not happen.¹⁹⁸

24 February 2010. Mr. Y told his Keyworker that his Care Coordinator had not called in to see him as expected.¹⁹⁹

25 February 2010. Mr. Y was reminded that an Outreach Worker was due to call in the following day to arrange his moving on.²⁰⁰

26 February 2010. The Outreach Worker met with Mr. Y. He explained about the flats he could move to, the removal process, rent and the neighbours.²⁰¹

4 March 2010. It was recorded in the Imagine records that Mr. Y was getting used to the idea of a move. The plan was to take him for a walk to assess the area that the new flat was located within. He appeared well in himself and there were no observable changes to his mental state.²⁰²

5 March 2010. Care Coordinator 3 visited Mr. Y at his flat and he was reported to be well.²⁰³ It was also recorded in the Imagine notes that Mr. Y appeared to be well. He told his Care Coordinator that he was looking forward to viewing the new flat.²⁰⁴

6 March 2010. It was recorded in the Imagine notes that Mr. Y had been taken to view the new flat. It was also recorded “*that seeing the house will give him a clearer idea about accommodation – what he thinks about moving in time for his review on Thursday*”.²⁰⁵

7 March 2010. It was recorded in the Imagine notes that Mr. Y had been to view a flat the previous day and that he seemed to be pleased with the location of the property.²⁰⁶

198. Imagine Notes. P. 369

199. Imagine Notes. P. 369

200. Imagine Notes. P. 370

201. Imagine Notes. P. 370

202. Imagine Notes. P. 372

203. CMHT Notes Post Discharge P. 32

204. Imagine Notes. P. 373

205. Imagine Notes. PP. 373-374

206. Imagine Notes. P. 374

Mr. Y Investigation Report

11 March 2010. Consultant Psychiatrist 3 wrote to inform the GP that Mr. Y had attended for his routine Effective Care Coordination Review. The meeting had also been attended by Care Coordinator 3, Social Supervisor 2, a worker from Imagine and the ‘Bridge Builder’ from Imagine. The Social Supervisor was also present. The focus of the meeting was to try and move Mr. Y into a more independent mode of living. He was maintaining his flat and was reported to have good daily living skills. Mr. Y was continuing to receive support from his Care Coordinator. The plan was to review Mr. Y in three-months time on the 24 June and the next CPA review was scheduled for the 23 September.²⁰⁷

Social Supervisor 2 wrote that the move was to ensure Mr. Y had a “*little more independence.*”²⁰⁸

Consultant Psychiatrist 3 wrote that Mr. Y had been able to maintain his flat and had developed good cooking and budget skills. It was also noted that Mr. Y “*has also not required access to the 24hr staffing over the past three years*” but that he would receive one-to-one daily support in the new accommodation.²⁰⁹

Sometime in March 2010 (date not given in Trust forensic records but probably around the 12 March). Mr. Y visited the home of a previous female acquaintance. On this occasion he was wearing women’s tights over a pair of underpants with no trousers. He gave her a cheque for £7,800 which was debited from Mr. Y’s account on the 18 March 2010.²¹⁰ Neither the Police nor Mr. Y’s treating team were aware of this event until after the ensuing death of Mrs. Y Senior later on in the month.

12-22 March 2010. It was recorded in the Imagine records that Mr. Y continued much the same. His mental state appeared to be normal and he seemed to be relaxed and happy with the idea of a move.²¹¹

19 March 2010. A Social Worker from the Forensic Integrated Resource Team tried to visit Mr. Y but he was not at home. She was told by Imagine staff that there were no problems.²¹²

207. GP Record PP. 60-61

208. CMHT Notes Post Discharge P. 32

209. CMHT Notes Post Discharge P. 31

210. Psychiatric Report for the Defence (date not given) P.4

211. Imagine Notes. PP. 374-382

212. CMHT Notes Post Discharge P. 31

Mr. Y Investigation Report

23 March 2010. Mr. Y was told that there was a possibility of a flat coming up soon in the local area at Derwent and that he could view it if he wished the following day.²¹³

Later on this same day Mr. Y visited the house of the father of the person that he had previously described (prior to the killing of Mr. Y Senior) as his “*ex-girlfriend*”. This “*girlfriend*” was the same person to whom he had tried to give money and possessions prior to the killing of his father in 2004. Mr. Y attempted to give her father a cheque for £7,800. The Police were subsequently informed. However neither the treating team nor Imagine staff were aware of this incident.²¹⁴

24 March 2010. Mr. Y went to visit the flat proposed for his next move. He appeared to be pleased with the location and how quiet it was. He was told that he could have the tenancy on a long-term lease if he wished.²¹⁵

25 March 2010. Mr. Y told Imagine staff that he did not want to move into the flat as it was too far away. He said that he would prefer to wait for a flat closer to Moscow Drive.²¹⁶ Later Mr. Y met with Social Supervisor 2 for lunch in Liverpool city centre. On this occasion he told her that he was uncertain about the move. He was advised to write a list of “*reasons to stay and reasons to go*”.²¹⁷

11.1. 5. Account of the Death of Mrs. Y Senior

30 March 2010. A Worker from Imagine contacted the Forensic Team as Mr. Y had given away his television to another service user. This kind of behaviour had been identified to be one of his relapse indicators. The Imagine notes record that staff had a discussion with him about this. Mr. Y said he had only loaned his television to another service user. Mr. Y asked the staff if they thought he was becoming unwell, and he said that he felt fine. He was asked by staff if he had anything on his mind, especially about the move. He said that he would rather stay at Moscow Drive as he had only recently moved to his current flat. The Team

213. Imagine Notes. P. 382

214. Psychiatric Report for the Defence (date not given) P.3.

215. Imagine Notes. P. 383

216. Imagine Notes. P. 384

217. CMHT Notes Post Discharge P. 31

Mr. Y Investigation Report

Leader was informed about Mr. Y's behaviour. The Team Leader telephoned Mr. Y's mental health team who said that they would send someone out later that day to speak to him.

Social Supervisor 2 went to visit Mr. Y at Moscow Drive, but he was not there. It was reported by Imagine staff that Mr. Y did not appear to be unwell and that he had loaned the television to another service user. As Care Coordinator 3 was on holiday the Social Supervisor contacted another member of the Community Mental Health Team in order to provide an update at 11.00 hours. Social Supervisor 2 told Imagine to contact her if they had any further concerns, otherwise she would visit the following Thursday as planned previously.²¹⁸

Meanwhile Mr. Y was having lunch with his mother. At approximately 11.25 hours Mrs. Y Senior was seen on closed circuit television walking towards Moscow Drive. According to Mr. Y's own account of events he was "*happy*" that his mother was coming to visit him. Apparently Mr. Y and his mother spent about two hours in his flat talking about a range of matters. He gave his mother a small gift, a radio, because he had not brought her anything for Mother's Day. Mr. Y said that his mother was "*properly made up with it*". A short while afterwards his mother went to the bathroom and when she came out he stabbed her to death.²¹⁹ Following this event Mr. Y left his flat.

At 19.45 hours Mr. Y returned to Moscow Drive. He spent some time with the staff talking about Scrabble and then went to his flat stating he was going to listen to music.²²⁰

Mrs. Y Senior was reported to the Police as missing at 20.00 hours. At 22.00 hours a number of witnesses saw Mr. Y attend the residence of his mother and enter the premises. He was seen to leave the building at the same time that it was noted to be on fire.²²¹ At 22.30 hours a neighbour of Mr. Y's mother called Moscow Drive stating that Mrs. Y Senior had not returned home, he subsequently called back to say that the mother's house was on fire.

At 10.40 hours Mr. Y was arrested at a bus stop close to the scene on the suspicion of arson. A search of Mr. Y's flat at Moscow Drive was authorised. Mrs. Y Senior was found dead in

218. Trust Record PP. 92-94 and 387

219. Psychiatric Court Report (November 2010) PP.21-22

220. Psychiatric Court Report (November 2010) P.5

221. Psychiatric Court Report (November 2010) P. 6

Mr. Y Investigation Report

the kitchen. She had been stabbed five times in the neck. Mr. Y was subsequently arrested on suspicion of murder.²²²

31 March 2010. At 13.00 hours Mr. Y was examined by Consultant Psychiatrist 3. Mr. Y admitted killing his mother when asked. The Consultant Psychiatrist could find no evidence of any acute psychotic symptoms in the form of delusions or hallucinations.²²³

1 April 2010. Mr. Y refused to move from his cell and had to be carried to Court. He was distracted and pre-occupied and incongruous in that he exposed his genitals. Consultant Psychiatrist 3 assessed Mr. Y. On this occasion he did not appear to be distracted but was guarded. It was recorded that Mr. Y “*appeared quite brittle and menacing in his presentation*”. Consultant Psychiatrist 3 felt that he was not fit for interview and the decision was made to detain him under Section 3 of the Mental Health Act (2007) at the Scott Clinic.²²⁴

7 June 2010. Due to a decline in his mental state Mr. Y was discharged from his Section 3 and recalled under Section 37/41 to Ashworth Hospital.²²⁵

28 March 2011. Mr. Y was found guilty of manslaughter and attempted arson. He was sentenced to life imprisonment with a 20-year determination. He was detained at Ashworth Hospital under Section 45 of the Mental Health Act (1983/2007).²²⁶

On the 19 April 2011, following an appeal by his defence team, Mr. Y’s sentence was reduced to a minimum of a 15-year determination.²²⁷

222. Psychiatric Court Report (November 2010) P.6

223. Trust Record PP. 75 and 85 and P. 156

224. Trust Record P. 75

225. Trust Record P. 113

226. Trust Record PP. 172-173

227. Liverpool Echo .co.uk 19 April 2011

12. Identification of the Thematic Issues

12.1. Thematic Issues

The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Y received from the Mersey Care NHS Trust and Imagine. These thematic issues are set out below.

- 1. Diagnosis.** Mr. Y had Paranoid Schizophrenia. This was identified at an early stage following his first contact with secondary care mental health services in March 2003. Following his admission to the Scott Clinic ‘Theory of Mind’ deficit was introduced into Mr. Y’s diagnostic formulation. Theory of Mind deficits have been observed in people with autistic spectrum disorders, with Schizophrenia, and some other conditions. There are clear links in the academic literature between ‘Theory of Mind’ and Schizophrenia, but these are far from being straight forward.

In the case of Mr. Y the ‘Theory of Mind’ deficits identified were descriptive only. They were not used to provide an explanation for his condition and presentation. The emphasis placed on Theory Mind by the Scott Clinic Treating Team displaced the thinking around Mr. Y’s Schizophrenia and this amounted to a serious clinical misjudgement. The emphasis on the concept of ‘Theory of Mind’ seems to have distorted the perception that clinicians had of Mr. Y, especially in relation to risk. A rather simplistic view was taken that focused upon a behavioural approach with Mr. Y, one which was at odds with the research literature on this subject available at the time.

There was no acknowledgement of the implication of the diagnosis of Schizophrenia for Mr. Y’s mental functioning. All psychological test results employed norms for the general population with no reference as to whether results might be different in persons with a diagnosis of Schizophrenia or any other serious mental illness. Although a clear diagnosis had been made, and the condition stabilised in the inpatient setting *via* some antipsychotic medication, the subsequent approach to the patient by the whole clinical team seems to have been unduly influenced by the apparent blind spot in regard to the possibility of ongoing influence of the current mental illness, even if he appeared superficially to be asymptomatic.

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In short there was a failure to understand Mr. Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.

- 2. Medication and Treatment. Medication.** Prior to the death of Mr. Y Senior, Mr. Y was not taking his antipsychotic medication on a regular basis. This served to ensure that his psychosis was, at best, only being partially treated. Following the death of Mr. Y Senior and Mr. Y's admission to the Scott Clinic in February 2004, a baseline assessment was not conducted prior to the introduction of his new medication regimen. It was concluded by the Independent Investigation Team that Mr. Y was in denial about the death of his father, had a flattened affect and masked his symptoms. This led to Mr. Y's condition being assessed poorly and to his being under medicated whilst in the Scott Clinic.

Mr. Y was reported to have had consistent concerns about the side effects relating to his medication, prior to the death of his father, whilst he was still living in the community. This meant that he took his medication in a sporadic manner. Following his discharge from the Scott Clinic in 2006 Mr. Y self-medicated from an early stage. There was never any overt evidence that he failed to comply with his medication, however he remained demonstrably ambivalent about it. In such circumstances it could reasonably be predicted that Mr. Y may not have been compliant with his medication. Whether he was, or whether he was not, it would have been good practice to have had a medication management plan in place. This was absent.

Treatment. The lack of a clear formulation of Mr. Y's problems impacted upon the development of a clear treatment plan throughout his time with mental health services. From early in his contact with mental health services issues around family dynamics were identified but:

- this was never clearly formulated to inform an intervention;
- terms such as 'High Expressed Emotion' were used loosely. During the interviews with witnesses there appeared to be confusion between 'expressed emotion' (EE) and 'over involvement' (OI). Though both terms are used to describe families in the research of Wing, Leff, Beddinton *et al* this research does not make them interchangeable. Depending on which, EE or OI, characterised the family different approaches would have been appropriate;

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- even at an early stage, prior to the first homicide, one would have expected some structured input to address the perceived family difficulties which did not happen;
- when Mr. Y was being prepared for discharge from the Scott Clinic some form of family intervention should have been put in place. In the absence of this how was his mother supposed to understand Mr. Y's problems and respond to him?

When examining the care and treatment Mr. Y received a theme was detected of identifying problems but not identifying the interventions to address them. Mr. Y clearly displayed the symptoms of a psychotic illness. The National Institute for Health and Clinical Excellence guidelines state that Cognitive Behaviour Therapy (CBT) should be available to such individuals. There is a substantial literature on CBT approaches to auditory hallucinations, delusions etc. Mr. Y was not offered this kind of therapy and neither was he supported in being able to develop coping strategies to manage his condition.

At the point of his discharge from the Scott Clinic there was talk of employing the recovery model but neither the structured steps to independence nor a Wellness Recovery Action Plan (WRAP) were evident.

In short: if the treating team believed the things that they did about Mr. Y then they should have proceeded within a best-evidence treatment framework. The prevailing belief was that Mr. Y had somehow been 'cured' when it was highly likely he was probably masking his symptoms and his mental health and cognitive problems were understood in a rudimentary manner only.

3. Use of the Mental Health Act (1983 and 2007), Ministry of Justice and Criminal Justice Systems. There are three main issues in relation to the use of the Mental Health Act (1983) before the first homicide:

1. the awareness of the Community Mental Health Team of the appropriate use of the Act;
2. active use of the provisions of the Act; and
3. timeliness of intervention.

The Independent Investigation Team concluded that Mr. Y could have been considered to have met the criteria for assessment under the Act at any time following his first presentation to his GP in March 2003. However, because Mr. Y had not manifested a threat of violence to

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either himself or to others, the degree of urgency to intervene was perceived to be low. This caused a delay in getting Mr. Y the treatment that he needed and consequently his mental health continued to deteriorate.

Following the death of Mr. Y Senior Mr. Y was detained at the Scott Clinic subject to a Court Order under Section 37/41. On the 15 December 2006 he was conditionally discharged from this Order by a Mental Health Review Tribunal (the issues relating to this discharge are detailed in bullet 6 below). At the point of his discharge Section 117 arrangements were not made explicit and this was to cause significant disruptions to his supported living housing arrangements in the years that followed.

After discharge from the Scott Clinic Mr. Y had nominated Social Supervisors and Care Coordinators allocated to him. The pattern of contact with the Social Supervisor, Care Coordinator and Responsible Clinician was maintained through a series of formal reviews in the out-patient clinic at Rodney Street, Liverpool and contacts with staff at a number of venues in the Liverpool City centre. Day to day contact and support was in the hands of the staff at Imagine who also took part in reviews.

From the evidence it appears there were several critical issues in relation to the use of the Mental Health Act post discharge from the Scott Clinic and the practical interpretation of the conditions. These are set out below (please note the conditions of discharge are set out in full in Section 13 below).

- Handovers between members of the treating team were poor and failures occurred when transferring critical information e.g. the Theory of Mind construct.
- There was a lack of knowledge about the role of the Social Supervisor.
- The conditions of discharge were not protective in that they relied on Mr. Y to notify staff of contact with his mother (condition 7).
- Condition 8 did not take account of the potential risk in meetings between Mr. Y and his mother at other venues; it assumed that requiring Mr. Y to keep away from the family home would be effective.
- The discussion about moving Mr. Y to another residence (from 123 Moscow Drive to 133 Moscow Drive and then on to an independent flat) was not discussed with the Ministry of Justice and there is no record of their approval.

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- The review by Supporting People staff of the financial support provided to enable Mr. Y to remain successfully in the community did not acknowledge that Mr. Y was subject to Section 117 after-care, and that his funding was assured. There appeared to be pressure to move him on to less supported and less supervised accommodation. This should not have applied to Mr. Y. There were clinical reasons to be cautious when introducing changes to his living arrangements which were disregarded.
- Staff at Imagine were not aware of the full range of conditional discharge arrangements and procedural requirements for changes in circumstances. They saw this as the role of the Social Supervisor and regarded the staff from the Scott Clinic as a 'crack team' who would advise them appropriately.
- It is not clear whether, or how, the family of Mr. Y were involved in the construction of the conditional terms of discharge.

4. Care Programme Approach (CPA). Mersey Care NHS Trust had a Care Programme Approach policy in place and operational during 2003 and 2004. Given that the documentation completed as part of the CPA process refers to Effective Care Coordination, it appears reasonable to conclude that this had taken into consideration the national guidance on effective care coordination issued in 1999.

It is not clear whether the Care Programme Approach was used at the point Mr. Y was first treated by the day hospital. There is no recorded Care Coordinator or evidence of hand over from the day hospital Keyworker to the community team Care Coordinator or of a Care Coordinator initiating a CPA review meeting to identify Mr. Y's needs and how these might be best/most effectively met.

Once Mr. Y had been transferred to the Community Mental Health Team he was designated as requiring Standard CPA. The Investigation Team concluded that on balance given Mr. Y's presentation of serious mental illness, with accompanying positive risk factors such as non compliance with treatment, there was sufficient evidence to suggest he should have been on Enhanced CPA. This may have led to an increased sense of concern from the team when the Care Coordinator raised issues regarding risk with them. These identified risk issues appear to have been minimised by the team.

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Following Mr. Y's admission to the Scott Clinic seven Effective Care Coordination reviews were recorded between the 23 March 2003 and the 27 November 2006. During this period the Care Coordinator role appeared to be nominal as the Responsible Medical Officer took on this role. It was evident that this role was understood poorly. Mr. Y did not engage with the CPA process and often refused to take part in any of the review and planning processes. The content of CPA documentation did not vary from one review meeting to the next and the information recorded was often incorrect (for example: it often recorded the presence of individuals that had left the employ of the Trust several years previously).

The clinical documentation that records CPA activity following Mr. Y's conditional discharge into the community is sparse. The documentation that is extant provides evidence for risk assessment and care planning having been considered, but there is little evidence to demonstrate that care planning was developed or implemented in a systematic manner. It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y worked in silos to the detriment of Mr. Y's overall case management.

5. Risk Assessment. Mr. Y was not understood in the context of his full risk profile. The issues around the management of risk are many fold.

- Risk assessments were not consistently undertaken at critical times/junctures.
- The conclusions of risk assessments were not always consistent with the evidence cited.
- There was a failure to involve Mr. Y's family, his mother in particular, with risk assessment processes and management plans. This meant that ultimately there was no risk management around the mother's safety at the time of Mr. Y's discharge from the Scott Clinic.
- There was a lack of formulation around risk. For example the treating team did not explore why Mr. Y killed his father.
- Risk assessment was not dynamic and did not lead to risk management plans. Risk plans were little more than a list of actions which did not of themselves address the risks identified.

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- Multi-Agency Public Protection Arrangements (MAPPA) and Police National Computer (PNC) processes were neither considered nor put into place appropriately.

The identified problems as set out above combined together to ensure that Mr. Y's risk was not formulated, assessed in a dynamic manner, communicated appropriately with either his family or all relevant agencies, or mitigated against.

- 6. Referral, Admission and Discharge Planning.** Prior to the death of Mr. Y Senior there were delays in admitting Mr. Y to an inpatient setting. It was evident that Mr. Y needed a bed urgently in February 2004. There were delays to his admission due to the fact that no bed was available. Once a bed was available there was a tardy response to ensuring the admission took place in a timely manner. This delay was significant as it was during this period Mr. Y killed his father and it had been identified that Mr. Y would need to be admitted under the Act if he refused an informal admission.

On the 30 September and 11 October 2006 Special Circumstances Reports were written for the Home Office in support of Mr. Y's forthcoming Tribunal by his Social Supervisor and his Responsible Medical Officer. On the 24 October the statement for the Home Secretary for the consideration of the Tribunal stated that whilst he was pleased to note Mr. Y's progress he would not be prepared to support his discharge at this time and that he needed to stay in hospital in order to receive treatment for both his own health and safety and for the protection of others. Despite this communication plans for Mr. Y's discharge went ahead. Whilst it was good practice to arrange overnight leave (with the permission of the Ministry of Justice) to prepare Mr. Y for an eventual discharge, it is not clear how well-considered the move to supported accommodation in Moscow Drive was.

Mr. Y's discharge in December 2006 appeared to have taken place in a hurried manner. It is unclear why this should have been the case. Mr. Y was discharged *de facto* on the 18 December and officially on the 20 December 2006 without his medication and without a discharge CPA and plan. Also, whilst it was recorded that some kind of Section 117 meeting had been arranged there was no documentation produced that details what occurred in this meeting.

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- 7. Service User Involvement in Care Planning and Treatment.** Between March 2003 and March 2010 it was evident that Mr. Y's treating teams attempted to provide a service that was acceptable to him. However this meant that, at times, there was no assertive management of his medication regimen or liaison with his family. Whilst Mr. Y's wishes were taken into account, these were not always in the best interests of either himself or those around him.

It is a fact that health and social care staff found it difficult to access Mr. Y's inner world. This meant that he was understood poorly and that engagement was maintained at a fairly superficial level. It is recorded in the clinical record that Mr. Y rarely attended his CPA meetings whilst at the Scott Clinic and at times would refuse to sign off his care plans. Mr. Y was generally perceived as being a quiet and private person by members of his treating team and this appears to have become a barrier to a genuine therapeutic relationship being built up with him over time. His lack of involvement in his care planning and treatment, which was ostensibly regarded as Mr. Y 'being the way he was,' should have been challenged *via* the building and maintenance of a therapeutic relationship so that he could genuinely engage more fully in his own recovery.

- 8. Carer Assessment and Involvement.** Between March 2003 and March 2010 there was no active or documented plan in place to ensure that Mr. Y's family were involved in his care and treatment.

Prior to the death of Mr. Y Senior, members of the treating team mistakenly thought that they could not gain collateral information from the family because Mr. Y refused to give his consent. Once it was evident that Mr. Y was suffering from a severe and enduring mental illness no effort was made to either educate his family or to support them. At no time was a carer assessment considered.

During the period that Mr. Y was an inpatient at the Scott Clinic no family focused interventions took place and it is unclear from either reading the clinical documentation or from talking to members of the treating team what exact involvement the family had with Mr. Y's care and treatment programme and discharge planning arrangements.

Following Mr. Y's discharge from the Scott Clinic in 2006 it would appear that the family of Mr. Y made its own arrangements to protect Mrs. Y Senior in the absence of any

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management plan developed by the treating team. Communication with Mr. Y's mother appeared to take place in an unstructured manner and in isolation from any CPA processes. It is the conclusion of the Independent Investigation Team that this placed Mrs. Y Senior in a position of unmitigated risk.

- 9. Housing.** Whilst at the Scott Clinic Mr. Y was identified as needing a small group nursing home. This was based on the belief that he suffered from Asperger's Syndrome and the observations made about 'Theory of Mind'. There is no evidence that this 'need' was taken into consideration as part of his discharge planning. There is no record as to an evaluation regarding the appropriateness of fit between Mr. Y's needs and the environment/support offered by Moscow Drive and Imagine. Mr. Y appears to have been placed at Moscow Drive because that was the place that was available. This is common practice for services, but still poor practice. This lack of assessment for appropriate placement led to the care team taking a purely pragmatic approach to disposal after Mr Y left the Scott Clinic. A wider implication was that it obscured the need for the Local Authority and the Primary Care Trust to offer appropriate after-care under the terms of Section 117 of the Mental Health Act (1983). A further implication was that the type of supported accommodation offered to Mr Y, carried with it an expectation that people would 'move on' to more independent living. Although this might be a reasonable aim for many people with mental health problems, it put pressure on Mr Y to move through the system at an inappropriate pace.

Mr. Y was moved from one property at Moscow Drive to another because the first property was considered no longer suitable. In a material sense the move might have been a beneficial one however, given Mr. Y's known aversion to change, it was not necessarily psychologically so beneficial. There is no evidence of appropriate psychological preparation for this move. It appears, however, that the move went well and Mr. Y reported that he enjoyed his new accommodation and made (possibly for the first time in his life) a friend. The cost of increased independence was decreased supervision. This does not appear to have been reflected upon or included in a risk assessment. Most importantly of all the Ministry of Justice was not consulted prior to this decision being made. This was a serious omission.

In the January of 2010 the Local Authority Supporting People Team conducted an assessment of Mr. Y without the input of either the Imagine staff or mental health services. This was also conducted without understanding the statutory basis of Mr. Y's status in the community

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(Section 117 aftercare and his Conditional Discharge) and of the impact that this assessment could have made on Mr. Y's mental state. This action was inappropriate.

10. Documentation and Professional Communication. Three main issues were identified by the Independent Investigation Team. First: The Trust has not archived Mr. Y's clinical records appropriately and a significant proportion of his clinical record appears to be lost and could not be made available to this Investigation. This is a serious omission, especially in light of the fact that Mr. Y's case is still open to the Trust and all of his clinical records should be available to his current treating team.

Second: the practice of clinical record keeping was poor. Significant CPA and Ministry of Justice documentation has not been held within the main body of the clinical record. It was evident to this Investigation that the general maintenance of the clinical record took the form of a continuous 'cut and paste' process. Assessment and care planning was not dynamic and did not change over time and incorrect information was carried forward from one assessment to the next.

Third: levels of professional communication fell below the level to be expected from a tertiary service team. Communication between Care Coordinators and Social Supervisors was poor in relation to Mr. Y's mother. Communication between Care Coordinators and other agencies, such as the Local Authority and Supporting People, was non-existent. It is expected that a tertiary forensic service would communicate with the Ministry of Justice in a systematic and professional manner. This did not take place in accordance with statutory requirements and consequently the conditions of Mr. Y's discharge were breached.

11. Adherence to Local and National Policy and Procedure, Clinical Guidelines.

- CPA: While the Trust had in place a CPA Policy that reflected national guidelines this did not appear to have been adhered to in Mr. Y's case:
 - there was a lack of clarity and of appropriate training regarding the role and responsibilities of the Care Coordinator;
 - comprehensive needs assessments and plans were not drawn up and reviewed in a timely manner;
 - Mr. Y and his mother were not involved when identifying his needs and developing his care plans. This involvement should have involved more than

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inviting people to CPA review meetings. There should have been an ongoing and proactive effort at engagement.

- Risk assessment and management planning:
 - the Trust had an appropriate policy in place and at least while Mr. Y was in the Scott Clinic some appropriate standardised devices were employed. However the Best Practice guidance goes beyond the collection of data and requires an understanding of the risk that an individual poses. This was not evident in Mr. Y's case. The guidance recommends that the individual and his family should be involved when identifying and understanding risk and in developing the management plan. This did not happen in Mr. Y's case.
- There are guidelines available for the treatment of, and intervention for, individuals suffering with Schizophrenia/psychosis and for personality disorders, these do not appear to have considered when planning Mr. Y's care and treatment.
- The Independent Investigation Team was informed that the practice of the Scott Clinic in referring people to MAPPa was at odds with that of the rest of the Trust. The primary aim of MAPPa is to share information relating to the risk an individual poses and to put in place arrangements for managing and, where possible, reducing that risk. This function of MAPPa does not seem to have been reflected upon; rather the emphasis was on whether Mr. Y met the criteria for referral.
- Mental Health Act: Some clinical witness appeared to be unclear as to the provisions of the Mental Health Act and its accompanying Code of Practice. Neither the Trust nor the Local Authority and those representing it appeared to be familiar with responsibilities under Section 117 of the Act and the requirement to monitor and adhere to the terms of the Conditional Discharge.
- Social Supervisors were unclear as to their role and did not appear to have received appropriate training or supervision.

12. Overall Management of the Care and Treatment of Mr. Y.

- **There was a consistent lack of clarity in understanding and formulating Mr. Y's problems and needs.**
 - There is no clear evidence in Mr. Y's clinical notes of the process of: assessment, formulation, identification of needs, interdisciplinary/agency planning, intervention and evaluation of the intervention.

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- Prior to Mr. Y killing his father he was displaying the symptoms of a serious mental illness. He was non-compliant with the interventions identified (medication and attendance at the day hospital) and he was deemed to need admission as an inpatient. Mr. Y had been identified as needing a Mental Health Act assessment but his situation was allowed to drift for several months. This resulted in a number of missed opportunities and consequently his acute psychosis went untreated and continued to deteriorate.
- Whilst in the Scott Clinic there was no evident sustained planning for his discharge other than that provided by the Occupational Therapist. There was no evident effort, recorded in Mr. Y's notes, to discover why he killed his father, to consider the relationship(s) of his 'Theory of Mind' (ToM) difficulties to his other symptomatology, to consider the implication of his ToM difficulties on his ability to function successfully outside the highly structured environment of the Scott Clinic and on the risks he might pose to others. There was no meaningful involvement of Mr. Y's mother in planning for Mr. Y's discharge, identifying the risks he might pose to her or identifying her needs e.g. for understanding her son's problems. Cognitive Behaviour Therapy and other strategies for coping with psychological distress/difficulties recommended by Best Practice guidance were not made available to Mr. Y.
- Following Mr. Y's discharge from the Scott Clinic there was no clear formulation of his problems other than that his ToM difficulties might present difficulties in social situations. The result of this was that there were no focused interventions put in place, monitoring lacked focus and there was a lack of clarity as to how Mr. Y's progress or changing risk profile might be monitored and evaluated.
- **Mr. Y was known to be reluctant to comply with interventions and was described on a number of occasions as 'a private person' however there were a number of levers that could have been used more effectively to promote Mr. Y's engagement and involvement.**
 - Prior to Mr. Y killing his father the provisions of the Mental Health Act (1983) could have been used in a more timely and assertive manner.
 - The terms of Mr. Y's conditional discharge should have formed the basis for a clear and more constructive risk management plan; this did not happen.

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- Section 117 of the Mental Health Act (1983) should have been used more forcefully and creatively to ensure that Mr. Y had fully funded ongoing support. This should have been informed by a robust and comprehensive care plan which Mr. Y and his mother should have been involved in drawing up.
- **Interagency collaboration and communication.**
 - Given Mr. Y's history it was of considerable importance that information regarding the risks he posed, or changes in his risk profile, should have been shared between relevant agencies. MAPPAs were the obvious forum for this sharing of information and for establishing protocols for information sharing between agencies. Mr. Y was not referred to MAPPAs this was a significant omission in the management of his care.
 - Imagine staff provided a significant amount of support and supervision for Mr. Y following his discharge from the Scott Clinic. They were invited to his CPA reviews and Mr. Y's Care Coordinators and Social Supervisors communicated with the Imagine staff on a regular basis. However, on at least one occasion Imagine had to ask for the minutes of the CPA review and the related care and risk management plan. It was noted by this Investigation that CPA documentation was far from complete in Mr. Y's Imagine-held record. The meetings with the Care Coordinators were unstructured and not focused upon the responsibilities of the two agencies for delivering an agreed care plan. There appeared to be a lack of clarity as to the roles and responsibilities of the two organisations. A robust management plan with a clear review structure would have addressed this and increased the efficacy of both organisations.
- **Clarity of roles and responsibilities**
 - Following Mr. Y's discharge from the Scott Clinic his two Care Coordinators were Community Psychiatric Nurses (CPNs). They appear to have fulfilled the role of the CPN rather than assuming the role of the Care Coordinator and ensuring that Mr. Y's needs were identified, that there were plans in place to meet these needs, that these plans were reviewed in a timely manner and that these plans were delivered.
 - One of Mr. Y's Social Supervisors informed the Independent Investigation Team that she had no training as a Social Supervisor and received very

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limited supervision. Both Social Supervisors appeared not to focus upon their primary role of monitoring Mr. Y's terms of Conditional Discharge.

- Whilst in the Scott Clinic Mr. Y's Responsible Medical Officer/Clinician was also his nominal Care Coordinator. There appears to have been some confusion about the roles of the Responsible Medical Officer/Clinician and Care Coordinator once Mr. Y had been discharged from the Scott Clinic.
- The Local Authority, as represented by Supporting People, does not appear to have understood its responsibilities under Section 117 of the Mental Health Act (1983). The Local Authority does not have to make funding available to support an individual in the community *via* the Supporting People funding stream on an ongoing basis if it is no longer deemed to be appropriate. However if funding is removed from this stream, and the individual concerned is eligible for Section 117 aftercare, the Local Authority and Primary Care Trust must make it available *via* an alternative route. The Local Authority has a duty to ensure that such changes are not detrimental to the well-being of the individual. In the case of Mr. Y the change in funding had two immediate and probably detrimental consequences to his accommodation arrangements: (i) uncertainty was introduced into Mr. Y's life without the necessary time being available to prepare him for the proposed change; (ii) he would have been moved to a living situation which entailed less supervision and possibly less support.

13. Clinical Governance and Performance. The quality and effectiveness of Trust governance systems cannot be assessed when viewed through the single lens of this particular case. It would appear that the Trust has robust policies and procedures which are both evidence-based and robust. It is also evident that the Trust has in place a comprehensive governance system which is compatible with national best practice expectations.

Whilst the Trust had in place a number of appropriate policies and procedures informed by national best practice policy guidance there were some instances in the care received by Mr. Y where these policies were not adhered to. This lack of adherence was not identified in a timely manner by the Trust governance procedures and protocols and as a result weak (remedial) action was put into place to ultimate detriment of Mr. Y's care, treatment on ongoing case management.

13. Further Exploration and Identification of Contributory Factors and Service Issues

In the simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'Five Whys' could look like this:

- serious incident reported = serious injury to limb
- immediate cause = wrong limb operated upon (ask why?)
- wrong limb marked (ask why?)
- notes had an error in them (ask why?)
- clinical notes were temporary and incomplete (ask why?)
- original notes had been mislaid (ask why?)
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. If it was applied to Mr. Y it would look like this:

- Mr. Y killed his father (ask why?)
- Because he had an abnormality of mind which caused him to kill his father.

and

- Mr. Y killed his mother (ask why?)
- Because he had an abnormality of mind which caused him to kill his mother.

Ultimately, when sentencing Mr. Y for the deaths of both his father and mother, the Courts found him guilty of manslaughter due to diminished responsibility caused by an abnormality of mind. The forensic psychiatry reports presented to the Court following the killing of his mother, both for the prosecution and defence, identified that Mr. Y's presentation was difficult to read and that it may not have been apparent to either his treating team or to Imagine staff that he was suffering from a relapse of his Paranoid Schizophrenia.

It was not the purpose of the Court to assess in detail the effectiveness of Mr. Y's care and treatment between 2003 and March 2010. This task is the subject of this Investigation. This Investigation was charged with assessing whether or not any acts or omissions in the care and treatment provided to Mr. Y could have made either a significant contribution to the deaths of his parents, or could be seen to have a direct causal relationship. This Investigation has

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primarily focused upon the lessons to be learned from the death of Mrs. Y Senior. This is because the death of Mr. Y Senior has already been subject to both Internal and Independent Review. However this Independent Investigation has been charged with assessing whether or not any of the circumstances relating to the care and treatment of Mr. Y between March 2003 and February 2004 continued to impact upon the care and treatment he received after the death of his father, thus contributing to the death of his mother in 2010.

RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. causal, contributory and service issue factors.

In the interests of clarity each thematic issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms ‘contributory factor’ and ‘service issue’ are used in this section of the report. They are explained below.

Causal Factor. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term ‘causal factor’ is used in this report to describe an act or omission that the Independent Investigation Team have concluded had a direct causal bearing upon the failure to manage Mr. Y effectively and that this as a consequence impacted directly upon the events leading to the death of his mother.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a contribution to the breakdown of Mr. Y’s mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to

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occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the deaths of Mr. and Mrs. Y need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

13.1. Findings Relating to the Care and Treatment of Mr. Y

The findings in this chapter analyse the care and treatment given to Mr. Y by the Mersey Care NHS Trust between April 2003 and the 30 March 2010, and Imagine Independence between December 2006 and 30 March 2010.

13.1.1. Diagnosis

The Independent Investigation Team would like to note that the diagnoses that are considered below are based on what the treating clinical team knew about Mr. Y between April 2003 and 30 March 2010.

13.1.1.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs and symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information

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from carers, family, GP, interested or involved others, Mental State Examination and observation.

The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (10th revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

Background Information

Paranoid Schizophrenia

Mr. Y was given a diagnosis of Paranoid Schizophrenia from an early stage. This diagnosis has never been called into question by any party involved with examining Mr. Y's case in any capacity. The ICD 10 classification for Paranoid Schizophrenia is set out *verbatim* below.

“This is the commonest type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition, and speech, and catatonic symptoms, are not prominent.

Examples of the most common paranoid symptoms are:

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- *delusions of persecution, reference, exalted birth, special mission, bodily change, or jealousy;*
- *hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form, such as whistling, humming, or laughing;*
- *hallucinations of smell or taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.*

Thought disorder may be obvious in acute states, but if so it does not prevent the typical delusions or hallucinations from being described clearly. Affect is usually less blunted than in other varieties of schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, sudden anger, fearfulness, and suspicion. "Negative" symptoms such as blunting of affect and impaired volition are often present but do not dominate the clinical picture."

The National Institute for Health and Clinical Excellence (NICE) states the following: *"Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect, and behaviour. Each person with the disorder will have a unique combination of symptoms and experiences. Typically there is a prodromal period often characterised by some deterioration in personal functioning. This includes memory and concentration problems, unusual behaviour and ideas, disturbed communication and affect, and social withdrawal, apathy and reduced interest in daily activities. These are sometimes called 'negative symptoms'. The prodromal period is usually followed by an acute episode marked by hallucinations, delusions, and behavioural disturbances. These are sometimes called 'positive symptoms', and are usually accompanied by agitation and distress. Following resolution of the acute episode, usually after pharmacological, psychological and other NICE clinical guideline 82 – Schizophrenia 5 interventions, symptoms diminish and often disappear for many people, although sometimes a number of negative symptoms may remain. This phase, which can last for many years, may be interrupted by recurrent acute episodes, which may need additional intervention."*²²⁸

228. Schizophrenia Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care Issue 82. (2009) P. 1

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Theory of Mind

Mr. Y was thought to have been affected by Theory of Mind problems. *“Theory of mind is a theory insofar as the mind is not directly observable.”²²⁹ The presumption that others have a mind is termed a theory of mind because each human can only intuit the existence of his or her own mind through introspection, and no one has direct access to the mind of another. It is typically assumed that others have minds by analogy with one’s own, and based on the reciprocal nature of social interaction, as observed in joint attention,²³⁰ the functional use of language,²³¹ and understanding of others’ emotions and actions.²³² Having a theory of mind allows one to attribute thoughts, desires, and intentions to others, to predict or explain their actions, and to posit their intentions. As originally defined, it enables one to understand that mental states can be the cause of - and thus be used to explain and predict - others’ behaviour.²³³ Being able to attribute mental states to others and understanding them as causes of behaviour implies, in part, that one must be able to conceive of the mind as a “generator of representations”.²³⁴ If a person does not have a complete theory of mind it may be a sign of cognitive or developmental impairment.”²³⁵*

Asperger’s Syndrome

When Mr. Y was first admitted to the Scott Clinic following the killing of his father Asperger’s Syndrome was initially considered as part of his presentation. *“Asperger’s Syndrome is a Pervasive Developmental Disorder that falls within the autistic spectrum. It is a life-long condition, which affects about 1 in 200 people, more commonly in men than women. Those with Asperger’s Syndrome are usually of average or above average intelligence. The condition is characterised by difficulties with Social Interaction, Social Communication and Flexibility of Thinking or Imagination. In addition, there may be sensory, motor and organisational difficulties. This condition was first identified over 50 years ago by Hans Asperger, a Viennese paediatrician. A pattern of behaviours and abilities was identified, predominantly amongst boys, including a lack of empathy, impaired imagination, difficulty in making friends, intense absorption in a special interest and often*

229. Premack, D. G.; Woodruff, G. (1978). "Does the chimpanzee have a theory of mind?". *Behavioral and Brain Sciences* 1 (4): 515–526.

230. Baron-Cohen, S. (1991). Precursors to a theory of mind: Understanding attention in others. In A. Whiten (Ed.), *Natural theories of mind: Evolution, development and simulation of everyday mindreading* (pp. 233-251). Oxford: Basil Blackwell

231. Bruner, J. S. (1981). Intention in the structure of action and interaction. In L. P. Lipsitt & C. K. Rovee-Collier (Eds.), *Advances in infancy research*. Vol. 1 (pp. 41-56). Norwood, NJ: Ablex Publishing Corporation

232. Gordon, R. M. (1996). 'Radical' simulationism. In P. Carnuthers & P. K. Smith, Eds. *Theories of theories of mind*. Cambridge: Cambridge University Press

233. Courtin, C. (2000). "The impact of sign language on the cognitive development of deaf children: The case of theories of mind". *Cognition* 77: 25–31

234. Courtin, C.; Melot, A.-M. (2005). "Metacognitive development of deaf children: Lessons from the appearance-reality and false belief tasks". *Journal of Deaf Studies and Deaf Education* 5 (3): 266–276

235. http://en.wikipedia.org/wiki/Theory_of_mind#Defining_theory_of_mind

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problems with motor co-ordination. Whilst people with Asperger's Syndrome will exhibit some or all of these characteristics to a greater or lesser degree, many tend to experience isolation and a lack of understanding in their everyday lives, which often results in frustration, anger, depression and a lack of self-esteem."²³⁶

13.1.1.2. Findings

13.1.1.2.1. Prior to the death of Mr. Y Senior

The irony in this case is that the ostensible diagnosis has never been in doubt. Mr. Y presented to his GP on the 7 July 2003 with a history dating back to early 2001 of feeling that there was a device in his taxicab that allowed him to be monitored by the office. Since he had been off work from the end of 2001 these feelings had escalated and he had felt that people were influencing him and knew what he was thinking. He now found this distressing. The GP thought that he could be suffering from Schizophrenia and referred him to the Community Mental Health Team.²³⁷

Mr. Y was seen by a Locum Consultant on 28 March 2003 who diagnosed "*psychotic illness with paranoid schizophrenia (symptoms)*" and he was referred to the Day Hospital.²³⁸ On the 2 May 2003 an assessment was completed at the Day Hospital and a diagnosis of Schizophrenia was made.²³⁹ This diagnosis remained consistent (e.g. Effective Care Coordination meeting 11 January 2007 following conditional discharge to the Imagine hostel, "*major psychiatric diagnosis – paranoid schizophrenia*"²⁴⁰) and the same diagnosis is identified in the Care Programme Approach record from Ashworth Hospital dated 13 September 2010 after the commission of the second major offence.²⁴¹

The Independent Investigation Team concur with the findings of the Trust Internal Review into the care and treatment of Mr. Y (that took place following the killing of his father in 2004) in that Mr. Y's mother was not informed about his diagnosis and that this prevented the family from understanding the "*severity of his illness*".²⁴² When witnesses gave evidence to the Independent Investigation Team they gave two reasons for Mr. Y's diagnosis not being discussed with family members. First: Mr. Y refused to allow his family to be contacted by

236. http://www.aspergerfoundation.org.uk/what_as.htm

237. Internal Investigation (2004) P.5

238. Internal Investigation (2004) P. 6

239. Internal Investigation (2004) P. 4

240. Clinical Records Set 2 P. 179

241. Clinical Records Set 2 P.124

242. Internal Investigation (2004) PP. 28-29

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members of the treating team. Second: members of the treating team thought that Mrs. Y Senior would not be able to cope with the knowledge that her son had Schizophrenia and therefore decided not to tell her. This approach ensured that Mr. Y's parents had no knowledge or understanding of his possible disease progression and the consequences that this could have upon both Mr. Y and his family. This is discussed in more depth in Subsection 13.1.9. below.

The Independent Investigation Team was not able to access Mr. Y's full clinical record for this period. However it would appear that the treating team did not discuss the diagnosis of Schizophrenia with Mr. Y together with its full implications. Whilst this can be a difficult thing to do it is an essential stage when involving a service user in the long-term management of the condition.

13.1.1.2.2. Prior to the Death of Mrs. Y Senior

Following the killing of Mr. Y Senior Mr. Y was admitted to the Scott Clinic where the diagnosis of Schizophrenia was not contested.

One of the unusual features in the case, which very probably did contribute to errors of judgement, both in the assessment of risk and the medical management of Mr. Y's condition, arises from the introduction of the concept of 'Theory of Mind' (ToM) which seemed to have distorted the perception of a number of the clinicians involved in the case, particularly the Responsible Clinician, Consultant Psychiatrist 3.

Everyone who had dealings with Mr. Y, and those who were interviewed by this Investigation, agreed that he was a difficult person to relate to. A Locum Consultant spoke of his "mumbling". Staff and others repeatedly referred to 'monosyllabic responses'. Once his acute psychotic state had subsided, following introduction of regular antipsychotic medication, he appeared amenable and compliant to treatment. A rather revealing description of him nearly a year after admission comes from the Trainee Psychologist's report.²⁴³ He *"had not posed any significant management problem...[but] regularly isolated himself from many of the spontaneous, general social interactions on the ward. He attends pre-scheduled, staff-supported groups including a woodwork class and a sport group within the clinic, but*

243. Clinical Records Set 2 P.22

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spends the majority of his unstructured time alone in his bedroom. Staff commented that ... [Mr. Y] was observed to be lying stiffly on his bed during these periods, and [often] not engaging in activities such as listening to music or watching television.” However, when interviewed by this Investigation and asked about access to Mr. Y’s inner world, a senior member of the clinical team said that this was ‘difficult’. When pressed regarding access to Mr. Y’s feelings towards his parents, after the killing of father, the same clinician said in effect, *“I felt that I had understood what might make his illness relapse and the symptoms when he was unwell. Perhaps what was less possible to explore were his actual feelings towards people such as his parents... ..the clinical psychologists did that work, probably more effectively.”*

What the Senior Psychologist did in fact do was to introduce the idea of ‘Theory of Mind’ (and as will be made evident, below, this work did not in any sense probe his feelings towards his parents, particularly in regard to the first index offence (killing of father)). To quote one academic source *“Theory of Mind impairment describes a difficulty someone would have with perspective taking....This means that individuals with such impairment would have a hard time seeing things from any other perspective than their own. Individuals who experience a theory of mind deficit have difficulty determining the intentions of others, lack understanding of how their behaviour affects others, and have a difficult time with social reciprocity. Theory of Mind deficits have been observed in people with autistic spectrum disorders, with schizophrenia, and some other conditions.”* As far as clinical practice is concerned, the use of the concept has been current in research in the autism/autistic spectrum field for 25 years and has led to well-validated proposals for improving recognition of emotional states in others using cognitive behavioural techniques in children, indeed of the kind proposed in Mr. Y’s case, to help him to recognise particularly emotional states in others (this issue will be returned to, below in Subsection 13.1.2.). However, understanding of theory of mind deficits and their role in Schizophrenia and their implications is far from straightforward.²⁴⁴

To quote a review of the subject published around the time Mr. Y was being treated *“There is good empirical evidence that Theory of Mind is specifically impaired in schizophrenia and that many psychotic symptoms - for instance, delusions of alien control and persecution, the*

244. Tager-Flusberg, H (2007) Current Directions in Psychological Science 16: 311-315

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presence of thought and language disorganization, and other behavioural symptoms - may best be understood in light of a disturbed capacity in patients to relate their own intentions to executing behaviour, and to monitor others' intentions. However, it is still under debate how an impaired Theory of Mind in schizophrenia is associated with other aspects of cognition, how the impairment fluctuates with acuity or chronicity of the schizophrenic disorder, and how this affects the patients' use of language and social behaviour."²⁴⁵ What this research article review suggests is that a simplistic behavioural approach to educating Mr. Y about recognising emotions in himself and in others is not consistent with the acknowledged view of researchers in the field. The deficit when present has global effects, and therefore in this mental condition the deficit is not likely to be amenable to simple educational approaches alone.

The three reports prepared by the Senior Psychologist and her colleagues between April and September 2005 recognise that there is no certainty of benefit from the treatment that they propose, nor do they make clear in what way such intervention would reduce risk, although this is referred to in passing.²⁴⁶ What is more telling is that in more than 45 pages of reports, apart from one reference in the initial psychological assessment to "*a provisional diagnosis of paranoid schizophrenia*" prior to admission, there is no relevant discussion or even mention of Mr. Y's mental illness.²⁴⁷ This is important because if an intervention is to be effective there has to be some understanding of the interaction between a ToM type deficit and the distorted/abnormal cognitive process which characterise psychosis.

In other words, there was no acknowledgement of the implication of the diagnosis of Schizophrenia for Mr. Y's mental functioning. All psychological test results were validated against norms for the general population with no reference whatsoever as to whether results might be different in persons with a diagnosis of Schizophrenia. Reference was made to Mr. Y being 'somewhat concrete in his thinking'. It was recorded in the psychology records that "*it seemed that Mr. Y's answers to the psychometric data were not an accurate reflection of him and therefore had no clinical validity... [he] appeared to have little concept of self from which to reflect upon and to provide answers consistent with clinical impression. As a consequence, it was felt that the psychometrics would provide an inaccurate picture and are*

245.Brune. M (2005) Schizophrenia Bulletin 31:21-42

246.Psychology Notes PP.21-66

247. Psychology Notes P. 14

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therefore not detailed here.”²⁴⁸ These features are of course quite consistent with the existence of a Schizophrenic illness. The Independent Investigation Team concluded that this particular Clinical Psychologist may not have understood the implications of a diagnosis of Schizophrenia. However, the Independent Investigation Team would have expected other senior clinicians within the treating team to have recognised that this is not how most forensic clinical psychologists might report on a patient with this established diagnosis.

In other words, although a clear diagnosis had been made, and the condition stabilised in the inpatient setting *via* some antipsychotic medication, the subsequent approach to the patient by the whole clinical team seems to have been unduly influenced by the apparent blind spot shown in the psychology reports in regard to the possibility of ongoing influence of the current mental illness, even if Mr. Y appeared superficially at this stage to be asymptomatic. Put more succinctly, there was an absence of a clear formulation which attempted to explain all Mr. Y’s symptomatology and which lead to a coherent intervention strategy. This reflects itself not only in the lack of utilisation of psycho-education (a behavioural approach to help the patient recognise symptoms were they to recur in the future and to understand the treatment plan and likely prognosis), which it was acknowledged subsequently by the treating team as not having been provided, despite the National Institute of Health and Clinical Excellence guidelines in respect to Cognitive Behaviour Therapy for psychosis, but is also reflected in the continuing lack of clarity regarding the role of ‘Theory of Mind’ that was applied to Mr. Y at the Scott Clinic.

The questions raised by the Clinical Psychologist in the initial assessment in regard to aetiology (and presumably therefore, diagnosis) were:

1. *“Is... [Mr. Y’s] presentation and psychological difficulties resulting from his temperament, developing personality, relationships, life events and the employment of psychological defences in order to cope?”*
2. *“Has there been any neuropsychological damage acquired as a result of anoxia; interrupted oxygen flow to the brain... [history of breath-holding as child]?”*
3. *“Does his presenting difficulties warrant consideration of a diagnosis of Asperger’s disorder [sic] due to issues surrounding important of routine and resistance to change, queried narrow interests, theory of mind difficulties...etc.?”*²⁴⁹

248. Psychology Notes P. 17

249. Psychology Notes P. 19

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The Independent Investigation Team considered that the first of these questions refers to the stress-vulnerability model of relative predisposition to psychotic illness. However the subsequent neuropsychological assessment by the Student Psychologist that followed chose to interpret the ‘limited repertoire of coping strategies’ as evidence of longstanding difficulties with Theory of Mind function, with no reference to a predisposition to psychosis.²⁵⁰ The neuropsychological tests confirmed no evidence of anoxic damage but specific tests were carried out which led to the conclusion that there was “*a longstanding neurological deficit in theory of mind functioning.*”²⁵¹ The Independent Investigation Team makes the observation that the tests used were tests of cognitive functioning. The neurobiological basis for ‘Theory of Mind’ problems in this, or any other patient, are still the subject of current research using neuroimaging techniques etc. The third question raised by the Clinical Psychologist is not addressed because it was acknowledged that they had already had discussions with the Asperger Team (discreetly declining in the report to mention that the latter had discounted the condition in this patient). The conclusion therefore was that a clinical intervention be offered to Mr. Y with a focus on learning basic theory of mind skills. Unfortunately no reference is made as to whether there is an evidence base for offering such treatment for the first time to a man of 30 years or reference to what relation ‘Theory of Mind’ problems might have to his Schizophrenic illness.

It seems therefore that ‘Theory of Mind’ (ToM) became a substitute diagnosis in this particular case, which while on the one hand was experienced as “*a major breakthrough in terms of how we felt we could work with Mr ... [Y] within the clinical team, because it answered a lot of questions at the time about the difficulty he had in expressing himself*”,²⁵² on the other hand was one which managed to divert attention from aspects of the patient’s function which could be better understood in terms of the presence of an ongoing Schizophrenic process.

This is illustrated by the differing interpretations of ‘Theory of Mind’ given by members of the clinical team at different times, subsequent to the departure of the Clinical Psychologist from the team (and the lack of a replacement due to a shortfall of resources).²⁵³ At the post-incident review immediately following the death of Mrs. Y Senior in March 2010, Consultant

250. Psychology Notes P. 29

251. Psychology Notes P. 28

252. Witness Interview Transcription

253. Witness Interview Transcription

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Psychiatrist 3 is quoted as reporting “... [Mr. Y is] a thirty-eight year old man with a diagnosis of Paranoid Schizophrenia, with an unusual personality style, he has theory of mind problems and finds it difficult to interpret emotions of others and because of this may respond in violence to people.”²⁵⁴ In other words Consultant Psychiatrist 3 is suggesting that the source of risk is not the mental illness, but the ‘Theory of Mind’ problem. This echoes the psychology report written in August 2005 which states “in terms of risk of further violence or aggression, it is likely that Mr. Y may resort to this if he perceives he has no other options for coping with extremely confusing and distressing situations when under perceived threat.”²⁵⁵

On the other hand, another Senior Clinician, when interviewed by the Independent Investigation Team and asked about ‘Theory of Mind’, (which this person and other members of the team took over when there was reduced psychology input to the Scott Clinic) said: “My view was that for the work I was doing, it was based upon work that I had done previously with people who had similar problems.

(Question from the Investigation Team: ‘People with Schizophrenia?’). Answer: ‘People with Schizophrenia, but not necessarily in terms of my understanding of what I would have labelled Theory of Mind difficulty’.

(Question from the Independent Investigation Team: ‘Would you have called it something else?’). Answer: ‘Yes, I did recognise it as a functional difficulty’.

(Question from the Independent Investigation Team: ‘Was it a risk factor?’). Answer: ‘When he started to explain some of the things he found difficult, it was clear that he would make assumptions about people and their understanding of him and what he was going through, and that could often lead to anger...he would then go back to his room and ruminate on it’. For me then there was the potential for anger developing, frustration developing.

(Question from the Independent Investigation Team: ‘But he did not ever show anger by doing anything?’) Answer: ‘No...from a very early point he appeared as very compliant, very gentle. He was very pleasant to be round, not necessarily a warm person but did not challenge in that same way’.²⁵⁶

254. Imagine Records P.481

255. Psychology Notes P.29

256. Witness Interview Transcription

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When asked similar questions, the professionals who were seeing Mr. Y in the community in the weeks before the second index offence said in response to the question “*what did you understand about the Theory of Mind concept and how it related to his risks?*”, that they had read about Theory of Mind but not worked with it previously. A witness to this Investigation said “*I would make sure that he knew what I was saying, because the risk would have been that he would not understand what people were saying to him. He did not show outwardly what he was feeling internally*’ (Question from the Independent Investigation Team: ‘*and why would that be a danger to anybody?*’) Answer: ‘*I think it would be a danger to ... [Mr. Y] especially, because if he is not feeling, it might stress him, and the stress vulnerability model would bring on other things, his illness and things like that*’.²⁵⁷ This answer suggests that this witness, who came late to the case, and was not involved when Mr. Y was an inpatient, had a much more measured and realistic view of this aspect of the case (i.e. diagnosis).

It is a generally accepted precept that diagnosis in psychiatry is never a fixed entity. Following initial evaluation, a list of potential diagnoses is created (differential diagnoses) and the most likely identified. This provisional diagnosis is, by definition, open to modification by subsequent information. Even when a definitive diagnosis is agreed, new evidence may result in alteration, even years later. This is in the nature of our understanding of complex psychiatric illnesses and Schizophrenia, which represents a spectrum of overlapping conditions, is very much a case in point.

However, it is also a relatively common phenomenon, something that clinical teams that have longstanding relationships with individual patients need to constantly guard against, namely that ideas about the patient become institutionalised, the thinking becomes inflexible. These are what we might call ‘factoids’: impressions or common beliefs that after a period of time come to be treated as facts and therefore not amenable to change when new information arises.

A relevant example here comes from the interview with a senior clinical witness to this Investigation. When asked about the referral by the Clinical Psychologist for an opinion by the Asperger Team the response was: “*all I know is that he [Mr. Y] was considered not to have Asperger’s because what we were looking for was some assistance in management...*

257. Witness Interview Transcription

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(Question from the Independent Investigation Team: ‘...following that answer from them that the Asperger story was out the window?...Yes... (Your understanding of him, in the longer term, was whatever peculiar behaviours there were, it was related to his Schizophrenia and presumably the prodrome or the personality elements which contributed?’)... ‘I believe he was somewhere on the Asperger-autism spectrum’.... (You do?)... ‘Because of his characteristics. I believe that is part of him because of his interpersonal style and his, at times, withdrawal and lack of ability to speak directly to people. The other aspect that was explored much more through the Psychologist was this theory of mind issue around his ability to think about his emotions and to interpret other people’s emotions’... (Question: have you come across that, in relation to patients with a diagnosis of Schizophrenia, as being a focus of work in other cases?)... ‘Yes, but to a lesser extent than in this case. Yes, clearly, in my view, people with Schizophrenia often become very blunted emotionally....but there was something different about him, I believe, in his ability to express his emotions....’²⁵⁸

This inability on the part of a senior clinician to recognise that they were continuing to hold to a belief, even when the experts (from the Asperger Team) they had consulted had told them it was not correct, illustrates the problem of factoids. It is not a reflection on one individual, but a warning that, especially in forensic services, it pays to have a reappraisal review, in depth, (ideally with external input), once in a while, of a high profile or unusual case, especially when the patient has killed in circumstances that are not immediately understandable. This is also a matter of risk management, which is discussed below in Subsection 13.1.5.

13.1.1.3. Conclusions

The tragic death of Mrs. Y Senior has allowed just such a reappraisal of the diagnosis based upon an examination of the information both already known about Mr. Y, and brought forward following the killing of his mother in March 2010. This re-examination is described in the psychiatric reports prepared at Ashworth Hospital for Mr. Y’s Court appearances during 2010 and 2011. What the Ashworth Doctors agreed (supported by a Forensic Psychiatrist from Manchester assigned by the Court) was that the diagnosis of Paranoid Schizophrenia was confirmed and that the ‘Theory of Mind’ difficulties needed to be put into the context of Mr. Y’s underlying chronic mental illness. This, in other words, is an

258. Witness Interview Transcription

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enforcement of the principle described in the paragraph directly above, that a reappraisal can help clarify an initial diagnosis. It is most unfortunate that in this case a second homicide was the instigating factor.

In the case of Mr. Y the ‘Theory of Mind’ deficits identified were descriptive only. They were not used to provide an explanation for his condition and presentation. The emphasis placed on ‘Theory Mind’ by the Scott Clinic Treating Team displaced the thinking around Mr. Y’s Schizophrenia and this amounted to a serious clinical misjudgement. The emphasis on the concept of ‘Theory of Mind’ seems to have distorted the perception that clinicians had of Mr. Y, especially in relation to risk. A rather simplistic view was taken that focused upon a behavioural approach with Mr. Y, one which was at odds with the research literature on this subject available at the time.

There was no acknowledgement of the implication of the diagnosis of Schizophrenia for Mr. Y’s mental functioning. All psychological tests employed norms for the general population with no reference as to whether results might be different in persons with a diagnosis of Schizophrenia. Although a clear diagnosis had been made, and the condition stabilised in the inpatient setting *via* antipsychotic medication, the subsequent approach to the patient by the whole clinical team seems to have been unduly influenced by the apparent blind spot shown in the psychology reports in regard to the possibility of ongoing influence of the current mental illness, even if he appeared to be asymptomatic.

- *Contributory Factor One. There was a failure to understand Mr. Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.*

13.1.2. Medication and Treatment

13.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho

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education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

In prescribing medication there are a number of factors that the clinician must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

Consent is defined as *“the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent”* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient’s consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act under a Treatment Order (Section 3 or 37), medication may be administered without the patient’s consent for a period of up to three months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Appointed Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

The patient’s ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given

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orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly/monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and/or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called ‘extra pyramidal’ side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiographic (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

Olanzapine

Olanzapine is an ‘atypical antipsychotic’ drug. This kind of drug is thought to be better tolerated than other kinds of antipsychotics and extrapyramidal symptoms (extreme restlessness, involuntary movements, and uncontrollable speech) may be seen less frequently than with older kinds of antipsychotic medication. Olanzapine has been recommended by the National Institute for Health and Clinical Excellence (NICE) when choosing ‘first line’ medication in newly diagnosed Schizophrenia. This medication is administered orally (by mouth) when used as a regular maintenance prescription and the dose for an adult falls within a usual range of 5 -20mg daily.²⁵⁹

Standardised Symptom Assessment Scale

Resolution of symptoms in response to medication is usually assessed ‘clinically’, that is by clinical impression, which risks subjective distortions, but the reliability of clinical impression can be cross-checked by use of a standardised symptom assessment scale, the best known and widest used scales being the BPRS, PANSS or the KGV (also known as the Manchester scale), the last mentioned being the one in general use at the Scott Clinic during the period in question. The KGV Scale (also called the Krawiecka, Goldberg and Vaughn Scale) is a clinical tool which measures how severe the symptoms are of someone suffering from a psychiatric illness or disorder such as Schizophrenia or Bipolar Disorder. It is used to evaluate the severity of symptoms in order to incorporate the correct treatment. When using

259.British National Formulary PP. 191-192

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this tool, it is very important that the user is fully trained to a high standard so that an accurate evaluation can be made.

National Institute for Health and Clinical Excellence (NICE) Guidelines for the Treatment of Schizophrenia

NICE first published Schizophrenia treatment guidelines in 2002. These guidelines were published in full in 2003, and updated in 2009. NICE guidance states that *“Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.”*²⁶⁰

The 2002/3 Guidelines included the following:

1. *“In primary care, all people with suspected or newly diagnosed schizophrenia should be referred urgently to secondary mental health services for assessment and development of a care plan. If there is a presumed diagnosis of schizophrenia then part of the urgent assessment should include an early assessment by a consultant psychiatrist. Where there are acute symptoms of schizophrenia, the GP should consider starting atypical antipsychotic drugs at the earliest opportunity – before the individual is seen by a psychiatrist, if necessary. Wherever possible, this should be following discussion with a psychiatrist and referral should be a matter of urgency.”*²⁶¹
2. *“It is recommended that the oral atypical antipsychotic drugs amisulpride, olanzapine, quetiapine, risperidone and zotepine are considered in the choice of first-line treatments for individuals with newly diagnosed schizophrenia.”*²⁶²
3. *“The services most likely to help people who are acutely ill include crisis resolution and home treatment teams, early intervention teams, community mental health teams and acute day hospitals. If these services are unable to meet the needs of a service user, or if the Mental Health Act is used, inpatient treatment may prove necessary for a period of*

260. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care Issue 82. (2009) P. 1

261. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 8

262. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 8

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time. Whatever services are available, a broad range of social, group and physical activities are essential elements of the services provided.”²⁶³

4. *“The assessment of needs for health and social care for people with schizophrenia should, therefore, be comprehensive and address medical, social, psychological, occupational, economic, physical and cultural issues...Psychological treatments [to include]*

- *Cognitive behavioural therapy (CBT) should be available as a treatment option for people with schizophrenia.*
- *Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user.*
- *Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available. However, service user preferences should be taken into account, especially if other more efficacious psychological treatments are not locally available”.*²⁶⁴

13.1.2.2. Findings

13.1.2.2.1. Medication

Prior to the Death of Mr. Y Senior

Mr. Y had probably been acutely psychotic since sometime in 2002. According to his own account to the GP on the 7 March 2003. Mr. Y reported feeling shaky and that he had not worked since a road traffic accident the previous July. He was described in the GP record as tense and describing hallucinatory experiences. Mr. Y said that he talked to himself and read meanings into what people said to him. He reported that he thought people knew what he was thinking. The GP reached no diagnosis but suspected that Mr. Y was bordering on psychosis.²⁶⁵

On the 10 March when Mr. Y returned to his General Practice the GP wrote “RX = Risperidone Tablets 1 mg: mental illness referral.” The GP acted in full accordance with the (then) new NICE guidelines.

263. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 9
264. NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 12-13

265. GP Record P. 14

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On the 28 March 2003 Mr. Y was seen in Consultant Psychiatrist 1's Outpatient Clinic. The provisional diagnosis was "*a psychotic illness, paranoid schizophrenia*". There was a reluctance to "*label*" him until he had been assessed at the Day Hospital. Mr. Y was not currently taking his Risperidone as he thought it was affecting his testicles. The plan was to admit him to the Day Hospital; an inpatient admission was not thought to be necessary at this stage.²⁶⁶

On the 15 April the GP recorded "*has stopped medication, not yet heard re day hospital placement*". It was also recorded that medication had been issued to Mr. Y for stress and anxiety.²⁶⁷ On this same day it was recorded that a 'Standard Care Plan Medication Review' had taken place. The plan was to clarify the diagnosis and to stabilise Mr. Y's mental state. It was also hoped that his insight would improve and that he would accept antipsychotic medication.²⁶⁸ On the 28 April Olanzapine 10mg was commenced.²⁶⁹ A KGV was completed but not rated, however the initial findings suggested that Mr. Y was responding to his medication even though he remained guarded and was observed to laugh inappropriately at times.²⁷⁰

Mr. Y attended the Day Hospital between the 4 April and the 14 August 2003 in a sporadic manner. The diagnosis of Schizophrenia was made on the 2 May and antipsychotic medication continued to be prescribed. Mr. Y however did not adhere to his medication regimen. On the 14 July it was decided that the Olanzapine would be reduced and then stopped and that Quetiapine would be commenced and titrated to 200mg over a period of five days.²⁷¹

Between the 14 and 28 July 2003 there were "*growing problems*" with Mr. Y failing to comply with his medication. By the 30 July 2003 consideration was being given regarding the assessment of Mr. Y under the Mental Health Act (1983) due to his continued non compliance with medication and the continued deterioration of his mental state. However agreement within the treating team was not reached and no assessment took place.²⁷² At this stage it was planned for Mr. Y's medication to be changed to Risperidone Consta (a depot

266. GP Record PP. 54-55

267. GP Record P. 17

268. GP Record P. 50

269. Internal Investigation (2004) P. 8

270. Internal Investigation (2004) P. 8

271. Internal Investigation (2004) P. 11

272. Internal Investigation (2004) P. 4

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injection) but it was not available and Mr. Y continued with the Quetiapine. It must be noted here that Mr. Y did not want his medication to be administered by injection.

Mr. Y continued to be non compliant with medication and by February 2004 his mental health had deteriorated to the point where an inpatient admission had to be considered. This was arranged for the 17 February 2004.

Between the time of Mr. Y's referral to secondary care mental health services in March 2007 and the death of his father in February 2004 it is probable that Mr. Y failed to take a consistent therapeutic dose of medication. In short Mr. Y did not receive a medication regimen that could have been expected to have had a positive effect upon his mental illness.

Prior to the Death of Mrs. Y Senior

Scott Clinic

When Mr. Y was admitted to the Scott Clinic, on the 19 February 2004 following the killing of his father, he was prescribed Olanzapine Velotabs 10mg at night together with prn Lorazepam.²⁷³ He had been admitted under Section 2 of the Mental Health Act (1983) under which a patient can be detained for a period of 28 days for assessment. This is not a treatment order and consequently Mr. Y refused to take his medication.²⁷⁴

Between the 25 and 29 February 2004 it was decided to increase Mr. Y's Olanzapine to 20mg with his consent.²⁷⁵ On the 15 March 2003 Mr. Y was commenced on a Section 3 of the Mental Health Act. This Section being a treatment order ensured that Mr. Y would now be required to comply with his medication regimen. Mr. Y continued from this point on with Olanzapine 20mg until the 14 December 2004 when it was reduced down to 15mg. The clinical record indicates that this reduction was prompted by postural hypotension. Mr Y's antipsychotic prescription of Olanzapine was further reduced from 15mg to 10mg on 8 March 2005. The records do not give a clear indication as to why the medication was reduced. However, it was noted that *"he appears fairly settled. At times he converses well with staff, and he utilises escorted leave at staff discretion"*.²⁷⁶

273. Clinical Records Set 2. PP. 5-7

274. Clinical Records Set 2. PP. 7-9

275. Clinical Records Set 2. PP. 12-15

276. Addendum Court Report 25 March 2011. P. 12

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In such circumstances where a person has been psychotic for a long period of time prior to assessment, diagnosis, and treatment it is widely accepted that symptoms will take much longer to resolve. In Mr. Y's case he had experienced at least 18 months of acute psychotic symptoms prior to the killing of his father which had only ever been partially treated at best. Yet in Mr. Y's case, if one scrutinises the case records, on the surface the delusional ideas that he had been preoccupied with for more than a year had seemingly disappeared within four to six weeks of admission to the Scott Clinic. This apparent fact ought to have raised antennae. It is quite probable that he was masking his symptoms to some extent and that his sustained social withdrawal on the ward ensured that they remained so. While the observations made so far in this report subsection could reasonably be seen as part of the review of case management, they are offered also as providing a basis for concluding that one of the risk factors which was not appreciated, because of a combination of circumstances, was that the patient was under-medicated.

The Independent Investigation Team identified two other issues which may have contributed to the approach the treating team took in the long term regarding Mr. Y's medication management. First: when Mr. Y first arrived at the Scott Clinic following the killing of his father a baseline assessment prior to introduction of medication was not carried out. Use of the KGV requires some level of rapport between the patient and the staff member administering it (in the case of Mr. Y, always a nurse) and the records indicate that Mr. Y was too ill to take in what was said to him at the time (20 February 2004) that antipsychotic treatment was started. As will be discussed in a moment, the initial symptoms appeared to disappear very rapidly, such that from May 2004 until his conditional discharge in December 2006, KGV scores were always rated as zero (in terms of symptoms that Mr. Y would admit to) although some blunting of affect was noted.²⁷⁷ The Independent Investigation Team considered that Mr. Y's symptoms may not have been assessed with an appropriate degree of accuracy.

Second: as is not uncommon in Schizophrenia, where denial may feature prominently as a defence mechanism for the patient, whether as to the existence of their illness, the effects of medication or even in relation to their past actions, staff may find monitoring fluctuations in mental state difficult if direct questions are nearly always responded to in the negative. The prime task is for the team as a whole to recognise that the apparent lack of is actually a cause

277. CMHT Records P. 13-14

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for concern and requires further exploration with the patient.²⁷⁸ There is an example in the clinical record from the 6 May 2006 “*Staff conducting KGV [felt] that although Mr. Y denied any symptoms, he was masking symptoms and answering questions how he thought staff wanted him to. Informed Mr. Y that the assessment will be discussed at CTM [clinical team meeting]; throughout assessment Mr. Y presented as settled and calm, however eye contact was limited*”. The Independent Investigation Team found that there was no evidence to suggest that the concerns recorded by staff at this stage were discussed at the Clinical Team Meeting (CTM) which occurred two days later. This ensured that the outcomes of clinical assessment were neither developed further nor used to inform the care and treatment plan.²⁷⁹

The very last mentioned point identifies one means whereby a clinical team can be lulled into a false sense of security as to the mental condition of such a patient, a position bordering on complacency, through familiarity. The next day a medical note read “*generally settled*”. At the CTM the day after, the medical note read “*progress remains unchanged*”. It would appear that neither of the Doctors making these entries had reflected upon preceding case note entries that stated Mr. Y may be masking his symptoms. The Independent Investigation Team speculated that the phenomenon here is that of ‘the compliant patient.’ This is a situation exemplified by a patient who for most of the staff ‘falls beneath the radar’. In the case of Mr. Y, staff repeatedly stated in the nursing notes “*Mr. Y low profile on the ward, remaining mostly in the bedroom*”.²⁸⁰ This again is a kind of ‘factoid’; the mental state is ‘stable’ (in this case inaccessible without a great deal of effort on the part of professionals) to the extent that when observations that point to things being otherwise than what was believed occasionally crop up, such as the nurses’ observation in May 2006 quoted in the preceding paragraph, they pass un-noticed. Going through the inpatient records between February 2004 and December 2006, there are a number of entries which could and should have given pause to senior clinical staff. None of them provided absolute proof of the existence of ongoing psychotic symptoms, but all of them imply that the mental state needed further clarification.

Supported Living in the Community

The final observation pertinent to this section on medication is in regard to both compliance and concordance with medication. Mr. Y was treated more or less throughout his stay in the Scott Clinic with an oral antipsychotic, Olanzapine. There was never any overt evidence that

278.Clinical Records Set 2 P.240

279.Clinical Records Set 2 P. 265

280.Clinical Records Set 2 PP. 91,191, 248 (these are three specific examples, there are many more contained within the records)

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he failed to comply e.g. that he might have been hoarding tablets or taking them and then spitting them out. On the other hand he was quite ready to admit that he didn't believe that medication helped him and that he would prefer if the medication was not increased. This ambivalence regarding medication is not uncommon in individuals experiencing their first major episode of Schizophrenia but it raises questions about risk management in the event of relapse of illness. In such circumstances one could reasonably predict, in this case, that Mr. Y would be less willing to accept medication or to comply with his prescribed dose, because of his known long-term preoccupations with his health and his anxiety about the harm that medicines might do him, which when he was relapsing would be likely to be exacerbated. Prior to his conditional discharge from the Scott Clinic Mr. Y was described as being compliant with his medication and that work had been undertaken to ensure that he understood the reasons for its continued use. Medication was recorded as being a key protective factor in ensuring Mr. Y remained well.²⁸¹ However medication compliance is distinct from medication concordance. Compliance is where a service user takes medication as prescribed. In the case of Mr. Y whilst an inpatient at the Scott Clinic this matter was outside of his control. Concordance implies a voluntary agreement between service user and clinician in regard to a medication regimen. It would appear that compliance and concordance may have been viewed as being the same thing by Mr. Y's treating team.

Mr. Y was conditionally discharged from the Scott Clinic to 123 Moscow Drive on 20 December 2006. One of the conditions issued by the Mental Health Review Tribunal for Mr. Y's discharge stated: *"To comply precisely with all aspects of treatment as directed by the clinical team, whether in the form of medication or other therapeutic intervention"*.²⁸²

Mr. Y was discharged on Olanzapine 10mg. At the Effective Care Coordination Review held on the 11 January 2007 the risk assessment acknowledged that Mr. Y had previously been non compliant with his medication regimen prior to the killing of his father and this could, if it occurred again in the future, contribute to further offending behaviour.²⁸³

Between the date of his discharge from the Scott Clinic and the 3 April 2008 Mr. Y was purported to have been supervised when taking his medication and it was noted within the clinical record that he was compliant with it. On the 3 April 2008 there was an Effective Care

281. CPA Record PP. 183 – 194 (24 July 2006 provides a good example of this)

282. Tribunal Records P. 3

283. Trust Record PP. 178-200

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Coordination Review when it was noted Mr. Y was due to commence self-medication.²⁸⁴ It is unclear what the plan was to ensure Mr. Y's continued compliance. The Independent Investigation Team could not find any care plan relating to this aspect of Mr. Y's clinical management. Considering Mr. Y's known risk factors in regard to medication non-compliance it was remiss not to have developed a plan that would have been able to monitor his continued compliance and associated progress. Throughout the rest of 2008 it was noted in the clinical record that Mr. Y was compliant with his medication and that he continued to do well. It is unclear how his compliance was actually being monitored throughout this period. Trust records note that by September 2008 he was receiving his medication by weekly supply from the Pharmacist.²⁸⁵

There is a distinct paucity in the extant clinical record held by the Trust detailing the outcome of Effective Care Coordination for the period between 2009 and early 2010. It is not possible to discern how Mr. Y's care and treatment was managed beyond a superficial level. However the GP record does contain correspondence sent on behalf of the treating team. It is therefore possible to determine that the treating team thought Mr. Y to be compliant with his Olanzapine throughout this period and that Mr. Y continued to be responsible for self medicating. There is no extant record that sets out how either Mr. Y's mental state was being assessed or how his medication regimen was being monitored. Witnesses to this Investigation could not cast any further light on what the clinical practice was regarding this but reflected that Mr. Y's mental state was being assessed during routine interactions with him when he was seen at his accommodation by either his Care Coordinator or Social Supervisor.

A Court Report prepared by a Forensic Psychiatrist who had assessed Mr. Y following the killing of his mother stated that *"It appears that Mr. Y did comply with his antipsychotic medication as prescribed. Checks were made and he collected all his weekly prescriptions. A check of his dosette box notes he seemed to have taken all doses other than the day of the alleged offences"*.²⁸⁶ It must be noted however that no one actually witnessed Mr. Y taking his medication for at least two years prior to the death of Mrs. Y Senior. Knowing Mr. Y's continued ambivalence towards taking his medication and his previous history of non-compliance it cannot be known with any degree of certainty whether he actually took it or not.

284. GP Record PP. 93-97

285. Addendum Court Report 25 March 2011. P. 14

286. Addendum Court Report 25 March 2011. P. 15

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13.1.2.2.2. Treatment

Prior to the Death of Mr. Y Senior

Between the 4 April 2003 and the killing of Mr. Y Senior in February 2004 Mr. Y received care and treatment from a secondary care community mental health team. However due to the paucity of the extant clinical record for this period it is not possible to really understand what treatment approaches were deployed.

Mr. Y was admitted to Day Hospital care early in April 2003 and by May 2003 a diagnosis of Schizophrenia was made. It is difficult to understand exactly what care and treatment plan was developed for him. The Trust Internal Review (2004) clearly had access to a complete clinical record and the review report stated that the Day Hospital plan was to provide:

- support;
- community group participation;
- problem solving;
- leisure group activities;
- creative therapy;
- goal setting;
- individual sessions.

On the 28 April Mr. Y saw Staff Grade Doctor 1 when it was decided to commence him on Olanzapine 10mg. It was decided that Mr. Y's behaviour required ongoing assessment and monitoring.²⁸⁷ The initial actions instigated by secondary care services were in accordance with extant NICE guidelines.

However, as can be seen from the Chronology in Section 11 of this report Mr. Y did not attend the Day Hospital regularly and neither did he comply with his medication regimen. At regular stages during this period concerns were raised about Mr. Y's deteriorating mental health. NICE guidelines for this period stated that individuals who were newly diagnosed with Schizophrenia required an approach that ensured comprehensive assessment and a rapid access to effective treatment. In the case of Mr. Y this did not occur. His refusal to engage with services beyond the most basic manner ensured his mental illness was only ever partially

287. Trust Internal Investigation Report (2004) PP.6-7

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treated. His mental health continued to decline and services did not intervene in a manner best suited to treat a person who had been newly diagnosed with Paranoid Schizophrenia.

Prior to the Death of Mrs. Y Senior

The Clinical Witnesses who gave evidence to this Investigation explained that Mr. Y was a difficult person to build a rapport with and to get to know beyond a superficial level. Mr. Y's inner world remained inaccessible to them. However there were several interactions recorded within the clinical record which could have been explored within a wider care and treatment programme. Three examples are given below, none of which apparently led to any further response from the senior professional staff:

- a) (Early on in the admission) 17 March 2004 *“(nurse) I reminded Mr. Y of a situation a week or so ago when he was found with a broken toothbrush in his bed. He then stated that he had intended to remove his testicles... (nurse: why chose that part of your body to self harm?) .. ‘I think it will make me a better man... it was testicles that made men do bad things’...He described an argument that became ‘explosive’ and Mr. Y seemed to have total recall of the events and the subsequent death of his father. He further stated that he had often thought of killing his father”.*²⁸⁸ This is important information as elsewhere in the clinical record it was recorded that Mr. Y claimed the killing of his father to be as a result of an argument, not having been premeditated.
- b) (Prior to his mother's first visit to see Mr. Y in hospital) on the 13 December 2004 Consultant Psychiatrist 3 recorded *“Some insight into how he may be feeling, although still limited. Regrets what he did to her – less so about his father. Does not consider himself a risk to her”.*²⁸⁹
- c). (During a discussion of early warning signs for relapse of Mr. Y's illness) It was recorded on the 21 July 2006 *“Mr. Y then (was) asked a series of questions regarding his EWS [early warning signs] (nurse: what help would you like to be offered?) ... [Mr. Y] says he would request to see a doctor, he would like to talk to his brother and he would like to use his coping strategy of going swimming more often....”*²⁹⁰

Above are three examples of glimpses of what might have been explored further, it is important to note for instance that Mr. Y had not spoken to his elder brother for many years and had no current contact with him whatsoever, therefore his suggestion of incorporating his

288. Clinical Records Set 2 P. 25 and CPA Records P. 225

289. Clinical Records Set 2 P. 162

290. Clinical records Set 2 P. 289

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brother into a relapse plan should have been explored. Why were these pointers not picked up and acted upon? One could make an argument about communication, but in fact the purpose of case notes is so that there is a common record and senior staff, which inevitably spend less time on the ward, can have access to observations made by others who are able to spend more time with the patient. It is the responsibility of the former to pick up information which, through their greater experience, they will recognise the value or significance of.

The Independent Investigation Team gained the impression that the treating team may not have known the patient very well despite prolonged contact with him. It seems never to have been suggested for example that perhaps the patient might not be giving a completely honest account of himself (including the persistence of abnormal ideas). There seems no evidence in hundreds of pages within the clinical record written about interactions with him, of anyone actually challenging him over a statement he had made. A small example of this was with Consultant Psychiatrist 3 at interview regarding his psychosexual history. The account given by Mr. Y's mother, by his aunt and the evidence from the newspapers about a fantasy relationship he developed with a young woman who had been a passenger in his taxi all suggested that what had been originally recorded about this aspect of his life based on his initial account, was unlikely to be accurate. Examination of the records shows that the account of Mr. Y's psychosexual history in the psychiatric (medical) reports to Court and the Mental Health Review Tribunal differs from that of the Social Worker (Managers Hearing Report September 2004)²⁹¹ and from that provided by the Clinical Psychologist (early 2005 [date not supplied in record] Psychology report).²⁹²

Attention to detail is a key aspect of clinical skills, particularly in cases that are not straightforward. There may have been a compliance with requisite form filling by professionals or regular structured reviews by the nurses, (who recorded in the notes religiously), but there is little to demonstrate evidence that clinicians sat down and thought about the potential problems posed by an inaccessible Schizophrenic who had killed.

Perhaps the only exception to this were the reports emanating from the Clinical Psychologist, who certainly speculated at length about the patient in the initial psychology reports, and instituted a work programme with Mr. Y which could have provided useful information had it been completed and reviewed by the clinician concerned (although the Independent

291.Legal Documents P.29

292.Psychology Records P. 23

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Investigation Team observed that the pace of this was not timely. Mr. Y was admitted in February 2004 and the work did not really get going until the summer of 2005). Unfortunately from September 2005 to December 2006 there was no meaningful input from psychology services, through an identified lack of resources. A senior Occupational Therapist stepped into the breach as far as she was able, but this could not replace the input that a specialised service from psychology would have made.

There are two kinds of institutional lack of curiosity that have so far been described, that which follows a lengthy period of apparent stability of the patient ('no management problem') so that unknowns gradually slip from collective awareness, and that associated with a lack of vigilance for small details that can point to matters just below the surface, that need attention. There is a third factor operating here, one might argue, which is of considerable significance in helping to understand how things went badly wrong in the management of this case. This can best be described as group collusion with a person whose stance is 'I am not a person who made a calm decision to fetch a hammer and kill my father'.

This is a major issue here. There was a reduction in vigilance regarding the second victim of the attack in 2004, that is, Mr. Y's mother, so that by the time she was about to be fatally attacked one could reasonably argue that the awareness that she was a potential victim within the team had ceased to exist. What one sees here is how a person with Schizophrenia can powerfully influence a clinical team with their internal, psychotic beliefs (I decided to kill my father, but I am not a killer). This case does not represent a unique circumstance. The unconscious, primitive defensive posture of the patient is easy to comprehend. They have limited psychic capability for coping with the emotions associated with awareness that they have broken a major taboo; not only have they killed another person but they have killed their parent.

Forensic professionals know how traumatic it is for most people serving sentences for homicide to come to terms with what they have done, despite popular ignorance of this. It is a fact, and one that needs to be explored with the individual as a humane part of their offence-related work and risk management processes. When the situation is complicated by mental illness, significant sensitivity is required, because the individual may have limited capacity to deal with psychic pain. This is after all the basis of the individual's attempt to protect themselves by denying the reality of what they have done. The real danger, as here, is if staff do

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not recognise the pressure they come under from the patient to collude with that defence, both in terms of finding their own (in this case plainly faulty e.g. the proposition that the killing of father was an impulsive act) rationale for what happened but also in playing into the denial by not challenging it at all. Not only is this poor practice (in that it contributes to a lack of recognition of the ongoing risk the patient manifests) but it is also unwittingly unkind, because it gives the patient no sense of other's awareness of the burden they are carrying as a consequence of their offence behaviour.

The above discussion leads us to consider the treatment options that were recommended by NICE, but not utilised by the treating team at the Scott Clinic. During this period the NICE guidelines for the treatment of Schizophrenia would have recommended that Cognitive Behaviour Therapy was utilised together with a family-based therapy approach. Neither was offered to Mr. Y during the three-year period he spent at the Scott Clinic, or during the three years he spent living in the community following his discharge.

Cognitive Behavioural Therapy (CBT) is a psychotherapeutic approach that addresses dysfunctional emotions, behaviours, and cognitions through a goal-oriented, systematic process. Had Mr. Y been offered this kind of therapy it is probable that the therapist would have been able to understand Mr. Y better and access more of the inner world that he kept hidden. Had Mr. Y been offered this kind of therapy he may have been able to explore reality testing, challenge delusions and hallucinations, examine factors which may precipitate relapse, and develop practical coping strategies. CBT has been a key treatment for Schizophrenia in most secondary care mental care teams across the country for many years. The NICE guidelines for Schizophrenia have recommended this approach since 2002. The Independent Investigation Team therefore found it to be an omission of significance that this kind of therapy was not made available to Mr. Y.

Another omission of significance was that of a family therapy-based approach. The NICE guidance states that "*Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user.*" It is possible that the treating team considered this recommendation in a very literal sense and therefore decided to disregard it. It is a fact that following the killing of his father Mr. Y did not live with his family, and neither could he be described as being in close contact with them. However his mother was visiting him on a regular basis and a relationship was being

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fostered between them. It was essential that the family dynamic was explored, both to assess and to understand Mr. Y's mental state, and to also understand any future risk pertaining to the long-term safety and wellbeing of his mother. Members of the treating team used terms such as 'High Expressed Emotion' when describing Mr. Y's mother but the reasons for this were not clarified and the potential consequences of such a dynamic were not explored in the context of the newly developing relationship between Mr. Y and his mother. (This will be explored in more depth in Subsection 13.1.9 below).

At the point of Mr. Y's discharge from the Scott Clinic there was some talk of employing the Recovery Model but neither the structured steps to independence nor a Wellness Recovery Action Plan (WRAP) were evident. The Independent Investigation Team heard from witnesses that neither the community-based health and social care professionals nor members of the Imagine staff received any training in 'Theory of Mind' interventions. In short, following his discharge from the Scott Clinic Mr. Y received a degree of monitoring of his mental state (from the Scott Clinic) and a continued level of input regarding his activities of daily living (from his supported living accommodation provided by Imagine). However this meant that in practical terms the only treatment that Mr. Y was receiving was medication.

13.1.2.3. Conclusion

Medication

Prior to the Death of Mr. Y Senior

The Independent Investigation Team would concur with the findings of the Trust's own Internal Review into the care and treatment of Mr. Y following the death of his father (2004) in that a more proactive approach should have been taken to the management of Mr. Y's medication and the compliance issues which were apparent between March 2003 and February 2004.

By the time Mr. Y killed his father he had been experiencing acute psychotic symptoms for a period of at least 18 months. Antipsychotic medication is an essential component of any care and treatment package offered to a person with Schizophrenia, especially when they are presenting with acute symptoms. The failure to try to ensure that Mr. Y received the medication that his condition required ensured that his psychosis was allowed to deteriorate. Mr. Y should have been in receipt of a robust care plan to manage his compliance issues. His mental state should have been more frequently assessed using such tools as the KGV scale,

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and ultimately, the Mental Health Act (1983) should have been considered as a means to provide him with the care and treatment that he clearly required in a timelier manner.

Prior to the Death of Mrs. Y Senior

The Trust Internal Review into the care and treatment of Mr. Y following the death of his father (2010) records a different version of events to those offered to the Independent Investigation Team *via* the clinical records and witness statements. Namely that Mr. Y was in fact probably self-administering his medication, unwitnessed, from as early as February 2007. This difference in account serves to demonstrate a poor communication link between the Scott Clinic and Imagine. It would appear that the Scott Clinic staff had no true idea of what was actually occurring and that the Imagine staff had received no clear medication monitoring plan from the Scott Clinic. The result was that Mr. Y received minimal supervision at a critical point in his care pathway. The Trust Internal Review states that *“during the first two weeks following his discharge from the Scott Clinic, Imagine staff monitored ... [Mr. Y’s] compliance with medication witnessing him taking his tablets. From then on, he collected his prescription from his General Practitioner, which was filled at a local pharmacy as a matter of routine, and ...[Mr. Y] self-administered. His Care Team monitored that he adhered to this arrangement throughout his discharge period. Additionally, they took stability of his behaviour as further evidence of his compliance.”*²⁹³ The Report went on to identify the following finding *“a key risk management strategy for Mr. Y was continued compliance with prescribed psychotropic medication. There is no evidence of actual checks on this other than the first two weeks following his discharge”*.²⁹⁴ The Independent Investigation Team concurs with the above finding of the Trust Internal Review.

Mr. Y was known to be ambivalent about taking medication. He had a long history of non-compliance prior to the killing of his father in February 2004. Whilst witnesses may have become confused as to the difference between Mr. Y’s medication regimen being either ‘unwitnessed’ or ‘unsupervised’ it would seem apparent that Mr. Y took his medication in private, and that his dosette box only was checked. The treating team (Scott Clinic) and the care team (Imagine staff) placed a great deal of importance on how Mr. Y was presenting when assessing whether he was being compliant with his medication or not. Knowing that

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Mr. Y masked his symptoms and was not known for verbalising his feelings or reflections upon his mental state, this could *not* be seen as constituting an appropriate medicines management approach.

At the point of Mr. Y's discharge from the Scott Clinic in December 2006 the following was known.

1. Mr. Y's risk assessment prior to his discharge from the Scott Clinic had identified his mental state was at risk of relapse if he did not take his medication and that this could lead to a repeat of his offending behaviour; namely that he could kill again if he did not take his medication (this was written in his Scott Clinic care plan).
2. Mr. Y had a history of non-compliance with his medication and that, at the point of discharge from the Scott Clinic, he remained ambivalent about taking it.
3. The Mental Health Review Tribunal had stipulated that Mr. Y had to remain compliant with all aspects of his medication and treatment regimen following his discharge from the Scott Clinic.

Whilst it cannot now be known whether Mr. Y adhered to his medication regimen or not, what is known is that he suffered a relapse of his mental illness and that this led him to kill his mother. The fact that no one from either the treating team or care team can state with assurance that Mr. Y had in fact been taking his medication leaves a very important issue open to debate, namely was Mr. Y under medicated or un-medicated at the time of his mother's death and did this contribute to the relapse of his mental health and the subsequent death of his mother?

This cannot be proved either way; therefore it cannot be cited as either a contributory or causal factor in this Investigation. However the Independent Investigation Team concludes that whilst there was never any overt evidence that Mr. Y failed to comply with his medication, he remained demonstrably ambivalent about it. In such circumstances it could reasonably be predicted that Mr. Y may not have been compliant with his medication. Whether he was, or whether he was not, it would have been good practice to have had a medication management plan in place. This was absent and has been identified by this Investigation as an example of unacceptable clinical practice. This is of particular concern when assessing the quality of the care and treatment an individual such as Mr. Y received from a specialist tertiary forensic service.

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Treatment

Prior to the Death of Mr. Y Senior

Despite the sure footed and sensible approach of the GP when referring Mr. Y to secondary care services in March 2003, and the admission of Mr. Y to Day Hospital care in April 2003, the approach taken to providing a comprehensive care and treatment plan to Mr. Y was not effective. Clinicians observed the continued and steady decline in his mental state for a period of twelve months. During this time Mr. Y was not compliant with his medication regimen and neither was he receiving any other consistent kind of treatment in accordance with NICE guidelines. This was to the ultimate detriment of his mental health.

Prior to the Death of Mrs. Y Senior

The Independent Investigation Team concluded that because there was no clear formulation of Mr. Y's problems there was a lack of a clear treatment plan throughout his time with Mental Health services.

There was a consistent theme of identifying problems but not identifying interventions to address them. A month after Mr. Y had been admitted to the Scott Clinic the only intervention that had been initiated was medication. In-depth assessment was ultimately deferred until 2005 and could not be said to be timely. Throughout Mr. Y's time with the Scott Clinic Service assessment frequently appeared to be identified as an end in itself and recorded as an intervention. While "*further assessment*" is frequently recorded as a planned future activity there is no:

- plan for the assessment;
- treatment strategy;
- focus;
- identified relationship between assessment and intervention.

As has been discussed in Subsection 13.1.1. 'Theory of Mind' (ToM) factors were identified. Some potential issues as to how this might affect Mr. Y's presentation were acknowledged and some (basic) guidance relating to the environment that might best suit him were offered but there was no structured intervention, advice to staff on how to interact, or supervision provided.

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No consideration as to how Mr. Y's beliefs and perceptions of the world might affect his mode of interaction and ability to see the world from another's point of view was reflected upon. Neither was it considered how psychotic symptomatology and 'Theory of Mind' issues might interact or be monitored.

Another important factor is that most of the psychology assessment inputs were carried out by trainee or assistant psychologists. It is not certain how this affected the formulation, but this could have been a significant factor in regard to the lack of treatment strategy that ensued. The Independent Investigation Team was told that there was a shortage of psychology resources and that this ultimately led to other members of the treating team attempting to carry out the interventions relating to ToM. Unfortunately because no psychology time was available for interventions a detailed programme was not set up regarding ToM and no regular supervision was available. Clear, measurable goals were not established and the quality of the work intended to address ToM issues could not be appropriately monitored. Basically an 'understanding' of Mr Y's problems was reached which was primarily psychological in nature (ToM) with a noticeable absence of psychology input to implement a treatment strategy.

Mr. Y clearly displayed the symptoms of a psychotic illness. The NICE guidelines state that Cognitive Behaviour Therapy (CBT) should be available to such individuals. There is an extensive literature on CBT approaches to voices, delusions etc. Why this type of intervention was not considered at an early stage is inconceivable. Equally difficult to understand was the lack of family focused-therapy offered to Mr. Y and his mother.

Once Mr. Y was discharged from the Scott Clinic, other than medication and monitoring visits from his Care Coordinators and and Social Supervisors, there appears to have been no identified therapeutic interventions or goals. Other than it being required by the Ministry of Justice, it is difficult to understand why Mr. Y continued under the care of a mental health service if no therapeutic interventions were thought to be appropriate. The prevailing belief was that Mr. Y had somehow been 'cured' when in actual fact he was prone to masking his symptoms and was understood in a rudimentary manner only. Whilst the Independent Investigation Team acknowledges that Mr. Y lived in the community for three incident-free years prior to the killing of his mother, the care and treatment offered to him was not optimal. The treatment strategy utilised for Mr. Y was neither evidence-based nor in line with extant

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NICE guidelines for the treatment of Schizophrenia. Consequently he remained poorly understood and only partially treated. It cannot be known whether or not a more clinically effective approach regarding his medication and therapy treatment could have prevented a relapse of his mental illness and the subsequent death of his mother. However it can be said with a degree of confidence that significant omissions were evident within the care pathway that Mr. Y followed and that this left him vulnerable to relapse.

- *Service Issue One. The Scott Clinic practiced an unacceptable level of medicines management in the case of Mr. Y. Whilst this cannot be cited as either a contributory or causal factor it demonstrates a lack of medicines management systems and understanding on the part of Scott Clinic clinicians.*
- *Contributory Factor Two. Mr. Y did not receive treatment in line with national best practice guidelines. This represents a missed opportunity that left Mr. Y vulnerable to relapse.*

13.1.3. Use of the Mental Health Act (1983 and 2007)

13.1.3.1. Context

The Mental Health Act (1983) was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as ‘sectioning’. The Act has been significantly amended by the Mental Health Act 2007.

At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing

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medical intervention and have been assessed to be either a danger to themselves or to others.²⁹⁵ The main purpose of the Mental Health Act (1983 and 2007) is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.²⁹⁶ There is a requirement to ensure that care and treatment are provided in the least restrictive environment possible and all other alternatives are considered prior to assessment under the Act.

Mr. Y was detained under/subject to the following Sections of the Mental Health Act (1983 and 2007).

Section 2 of the Mental Health Act (1983 and 2007) allows for a 28-day period of compulsory detention in hospital for assessment purposes only. A patient has the right to appeal within 14 days of the section being ordered. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 3 of the Mental Health Act (1983 and 2007) is an admission for treatment order for a period of up to six months. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and treatment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 17 of the Mental Health Act (1983) allows the responsible medical officer (RMO) to give a detained patient leave of absence from hospital, subject to conditions the RMO deems necessary. These included a requirement to take medication while on leave and to reside at a particular address, among others. Although the RMO could require a patient to take medication while on Section 17 leave, treatment could not be forced on the patient while they were in the community. There is no limit to the duration of Section 17 leave provided the original authority to detain remains in force.

295 Mental Health Act Commission 12th Biennial Report 2005-2007

296. http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034

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Sections 37/41 of the Mental Health Act (1983 and 2007). A Section 37 is a Court Order imposed instead of a prison sentence, if the offender is sufficiently mentally unwell at the time of sentencing to require hospitalisation. A Section 41 is a Restriction Order which is applied for more serious and persistent offenders. It means the Home Office becomes responsible for granting leave and allowing discharge (discharge can also be granted by a Mental Health Review Tribunal). A Section 37/41 is a Court Order, which can only be made by the Crown Court, which imposes a Section 37 hospital order together with a Section 41 Restriction Order. The restriction order is imposed to protect the public from serious harm. The restrictions affect leave of absence, transfer between hospitals, and discharge, all of which require Ministry of Justice permission.

“Restricted patients represent only a small percentage of all patients in mental hospitals. There are about 3900 restricted patients detained in hospital. Over 50% have been convicted of offences of violence against the person, with a further 12% convicted of sexual offences and 12% of arson. About 600 are detained in the high secure hospitals. Only patients who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities are admitted to the high secure hospitals (Section 4, National Health Service Act 1977). The remaining detained restricted patients are in medium and low secure units, or other National Health Service or independent sector hospitals. ...The number of conditionally discharged patients under active supervision in the community is currently around 1600.” ... “The Mental Health Casework Section of the Ministry of Justice employs nearly 60 officers whose sole concern is to carry out the Secretary of State’s responsibilities under the Mental Health Act 1983 and related legislation... Staff in Mental Health Casework Section are ready and willing to discuss the case of any restricted patient with a clinical supervisor. The letter to the clinical supervisor which notes the discharge of a restricted patient should contain a name and telephone number for use in that case.”²⁹⁷

Section 117 of the Mental Health Act (1983 and 2007) provides free aftercare services to people who have been detained under Sections 3, 37, 45A, 47 or 48. It is the duty of the Primary Care Trust and the Local Social Services Authority to provide and pay for aftercare services. There is no definition of aftercare in the legislation, but services could include amongst others, psychological therapy, crisis planning, accommodation, and help with managing money. The purpose of Section 117 is to prevent someone needing to go back to an

297. <http://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/guidance-for-clinical-supervisors-0909.pdf>

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inpatient unit. Services should ensure immediate needs are met and should also support people in gaining the skills they require to cope with life outside of hospital.

Section 131 of the Mental Health Act (1983 and 2007) allows for people to be admitted into a psychiatric hospital on either a voluntary or informal basis, this means they can be treated without a compulsory detention order. Following the Bournemouth findings in 2004 at the European Court of Human Rights a distinction was made between ‘voluntary’ and ‘informal’. ‘Voluntary’ patients are people who are judged to have full capacity to consent or refuse consent to treatment; this means that they have the right to refuse all treatment and to discharge themselves from hospital at any time they wish. An ‘informal’ patient is a person who is judged as not having the capacity to give consent. This means that whilst they may raise no objection to being admitted and receiving treatment additional measures have to be taken to ensure their continued risk is contained and that their human rights are safeguarded. Many mental health Trusts in effect treat ‘voluntary’ and ‘informal’ patients in the same way.

13.1.3.2. Findings

Prior to the Death of Mr. Y Senior

There are three main issues in relation to the use of the Mental Health Act (1983) before the death of Mr. Y Senior:

1. the awareness of the Community Mental Health Team of the appropriate use of the Act;
2. active use of the provisions of the Act; and
3. timeliness of intervention.

Between March 2003 and February 2004 it was obvious that Mr. Y displayed overt psychotic symptoms. It is evident from reading the extant clinical record and the Trust Internal Review into the care and treatment of Mr. Y (2004) that he engaged with services on the most basic level possible. During this period he did not comply with his medication regimen and was therefore not receiving the treatment that he required urgently for his newly diagnosed Paranoid Schizophrenia. The clinicians involved were aware of the fact that his mental illness was growing worse and that his health was deteriorating.

On 7 March 2003 Mr. Y went to see his GP as he was troubled by hallucinatory experiences and intrusive thoughts. The GP made a referral to secondary care mental health services on

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the 10 March and Mr. Y was assessed by a Consultant Psychiatrist on the 28 March; the provisional diagnosis was “*a psychotic illness, paranoid schizophrenia*”. The plan was to admit Mr. Y to the Day Hospital as it was thought that he would require inpatient admission at this stage.

Between the 4 April and the 23 June 2003 Mr. Y was noted to have been non-compliant with his medication and that his attendance at the Day Hospital was poor. Mr. Y’s symptoms remained unabated and it was recorded that he required a close monitoring of his mental state and that a hospital admission might have to be considered.²⁹⁸

On the 27 June Mr. Y attended his appointment with a Staff Grade Doctor at the Day Hospital. He was confused and withdrawn and admitted to only taking his Olanzapine twice a week. Mr. Y agreed to comply with his medication.

Throughout July it became apparent that Mr. Y was not taking his medication, despite several reviews being instigated, and that he was not attending the Day Hospital. Mr. Y continued to describe psychotic symptoms which appeared to be growing worse. On the 29 July it was recorded that Mr. Y had no insight into his illness and was becoming more paranoid. Mr. Y said that he would no longer be attending the Day Hospital and an inpatient admission was offered to him which he refused. At this stage The Staff Grade Doctor who had been assessing Mr. Y thought that an assessment under the Mental Health Act should be arranged. In the event the Consultant Psychiatrist (Consultant Psychiatrist 2) did not think that this was appropriate as Mr. Y had not threatened to harm either himself or others.

Throughout August and September 2003 Mr. Y’s situation did not change. He was not compliant with his medication regimen, attended the Day Hospital in a sporadic manner, and his mental health continued to deteriorate.

On the 18 August Mr. Y was discharged from the Day Hospital because he refused to attend, he was however to be followed up by a Community Mental Health Nurse (Care Coordinator 1). On this same day a risk assessment was conducted. It was recorded that Mr. Y was paranoid about members of his family and his neighbours. His psychosis was described as

298.Trust Internal Investigation Report (2004) PP. 7-10

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untreated, it was also recorded that Mr. Y had a limited insight into his illness. He continued to avoid contact with mental health services.

By the 30 October 2003 Mr. Y was recorded as spending most of his time in his bedroom at his parent's home. On the 31 October Care Coordinator 1 and Consultant Psychiatrist 2 visited Mr. Y at his home. Mr. Y continued to be paranoid it was noted that his mental state had deteriorated over the past four weeks and that he was not taking his medication. It was thought that at this stage Mr. Y was not detainable under the Mental Health Act (1983). It was also recorded that due to Mr. Y being highly paranoid it was advised that he needed to be approached "*very carefully and tactfully to build a rapport with him.*"

Throughout November 2003 Mr. Y avoided contact with mental health services. On the 2 December Care Coordinator 1 and Consultant Psychiatrist 2 visited Mr. Y at his home where it was observed that he continued to be paranoid and that it was not possible to complete the assessment due to the poor rapport that was established with him.

By the end of January 2004 Consultant Psychiatrist 2 telephoned the GP surgery to say that Mr. Y had a "*florid psychosis, not taking medication*". It was thought that the situation could not continue and that an assessment under the Mental Health Act (1983) was needed. On the 30 January Consultant Psychiatrist 2 visited Mr. Y's home with an Approved Social Worker the purpose being to conduct a Mental Health Act assessment. During this visit it became clear that Mr. Y did not intend to engage with services. He was given a letter that set out the duty of care that the treating team had towards him and that he needed an inpatient admission. Mr. Y was asked to respond to this by the 2 February, the plan being to go forward with a Mental Health Act (1983) assessment if Mr. Y did not respond to the letter or engage with services. There appeared to have been some confusion between Consultant Psychiatrist 2 and the Approved Social Worker as to what the purpose of the visit was actually for.

On the 2 February Consultant Psychiatrist 2 wrote that "*the mental illness is of a degree and severity which can jeopardise his safety in the community (his self neglect) he is getting more withdrawn and not leaving the house as he used to do. To rely on his mother is not practical as she doesn't see the severity of his symptoms and the stress he is passing through. There is*

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a hx [history] of suicide in the family".²⁹⁹ The GP was written to on the 5 February stating that an assessment under the Act needed to be arranged. A visit for this purpose duly took place on the 11 February. Once again there appeared to have been some confusion between Consultant Psychiatrist 2 and the Approved Social Worker as to the purpose of the visit. It would appear that neither Mr. Y nor his parents had been advised as to the visit and the home could not be accessed.

Ultimately another visit was made on the 16 February 2004. It was made clear to Mr. Y and his mother that the situation could not continue as his mental health was deteriorating. It was agreed that Mr. Y would come into hospital the following day and that if he changed his mind a Mental Health Act (1983) assessment would take place. In the event a bed could not be found for Mr. Y on the 17 February, it was arranged that the Approved Social Worker would take Mr. Y into hospital on the morning of the 19 February. Mr. Y was to kill his father in the hours before he was due to be collected on the day of his planned admission.

When the Independent Investigation Team met with witnesses it became apparent that members of the treating team were of the view that patients could only be considered for a Mental Health Act (1983) assessment if violence, or the threat of violence, was imminent. This is not correct. This was the view of the treating team in 2003/2004, and was also the view of the individuals when interviewed eight years later during this Investigation. This is a significant point of learning for the Community Mental Health Team in question. The lack of timely use of the Mental Health Act (1983) was exacerbated by a degree of confusion regarding roles and functions on the part of the Approved Social Worker and Consultant Psychiatrist 2 when making arrangements for the assessment to take place.

Prior to the Death of Mrs. Y Senior

Mr. Y was detained under Section 2 on 19 February 2004 and then Section 3 Mental Health Act (1983) on 15 March 2004. He was made subject to an order under Section 37/41 at Liverpool Crown Court on 18 October 2004.

Under the Mental Health Act (1983) Responsible Medical Officers (RMOs) needed the Secretary of State's consent before granting leave from hospital to detained restricted

299.Trust Internal Investigation Report (2004) P. 18

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patients. The role of the Home Office (and later the Ministry of Justice) in the management of restricted patients is to protect the public from serious harm. During the time that Mr. Y was at the Scott Clinic he was routinely given Section 17 Leave in accordance with both local and national policy guidelines.

Mr. Y appealed to the Mental Health Review Tribunal (MHRT) successfully on 15 December 2006 and was conditionally discharged from the Scott Clinic; the appeal was made with the full support of the treating team. At this stage Mr. Y would have been eligible for Section 117 aftercare. It is unclear exactly how the Scott Clinic made arrangements or assessments under Section 117. There is little evidence in the extant clinical record to show how these arrangements were made, or what in fact they were. During the course of this Investigation it became evident that neither the Scott Clinic nor Imagine understood exactly what the Section 117 aftercare arrangements were for Mr. Y and how this would affect his tenancy arrangements, both at the point of his discharge, or at any point in the future. It would appear that Section 117 arrangements were not discussed and planned in a multiagency forum. This is explored further in Subsection 13.1.9.

Mr. Y was discharged from the Scott Clinic on 20 December 2006 on the following conditions that he was:

1. to reside at 123, Moscow Drive Liverpool (24-hour supported accommodation);
2. to provide access to any members of staff caring for him and to have face to face contact with staff on a daily basis;
3. to comply precisely with all aspects of treatment as directed by the clinical team whether in the form of medication or other therapeutic interventions;
4. to attend appointments with his Responsible Medical Officer (Consultant psychiatrist 3), his successor or nominated deputy as required;
5. to attend appointments with his Social Supervisor, her successor or nominated deputy as required;
6. to attend appointments with his Community Psychiatric Nurse (Care Coordinator 2), her successor or nominated deputy as required;
7. to notify a member of staff (Imagine) at Moscow Drive of any face to face meeting with his mother;

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8. not to go within 200 metres of his mother's home;³⁰⁰
9. to be aware that powers of recall by the Ministry of Justice could be triggered at any time if the conditions were not fulfilled.

After discharge from the Scott Clinic Mr. Y had nominated Social Supervisors and Care Coordinators to both supervise and support him in the community. Following the conditional discharge of a patient into the community regular reports are required to be sent to the Secretary of State, namely a report one month after discharge is agreed, and then at quarterly intervals thereafter. Reports were sent by the Scott Clinic staff to the Secretary of State *via* the Ministry of Justice on a regular basis in accordance with requirements on most occasions.

The pattern of contact between Mr. Y and the Social Supervisor, Care Coordinator and Responsible Clinician was maintained through a series of formal reviews in the Outpatient Clinic at Rodney Street in Liverpool. Mr. Y was also seen once a week by either his Care Coordinator or Social Supervisor who met with him on alternate weeks. Day to day contact and support was in the hands of the staff at Imagine who also took part in Care Programme Approach reviews.

From the evidence presented to this Investigation it appears there were several critical issues in relation to the implementation of the terms of the conditional discharge following Mr. Y's departure from the Scott Clinic and the practical interpretation of those conditions. These are set out below.

1. Witnesses to this Investigation claimed that there was inadequate training and supervision of Social Supervisors. In the case of Mr. Y poor handover processes were in place when Social Supervisor 1 passed the case over to Social Supervisor 2 ensuring a failure to transfer critical information e.g. the 'Theory of Mind' construct.
2. Witnesses to this Investigation stated that the roles and responsibilities of the Social Supervisor were not understood and that training, supervision and handover processes were poor.
3. The terms set out in the conditional discharge in themselves were not explicit enough to ensure the protection they sought to achieve. The Scott Clinic treating team should have developed clear and detailed care plans to provide a robust management strategy. For

300. For the purpose of this report and to ensure anonymity the actual address has not been included

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example, the practical implementation of condition seven relied upon Mr. Y to notify staff of contact with his mother. The condition did not specify whom he was to notify, or when. It is obvious that this condition was intended to provide a degree of protection for Mr. Y's mother, but it required a clear management strategy which was neither developed nor put into place. When witnesses were interviewed it was clear that neither members of the treating team nor Imagine staff knew how to interpret condition seven and had not really given it any thought.

Another example of this is condition eight. In itself condition eight did not take into account the risk factors involved if Mr. Y and his mother were to meet at venues other than the family home. It appears that it was assumed that simply requiring Mr. Y to keep away from his mother's house would be effective in keeping her safe. Once again this condition should have been discussed and a widely -communicated management strategy put into place.

4. Condition one stated clearly that Mr. Y was to reside at 123 Moscow Drive Liverpool. This was a 24 hour supported living accommodation. It is apparent that Mr. Y was moved from 123 to 133 Moscow Drive without any prior request to the Ministry of Justice being made. In correspondence to this Investigation from the Ministry of Justice the Independent Investigation Team was told *"Prior to Mr. Y moving to 133 Moscow Drive there was no indication in the reports submitted by the Responsible Clinician and Social Supervisor that a change in accommodation was being considered. The first notification the Secretary of State had was in the Social Supervisor's report dated 8th October 2009 in which the new address of 133 Moscow Drive was given as Mr...[Y's] place of residence and the Social Supervisor stated that 'Since my last report ... [Mr. Y] has moved to a new address and although 24hr support is available as needed, he has his own flat'".*

The correspondence also stated *"As I mentioned above the Tribunal set the condition regarding accommodation to a specific address. When such a condition exists the care team must request a change of condition from the Secretary of State before moving the patient. The purpose of this process is to allow the Secretary of State the opportunity to consider the appropriateness of the proposed accommodation, for example if the level of support offered is correct or whether there are any concerns regarding the location of the*

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*accommodation. I can confirm that there is no record on our files that indicates such a request being made before ... [Mr. Y] moved to 133 Moscow Drive”.*³⁰¹

It is clear that the Ministry of Justice did not know about the first move from 123 to 133 Moscow Drive. It was also clear that the Ministry of Justice had not been consulted about the plans to move Mr. Y from 133 Moscow Drive to an independent flat which were in train shortly before Mr. Y killed his mother.

5. The workers at Imagine were not aware of the full range of conditional discharge arrangements that Mr. Y was subject to and neither were they aware of the procedural requirements for any changes to his place of residence. They saw this as the role of the Social Supervisor and regarded the staff from the Scott Clinic as a ‘crack team’ who had the terms of the conditional discharge ‘under control’. It was evident that Imagine were not aware that moving Mr. Y from one place of residence to another had to be approved by the Ministry of Justice. It was also evident to this Investigation that the terms of the conditional discharge were not being monitored in full as the Imagine workers, who were *in situ* on a 24 hour basis, were not aware of them or what their full responsibilities should have been.
6. A major area of omission in regard to the conditional discharge terms and conditions was that Mr. Y’s family were not explicitly involved. It is not clear whether, or how, the family of Mr. Y were consulted in either the construction of the conditional terms or their implementation. It was evident that the family and friends of Mrs. Y Senior put protective plans in place for her, and it was these plans that alerted services to the fact that she had probably come to harm on the day of her death.

The Independent Investigation Team found no evidence to suggest that the terms of Mr. Y’s conditional discharge had been integrated into the Care Programme Approach process or that any robust management plan had been constructed around them. The terms of the conditional discharge appeared to be communicated poorly between the Scott Clinic and Imagine and roles and responsibilities for the implementation of the conditions were not understood.

301. Ministry of Justice letter P.1

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It was evident that Mr. Y was left to self-report his own actions in relation to contact with his mother. Imagine were left to monitor Mr. Y's medication regimen (which they appeared to have done in isolation from the CPA review see Subsection 13.1.2. above) and it remained unclear to them what their role was after Mr. Y had notified them of visiting his mother. At interview staff did not know for example whether or not Mr. Y was supposed to have notified them, before, during or after a visit had taken place. Neither did the staff know what they were supposed to have done with this information once it had been given to them.

In short the terms of the conditional discharge were not the subject of a multidisciplinary/multi-agency discussion that went onto develop robust implementation plans. It would appear that none of the conditions were reviewed actively or framed part of an ongoing risk management strategy.

13. 1.3.3. Conclusions

Prior to the Death of Mr. Y Senior

The Independent Investigation Team concurs with the findings of the Trust Internal Review Report (2004) which stated *“There was significant confusion as to the protocol for establishing a formal assessment under the Mental Health Act 1983. There was also uncertainty about the responsibility of individual staff members in this regard even though a procedure exists, whereby a referral can be made to an Approved Social Worker to co-ordinate such a visit”*.... *“It is noted that consideration was given to detaining Mr...[Y] under the Mental Health Act, in July 2003, given growing concern with regards to his condition, lack of insight, non-compliance of medication and erratic attendance pattern. It is also noted, by the Review Team, that all but one of staff members involved in his care were of the opinion that Mr....[Y] was detainable under Section 2 of the Act and should have been formally assessed at that time. The Review Team is of the view that, had a formal assessment been undertaken, and M....[Y] sectioned and detained, it could have had an impact on his treatment”*.³⁰²

This Investigation would go one step further and say that it was evident that had the Mental Health Act (1983) been used at any stage between April 2003 and February 2004 Mr. Y's mental state would have been assessed and treated in a more timely manner and that he would

302. Trust Internal Review P. 29

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have been able to access the urgent the care and treatment that he required. The Independent Investigation Team concluded that had Mr. Y received the care and treatment he required then his mental illness would not have continued to deteriorate and that the events that led to the death of his father may well have been prevented. The treating team knew that Mr. Y was psychotic, refusing medication and becoming increasingly paranoid. It is unclear why they refused to use the statutory means that they had available to them in order to protect Mr. Y's continued health and safety. It would appear that most members of the treating team considered, and still do consider, that the only time a Mental Health Act (1983) assessment can be sought is if a person is a direct threat of violence to either themselves or to another person. This view is not in keeping with the ethos of the Act and the treating team's reticence ensured that too little was done too late.

In summary:

- Mr. Y could have met the criteria for assessment under the Mental Health Act (1983) at any time after his first presentation to the GP as he steadfastly refused medication and his mental health continued to deteriorate;
- there was a misunderstanding within the Community Mental Health Team that violence or the threat of violence was a necessary condition for use of the Mental Health Act (1983) and this prevented timely intervention. It has to be noted however that an assessment alone would not necessarily have guaranteed detention under the Act.

This Investigation does not intend to assign contributory or causal factors relating to the killing of Mr. Y Senior as this incident has already been subject to both internal and independent scrutiny, and the passage of time has made collecting a full set of documentation difficult. However this Investigation has been asked to identify whether there were any factors present in relation to the first homicide (the death of Mr. Y Senior) that may have impacted upon the second (the death of Mrs. Y Senior). It is the conclusion of the Independent Investigation Team that there were significant delays in providing timely care and treatment to Mr Y between April 2003 and February 2004. As a person with a newly identified Schizophrenia he should have received rapid treatment interventions. The failure to ensure this occurred led to a deterioration of his mental health and this may ultimately have led to his illness becoming more intractable in the years that were to follow.

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Prior to the Death of Mrs. Y Senior

There are no particular issues regarding the use of the Mental Health Act (1983 and 2007) until the point of Mr. Y's discharge from the Scott Clinic on the 20 December 2006. The Section 117 planning at the point of discharge was neither explicit nor robust and did not ensure the stability of either Mr. Y's immediate or long term future with regards to his accommodation and ongoing support. Whilst this omission cannot be seen to have made a contribution to the death of Mrs. Y Senior it can be seen to have left Mr. Y's long term future vulnerable to the budget pressures that the Local Authority Supporting People funding was subject to. This aspect is discussed in the housing Subsection 13.1.9. below.

The Trust Internal Review into the care and treatment of Mr. Y (2010) following the killing of his mother stated that *"there was no evidence a management plan was in place to ensure ... [Mr. Y] met the conditions of his discharge. There were inconsistent reports as to the nature, scope and frequency of his mother's visit. Given the layout of both 123 and 133 Moscow Drive, no guarantee could be given that visitors were always seen coming or going...There were no discussions as to the consequences of ...[Mr. Y's] conditions of discharge when he moved to 133 Moscow Drive. There was no system in place to monitor visitors. Staff accommodation was on the top floor and staff had no right of entry to tenants' accommodation"*.³⁰³

The Trust Internal Review concluded that the discharge arrangements for Mr. Y were *"precipitous"* and that there was little planning to inform either the community team or Imagine.

The Independent Investigation Team concurs with the findings and the conclusions of the Trust Internal Review (2010). This Investigation would also add that the Responsible Medical Clinician (Consultant Psychiatrist 3) and the Social Supervisors were remiss in the extreme in they did not consult with the Ministry of Justice with regard to their plans to move Mr. Y from 123 to 133 Moscow Drive, and neither did there appear to be any plans to consult with the Ministry of Justice with regard to the second move that was being planned immediately prior to the killing of Mrs. Y Senior. The permission for any change of residence

303. Trust Internal Review (2010) P.23

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had to be approved by the Secretary of State. It is entirely unacceptable that this breach of statutory process occurred.

It is inconceivable how a specialist tertiary forensic team could fail to understand its accountabilities and responsibilities relating to the terms of Mr. Y's conditional discharge. It was evident that roles and responsibilities were not clear and that several individuals understood their obligations poorly. However each of these individuals had not only a duty of care to the patient but a professional accountability to ensure that they were acting in a competent manner. Section 41 of the Mental Health Act (1983 and 2007) is a Restriction Order imposed to protect the public from serious harm. The restrictions affect leave of absence, transfer between hospitals, and discharge, all of which require Ministry of Justice permission and ongoing supervision. It was not acceptable for a specialist tertiary forensic team to ignore such a fundamental requirement.

There are significant points of learning for both the Trust and for the individual practitioners involved. The Trust should ensure that all personnel working in forensic services understand the statutory aspects of their roles and that robust supervision is provided to support this. Team Managers need to ensure staff are competent and supported and that processes are followed and are subject to audit. Individuals must not act outside of their areas of competence and if they do not feel that they can fulfil the demands of their role should raise this with their managers as required to do so by their registration bodies.

The Independent Investigation Team concludes that serious and significant omissions occurred at the point of discharge with regard to the terms of Mr. Y's conditional discharge. These conditions were not the subject of a robust management strategy and consequently, over time, they were not implemented in a manner likely to ensure any reasonable or achievable degree of protection to the public.

- ***Contributory Factor Three. There were serious failures in the implementation of the terms of Mr. Y's conditional discharge. This meant that the conditions put into place by the Ministry of Justice to protect the public were rendered ineffective.***

13.1.4. The Care Programme Approach

N.B. The terms ‘Effective Care Coordination’ and the ‘Care Programme Approach’ are used interchangeably in the following text reflecting the alternating use of terminology within the Trust clinical record.

13.1.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.³⁰⁴ Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*.³⁰⁵

*“The Care Programme Approach is the cornerstone of the Government’s mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services”*³⁰⁶ (Building Bridges: DoH 1995). This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

304. The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

305. Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

306. Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH; 1995

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The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
 1. to keep in close contact with the patient;
 2. to monitor that the agreed programme of care remains relevant and;
 3. to take immediate action if it is not;
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

Mersey Care NHS Trust Care Programme Approach (CPA) Policy

2003-2004

The Trust could not supply the CPA policy that was in place during the time that Mr. Y received his care and treatment prior to the killing of his father. However during this time the national Effective Care Coordination guidance of 1999 was in force. This policy guidance recommended a number of changes to the implementation of the Care Programme Approach. These recommendations included;

- going from the recognition of multiple levels of CPA to only two; enhanced and standard;
- the removal of the requirement to maintain a supervision register (replaced by Supervised Community Discharge Orders within the Mental Health Act (1983));
- closer integration of the Care Programme Approach (CPA) and Local Authority care management, ensuring a single integrated process of care assessment and care delivery;
- a change of title from Key Worker to Care Coordinator for the person responsible for coordinating the individual care plan;
- introduction of a principle of CPA not placing an undue burden on professionals whose prime responsibility is to care for service users;

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- that the review and evaluation of care planning should be regarded as an ongoing process and the requirement for a nationally determined review period was removed;
- local service providers were required to ensure they had systems to collect data on all service users;
- local audit should focus on the quality of the CPA in terms of content of care plans and attainment of treatment goals;
- risk assessment was reinforced as an essential part of the ongoing CPA process;
- CPA should meet the needs of the whole family and must comply with the Carers Recognition and Service Act 1995 and the National Service Framework Standard on caring for carers;
- that it was made clear the policy pertained equally to residential as it did to community services;
- that the responsibility for implementing the Care Programme Approach was identified as lying with the provider Chief Executives and Directors of Social Services;
- that the guidance in this policy laid out the role and characteristics of a Care Coordinator but did not recommend any specific level of training. The roles and characteristics included:
 - competence in delivering mental health care (including an understanding of mental illness);
 - knowledge of service user/family (including awareness of race, culture and gender issues);
 - knowledge of community services and the role of other agencies;
 - coordination skills; and
 - access to resources.

2006-2007

The Independent Investigation Team was given access to a policy dated June 2006 – June 2007. This policy was compiled initially in 2000 as the *Protocol for Effective Care Coordination* and it is therefore possible that this policy had a similar content to earlier editions and can be cited for the period between 2003 and 2004. It stated the following:

“The Care Coordinator must be able to pass on essential service user information between the NHS, local authority and voluntary or independent services, where those agencies are

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*contributing to or planning a programme of care, or where one may need to be initiated. This clearly results in the need for identified risks to be communicated to these agencies in order to facilitate their involvement in the effective management and implementation of the care plan”.*³⁰⁷

“Standard Level ECC

The characteristics of those service users requiring Standard ECC will include some of the following:

- a) They require the support or intervention of one agency or discipline, or require only low key support from more than one agency or discipline*
- b) They are more able to self manage their mental health/learning disability problems*
- c) They have an active informal network*
- d) They pose little danger to themselves or others*
- e) They are more likely to maintain appropriate contact with services*

Enhanced Level ECC

The characteristics of those service users requiring Enhanced ECC will include some of the following:

- a) All service users admitted to inpatient or Crisis Resolution and Home Treatment care*
- b) They may be in contact with a number of agencies (including the Criminal Justice system)*
- c) They have complex/multiple needs which in general require the input of two or more professionals/agencies*
- d) They are only willing to co-operate with one professional or agency but have multiple needs...*
- e) They have a high level of social disability that reflect agreed joint criteria*
- f) They are more likely to disengage from services*
- g) They are more likely to have mental health problems coexisting with other problems or substance misuse*
- h) They are more likely to be at risk of harming themselves or others*
- i) They are more likely to be at risk of serious self-neglect and/or highly vulnerable*
- j) They are likely to require more frequent and intensive interventions, perhaps with medicines management”.*³⁰⁸

307. Policy and Procedure for Effective Care Coordination June 2006 – June 2007. P. 12

308. Policy and Procedure for Effective Care Coordination June 2006 – June 2007. PP. 16-17

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The responsibilities of the Care Coordinator were identified as being to:

- coordinate all aspects of service user care;
- coordinate multidisciplinary assessment, to include risk;
- maintain contact when a service user is an inpatient;
- formulate and maintain a care plan with the service user and to communicate this plan with other multidisciplinary team members;
- commission and secure funding to meet prioritised assessed need;
- formulate contingency and crisis plans;
- be responsible for maintaining a current risk assessment document and risk management plan;
- maintain contact with the service user;
- provide a point of contact with the service user and carers, and to be responsible for sharing relevant information with carers.³⁰⁹

Current Policy 2011/2012

The Independent Investigation Team could not access a policy for the periods between June 2007 and June 2011. However there is a current policy in place that takes into full account the national changes made to the Mental Health Act in 2007 and CPA in 2008. The Independent Investigation Team is confident that in the intervening years the Trust CPA policy was robust and followed the precedent of predecessor documents. All policies examined as a part of this Investigation were deemed to be of a good quality and fit for purpose.

13.1.4.2. Findings

13.1.4.2.1. Prior to the Death of Mr. Y Senior

Roles and Responsibilities

The Independent Investigation Team reviewed documentation contained within the GP clinical record and a printout from the Trust electronic E-Pex record (electronic record). This Investigation was not able to access a full set of CPA documentation. It was evident from the extant clinical record, and from the findings of the Trust Internal Review (2004), that following the GP referral in March 2003 Mr. Y was initially allocated a Key Worker and that he was not placed on CPA at all at this stage despite his presentation and assessed clinical need. The documents that were available identified that Mr. Y was placed on Standard CPA

309. Policy and Procedure for Effective Care Coordination June 2006 – June 2007. PP. 18-19

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(probably by default) and that a Day Hospital worker commenced CPA documentation sometime at the end of July/beginning of August 2003.

A Community Psychiatric Nurse became involved with the case at the instigation of Consultant Psychiatrist 2, and whilst she was not formally allocated to Mr. Y, as she received the referral (in accordance with Trust Policy), she became his *de facto* Care Coordinator (Care Coordinator 1) from 30 July 2003 until some time after his admission to the Scott Clinic following the killing of his father. It appears that no handover took place between the Key Worker and Care Coordinator 1.

Neither the Key Worker nor Care Coordinator 1 appeared to take an assertive stance in the roles that they filled with regard to the Care Programme Approach and it was evident to both the Trust Internal Review (2004) and the Independent Investigation Team that neither individual was able to ‘embrace’ their role in the context of a “*lack of overall management... [which] led to a disjointed, incomplete and less than effective programme.*”³¹⁰

Care Coordination

The CPA policy for this period was not available to this Investigation, however based on national thinking about CPA at this time Mr. Y should have been considered as eligible for Enhanced CPA; the reason for this being that he had a severe mental illness in the form of a newly diagnosed Schizophrenia for which he refused to take medication. This was compounded by the fact that he refused to engage with services on a regular basis and this was contributing to a steady deterioration in his mental state. Mr. Y required a regular input from many members of the multidisciplinary team, and it was recognised for at least six months prior to the killing of his father that a skilled and consistent approach would be required in order to build a therapeutic relationship with him and ensure adherence to the care and treatment plan that he needed. Had Mr. Y been placed on Enhanced CPA at the outset he may have been perceived by the treating team as requiring a more assertive approach in keeping with his presentation and assessed need.

Neither the Key Worker nor the Care Coordinator appeared to have worked with the Care Programme Approach in the spirit of either Trust policy or national policy expectation. Care

310. Trust Internal Review (2004) P.29

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Coordination is about ensuring that assessment, care planning, monitoring and review occur on a regular and systematic basis. CPA requires the Care Coordinator to ensure communication takes place between members of the treating team, the service user, and where relevant, the carer. Care Coordination should ensure that assertive and timely action is taken when a service user's mental health begins to break down in order to ensure effective intervention follows in accordance with an explicit and pre-agreed plan. In the case of Mr. Y this did not occur.

Documentation, Assessment and Care Planning

The extant clinical record for the period between 2003 and 2004 is now incomplete. The Trust Internal Review (2004) into the care and treatment that Mr. Y received found that the documentation available to its investigation, whilst extant, was poorly executed. It has however been possible to ascertain some facts. These are set out below.

- **1 August 2003.** A Standard ECC assessment was conducted by a worker at the Day Hospital. The assessment documentation was not completed. Mr. Y's mother and father were not involved in this review. The documentation noted that his mother did not believe he was unwell or that he needed the prescribed medication. The Effective Care Coordination Documentation stated under 'Family/Carers views' "*not sought and not offered*". The risk assessment document under 'Carer's view' of assessment (including any disagreements) stated "... [Mr. Y] does not want his mother involved in care plan so opinion not sought".
- **18 August 2003.** A risk assessment was completed by Care Coordinator 1 following Mr. Y's discharge from the Day Hospital. On this occasion it was noted that Mr. Y had paranoid ideas about his neighbours and his family. His psychosis was assessed as being untreated. Mr. Y did not sign this document; the reason given being that it was feared Mr. Y would disengage if required to do so because of his paranoia. It was also recorded "... [Mr. Y] does not agree that there are risk indicators".³¹¹ The care plan stated that Mr. Y was to be invited to meet with Care Coordinator 1 at Moss House once a week and to see Consultant Psychiatrist 2 as necessary. It was also noted that Mr. Y's diagnosis was to be confirmed, that his mental state needed to be stabilised and his medication regimen accepted by him. The contingency/crisis plan was for Mr. Y or his carer to contact Care

311. GP Record P. 49

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Coordinator 1, the Crisis Team or the GP. He was also advised to visit the Accident and Emergency Department if in crisis.

- **20 August 2003.** ‘Effective Care Coordination Multidisciplinary Team Assessment’ documentation was partially completed on this day.
- **31 October 2003.** Consultant Psychiatrist 2 and Care Coordinator 1 visited Mr. Y at his home. There had been significant concerns about his deteriorating mental state. This visit also served as a CPA review. It was noted that Mr. Y was not taking his medication and that urgent talking therapy should be made available to him to help him with his anxiety and paranoia issues. It was decided that the 18 August 2003 care plan required no revisions. It was also recorded that Mr. Y was not considered detainable at that time under the Mental Health Act (1983). Due to Mr. Y being highly paranoid it was advised that he needed to be approached “*very carefully and tactfully to build a rapport with him.*”³¹²

The Independent Investigation Team concurs with the findings of the Trust Internal Review (2004) which identified the following findings:

1. there was a focus on assessment rather than treatment;
2. documentation was not completed and processes did not follow the Trust requirements for Effective Care Coordination;
3. the treating team did not understand Trust policy and procedure regarding CPA and the “*management and planning of care and treatment of patients*”.³¹³

The Independent Investigation Team found that the general quality of the Care Programme Approach offered to Mr. Y to be of a poor overall standard. As a basic minimum care plans should have been developed to address:

- medication non compliance;
- service user non engagement;
- mental health deterioration;
- service user and carer education about Schizophrenia;
- a detailed contingency plan;
- a crisis plan.

312. Trust Internal Investigation Report (2004) P. 17 and GP Record PP. 42-43

313. Trust Internal Investigation Report (2004) P. 17 and GP Record P. 29

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Assessment and care planning were superficial and did not go far enough to provide Mr. Y with the care and treatment that he needed. Contingency and crisis planning were, in practical terms, absent and consequently the treating team spent six months deliberating over how to engage Mr. Y when a clear planning process could have specified when a Mental Health Act (1983) assessment was indicated, who should coordinate the process, and how the process was to be managed.

Summary

It was evident from examining the Trust E-Pex record that Care Coordinator 1 and other members of the multidisciplinary team attempted to visit Mr. Y on a regular basis. It was also evident however that Mr. Y's mental state was deteriorating and that a more assertive approach was needed if he was to receive the care and treatment that he needed.

Witnesses told the Independent Investigation Team that Mr. Y had a presentation that made them feel uneasy when meeting with him in his home. It is evident from reading the clinical record that it was decided that Mr. Y needed to be approached in a sensitive manner. This factor may have contributed to members of the treating team seemingly keeping Mr. Y 'at arms length'. However this factor should have been considered when assessing Mr. Y's potential risk and the plan that would be required to manage it.

There are four significant findings:

1. Mr. Y's presentation indicated that he was eligible for Enhanced CPA; this level would have been commensurate with his presentation and assessed need;
2. clinical assessment, care planning and case management strategies were under developed and did not meet the requirements of the Care Programme Approach;
3. roles and responsibilities were not made explicit;
4. the CPA process took place without an appropriate overarching management plan which could have ensured a more sure-footed and timely intervention once it was apparent Mr. Y required assessment under the Mental Health Act (1983).

13.1.4.2.2. Prior to the Death of Mrs. Y Senior

Scott Clinic

The Trust provided this Investigation with the Effective Care Coordination policies for both mainstream and forensic services, both were due for review in 2007 (dated 2006-2007 for the

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general CPA policy and 2005-2007 for the forensic CPA policy).³¹⁴ These policies covered some of the time Mr. Y was an inpatient at the Scott Clinic. The Independent Investigation Team did not see a CPA policy which was current at the time of his mother's death.

At the time Mr. Y killed his mother in March 2010 the new national CPA guidance of 2008 had been issued. This guidance reduced Standard and Enhanced CPA to one single level to be applied only to clients requiring more complex care plans. The new guidance explicitly spelled out the type of service user who should be subject to the new CPA. In addition it more specifically defined the role and competencies expected from Care Coordinators.

Roles and Responsibilities

The presence of Care Coordinator 1 during CPA reviews at the Scott Clinic is recorded within the Effective Care Coordination documentation between February 2004 and the 6 January 2006.³¹⁵ Whilst it is not clear when Care Coordinator 1 left the employ of the Trust it was probably within six months of Mr. Y's admission to the Scott Clinic, and her presence at CPA reviews was recorded in error. This means that Care Coordinator 1 was not acting as a Care Coordinator for the majority of this period.

The Care Coordination process did not for the most part appear to have a designated Care Coordinator. The Independent Investigation Team was told during interviews with witnesses that the Care Coordinator was Consultant Psychiatrist 1 at the Scott Clinic. This Investigation was also told that CPA meetings were highly collaborative and collegiate, with each multidisciplinary team member able to express their views and influence the CPA assessment and care plan. The Independent Investigation Team makes the observation that this is good practice; however Care Coordination comprises a specific set of responsibilities that supports the management of a collaborative plan of care. Responsible Consultants do not typically take on the role of Care Coordinator, as they have specific responsibilities both in relation to the service user's treatment plan, and the Mental Health Act (1983 and 2007). In addition they are unlikely to have the time to commit to both managing and coordinating the inputs of other disciplines and agencies or spend the required amount of time with the client. The Independent Investigation Team was told during witness interviews that Consultant Psychiatrist 3 was the *de facto* Care Coordinator for all his patients in the Scott Clinic. Trust

314. Effective Care Coordination policies (2006)

315. Trust Record PP. 327-344

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CPA policy for 2006-2007 stated that “*Generally the Care Coordinator will be a member of a community team best placed to fulfill the responsibilities of the role*”.³¹⁶

Care Coordination

Taking the above points into account, it is unlikely that Consultant Psychiatrist 3 was able to fulfil all of the requirements of CPA. These requirements include:

- regular communication and consultation with carers and family members, the forensic service CPA policy (2005-2007) stated that relatives and carers should be able to have reasonable access to the Care Coordinator within office hours;
- regular communication, consultation and rapport building with the service user;
- multidisciplinary risk assessment and management planning;
- care planning and care plan monitoring and review;
- liaison and coordination within the treating team;
- communication, consultation and liaison with other agencies, e.g. primary care, Ministry of Justice, Housing, Local Authority;
- commission and secure funding to meet identified needs;
- coordination and management of Section 117 requirements;
- development of care plans prior to a Mental Health Tribunal;
- CPA documentation development and maintenance.

When Care Coordinator 1 left the employ of the Trust it was not clear why the Community Mental Health Team (CMHT) did not replace her with another member of staff. The Independent Investigation Team was unable to ascertain the reasons for this not happening. It is possible that the CMHT withdrew as Mr. Y was being treated in a tertiary forensic service. However it was evident that Mr. Y's rehabilitation and discharge was being considered from an early stage and active Care Coordination should have been part of this process. The extant forensic CPA policy (2005-2007) did not provide detailed guidance with regard to how the interface between a CMHT and forensic inpatient service should be managed from a Care Coordination point of view.

Consultant Psychiatrist 3 continued in the role of Care Coordinator until the point of Mr. Y's discharge from the Scott Clinic. Five days before the discharge a Care Coordinator appears to

316. Effective Care Coordination policies (2006) P. 17

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have been allocated from the Forensic Integrated Resource Team (forensic community team). There is no record of this person (Care Coordinator 2) having been part of any preceding Effective Care Coordination reviews or discharge planning processes. Care Coordinator 2 was not able to meet with Mr. Y prior to the discharge taking place and was neither able to discuss the role of the Care Coordinator with him. It was not good practice to leave the allocation of a Care Coordinator so late in the discharge process. Mr. Y was about to experience a significant milestone in his care pathway and this should have been Care Coordinated by a person who knew him well.

Documentation, Assessment and Care Planning

The Independent Investigation Team has seen records relating to seven Effective Care Coordination reviews between the dates of the 23 March 2004 and 27 November 2006, all of which took place during Mr. Y's time in the Scott Clinic.³¹⁷ The review documentation in each case consists of:

- a list of who was involved in Mr. Y's care;
- a list of who attended the meetings;
- care plan review documents;
- health and social care needs assessment documents;
- risk assessment documents;
- action plan documents;
- notes on Mr. Y's views on his care (for five of the reviews only).

On the face of it, the CPA documentation looks to have been developed in keeping with the Trust Effective Care Coordination policy insofar as all of the requisite paperwork is present in the inpatient record. However on closer examination it becomes evident that the content of the Care Coordination documentation does not change a great deal from one review to the next and that much of the text has been cut and pasted from one review to another. A particular example of the 'cut and paste' approach that was taken to CPA documentation is the recurrent mention of Care Coordinator 1 being present at CPA meetings for approximately 18 months after she had ceased to be employed by the Trust. Other examples include text boxes for care planning, risk prevention and risk management strategies remaining fixed over time. Whilst this could be due to Mr. Y's mental state remaining stable,

317. Clinical Records PP. 3,4, and 5

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it could also be evidence of a treating team which was not working within the true ethos of CPA and that consequently documentation was not being reviewed in a dynamic manner. It is of particular note that the CPA documentation developed for both the pre and post discharge reviews contain unchanged text from previous CPA meetings to the extent that it is difficult to detect any changes to the management plan brought about by Mr. Y reaching a significant milestone in his care pathway.

The overarching CPA plan in the early stages was focused on the stabilisation of Mr. Y's initially disturbed behavior, the establishment of his treatment regimen, and the provision of an in depth clinical assessment. It was evident to the Independent Investigation Team that detailed assessments were conducted by several members of the multidisciplinary team. Whilst some of them were far from timely (the Psychology assessment did not occur until September 2004) the work was significant. It can therefore be seen as a missed opportunity that these assessments and recommendations did not frame the focus of the Care Programme Approach and that these assessments appear to have influenced the CPA in the most superficial manner only.

As time went on the care planning focus became more orientated towards improving Mr. Y's social skills in line with the Clinical Psychologist's 'Theory of Mind' formulation. It also focused upon increasing levels of escorted leave from the ward and activities off the ward. Care plans were supportive of Mr. Y's preferences and identified ways in which he could develop coping skills by incorporating exercise such as running into his daily routine. However the care planning process failed to consider systematic interventions and management strategies around identified potential areas of risk and care and treatment need. These areas were identified in the CPA documentation as being:

1. the continued risks presented by Mr. Y to his mother due to identified family dynamics issues;
2. Mr. Y's ongoing ambivalence regarding his medication regimen;
3. Mr. Y's limited connection with his own feelings and the feelings of others;
4. Mr. Y's limited insight into his illness and refusal to engage in the CPA process.

The CPA plans in the extant documentation record statements such as:

- *“Review his mental state*

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- *Unescorted leave in community*
- *Medication*
- *Engage in gym and other activities*
- *Psychological assessment*
- *Build therapeutic relationship*
- *Occupational Therapy input”*.³¹⁸

The problem with this approach is that the plans appear to have been comprised as a simple list of ‘statements of intent.’ The plans did not set out an overarching aim or a set of objectives. These simple lists did not set out the required interventions and neither did they set out the method for review. This is a significant omission. The Independent Investigation Team speculated that the treating team appeared to have mistaken activity for meaningful intervention. The clinical record does not detail how Mr. Y’s care plan was implemented, or how it was reviewed. It would appear that the care plan was not reviewed against a clear set of objectives and therefore it is difficult to see what change, if any, the treating team thought they were effecting. This is of particular significance in that Mr. Y remained unengaged with the CPA process for a great deal of the time, remained isolative and withdrawn. It is difficult to understand how Mr. Y’s condition improved whilst at the Scott Clinic as the CPA documentation remains relatively static over time providing no details about his actual progression. The Independent Investigation Team was left with the impression that Mr. Y may not have changed substantially and that it was the perception of the treating team that changed with regard to the significance of Mr. Y’s problems.

Whilst an inpatient at the Scott Clinic Mr. Y did not attend his CPA review meetings, the only exception to this being the pre-discharge meeting held on the 27 November 2006. For the first three review meetings (22 March 2004, 22 April 2004, and 4 October 2004) Mr. Y refused to sign the review documentation or engage with the process at all. It remains unclear as to how Mr. Y was involved in his care and treatment and who, if anyone, discussed his Care Programme Approach with him.

Mr. Y’s mother and aunt are recorded as not being present for the first two CPA reviews, but that they did attend the last five. There is however very little evidence of their active

318. Trust Record PP. 275-311

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involvement in these reviews. In most instances they are noted to be happy with the progress made. That they were invited and attended the reviews is good practice, and the Scott Clinic is to be commended for this. It is however unfortunate that more does not appear to have been made of this opportunity. A review with multiple professionals can be quite a daunting experience, and it may be difficult to express ones views or concerns. There is no evidence of the mother's views being sought outside of the review process, or questions being asked to evaluate whether she found the review process helpful. Furthermore the recognition of her as a past victim, and potential future victim, is not acknowledged beyond a superficial level in the CPA assessment, care plan or risk documentation. This was a significant omission given his index offence, and should have been addressed.

A pre discharge Effective Care Coordination review was held on the 27 November 2006. A gradual transition to community accommodation was planned "*in terms of theory of Mind difficulties*".³¹⁹ A post discharge Effective Care Coordination review was to be held if Mr. Y achieved his conditional discharge.

Mr. Y was conditionally discharged from his Section 37/41 on the 15 December 2006. At this stage Mr. Y was allocated to Care Coordinator 2's caseload. There is no evidence within the CPA record to suggest that the terms of the conditional discharge were incorporated into an ongoing care and treatment management plan. The post discharge review meeting held on the 25 January 2007 did not appear to consider the implications of the terms of the conditional discharge and there is no written evidence to suggest that these conditions were incorporated into the Care Programme Approach. The extant documentation of the post discharge review is virtually identical to that of pre discharge review and it is evident that the nine terms of the conditional discharge were not addressed.

It is a fact that Mr. Y was discharged from the Scott Clinic in December 2006 without ever having met his new Care Coordinator, with no finances sorted out, and medication for a single day only. At this stage Mr. Y had not been registered with a GP and therefore his prescription could not be issued and neither could any sick certificate notification for finance benefits. It was not good practice at the point of such a significant transition to have overlooked such fundamental basic building blocks of care provision. This is additional

319. Trust Record P. 224

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evidence that demonstrates a robust Care Programme Approach was not in place. It must be noted however that Care Coordinator 2, who was new to her role as Mr. Y's Care Coordinator, diligently visited Mr. Y several times a week during the first six weeks after his discharge to retrospectively put key interventions in place. This was good practice.

Community Care Post Discharge from the Scott Clinic

Roles and Responsibilities

Mr. Y was conditionally discharged from the Scott Clinic under the care of Consultant Psychiatrist 3 who was also the Responsible Medical Officer. The Social Supervisor had been involved with Mr. Y throughout his time as an inpatient and could provide continuity of care. Care Coordinator 2 was new to the case and entered the CPA process at a late stage once Mr. Y was at the point of leaving the Scott Clinic for a placement in the community. Once in the community Mr. Y's ongoing care and treatment needs were provided for, and monitored by, this multidisciplinary 'triad'.

Each member of this 'triad' had particular roles and responsibilities. Put in the most simple of terms; Care Coordinator 2 was responsible for all aspects of Care Coordination (these have been set out above). The Responsible Medical Officer and Social Supervisor were responsible for implementing and supervising the plan around the conditional discharge. The Independent Investigation Team found it difficult to identify how this 'triad' discharged their roles and responsibilities in a systematic and effective manner, especially when the absence of any systematic planning was evident.

It was clear from reading through the CPA documentation produced on the 11 January 2007 that a huge reliance for Mr. Y's ongoing monitoring and review was to be placed upon his supported living arrangements at Imagine. The responsibility for ensuring that Imagine received a detailed handover and specific plan relating to the implementation of the terms of the conditional discharge rested upon the collective shoulders of the 'triad'. It would appear that in the absence of any coherent, written plan that this was not achieved effectively. This finding is supported by the fact that the workers at Imagine when interviewed by this Investigation expressed confusion when discussing roles and responsibilities in relation to the terms of the conditional discharge. They also expressed a degree of confusion as to what all of the terms and conditions actually were.

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At the point of Mr. Y's discharge on the 20 December 2006 it was agreed that the Care Coordinator would visit him once a week, that the Social Supervisor would visit him every two-three weeks and that Consultant Psychiatrist 3 would meet with Mr. Y every four-six weeks.³²⁰ Eventually this level of contact frequency was to decrease to a once weekly visit from either his Care Coordinator or Social Supervisor who each alternated on a bi-weekly basis.

Care Coordination

It became evident at interview that neither Care Coordinator 2 nor Care Coordinator 3, (who took on the case in April 2009), met with Mr. Y's mother. At interview the Independent Investigation Team was told that the ongoing liaison with, and support to, Mrs. Y Senior was the role of the Social Supervisor. It was evident that the terms of the Conditional Discharge, as they related to the safety of Mr. Y's mother, were not considered to be part of the Care Coordination role. Mrs. Y Senior attended the Effective Care Coordination Reviews whilst her son remained an inpatient at the Scott Clinic. Following his discharge she ceased her attendance. There was no explanation given to the Independent Investigation Team as to why this was the case and consequently Mrs. Y Senior was effectively excluded from the process.

Both Care Coordinators described ongoing liaison with Imagine, which took place on a fortnightly basis, and occurred prior to the pre-arranged meeting with Mr. Y himself. It was evident that the GP was communicated with on a regular basis; however this communication regarding Outpatient and Effective Care Coordination Reviews appeared to be made by Consultant Psychiatrist 3.

The relative absence of CPA documentation made it difficult for the Independent Investigation Team to understand how Care Coordination was managed. Significant issues regarding Mr. Y's accommodation and Supported Housing have been identified by this Investigation. These issues led to the breaching of the terms of Mr. Y's conditional discharge. Had Care Coordination been more robust then these shortcomings may have been prevented. These issues are examined in full in the Housing Subsection 13.1.9. below.

320. Trust Record PP. 178-200

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Documentation, Assessment and Care Planning

Throughout Mr. Y's time with Imagine he was acknowledged as being subject to Enhanced Care Programme Approach (the new single level of CPA post 2008) and had a multiagency team involved in his care.

Unfortunately the Independent Investigation Team could not be provided with copies of a full set of the Trust's contemporaneous notes or CPA review documentation for this period (despite the Trust's best efforts). Supporting documentary evidence was taken from the Imagine records, the GP records and the Trust Internal Review (which clearly had access to the full records for this period). Evidence was also obtained from witness interviews. It was however possible identify that eight CPA reviews took place during this period of time. These reviews took place on the following dates:

- 11 January 2007
- 19 April 2007
- 1 November 2007
- 3 April 2008
- 18 September 2008
- 2 April 2009
- 24 September 2009
- 11 March 2010

Full review documentation was only seen for two of these reviews within the extant Trust-held record (11 January 2007, 17 April 2007). Details of the other reviews are drawn from the Imagine and GP-held records.

Where CPA documentation is provided, the full range of forms and documents are completed. The care plans provide a clear list of the areas of care and risk management to be provided, and early warning indicators and contingencies to be enacted in the event of an emergency. This was identified by the Independent Investigation Team as being good practice. Unfortunately the format that the care plans and risk management strategies take remain that of 'statements of intent' rather than a comprehensive breakdown of the specific interventions required. The specific problems regarding assessment and care planning are examined below.

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11 January 2007. An Effective Care Coordination post discharge CPA review was held on this day. The Independent Investigation Team were concerned that the post discharge review commenced on the 11 January 2007 remained substantially unaltered from the pre discharge review. It was recorded *“Poor theory of mind issues ongoing. Staffed accommodation which is able to provide support and monitoring. Monitoring and support through Conditional Discharge”*.³²¹ No detailed plan of intervention was developed and it was unclear who was going to be responsible for interventions and supervision and how these were to be monitored.

19 April 2007. Mr. Y was present at this review. He did not express any concerns and was happy with his current placement at 123 Moscow Drive supported by Imagine. His mental state was noted to have remained stable, however he had developed a routine which was quite isolative and was spending quite a lot of time on his own. There were no revisions made to the care plan and the CPA documentation remained largely unaltered. Every clinical record entry made by both Care Coordinator 2 and Social Supervisor 1 between the 11 January 2007 and the date of this review commented on their concerns about Mr. Y’s social isolation. On the 13 March Social Supervisor 1 wrote in the CMHT record that she *“felt uneasy”* about Mr. Y’s isolation and that *“I feel he still presents a risk in keeping things to himself and letting them build up until its too late”*.³²² There is no evidence to suggest that these concerns were discussed at this review meeting. It would have been good practice for a specific care plan to have been developed at this stage to address this issue.

1 November 2007. The main points of the Effective Care Coordination Review held on this date were:

- *“To continue living at Moscow Drive 24hr supported housing.*
- *To see CPN for arranged appointments.*
- *To see Social Supervisor for arranged appointments.*
- *Access to 24hr crisis intervention”*.

No changes were identified to the care plan.³²³ On the 21 November 2007 Social Supervisor 1 visited Mr. Y at 123 Moscow Drive. He appeared to be progressing as usual. She however

321. Trust Record PP. 178-200

322. CMHT Notes Post Discharge P. 5

323. GP Record P. 101 and PP. 206-207 and Trust Record PP. 205-

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recorded that *“I still worry that if he was experiencing any symptoms he would not discuss them with anyone. This to me is part of the ongoing risk with ... [Mr. Y]”*.³²⁴ It is unclear whether or not she expressed these concerns at this review meeting or at the next meeting on the 3 April 2008. Whether she did, or whether she did not, her concerns were not recorded within the CPA documentation and did not inform Mr. Y’s ongoing management strategy.

3 April 2008. Mr. Y attended for his routine Effective Care Coordination review with Consultant Psychiatrist 3. It was recorded that Mr. Y was meeting with his mother every six weeks and was commencing self medication. The new Social Supervisor (Social Supervisor 2) met with him every fortnight. No concerns had been expressed by the staff at 123 Moscow Drive. It was recorded that Care Coordinator 2 was now visiting Mr. Y on alternate weeks to those of Social Supervisor 2.

The Care Plan was reviewed; it noted the following:

1. Signs of relapse: feeling that he is being talked about, being irritated by those around him, and feeling tired.
2. Crisis Plan: this would comprise an early review by the Care Coordinator/Social Supervisor and Consultant Psychiatrist 3. A crisis situation would also require increased support and a review medication.
3. Contingency Plan: this was to admit to the Scott Clinic.
4. Summary of Risk Intervention: Mr. Y’s mental state was recorded as being stable. It was also recorded that Mr. Y was living in 24 hour supported accommodation and that he was receiving weekly support and monitoring of his mental state from the Scott Clinic.
5. Medication: Mr. Y was taking Olanzapine 10mg at night which was being prescribed by his GP (he was about to commence his self-medication regimen).
6. Plan: Mr. Y was to see Care Coordinator 2 fortnightly and Social Supervisor 2 fortnightly on alternate weeks. Mr. Y was to continue to see Consultant Psychiatrist 3 every three months and for his case to be reviewed on a six-monthly basis.³²⁵

The Independent Investigation Team would have expected to see a medicines’ management plan in place for Mr. Y as he commenced his self-medication regimen. This was a significant omission as non-compliance had been identified as being a significant risk to any future

324. CMHT Notes Post Discharge P. 59

325. GP Record PP. 93-97

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relapse of his mental illness. Another factor that appears to have been overlooked was that on 11 February 2008 Care Coordinator 2 visited Mr. Y at Moscow Drive. Imagine staff said that Mr. Y was becoming more isolative and they would attempt to address this with Mr. Y and try to negotiate specified times when he would spend time with staff and other residents.³²⁶ Once again this issue was known to a member of the treating team, and once again there appears to have been no attempt to assertively manage the situation by qualified professionals.

18 September 2008. No changes were made to the CPA documentation. The letter sent to the GP stated that Mr. Y was making progress and that no problems had been identified.

2 April 2009. No CPA documentation exists for this review. However a letter to the GP stated that Mr. Y was making progress and that there was no change to his condition. It was noted that Care Coordinator 2 was leaving the team and was being replaced by Care Coordinator 3. Care Coordinator 3 met with Mr. Y every two weeks to monitor his mental state.

24 September 2009. An Effective Care Coordination meeting was held prior to Mr. Y being moved from 123 to 133 Moscow Drive. The Independent Investigation received no documentation for this review, but it was apparently recorded. A brief letter was written to the GP stating that Mr. Y's address was due to change and that he would have "*much the same*" level of support at the new accommodation.³²⁷

The Independent Investigation Team cannot know with certainty whether or not a care plan was devised around this move as no documentation exists. However it would appear that Mr. Y's visits from both Care Coordinator 3 and Social Supervisor 2 remained at the same level of regularity and that no additional inputs were considered to support Mr. Y at this significant milestone in his care pathway. This is a significant omission as Mr. Y's risk assessments all cite change to his environment as being a potential factor for relapse.

11 March 2010. Consultant Psychiatrist 3 wrote to inform the GP that Mr. Y had attended for his routine CPA review. The meeting had also been attended by a worker from Imagine and

326. CMHT Notes Post Discharge PP. 56-57

327. GP Record PP. 65-66

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the ‘Bridge Builder’ from Imagine. The Social Supervisor was also present. The focus of the meeting was to try and move Mr. Y into a more independent mode of living. He was maintaining his flat and was reported to have good daily living skills. Mr. Y was continuing to receive support from his Care Coordinator. The plan was to review Mr. Y in three-months time on the 24 June and the next CPA review was scheduled for the 23 September.³²⁸

No CPA documentation exists for this review. The Independent Investigation Team found the lack of this clinical record to be of grave concern. It is apparent that a significant amount of work was afoot to move Mr. Y from 133 Moscow Drive to an independent flat. There is no evidence of any care plan to support Mr. Y at this stage. The Imagine record details Mr. Y’s growing anxiety as a second move within a five-month period was being pursued on his behalf. The paucity of the extant Trust clinical record is unfortunate on two counts:

1. it is not possible to know with certainty how the Care Programme Approach was supporting Mr. Y at this time;
2. it is not possible to understand which agency was leading the pursuit of the move for Mr. Y to access more independent accommodation.

At this stage it would appear that the Care Programme Approach and Care Coordination *per se* failed to ensure both the clarity of inter agency communication and coordination, and the support of Mr. Y. It must be noted however that Care Coordination was not the only mechanism that failed to operate at this stage. The terms of the conditional discharge were not being supervised appropriately and this function did not fall within either the role or responsibility of the Care Coordinator.

13.1.4.3. Conclusions

13.1.4.3.1. Prior to the Death of Mr. Y Senior

The Care Programme Approach was implemented in a superficial manner. This ensured that Mr. Y was not appropriately assessed and no effective interventions were either identified or delivered. The failure to develop a detailed contingency and crisis plan meant that the treating team spent six months deliberating about what to do rather than making certain that assertive action was taken which ensured Mr. Y obtained the care and treatment that he needed. The Independent Investigation Team concurs with the conclusion of the Trust Internal Review

328. GP Record PP. 60-61

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(2004) which said “*had these protocols been applied correctly [CPA and risk], then Mr. Y’s care and treatment could have been improved and enhanced*”.³²⁹

The Independent Investigation Team also concluded that the failure to implement appropriate CPA resulted in a significant delay to Mr. Y’s psychosis being treated, and this may ultimately have led to his illness becoming more intractable in the years that were to follow.

13.1.4.3.12 Prior to the Death of Mrs. Y Senior

The Trust Internal Review (2010) did not examine Mr. Y’s care and treatment through the lens of the Care Programme Approach and so it is not possible to comment upon either its findings or conclusions for this particular Subsection.

Scott Clinic

The Independent Investigation Team concluded that the Care Programme Approach was not implemented in the true meaning of the guidance whilst Mr. Y was an inpatient at the Scott Clinic. The *de facto* Care Coordinator, Consultant Psychiatrist 3, was unable to fulfil all of the requirements that the role necessitated. Whilst documentation was completed it was evident that a ‘cut and paste’ approach was often taken whereupon clinical information was replicated from one document version to another with no evidence of either review or reflection having taken place.

A close examination of the clinical record shows that numerous assessments took place, however these assessments did not evolve into detailed care and management plans. Nonetheless Occupational Therapy worked with Mr. Y in a useful manner to develop both his social, and activities of daily living, skills. Attempts were also made by the Senior Occupational Therapist to work with Mr. Y on his ‘Theory of Mind’ issues. The input provided by Occupational Therapy was significant, but this is the only example of any consistent therapeutic input that Mr. Y received whilst at the Scott Clinic. However it has to be noted that even this input was delivered in the absence of a structured care plan that identified treatment aims and objectives.

329. Trust Internal Investigation Report (2004) P. 17 and GP Record P. 29

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It is difficult to understand how the Care Programme Approach affected any therapeutic input from the ward nursing staff. The nursing record offers few examples of any care planning aside from some rudimentary activities of daily living and medicines management plans. It is far from easy to link these plans to the Care Programme Approach Reviews and neither is it possible to track the implementation and review processes, if any, which ensued.

The allocation of a community-based Care Coordinator occurred at the point of Mr. Y's conditional discharge from the Scott Clinic. This allocation should have taken place, at the latest, at the time Mr. Y's discharge was first being planned. It should not have been the apparent afterthought that it seemingly was. This lack of timely allocation would have contributed to the poor levels of discharge planning that occurred both prior to, and immediately after, Mr. Y's departure from the Scott Clinic.

Community Care Post Discharge from the Scott Clinic

The extant Care Programme Approach documentation for this period is sparse. However the extant Trust record, in combination with the GP record and the Imagine record, evidences the fact that the Care Programme Approach existed in name only. Care plans in the true meaning of the sense are absent and Care Coordination did not take place. Mr. Y encountered significant milestones on his care pathway that were neither recognised nor managed in a systematic manner.

There is no evidence to suggest that Care Coordinators 2 and 3 actually coordinated the inputs of either the treating team or any of the other agencies involved (e.g. Imagine and Local Authority funding departments) to ensure all Mr Y's needs were properly met. The Care Coordinator role appeared more like that of a traditional Community Psychiatric Nurse in that it appeared to focus exclusively upon mental state and medication compliance monitoring.

On the 27 February 2007 Consultant Psychiatrist 3 wrote to the Park Lodge CMHT Manager with a formal request for Mr. Y to be accepted onto the caseload, the reason being that it was thought Mr. Y would progress better within a mainstream service. The Park Lodge CMHT accepted the referral and was happy to place Mr. Y onto the caseload as soon as it was

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deemed appropriate by the Scott Clinic.³³⁰ This referral was not pursued further and Mr. Y remained with the Forensic Integrated Resource Team. It is possible that had this referral been pursued Mr. Y would have been in receipt of a more robust Care Programme Approach process. The Independent Investigation Team concluded that the Care Programme Approach was understood poorly by all of the witnesses that gave evidence to this Investigation and that this appeared to be part of the prevailing culture of the Scott Clinic Service.

That Mr. Y lived successfully in the community for three years prior to the killing of his mother cannot be denied. It was evident that both the treating team (forensic services) and the care team (Imagine) worked with Mr. Y to facilitate his rehabilitation and recovery. It was evident from a close examination of the clinical record that visits to Mr. Y took place on a regular basis and that every attempt was made to build a therapeutic rapport with Mr. Y. However this activity took place in the absence of any systematic planning and interagency liaison.

The Care Programme Approach is an essential safety net of care that is required to be in place for service users such as Mr. Y. The Care Programme Approach is designed to proactively facilitate recovery, provide timely intervention in the event of relapse, and to ensure a coordinated care and treatment approach is understood by the service user, carers and all other professionals and agencies involved with the case. The strength of the Care Programme Approach is that it provides a systematic and widely communicated care, treatment and management strategy. The Independent Investigation Team concluded that in the case of Mr. Y this essential safety net of care failed to operate to the ultimate detriment of Mr. Y's case management, care and treatment.

- ***Contributory Factor Four. It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y appeared to be working in silos to the detriment of Mr. Y's overall case management, care and treatment.***

330. Trust Record PP. 10-11

13.1.5. Risk Assessment

13.1.5.1. Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual service user. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that 'positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach ... any risk related decision is likely to be acceptable if:

- *it conforms with relevant guidelines;*

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- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed”*.³³¹

As long as a decision is based upon the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Mersey Care NHS Trust Policy (June 2009 - December 2012)

The Independent Investigation Team was not supplied with a clinical risk assessment policy that covered the period prior to 2009. However it was obvious that the June 2009 - December 2012 policy took into account all previous national best practice guidance and that it was a successor document to earlier policies that had also taken national best practice into account.

The policy makes explicit links between clinical risk assessment and the Department of Health 2007 guidance (of which the co-author is also the Trust policy author), safeguarding children national and local policy guidance, and Royal College of Psychiatry publications.

Professionals reading the policy are also referred to:

- *“The Mental Health Act 1983 and its amended form issued in 2007*
- *The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Amended Mental Health Act 2007)*
- *The respective Codes of Practice of the above Acts of Parliament*
- *The Human Rights Act 1998 and the European Convention on Human Rights]*

331 Best Practice in Managing Risk; DoH; 2007

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- *The Violence, Crime and Victims Act 2004*
- *The Care Programme Approach*
- *All Mersey Care NHS Trust policies on the Mental Health Act 1983 as appropriate*.³³²

This policy and procedure states that it “*applies to all practitioners in Mersey Care NHS Trust, regardless of qualifications and experience, who are required to assess and manage clinical risks as a part of their duties, whether on Trust premises or not*”.³³³

The Policy has this to say about risk assessment methodology: “*Positive risk management of service users will be promoted but only when (i) there is a shared and good understanding of the risks posed by the service user, (ii) when risk can be effectively and repeatedly assessed and there are the resources to manage the risk and protective factors identified as relevant to the case at hand, and (iii) where the outcome of assessment and management activity will be an improvement in the service user’s quality of life and mental health over time.*”

Risk is an unavoidable component of the life of any individual and it is neither possible – nor desirable – to remove all risk from the experience of service users. However, members of the public have a right to be protected from any significant harm that may be posed by a service user of Mersey Care NHS Trust, where those rights are legitimately subject to (a) the limitations of available information and (b) the capacity of Trust staff to anticipate often complex clinical risk”.³³⁴

The policy states clearly that risk assessment is integral to the Care Programme Approach and that the general format provided within the policy seeks to enhance and support it. The policy sets out five elements that a clinical assessment should always make reference to.

1. A clear statement about the nature of the harmful outcome to be prevented.
2. A brief summary of the risk and related protective factors that are relevant to the harmful outcome being prevented. Tools, such as the CPA risk assessment are recommended, or “*a technically demanding tool like the START, can be used.*”
3. A risk formulation, in which the practitioner or multidisciplinary team, provides an account or explanation for the risks presented by the service user.

332. POLICY AND PROCEDURE FOR THE USE OF CLINICAL RISK ASSESSMENT TOOLS P. 4

333. POLICY AND PROCEDURE FOR THE USE OF CLINICAL RISK ASSESSMENT TOOLS P. 4

334. POLICY AND PROCEDURE FOR THE USE OF CLINICAL RISK ASSESSMENT TOOLS P. 5

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4. A risk management plan will be linked directly to the risk and protective factors used in the risk formulation. *“The plan will provide suggestions of treating strategies designed to repair or restore psychological (and/or physical) functioning”*. The plan will provide suggestions for supervision and monitoring and will identify warning signs of relapse and suggestions about what might be done if the situation arises.
5. A review of the risk management plan should examine how effectively the risk is being managed and be outcome based in terms of expected levels of improvement.³³⁵

Risk assessments were advised at the following junctures (the policy states that ‘key turning points’ include but are not limited to the following):

- *“first referral to secondary mental health services*
- *re-referral due to a deterioration in mental state*
- *on admission into acute inpatient services*
- *pre-leave of absence trip from inpatient services*
- *pre-discharge from inpatient services*
- *when mental state or risk management appears to be deteriorating and the concerns of staff about the safety of the service user increase”*.³³⁶

The policy sets out the expectation that a Level One assessment (a brief 5-30 minute exercise) should commence at the point of the initial referral for all service users. A Level Two assessment (requiring more in-depth procedures) should take place within one month of referral, leading to a formulation and risk management plan. A Level Three assessment (an in-depth process that may take a least a day to complete) should take place if a service user’s risk profile changes in a manner that raises concern.

The policy sets out in appendix 1 the clinical risk assessment tools that were acceptable for use in Mersey Care NHS Trust. The Health of the Nation Outcome Scale (HoNOS) was not included on this list.

The Independent Investigation Team found this policy to be evidence-based and of an excellent standard.

335. POLICY AND PROCEDURE FOR THE USE OF CLINICAL RISK ASSESSMENT TOOLS PP. 7-8

336. POLICY AND PROCEDURE FOR THE USE OF CLINICAL RISK ASSESSMENT TOOLS P. 10

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Health of the Nation Outcome Scale (HoNOS)

In 1993 the Department of Health commissioned the Royal College of Psychiatrists' Research Unit (CRU) to develop scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target "*to improve significantly the health and social functioning of mentally ill people*".³³⁷ The Royal College Psychiatry states that "*HoNOS-secure is specifically designed for use in health and social care settings such as secure psychiatric, prison health care and related forensic services, including those based in the community. Parts of the original HoNOS can be hard to interpret in secure settings, and this scale meets that need*".³³⁸ HoNOS and HoNOS-secure should not be viewed as risk assessment tools *per se*. Instead it allows the outcome of clinical risk assessment to be rated in terms of need for care and need for clinical risk management procedures.

13.1.5.2. Findings

13.1.5.2.1. Prior to the Death of Mr. Y Senior

Mr. Y was first seen by Consultant Psychiatrist 1 on the 28 March 2003 following a referral to secondary care mental health services by the GP. The provisional diagnosis at this stage was "*a psychotic illness, paranoid schizophrenia*".³³⁹ The Consultant wrote to the GP on the 4 April 2003 to say that a period of assessment would be required. It was noted at this stage that Mr. Y was not taking his Risperidone.³⁴⁰

Between the 28 March and the beginning of August 2003 Mr. Y's mental health continued to deteriorate and he failed to comply with his medication. The Independent Investigation Team cannot state with any degree of certainty what actually occurred during this period as it did not have access to the Day Hospital clinical record. However it would appear that Mr. Y did not receive a risk assessment until the beginning of August 2003 when Care Coordinator 1 took over the case.

A risk assessment was commenced on the 1 August 2003. There is no extant record of this; however the Trust Internal Review (2004) report stated that it was not completed. Another risk assessment was commenced on the 18 August 2003. On this occasion it was noted that

337. <http://www.rcpsych.ac.uk/training/honos/whatishonos.aspx>

338. <http://www.rcpsych.ac.uk/training/honos/secure.aspx>

339. GP Record PP. 54-55

340. Trust Internal Investigation Report (2004) P. 6

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Mr. Y experienced delusions of reference and persecution. It was also noted that he had paranoid ideas about his neighbours and members of his family. His psychosis was described as being untreated at the time of the assessment and the diagnosis was not clear. Mr. Y had some suicidal ideas, but no plans. He also had limited insight into his situation.

It was recorded that Mr. Y had a supportive family and that he was being monitored by Moss House. The summary of the risk assessment was as follows:

- *“Risk of aggression/violence – low*
- *Risk of suicide – low/moderate*
- *Risk of self neglect – low/moderate*
- *Other risks – low”.*

Mr. Y did not think he had any risk factors and he did not want his mother involved in a care plan *“so opinion not sought”*.³⁴¹

On the 31 October 2003 Mr. Y was visited at his home by Care Coordinator 1 and Consultant Psychiatrist 2. By this stage Mr. Y’s mental health was a considerable cause for concern within the treating team. This visit also served as a Care programme Approach review. A Health of the Nation Outcome Scale (HoNOS) was completed probably in lieu of a risk assessment. The following was recorded:

Aggressive 0

Self injury 0

Drinking and Drugs 0

Cognitive 0

Relationships 3

Daily living (left blank)

Physical 1

Hallucinations/Delusions 3

Depressed 1

Occupation and Activities (left blank)

Other Mental Behaviour 0

Living Conditions 0

341. GP Record P. 51

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It was noted that Mr. Y was not detainable at that time under the Mental Health Act (1983). Due to Mr. Y being highly paranoid it was advised that he needed to be approached “*very carefully and tactfully to build a rapport with him*”.³⁴² No revisions to the care plan were deemed necessary.

No further risks assessments appear to have been undertaken for Mr. Y. As can be charted from the Chronology in Section 11 of this report, Mr. Y’s mental health deteriorated steadily from the time of his referral in March 2003 to the killing of his father in February 2004. Mr. Y was not compliant with his medication and he engaged with mental health services on the most superficial basis. During this period it would have been good practice to have ensured that regular risk assessments were undertaken. It would have been good practice to have considered undertaking a risk assessment each at the following junctures:

- at the point of the initial referral to secondary care mental health services;
- at the point when it became apparent Mr. Y would not take antipsychotic medication;
- at the point of admission to the Day Hospital;
- at the point when Mr. Y’s engagement with secondary care mental health services became sporadic;
- on the allocation of Care Coordinator 1 (this was done)
- at the point of discharge from the Day Hospital;
- each time clinicians recorded their concerns about Mr. Y’s declining mental state;
- each time clinicians began to consider the need for a Mental Health Act (1983) assessment;
- at each CPA review.

It was the finding of the Independent Investigation Team that Mr. Y did not receive an appropriate degree of risk assessment between March 2003 and February 2004. Consequently no risk management plans were either considered or developed. The quality of the Care Programme Approach provided to Mr. Y was also poor and consequently Mr. Y’s care and treatment was not appropriately assessed, monitored or managed.

342. Trust Internal Investigation Report (2004) P. 17 and GP Record PP. 42-43

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13.1.5.2.2. Prior to the Death of Mrs. Y Senior

Scott Clinic

Mr. Y had eight recorded risk assessments conducted whilst he was an inpatient at the Scott Clinic. Three of these reviews included a HCR-20 (Historical-Clinical-Risk Management 20) risk assessment during 2006. The relatively late introduction of this risk assessment tool may have been due to a change in Trust policy and process coming into being at this time. The HCR-20 tool was designed to be used as a level three assessment by clinicians experienced in working with individuals who have a history of violent behaviour. The Independent Investigation Team noted that HoNOS and HoNOS-secure were also used as part the clinical assessment process.

Recorded clinical risk assessments took place on the following dates (the first assessment is set out in full):

- 1. 22 March 2004.** On this occasion Effective Care Coordination risk assessment documentation was used. Some of the boxes ticked appear not to have taken into account Mr. Y's presentation immediately after admission onto the ward and is therefore not accurate. The narrative part of the assessment was at odds with the 'tick box' section e.g. finances and medication compliance.

Key issues were identified as:

- acute psychosis with persecutory delusions
- previous disengagement from mental health services
- difficulty in gaining compliance with medication
- possible previous head injury
- financial difficulties
- previous heavy alcohol consumption

Protective factors were identified as being:

- compliance with medication
- level three observations
- a secure environment

Short term crisis management options:

- inpatient admission/medium security
- medical and nursing care
- medication
- level three observations

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- detention under the Mental Health Act (1983)

Long term risk management options:

- family dynamics
- personality issues
- possible head injury
- psychotic illness issues

Current risk was identified as:

- risk of self harm
- risk of violence to others

What might precipitate further violence was identified as:

- medication non compliance
- acute illness
- alcohol/drugs
- relationship issues

Observable indicators of repetition of offence:

- persecutory beliefs
- withdrawal
- non compliance

Current risk management strategy:

- reviews of mental state
- medication
- visits to gym-allow for further engagements

Mr. Y's overall risk was deemed to be:

- medium to high³⁴³

2. **22 April 2004.** A risk assessment took place as part of an Effective Care Coordination review. It was noted that 1:1 observations were being used to undertake assessment and to manage risk. It was noted that the care plan required revision due to Mr. Y's changing presentation, but it appeared to remain the same. A total score of 9 was obtained which indicates insufficient information to make an informed estimate of severity. A HoNOS was completed. It was as follows:

- *Aggressive 4*
- *Self injury 3*

343. Trust Record PP. 495-500 and PP. 502-513

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- *Drinking and Drugs 9 (score should a maximum of 4)*
- *Cognitive 3*
- *Relationships 2*
- *Daily living 0*
- *Physical 0*
- *Hallucinations/Delusions 4*
- *Depressed 1*
- *Occupation and Activities 0*
- *Other Mental Behaviour 0*
- *Living Conditions 0”*.³⁴⁴

3. 4 October 2004. As part of an Effective Care Coordination Review a HoNOS was completed with an overall score of seven. A HoNOS secure was also completed with an overall score of 13. The total risk related documentation stated: “*Risk Management: secure environment; graded exposure to risk; medication; psychological; SPECT scan of brain normal*”.³⁴⁵

4. 7 March 2005. The content of the documentation remained virtually unchanged from that of previous assessments. It was noted that Mr. Y was settled although he still remained isolative.³⁴⁶

5. 5 September 2005. An Effective Care Coordination risk assessment form was completed. The content of this form remained substantially unchanged from that first recorded on the 22 March 2004. However it was now recognised that factors leading to the index offence also included:

- acute psychosis and the giving away of his possessions
- heightened arousal
- disengagement from psychiatric services
- difficulties with medication compliance
- relationship issues with parents
- suppression of anger and difficulty in expressing and recognising feelings

344. GP Record PP. 29-30

345. Trust Record P. 458

346. Trust Record PP. 417-424

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- deterioration in social functioning
- lack of routine and increasing isolation
- personality issues/developmental disorder
- isolation and withdrawal
- previous communication of his needs through avoidance and defiance. *“Could be problematic... escalating the risk of violence”*.

Mr. Y's overall risk was deemed to be low.³⁴⁷

6. 6 February 2006. A risk assessment was conducted as part of the Effective Care Coordination Review. The CPA and the Historical-Clinical-Risk Management 20 (HCR-20) risk assessment tools were used together for the first time.

The Independent Investigation Team noted some significant contradictions when comparing the content of this document with those previously compiled. These included:

- the HCR-20 recorded no history of alcohol abuse, the previous assessments all stated that there was a significant history of heavy drinking;
- the HCR-20 placed a ‘?’ by his ability to sustain relationships, all previous assessments had noted this as being a problem;
- the HCR-20 put a ‘?’ next to early maladjustment, all previous assessments had indicated a developmental disorder;
- the HCR-20 put a ‘?’ next to compliance with previous supervision. Technically this was correct as Mr. Y had not been on a supervision order, but this was perhaps misleading as it was known Mr. Y had significant previous disengagement and non compliance issues when psychotic.

It was noted that Mr. Y had good levels of insight into his illness, but poor levels of insight into his difficulties, and that it was *“likely”* he would misread social situations and had the potential to engage in violent behaviour if placed in certain social situations as he was not able to modulate his reaction to stress.³⁴⁸

347.Trust Record PP. 400-411

348.Trust Record PP. 315-322

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7. **24 July 2006.** A risk assessment was conducted as part of the Effective Care Coordination Review.³⁴⁹ By this stage consideration was being given to moving Mr. Y back into the community and plans were being developed to facilitate this. The CPA and the HCR-20 risk assessment tools were used together. The content of the documentation remained the same as that prepared for the earlier 6 February 2006 assessment.

Plans focused around Mr. Y's exercise regimen as a coping mechanism and interventions (unspecified) were planned to support Mr. Y's goals for further unescorted leave. Mr. Y was maintaining regular contact with Occupational Therapy services. The plan was to continue assessing Mr. Y's ability to recognise emotions in both himself and others.³⁵⁰ However these plans were never developed beyond a simple list of 'statements of intent'.

Of concern to the Independent Investigation Team was the following work that was undertaken with Mr. Y on early warning signs self management. Mr. Y's coping strategies "*to prevent psychosis returning*" was "*going for a walk; talk to mum; listening to the radio*".³⁵¹ First: it is naïve to state that the above activities could actually prevent a psychotic relapse. Second: Mr. Y had previously when psychotic had ideas of reference from the radio, and when psychotic had killed his father and tried to kill his mother. It was not perhaps the best advice to support him in maintaining close contact with his mother if beginning to experience a relapse of his mental illness.

8. **27 November 2006.** The Effective Care Coordination Review held on this date served as the pre discharge meeting. A standard CPA risk assessment was completed which was identical to those of a similar kind that had completed at previous reviews. A HCR-20 was also completed which was good practice. It was evident that whilst the majority of the entries were the same as those for previous HCR-20 assessments Mr. Y was now being assessed as having increased levels of insight. Issues relating to his mother were mentioned briefly under 'Victim Issues' "*his mother is his surviving victim who has been involved throughout his admission. Home Office restrictions not to allow him to visit her home address*".³⁵² Concerns remained regarding Mr. Y's personality and theory of mind difficulties in that he misinterpreted situations and could act impulsively when he

349. Trust Record PP. 275-311

350. Trust Record P. 313

351. Trust Record P. 271

352. Trust Record P.225

Mr. Y Investigation Report

perceived a threat against him. He needed to be able to recognise both his emotions and those of others and to develop coping skills. It was recorded that Mr. Y's potential risk of violence "*appeared to be very specific to the interaction and the dynamics in his relationship with his parents*". Future risk factors were identified as being:

- "*Medication non compliance*
- *Acute illness*
- *Alcohol/drugs*
- *Relationship issues*
- *Misinterpretation of social situations and of threat towards him*".

"*Observable indicators of repetition*" were recorded as being: persecutory beliefs; withdrawal; non compliance; relationship issues; and physical violence. The plan was to monitor Mr. Y and to provide support and restrict his visiting and access to his mother's address. Long-term risk as recorded as requiring nursing staffed accommodation which would be able to support and monitor Mr. Y.³⁵³

The risk scenario case management form stated that Mr. Y would be monitored by the clinical team. Treatment and rehabilitation would be provided at the new placement with the support of the Crisis Service if required. It was also written "*deterioration of mental state. Changes in physical behaviour to demonstrate anger/happiness need to be picked up quickly*".³⁵⁴ How this was to be achieved, and by whom, was not specified. It was acknowledged that if Mr. Y's mental health relapsed then the consequences could be severe resulting in a death.³⁵⁵

It was apparent to the Independent Investigation Team that Mr. Y had been subject to risk assessment processes throughout his time as an inpatient at the Scott Clinic broadly in keeping with Trust policy and procedure. There were however some significant omissions in that Mr. Y did not appear to have been risk assessed until some four weeks after his admission, and a risk assessment could not be found to support Mr. Y's increasing Section 17 leave arrangements.

353. Trust Record PP. 221-229, 232- (241) 250

354. Trust Record P. 250

355. Trust Record P.251

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The Trust Internal Review (2010) into the care and treatment that Mr. Y received made the following finding about risk assessment and risk management at the Scott Clinic:

1. *“Staff reported that ... {Mr. Y} was difficult to read and understand. It was their impression that he could become easily frustrated if he felt others had misread his emotional state....there was no evidence to suggest ... [Mr. Y's] risk of harm and the relationship between this and his mental disorder was not fully understood.*
2. *Managed risk was too readily associated with the absence of acute mental illness. The Review Team looked for evidence that formulation included an acknowledgement of the relationship between risk and ... [Mr. Y's] related mental disorder and that this was reflected in his care management plan regarding his return to the community. There an absence of this kind of formulation in the case notes.*
3. *...when a service user is subject to a range of assessments it is usual practice for clinical teams to make sense of the information generated by these assessments. This is known as formulation. In ... [Mr. Y's] case the standard and quality of formulation exposed a lack of understanding of the risks ... [Mr. Y] posed and reveals a problem with the way in which the care team monitored him. This lack of understanding did not limit his progress towards conditional discharge.*
4. *[Regarding Theory of Mind]...Assessments highlighted this difficulty – but no intervention delivered to ... [Mr. Y] during the course of his inpatient stay altered this aspect of his clinical presentation... A Clinical Psychologist at the Scott clinic...concluded from the literature and her assessment of ... [Mr. Y] that it was not possible to effect change and that ... [Mr. Y's] difficulties most likely predated his schizophrenia, rather than being a function of it.*
5. *...the link between Theory of Mind deficits and/or ...[Mr. Y's] mental health problems in general – and the violent offences perpetrated against his mother and father in 2004 were not explored or understood. ...the formulation of ... [Mr. Y] did not lead to a full understanding of his future risk of harm particularly with regard to ... [Mr. Y's] mother despite the serious injuries she had previously received.*
6. *The relevance of ... [Mr. Y's] mental disorder and its correlation and consequences to future risk of harm was not adequately delineated and did not appear to inform future decision making towards conditional discharge or subsequent risk assessment and management”.*³⁵⁶

356. Trust Internal Investigation Report (2010). PP. 19-20

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The Independent Investigation Team concurs fully with the findings of the Trust Internal Review (2010). In addition it must be noted that significant areas of risk were identified with regard to Mr. Y whilst he was an inpatient at the Scott Clinic. It is apparent that these risk factors were accepted by the treating team as they were repeated over time in every risk assessment that Mr. Y was subject to. However the treating team did not develop the identified risk factors into a coherent set of risk management plans. There were two stages regarding risk management that were omitted.

First: there was a basic lack of formulation around risk. For example there was a fundamental failure to explore the reasons why Mr. Y killed his father and tried to kill his mother. In short; there was no evidence to suggest Mr. Y was understood any better on the day of his conditional discharge from the Scott Clinic, than on the day of his admission.

Second: the response to the identified risk factors was nothing more than a simple list of standard actions, mostly relating to informing or contacting people. They cannot in themselves be seen as comprising an appropriate risk management plan. For example, the risks to Mr. Y's mother were identified from an early stage. The initial (very basic) risk management plan was to introduce family therapy to explore the family dynamic. This was never done. Ultimately the only action to protect Mr. Y's mother was addressed in this simple statement at the point of his conditional discharge *"his mother is his surviving victim who has been involved throughout his admission. Home Office restrictions not to allow him to visit her home address"*.³⁵⁷

These omissions, and the unmitigated risks they represented, were to travel with Mr. Y as he moved back into the community at the point of his conditional discharge. At this stage Mr. Y's mental state remained poorly understood and he was in receipt of no effective risk management plan. These problems were to be compounded by substandard management arrangements regarding the terms of Mr. Y's conditional discharge and poor handover processes.

357. Trust Record P.225

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Community Care Post Discharge from the Scott Clinic

At the point of Mr. Y's discharge it was evident that handover processes were poor and the arrangements appear to have been rushed and lacking coordination. It is a fact that Mr. Y had been allocated a new Care Coordinator at the point of his conditional discharge. Care Coordinator 2 retrospectively arranged a meeting between herself, the Scott Clinic Senior Occupational Therapist and Imagine staff on the 28 December 2006. During this visit time was spent with the Imagine staff to provide a transfer of information that included the work Mr. Y had undertaken in relation to his 'Theory of Mind' difficulties. Workers were encouraged to look at Mr. Y's work book and to spend time with him in the future to go through its contents.³⁵⁸ It was not evident from either reading through the clinical records, or undertaking witness interviews, exactly what the process was regarding a handover from the Scott Clinic team to Imagine staff in relation to the risks that Mr. Y presented. It would appear that Imagine workers were not briefed in either a timely or comprehensive manner about Mr. Y; this is of particular concern in that he had been spending a considerable amount of time at 123 Moscow Drive in the weeks prior to his discharge.

Once Mr. Y was in the community he had risk assessments on the following dates:

1. **11 January 2007.** A risk assessment was conducted as part of the post discharge review. An HCR-20 was completed. The information on the form was identical to that of the HCR-20 assessment of the 24 July 2006. A new community section had been added which graded Mr. Y as a 'low' priority and 'routine' case. This may have been little premature considering that Mr. Y had just been conditionally discharged from a medium secure unit.

Two risk scenarios were developed. The scenarios jointly identified the following risks:

- those to Mr. Y's mother;
- any changes to the stability of Mr. Y's environment;
- frustration and anger.

There was no plan other than to refer to the terms of the conditional discharge and to the support that Mr. Y could expect from community-based workers. It was written that his general stability would be ensured by maintaining his mental health and that this could be facilitated by encouraging Mr. Y to keep up his interest in running and by ensure that his

358. CMHT Notes Post Discharge PP. 1-2

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home environment remained stable.³⁵⁹ Considering that this was such a major milestone in Mr. Y's care pathway, and change to his environment had been identified as being a major relapse factor, it is incomprehensible why there was no risk management plan developed for the months either side of the discharge.

- 2. 19 April 2007.** An Effective Care Coordination Review took place on this day. The Independent Investigation Team was not supplied with risk assessment documentation for this event. It was noted that Mr. Y appeared to have settled well and that he was socialising with Imagine staff and residents. There were no revisions made to the care plan and the CPA documentation remained largely unaltered. Every clinical record entry made by both Care Coordinator 2 and Social Supervisor 1 between the 11 January 2007 and the date of this review commented on their concerns about Mr. Y's social isolation which is contradictory to the statement that he was socialising well. On the 13 March Social Supervisor 1 wrote in the CMHT record that she "*felt uneasy*" about Mr. Y's isolation and that "*I feel he still presents a risk in keeping things to himself and letting them build up until its too late*".³⁶⁰ There is no evidence to suggest that these concerns were discussed at this review meeting. It would have been good practice for a specific risk management plan to have been developed at this stage to address this issue.
- 3. 1 November 2007.** The Independent Investigation Team was not supplied with risk assessment documentation for this event. Two pages of CPA documentation were available together with a letter to the GP. These documents stated that Mr. Y was settled and that no revisions were required to the care plan. On the 21 November 2007 Social Supervisor 1 visited Mr. Y at Moscow Drive. He appeared to be progressing as usual. She however recorded that "*I still worry that if he was experiencing any symptoms he would not discuss them with anyone. This to me is part of the ongoing risk with ... [Mr. Y]*".³⁶¹ It is unclear whether or not she expressed these concerns at this review meeting or at the next meeting on the 3 April 2008. Whether she did, or whether she did not, her concerns were not recorded within the CPA documentation and did not appear to inform Mr. Y's ongoing risk management strategy.

359. Trust Record PP. 178-197

360. CMHT Notes Post Discharge P. 5

361. CMHT Notes Post Discharge P. 59

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- 4. 3 April 2008.** An Effective Care Coordination Review took place on this day. The Independent Investigation Team accessed the documentation *via* the GP record. At this stage Social Supervisor 1 was replaced by Social Supervisor 2. We were told during witness interviews that no handover took place between them. No risk assessment documentation appears within the record. There was however a 'Summary of Risk Intervention'. Mr. Y's mental state was recorded as being stable. It was recorded that Mr. Y was living in 24-hour supported accommodation and that he was receiving weekly support and monitoring of his mental state from the Scott Clinic.

It was also noted that Mr. Y was commencing a self-medication regimen. Non compliance had been identified on previous occasions as a significant factor for relapse. No medicines management plan was put into place.

- 5. 18 September 2008.** An Effective Care Coordination Review took place. The Independent Investigation Team accessed copies of the risk assessment from the Imagine records, no changes had been made from earlier assessments. It was noted that Mr. Y was not on a supervision register, that it had been considered, but not thought necessary. It was noted that he was on a Section 41. Mr. Y continued to be monitored for paranoid thoughts. Both the Care Coordinator and the Social Supervisor were to continue to work with Mr. Y and liaise with Imagine staff. Early signs of relapse were identified as being feeling tired and thinking people were watching him and talking about him. More serious indicators included being irritable, preoccupied, withdrawn and giving his belongings away. It was noted that his mental state was stable and his risk was low. The risk statement for this period noted the condition placed on Mr. Y not to go to his mother's address.³⁶²

- 6. 2 April 2009.** No risk documentation was supplied to the Independent Investigation Team for this Effective Care Coordination Review. The limited CPA documentation supplied to the GP noted that there were no changes to Mr. Y's condition.

362. GP Record PP. 84-90

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7. **24 September 2009.** An Effective Care Coordination Review was held prior to Mr. Y being moved from 123 to 133 Moscow Drive. No documentation exists for this review. A brief letter was written to the GP stating that Mr. Y's address was due to change and that he would have "*much the same*" level of support at the new accommodation.³⁶³

It would appear that no risk assessment was undertaken which was remiss. Neither is there any evidence that a care plan was developed. This was a significant omission as Mr. Y's risk assessments all cite change to his environment as being a potential factor for relapse.

8. **11 March 2010.** No risk or CPA documentation was supplied to the Independent Investigation Team for this Effective Care Coordination Review. From the letter sent to GP it is possible to infer that the meeting focused upon Mr. Y moving to another flat in the near future in order to improve his levels of independence. It would appear that no risk assessment or care management plan was considered at this stage.³⁶⁴

It was evident to the Independent Investigation Team that the method of assessing, managing and monitoring Mr. Y's risk once he had been discharged into the community continued in the same vein as when he was an inpatient. There was a strong reliance on the powers of 'supervision' and 'monitoring' without ever specifying exactly what this meant and how it was to be implemented. There appears to have been a false sense of security regarding what Imagine was able to provide. In reality Mr. Y was being seen once a week by either his Care Coordinator or Social Supervisor and for an hour a day by Imagine workers. It was recorded that Mr. Y liked to keep himself to himself and would rarely initiate conversation. Mr. Y continued to keep all social interaction to the minimum. During the time that he was living in the community there were changes to the key personnel in the treating team. Social Supervisor 1 left in April 2008, and Care Coordinator 2 left in April 2009. The Independent Investigation Team were told during witness interviews that handover processes were poor and it would seem that the new members of the treating team probably took Mr. Y at face value. The fact that Mr. Y had a propensity to mask his symptoms and shield his inner world from those around him made this an unsatisfactory arrangement.

363. GP Record PP. 65-66

364. GP Record PP.60-61

Mr. Y Investigation Report

It is evident from reading the chronology that in February 2010 plans were afoot to move Mr. Y from his accommodation at 133 Moscow Drive to another flat. Mr. Y appeared to be resistant to this idea as he had settled happily into his new home to which he had moved only five months previously. Despite having identified that a stable home environment and the avoidance of unnecessary change to his routine were essential to Mr. Y's continued mental health, it would appear that another move was imminent. It could be seen as fortuitous that the move Mr. Y had undertaken five months earlier had not destabilised him, even though there had been no coherent risk assessment or management of the process. Whilst it cannot be known with certainty what led to the breakdown in Mr. Y's mental health, and the subsequent killing of his mother in March 2010, it would seem that at this stage stressors were building up in Mr. Y's life of the kind that had been identified as requiring avoidance if at possible. The issue here is that during this potentially unsettling time Mr. Y did not receive a risk assessment or accompanying risk management plan to support him through this transition. The reason these omissions occurred was in part due to the fact that the treating team no longer viewed Mr. Y through the lens of his potential risk, to the point that once again, not even the Ministry of Justice was consulted.

The Trust Internal Review (2010) stated that Mr. Y was subject to continued CPA and risk assessment utilising the HCR-20 assessment tool. This Investigation could find no evidence for the continued use of HCR-20, or any other risk assessment tool for this period, in the Trust, the GP or the Imagine-held records. However we acknowledge that this information may have been available to the previous investigation.

The Trust Internal Review Report (2010) stated that *"The lack of understanding regarding the risk... [Mr. Y] posed that were noted during his inpatient stay at the Scott Clinic pervaded the assessments carried out following his conditional discharge"*.³⁶⁵ The report also went onto say that:

- the initial discharge plan was basic;
- succeeding plans contained exactly the same information;
- major changes had occurred on Mr. Y's pathway (e.g a change of accommodation);
- risk assessments did not reflect the dynamic risk management of Mr. Y;

365. Trust Internal Investigation Report (2010) P. 20

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- assessments failed to consider the ongoing risks to Mrs. Y Senior, the HCR-20 requires an assessment consideration of previous victims, this was not conducted;
- Mrs. Y Senior was not the subject of a carer's assessment, and neither could the Review find evidence of a victim's safety plan. It was evident that Mrs. Y Senior and her family had ongoing concerns which were not addressed;
- it was not clear whether risk management information was passed between 123 and 133 Moscow Drive.³⁶⁶

The Independent Investigation Team concurs with the findings of the Trust Internal Review (2010).

Multi Agency Public Protection Arrangements (MAPPA)

MAPPA is the *"arrangement in England and Wales for the Responsible Authorities tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. The Responsible Authorities of the MAPPA include the National Probation Directorate, Her Majesty's Prison Service and England and Wales Police Forces. MAPPA is coordinated and supported nationally by the Public Protection Unit within the National Offender Management Service. MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and was strengthened under the Criminal Justice Act 2003"*.³⁶⁷ The legislation requires a three-stage process for managing dangerous offenders. These authorities in conjunction with partner agencies, such as social services and health, need to identify three types of offender living in their area.

There are three categories:

- **Category 1:** Registered Sex Offenders (RSOs),
- **Category 2:** All offenders who have received a custodial sentence of twelve months or more in prison for a sexual or violent offence and whilst they remain under Probation supervision.
- **Category 3:** Anyone else who poses a *"risk of serious harm to the public"* who has received a conviction and whose risk would be better managed in a multi-agency setting.

366. Trust Internal Investigation Report (2010) PP. 21-22

367. http://en.wikipedia.org/wiki/Multi-Agency_Public_Protection_Arrangements

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“The legislation requires that the agencies conduct a formal risk assessment of each offender and allocate them to a tier of multi-agency management — known as level one, two or three.

- *Level One represents the normal inter-agency management of the offender in the community by one agency, with some liaison.*
- *Level Two means that Multi Agency Public Protection meetings (MAPPs) will be held where the offender's management will be discussed between various parties involved in their case.*
- *Level Three is essentially the same as Level Two, except that senior management representatives will be in attendance and greater resources are expected to be used in the management of the offender”.*³⁶⁸

A risk assessment is conducted and a management plan put into place.

It is a fact that Mr. Y had been convicted of manslaughter at the Liverpool Crown Court on the 18 October 2004. Mr. Y met the conditions of a Category Two/Three offender. It is also a fact that Mr. Y was conditionally discharged without being either considered or referred for a MAPP.

The Trust Internal Review (2010) examined this issue and stated that the Scott Clinic became part of Mersey Care NHS Trust in 2002. At this stage it was apparent that the Merseyside Forensic Psychiatric Services *“were of the view that it was more appropriate for them to retain their own protocols and procedures governing their care and services. The context for this predates the inclusion of the Scott Clinic into Mersey Care NHS Trust when it operated as a Regional Medium Secure Unit...”.*³⁶⁹ The Review Team went on to say that at the time of their investigation some Mersey Care policies and procedures were either not in place or were being implemented in an incomplete manner. Paradoxically it was found that the Police liaison role to the Scott Clinic was not as robust as that to be found throughout the rest of the organisation. This was found to be a reason why MAPP and the Police National Computer system (PNC) processes were not followed through appropriately. This information was corroborated by the Independent Investigation Team during witness interviews.

368. http://en.wikipedia.org/wiki/Multi-Agency_Public_Protection_Arrangements

369. Trust Internal Investigation Report (2004) P. 24

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MAPPA and PNC arrangements should have been considered at the same stage that Mr. Y's discharge was being discussed. Had these arrangements been put into place then the visits Mr. Y made to his two previous female acquaintances, to whom he gave money in February 2004 and again in March 2010, would have raised an alert *via* the Police National Computer system and mental health services would have been notified of the fact that Mr. Y was exhibiting significant relapse indicators and was acting out his rapidly developing delusional thoughts. The Independent Investigation Team noted with concern that several clinical witnesses when interviewed by this Investigation still maintained the view that Mr. Y had not been eligible for MAPPA.

The Trust issued a revised MAPPA policy in November 2010 based upon national MAPPA guidance (version 3 2009). The policy applies to *all* services provided by Mersey Care NHS Trust. MAPPA runs together with Health and Risk Assessment Management Meetings (H-RAMM) which are multiagency and multidisciplinary.

13.1.5.3. Conclusions

13.1.5.3.1. Prior to the Death of Mr. Y Senior

The Trust Internal Review (2004) into the care and treatment that Mr. Y received did not examine the area of risk assessment in depth. The report did conclude however that risk assessments were incomplete and that the work that had been commenced did not develop into any form of care planning. The Independent Investigation Team would concur with this conclusion.

This Investigation also concluded that the risk assessment practice of clinicians within both the Day Hospital and the Community Mental Health Team fell below that to be expected of a secondary care mental health service. The failure to undertake a robust risk assessment process ensured that no risk management plan was either developed or delivered. Mr. Y had been newly diagnosed with Paranoid Schizophrenia. He was neither taking his medication nor engaging with services. He was noted as being paranoid and suspicious as well as experiencing ideas of reference.

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On the 12 January 2004 Mrs. Y Senior was reported as saying that her son “*explodes if anyone interferes with what he is doing*”. She denied that he had been aggressive towards anyone. Mr. Y continued to refuse his medication and mental health continued to decline.³⁷⁰

By the 2 February 2004 Consultant Psychiatrist 2 wrote that “*the mental illness is of a degree and severity which can jeopardise his safety in the community (his self neglect) he is getting more withdrawn and not leaving the house as he used to do. To rely on his mother is not practical as she doesn’t see the severity of his symptoms and the stress he is passing through. There is a hx [history] of suicide in the family*”.³⁷¹

The Independent Investigation Team was presented with the picture of a treating team that was seemingly frozen by indecision as to how to manage Mr. Y. The Independent Investigation Team came to the conclusion that had all of the objective evidence relating to Mr. Y’s presentation been examined in detail, in the form of a risk assessment, a better understanding of his risk would have been apparent. Had this risk been identified then a management plan could have been developed and the hesitation and uncertainty on the part of the treating team when deciding what to do and when to act may have been avoided and a more assertive and timely approach could have been proactively planned and implemented in the best interests of both the patient and his parents.

13.1.5.3.2. Prior to the Death of Mrs. Y Senior

Scott Clinic

Mr. Y was understood poorly in the context of his mental illness. Risk assessment and management processes at the Scott Clinic appear to have been subject to the ‘Boiling Frog’ [sic] syndrome. The premise is that if a frog is placed in boiling water, it will jump out, but if it is placed in cold water that is slowly heated, it will not perceive the danger and will be cooked to death. The story is often used as a metaphor for the inability of people to react to significant changes that either occur gradually or have not been taken into account fully over time. In the case of Mr. Y both his Care Programme Approach and his risk assessment documentation remained largely unaltered for a three-year period. An examination of the clinical record shows that Mr. Y was clean, neat and tidy, isolated himself and did not like to socialise or initiate conversations. It would appear that the only thing that was subject to

370.CMHT Notes (2003-2004) P. 10

371.Trust Internal Investigation Report (2004) P. 18

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change was the ever - rising tolerance levels of the treating team with regard to Mr. Y's presentation. For example, what was initially identified as a source of concern at the time of his admission (his isolation and poor social interaction) was seen as somehow being ameliorated at the time of his conditional discharge, when in actual fact it was not. The extant documentation shows that Mr. Y's identified risk remained constant and that his presentation and difficulties also remained constant. Nothing had changed apart from the treating team's perception of Mr. Y.

The Independent Investigation Team would concur with the conclusions of the Trust Internal Review (2010) which had this to say regarding the treating team *"their assessments and interventions were limited and did not recognise the level of risk he posed to himself and others. When discharge from the Scott Clinic was proposed, the assessment undertaken should have included informed judgements about the risk of harm to his mother and other family members, as well as the general public, other residents of the accommodation he was moving to and himself"*.³⁷²

At the point of Mr. Y's discharge several identified risks of long standing had been identified and nine terms had been set for Mr. Y's conditional discharge. The treating team did not address adequately any of these issues in the form of a coherent and well communicated risk management strategy.

Community Care Post Discharge from the Scott Clinic

By the time Mr. Y was conditionally discharged from the Scott Clinic the prevailing 'factoid' about his stable mental health and low risk profile had become a premise central to the ethos regarding both the care and treatment that he was provided with and the manner in which it was delivered. This served to prevent practitioners from acting swiftly with regards to any concerns that they may have had. This can be seen in the records produced by Social Supervisor 1 who wrote twice about the possibility that Mr. Y was masking his symptoms and would relapse swiftly before anyone could notice. Regardless of these concerns, which must have been of significance for her to commit them to the written record, CPAs, risk assessments and reports to Ministry of Justice continued to be produced in an 'up beat' rather than reflective manner. As Care Coordinators and Social Supervisors moved on, to be

372. Trust Internal Investigation Report (2010) P. 25

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replaced by new colleagues, the ‘factoids’ around Mr. Y grew stronger and the level of risk that he represented had seemingly disappeared from the consciousness of the collective team. The fact that Mr. Y had been diagnosed with Paranoid Schizophrenia had been lost.

Clinical witnesses to this Investigation placed a strong reliance, post discharge, on the notion that Imagine workers were available to monitor Mr. Y “24-hours a day”.³⁷³ However once Mr. Y had moved into 133 Moscow Drive he was only obliged to spend an hour each day with staff. This meant that in reality Imagine staff could only be relied upon to monitor Mr. Y at a single, set interval during any twenty-four hour period. The treating team had therefore lulled itself into a false sense of security about how Mr. Y’s risk factors were to be identified and managed if he was to experience an acute relapse of his mental health. A single hour each day may not have been sufficient for staff to detect any early stages of mental illness, particularly as Mr. Y was so adept at masking his symptoms. Incomplete risk management processes coupled with poor handovers and general communication processes ensured Mr. Y was not appropriately supervised in the community.

General Summary

There were three safety nets that failed to operate regarding the way Mr. Y’s risk was managed.

First: Mr. Y was not understood in the context of either his index offence or his potential to commit another offence. Risk formulation was poor and management strategies embryonic. Poor levels of active Care Coordination ensured that communication processes and interagency risk management operated on a superficial level only. The Care Programme Approach and risk assessment and management processes did not work to their optimum level. These essential safety nets of clinical care failed to operate.

Second: the terms of the conditional discharge were neither addressed nor understood. No practical management plan was developed around them and consequently they were largely ignored.

373. Witness Transcriptions

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Third: MAPP arrangements could have been used to ensure that Mr. Y had an appropriately resourced and supervised discharge plan. This would have provided the opportunity to work with other agencies and would also have ensured Police oversight of the case.

CPA and risk assessment documentation was routinely compiled. However nowhere in the clinical record is there evidence that multidisciplinary discussions took place in a reflective manner. The Independent Investigation Team looked for evidence to suggest that a clear rationale was recorded regarding the decisions made about Mr. Y's care and treatment strategy. This was absent from the record. It was not possible to ascertain that decisions were based upon the best evidence, information and clinical judgement available. It is accepted that it is neither possible nor desirable for people to be locked away indefinitely in a risk free environment. In this context moving Mr. Y in to the community was an appropriate step to consider but each decision should explicitly have identified the benefits to Mr. Y and weighed these against identified risks. The task of the clinical team was then to put in place a risk management plan/strategy to minimise those risks.

- *Contributory Factor Five. Mr. Y was not understood in the context of his full risk profile. Assessments of risk were undertaken in the absence of a robust formulation of the case. Consequently risk management plans and strategies were superficial and non-explicit. This, when taken alongside the failure to abide by the terms of the conditional discharge and decision not to consider MAPP arrangements, ensured a critical lack of supervision and management. This was to the ultimate detriment of Mr. Y's health, safety and wellbeing and to the continued safety of his mother.*

13.1.6. Referral, Transfer and Discharge Planning

13.1.6.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies

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communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

13.1.6.2. Findings

13.1.6.2.1. Prior to the Death of Mr. Y Senior

Referral

Mr. Y was first referred to secondary care mental health services on the 10 March 2003 by his GP. This was good practice. The GP prescribed antipsychotic medication with immediate effect in line with the extant NICE guidelines. This referral went through to the local Community Mental Health Team (CMHT).

Mr. Y was seen 18 days later by Consultant Psychiatrist 1 at Moss House who made a provisional diagnosis of “*a psychotic illness, paranoid schizophrenia*”.³⁷⁴ During the period of time that it took, between the referral being made and Mr. Y being seen, the GP continued to provide primary care based inputs. Consultant Psychiatrist 1 decided to refer Mr. Y to the Day Hospital for further assessment in order to clarify that his symptoms were genuine prior to accepting him onto the CMHT caseload.³⁷⁵ The referral was received at Arundel House on the 11 April and he was admitted to the Day Hospital for assessment on the 25 April. During this period Consultant Psychiatrist 1 wrote telling the GP he could stop prescribing antipsychotic medication until Mr. Y’s assessment was completed. In effect it took seven weeks before Mr. Y was admitted for assessment; during this period Mr. Y was receiving no treatment which was poor practice. The referral process at this stage did not provide timely intervention for a person who was thought to be suffering from acute psychosis and who had been given a provisional diagnosis of Paranoid Schizophrenia. Mr. Y met the criteria for the CMHT caseload and he should have been managed by this team from the outset due to the fact that he was experiencing severe psychotic symptoms. The CMHT Operational Policy (2002) in place during this period stated that all service users with severe mental illness (e.g. Paranoid Schizophrenia) should be referred to and accepted by them.

Transfer and Discharge

At the end of July 2003 it was evident that Mr. Y’s mental health was deteriorating. At this stage he was referred to the CMHT for a Community Psychiatric Nurse assessment. On the

374. GP Record PP.54-55

375. Trust Internal Review Report (2004) P. 24

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15 August Mr. Y was discharged from the Day Hospital as he was refusing to attend. From this point forward he was managed exclusively by the CMHT. At this stage Mr. Y was non-compliant with his medication, engaging with services in a sporadic manner and was experiencing severe psychotic symptoms which were observed to be worsening. At this stage an inpatient admission should have been considered and the Mental Health Act (1983) considered in the best interests of the patient.

13.1.6.2.1. Prior to the Death of Mrs. Y Senior Referral, Transfer and Discharge

Mr. Y's referral process to the Scott Clinic following the killing of his father followed all due process. The Independent Investigation Team has no other finding to make regarding the care and treatment that Mr. Y received during this particular transition.

Mr. Y was discharged from the Scott Clinic on the 20 December 2006 following his conditional discharge on the 15 December 2006. Discharge preparations commenced in July 2006. It was recorded on the 3 July that the Social Worker had started liaising with 123 Moscow Drive and that work relating to Mr. Y's early relapse warning signs had been completed.³⁷⁶

It was recorded at the 24 July 2006 Effective Care Coordination meeting that a Mental Health Tribunal was to be pursued and that planning was underway to identify a staffed placement at 123 Moscow Drive. It was decided at this stage to take Mr. Y to view the accommodation. Mr. Y's mother and aunt, who were present at the review, were recorded as being happy with the plan and the progress that Mr. Y was making. It was also recorded that Consultant Psychiatrist 3 had spent some time with Mrs. Y Senior to discuss "*developments*" with her.³⁷⁷ The care plan was to address self-catering and budgeting as part of a discharge strategy.

On the 24 August Mr. Y visited Moscow Drive. He liked it and said that he would be happy to live there when he was discharged. Mr. Y had been having Section 17 unescorted leave in the community from May 2006, the condition being that he did not visit his mother's house. Consultant Psychiatrist 3 wrote in his reports to the Ministry of Justice that between May and September 2006 Mr. Y had been monitored whilst on leave (it was not clear how he had been

376. Clinical Records Set 2 P. 279

377. Clinical Records Set 2 P. 291

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monitored) and that he had not shown any signs of aggression or violence since the time of his admission.

On the 5 September the Senior Occupational Therapist wrote that she intended to make plans to take Mr. Y for further visits to 123 Moscow Drive.³⁷⁸ It was recorded on the 11 September 2006 that 123 Moscow Drive had accepted Mr. Y for placement and he was welcome to make visits to acclimatise himself.³⁷⁹ On the 27 September the Manager at 123 Moscow Drive was contacted by the Scott Clinic in order to arrange periods of leave for Mr. Y. The Manager was unable to make or confirm any arrangements and said that the “*agency who runs this service is currently restructuring*”. She hoped to be able give more information the following week.³⁸⁰

On the 11 September Consultant Psychiatrist 3 wrote to the Ministry of Justice requesting overnight leave for Mr. Y at 123 Moscow Drive as this placement had been identified as his potential place of discharge. It was stated “... *[Mr. Y] has utilised unescorted leave without incident now for some time. He has taken up various opportunities to utilise his leave which has also allowed him to visit Moscow Drive, his identified residential placement within the community*”.³⁸¹

On the 28 September the Social Worker visited Mrs. Y Senior at her home. She was confused about the forthcoming Tribunal and what it would mean. Moscow Drive was not far away from her home and did not feel she could bear Mr. Y coming back into the house; her feelings were described still being “*raw*”. It was clear that members of the extended family had very strong negative feelings about Mr. Y. They were angry with Mrs. Y Senior for accepting her son and felt that she should have “*locked him up and thrown away the key*”.³⁸²

On the 13 October 2006 Consultant Psychiatrist 3 recorded that he was going to write to the Home Office to request overnight leave for Mr. Y to stay at 123 Moscow Drive prior to his Mental Health Tribunal planned for December.³⁸³ Mr. Y had not been able to revisit since the 24 August. On the 24 October 2006 Mr. Y asked the ward staff what was happening with

378. Clinical Records Set 2 P. 317

379. Clinical records Set 2 P. 320

380. Clinical Records Set 2 P. 329

381. Ministry of Justice Records Vol. 1 P. 10

382. Clinical Records Set 2. P. 330

383. Clinical Records Set 2 P. 337

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regards to his move as he was growing anxious. He was told that there were organisational issues which were causing delays.³⁸⁴

On the 6 November 2006 at the clinical team meeting it was noted that Mr. Y had asked whether he could use some of his unescorted leave to visit Moscow Drive as he wanted to view his future accommodation. It was noted that this was not possible and that it was hoped Imagine would be able to sort out the issues soon. It was also noted that a Social Supervisor and Care Coordinator would need to be allocated soon and that the Clinical Psychologist would be available to discuss Mr. Y's 'Theory of Mind' problems with them.³⁸⁵

On the 7 November 2006 the Social Worker visited Mrs. Y Senior at her home. Clarification around the likely Section 41 conditions was given to her. Mrs. Y Senior said that she would like to visit Moscow Drive and she was told that this would be possible once Mr. Y had been given the opportunity to familiarise himself with the place.³⁸⁶

On the 12 November 2006 the Social Worker explained to Mr. Y that Imagine, the organisation that ran 123 Moscow Drive, was undergoing restructuring and that this was causing delays. She promised to try and arrange Section 17 leave to commence that week at the new accommodation.³⁸⁷ On the 20 November 2006 a clinical team meeting was held. The situation at 123 Moscow Drive had still to be resolved. Mr. Y was described as being anxious because he thought he was "*never going to get out*". Consultant Psychiatrist 3 pointed out that Mr. Y's Mental Health Tribunal was due in four-weeks time and that he needed to have had some leave at the new accommodation before it took place.³⁸⁸ Mr. Y had received permission from the Home Office for the leave, both for the day and overnight, to take place at Moscow Drive. It had been arranged for the 123 Moscow Drive staff to attend Mr. Y's Effective Care Coordination meeting due on the 27 November.

On the 24 November the Social Worker met with the Manager at 123 Moscow Drive. It was "*negotiated*" that Mr. Y would be able to spend some time there on Section 17 leave. It was agreed that Mr. Y's time at Moscow Drive should be built up so that by the time of his tribunal he was spending more time at the new accommodation than at the Scott Clinic. It

384. Clinical Records Set 2 P.344

385. Clinical Records Set 2 P.353

386. Clinical Records Set 2 P. 351

387. Clinical Records Set 2 P. 355

388. Clinical records Set 2 P. 259

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was also planned that he would need at least one overnight stay prior to the tribunal. It was arranged for Mr. Y to visit the following Sunday (26 November) for lunch.³⁸⁹ In the event this did not take place. 123 Moscow could no longer collect Mr. Y and he felt that he did not want to take public transport on a Sunday as it was unreliable. It was recorded “*needs to be arranged for another day*”.³⁹⁰

On the 27 November the Effective Care Coordination Review was held. The staff from Moscow Drive sent their apologies and did not attend.³⁹¹ It was recorded that Mr. Y needed an overnight stay prior to the tribunal and that this was being pursued. It had been arranged for Mr. Y to visit Moscow Drive the next day. It was also arranged for him to have an overnight stay on the Saturday (2 December) and to stay on for Sunday lunch afterwards.³⁹²

On the 28 November Mr. Y attended Moscow Drive for day leave as planned. The day went well. It was agreed that he would visit Moscow Drive again on the Friday. In the event a worker at Moscow Drive telephoned the Scott Clinic to say that Mr. Y could not have overnight leave until the tribunal had taken place and his tenancy confirmed, however the day leave could continue as planned. It was agreed that Mr. Y would attend for as many days as possible and that the Senior Occupational Therapist would visit Mr. Y’s new Key Worker to provide a handover relating to the work she had been doing regarding his ‘Theory of Mind’ problems.³⁹³

On the 1, 3 and 5 December Mr. Y visited Moscow Drive for the day.³⁹⁴ On the 10 December Mr. Y attended Moscow Drive for lunch and on the 12 December for the afternoon. Mr. Y was conditionally discharged by the Mental Health Tribunal on the 15 December. It was agreed that he would be discharged on the 18 December which was the following Monday. In the event although Mr. Y went to live at Moscow Drive on the 18 December he was not formally discharged from the Scott Clinic until two days later.³⁹⁵ At this stage it was recorded that the Social Worker who had been involved with him whilst an inpatient would become his Social Supervisor. Mr. Y was also allocated a Care Coordinator from the Forensic Integrated Resource Team whom he had not met before.

389. Clinical Records Set 2 PP. 362-363

390. Clinical Records Set 2 P. 365

391. Trust Record P.222

392. Clinical Records Set 2 P.365

393. Clinical Records Set 2 P. 367

394. Clinical Records Set 2 PP. 368-372

395. Clinical Records Set 2 P. 378

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It was apparent from reading through the clinical records and from interviewing witnesses that the handover process between the Scott Clinic and Imagine were poor. On the 18 December 2006 a letter was written by Consultant Psychiatrist 3 to the Manager of 123 Moscow Drive. This letter set out ‘follow up’ information. It was stated that Mr. Y would be followed up by the Forensic Integrated Resource Team and the names of the Social Supervisor, Care Coordinator and Responsible Medical Officer were given together with their contact details. The conditions of discharge were recorded as being “*that he complies with appointments with his RMO and with his Social Supervisor that he resides where specified and he does not visit his mother at home or go within 200 metres of ...Close. He is also to inform the care team of any planned meetings with his mother*”. A very brief psychiatric history was given. At this stage no relapse signature indicators were identified. The date of the CPA review meeting that was due to be held on the 11 January 2007 was given.³⁹⁶

The only other extant documentation in the clinical record relating to the discharge is a two-page synopsis from the Forensic Occupational Therapy and Rehabilitation Department. This documentation recorded that Mr. Y had significant difficulties in understanding his own emotional states and also those of others. The document went on to say what psychological interventions had been covered whilst Mr. Y was an inpatient at the Scott Clinic. They were recorded as being:

1. *“Identifying his own emotions and how these may be conveyed to others.*
2. *Recognition of emotions in other people.*
3. *Development of coping strategies”.*³⁹⁷

This document also mentioned that Mr. Y held his own personal file and that he could use this as a future source of reference. It was recorded that Mr. Y had clear likes and dislikes but that he had a tendency to mimic the responses of the people around him rather than stating what it he himself actually wanted. It is probable that his document was taken to 123 Moscow Drive on the 28 December when Care Coordinator 2 and the Senior Occupational Therapist visited to provide a handover. It would appear that this rather limited intervention was all that actually occurred.

396. Imagine Notes PP. 72-73

397. Imagine Notes PP. 79-80

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When examining the clinical record the Independent Investigation Team could find no evidence of Section 117 aftercare arrangements having been made. It was evident that the pre-discharge CPA served as a Section 117 meeting; however no documentation could be brought forward to demonstrate what arrangements had been made and how these arrangements were to be both funded and reviewed.

At the point of discharge Mr. Y required registering with a new GP. This was not achieved until the January and caused subsequent delays to his financial situation as a sick note for benefits could not be issued. It would appear that the care planning process was limited and that there were no protective plans put into place regarding his conditional discharge and the safety of his mother.

13.1.6.3. Conclusion

13.1.6.3.1. Prior to the Death of Mr. Y Senior

Referral, Transfer and Discharge

Referral processes were managed poorly by secondary care mental health services during this period. The ethos of the CMHT Operational Policy was not adhered to and this prevented Mr. Y being referred to the appropriate service in a timely manner. It is not possible to draw any conclusion as to how this may have impacted upon his long-term mental health or the death of his father and the wounding of his mother.

13.1.6.3.2. Prior to the Death of Mrs. Y Senior

Referral, Transfer and Discharge

The process of discharge from any mental health inpatient setting represents a key milestone on a service user's care pathway; one which can present significant risks. It was evident that plans were afoot to discharge Mr. Y for at least six months prior to the event taking place. The Independent Investigation Team found it surprising that in the event the actual discharge itself appeared to have been rushed and lacking in coordination.

It would appear that progress reports to the Ministry of Justice and the 11 October 2006 report for the Mental Health Tribunal (held on the 15 December 2006) may have presented an impression that the plans for discharge were more advanced than they actually were. It is unfortunate that the treating team did not state clearly that Mr. Y had yet to have an overnight stay at 123 Moscow Drive, and that his induction to the accommodation had been severely

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disrupted. The discharge, rather than occurring with immediate effect, could have been delayed until such time as the necessary arrangements had been put into place. This was within the powers of the Tribunal. Had it been appropriately informed then the Tribunal might have agreed to the conditional discharge being deferred until all of the arrangements were complete.

It was not good practice for the treating team to have proceeded with such haste knowing that the Imagine service had experienced significant organisational difficulties which had led to serious delays in facilitating the discharge process. Mr. Y was ill prepared and a professional and timely handover did not take place. It was not good practice to have allocated a Care Coordinator that Mr. Y had not met before at the point of his discharge. Neither was it good practice to hold the handover meeting with Imagine ten days after Mr. Y had gone to live at his new accommodation. The wisdom of discharging a patient so close to Christmas is always questionable; leaving the Imagine staff with the instruction to contact the Crisis Service in the event of Mr. Y relapsing, could be seen to have been irresponsible.

In effect Mr. Y was discharged without a handover, a robust risk assessment or a coherent care plan. Consultant Psychiatrist 3 had been party to the development of the terms of the conditional discharge. The treating team knew what these conditions were likely to be; therefore it is difficult to understand why robust care plans were not developed in advance of the Tribunal taking place. The letter sent to Imagine by Consultant Psychiatrist 3 on the 18 December 2006 was not helpful in that it only mentioned four out of the nine conditions of the discharge. Nowhere in any of the extant documentation (developed during the period of the discharge) can it be noted that relapse signatures were identified and sent to the Imagine team.

As has already been mentioned above, MAPPA was not considered to have been appropriate and was so was not considered. The Section 117 aftercare arrangements were not explicit and this was to prove problematic in the years to follow (please see Subsection 13.1.9. below).

The essential safety nets of care were not put into place prior to Mr. Y being moved back into the community. This is of concern for a number of reasons.

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- First: it had been identified that Mr. Y could relapse if subjected to unmanaged change (disruption to his home environment had been cited as a particular thing to avoid/or manage carefully).
- Second: Mr. Y was eligible for Section 117 aftercare which should have ensured his future aftercare needs were both funded and provided. The aftercare arrangements were not explicit.
- Third: Mr. Y was subject to a conditional discharge which required careful planning, implementation and monitoring.
- Fourth: Mr. Y was erroneously not considered eligible for Multi Agency Public Protection Arrangements (MAPPA) which rendered him invisible to other statutory services such as the Police.
- Fifth: Mrs. Y Senior was the surviving victim of her son's index offence and required a protection plan to be placed around her.
- Sixth: Mr. Y had a severe and enduring mental illness which would require ongoing care and treatment.

At the point of Mr. Y's discharge the abiding impression is that the arrangements were made in haste and the omissions that occurred at this stage were not rectified at a later date. These omissions were to 'set the tone' for the care and treatment that Mr. Y was to receive over the following three years.

- *Contributory Factor Six. The discharge process did not address in sufficient detail either the needs of Mr. Y or the continued safety of the public, with particular reference to Mrs. Y Senior. The process appeared to have been rushed and coordinated poorly. As a consequence the essential safety nets of care were not put into place to the ultimate detriment of the care, treatment and supervision that Mr. Y received up until the time of the killing of his mother.*

13.1.7. Service User Involvement in Care Planning and Treatment

13.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice.

The NHS and Community Care Act 1990 stated that:

“the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes”.

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *“people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care”*. It also stated that it would *“offer choices which promote independence”*.

13.1.7.2. Findings

Prior to the Death of Mr. Y Senior

Due to the paucity of the available clinical record charting events between March 2003 and February 2004 it has not been possible to understand exactly how services involved Mr. Y with his care planning and treatment. It was evident that attempts were made to engage him and that his views were listened to with respect. At times Mr. Y was even permitted to dictate the course of his care and treatment in ways that were neither best practice nor in his best interests. Two issues were of particular note. The first being his refusal to allow his parents to be spoken to, the second being his refusal to comply with his medication even when it was evident he had an acute psychosis that was of a serious nature.

Witnesses to this Investigation remarked that Mr. Y was difficult to engage and to get to know. It was evident that the treating team did not know how to work with Mr. Y in the light of his refusal to comply with either medication or treatment. A view was taken mistakenly that the service user had the right to disengage and to deny inputs from family members. Whilst this is in the main true, this stance must be reviewed when a service user is unwell with an acute, severe psychotic illness which impairs both their wellbeing and capacity. The lack of an assertive stance on the part of the treating team led to significant delays in providing the care and treatment that Mr. Y required.

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Prior to the Death of Mrs. Y Senior

Engagement Whilst in the Scott Clinic

During Mr. Y's time at the Scott Clinic it can be seen clearly that regular attempts were made to engage Mr. Y and to work with him in a therapeutic manner. It was apparent however that Mr. Y engaged on a superficial level with staff. Typical entries in the clinical records were "... [Mr. Y] remained in his room all shift, unable to assess mental state;"³⁹⁸ "Very quiet and isolative, responds to direct questioning only initiates interactions on a needs led basis, does not appear to have social engagement with others;"³⁹⁹ "Informed ... [Mr. Y] that staff conducting KGV felt he was masking his symptoms. However ... [Mr. Y] denies this and has stated he has been symptom free since being nursed on Hawthorn Ward;"⁴⁰⁰ "When querying ... [Mr. Y] on his thoughts related to the index offence he said 'I don't know'."⁴⁰¹ "Incongruous affect – smiling and laughing evident for no apparent reason when discussing hallucinations/delusion ... [Mr. Y] denied any symptoms".⁴⁰²

It would appear that clinical and social care staff always approached Mr. Y with courtesy and kindness. What they did not appear to do was approach Mr. Y with any degree of challenge. Had a more challenging approach been taken as part of a therapeutic engagement strategy it is possible that Mr. Y would have been understood better as challenge appeared to provoke emotion and strong feelings in him. An interesting example of this took place following Mr. Y's first period of unescorted leave when his room was searched on his return. This invasion of his personal space made him "upset and uncomfortable". It was probably the first time that his privacy had been invaded for some time and his reaction to it was interesting.⁴⁰³ This was an example of placing Mr. Y, albeit inadvertently, in a position where he felt uncomfortable. For several years whilst at the Scott Clinic he had been able to largely avoid interaction, answer questions in a short and nonspecific manner and remain in a self-contained world of his own. Staff did not appear to push any boundaries with him and maintained a peaceful *status quo*. Whilst this was both respectful and kind, it may not have been the best therapeutic approach. At the point of Mr. Y's discharge he was exposed to a world full of challenge outside of the structured environment of an inpatient setting. At the

398.Clinical Records Set 2 P. 295

399.Clinical Records Set 2 P. 256

400.Clinical Records Set 2 P. 270

401.Clinical Records Set 2 P. 275

402.Clinical Records Set 2 P. 265

403 Clinical Records Set 2 P. 271

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point of his discharge his resilience to stress and his coping strategies remained largely untested.

Therapeutic Work Whilst in the Scott Clinic

It is evident from examination of the clinical record that whilst Mr. Y was in the Scott Clinic time was spent with him on a regular basis helping him to understand his ‘Theory of Mind’ problems and his early warning signs of relapse. This was good practice. What however was of concern to the Independent Investigation Team was the way in which Mr. Y’s suggestions and inputs went unchallenged. For example on the 21 July 2006 when asked how he would prevent a relapse Mr. Y responded that he would “*like to be able to talk to his brother every day*”.⁴⁰⁴ In reality the brother lived in Germany, claimed to no longer speak English and wanted nothing to do with Mr. Y. On the 27 July 2006 in another early warning signs session Mr. Y suggested that if he thought he was relapsing he would talk to his mother. This should have been identified as being a potentially problematic strategy due to the fact that Mr. Y had been identified as being a risk to his mother when psychotic. This particular coping strategy was not appropriate in light of the connection between Mr. Y’s psychosis and potential risk of future harm to his mother. The point being made here is, that it was good practice to work with Mr. Y on his early warning signs and coping strategies, but that it was neither helpful, nor professional to support him in identifying unrealistic and potentially unsafe plans. It was also demonstrative of the fact that Mr. Y had a limited insight into his situation.

Involvement in Care Planning whilst in the Scott Clinic

During the time that Mr. Y was in the Scott Clinic he refused to attend CPA meetings. It is not certain why work was not undertaken to ensure that he engaged more positively with the process. A read through of the clinical record shows that it was common practice for Mr. Y to sign documentation (care plans) sometimes three months after the CPA review had taken place.⁴⁰⁵ In the lead up to Mr. Y’s discharge he began to attend his CPA reviews but this was part of a strategy to engage with the discharge process rather than a genuine example of engagement. It would appear that Mr. Y engaged in the most superficial manner possible and that whilst staff persevered in ensuring Mr. Y filled in LUNSARS and KGV assessment forms his true level of involvement was minimal.

404. Clinical Records Set 2 P. 281

405. Clinical Records Set 2 P. 260

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Involvement and Engagement Whilst in the Community Post Conditional Discharge

When Mr. Y was conditionally discharged into the community he was retained by Consultant Psychiatrist 3 and the Social Worker (Social Supervisor 1) who had been part of his inpatient treating team. At the point of discharge he was allocated a Care Coordinator who was new to his case. It was evident that Social Supervisor 1 was concerned about the progress Mr. Y was making, that his engagement was minimal and that he would be able to relapse without anyone being the wiser until it was too late. She wrote on the 13 March 2007, some eight weeks following his discharge that *“I feel he still presents a risk in keeping things to himself and letting them build up until its too late”*.⁴⁰⁶ This was written by a person who had known Mr. Y for some time.

Care Coordinator 2 did not appear to have known Mr. Y well despite her attempts to engage with him. She visited Mr. Y on a weekly basis and engaged with him by talking to him about his life and general activities. During these conversations she took the opportunity to monitor his mental state.⁴⁰⁷ Efforts were made to ensure that Mr. Y involved himself in the world around him and increasingly the meetings with Care Coordinator 2 were held in public places which Mr. Y enjoyed. However due to the fact that Mr. Y seldom initiated conversation it is questionable how much actual involvement Mr. Y had in developing his care and treatment programme.

On the 6 February 2008 Social Supervisor 1 was replaced by Social Supervisor 2 who had not met Mr. Y before. She engaged with Mr. Y by taking him out for lunch which he apparently enjoyed. During this period it was noted that Mr. Y was thinking about returning to driving a taxi, that he wished to resume his studies and that he even had plans to travel abroad on holiday. In April 2009 Care Coordinator 2 was replaced with Care Coordinator 3. Once again this individual had not met Mr. Y prior to the case being allocated.

During the period that Mr. Y was living in the community there is no extant record to suggest that Mr. Y was actually involved in the development of his care and treatment plans. In fact there is no extant documentation to suggest that care and treatment plans in any meaningful sense actually existed. It would appear that Care Coordinators and Social Supervisors met with Mr. Y on a rotating weekly basis. Most of these meetings took place in cafes or

406. CMHT Notes Post Discharge P. 5

407. Witness Transcription

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restaurants and as such efforts were made to ensure that Mr. Y was encouraged to ‘get out and about’. However the clinical record shows that Mr. Y remained difficult to engage beyond a certain level and rarely initiated conversation. The weekly meetings ensured that services remained in contact with Mr. Y but these meetings did not ensure that he was involved in a therapeutic engagement as no active care and treatment plan was being implemented.

13.1.7.3. Conclusions

Prior to the Death of Mr. Y Senior

The Independent Investigation Team concluded that Between March 2003 and February 2004 it was evident that Mr. Y’s treating team attempted to provide a service that was acceptable to him. However this meant that, at times, there was no assertive management of his medication regimen or liaison with his family. Whilst Mr. Y’s wishes were taken into account, these were not always in the best interests of either himself or those around him. A great deal of emphasis was placed on the need to build a therapeutic relationship with Mr. Y prior to any assertive intervention being made. Whilst to some extent this can be seen as laudable, when a person’s mental health has deteriorated to the point where they are floridly psychotic and continuing to deteriorate, there has to be an assertive stance taken to fulfil the duty of care. This was not achieved.

Prior to the Death of Mrs. Y Senior

Mr. Y was a difficult person to get to know. Following his admission to the Scott Clinic consistent attempts were made to engage with him. This consistent activity, both before and after his conditional discharge back into the community, coupled with the fact that Mr. Y appeared to be relatively pleasant and symptom free, led to the assumption that Mr. Y was engaged and that the treating team understood his situation well. The fact was that no one actually knew whether Mr. Y was engaged or not, and no one actually understood this very ‘closed off’ man despite thinking that they did. With a case like this it is probably more professional for a treating team to acknowledge that despite its best efforts engagement and understanding will always remain subject to debate and that increased supervision and vigilance will always be required.

The Independent Investigation Team concluded that there was a reasonable degree of activity regarding inputs to Mr. Y in order to involve and engage him. It was evident that his likes and

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dislikes were always taken into account and that he was treated in a respectful manner at all times. This activity was in itself judged by the treating team to be evidence that meaningful engagement was taking place. However Mr. Y was adept at masking both his emotions and his symptoms. In situations such as this Health and Social Care professionals have to be realistic about how effective interventions can be. In a case such as Mr. Y's it would not have been unreasonable for his involvement with services to have been managed in a more assertive manner which would have afforded a greater degree of therapeutic challenge. In the event Mr. Y's involvement with his care and treatment programme remained at a superficial level. Staff identified the fact that he frequently told people what he thought they wanted to hear, but never really examined this tendency in relation to the consequences of his ongoing recovery. This lack of engagement may have fostered the rather enthusiastic response on behalf of the treating team to any suggestions that Mr. Y made about his relapse management plan and future stance to his recovery regardless of either how unrealistic or inappropriate they were. Of more concern is the fact that it was the erroneous belief on the part of the treating team that they knew Mr. Y well which perhaps led to the 'lowering of their guard' in that the basic protective factors (already discussed in the Subsections above) were not put into place.

It is a fact that ultimately Mr. Y's views and desires were not taken into account. Between January and March 2010 it was evident that he did not want to be moved to a more independent mode of accommodation. It is obvious from reading through the clinical record that Mr. Y was, uncharacteristically for him, actually making his thoughts and feelings very clear. It is unfortunate that Mr. Y's concerns were not addressed appropriately at this stage and the pressure on him to change his mind was significant. Whilst it cannot be known to what extent this last planned move had on Mr. Y, it is not unreasonable to speculate that it played a substantial part in the relapse of his mental health. A change such as this had long been predicted by the treating team as being a potential 'flashpoint'. It was therefore not good practice to apply such a high degree of pressure without a robust management strategy having first been put into place.

Mr. Y was not understood well by his treating team; however the treating team thought that he was and were genuinely of the view that Mr. Y was involved with, and committed to, his recovery plan. As a consequence routine protective plans were not put into place with the rigour that was required. This meant that when this very private and difficult to get to know

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man began to relapse there were few measures in place to monitor his mental state and few safety nets in place to ensure a safe and timely resolution.

Mr. Y was generally perceived as being a quiet and private person by members of his treating team and this appears to have become a barrier to a genuine therapeutic relationship being built up with him over time. His lack of involvement in his care planning and treatment, whilst ostensibly regarded as being Mr. Y ‘being the way he was,’ should have been challenged *via* the building and maintenance of a therapeutic relationship so that he could have genuinely engaged more fully in his own recovery.

- ***Contributory Factor Seven. Mr. Y’s involvement in his care and treatment programme was superficial at best. The treating team placed too much confidence in his ability to work with his recovery programme and consequently failed to put routine protective plans in place to the ultimate detriment of the health and wellbeing of Mr. Y.***

13.1.8. Carer Assessment and Involvement

13.1.8.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that “*the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes*”. In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that ‘*people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care*’. Also that it will “*deliver continuity of care for as long as this is needed*”, “*offer choices which promote independence*” and “*be accessible so that help can be obtained when and where it is needed*”.

Carer involvement

The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer

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(Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared for person's type and level of service provision required.

Further to this, The Carers and Disabled Children Act 2000 gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they care for.

The Carers (Equal Opportunities) Act 2004 placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. Also that it facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis.
- have their own written care plan which is given to them and implemented in discussion with them.

13.1.8.2. Findings

Prior to the Death of Mr. Y Senior

Between the time that Mr. Y was referred to secondary care mental health services on the 10 March 2003 and the killing of his father on the 19 February 2004 he lived at his parents' home.

From an early stage Mr. Y made it clear that he did not wish for his parents to be contacted by mental health services. Following the referral to secondary care mental health services in March 2003 it was evident that Mr. Y was acutely psychotic, was not complying with medication and that his mental health was continuing to deteriorate. On the 23 June 2003 the

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Staff Grade Doctor at the Day Hospital recorded that collateral information was required from Mr. Y's parents. Mr. Y refused to give consent for his parents to be contacted.⁴⁰⁸ At this stage it was agreed that the Day Hospital staff would continue to discuss with Mr. Y the need for his parents to be contacted.

On the 28 July Mr. Y was still refusing to comply with his medication. He described delusional thoughts and was becoming increasingly paranoid. Once again it was recorded that he refused to allow his parents to be contacted. On the 30 July 2003 Mr. Y's mental state had deteriorated to the point that a Community Psychiatric Nurse (Care Coordinator 1) was asked to visit him at his home. At this stage no prior contact had been made with Mr. Y's parents.

On the 11 August 2003 a review meeting was held. It was evident that Mr. Y's mental state was continuing to worsen. The Consultant Psychiatrist once again asked Mr. Y for permission to contact his parents. On this occasion Mr. Y's response was not recorded. Shortly after this time Mr. Y was discharged from the Day Hospital.

On the 18 August 2003 a risk assessment was conducted which stated that Mr. Y had paranoid thoughts about both his neighbours and members of his family. Mr. Y did not think that he had any risk factors and did not want his mother involved in any care plan. It was recorded under the carer section "*so opinion no sought*".⁴⁰⁹

On the 26 August 2003 it was recorded that both Mr. Y and his mother needed to be told that when a service user's mental health was deteriorating services would maintain contact and if needs be, a Mental Health Act (1983) assessment would be conducted.

Throughout the autumn of 2003 Care Coordinator 1 visited Mr. Y at his home, often with his mother present. It was evident that Mr. Y was still not complying with his medication and that his mental state was not improving.

On the 7 January 2004 another home visit was made. On this occasion Mr. Y Senior mentioned that her son "*explodes if anyone interferes with what he is doing*" but she denied

408. Trust Internal Investigation Report (2004) PP. 9-10

409. GP Record P. 51

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he had been aggressive towards anyone. It was also recorded that Mr. Y continued to refuse to take his medication.⁴¹⁰

The situation continued unaltered until the 16-17 of February 2004 when a home visit was made by an Approved Social Worker and Consultant Psychiatrist 2. On this occasion it was made clear to both Mr. Y and his mother that the situation could not be allowed to continue as it was and that Mr. Y required an inpatient admission to which he agreed on an informal basis. At this stage Mrs. Y Senior is recorded as beginning to understand the seriousness of her son's mental illness and to support the suggestion of the inpatient admission.⁴¹¹

Four main findings were made in relation to the involvement of Mr. Y's parents between March 2003 and February 2004.

First: the Independent Investigation Team was left with the impression that clinical staff believed that Mrs. Y Senior was in denial about the seriousness of her son's mental health problems and did not take his condition seriously. It was recorded in Mr. Y's clinical records subsequent to the killing of his father, that no one had ever told Mrs. Y Senior about the nature of her son's mental illness. She was to tell members of the Scott Clinic treating team, following the killing of her husband, that she had not been told about the seriousness of the diagnosis and that she would have advised her son differently with regard to engagement with services had she known. She stated that she genuinely did not know what Schizophrenia was or why the medication regimen was important. She also stated that with the benefit of hindsight had someone spent time with her explaining the situation she would have tried more assertively to have supported her son. Witnesses were asked at interview whether or not any educational work had been undertaken with Mr. Y's parents prior to the killing of his father. Witnesses stated that in their view discussing Schizophrenia with Mrs. Y Senior would potentially have led to her total disengagement with any treatment plan. Witnesses also expressed the view that diagnosis was perhaps not a helpful model to introduce to the family.⁴¹² The Trust Internal Review (2004) into the care and treatment Mr. Y received prior to the killing of his father stated that *"more effort should have been deployed in engaging family members particularly bearing in mind that, when his mother was in attendance, during*

410. CMHT Notes (2003-2004) P 10.

411. Trust Internal Investigation Report (2004) P. 20 and GP Records PP. 36-37

412. Witness Transcriptions

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a home visit on 16 February 2004, she became aware for the first time, of the severity of his condition".⁴¹³ The Independent Investigation Team concurs with this finding.

Second: the main reason given for services not contacting the family directly was that Mr. Y did not wish them to. The Trust Internal Review (2004) stated the following "*The Data Protection Act (1998) allows the processing of data under a number of conditions, other than with the subject's consent. There is, indeed legal precedent arising from a similar set of circumstances, to the case of ... [Mr. Y] when the judge found that obtaining information without the patient's consent ...with the object of obtaining information relevant to the patient's risk assessment and treatment, permitted under English law*".⁴¹⁴ The Internal Review Team was of the view that Mr. Y's family should have been contacted in order to obtain a collateral history. The Independent Investigation Team concurs with this finding.

Third: a carer assessment was not offered to Mr. Y's parents. The Independent Investigation Team acknowledges that in 2003/2004 carer assessments were implemented poorly across the country as a whole. The Team also acknowledges that this concept was understood poorly by the community-based treating team who thought that this kind of intervention was not relevant. Had it been decided that a carer assessment was not relevant, then other extant guidance in place at the time (NICE and Care Programme Approach policy and procedure) should have been considered. NICE guidance and CPA guidance all place a duty of care on secondary care mental health teams to involve carers in order to ensure that support and advice is available. It is a fact that Mr. Y was suffering from an acute psychosis and had been diagnosed as having Paranoid Schizophrenia. It is a fact that Mr. Y was living at home and that his family was described as being supportive and thus cited as a protective factor in the maintenance of his health and wellbeing. In this regard they were *de facto* being identified as carers. At no stage were they given the support and advice they needed to fulfil this role appropriately.

Fourth: safety, contingency and crisis planning processes were not considered through the lens of either carer participation or risk. It had been recorded that Mr. Y was harbouring paranoid thoughts about his neighbours and his family. Unfortunately the extant clinical record does not detail what these paranoid thoughts consisted of, or whether his parents were

413. Trust Internal Investigation (2004) P. 30

414. Trust Internal Investigation (2004) P. 30

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thought to be at risk. It was evident that Mr. Y was deluded and paranoid, suspicious and experiencing ideas of reference. It was known that he was not taking his medication and that his mental health was deteriorating. The parent's of Mr. Y should have been given very clear information regarding the nature of his mental illness and also what actions they needed to take if his condition grew worse or reached a state of crisis. This was not done.

Prior to the Death of Mrs. Y Senior

Support to Mrs. Y Senior Following the Index Offence

Following the death of Mr. Y Senior, and the attack that was perpetrated upon her by her son, it would appear that Mrs. Y Senior received neither counselling nor support from the Trust. At the present time a Trust would be expected to put into place an ongoing counselling and support programme for any surviving victim of an attack perpetrated by a mental health service user. The events of 2004 pre-dated the national 2005 *Being Open* guidance which sets out the requirements for this. However given the severity of the attack, the fact that Mr. Y was an inpatient at the Scott Clinic and that the requirement for family therapy interventions had been identified, and that Mrs. Y Senior was regarded as a future potential victim, it would have been good practice for this to have been taken into consideration and acted upon.

Clinical Assessment Contacts with Mrs. Y Senior

On the 14 July 2004 the Social Worker made a visit to Mrs Y Senior's home. Mrs. Y Senior was noted to have felt better able to talk on this occasion (there is no record of what the previous occasion had consisted of). She mentioned that Mr. Y had always had a loving relationship with his father, that he liked history and keeping fit. She also said that Mr. Y had never been an aggressive person and had never been in fights. Mr. Y had recently written a letter to his mother. The letter was reported to have been full of love for his mother and regret for killing his father. Mr. Y had requested that his mother visit him. At this stage Mrs. Y Senior felt that she could not visit him, but may be able to do so in the future. She said her sister would probably visit him in the meantime.⁴¹⁵ It is unclear what the purpose of this visit was, whether it was to provide support to Mrs. Y Senior, or to gain some understanding of Mr. Y.

415. Clinical Records Set 2. PP. 82-83

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On the 6 September 2004 the carer perspective was recorded as being that Mrs. Y Senior was grieving for her husband, but at the same time felt she had lost her son for whom she could not grieve. She felt it would have been better if her son had killed her as well. She could not feel sorry for her son, nor sympathise, as she was still trying to come to terms with what had happened. Mrs. Y Senior said that she had not been informed about her son's mental illness in the past or about what signs and symptoms to be aware of. Any perceived non-compliance on her part in the past was "*done in complete ignorance*".⁴¹⁶

During September 2004 the Psychologist recorded that Mr. Y's mother said that as a young child, he periodically held his breath until he went blue in order to get his way. Upon starting school she described him as anxious not wanting to be separated from herself or travel on the school bus. Mr. Y had expressed feelings of jealousy about his brother. Alternately Mr. Y said that whilst he had a close relationship with his mother; she was an anxious woman who was "*interfering, controlling and critical*". He said that her intrusiveness had undermined his confidence. As a consequence he withdrew and bottled up his feelings. Shortly after leaving school he had left home, but his mother had "*ordered him to return*". It was around this time that Mrs. Y Senior started to be described as being as a 'high EE' mother in Mr. Y's clinical record. 'High EE' or high expressed emotion is a term used to describe the behaviour of people who are very critical and, at times, hostile. These people do not know any other way to help support a family member with mental illness. They feel that the illness can be controlled by the service user. The only way they feel that the service user will change their behaviour is through criticism which actually often contributes to a relapse. It would appear that the evidence used to make this judgement was based solely upon the history given by Mr. Y. Witnesses to this Investigation disagreed strongly with the notion that Mrs. Y Senior was a 'high EE' mother.⁴¹⁷

On the 4 October it was noted in the Effective Care Coordination Review that the Social Worker and Clinical Psychologist had visited Mrs. Y Senior in order to gain assistance with Mr. Y's assessment. No mention was made about any support that she may have required at this stage in her own right.⁴¹⁸ At this stage Mrs. Y Senior did not feel able to meet with her son and was worried about the possibility of his returning home in the future.

416.Trust Record PP. 489-491

417.Mr. Y Trust Record PP. 52-61

418.Trust Record PP. 62-65

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In December 2004 Mrs. Y met with her son for the first time following the index offence; she was accompanied by members of her family. From this time forward there is little evidence to suggest that she took part in any other kind of clinical assessment process. At the 4 October 2004 Effective Care Coordination Review it was noted under long-term risk management that the required plans would be clarified after reviewing Mr. Y's psychotic illness, personality issues and family dynamics.⁴¹⁹ At the 5 September 2005 Effective Care Coordination review it was noted that future long-term risk management plans should consider exploring the family dynamic (this was resultant on the outcome of a pending neurological assessment).⁴²⁰ No further family-focused work took place even though it had been identified that Mrs. Y Senior remained at risk of future harm from her son and any possibility of future offending appeared to be "*very specific to the interaction between and the dynamics in his relationship with his parents*".⁴²¹

Care Programme Approach

Mrs. Y Senior attended Effective Care Coordination meetings at the Scott Clinic; the first being on the 7 March 2005. She always came accompanied by Mr. Y's aunt. Mrs. Y Senior's attendance commenced once she began to visit her son on a regular basis. It is not clear what kind of involvement she actually had at these meetings. It is a fact that the carer sections on the CPA documentation remained largely blank. On occasion Mrs. Y Senior's views were recorded but these views appear to have been restricted to saying that she did not want her son to return to the family home and that she was pleased with his progress. The Effective Care Coordination meeting that took place in July 2006 was the forum where Mr. Y's forthcoming Mental Health Review was discussed. It was noted that she was happy with what was being proposed and that she had met with Consultant Psychiatrist 3 who had discussed the forthcoming process with her. However it was recorded on the 28 September that the Social Worker visited Mrs. Y Senior at her home. On this occasion Mrs. Y was reported to be confused about the forthcoming Tribunal and what it would mean. Moscow Drive was not far away from her home and did not feel she could bear Mr. Y coming back into the house; her feelings were described still being "*raw*". It was clear that members of the extended family had very strong negative feelings about Mr. Y. They were angry with Mrs. Y Senior for accepting her son and felt that she should have "*locked him up and thrown away the key*".⁴²²

419. Trust Record P. 482

420. Trust Record P. 407

421. Trust Record P. 187

422. Clinical Records Set 2. P. 330

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Whilst it is not unusual for carers to find it difficult to express their views during ward rounds and Care Coordination meetings, it is always regrettable. Mrs. Y Senior had been visiting her son at the Scott Clinic for a period of two years at this stage and the treating team had had the opportunity to get to know her well. It would appear however that she was not able to discuss her concerns in such a public forum and that there was a limited therapeutic relationship developed with her.

Following Mr. Y's conditional discharge into the community in December 2006 Mrs. Y Senior no longer attended the CPA reviews. It is not clear why this was the case. The Independent Investigation Team noted however the following entry in the clinical record dated the 9 November 2006 "*...Section 37/41 MHA Rights read and I feel ... [Mr. Y] understood these. Next review date set for 9/2/07. ... [Mr. Y] does not wish for his nearest relative to be sent a copy of the section information leaflet*".⁴²³ It is speculation only, but it is possible that as Mr. Y prepared himself for his discharge he may not have wanted his mother involved in his care and treatment any longer. Whatever the reason, this served to isolate Mrs. Y Senior from the care, treatment and monitoring process. It is a fact that once Mr. Y was discharged into the community ongoing communications between Mrs. Y Senior and members of the treating team dwindled significantly.

It became apparent when the Independent Investigation Team interviewed witnesses that liaison and support to his mother was not considered to be a part of the Care Coordination process and for this reason neither Care Coordinators 2 nor 3 ever met with Mrs. Y Senior. This lack of association between Care Coordination and family liaison may also have contributed to Mrs. Y Senior no longer attending Effective Care Coordination meetings once her son was living back in the community.

Conditional Discharge Arrangements

It was evident that Mrs. Y Senior and her family were concerned about her continued safety when faced with the prospect of Mr. Y's discharge from the Scott Clinic. The Subsections above detailing risk assessment, care planning and discharge processes have already described in detail the fact that the terms of the conditional discharge were translated poorly

423. Clinical Records Set 2 P.353

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into a coherent set of care plans. In effect at the point of discharge Mr. Y was given the prime responsibility to regulate his own contacts in relation to meetings with his mother.

Mrs. Y Senior's family and friends appeared not to be happy with the discharge arrangements and they set up their own procedures to keep her safe. One such arrangement was that Mrs. Y Senior left her porch light on when she went out and turned it off again on her return. This provided a clear signal to anyone 'in the know' that she had arrived back safely from any visit to her son. It was this arrangement that signalled all was not well on the night of her death and led to her neighbours reporting her missing to the Police when she failed to return from the visit to her son which took place on the 30 March 2010.

Support and Protection

It has already been stated that neither Care Coordinator allocated to Mr. Y following his discharge ever met Mrs. Y Senior. The role of liaising with Mr. Y's mother fell to the Social Supervisors who when interviewed by this Investigation appeared not to understand what levels of communication and involvement Mrs. Y Senior should have expected from secondary care mental health services. The Social Supervisors focused their activities in relation to their role of monitoring the terms of the conditional discharge and appeared to have focused upon this alone. On the 14 October 2008 Social Supervisor 2 visited Mrs. Y Senior at her home. The visit was described in the clinical record as "*lengthy*" and focused upon the issues leading up to Mr. Y's admission to the Scott Clinic. Mrs. Y Senior was advised that she should contact Social Supervisor 2 if she needed any further input that may help her.⁴²⁴ The Independent Investigation Team make the observation that this offer of help, whilst well meaning, could not be described as timely seeing that it was made four and half years after the killing of Mr. Y Senior and the attempted manslaughter of Mrs. Y Senior.

It was recorded that on the 29 May 2009 Social Supervisor 2 visited Mrs. Y Senior once again at her home. On this occasion Mrs. Y Senior was said to be pleased with her son's progress.⁴²⁵ There are no further recorded interventions with Mr. Y's mother.

424. CMHT Notes Post Discharge P. 48

425. CMHT Notes Post Discharge P. 41

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13.1.8.3. Conclusions

Prior to the Death of Mr. Y Senior

The Trust Internal Review (2004) stated that *“family contact could have been an essential element in his care and treatment and should have been pursued in spite of ... [Mr. Y’s] reluctance”*.⁴²⁶ The Independent Investigation Team concurs with this conclusion. Had Mr. Y’s parents been involved by the treating team at the outset, in a manner in keeping with both NICE and CPA policy guidance, it is probable that Mr. Y would have received their informed support which could have made a substantial contribution to his care and treatment. In the event they were not told about his diagnosis and did not understand the importance of the medication regimen that he was so rejecting of. The Trust Internal Review did, however note that Mrs. Y Senior was not subject to a Carer’s assessment and in its recommendation to the Trust stated *“A review of the arrangements in place for Carers of service users admitted to the Scott Clinic should be undertaken. All Carers should be offered a Carer’s assessment”*.

At no stage did the treating team seem to consider the practical and emotional difficulties that Mr. Y’s parents may have experienced in providing support to a person who was suffering from an acute episode of psychosis. Neither support nor advice were offered to them. It was also apparent that Mr. Y’s paranoid thinking encompassed his parents and that he was volatile and angry within the home. Knowing this, it is of concern that the treating team did not develop a risk management strategy for Mr. Y’s parents.

Had Mr. Y’s parents been engaged with in a manner in keeping with extant national and local policy and procedure it is probable that they would have understood better the situation they, as a family were in, and could have been worked with to manage it better. It is also probable that Mr. Y could have been engaged with his care and treatment regimen more effectively with his parent’s informed support.

Prior to the Death of Mrs. Y Senior

The Trust Internal Review (2010) into the care and treatment Mr. Y received following the killing of his mother did not examine carer issues and therefore it is not possible to include any Trust-based conclusions stemming from the internal investigation process.

426. Trust Internal Investigation (2004) PP. 28-29

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The Independent Investigation Team concluded that Mrs. Y Senior did not at any stage have her own needs as a victim of the index offence, a carer, and a potential future victim of violence assessed. Mrs. Y Senior appeared from the outset, to have been treated exclusively by the Scott Clinic as a source of collateral information as it pertained to her son. Whilst there are references in Mr. Y's clinical record to the possibility of family interventions and family dynamics work comprising a future plan of action, at no time were these ever explored beyond a rudimentary level. This was contrary to extant NICE guidelines, which in the circumstances, should have been implemented as they were most clearly indicated.

Throughout Mr. Y's time as an inpatient at the Scott Clinic all risk assessment documentation stated that Mr. Y's future potential for violence focused upon his surviving parent, his mother. It was recognised that, although in the opinion of the treating team it was considered unlikely, Mr. Y was capable of a relapse and that his mental health could deteriorate in the future. It was understood that if that occurred it was possible that he would repeat the behaviour associated with his index offence and that he could kill again. The risk Mr. Y posed could not have been more clearly stated. What is incomprehensible is why no robust risk management plan was put into place to protect Mrs. Y Senior. The terms of the conditional discharge set out clearly what actions needed to be considered. However instead of working these conditions into a coherent management plan, they were left as simple statements of intent which were rendered meaningless because:

- they were not communicated effectively to partner agencies (such as Imagine);
- they were not broken down into a series of planned interventions;
- they were left largely to Mr. Y to self regulate;
- they were not monitored appropriately.

It was not good practice to isolate Mrs. Y Senior from the treating team following Mr. Y's conditional discharge into the community. Due to the fact that the Care Programme Approach and Care Coordination failed to provide ongoing liaison and support it is doubtful if she understood what crisis or contingency plans were in place, or how she could summon assistance for either her son or herself if the need arose. In the event this elderly lady and her family were left to put their own protection plan in place. Unfortunately whilst this plan proved to be effective in raising an alert, it proved not to be effective in saving Mrs. Y Senior's life

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- *Contributory Factor Eight. The Scott Clinic failed in its duty of care to Mrs. Y Senior. This left her unsupported and without the protection of risk management plan.*

13.1.9. Housing

13.1.9.1. Context

Supporting People

Supporting People is a United Kingdom government programme helping vulnerable people in England live independently and keep their social housing tenancies. It is run by local government and provided by the voluntary sector. It was launched on 1 April 2003. The Office of the Deputy Prime Minister wrote on the introduction of the scheme that “*On 1 April 2003 the Supporting People programme was launched. The programme is committed to providing a better quality of life for vulnerable people to live more independently and maintain their tenancies. The programme provides housing related support to prevent problems that can often lead to hospitalisation, institutional care or homelessness and can help the smooth transition to independent living for those leaving an institutionalised environment. The Supporting People programme provides housing related support services to over 1.2 million vulnerable people. The programme is delivered locally by 150 Administering Authorities, over 6,000 providers of housing related support, and an estimated 37,000 individual contracts*”.⁴²⁷

Supporting People client groups

Supporting People is a wide and varied programme that reaches out to different vulnerable members of society. Client groups include:

- people who have been homeless or a rough sleeper;
- ex-offenders and people at risk of offending and imprisonment;
- people with a physical or sensory disability;
- people at risk of domestic violence;
- people with alcohol and drug problems;
- teenage parents;
- elderly people;

427.<http://www.peoplefirsthousing.co.uk/downloads/Info%20What%20Is%20Supporting%20People.pdf>

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- young people at risk;
- people with HIV and AIDS;
- people with learning difficulties;
- travellers;
- homeless families with support needs.

The Office of the Deputy Prime Minister has the main responsibility for the *Supporting People* programme. It allocates a *Supporting People* grant to Administering Authorities and monitors their performances. Administering Authorities (unitary authorities and counties in two tier areas), are responsible for implementing the programme within their local area. The Administering Authorities contract with providers and partner organisations for the provision of *Supporting People* services. A Commissioning Body (a partnership of local housing, social care, health and probation statutory services) sits above an Administering Authority and plays a key role in advising and approving a *Supporting People* strategy.⁴²⁸

*“In October 2003, the Government commissioned RSM Robson Rhodes LLP to undertake an Independent Review of Supporting People as a result of the significant and late growth in costs by £400 million between December 2002 and April 2003. The Independent Review was asked to consider the value for money and the variation in unit costs and services across local authorities. The Independent Review concluded that: ‘£1.8 billion is too much to pay for the legacy provision... It is important that the cost of the legacy provision is brought in line with the proper market rate for good quality strategically relevant housing services. It is also important that efficiency savings are optimised and secured as early as possible to release funds for new provision’. A programme of work has been developed to take forward many of the recommendations. This focuses on improving how Administering Authorities, service providers and commissioning bodies manage and deliver value for money”.*⁴²⁹

Background to the Services Provided at Moscow Drive

The accommodation provided at Moscow Drive by Imagine was initially setup as a joint venture with the Scott Clinic and the Primary Care Trust to provide step down care for individuals within the forensic service as there was a lack of resource in the community. The financial model was that 80 per cent of the funding would come through *Supporting People*

428.<http://www.peoplefirsthousing.co.uk/downloads/Info%20What%20Is%20Supporting%20People.pdf>

429.<http://www.peoplefirsthousing.co.uk/downloads/Info%20What%20Is%20Supporting%20People.pdf>

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and the remainder would come from the Primary Care Trust.⁴³⁰ This joint commissioning arrangement was developed because there was willingness for the different agencies to work together. This was a model characteristic of Liverpool. The service was provided by the voluntary sector (Imagine) and was funded through Section 64 (joint commissioning) arrangements.

The Imagine Internal Review (2010) into the care provided to Mr. Y provides a useful synopsis of the services provided at Moscow Drive and the contracting arrangements that were in place at the time Mr. Y lived there.

123 Moscow Drive

“There appears to have been an informal arrangement between the Scott Clinic and Imagine to provide residential support for service users being discharged from the forensic service. This arrangement was set up bythe then community services manager for the Mersey Forensic Psychiatry Service.

In 123 Moscow Drive there had been five places three of these were occupied by former Scott Clinic patients the other two were occupied by service users from the general psychiatric service. [The then Community Manager] arranged for regular support to all 5 residents not just the former forensic patients. In practice this meant that when a forensic CPN was visiting he would discuss any patient the imagine staff had concerns about not just the forensic patients as problems for any resident could have knock on effects on the whole house. This informal arrangement had been put in place around eight years ago by a different generation of staff and in a different contracting culture; it would not be possible to replicate this arrangement today.

The inquiry panel heard from a number of different sources that there were 3 forensic beds in Moscow Drive commissioned and funded for the use of the Scott Clinic. No such contract ever existed and decisions regarding where to place clients have always been made by the Vacancy Panel, Multi disciplinary clinical teams can and do recommend particular placements. This may be due to the experience and expertise of particular agencies or

430. Witness Transcriptions

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perhaps because of the accessibility of the placement to a client's relatives or social network, (or lack of access in some cases).

The four agencies involved in this contract (directly or indirectly) are Imagine, Mersey Care NHS Trust, Liverpool PCT and Liverpool City Council. All four agencies have significant responsibilities for the welfare and safety of service users, staff and the general public yet it seems there is never an occasion when they come together to discuss the strategic direction of these services or their operational effectiveness".⁴³¹

133 Moscow Drive

"133 Moscow Drive has four flats for service users and a staff flat; the original group of tenants who transferred to the flats in 2009 included three former forensic patients who had been resident at 123 Moscow Drive. The essential difference at 133 is that each person has an individual tenancy for their own flat.

As part of the tenancy the service user has exclusive access to their flat, staff do not have spare keys and can only enter the flat by invitation. There are no communal areas other than the hall, stairs and laundry facilities. This requires staff to actively engage with tenants and discuss the kind of support the tenant requires at any given time, e.g. budgeting, social support or just for some company. Tenants can visit the staff accommodation and regularly do so, in ... [Mr. Y's] case this was usually at the initiation of staff.

The individual contracts for each service user detail the range of issues and quantity of engagement required from the Imagine staff. In the current financial climate even greater scrutiny is being exerted to ensure goals are being identified and achieved as cost effectively as possible".⁴³²

13.1.9.2. Findings

The Placing of Mr. Y

Mr. Y was ultimately placed at 123 Moscow Drive following a request from the Social Worker at the Scott Clinic in the spring of 2006. The Independent Investigation Team was told during witness interviews that referral processes were usually initiated by the allocated

431. Imagine Internal Review (2010) PP. 9-10

432. Imagine Internal Review (2010) P.10

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Care Coordinator. In the case of Mr. Y who had no Care Coordinator his Social Worker initiated the referral.

The Imagine Internal Review (2010) usefully clarified that previous psychology reports prepared on Mr. Y's behalf in September 2005 stated that "... [Mr. Y] will be offered a psychological intervention which will start on a one-to-one level and will have several aims. It is acknowledged however that, there is little evidence or research on the effectiveness of teaching theory of mind skills to adults with such disorders. It is likely that any intervention will be a long process and will require external structure and management for ... [Mr. Y's] foreseeable future as it is unlikely that he will ever develop these skills and effectively use them independently".

*"For long-term accommodation ... [Mr. Y] is more likely to cope within a small home in the community containing a stable small group of people for him to interact regularly with. As ... [Mr. Y] requires such a structured, predictable environment in order to feel safe and secure, he would benefit from supported accommodation with staff input who have an awareness of his limitations and will continue developing his lifestyle skills. His level of risk and management would not suggest a high level of physical security requirements if the above interventions were to continue in his new accommodation".*⁴³³

The Effective Care Coordination Review held on 5 September 2005 identified Mr. Y's need for a small group home in a predictable environment with staff experienced in autistic spectrum disorder.⁴³⁴

The Imagine Internal Review (2010) discussed the "apparent disparity" between what had been identified as being required for Mr. Y and what was in actual fact put into place. The Internal Review stated that "The first quotation strongly suggests that ... [Mr. Y] would require support indefinitely and even then would be unlikely to benefit sufficiently to live independently. The description of accommodation required to support ... [Mr. Y] in the second quotation is consistent with that provided by Imagine in Moscow drive. The inconsistency arises in an implicit assumption that Moscow Drive staff would have the skills and training to support a client with such complex needs and unusual diagnosis as ... [Mr.

433. Psychology Records PP. 21- 30

434. Trust Record PP. 377-382, 388-399, 400-411

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*Y]. In reality these skills are clinical and the input would be required from Mersey Care staff. It is unlikely that a single weekly visit from the social worker or CPN, as provided to ... [Mr. Y], would be frequent enough to provide this care”.*⁴³⁵

The Independent Investigation Team concurs with this finding. It was apparent that the Scott Clinic was aware of exactly the kind of care and support that would be provided at 123 Moscow Drive. However the Trust clinical record constantly states that Mr. Y was in ‘24-hour supported accommodation’. It was this assumption that appeared to have lessened Mr. Y’s risk prioritisation. It is a fact that the Mental Health Tribunal when making the first of nine conditions for Mr. Y’s conditional discharge stated he was “*To reside at 123, Moscow Drive, Liverpool (24-hour supported accommodation)*”.⁴³⁶ A witness to this Investigation from Imagine said that “*We never sought to offer 24-hour care. Our staff would be working with the other users in the premises and would have left the building frequently. There was never any suggestion that we had staff on site 24 hours a day...* ”.⁴³⁷

It would appear that at the point of Mr. Y’s conditional discharge into the community the decisions made about his supported living accommodation ran counter to those made previously regarding his long-term needs. Assumptions appear to have been made about the levels of support and supervision that he would be able to receive at 123 Moscow Drive which were erroneous and provided a false sense of security. At the stage when Mr. Y’s community placement was being planned the treating team’s perception of his ongoing risks and needs were not congruent. Risk assessments stated that he would need a structured management plan around any change to his environment and that any accommodation move could trigger a relapse. It was identified that Mr. Y would need ongoing support and that his ‘Theory of Mind’ problems would continue for the rest of his life and would need ongoing therapeutic input. The Independent Investigation Team found that the Imagine care workers were neither appropriately skilled nor qualified to provide the ongoing levels of therapeutic input that Mr. Y required. This could have been ameliorated by the required therapy being provided by the Scott Clinic team, but at the point of discharge the Scott Clinic team ceased abruptly all therapeutic inputs and segued into a monitoring and supervision role only.

435.Imagine Internal Review (2010) P. 13

436.Trust Internal Investigation Report (2010) P. 22

437.Witness Transcription

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Handover Processes and Multiagency Communication Processes

As has been concluded in Subsection 13.1.6. above the discharge planning processes that took place when Mr. Y left the Scott Clinic to at 123 Moscow Drive were poorly executed.

Care Coordinator 2 and the Senior Occupational Therapist from the Scott Clinic visited the Imagine staff at Moscow Drive on the 28 December 2006. The purpose of this visit was to provide a transfer of information which included the previous work done with Mr. Y whilst an inpatient regarding his 'Theory of Mind' difficulties. Imagine staff were given the opportunity to look at Mr. Y's work file and were encouraged to spend time with him to go through the contents. Mr. Y was told that the therapeutic intervention that he had previously received from the Senior Occupational Therapist would now cease.⁴³⁸ It is unclear why this kind of conversation was not instigated with Imagine in the summer of 2006 prior to Mr. Y taking Section 17 leave at Moscow Drive. Whilst it was evident that Care Coordinator 2 (who was new to the case) had facilitated this sensible input, this intervention should have taken place at least six months previously. The Independent Investigation Team concluded that it was not appropriate for such a complex notion to be handed over to unqualified staff for future therapeutic input with such a fleeting set of instructions.

As has been discussed above in previous subsections, there is no evidence to suggest that a management plan had been developed to ensure that the terms of Mr. Y's conditional discharge were met. It remains uncertain as to what exactly the Imagine workers knew about Mr. Y and the expectations that the Scott Clinic team had placed upon them by default. It is a fact that Imagine workers were invited to attend, and did attend, Mr. Y's Effective Care Coordination meetings once he was in the community. Unfortunately most of these meetings were either not recorded, and/or the documentation not filed in the Trust record keeping system, and/or not sent to the Imagine workers. It is difficult therefore to understand what took place at these meetings in any great detail. It is possible that these meetings fostered discussion about how Mr. Y was to be managed, but from examining the extant Trust and Imagine records formulated about Mr. Y this does not appear to have been the case. This view is supported by the findings of the Trust Internal Review (2010) and the Imagine Internal Review (2010). It was also supported by the findings of this Investigation when interviewing Imagine witnesses.

438. CMHT Notes Post Discharge PP. 1-2

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Moving On Processes

The Move from 123 to 133 Moscow Drive

The Imagine Internal Review (2010) identified concerns in that Mr. Y was being moved from 123 Moscow Drive, where his supervision and therapeutic inputs from the Scott Clinic team were already minimal, to an environment that would offer even less monitoring and social care input. The Review stated “*These concerns apply particularly to the apparent haste to move ... [Mr. Y] from his flat in 123 Moscow Drive to less supported accommodation elsewhere in the community. This drive seems to have been based on an assumption that ... [Mr. Y] could manage without the level of support previously considered to be essential for him to prosper in the community.*”

A further concern related to ... [Mr. Y's] 's transfer from 123 Moscow Drive to 133 Moscow Drive is the assumption that the accommodation in the new building was equivalent to that in the former property, this was not the case. As stated previously ... [Mr. Y's] new accommodation was a self-contained flat with 24 hour support available. This afforded him greater privacy but also the opportunity to isolate himself more. One of the terms of his conditional discharge was that he should be resident at 123 Moscow Drive any change of address required the notification and prior permission of the Ministry of Justice. This was not sought and consequently an important external check was missed.

Perhaps the most significant omission from the Mersey Care records is any risk assessment, formal or informal, regarding ... [Mrs. Y Senior]. ... [Mrs. Y Senior] was both a victim of ... [Mr. Y] and his next of kin/carer. She was his principal support and only visitor, (... [Mr. Y's] aunt and uncle came as support to ... [Mrs. Y Senior] when she visited, not to visit ... [Mr. Y] themselves). There is no satisfactory explanation for this omission”⁴³⁹

The Independent Investigation Team concurs with these findings. Additional findings also include the following:

- no risk management plan was put into place by the Scott Clinic team regarding Mr. Y's move; it had been identified that a change to his environment could cause a relapse in his mental state therefore this was a significant omission (it must be noted that Imagine put a

439. Imagine Internal Review (2010). 13

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risk management into place, but this was a basic plan that identified accidental fire setting and food poisoning issues around fridge hygiene);

- the actual level of required 1:1 input each day was identified as being one hour; somewhere along the line staff 24-hour support/supervision had been reduced to a single hour each day of social contact.

It is not clear what exactly prompted Mr. Y's move from 123 to 133 Moscow Drive in September 2009. The Independent Investigation Team was told by a Trust witness that a Local Authority assessor (an agency social worker employed during 2009) had assessed Mr. Y in the spring of 2009 as requiring a 22-hour input for support rather than a 37-hour level of input, hence instigating the move. The Independent Investigation Team was also told by an Imagine witness when interviewed that 123 Moscow Drive was no longer considered to be a suitable place of residence for building reasons and that the landlord was not prepared to make the appropriate changes.⁴⁴⁰ (The Local Authority was however at pains to say that a reduction in an individual's support hours would not automatically mean that the individual would need to move accommodation as individuals have a tenancy and any move to another accommodation would be part of an agreed plan with the individual service user). In a material sense the move might have been a beneficial one, however given Mr. Y's known aversion to change; it was not necessarily psychologically so beneficial. There is no evidence of appropriate psychological preparation for this move. It appears, however, that the move went well and Mr. Y reported that he enjoyed his new accommodation and had made a friend (possibly for the first time in his life). There is no account within the clinical record that any discussion took place either within the Scott Clinic team or during Effective Care Coordination Reviews as to whether this move was in Mr. Y's best interests or not. The cost of increased independence was decreased supervision. This does not appear to have been reflected upon or included in a risk assessment. Of obvious concern is the fact that the Ministry of Justice was neither consulted nor informed.

The Planned Move from 133 Moscow Drive

Mr. Y had been a resident at 133 Moscow Drive for approximately four months when plans commenced to move him to another place of residence that would offer him more independence. The Independent Investigation Team interviewed both Trust and Imagine

440. Witness Transcription

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witnesses and also held a meeting with Local Authority and Supporting People Managers. It has proven impossible to understand why this move was being planned. Very little survives in the extant clinical/social care record about the reasons why this move was being considered. However the evidence, such as it is, is as follows:

Trust Perspective

1. Witnesses at interview denied having any knowledge of an imminent move being planned. Witnesses understood that some discussion had taken place but had not thought anything to have reached an implementation phase. Recollections were at distinct odds with the extant clinical record which detailed that a move was indeed imminent. A letter sent to the GP by Consultant Psychiatrist 3 following the 11 March 2010 Effective Care Coordination Review stated that *“The main focus of the discussion was around consideration for slightly more independent living as move on from Moscow Drive...He has also not required access to the 24hr staffing over the past three years. Accommodation being considered is the Cluster Flat Scheme where he would receive support one to one support daily. ... [Mr. Y] is beginning to consider this as an appropriate move for himself”*.⁴⁴¹

Whether the move was ‘imminent’ or not it was evident that a place had been identified for Mr. Y to move into and that he was being actively advised to consider this option. Of concern to the Independent Investigation Team was the fact that Mr. Y having not accessed staff *support* in over the past three years was an indication that he did not require ongoing *supervision*, as one could not be reduced without the other this was problematic. Trust witnesses claimed not to have been the instigators of any proposed move. The fact remains however that the Scott Clinic team appeared to have supported the idea and were not adverse to this move taking place. At no time did the Scott Clinic team consider consulting with the Ministry of Justice as required to do so.

Imagine Perspective

2. Witnesses at interview were of the view that the urgency to move Mr. Y from 133 Moscow Drive may have been prompted by an ongoing *Supporting People* review. As a result of the review it was decided that Mr. Y no longer required the level of support that

441. GP Records P. 60

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he had enjoyed previously and that his support hours could be cut. This would have necessitated a move to less supported accommodation.

Mr. Y would have been eligible for Section 117 aftercare arrangements which should have ensured that his care in the community needs would be funded in full by both the Local Authority and the Primary Care Trust. Any change to a Section 117 plan of aftercare should have been needs driven, not funding driven, and the decision to instigate any change should have been made in an appropriate multiagency forum. If indeed it had been decided that Mr. Y's needs had changed, and that a subsequent change in funding and support was indicated, then an appropriate multiagency discussion did not appear to have taken place.

Regardless of where the impetus came from to move Mr. Y, it was Imagine workers who took Mr. Y to visit the new accommodation and who spent time with him persuading him that the move was in his best interests.

Local Authority and Supporting People Perspective

3. Local Authority and Supporting People Managers denied being the instigators of a plan to move Mr. Y from 133 Moscow Drive to the Cluster Flat Scheme. The Managers told the Independent Investigation Team that this kind of assessment and decision would not have been an appropriate thing for their services to have been involved with and that this kind of activity would not have framed part of an individualised care plan.

The Independent Investigation Team knows that a further move was being planned imminently from 133 Moscow Drive to the Cluster Flat Scheme. This move ran counter to the terms set by Mr. Y's conditional discharge and the Ministry of Justice who had not been consulted. It was evident from reading through the extant clinical records that Mr. Y was not happy about the move, and had uncharacteristically made his views very clear. Despite Mr. Y's objections there appeared to have been a great deal of pressure being exerted upon him. It is inexplicable as to why such a move was in fact being considered so quickly following his move the preceding September out of 123 Moscow Drive. It is also inexplicable why no risk management plan was put into place as moving Mr. Y had been identified as a major risk factor in the past, and he was actively expressing misgivings about this new venture.

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13.1.9.3. Conclusions

The Independent Investigation Team concluded that the care and support provided by the Imagine team at both 123 and 133 Moscow Drive was of a diligent and robust nature. It was characterised by social activities, like gym attendance and encouraging Mr Y to pursue interests. However, in the absence of skilled therapeutic inputs from the Scott Clinic team, it was unlikely that Imagine workers would have been able to provide the level of supervision and support that Mr. Y required. Indeed this was an unreasonable expectation on behalf of the Scott Clinic team. From the outset there was an over reliance upon the Imagine workers to provide a level of support (24-hour supervision) and therapeutic inputs (Theory of Mind) that they were not contracted to provide. These unrealistic expectations were to lead to a false sense of security about Mr. Y's ongoing management being fostered by the Scott Clinic team.

Mr. Y's discharge and aftercare arrangements were managed poorly when he moved from the Scott Clinic to 123 Moscow Drive. Both Imagine workers, and Mr. Y himself, were prepared poorly for this transition. That being said Mr. Y lived in the community with no seeming difficulties until a few weeks prior to the killing of his mother. However the failure to ensure that Mr. Y's aftercare arrangements were clear, documented, and communicated between all of the agencies involved with him, ensured that over time Mr. Y's risks to both himself and to others were minimised to the point that they were no longer an active consideration.

Weak Section 117 aftercare arrangements contributed to a lack of clarity around the short, medium and long-term plans surrounding Mr. Y's future, with particular regard to his required accommodation needs. These needs had been identified statutorily (by the Ministry of Justice) and clinically (by psychological assessment). Statutory agencies did not appear to have understood their obligations either with regard to Section 117 or Mr. Y's particular requirements.

Poor levels of Care Coordination, Social Supervision and clinical oversight ensured that Mr. Y's accommodation requirements were synchronised in a 'hap hazard' manner. The one abiding factor that had been identified as a long-term protective factor for Mr. Y was environmental stability. It was poor practice to have ignored this aspect of Mr. Y's ongoing risk management plan and to have pushed him into considering a second move within a four-month period of a previous change to his place of residence. The Forensic Psychiatrist preparing the Crown Court report for the Prosecution at Mr. Y's trial following the killing of

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his mother stated that *“It is plausible that the stress and anxiety of moving to alternative (independent living) accommodation was a contributory factor. [Mr. Y] reports not wishing to move on to alternative accommodation that was being explored for him”*.⁴⁴²

It is regrettable that none of witnesses interviewed by this Investigation could explain what instigated the pending move early in 2010. It is also regrettable that none of the witnesses appeared to ‘own’ the pending move and the risk management procedures that were required in order to ensure a legal and safe transition.

It was the conclusion of the Independent Investigation Team that Mr. Y’s accommodation and Supported Living arrangements were an essential part of his short, medium and long-term plan of care and risk management strategy. Supervision arrangements, and the terms of Mr. Y’s conditional discharge, were unspecified, diffuse and misunderstood. The Scott Clinic placed an over reliance upon Imagine to fulfil this responsibility when it was something that could be delegated in part only as 123 Moscow Drive could not provide the degree of monitoring, support and supervision that Mr. Y required. Consequently the terms of the conditional discharge were not implemented in the spirit in which they were intended. From the outset this aspect of Mr. Y’s ongoing care need was managed poorly to the ultimate detriment to his health, wellbeing and safety, and to that of his mother.

- ***Contributory Factor Nine. Significant failures to manage Mr. Y’s Section 117 aftercare arrangements and terms of his conditional discharge meant that his Supported Living provision was inadequately planned from the outset. This had the effect of creating a degree of instability in the life of a person who required structure and certainty and also prevented realistic protective measures being put into place.***

442. Psychiatric Court Report P. 30

13.1.10. Documentation and Professional Communication

13.1.10.1. Context

Documentation

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance.

The GMC states that:

*“Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off.”*⁴⁴³

Pullen and Loudon writing for the Royal College of Psychiatry state that:

*“Records remain the most tangible evidence of a psychiatrist’s practice and in an increasingly litigious environment, the means by which it may be judged. The record is the clinician’s main defence if assessments or decisions are ever scrutinised”.*⁴⁴⁴

Professional Communication

*“Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion”.*⁴⁴⁵

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one

443. <http://www.medicalprotection.org/uk/factsheets/records>

444. Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) PP 280-286

445. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P121

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agency alone.⁴⁴⁶ The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.⁴⁴⁷ The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

13.1.10.2. Findings

13.1.10.2.1. Prior to the Death of Mr. Y Senior

The Independent Investigation Team found it difficult to assess the quality of the clinical record during this period as very little of it was available for scrutiny. The Trust Internal Review (2004) stated that there were no Physical Health Care Records (P.H.C.) records for the period of time that Mr. Y was a patient at the Day Hospital (March-early August 2003). It was identified that all P.H.C. records after the beginning of August 2003 had been made by Care Coordinator 1, however it was not clear whether these notes represented the full record of activity.⁴⁴⁸

Day Hospital records were maintained in a spiral bound notebook and these provided a brief overview of the care and treatment that Mr. Y received.⁴⁴⁹

‘Clinical Records’ (presumably medical records) were found to have covered the period from 17 March 2003 to 16 February 2004.⁴⁵⁰

The Trust Internal Review (2004) found evidence of two risk assessments, neither of which were complete and one Effective Care Coordination Review (18 August 2003). It was noted that the documentation did not adhere to the policy requirements then in place for Effective Care Coordination. The clinical record indicated that a review also took place on the 31 October 2003 however the documentation content was of a poor standard.⁴⁵¹

446. Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999) P144.

447. Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

448. Trust Internal Review (2004) P. 20

449. Trust Internal Review (2004) P. 21

450. Trust Internal Review (2004) P. 23

451. Trust Internal Review (2004) P. 24

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Interagency Communication

The Trust Internal Review (2004) said that it could be seen from the GP record that secondary care services maintained communication. However it was apparent that the GP had not been incorporated into Mr. Y's care planning and review processes as then required by the Effective Care Coordination policy.⁴⁵²

13.1.10.2.2. Prior to the Death of Mrs. Y Senior

The basic standard of the clinical record generated whilst Mr. Y was an inpatient at the Scott Clinic looks at first glance to be of a good standard. However a close examination shows that a 'cut and paste' approach was often taken; this was of particular note when reading through Effective Care Coordination and risk assessment documentation. Consequently the clinical record suffers from a constant repetition of information which rarely appears to have been informed by any ongoing work with, or assessment of, Mr. Y. Of notable absence was any evidence of *multidisciplinary* discussion, risk assessment or care planning. Rationales for decision taking were not recorded. The Independent Investigation Team expected to find a clearly recorded risk assessment process with clear rationales setting out all aspects of Mr. Y's discharge and the risk management strategies that were subsequently agreed and put into place. These were absent. Consequently it is difficult to understand why Mr. Y's case was managed as it was. Unfortunately the witnesses to this investigation could not always give a rationale for the decisions that were taken and this, when unsupported by any contemporaneous clinical record, leaves health and social care professionals open to criticism which they find difficult to defend.

This trend continued once Mr. Y was conditionally discharged into the community in December 2006. However it must be noted that Imagine workers maintained an excellent set of care records, and that Scott Clinic Care Coordinators and Social Supervisors maintained a good series of progress reports. Unfortunately a significant amount of Effective Care Coordination and risk assessment documentation is no longer extant in the clinical record for this period. It is unclear whether this documentation failed to be developed in the first place or has been subsequently lost.

452. Trust Internal Review (2004) PP. 21-22

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Interagency and Professional Communication

Professional Communication

Once Mr. Y was conditionally discharged into the community it was evident that levels of professional communication between members of the treating team were poor. Consultant Psychiatrist 3, the Social Supervisors and Care Coordinators formed a 'triad' of health and social care management. The communication between them however appears to have been minimal and confined to Outpatient clinics and Effective Care Coordination reviews only. It was evident that the Social Supervisors contacted Mrs. Y Senior on a minimal basis and communication processes with her were poor during this period as she was no longer attending the Effective Care Coordination meetings. It was also evident that the Social Supervisors did not discuss Mrs. Y Senior's situation with the Care Coordinators and that they consequently had no understanding of the issues regarding the terms of the conditional discharge and their role in ensuring her continued safety and wellbeing.

Interagency Communication

It was evident from examining the GP record that forensic services sent regular letters and updates. However it was also evident that not all Care Programme Approach and risk assessment documentation was sent in accordance with the Trust Effective Care Coordination policy.

It was noted in the Imagine record that on occasion the Scott Clinic failed to send copies of Care Programme Approach and risk assessment documentation to them. The Imagine record pertaining to Mr. Y held very little in the way of Trust-generated documentation. This Investigation could only find two sets of complete Effective Care Coordination and risk assessment documentation. This in conjunction with the poor handover process at the point of Mr. Y's conditional discharge into the community ensured that Imagine did not have enough information in order to understand Mr. Y in the full context of his mental illness. The Trust Internal Review (2010) stated that "*Imagine staff in daily contact with ... [Mr. Y] advised [the Internal Review] that all of them were not told of his relapse indicators and , therefore, some had no knowledge of his diagnosis, with particular regard to the Theory of Mind deficits highlighted while he was an inpatient. Consequently, the prompt reaction of staff to changes in ... [Mrs. Y] prior to the index offence is to be commended*".⁴⁵³ The Independent

453. Trust Internal Review (2010) P. 23

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Investigation Team would concur with this finding. However it should be noted that whilst the Scott Clinic were remiss in not ensuring a robust brief was supplied to Imagine, Imagine must also be held accountable in part for not ensuring that the little that was known about Mr. Y was shared appropriately throughout the service.

It remains unclear exactly how the Scott Clinic, the Primary Care Trust, Imagine and the Local Authority worked together and communicated with other with regard to services users eligible for Section 117 aftercare arrangements. The Imagine Internal Review (2010) stated that there was no mechanism in place for Mersey Care NHS Trust, the Local Authority, Imagine and the Primary Care Trust to come together to discuss either the residents at Moscow Drive or the strategic direction in which the service was required to go.⁴⁵⁴ Mr. Y's circumstances and the manner in which his accommodation moves were planned and implemented is an example of how poorly managed interagency communications were. To this day no single agency seems to be aware of exactly what occurred with either the move from 123 to 133 Moscow Drive, or the proposed move from 133 Moscow Drive to the Cluster Flat Scheme. This is poor practice for statutory agencies responsible for providing support to vulnerable adults.

The Independent Investigation Team noted that correspondence with the Ministry of Justice failed to communicate essential information about Mr. Y at crucial stages on his care pathway. This Investigation was told by the Ministry of Justice that consultation processes about changes to Mr. Y's accommodation, both actual and planned, had not occurred in the manner expected by the Secretary of State. This is a serious omission on the part of tertiary forensic service and represents a significant error of judgement and failure in duty of care.

Archiving

The Independent Investigation Team noted that a significant amount of clinical documentation was missing from the extant clinical record. The Trust Internal Review (2010) made no mention of the quality of documentation and general record keeping except to state that there was evidence "*of regular CPA reviews and risk assessments and updates ... in accordance with Mersey Care policies and procedures*".⁴⁵⁵ This Investigation however found the content of the clinical record made available to it to be of an unsatisfactory nature.

454. Imagine Internal Review (2010) P. 10
455. Trust Internal Review (2010) PP. 18-19

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It is regrettable that documentation pertaining to critical junctures in Mr. Y's care pathway is missing.

13.1.10.3. Conclusions

Prior to the Death of Mr. Y Senior

The Independent Investigation Team was able, with the assistance of the Trust Internal Review Report (2004) and clinical witness interviews, to work with the extant clinical record in order to understand the care pathway that Mr. Y undertook. It is fortunate that in cases such as this, when Trust clinical records are largely unavailable, then a great deal of duplication is often to be found in the GP record as was the case in this Investigation.

Archiving

It was evident that the Trust Internal Review Team had access to more clinical documentation than was supplied to this Investigation. Missing documentation is of concern for two reasons.

1. Essential information about a living service user is not available to the current treating team.
2. Essential information cannot be made available to an Investigation of this kind which consequently can place both the Trust, and individual health and social care professionals, in a position vulnerable to criticism as key actions, rationales and reviews are no longer recorded within an extant clinical record and cannot be proven to have taken place.

Prior to the Death of Mrs. Y Senior

Documentation

It was the conclusion of the Independent Investigation Team that the clinical record was not of the standard to be expected from either a secondary or tertiary care mental health service. An individual such as Mr. Y required the development of detailed care and risk management plans which could provide both clarity of formulation and rationale for all aspects of the planned care and treatment to be delivered. This did not occur, and when coupled with the missing documentation in the clinical record, leaves an impression of poor clinical standards and professionalism.

Interagency Communication

Interagency communication processes were poor. The Scott Clinic team has to take responsibility for the poor quality of the discharge process and handover information when

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Mr. Y initially went to live at 123 Moscow Drive. However the Independent Investigation Team concluded that Imagine workers could have been more proactive in both obtaining additional information and in sharing it on a 'needs to know' basis as Mr. Y moved through the service.

Communication processes between the Trust, the Primary Care Trust, Imagine and the Local Authority were poor. This is evidenced by the fact that no single agency understands to this day what happened with Mr. Y's case regarding his accommodation moves and Supported Living arrangements. It is a fact that Mr. Y's case was not managed well and that vulnerable adults were being moved through the system in a manner that placed both them and those around them at risk. For this each agency has to take equal responsibility.

Issues regarding MAPPA and PNC processes have not been included in this Subsection as they have been detailed in other Subsections above; however a key finding of the Independent Investigation Team is that this failure to communicate appropriately may have prevented other statutory agencies from intervening in a timely manner when Mr. Y's mental health began to relapse in March 2010.

Archiving

The Independent Investigation Team found significant documentation to be missing in Mr. Y's extant clinical record. This Investigation has no reason to find a 'sinister' explanation for this. However once again it has to be pointed out that missing documentation potentially compromises the quality any future care and treatment for living service users such as Mr. Y, and missing documentation also places both the Trust, and individual health and social care professionals, in a position vulnerable to criticism as key actions, rationales and reviews are no longer recorded within an extant clinical record and cannot be proven to have taken place.

Summary

Had the clinical documentation contained a more detailed set of explanations, formulations and rationales for the care and treatment decisions taken it would have been a more straight forward task when trying to understand how the treating team worked with positive risk taking in the case of Mr. Y. This was absent and consequently an abiding impression is left that diagnostic formulation and clinical assessment processes were understood poorly by the treating team. This view is reinforced by the fact that the extant documentation was found to

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be of a very basic standard where CPA documentation, for example, remained unaltered over time, even though Mr. Y's circumstances underwent considerable change.

Health and social care provision and the protection of the public, for complex individuals such as Mr. Y, cannot be successfully delivered by a single agency alone. It is poor practice to imagine that this is the case. Poor interagency communication processes served to minimise both the risks that Mr. Y posed and the ongoing care needs that he continued to have. This made a substantial contribution to the poor synchronisation of the services that were delivered to Mr. Y (for example accommodation and ongoing community placements) and processes that could have ensured his continued risk management (for example MAPPA and PNC processes). Of particular concern was the failure of the Scott Clinic team to fulfil its statutory responsibilities to the Secretary State. This represents a serious omission and failure in duty of care.

- *Contributory Factor Ten. The standards of clinical record keeping and interagency communication were poor. This made a significant contribution over time to Mr. Y being neither understood nor managed in the full context of his mental illness in a multiagency arena.*

13.1.11. Adherence to Local and National Policy and Procedure

13.1.11.1. Context

Evidence-based practice has been defined as “*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients*”⁴⁵⁶ National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that

456. Callaghan and Waldo, *Oxford handbook of Mental Health Nursing*, (2006) P. 328

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policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 13.1.13. below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures in full where possible, and to report any issues regarding the effectiveness of the said policies or procedures or to raise any implementation issues as they arise with immediate effect.

13.1.11.2. Findings

Prior to the Death of Mr. Y Senior

The Trust Internal Review (2004) into the care and treatment Mr. Y received prior to the killing of his father concluded that the Effective Care Coordination process was not implemented in keeping with Trust policy and procedure. The Independent Investigation Team could not access a full set of policy documentation from this period, but made the finding that the treating team did not adhere to the policies and procedures that were available, and neither did the team adhere to what would have been deemed to be good practice on a national level for this period. Of concern to the Independent Investigation Team was the fact that several of the clinical witnesses when interviewed (December 2011) still maintained a poor understanding of policy and procedure and national best practice expectation. This was of particular note regarding the implementation of the Mental Health Act (1983 & 2007).

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Prior to the Death of Mrs. Y Senior

Quality of Local Policies and Procedures

The Independent Investigation Team found the policies and procedures that were made available during the course of this inquiry process to be of an excellent standard. The policies are evidence-based and provide a robust set of guidance for practitioners.

Non Adherence Issues

The Trust Internal Review Team (2010) into the care and treatment Mr. Y received prior to the killing of his mother explained that *“The Scott Clinic became part of Mersey Care NHS Trust in 2002.....The Review Team found that Merseyside Forensic Psychiatric Services were of the view that it was more appropriate for them to retain their own protocols and procedures governing their care and services.....The Review Team found that some of Mersey Care policies and procedures were not in place, or were being inconsistently followed, at the Scott Clinic and urged immediate action to remedy this situation”*.⁴⁵⁷ The Internal Review Team found that, for example, the MAPPA and PNC processes that were in place throughout the rest of the Trust worked well, but that the Police liaison service with the Scott Clinic was not as robust as for the rest of Mersey Care.

The Trust Internal Review Team (2010) also found that the Scott Clinic team appeared to adhere to CPA and risk assessment processes in accordance with Trust policy and procedure in that CPA and risk assessment were to be found within Mr. Y's clinical record.

The Independent Investigation Team concurs broadly with the findings of the Trust Internal Review. However this Investigation identified on close examination of the clinical record that serious omissions with regards to CPA and risk assessment processes were to be found. The following policy and procedures were not adhered to.

- NICE Guidelines: Mr. Y did not receive a comprehensive care and treatment programme in accordance with national best practice guidelines.
- Effective Care Coordination: care planning was embryonic and Care Coordination effectively did not exist.

457. Trust Internal Review (2010) P. 24

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- Risk assessment: risk management plans were limited and did not follow through from a clear formulation of the issues. Risk assessments were not multidisciplinary and rationales for decisions taken were not recorded.
- Discharge planning processes: communication and liaison were poor and did not adhere to the ethos set out in the Effective Care Coordination Policy.
- MAPPA and PNC: Trust guidance was not followed and neither were any other robust alternative arrangements.
- Ministry of Justice communications: consultation and communication failed to adhere to the statutory expectations of the Secretary of State.

At the time the Independent Investigation Team conducted its inquiry process and interviewed witnesses it was evident that many individuals still maintained the view that the Scott Clinic was somehow different and it was evident that Trust-wide policy and procedure may still not be widely understood or incorporated into day-to-day practice within this service.

13.1.11.3. Conclusions

The Independent Investigation Team concluded that policy and procedure adherence was poorly executed over time by the treating teams providing care and treatment to Mr. Y. It was evident that individual practitioners did not know what was detailed in policy and procedure documentation and neither did they understand the importance of either reading the information or adhering to it. Many witnesses when talking about the case with the Independent Investigation Team maintained views that still ran counter to both Trust policy and procedure and national best practice expectation. This is a grave concern.

Whilst a treating team should be able to reserve the prerogative to work outside of policy and procedure guidelines, this should only be done in exceptional circumstances and then as a part of a structured multidisciplinary team approach which is documented rigorously. Departures from Trust policy documentation should not be the result of either an *ad hoc* decision making process, or an ongoing collective team rejection of Trust corporately owned procedure.

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Local policy and procedure and national best practice guidelines are developed as a result of ongoing research into the evidence base for care and treatment delivery. The resultant guidelines form a robust framework for health and social care practitioners to work within. These frameworks form the essential safety nets of care and treatment and ensure that health and social care practice is as effective and safe as it can possibly be. There is a tripartite responsibility on the part of the Trust corporate body, the service management team and individual practitioners to ensure that policy and procedure and best practice guidelines are followed. It was the conclusion of the Independent Investigation Team that the culture, custom and practice of the Scott Clinic had fallen out of step with the rest of the Mersey Care Trust and that consequently policy and procedure was no longer adhered to. Consequently Mr. Y's care and treatment was delivered to him in an unstructured manner which became more problematic following his conditional discharge from the Scott Clinic. This made a direct contribution to Mr. Y's care and treatment being provided in an uncoordinated manner and to his not being subject to the levels of supervision that he required via MAPPA and Ministry of Justice processes.

- *Contributory Factor Eleven. Policy non adherence made a significant contribution to the poor overall management of Mr. Y's case which was to the overall detriment of his health, safety and wellbeing.*

13.1.12. Overall Management of the Care and Treatment of Mr. Y

This subsection serves to examine the overall impact of the care and treatment Mr. Y received upon his mental health and continued wellbeing. This subsection also serves to summarise the clinical findings set out in subsections 13.1.1 -13.1.11. Above.

13.1.12.1. Findings

13.1.12.1.1. Prior to the Death of Mr. Y Senior

The Independent Investigation Team found that the care and treatment of Mr. Y was of a poor general standard between March 2003 and February 2004. Trust policy and procedure were not adhered to and this meant that CPA and risk assessments were not implemented to the ultimate detriment of Mr. Y's wellbeing and the safety of his mother and father.

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13.1.12.1.2. Prior to the Death of Mrs. Y Senior

The Trust Internal Review (2010) made several important findings and conclusions. These findings and conclusions are set out below.

1. *“... Theory of Mind deficits ... and the violent offences perpetrated against his father and mother in 2004 were not explored or understood. ... The relevance of ... [Mr. Y’s] mental disorder and its correlation and consequences to future risk of harm was not adequately delineated and did not appear to inform decision making...”*⁴⁵⁸
2. *“Managed risk was too readily associated with the absence of acute mental illness. The Review Team looked for evidence that formulation included an acknowledgment of the relationship between risk and ... [Mr. Y’s] related mental disorder and that this was reflected in his care management plan regarding his return to the community. There is an absence of this kind of formulation in the case notes”*.⁴⁵⁹
3. *“The initial risk management plan derived for ... [Mr. Y] on his conditional discharge from the Scott Clinic was not markedly altered between 2006 and 2010... The four HCR-20 worksheets ... contained exactly the same information without variation, despite his changing circumstances... ... The assessments undertaken failed to consider the ongoing risk to ... [Mrs. Y Senior]”*.⁴⁶⁰
4. *“... [Mrs. Y Senior] was not the subject of a carer’s assessment. The Review Team could find no evidence of a victim’s safety plan: it is unclear why not”*.⁴⁶¹
5. *“The Review Team found that some of the Mersey Care policies and procedures were not in place, or were being inconsistently followed at the Scott Clinic and urged immediate action to remedy this situation”*. (The Internal Review gave the example of MAPPa and PNC processes).⁴⁶²
6. *“The Review Team found that, during the first two weeks following discharge from the Scott Clinic, Imagine staff monitored ... [Mr. Y’s] compliance with medication by witnessing him taking his tablets. From then on, he collected his prescription from his General Practitioner... and ... [Mr. Y] self administered. A key risk management strategy for ... [Mr. Y] was continued compliance with prescribed psychotropic medication. There is no evidence of actual checks on this other than the first two weeks following his discharge”*.⁴⁶³

458.Trust Internal investigation (2010) P. 20

459.Trust Internal Investigation (2010) P.19

460.Trust Internal Investigation (2010) P. 21

461.Trust Internal Investigation (2010) P. 22

462.Trust Internal Investigation (2010) P. 24

463.Trust Internal Investigation (2010) P. 25

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Diagnosis

Mr. Y had a diagnosis of Paranoid Schizophrenia. He was also assessed as having 'Theory of Mind' difficulties. Mr. Y was poorly understood by his treating team who acknowledged that he was difficult to get to know. During his time at the Scott Clinic attempts to engage Mr. Y took place very much on 'his own terms' and the possibility that he was masking his symptoms, whilst often recognised, went unchallenged. The Independent Investigation Team concurs with the finding of the Trust Internal Review (2010) in that neither the relevance of, nor the consequences pertaining to, Mr. Y's mental disorder were explored appropriately and that the diagnostic formulation was poorly executed. This was to have a negative impact upon the efficacy of his long term care and treatment plan and risk management strategy.

Medication and Treatment

Following the killing of his father and admission to the Scott Clinic Mr. Y was prescribed Olanzapine 20mg which was subsequently reduced down to 15mg and then 10mg. The Independent Investigation Team speculated that Mr. Y may have been under medicated. It was evident that Mr. Y complied with his medication whilst an inpatient at the Scott Clinic. This was in no small part due to fact that he had no choice in the matter as he was subject to a treatment order. It cannot be known whether or not Mr. Y adhered to his medication regimen once he was discharged into the community as no one witnessed him taking his Olanzapine. With Mr. Y's history of non compliance, and continued ambivalence about his need for medication, it is a possibility that he did not take his medication. The Independent Investigation Team know that members of the treating team felt assured that Mr. Y was taking his medication as prescribed because his mental state appeared to have been stable when assessed. However as has been discussed previously in this report, Mr. Y was adept at masking his symptoms and any changes to his mental state may have been difficult to detect.

Whether Mr. Y was taking his medication or not, it would have been good practice to have instituted a robust medicines management plan prior to his discharge from the Scott Clinic. The Independent Investigation Team concurs with the finding of the Trust Internal Review (2010) in that medication adherence had been identified as key protective factor in Mr. Y's risk management strategy and that this aspect of his ongoing care plan should have been subject to robust management which it was not.

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Mr. Y did not receive treatment in line with NICE guidance. Neither Cognitive Behaviour Therapy nor family focused therapy were considered. This amounts to a significant omission. 'Theory of Mind' difficulties were identified, but the therapeutic inputs may not have been best placed with Occupational Therapy staff. Therapy inputs for activities of daily living were appropriate, but in themselves could not be said to have constituted a coherent therapeutic treatment programme for an individual such as Mr. Y.

Care Programme Approach and Risk Assessment

It was evident to the Independent Investigation Team that the Care Programme Approach (CPA) was adhered to in name only and that the treating team did not understand the ethos behind either CPA or Care Coordination. This ensured that assessment and care planning were embryonic and did not develop into coherent care, treatment and management strategies that could be implemented and supervised. The failure to implement CPA meant that the activities of the treating team when working with Mr. Y following his conditional discharge did not translate into meaningful engagement. This was problematic on two counts. First: Mr. Y did not receive a coherent care and supervision plan, second: the treating team and Imagine staff were lulled into a false sense of security. It must be noted here that activity alone (visits and general social activity) does not deliver a Care Programme Approach.

The Independent Investigation Team concurs with the findings of the Trust Internal Review (2010) in regard to risk management. It was evident that risk assessments did not incorporate the inherent risks that Mr. Y's diagnosis and forensic history posed. Risk assessments remained static over time regardless of the milestones on Mr. Y's care pathway and the changes to his circumstances. The failure to implement an appropriate level of CPA compounded the poor level of risk management in that other vital stakeholders/agencies were neither invited to develop risk management plans nor supervise their implementation. These omissions were of particular note in relation to:

- Mr. Y's mother and family;
- Imagine workers;
- MAPPAs and PNC arrangements;
- Ministry of Justice communications.

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Mr. Y was not understood in the context of his true risk profile. It remains unclear why this should have been the case as on numerous occasions assessments were undertaken which produced clear risk and relapse indicators. It was evident that over time, whilst Mr. Y's presentation did not undergo any degree of change, the perception of him by his treating team did. This served to minimise the acuity of the treating team and this meant that by the time Mr. Y was conditionally discharged from the Scott Clinic risk assessment had become a 'tick box' activity which no longer served the purpose it was intended for; namely to prevent relapse and to protect both Mr. Y and others from any future harm. It is a fact that had Multi Agency Public Protection Arrangements (MAPPA) been put into place Mr. Y's relapsing mental state would have probably been detected by the Police at least two weeks prior to the killing of his mother and that this alone might have prevented her death. This is because Mr. Y's bizarre behaviour had been reported to them by an independent source which they did not understand the relevance of because the Trust had not alerted them to Mr. Y's discharge or levels of risk.

Adherence to Policy and Procedure

The Independent Investigation Team concurs with the findings of the Trust Internal Review (2010). Scott Clinic staff did not adhere to Trust policy and procedure and neither did they adhere to national best practice guidelines. This Investigation was told that the reasons behind this were historic and that forensic services still held themselves back from the corporate requirements of the Trust *per se*. It was evident that no alternative, specialist, ratified policy and procedure had been produced. Had this been the case it would have been acceptable. Instead a localised culture of individualised decision making appears to have been the norm set loosely within a 'tick box' response to corporate Trust policy and procedure.

This approach was problematic. The fact that Trust policy and procedure was being responded to, albeit loosely, was probably enough to confound the clinical governance operational and audit systems which in most Trusts are only sensitive enough to detect basic compliance rather than true adherence. The Independent Investigation Team noted that even the Internal Trust Review (2010) failed to identify the problems with CPA as on first glance the documentation appears to be 'present and correct', it is only on close examination that it is evident neither CPA nor Care Coordination was actually being delivered in any true meaning of the sense.

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The Independent Investigation Team speculated that had robust clinical/managerial supervision been in place the policy and procedure issues which obviously fell ‘sub-audit’ would have been detected *via* this essential safety net of care. It was evident that supervision was often either *ad hoc* or nonexistent for many of the witnesses that this Investigation interviewed. It was apparent that most of the witnesses interviewed by this Investigation either did not know what local Trust policy and procedure and national best practice guidance consisted of, or were adamant that their service was somehow exempt from them. In this kind of situation it is unlikely that neither clinical nor managerial supervision alone would be able to detect practice issues regarding policy non adherence because neither supervisee nor supervisor would have the requisite insight to provide the challenge needed.

Clinical Leadership and Overall Management of the Case

During the course of this Investigation several clinical leaders within the Scott Clinic team were identified. These represented all key members of the multidisciplinary team. The Independent Investigation Team was told that each member of the team had an equal say in how cases were managed and that a ‘democratic’ approach was maintained. This was probably the case.

Following his conditional discharge Mr. Y received his care, treatment and supervision from a health and social care ‘triad’ comprising Consultant Psychiatrist 3, Care Coordinators 1 and 2 (consecutively) and Social Supervisors 1 and 2 (consecutively). Each professional within this triad had a specific range of duties and responsibilities. These have been discussed in previous Subsections within this report. It was problematic that no single professional either understood, or delivered against, their unique role within the triad. This in effect left Mr. Y’s case unmanaged and unsupervised beyond a superficial level.

Governance and Audit Processes

Over time it would appear that Trust governance and audit processes were not sensitive enough to detect departures from both Trust and national best practice policy and procedure guidance. At the same time clinical and managerial supervision processes were not robust enough to act as a safety net under some of the ‘sub audit’ blind spot issues. It was evident that policy and procedure was being adhered to ‘loosely’ in that CPA and risk documentation was being completed, however this level of compliance fell short of delivering a quality care and treatment package to Mr. Y.

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13.12.2. Conclusions

Prior to the Death of Mr. Y Senior

The Independent Investigation Team concluded that the care and treatment of Mr. Y was of a poor general standard between March 2003 and February 2004. Trust policy and procedure were not adhered to and this meant that CPA and risk assessments were not implemented to the ultimate detriment of Mr. Y's health and wellbeing and to the safety of his mother and father.

Prior to the Death of Mrs. Y Senior

The Trust Internal Review (2010) found a causal link between the killing of Mrs. Y Senior and omissions in the care and treatment provided to Mr. Y. It stated *“The Review Team has identified one root cause which related to the lack of understanding gained by ... [Mr. Y's] Care Team of his past violence and potential for violence in the future. Their assessments and interventions were limited and did recognise the level of risk he posed to himself or others. When discharge from the Scott Clinic was proposed, the assessment undertaken should have included informed judgements about the risk of harm to his mother and other family members, as well as the general public, other residents of the accommodation he was moving to and himself”*.⁴⁶⁴

The Independent Investigation Team concurs with this finding, but would go further and place this causal factor within the context of the poor overall approach to care and treatment management that was taken between March 2004 and the time of the killing of Mrs. Y Senior in March 2010.

Corporate Learning. NHS Trusts have a statutory duty of care to provide fit for purpose clinical guidelines, to provide training and support for their implementation and to monitor and assure their effectiveness on behalf of the Trust Board. Clinical Governance and supervision systems have to be sensitive enough to detect non adherence issues in an effective and timely manner.

Team Learning. A treating team must ensure that both individual and collective responsibilities are understood and discharged in accordance with local and national best

464.Trust Internal Investigation (2010) P. 25

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practice guidance. Team managers and clinical leaders must ensure that training, support and structured supervision are made available to all professional and support workers. Performance management and policy adherence issues should be part of the ongoing local monitoring and review process provided within the wider Trust clinical governance assurance system.

Individual Learning. Registered professionals have distinct responsibilities when delivering care and treatment. These responsibilities require that each professional:

- reads all relevant clinical information in a timely manner;
- conducts comprehensive and timely assessments;
- formulates care and treatment plans;
- implements care and treatment plans;
- records diligently;
- fulfils the requirements of their designated role;
- pursues training, support and supervision activities in order to remain fit for practice;
- communicates clearly and effectively with other team members and agencies;
- adheres to local and national best practice policy and statutory procedure requirements.

Had the clinical team and the individuals involved provided a better standard of care and treatment there could still have been no absolute guarantee that the killing of Mrs. Y Senior would have been prevented. However had the clinical team and the individuals involved carried out every action that was reasonably within their gift then the Department of Health adage of *“as long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time”* would have held. It was evident that the overall management of Mr. Y’s case could, and should, have been managed in a more robust manner. It should be noted that no matter how many contributory factors of an influencing kind are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party. In this case however it was the conclusion of the Investigation Team that had the care and treatment been managed to a significantly better standard and evidence base, then it could reasonably be expected that Mr.

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Y's supervision and risk management plan would have provided better the protective factors required to ensure his continued recovery and a higher level of safety to his mother.

Summary

An event does not have to be predictable or foreseeable in order for it to be prevented. The Care Programme Approach and clinical risk assessment processes are in place to optimise the health, safety and wellbeing of service users. They are also in place to ensure the continued wellbeing and safety of carers and members of the general public. Certain individuals with a severe and enduring mental illness may always be prone to a relapse in their mental health. Relapses of any kind may lead to a sudden change in behaviour which may place these individuals and the people around them at risk. It would be naïve in the extreme not to recognise this as a fundamental fact when providing care and treatment for certain individuals. The Trust clinical risk policy states that: *“Positive risk management of service users will be promoted but only when there is a shared and good understanding of the risks posed by the service user, when risk can be effectively and repeatedly assessed and there are the resources to manage the risk and protective factors identified as relevant to the case at hand, and where the outcome of assessment and management activity will be an improvement in the service user’s quality of life and mental health over time. Risk is an unavoidable component of the life of any individual and it is neither possible – nor desirable – to remove all risk from the experience of service users. However, members of the public have a right to be protected from any significant harm that may be posed by a service user of Mersey Care NHS Trust, where those rights are legitimately subject to (a) the limitations of available information and (b) the capacity of Trust staff to anticipate often complex clinical risk”*.⁴⁶⁵

The Care Programme Approach and clinical risk assessment processes are essential safety nets of care. All health and social care professionals who work with mental health service users are obliged to adhere to their requirements in full. The research literature demonstrates that strict adherence to policy and process cannot always prevent an untoward incident from occurring. Mental health service users remain independent third parties and it is neither possible nor desirable to control a human being's thoughts and behaviour. However the test for every treating team should be *“was everything that could or should have been done, done”*?

465. POLICY AND PROCEDURE FOR THE USE OF CLINICAL RISK ASSESSMENT TOOLS P. 5

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The Management of Mr. Y's case was of a poor general standard. Each of the processes and milestones on Mr. Y's care pathway were managed in a manner which prevented optimal care and treatment processes to be implemented. Each poorly constructed process was compounded one by the other until the risks that Mr. Y posed were minimised to the point that they no longer impinged upon the consciousness of the treating team.

When assessing whether or not an act or omission on the part of a treating team constitutes a causal factor in relation to a serious untoward incident, in this case the killing of Mr. Y's mother, the following issues have to be considered:

- knowledge;
- opportunity;
- means.

Knowledge

It was evident that the treating team knew a great deal about Mr. Y. This is not surprising as Mr. Y was subject to a high degree of forensic assessment and examination following the killing of his father and wounding of his mother. It can be stated with a high degree of confidence that the treating team were privy to all aspects of Mr. Y's personal and psychiatric history. Despite accruing a significant amount of information about Mr. Y this intelligence was not taken into consideration in the development of care and treatment plans and risk management strategies. The Independent Investigation Team therefore concluded that the treating team had in its possession everything that was known and should have been known about Mr. Y but that this information was not used appropriately and did not appear to inform clinical decision making processes.

Opportunity

The treating team had the opportunity to engage with Mr. Y in a formal and structured manner on a regular basis. When Mr. Y was an inpatient at the Scott Clinic he was detained under Section 37/41 of the Mental Health Act (1983 and 2007). Once Mr. Y was living back in the community he had conditions of discharge imposed upon him which meant that he had to comply with his medication and treatment regimen and was expected to engage with both mental health and care services in accordance with his care and treatment plan. The only restrictions when accessing Mr. Y were those placed upon the treating team by itself.

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Means

The treating team had the powers to request Mr. Y be recalled to the Scott Clinic at any time should he not comply with his conditions of discharge or if it was thought that his mental health was relapsing.

Basically the treating team had the knowledge, opportunity and means to supervise and manage Mr. Y's case effectively. As such it can be stated with confidence that the Scott Clinic team had a high degree of control over the care and treatment it thought fit to provide to Mr. Y.

The Scott Clinical treating team held a genuine and deep-seated belief that Mr. Y had been successfully rehabilitated and that he no longer presented a risk of any kind to either himself or to others. However this belief was not based upon the facts known about Mr. Y and ran counter to much of the evidence collated in his clinical record. Even had this view been correct and even had Mr. Y not gone on to kill his mother; the stance of the treating team would still have to be assessed by this Investigation as being irresponsible and unprofessional. Mr. Y had a significant forensic history, had a severe and enduring mental illness and was required to be managed and supervised in strict accordance with Ministry of Justice conditions. In the event Mr. Y had no structured care plan and no risk management strategy. Supervision and monitoring processes were weak, and made more so by the failure to incorporate nationally required systems such as the Care Programme Approach (CPA) and Multi Agency Public Protection Arrangements (MAPPA). The Independent Investigation Team concluded that the care and treatment provided to Mr. Y was ineffectively provided and that had the above indicated basic building blocks of care been put into place Mr. Y would have received the level of supervision that he needed and that this would have provided a higher level of protection to his mother. Causality is not being assigned to this case because processes failed to protect Mrs. Y Senior, but because none of the protective measures that would be routinely expected to have been implemented by a secondary mental health team were put into place at all. Activity was mistaken for meaningful engagement to the ultimate detriment of the continued recovery of Mr. Y and the health and safety of his mother.

- ***Causal Factor One. There was a failure by the Scott Clinic treating team to ensure that best practice clinical policy guidance was applied to the care and treatment of***

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Mr. Y. Consequently Mr. Y's case was managed in an unstructured fashion which placed an over reliance upon 'gut instinct' over and beyond clinical formulation. This was compounded by the weak discharge planning processes that ensued when Mr. Y went to live at Moscow Drive. Protective measures were not put into place in accordance with statutory expectation that could have provided more support for Mr. Y's recovery and a higher level of protection to his mother.

13.1.13. Clinical Governance and Performance (to include clinical supervision, professional leadership and organisational change)

13.1.13.1. Context

"Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish".⁴⁶⁶

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. Y was receiving their care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the deaths of Mr. and Mrs. Y Senior. The issues that have been set out below are those which have relevance to the care and treatment that Mr. Y received.

466. Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

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13.1.13.2. Findings

Clinical Governance Processes

The Independent Investigation Team found that the Mersey Care NHS Trust has a comprehensive and robust clinical governance system that is assured and reviewed on a regular basis. This Investigation was given a substantial archive of governance documentation and all of the evidence that has been submitted is of a high and verifiable standard. The Independent Investigation Team acknowledges the significant input of the Mersey Care NHS Trust in providing both the information and documentary evidence for this section.

An Overview of Clinical Governance Working 2008 / 2009 and Current Working

This section will provide an overview of the corporate governance arrangements, as determined by the Trust Board, for the period 2008 through to the present day. There are numerous documents which provide the underpinning detail but it is anticipated the following information and appendices (Appendix 3 and 4) will be of sufficient detail to provide a meaningful overview.

It is important to note that the Trust amended the way in which its organisational structure operated from July 2009 following the establishment of Clinical Business Units (CBUs). Each CBU has established leadership and governance arrangements that have been agreed by the Trust Board and are now monitored by the Integrated Governance Committee.

Developments in 2008

Constituted Committees of the Board:

1. Audit Committee;
2. Remuneration and Terms of Service Committee;
3. Charitable Funds Committee;
4. Clinical Governance Committee;
5. Business and Resource Committee.

Key highlights of the corporate governance arrangements agreed by the Board for 2008.

1. It was acceptable, where appropriate, for those other than Non-Executive Directors to Chair Committees of the Board.

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2. The Ashworth Committee should cease and its responsibilities be explicitly subsumed within the new Committee structure.
3. There should be two new Committees built on established Committees but with greater clarity of their role. These two Committees should be:
 - a Committee concentrating on service user and carer experience. It was designed to subsume the issues of Clinical Governance, service user and carer involvement, the Care Quality Commission service quality areas and so on (the Clinical Governance Committee);
 - a Committee to deal with the business and resource issues of the Trust. This would cover targets, estates, staffing, finance, marketing and specifically the Care Quality Commission's use of resources standards (the Business and Resource Committee).
4. It was important that the arrangements fulfil three significant criteria: that they were comprehensive, clear and effective.

Developments in 2009

Constituted Committees of the Board:

- Audit Committee;
- Remuneration and Terms of Service Committee;
- Clinical Governance Committee.

Sub-committees:

- Mental Health Act Managers Committee;
- Health and Safety Committee;
- Infection Control Committee;
- Drugs and Therapeutics Committee;
- Research Governance Committee;
- Information Governance and Caldicott Committee.

Key highlights of the corporate governance arrangements agreed by the Board for 2009 are set out below.

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- In simple terms, the Board's role is to provide leadership and governance.
- The Chief Executive (as Accountable Officer) through the roles of the Executive Directors and the Services (whether they be line managed or had been approved for the greater freedom of Clinical Business Unit status) is expected to initiate plans for the Board's approval and implement the Board's requirements.
- The arrangements proposed to give clear expectations of the Accountable Officer supported by the checking mechanisms via Audit, Clinical Governance and the Board itself to ensure that those expectations are fulfilled.
- The terms of reference of the Committees explain their roles and responsibilities in that endeavour. The Standing Financial Instructions, Standing Orders and Scheme of Delegation give clarity to levels of authority and rules of conduct of business.
- The arrangements result in the cessation of the Business and Resource Committee.

2010

In January 2010 the Board agreed to the establishment of the Integrated Governance Committee to replace the Clinical Governance Committee in response to the findings of the due diligence process of the Foundation Trust application process. All other committees remained in place.

2011

Constituted Committees of the Board:

- Audit Committee;
- Remuneration and Terms of Service Committee;
- Integrated Governance Committee.

Sub-committees:

- Mental Health Act Managers Committee;
- Health and Safety Committee;
- Infection Control Committee;
- Drugs and Therapeutics Committee;
- Research Governance Committee;
- Information Governance and Caldicott Committee.

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An annual review of the corporate governance arrangements is now undertaken routinely in March each year through review and approval of the Scheme of Reservation and Delegation prepared by the Trust Secretary and approved by the Trust Board.

The Executive Director for Service Delivery and Development provides executive leadership to five of the six CBUs. The Executive Director of High Secure Service and Nursing has responsibility for High Secure Services, the sixth CBU, and was established to meet the 'line of sight' directive from the Department of Health, a requirement for all High Secure Services in England and Wales.

The Clinical Business Units cover the following Clinical areas:

- **Positive Care Partnerships CBU:** provides Older People and Adult Services to the North Liverpool, Sefton and Knowsley catchment area.
- **Liverpool CBU:** provides Older People's Services and Adult Services to the Central and South Liverpool Catchment area.
- **SAFE Partnerships CBU:** provides Medium and Low Secure Services to Merseyside and Cheshire. This is the CBU that cared for Mr Y.
- **Rebuild CBU:** provides Learning Disability, Rehabilitation and Brain Injury Services to Liverpool and Sefton.
- **High Secure CBU:** provides High Secure Forensic Services to the North West of England and to Wales.
- **Addictions CBU:** provides Alcohol and Drug Addiction Services to the Sefton and Liverpool areas.

Specialist Services which are provided by Psychologists and Allied Health Professionals are fully integrated into each CBU and where appropriate their clinical teams.

Prior to the implementation of Clinical Business Units, the Trust had an established structure of Service directorates which included:

- **Adult Mental Health Services:** (including Low Secure Low Secure Services, Rehabilitation and Brain Injury provision) covering Sefton, Knowsley and Liverpool.
- **Older Peoples' Services** covering Sefton, Knowsley and Liverpool.
- **High secure Services.**

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- **Medium Secure Services.**
- **Psychology Services:** covering all local geographies.
- **Addiction Services:** covering Sefton and Liverpool.
- **Learning Disability Services:** covering Sefton and Liverpool.

The changes made to the corporate governance process were in response to the changes made to the organisational structure and ensured that the performance of CBUs and the quality of care could be monitored.

How the Service has responded to the incident

The Clinical Business Unit established a working group of Senior Clinicians and Managers to oversee the implementation of the action plan. The Clinical Director disseminated the findings of the review across the CBU with the aim of ensuring all staff became aware of its findings and to work with colleagues on identifying solutions to the issues/risks raised.

Each individual involved in the care of Mr. Y has had an opportunity to consider the internal review report and to discuss its findings with senior staff. Ongoing support is offered to staff to enable them to work with the issues raised and develop their own practice where this has been identified as necessary.

Following the presentation of the internal review report at the Trust Board in November 2010, an update on progress with implementing the action plan was shared with the Trust's Integrated Governance Committee in September 2011. The Committee validated the work of the CBU and will continue to monitor the implementation of the agreed action plan and associated outcomes.

A significant number of recommendations have now been completed and will be audited to monitor their impact. The Executive Director responsible for the Service and the Director of Patient Safety have supported and guided the CBU in its work.

How the learning been disseminated

A series of mini 'Oxford Model' events (sharing the findings of investigations) have been facilitated by the lead reviewer and have involved all Clinical Business Units. Each CBU has

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been asked to consider the findings of the review and identify learning points that they will share with the staff and/or action as necessary.

Liaison with Commissioners

The Trust has close and effective working relationships with its commissioners. Liaison takes place at a variety of levels within the organisation including at Executive Director, Senior Manager/Clinician level. Systems and processes have been established where concerns or issues from both parties can be raised in a timely fashion.

The outcomes of Adverse Incidents are regularly shared with the Trust's lead commissioning organisation and any actions which may be required to prevent similar ones occurring are agreed.

Clinical Supervision

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.⁴⁶⁷

The NHS Management Executive defined clinical supervision in 1993 as:

*"...a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations".*⁴⁶⁸

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

467. Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses
468. Nursing and Midwifery Council, Advice Sheet C. (2006)

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Mersey Care NHS Trust Clinical Supervision Policy

The Trust recognises the importance of leadership within clinical practice and has developed systems to ensure that it is available from both a strategic and operational perspective. At Board level, the Directors of Nursing and Medicine are actively involved in the development and implementation of the Trust's strategic direction. Each Director has a leadership team that works together to provide mechanisms that will help:

1. practitioners to be confident and effective leaders and champions of care;
2. provide clinical practice that is valued, effective and within nationally agreed guidelines;
3. support the clinical authority of colleagues in visible roles;
4. those individuals in senior management positions champion quality at all levels of the organisation;
5. ensure that the training in leadership skills provided by the Trust is appropriate and meets the needs of the clinician.

Systems are in place to ensure that opportunities for sharing best practice and learning within different professional groups are available. Professional leads have been appointed for Allied Health Care Professionals, Social Care, Psychologists, Nursing, and Medicine. These individuals work at a senior level and are responsible directly to the Medical or Nursing Director. They provide individual clinical supervision and support to colleagues within clinical services as well as leading networks of clinicians with the aim of enhancing the leadership and learning of their colleagues within their particular sphere of practice.

Each professional lead will also direct clinically focused projects across the Trust. For example, the Clinical Lead for Psychology has recently developed a strategy that will direct therapeutic engagement with service users. This paper is now out for consultation and all Clinical Business Units are actively involved in shaping the final strategic direction for the Trust.

Each Clinical Business Unit:

- has a Clinical Director in post who has a pivotal role in leading the governance agenda within that Service and providing support and guidance to medical colleagues;

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- has Lead Nurses, Psychologists and Allied Health Professional who will work closely with colleagues to ensure that day to day practices are of an acceptable standard and participate actively in the development of the Clinical Business Unit, to ensure that the role and function of their specific professional role is represented.

As previously intimated the Trust sees the provision of clinical supervision as a key element in enhancing and maintaining the quality of the services that are provided to service users and their carers. Each Clinical Business Unit is responsible for ensuring that it has systems in place to implement the Trust's policy and procedure on this important aspect of practice. Key statements within the policy framework are:

- that supervision is a core component of best practice that supports individuals in developing their skills and competencies, and enables the maintenance of clinical practice standards;
- the Trust is committed to supporting practitioners in accessing clinical and managerial supervision;
- the Trust considers supervision to be essential to ensure high quality care to service users, enabling the appropriate development and support of staff in challenging situations and to identify training and development needs in pursuit of lifelong learning.

13.1.13.3. Conclusions

The Medium Secure Unit is now part of SaFE Partnerships Clinical Business Unit (CBU), which also includes low secure and Prison-In-Reach Services. Each CBU is both clinically and managerially led by a Service Director and Clinical Director.

Clinical and Service Directors are accountable to the Executive Director for Service Development and Delivery for the adherence to care and service delivery standards. An accountability framework is in place which clearly sets out the systems that will be used to identify any gaps in provision.

The Performance Assurance Framework which contains national, local and commissioning indicators is used to direct the work of the Clinical Business Units, monitoring is undertaken monthly and shared with the Accountable Executive Director. Quarterly Governance checks

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which include the key performance indicators and other key targets set by the Trust are facilitated by the Executive Director and her team. Remedial actions are agreed where gaps in provision are identified; the completion of actions and adherence to standards is reviewed by the Integrated Governance Committee a sub committee of the Trust Board.

Following concerns about the performance of SaFE Partnerships CBU the Clinical and Service Directors were replaced in February 2010.

A Consultant Clinical Psychologist was appointed to review the views of staff working in the CBU and this provided a baseline in which the newly appointed Directors could move forward and develop a plan that would specifically change practice and develop a more open culture.

Governance structures within the service have been reviewed with the aim of ensuring that accurate data is used to help clinicians and managers prioritise their work and to ensure that experiences of staff, carers and service users are represented. New arrangements have been put in place to supervise and support staff to ensure that they are provided with every opportunity to meet the standards set. The Independent Investigation Team concluded that the Trust has made a great deal of progress in ensuring the quality of service delivery across the Trust in general and at the Scott Clinic in particular.

14. Findings and Conclusions Regarding the Care and Treatment Mr. Y Received

14.1. Findings

The findings have been identified following a full review of the care and treatment that Mr. Y received from the Mersey Care NHS Trust and Imagine. These have been set out below together with their accompanying relevant causal, contributory and service issues.

The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Mr. Y received from the Mersey Care NHS Trust and Imagine. These thematic issues are set out below.

14.1. Thematic Issues

The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Y received from the Mersey Care NHS Trust and Imagine. These thematic issues are set out below.

Number One

Diagnosis. Mr. Y had Paranoid Schizophrenia. This was identified at an early stage following his first contact with secondary care mental health services in March 2003. Following his admission to the Scott Clinic ‘Theory of Mind’ deficit was introduced into Mr. Y’s diagnostic formulation. ‘Theory of Mind’ deficits have been observed in people with autistic spectrum disorders, with Schizophrenia, and some other conditions. There are clear links in the academic literature with ‘Theory of Mind’ to Schizophrenia, but these are far from being straight forward.

In the case of Mr. Y the ‘Theory of Mind’ deficits identified were descriptive only. They were not used to provide an explanation for his condition and presentation. The emphasis placed on ‘Theory Mind’ by the Scott Clinic Treating Team displaced the thinking around Mr. Y’s Schizophrenia and this amounted to a serious clinical misjudgement. The emphasis on the concept of ‘Theory of Mind’ seems to have distorted the perception that clinicians had of Mr. Y, especially in relation to risk. A rather simplistic view was taken that focused upon a

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behavioural approach with Mr. Y, one which was at odds with the research literature on this subject available at the time.

There was no acknowledgement of the implication of the diagnosis of Schizophrenia for Mr. Y's mental functioning. All psychological test results employed norms for the general population with no reference as to whether results might be different in persons with a diagnosis of Schizophrenia. Although a clear diagnosis had been made, and the condition stabilised in the inpatient setting *via* some antipsychotic medication, the subsequent approach to the patient by the whole clinical team seems to have been unduly influenced by the apparent blind spot shown in the psychology reports in regard to the possibility of ongoing influence of the current mental illness, even if he appeared superficially to be asymptomatic.

In short there was a failure to understand Mr. Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.

- *Contributory Factor One. There was a failure to understand Mr. Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.*

Number Two

Medication and Treatment. Medication. Prior to the death of Mr. Y Senior, Mr. Y was not taking his antipsychotic medication on a regular basis. This served to ensure that his psychosis was, at best, only being partially treated. Following the death of Mr. Y Senior and Mr. Y's admission to the Scott Clinic in February 2004, a baseline assessment was not conducted prior to the introduction of his new medication regimen. It was concluded by the Independent Investigation Team that Mr. Y was in denial about the death of his father, had a flattened affect and masked his symptoms. This led to Mr. Y's condition being assessed poorly and to his being under medicated whilst in the Scott Clinic.

Mr. Y was reported to have had consistent concerns about the side effects relating to his medication, prior to the death of his father, whilst he was still living in the community. This meant that he took his medication in a sporadic manner. Following his discharge from the Scott Clinic in 2006 Mr. Y self-medicated from an early stage. There was never any overt

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evidence that he failed to comply with his medication, however he remained demonstrably ambivalent about it. In such circumstances it could reasonably be predicted that Mr. Y may not have been compliant with his medication. Whether he was, or whether he was not, it would have been good practice to have had a medication management plan in place. This was absent.

Treatment. The lack of a clear formulation of Mr. Y's problems impacted upon the development of a clear treatment plan throughout his time with mental health services. From early in his contact with mental health services issues around family dynamics were identified but:

- this was never clearly formulated to inform an intervention;
- terms such as 'High Expressed Emotion' were used loosely. During the interviews with witnesses there appeared to be confusion between 'expressed emotion' (EE) and 'over involvement' (OI). Though both terms are used to describe families in the research of Wing, Leff, Beddinton *et al* this research does not make them interchangeable. Depending on which, EE or OI, characterised the family different approaches would have been appropriate;
- even at an early stage, prior to the first homicide, one would have expected some structured input to address the perceived family difficulties which did not happen;
- when Mr. Y was being prepared for discharge from the Scott Clinic some form of family intervention should have been put in place. In the absence of this how was his mother supposed to understand Mr. Y's problems and respond to him?

When examining the care and treatment Mr. Y received a theme was detected of identifying problems but not identifying the interventions to address them. Mr. Y clearly displayed the symptoms of a psychotic illness. The National Institute for Health and Clinical Excellence guidelines state that Cognitive Behaviour Therapy (CBT) should be available to such individuals. There is a substantial literature on CBT approaches to auditory hallucinations, delusions etc. Mr. Y was not offered this kind of therapy and neither was he supported in being able to develop coping strategies to manage his condition.

At the point of his discharge from the Scott Clinic there was talk of employing the recovery model but neither the structured steps to independence nor a Wellness Recovery Action Plan (WRAP) were evident.

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In short: if the treating team believed the things that they did about Mr. Y then they should have proceeded within a best-evidence treatment base. The prevailing belief was that Mr. Y had somehow been ‘cured’ when in actual fact he was probably masking his symptoms and was understood in a rudimentary manner only.

- *Service Issue One. The Scott Clinic practiced an unacceptable level of medicines management in the case of Mr. Y. Whilst this cannot be cited as either a contributory or causal factor it demonstrates a lack of medicines management systems and understanding on the part of Scott Clinic clinicians.*
- *Contributory Factor Two. Mr. Y did not receive treatment in line with national best practice guidelines. This represents a missed opportunity that left Mr. Y vulnerable to relapse.*

Number Three

Use of the Mental Health Act (1983 and 2007), Ministry of Justice and Criminal Justice Systems. There are three main issues in relation to the use of the Mental Health Act (1983) before the first homicide:

4. the awareness of the Community Mental Health Team of the appropriate use of the Act;
5. active use of the provisions of the Act; and
6. timeliness of intervention.

The Independent Investigation Team concluded that Mr. Y could have been considered to have met the criteria for assessment under the Act at any time following his first presentation to his GP in March 2003. However, because Mr. Y had not manifested a threat of violence to either himself or to others, the degree of urgency to intervene was perceived to be low. This caused a delay in getting Mr. Y the treatment that he needed and consequently his mental health continued to deteriorate.

Following the death of Mr. Y Senior Mr. Y was detained at the Scott Clinic subject to a Court Order under Section 37/41. On the 15 December 2006 he was conditionally discharged from this Order by a Mental Health Review Tribunal (the issues relating to this discharge are

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detailed in bullet 6 below). At the point of his discharge Section 117 arrangements were not made explicit and this was to cause significant disruptions to his supported living housing arrangements in the years that followed.

After discharge from the Scott Clinic Mr. Y had nominated Social Supervisors and Care Coordinators allocated to him. The pattern of contact with the Social Supervisor, Care Coordinator and Responsible Clinician was maintained through a series of formal reviews in the out-patient clinic at Rodney Street, Liverpool and contacts with staff at a number of venues in the Liverpool City centre. Day to day contact and support was in the hands of the staff at Imagine who also took part in reviews.

From evidence it appears there were several critical issues in relation to the use of the Mental Health Act post discharge from the Scott Clinic and the practical interpretation of the conditions. These are set out below (please note the conditions of discharge are set out in full in Section 13):

- Handovers between members of the treating team were poor and failures occurred when transferring critical information e.g. the Theory of Mind construct.
- There was a lack of knowledge about the role of the Social Supervisor.
- The conditions of discharge were not protective in that they relied on Mr. Y to notify staff of contact with his mother (condition 7).
- Condition 8 did not take account of the potential risk in meetings between Mr. Y and his mother at other venues; it assumed that requiring Mr. Y to keep away from the family home would be effective.
- The discussion about moving Mr. Y to another residence (from 123 Moscow Drive to 133 Moscow Drive and then on to an independent flat) was not discussed with the Ministry of Justice and there is no record of their approval.
- The review by *Supporting People* staff of the financial support provided to enable Mr. Y to remain successfully in the community did not acknowledge that Mr. Y was subject to Section 117 after-care, and that his funding was assured. There appeared to be pressure to move him on to less supported and less supervised accommodation. This should not have applied to Mr. Y. There were clinical reasons to be cautious when introducing changes to his living arrangements which were disregarded.

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- Staff at Imagine were not aware of the full range of conditional discharge arrangements and procedural requirements for changes in circumstances. They saw this as the role of the Social Supervisor and regarded the staff from the Scott Clinic as a ‘crack team.’
 - It is not clear whether, or how, the family of Mr. Y were involved in the construction of the conditional terms.
- *Contributory Factor Three. There were serious failures in the implementation of the terms of Mr. Y's conditional discharge. This meant that the conditions put into place by the Ministry of Justice to protect the public were rendered ineffective.*

Number Four

Care Programme Approach (CPA). Mersey Care NHS Trust had a Care Programme Approach policy in place and operational during 2003 and 2004. Given that the documentation completed as part of the CPA process refers to Effective Care Coordination, it appears reasonable to conclude that this had taken into consideration the national guidance on effective care coordination issued in 1999.

It is not clear whether the Care Programme Approach was used at the point Mr. Y was first treated by the day hospital. There is no recorded Care Coordinator or evidence of hand over from the day hospital Keyworker to the community team Care Coordinator or of a Care Coordinator initiating a CPA review meeting to identify Mr. Y's needs and how these might be best/most effectively met.

Once Mr. Y had been transferred to the Community Mental Health Team he was designated as requiring Standard CPA. The Investigation Team concluded that on balance given Mr. Y's presentation of serious mental illness, with accompanying positive risk factors such as non compliance with treatment, there was sufficient evidence to suggest he should have been on Enhanced CPA. This may have led to an increased sense of concern from the team when the Care Coordinator raised issues regarding risk with them. These identified risk issues appear to have been minimised by the team.

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Following Mr. Y's admission to the Scott Clinic seven Effective Care Coordination reviews were recorded between the 23 March 2003 and the 27 November 2006. During this period the Care Coordinator role appeared to be nominal as the Responsible Medical Officer took on this role. It was evident that this role was understood poorly. Mr. Y did not engage with the CPA process and often refused to take part in any of the review and planning processes. The content of CPA documentation did not vary from one review meeting to the next and the information recorded was often incorrect (for example: it often recorded the presence of individuals that had left the employ of the Trust several years previously).

The clinical documentation that records CPA activity following Mr. Y's conditional discharge into the community is sparse. The documentation that is extant provides evidence for risk assessment and care planning having been considered, but there is little evidence to demonstrate that care planning was developed or implemented in a systematic manner. It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y worked in silos to the detriment of Mr. Y's overall case management.

- ***Contributory Factor Four. It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y worked in silos to the detriment of Mr. Y's overall case management, care and treatment.***

Number Five

Risk Assessment. Mr. Y was not understood in the context of his full risk profile. The issues around the management of risk are many fold.

- Risk assessments were not consistently undertaken at critical times/junctures.
- The conclusions of risk assessments were not always consistent with the evidence cited.
- There was a failure to involve Mr. Y's family, his mother in particular, with risk assessment processes and management plans. This meant that ultimately there was no risk management around the mother's safety at the time of Mr. Y's discharge from the Scott Clinic.

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- There was a lack of formulation around risk. For example the treating team did not explore why Mr. Y killed his father.
- Risk assessment was not dynamic and did not lead to risk management plans. Risk plans were little more than a list of actions which did not of themselves address the risks identified.
- Multi-Agency Public Protection Arrangements (MAPPAs) and Police National Computer (PNC) processes were neither considered nor put into place appropriately.

The identified problems as set out above combined together to ensure that Mr. Y's risk was not formulated, assessed in a dynamic manner, communicated appropriately with either his family or all relevant agencies, or mitigated against.

- *Contributory Factor Five. Mr. Y was not understood in the context of his full risk profile. Assessments of risk were undertaken in the absence of a robust formulation of the case. Consequently risk management plans and strategies were superficial and non-explicit. This, when taken alongside the failure to abide by the terms of the conditional discharge and decision not to consider MAPPA arrangements, ensured a critical lack of supervision and management. This was to the ultimate detriment of Mr. Y's health, safety and wellbeing and to the continued safety of his mother.*

Number Six

Referral, Admission and Discharge Planning. Prior to the death of Mr. Y Senior there were delays in admitting Mr. Y to an inpatient setting. It was evident that Mr. Y needed a bed urgently in February 2004. There were delays to his admission due to the fact that no bed was available. Once a bed was available there was a tardy response to ensuring the admission took place in a timely manner. This delay was significant as it was during this period Mr. Y killed his father and it had been identified that Mr. Y would need to be admitted under the Act if he refused an informal admission.

On the 30 September and 11 October 2006 Special Circumstances Reports were written for the Home Office in support of Mr. Y's forthcoming Tribunal by his Social Supervisor and his Responsible Medical Officer. On the 24 October the statement for the Home Secretary for the

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consideration of the Tribunal stated that whilst he was pleased to note Mr. Y's progress he would not be prepared to support his discharge at this time and that he needed to stay in hospital in order to receive treatment for both his own health and safety and for the protection of others. Despite this communication plans for Mr. Y's discharge went ahead. Whilst it was good practice to arrange overnight leave (with the permission of the Ministry of Justice) to prepare Mr. Y for an eventual discharge, it is not clear how well-considered the move to supported accommodation in Moscow Drive was.

Mr. Y's discharge in December 2006 appeared to have taken place in a hurried manner. It is unclear why this should have been the case. Mr. Y was discharged *de facto* on the 18 December and officially on the 20 December 2006 without his medication and without a discharge CPA and plan. Also, whilst it was recorded that some kind of Section 117 meeting had been arranged there was no documentation produced that details what occurred in this meeting.

- *Contributory Factor Six. The discharge process did not address in sufficient detail either the needs of Mr. Y or the continued safety of the public, with particular reference to Mrs. Y Senior. The process appeared to have been rushed and coordinated poorly. As a consequence the essential safety nets of care were not put into place to the ultimate detriment of the care, treatment and supervision that Mr. Y received up until the time of the killing of his mother.*

Number Seven

Service User Involvement in Care Planning and Treatment. Between March 2003 and March 2010 it was evident that Mr. Y's treating teams attempted to provide a service that was acceptable to him. However this meant that, at times, there was no assertive management of his medication regimen or liaison with his family. Whilst Mr. Y's wishes were taken into account, these were not always in the best interests of either himself or those around him.

It is a fact that health and social care staff found it difficult to access Mr. Y's inner world. This meant that he was understood poorly and that engagement was maintained at a fairly superficial level. It is recorded in the clinical record that Mr. Y rarely attended his CPA meetings whilst at the Scott Clinic and at times would refuse to sign off his care plans. Mr. Y was generally perceived as being a quiet and private person by members of his treating team

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and this appears to have become a barrier to a genuine therapeutic relationship being built up with him over time. His lack of involvement in his care planning and treatment, which was ostensibly regarded as Mr. Y 'being the way he was,' should have been challenged *via* the building and maintenance of a therapeutic relationship so that he could genuinely engage more fully in his own recovery.

- ***Contributory Factor Seven. Mr. Y's involvement in his care and treatment programme was superficial at best. The treating team placed too much confidence in his ability to work with his recovery programme and consequently failed to put routine protective plans in place to the ultimate detriment of the health and wellbeing of Mr. Y.***

Number Eight

Carer Assessment and Involvement. Between March 2003 and March 2010 there was no active or documented plan in place to ensure that Mr. Y's family were involved in his care and treatment.

Prior to the death of Mr. Y Senior, members of the treating team mistakenly thought that they could not gain collateral information from the family because Mr. Y refused to give his consent. Once it was evident that Mr. Y was suffering from a severe and enduring mental illness no effort was made to either educate his family or to support them. At no time was a carer assessment considered.

During the period that Mr. Y was an inpatient at the Scott Clinic no family focused interventions took place and it is unclear from either reading the clinical documentation or from talking to members of the treating team what exact involvement the family had with Mr. Y's care and treatment programme and discharge planning arrangements.

Following Mr. Y's discharge from the Scott Clinic in 2006 it would appear that the family of Mr. Y made its own arrangements to protect Mrs. Y Senior in the absence of any management plan developed by the treating team. Communication with Mr. Y's mother appeared to take place in an unstructured manner and in isolation from any CPA processes. It is the conclusion of the Independent Investigation Team that this placed Mrs. Y Senior in a position of unmitigated risk.

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- *Contributory Factor Eight. The Scott Clinic failed in its duty of care to Mrs. Y Senior. This left her unsupported and without the protection of risk management plan.*

Number Nine

Housing. Whilst at the Scott Clinic Mr. Y was identified as needing a small group nursing home. This was based on the belief that he suffered from Asperger's Syndrome and the observations about 'Theory of Mind'. There is no evidence that this 'need' was taken into consideration as part of his discharge planning. There is no record as to an evaluation regarding the appropriateness of fit between Mr. Y's needs and the environment/support offered by Moscow Drive and Imagine. Mr. Y appears to have been placed at Moscow Drive because that was the place that was available. This is common practice for services, but still poor practice. This lack of assessment for appropriate placement led to the care team taking a purely pragmatic approach to disposal after Mr Y left the Scott Clinic. A wider implication was that it obscured the need for the Local Authority and the Primary Care Trust to offer appropriate after-care under the terms of Section 117 of the Mental Health Act. A further implication was that the type of supported accommodation offered to Mr Y, carried with it an expectation that people would 'move on' to more independent living. Although this might be a reasonable aim for many people with mental health problems, it put pressure on Mr Y to move through the system at an inappropriate place.

Mr. Y was moved from one property at Moscow Drive to another because the first property was considered no longer suitable. In a material sense the move might have been a beneficial one, however given Mr. Y's known aversion to change; it was not necessarily psychologically so beneficial. There is no evidence of appropriate psychological preparation for this move. It appears, however, that the move went well and Mr. Y reported that he enjoyed his new accommodation and made (possibly for the first time in his life) a friend. The cost of increased independence was decreased supervision. This does not appear to have been reflected upon or included in a risk assessment. Most importantly of all the Ministry of Justice was not consulted prior to this decision being made. This was a serious omission.

In the January of 2010 the Local Authority Supporting People team conducted an assessment of Mr. Y without the input of either the Imagine staff or mental health services. This was also conducted without understanding the statutory basis of Mr. Y's status in the community

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(Section 117 aftercare and his Conditional Discharge) and of the impact that this assessment could have made on Mr. Y's mental state. This action was inappropriate.

- *Contributory Factor Nine. Significant failures to manage Mr. Y's Section 117 aftercare arrangements and terms of his conditional discharge meant that his Supported Living provision was inadequately planned from the outset. This had the effect of creating a degree of instability in the life of a person who required structure and certainty and also prevented realistic protective measures being put into place.*

Number Ten

Documentation and Professional Communication. Three main issues were identified by the Independent Investigation Team. First: The Trust has not archived Mr. Y's clinical records appropriately and a significant proportion of his clinical record appears to be lost and could not be made available to this Investigation. This is a serious omission, especially in light of the fact that Mr. Y's case is still open to the Trust and all of his clinical records should be available to his current treating team.

Second: the practice of clinical record keeping was poor. Significant CPA and Ministry of Justice documentation has not been held within the main body of the clinical record. It was evident to this Investigation that the general maintenance of the clinical record took the form of a continuous 'cut and paste' process. Assessment and care planning was not dynamic and did not change over time and incorrect information was carried forward from one assessment to the next.

Third: levels of professional communication fell below the level to be expected from a tertiary service team. Communication between Care Coordinators and Social Supervisors was poor in relation to Mr. Y's mother. Communication between Care Coordinators and other agencies, such as the Local Authority and Supporting People, was non-existent. It is expected that a tertiary forensic service would communicate with the Ministry of Justice in a systematic and professional manner. This did not take place in accordance with statutory requirements and consequently the conditions of Mr. Y's discharge were breached.

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- *Contributory Factor Ten. The standards of clinical record keeping and interagency communication were poor. This made a significant contribution over time to Mr. Y being neither understood nor managed in the full context of his mental illness in a multiagency arena.*

Number Eleven

Adherence to Local and National Policy, Procedure and Clinical Guidelines.

- CPA: While the Trust had in place a CPA Policy that reflected national guidelines this did not appear to have been adhered to in Mr. Y's case:
 - there was a lack of clarity and of appropriate training regarding the role and responsibilities of the Care Coordinator;
 - comprehensive needs assessments and plans were not drawn up and reviewed in a timely manner;
 - Mr. Y and his mother were not involved when identifying his needs and developing his care plans. This involvement should have involved more than inviting people to CPA review meetings. There should have been an ongoing and proactive effort at engagement;
- Risk assessment and management planning:
 - the Trust had an appropriate policy in place and at least whilst Mr. Y was in the Scott Clinic some appropriate standardised devices were employed. However the Best Practice guidance goes beyond the collection of data and requires an understanding of the risk that an individual poses. This was not evident in Mr. Y's case. The guidance recommends that the individual and his family should be involved in identifying and understanding risk and in developing the management plan. This did not happen in Mr. Y's case.
- There are guidelines available for the treatment of/intervention for individuals suffering with schizophrenia/psychosis and for personality disorders, these do not appear to have considered when planning Mr. Y's care and treatment
- The Independent Investigation Team was informed that the practice of the Scott Clinic in referring people to MAPPa was at odds with that of the rest of the Trust. The primary aim of MAPPa is to share information relating to the risk an individual poses and to put in place arrangements for managing and, where possible, reducing

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that risk. This function of MAPPAs does not seem to have been reflected upon; rather the emphasis was on whether Mr. Y met the criteria for referral.

- Mental Health Act: Some clinical witness appeared to be unclear as to the provisions of the Mental Health Act and its accompanying Code of Practice. Neither the Trust nor the Local Authority and those representing it appeared to be familiar with responsibilities under Section 117 of the Act and the requirement to monitor and adhere to the terms of the Conditional Discharge;
- Social Supervisors were unclear as to their role and did not appear to have received appropriate training or supervision.

- *Contributory Factor Eleven. Policy non adherence made a significant contribution to the poor overall management of Mr. Y's case which was to the overall detriment of his health, safety and wellbeing.*

Number Twelve

Overall Management of the Care and Treatment of Mr. Y.

- **There was a consistent lack of clarity in understanding and formulating Mr. Y's problems and needs.**
 - There is no clear evidence in Mr. Y's clinical notes of the process of: assessment, formulation, identification of needs, interdisciplinary/agency planning, intervention and evaluation of the intervention.
 - Prior to Mr. Y killing his father he was displaying the symptoms of a serious mental illness. He was non-compliant with the interventions identified (medication and attendance at the day hospital) and he was deemed to need admission as an inpatient. Mr. Y had been identified as needing a Mental Health Act assessment but his situation was allowed to drift for several months. This resulted in a number of missed opportunities and consequently his acute psychosis went untreated and continued to deteriorate.
 - Whilst in the Scott Clinic there was no evident sustained planning for his discharge other than that provided by the Occupational Therapist. There was no evident effort, recorded in Mr. Y's notes, to discover why he killed his father, to consider the relationship(s) of his 'Theory of Mind' (ToM) difficulties to his other symptomatology, to consider the implication of his

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ToM difficulties on his ability to function successfully outside the highly structured environment of the Scott Clinic and on the risks he might pose to others. There was no meaningful involvement of Mr. Y's mother in planning for Mr. Y's discharge, identifying the risks he might pose to her or identifying her needs e.g. for understanding her son's problems. Cognitive Behaviour Therapy and other strategies for coping with psychological distress/difficulties recommended by Best Practice guidance were not made available to Mr. Y.

- Following Mr. Y's discharge from the Scott Clinic there was no clear formulation of his problems other than that his ToM difficulties might present difficulties in social situations. The result of this was that there were no focused interventions put in place, monitoring lacked focus and there was a lack of clarity as to how Mr. Y's progress or changing risk profile might be monitored and evaluated.
- **Mr. Y was known to be reluctant to comply with interventions and was described on an number of occasions as 'a private person' however there were a number of levers that could have been used more effectively to promote Mr. Y's engagement and involvement:**
 - prior to Mr. Y killing his father the provisions of the Mental Health Act (1983) could have been used in a more timely and assertive manner;
 - the terms of Mr. Y's conditional discharge should have formed the basis for a clear and more constructive risk management plan; this did not happen;
 - Section 117 of the Mental Health Act (1983) should have been used more forcefully and creatively to ensure that Mr. Y had fully funded ongoing support. This should have been informed by a robust and comprehensive care plan which Mr. Y and his mother should have been involved in drawing up.
- **Interagency collaboration and communication.**
 - Given Mr. Y's history it was of considerable importance that information regarding the risks he posed, or changes in his risk profile, should have been shared between relevant agencies. MAPPa was the obvious forum for this sharing of information and for establishing protocols for information sharing between agencies. Mr. Y was not referred to MAPPa this was a significant omission in the management of his care.

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- Imagine staff provided a significant amount of support and supervision for Mr. Y following his discharge from the Scott Clinic. They were invited to his CPA reviews and Mr. Y's Care Coordinators and Social Supervisors communicated with the Imagine staff on a regular basis. However, on at least one occasion Imagine had to ask for the minutes of the CPA review and the related care and risk management plan. It was noted by this Investigation that CPA documentation was far from complete in Mr. Y's Imagine-held record. The meetings with the Care Coordinators were unstructured and not focused upon the responsibilities of the two agencies for delivering an agreed care plan. There appeared to be a lack of clarity as to the roles and responsibilities of the two organisations. A robust management plan with a clear review structure would have addressed this and increased the efficacy of both organisations.
- **Clarity of roles and responsibilities.**
 - Following Mr. Y's discharge from the Scott Clinic his two Care Coordinators were Community Psychiatric Nurses (CPNs). They appear to have fulfilled the role of the CPN rather than assuming the role of the Care Coordinator and ensuring that Mr. Y's needs were identified, that there were plans in place to meet these needs, that these plans were reviewed in a timely manner and that these plans were delivered.
 - One of Mr. Y's Social Supervisors informed the Independent Investigation Team that she had no training as a Social Supervisor and received very limited supervision. Both Social Supervisors appeared not to focus upon their primary role of monitoring Mr. Y's terms of Conditional Discharge.
 - Whilst in the Scott Clinic Mr. Y's Responsible Medical Officer/Clinician was also his nominal Care Coordinator. There appears to have been some confusion about the roles of the Responsible Medical Officer/Clinician and Care Coordinator once Mr. Y had been discharged from the Scott Clinic.
 - The Local Authority, as represented by Supporting People, does not appear to have understood its responsibilities under Section 117 of the Mental Health Act (1983). The Local Authority does not have to make funding available to support an individual in the community *via* the Supporting People funding stream on an ongoing basis if it is no longer deemed to be appropriate. However if funding is removed from this stream, and the individual

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concerned is eligible for Section 117 aftercare, the Local Authority and Primary Care Trust must make it available *via* an alternative route. The Local Authority has a duty to ensure that such changes are not detrimental to the well-being of the individual. In the case of Mr. Y the change in funding had two immediate and probably detrimental consequences to his accommodation arrangements: (i) uncertainty was introduced into Mr. Y's life without the necessary time being available to prepare him for the proposed change; (ii) he would have been moved to a living situation which entailed less supervision and possibly less support.

- *Causal Factor One. There was a failure by the Scott Clinic treating team to ensure that best practice clinical policy guidance was applied to the care and treatment of Mr. Y. Consequently Mr. Y's case was managed in an unstructured fashion which placed an over reliance upon 'gut instinct' over and beyond clinical formulation. This was compounded by the weak discharge planning processes that ensued when Mr. Y went to live at Moscow Drive. Protective measures were not put into place in accordance with statutory expectation that could have provided more support for Mr. Y's recovery and a higher level of protection to his mother.*

Number Thirteen

Clinical Governance and Performance. The quality and effectiveness of Trust governance systems cannot be assessed when viewed through the single lens of this particular case. It would appear that the Trust has robust policies and procedures which are both evidence-based and robust. It is also evident that the Trust has in place a comprehensive governance system which is compatible with national best practice expectations.

Whilst the Trust had in place a number of appropriate policies and procedures informed by national best practice policy guidance there were some instances in the care received by Mr. Y where these policies were not adhered to. This lack of adherence was not identified in a timely manner by the Trust governance procedures and protocols and as a result weak (remedial) action was put into place to ultimate detriment of Mr. Y's care, treatment on ongoing case management.

14.2. Conclusions

14.2.1. Issues Relating to the Killing of Mr. Y Senior

Quality of Care and Treatment and Trust and Independent Investigation Processes

The Independent Investigation Team concurs broadly with the findings of the Trust Internal Review 2004. The care and treatment that Mr. Y received did not adhere to the expectations of extant Trust policy and procedure in place at the time of the killing of Mr. Y Senior. The treating team did not act in a timely manner which would have ensured Mr. Y's acute psychosis was appropriately treated. This impaired his recovery and led to his mental health continuing to deteriorate up until the time he killed his father. Court processes and the Criminal Justice system found a link between Mr. Y's mental state and the killing of his father.

In 2004 the National Patient Safety Agency had commenced a training programme that required NHS Trusts to adopt a Root Cause Analysis (RCA) methodology when conducting internal investigations. The Trust Internal Review (2004) into the care and treatment that Mr. Y received was conducted prior to the national requirement for implementation and consequently did not use a RCA methodology. Even so, the report produced a useful and insightful set of findings.

Impact of Lessons to be Learned from the Killing of Mr. Y Senior and any Consequences Regarding the Killing Mrs. Y Senior

NHS North West (the Strategic Health Authority who commissioned this Investigation) requested that the Independent Investigation Team assess whether its decision not to subject the homicide of Mr. Y Senior (2004) to an HSG 94 (27) full Independent Investigation impacted upon the killing of Mrs. Y Senior (2010) in any way.

In 2007 Strategic Health Authorities (SHAs) across the country had difficulty in responding to HSG 94 (27) requirements in a timely manner due to extensive NHS reorganisation. Consequently many SHAs made the decision to conduct large-scale 'Legacy Reviews' in order to ensure that lessons were learned. NHS North West commissioned a Legacy Review analysis of 22 cases in 2007. The case of Mr. Y was one of the cases commissioned for

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investigation as part of this review. An Independent Investigation Team was appointed to conduct this work. It was decided that:

“As requested by NHS North West, the panel considered the option of recommending a further independent investigation for each case where this had not taken place. On balance, the panel decided against this approach on the grounds that:

- the time lapse since the incidents was such that many families would find further investigation distressing;*
- staff would have moved on and would need to be traced or may be unavailable;*
- service users had not given consent for their personal information or health records to be accessed or made public;*
- as a result of this review, all cases had been subjected to further scrutiny by an expert panel and the root cause and contributory factors had been identified”.*⁴⁶⁹

It was not recommended that the case of Mr. Y needed to be put forward for a separate Independent Review.

It is unlikely that a separate Independent Investigation would have yielded information of a kind to have prevented the death of Mrs. Y senior six years into the future. The reasons this Independent Investigation Team hold this view are set out below.

- The Trust Internal Review (2004) was of a good standard and yielded robust findings and valuable insights. Examination of the Trust action plan demonstrates service improvements took place.
- The Independent Legacy Review process was conducted by a panel of experts who were able to identify key areas of learning on both a thematic and individual case basis.
- The services that Mr. Y received his care and treatment from prior to the killing of his father in 2004 and prior to the killing of his mother in 2010 were entirely different services, albeit within the same Trust. This meant that the service improvements that subsequently occurred in one service (CMHT secondary care) did not necessarily impact directly upon the other service (Scott Clinic forensic tertiary care). This is because the findings and recommendations were not generalisable.

469. NHS North West *Patient Safety: a review of case requiring mental health Independent Investigation in the North West (2007)*

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- There was a time interval of six years between the killing of Mr. Y's mother and father. It is unlikely, in the light of constant NICE and Department of Health policy guidance change, that the issues regarding the learning in 2004 automatically carried forward to 2010.
- Following the death of Mrs. Y Senior the Scott Clinic treating team were supported by the secondary care CMHT for a period of several months in order to ensure that Mr. Y's past psychiatric history was understood and incorporated into forensic service assessment processes. Therefore an independent investigation process would not have contributed information about Mr. Y which was not already understood by the Scott Clinic utilising a more reliable and professional process; that of clinical team cooperation.

It was the conclusion of the Independent Investigation Team that the decision not to commission a traditional HSG 94 (97) process following the killing of Mr. Y Senior in 2004 had no far-reaching consequences in relation to the death of Mrs. Y Senior in 2010.

14.2.2. Issues Relating Specifically to the Killing of Mrs. Y Senior

It was evident that there was a causal link between the omissions of the treating team providing care and treatment to Mr. Y and the killing of his mother. This is because the treating team did not:

- accept the significance of the patient's condition in relation to his potential for high risk behaviours (this was despite having identified significant risk factors in relation to Mr. Y's potential for future offending and the ensuing risk to his mother);
- put into place an appropriate system to detect any relapse in Mr. Y's mental state;
- put into place an appropriate supervision and risk management plan;
- adhere to either local or national best policy guidance in order to ensure that essential safety nets of care were put into place which would have been considered the norm for any patient with the history and diagnosis that Mr. Y presented with (e.g. CPA, MAPPA, and Ministry of Justice conditions of discharge).

When examining the effectiveness and quality of care and treatment it is reasonable to assume the following:

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- sound assessment leads to a) a plan to manage risk, care and treatment b) informed care and treatment;
- risk management and treatment plans can reasonably be expected to reduce risk and to improve and maintain mental health.

On the 28 March 2011 the Crown Prosecution Service stated *“The experts preparing these reports, having access to all the evidence and to the defendant's medical records, ultimately concluded that ... [Mr. Y] was suffering from an abnormality of the mind that substantially impaired his mental responsibility for his acts at the time he killed his mother. Taking account of the weight of medical opinion as to the defendant's mental condition the Crown accepted the defendant's plea to manslaughter on the grounds of diminished responsibility”*.⁴⁷⁰ Mr. Justice Calvert-Smith also made orders under the Mental Health Act, sending Mr. Y to Ashworth hospital without a time limit. He said: *“This was a dreadful offence committed by a man who had already unlawfully killed his father some six years before and made a serious attack on his mother at the same time. This was about a serious breach of trust as can be imagined, to kill your mother who was of advanced years and therefore vulnerable”*. The Court was also told how three psychiatrists agreed Mr. Y was suffering from an abnormality of mind and his responsibility was *“substantially, although not necessarily entirely, impaired”*.⁴⁷¹ This Investigation found a direct causal link between the lack of appropriate supervision and risk management strategy implementation that Mr. Y was subject to and the killing of his mother and as such concurs with the findings and conclusions of the Trust Internal Review Report (2010) which also made the same causal link.

However, despite the above finding, it was also the conclusion of the Independent Investigation Team that the Mersey Care NHS Trust in 2012 has sound governance processes and that this particular tragic incident does not indicate that the Trust is operating poorly in general. The Independent Investigation Team recognises that it is not possible to assess the functioning of an entire organisation when examined through the lens of a single case. However the evidence collected throughout the course of this inquiry process has given the Independent Investigation Team a high degree of confidence in the Trust, both as a learning organisation, and as a responsible provider of clinical services in general.

470. http://www.cps.gov.uk/mersey-cheshire/cps_merseyside_cheshire_news/sentencing_of_Mr_Y

471. <http://www.thefreelibrary.com/FREED+TO+KILL+HIS+MUM,+70%3B+Man,+39+had+battered+dad+to+death.-a0252645494>

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When examining the quality of the care and treatment a person receives from a mental health Trust the following four findings categories can be utilised when causality is being considered.

Category 1. The Trust implemented high standards of service delivery that were appropriate, effective and in keeping with best practice and the Independent Investigation Team was unable to identify any causal or contributory factors to the homicide in question.

Category 2. The Trust implemented high standards of service delivery that were appropriate, effective and in keeping with best practice. However a single act or omission, or the unexplained practice of a single team, led directly to the circumstance in which a serious untoward incident occurred. Causality was found between the untreated mental state of the service user/the quality of the care and treatment provided, and the subsequent actions of the service user.

Category 3. The Trust delivered less than effective services where systems were chaotic and best practice standards were not implemented. However no direct causal relationship between what the services actually did or did not do was connected to the incident.

Category 4. The Trust delivered less than effective services where systems were chaotic and best practice standards were not implemented. Causality was found between the untreated mental state of the service user/the quality of the care and treatment provided, and the subsequent actions of the service user.

It was the conclusion of the Independent Investigation Team that the Mersey Care NHS Trust findings belonged to Category 2. However it was evident that there was a direct causal link between the omissions of the clinical team providing care and treatment to Mr. Y, the lack of appropriate supervision and risk management strategy implementation, and the death of Mrs. Y Senior. The Independent Investigation Team concludes that there were significant omissions on the part of the Scott Clinic treating team and the overall standard and of care and treatment offered to Mr. Y over a period of several years fell below that to be expected from either a secondary or tertiary care service. This Investigation concludes that the omissions and poor levels of care and treatment occurred due to three principle reasons.

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1. Scott Clinic culture, custom and practice had not been successfully incorporated into those of the Mersey Care NHS Trust prior to the killing of Mrs. Y Senior. Consequently the Scott Clinic adhered to processes which could not be described as best practice.
2. Scott Clinic staff did not appear to have accessed suitable levels of training and supervision which exacerbated the non adherence to both local and national best practice policy guidance.
3. Trust clinical governance systems were not sensitive enough to detect policy and procedure non adherence. This was because the Scott Clinic staff applied the principles of policy and procedure to the point where a loose and poorly constructed compliance took place. This is demonstrated by the fact that forms were filled in and reports and care plans written. However there is a substantial difference between *basic* compliance and *quality* care and treatment delivery. It has to be noted here that many NHS mental health Trust's may not have governance systems that are sensitive enough to assess the quality of clinical work. Nationally, audit processes tend to focus mainly on compliance.

It is to the credit of the Mersey Care NHS Trust that these issues were identified within its own Internal Review Report (2010) and that a substantial amount of work has been put into train and significant improvements have been accomplished since the killing of Mrs. Y Senior. These are detailed in Sections 17 and 19 below.

Summary

Had Mr. Y been subject to a robust supervision and management strategy the risk that he would have killed his mother would have been substantially reduced. This is a complex case. There were numerous factors to take into consideration all of which interacted with each other as well as having significant relevance in their own right. Over time it was evident that Mr. Y was understood poorly and factoids developed within the treating team in regard to his mental state and likelihood of relapse, none of which were based on the evidence that had been collected.

It is essential that all NHS clinicians adhere to both national guidance and local policy and procedure. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any

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issues regarding the effectiveness of the said policies or procedures or to raise any implementation issues as they arise with immediate effect. The failure to abide by policy and procedure ensures that the safety nets of care are not effectively in place. This puts the service user at risk and places the clinician in a vulnerable and often indefensible position. The Trust had, and continues to have, sound policies and procedures. However it remains a corporate, local management and individual worker responsibility to ensure that they are used at all times and that audit assures the Trust Board that this is in fact occurring.

The Independent Investigation Team concludes that the treating team had the knowledge, opportunity and means to intervene in order to ensure Mr. Y was supervised and managed appropriately. However the treating team did not fulfil its obligations and failed in its duty of care. The treating team both *could* and *should* have put into place a coherent care and management strategy around the conditions of discharge imposed by the Ministry of Justice. This was not achieved. This in effect left Mr. Y to regulate his own activities and set his own boundaries, consequently he fell through the safety net of care that was not robust enough to try and ensure the safety of either Mr. Y or his mother.

15. Mersey Care NHS Trust Response to the Incident and Internal Review

15.1. The Trust Serious Untoward Incident Process 2004 and the Strategic Health Authority Response to the Death of Mr. Y Senior

The Trust Internal Review following the homicide of Mr. Y Senior took place in 2004 which was eight years prior to the writing of this report. After such a long period of time it was difficult to understand exactly how the investigation was managed and how Serious Untoward Incident processes were implemented. However it was possible to interview members of the original Internal Investigation Team.

The Independent Investigation Team concluded that the internal investigation report was written well. The report was of a high standard which, given that it was written in 2004, is of particular note as the quality of Trust internal investigation reports was generally poor across the country at this time. The Trust Internal Investigation made useful recommendations which were implemented.

The Strategic Health Authority commissioned an Independent Investigation into the care and treatment that Mr. Y received as part of a legacy review which incorporated several other cases pertaining to service user's in the North West. This review was conducted in such a manner that individual case, Trust, and SHA-wide points of learning could be identified and the necessary recommendations set.

This Independent Investigation Team was asked to assess whether or not any omissions in the original investigation processes contributed to the death of Mrs. Y Senior in 2010 in so far as any points of learning were either overlooked or not resolved *via* service improvement. It was the conclusion of this Investigation that this was not the case. No link could be made by this Investigation between previous investigations into the care and treatment Mr. Y received in 2003/2004, and any subsequent service changes made or not made, and the death of Mrs. Y Senior in 2010. This was for two principle reasons which are set out below.

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1. There was a space of eight years between the killing of Mr. Y Senior in 2004 and the killing of Mrs. Y Senior in 2010. It was not possible to find any continuity between the investigation processes deployed and subsequent service changes made in 2004, and all following service developments which took place as a result of 'natural' Trust evolution, and the killing of Mrs. Y Senior in 2010.
2. Prior to the killing of Mr. Y Senior Mr. Y was treated by a General Adult Psychiatry Community Mental Health Team. Prior to the killing of Mrs. Y Senior Mr. Y was treated by a Specialist Forensic Team. This means that Mr. Y was treated by two separate services, one prior to the events of 2004, and the other prior to the events of 2010. Therefore any service changes which took place as a direct result of the first set of investigations would not have impacted upon the running of the Forensic Team. It must be noted here that the findings, conclusions and recommendations of the investigation processes were not generalisable across the Trust as a whole and were specific to the services under review.

15.2. The Trust Serious Untoward Incident Process 2010

The Mersey Care NHS Trust followed its Serious Untoward Incident Policy following the death of Mrs. Y Senior. This policy reflected extant national best practice.

15.3. The Trust Internal Review

The Internal Investigation Review Team comprised the following personnel:

- Mersey Care NHS Trust Non Executive Director (Chair);
- Mersey Care NHS Trust Executive Director of High Secure Services;
- Mersey Care NHS Trust Consultant Psychiatrist;
- Mersey Care NHS Trust Lead for Quality and Professional Practice;
- Great Manchester West Mental Health NHS Foundation Trust Consultant Forensic Clinical Psychologist;

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- Carer Representative.

The Terms of Reference

1. To establish a chronology of the events leading up to the incident involving Mr. Y on 30 March 2010 originating from his initial contact with the Scott Clinic.
2. To examine all the circumstances surrounding the care and treatment of Mr. Y as provided by the Merseyside Forensic Psychiatry Service at the Scott Clinic whilst he was an inpatient (from February 2004) then, post discharge, by the Forensic Integrated resource Team (FIRT) up to the 31 March 2010.
3. To consider and comment on the appropriateness or otherwise of the care and treatment received by Mr. Y including:
 - his assessed health and social care needs;
 - his assessed risk of potential harm to himself and others;
 - his engagement with mental health services;
 - communication between, and shared management arrangements with, other key providers of care.
4. To consider any specific issues that Mr. Y or his family may wish to raise with due regard to confidentiality.
5. To raise immediate concerns with the service management team to ensure remedial action can be taken without undue delay.
6. To identify the root cause or influencing factors that contributed to the incident occurring.
7. To identify where improvements in practice/systems could be made to prevent a similar incident occurring in the future.
8. To prepare a report for the Board of Mersey Care NHS Trust.

Methodology

1. The Internal Review Team's methodology was directed by the Mersey Care NHS Trust's Policy and Procedure for the Reporting, Management and Review of Adverse Incidents, which was published in January 2007.
2. The investigative work followed a Root Cause Analysis (RCA) approach as is now required across the NHS.

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3. RCA is a methodology by which adverse incidents are evaluated to identify primary and contributory causes of the index incident thereby enabling corrective actions to be developed.
4. The focus of the review was the care and treatment of Mr. Y since 2004 as provided by the Merseyside Forensic Psychiatry Service.
5. Clinical, nursing and E-Pex (electronic records) notes, reports, policies and documentation were examined as part of the process.
6. The Review Team met on eight occasions and interviewed various clinical, nursing, social work, probation and support staff involved in the care and treatment or support of Mr. Y from both statutory and non statutory organisations. The Review Team also met with members of Mr. Y's family.

Key Findings

These were as follows:

1. Risk assessment and risk management in the Scott Clinic was managed poorly. Mr. Y's risk was assessed in the light of the seeming absence of acute mental illness alone. There was no formulation that included an acknowledgement of the relationship between risk and Mr. Y's mental disorder and consequently no care management plan was formulated prior to his conditional discharge to the community. The quality of formulation exposed a lack of understanding of the risks that Mr. Y posed and revealed a lack of understanding with the way the care team monitored him.
2. Formulation and understanding of Mr. Y's risk to others was not understood. Mr. Y was difficult to get to know and engage. The relevance of Mr. Y's mental disorder and its correlation and consequences to future risk of harm was not adequately delineated and did not appear to inform decision making toward conditional discharge or subsequent risk assessment and management.
3. Risk assessment and management following Mr. Y's conditional discharge were negatively affected by the approach taken whilst he was still an inpatient. The lack of understanding regarding the risk Mr. Y posed whilst at the Scott Clinic pervaded the assessments carried out following his conditional discharge. No protective plan was put into place for Mr. Y's mother and risk information was not passed between 123 and 133 Moscow Drive following his move. The following were relied upon to manage future risk:

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- psychotropic medication;
 - contact with staff in order for his mental state to be monitored;
 - maintenance of reasonable levels of physical and social activity (e.g. running and going to the library).
4. The conditional discharge detailed nine conditions. There was no evidence to suggest that a management plan was put into place to ensure that Mr. Y met the conditions of his discharge. There were no discussions about how these conditions of discharge were to be met when Mr. Y moved from 123 to 133 Moscow Drive.
 5. Arrangements for ongoing discussions with partner agencies were found to be inadequate and it was concluded that detailed Service Level Agreements should be developed to ensure that service users' needs are linked to appropriate settings before community placements are agreed.
 6. Multi Agency Public Protection Arrangements (MAPPA) were not considered in Mr. Y's case. In addition the Police National Computer (PNC) alerting system was not implemented by the Scott Clinic. It was evident that the Scott Clinic was not operating to Trust wide policy and procedure consequently the opportunity for partnership working with other relevant agencies (e.g. the Police) was overlooked and did not happen.
 7. Mr. Y's medication adherence was checked by the Imagine staff for the first two weeks following his discharge. After the first two weeks Mr. Y self-medicated unobserved. The continuation of Mr. Y's psychotropic medication was a key part of Mr. Y's risk management plan but there was no evidence that his compliance was ever checked.

Internal Review Team Analysis and Conclusions

Root Cause

The Review Team identified one root cause which related to the lack of understanding gained by Mr. Y's care team of his past violence and potential for violence in the future. Their assessments and interventions were limited and did not recognise the level of risk he posed to himself or to others. When discharge from the Scott Clinic was proposed the assessment undertaken should have included informed judgements about the risk of harm to his mother and other family members as well as the general public and other residents of the accommodation he was moving to.

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At the point of discharge there was little planning to inform either the community team or Imagine. The Review Team found the safety aspects of Mr. Y's discharge were poor.

Contributory Factors

1. There was little family involvement or regular contact with Mr. Y's mother or his extended family. The Internal Review Team considered this to be a missed opportunity.
2. The formulation did not identify the reasons for the first index offence.
3. It was concluded that the Care Coordinator and Social Supervisor contact focused mainly on social activities rather than the monitoring of Mr. Y's mental state and risk profile.
4. Prior to the second index offence Mr. Y exhibited several warning signs that were not recognised as being significant:
 - he missed an arranged appointment with the Imagine Bridge Builder (this was the first occasion that he had missed a pre-arranged appointment);
 - he gave money away to an ex-girlfriend which was reported to the Police (PNC alerting would have provided a basis for the Police responding to this important and relevant information);
 - he gave his television to another resident and the rationale given by Mr. Y was accepted;
 - he reported that he did not want to move again on two occasions.
5. Members of the MDT felt that there was no point in sharing their concerns during MDT discussions as these concerns were either downgraded or ignored.
6. The Review Team found that the Merseyside Forensic Psychiatry Services were not adhering to Trust-wide policy and procedure in relation to the use of MAPPA. Whilst the Review Team could not state with confidence whether or not this could have prevented the death of Mrs. Y Senior, it was of the view that this approach would have led to more multi-agency approach being taken.

Internal Review Team Positive Factors Identified

The Internal Review Team identified that Mr. Y had regular visits from his Care Coordinator and Social Supervisor who consistently kept all appointments. Any changes of staff were notified in advance and good handover processes were in place. There were regular entries made in both the E-Pex and hand written clinical records.

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The nature of the treatment Mr. Y received whilst at the Scott Clinic was appropriate both for his mental health problems and in relation to the assessment and management of risk presented as an inpatient. It was reasonable to assume that his mental health problems in general, and the Theory of Mind deficits in particular, were a key issue and that efforts were required, and made, to address the extent of change possible as a way of managing risk of harm.

Independent Investigation Team Feedback on the Internal Investigation Report Findings

The Independent Investigation Team concluded that the Trust internal review was of a high standard. The report made many useful and insightful findings with which this generally Investigation concurred.

A point of learning for the Trust is that the internal investigation archive should be maintained until such time as all external and criminal justice processes are complete. This Independent Investigation was not able to access the Trust internal investigation archive as it was seemingly destroyed. This prevented the Independent Investigation from being able to validate all of the findings, rationales, conclusions and recommendations set out within the Trust internal investigation report.

15.4. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

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- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

The Trust conducted their 2004 Internal Investigation prior to national *Being Open* guidance being issued. At the time of the Trust Internal Investigation (2010) robust *Being Open* guidance was available within the organisation.

Following the death of Mrs. Y Senior the Assistant Chief Executive: Complaints, Incidents and Legal Management and the Internal Investigation Chair (a Non Executive Director) met with the deceased's friends and family. On this occasion the Trust representatives consulted upon the terms of reference for the pending investigation that was due to commence. The friends and family of Mrs. Y Senior expressed the view that they had not been involved sufficiently by the Trust in the care and treatment of Mr. Y and that their views had not been listened to. The friends and family of Mrs. Y Senior were able to make several important observations and contributions to the internal investigation but did not request any further input.

15.5. Staff Support

All staff who were called as witnesses, and those who managed services at the Scott Clinic, were written to at the inception of the investigation process. Staff requiring support were offered it as part of an ongoing process. The finalised report went to the Trust Board in November 2010, and the report was shared with the new Service Directors at the Scott Clinic

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in February 2011. Whilst the Trust uses the Oxford Model for investigation findings dissemination it is unclear how promptly staff at the Scott Clinic received feedback from the internal investigation process.

15.6. Trust Internal Review Recommendations

The recommendations of the internal investigation are set out below.

1. *“The management arrangements and working practices of multidisciplinary teams (MDTs) at the Scott Clinic should be reviewed to ensure a consensus approach to decision making. The outcomes should be reflected in an operational procedure governing the working of MDTs.*
2. *A review of the arrangements in place for carers of service users admitted to the Scott Clinic should be undertaken. All carers should be offered a carer’s assessment.*
3. *Arrangements for the risk assessment, management and discharge of service users should be reviewed at the Scott Clinic. This review should include:*
 - *An overall assessment of the quality of information provided to the Ministry of Justice and relevant partners involved with ongoing care responsibilities and identification of associated actions for improvement.*
 - *A set of criteria to be drawn up to clarify the reasons why service users are – or are not – considered suitable for discharge from inpatient care in a medium secure unit. This should include details of what a service user must achieve before they are considered suitable for discharge and information on what alternative provision needs to be made if the criteria are not, or cannot be met, (e.g. enhanced risk management).*
 - *Evidence that carers/family members have been invited to participate in the process audited to ensure this happens.*
 - *Identifying and adopting good practice for the management of other service users eligible for conditional discharge into the community.*
4. *Working arrangements with partners/non statutory organisations (e.g. Imagine) require immediate review with particular regard to the following:*

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- *Interagency sharing of information.*
 - *Preparation of and actual arrangements for, handover of clinical care.*
 - *Arrangements for supporting the training needs of staff as part of the transfer of the service users care to a non statutory agency.*
 - *Arrangements for the commissioning of care packages in the community.*
 - *Links between the Scott Clinic, the Criminal Justice Liaison Service and involvement in MAPPA.*
 - *Clear protocols to be in place which reflect and maintain formal arrangements between partners (e.g. Service Level Agreements).*
5. *The Merseycare Forensic Psychiatric Service should routinely participate in benchmarking exercises against other medium secure units, with regard to both operational and a management arrangements.*
6. *Governance arrangements integral to the Scott Clinic need to be reviewed, strengthened and aligned with the corporate processes and systems adopted by all services in Mersey Care NHS Trust. The review should ensure that all the safety regulations are being met as part of the registration requirements of the Care Quality Commission and detailed assurance provided to the Board of Mersey Care NHS Trust that the requirements have been satisfied.*
7. *That the Trust ensures that robust systems are in place to give assurances that all Trust-wide policies are implemented and adhered to throughout Mersey Care and that audit arrangements evaluate compliance.*
8. *The Trust Board considers the need for any further action it may wish to take following receipt of this report.*⁴⁷²

15.7. Progress against the Trust Internal Review Action Plan

Please see Report Section 19 and Appendix Two for this information.

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16. Imagine Response to the Incident and Internal Review

Internal Investigation Process

Responding to the incident Imagine immediately set in place two things:

1. media response;
2. internal investigation.

Media Response

Imagine recommended a 'script' be prepared to deal with any media queries. All administrative, switchboard, and management personnel were advised to work through the internal media spokesperson, and all queries were directed to that one individual/department. A media folder was established recording what contact, and responses were made. Representation to the Police was also made regarding media handling; and advice and support from them was made available.

Internal Investigation

The Senior Management Team established an investigation panel immediately; this was constructed of four panel members, each with a particular expertise in their own field that would assist understanding of the service and the incident. It was agreed that the panel would include an independent chair, a senior officer from the Primary Care Trust, an Imagine staff member with clinical risk expertise, and, a Trustee. Administrative and management support would be made available, and where required, funding for consultants would be in place.

It was vital that the panel comprised external experts, to ensure an objective, and fresh perspective was brought to the investigation. For this reason the Chair was carefully selected, and appointed to lead the internal investigation with a degree of independence. It was also determined that a member from the clinical care provider be part of the panel. This was to be a reciprocal arrangement, and would assist in accessing personnel and information from each organisation. Terms of reference were agreed by the Board of Trustees, and objectives set for the inquiry established.

"The Review Panel was established to consider the following:

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1. *Establish and define the nature of the service at Moscow Drive, the expectations of the Commissioners and contractual obligations.*
2. *To consider whether risk identification, risk assessment and risk management were adequate and followed best practice.*
3. *To review case notes and files to consider whether care plans were appropriate, safe and sound in relation to ... [Mr. Y]. To review notes to determine that written care plans were in fact implemented.*
4. *To interview key stakeholders including Imagine staff and Mersey Care staff to establish the sequence of events leading to the incident and whether there were warning signs/ relapse indicators that were missed that may have been able to prevent the incident.*
5. *To, review staffing to ensure that correct levels of capacity and competence were available including senior managerial; oversight and support and relevant training. To establish the drivers for the staffing levels i.e. the balance of service user requirements and cost.*
6. *To draw conclusions and make recommendations as a result of the above that can improve services, risk management and quality. The Action Plan produced should be regularly audited”.*⁴⁷³

In order to meet these objectives the panel scrutinised all relevant documentation this included:

- Mr. Y's Mersey Care documentation;
- Scott Clinic notes;
- community notes;
- all risk assessment documentation;
- all correspondence;
- post-incident documentation;
- Mr. Y's Imagine notes including; all Star plans; all daily record sheets; all assessment forms; all correspondence; post incident documentation.

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The panel interviewed all Imagine staff employed at Moscow Drive and relevant Imagine senior managers. The panel was also provided with copies of all interview transcripts from all relevant Mersey Care staff.

Panel members visited Moscow Drive to assess the premises and recommend any possible physical improvements to the facility. The panel met on five occasions to discuss the progress of the investigation and to decide next steps. The panel Chair worked with the investigator who had been appointed by Mersey Care to review the incident from the Trust's perspective, in order to, where possible, share information and conduct joint interviews. There were three attempts made to interview Mr. Y's relatives but unfortunately the appointment eventually made was cancelled at short notice, (for legitimate reasons). The investigation concluded its work without the opportunity to meet with the relatives. Imagine senior management did however meet with them following completion of the report. They were seeking answers, it was hoped that the Independent Investigation (the HSG (94) 27 work) would supply these.

The Chair of the inquiry presented his findings to the Board of Trustees in person and answered questions. The senior management team drew up an action plan to implement the report's recommendations.

Conclusions and Recommendations (as taken from the internal investigation report)

Subsequent to the Trust internal investigation the following conclusions and recommendations were made:

Contracts

- Contracts must be more robust and reviewed regularly in terms of performance and cost by all agencies involved in the contract and/or the care of the client, at least annually with all agencies present. The principal objective must be to establish the primacy of the safety of clients, staff and the general public.
- The relationship between funders, social care and residential care providers and mental health care providers must be discussed, agreed and recorded in service contracts.

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Risk assessment and notes

- Mersey Care: absence of plans for Mrs. Y Senior was identified as a problem, therefore in future Imagine needed to understand how to assist in this process.
- Mersey Care staff should be required to make a recording in Imagine notes on every visit.
- Clinical risk assessment and management must be clearly separated from social care and support assessments to give clarity of responsibilities to staff from all agencies.

Accommodation

Ministry of Justice requirements must be complied with at all times, specifically as in this case, residential requirements. The change from 123 to 133 Moscow Drive involved moving from supported group living to a supported individual tenancy. The environment at 133 Moscow drive did not contribute directly to this event, however, on reflection some changes to the physical environment may improve the safety and effectiveness of the property.

- Move the staff flat to the ground floor; this will improve the staffs' awareness of whether residents are in or out of the premises and whether visitors are present.
- Install an intercom system between the staff flat and the residents' flats to allow residents to call staff or vice versa.
- Modify tenancies to allow staff to retain a copy of residents' keys for use in emergencies e.g. a resident being ill and unable to leave the flat.

Staffing

Imagine staff could not have performed any better than they did on the day of the homicide and subsequently.

- Staffing levels and skills must reflect the complexity and scale of the clients' needs rather than simply fit a cost envelope.
- Staff need regular training and updating on the skills required to meet the needs of the clients they work with.

Action Taken by Imagine

Progress of the Senior Management Action Plan in addressing the recommendations highlighted by the internal investigation is set out below.

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Contracts

It was noted that some recommendations were outside the scope of the charity. The Senior Management Team continues to review and monitor existing contracts regularly. The team uses its best endeavours to promote multi-agency review, but key to these changes are the Commissioners. The Senior Management Team also uses its best endeavours to promote the discussion and appropriate recording of relationships within service contracts. Funding bodies should recognise the specialist nature of the service and fund accordingly.

Risk Management

A specialist review of risk management in these services was made, and in collaboration with Mersey Care NHS Trust the following implemented within Imagine:

- absence of plans - checklists created and maintained;
- Mersey Care staff now make recording in Imagine notes on every visit;
- clinical risk assessment and management is clearly separated from social care and support assessments.

Accommodation

The recommendations for changes within the property have all been implemented.

Staffing

- The Senior Management Team continues to endeavour to convince funding bodies of the specialist nature of the service and fund for specialist staffing accordingly.
- Within Imagine a specialist training programme has been put in place.
- Risk management is a primary responsibility for the Director of Operations and Development.

17. Notable Practice

The following notable practice was identified.

- 1. Clinical Policies and Procedures.** Mersey Care NHS Trust policies and procedures were of a high standard. Each policy set out national best practice expectation and how this should be implemented by services locally in a clear and concise manner. Of particular note were the Trust Clinical Risk and Multi Agency Public Protection Arrangements policies and procedures. The Independent Investigation Team concluded that these policies represented notable practice and that they would be a useful reference point for any other mental health service to be signposted to.
- 2. Internal Investigation Processes. Mersey Care NHS Trust** The standard of the Trust internal review reports for both 2004 and 2010 were of a high standard. The Independent Investigation Team noted that the Trust 2004 report represented an exceptional example of its kind considering that nationally most Mental Health NHS Trusts at this time struggled to compile such comprehensive and useful investigation reports. The 2010 Trust internal report was insightful and far-reaching ensuring that sound recommendations were set based upon solid findings and conclusions. The Review Team was comprised of senior and experienced personal and the friends and family of Mrs. Y Senior were offered the appropriate levels of support by senior members of the Trust Board.

Imagine. It must be drawn to the reader's attention that Imagine Independence has never had to deal with a serious untoward incident of this nature before. It is therefore remarkable that this organisation was able to produce an internal review of such a high standard. The findings, conclusions and recommendations were both insightful and robust.

Both the Trust and Imagine worked together to ensure that the findings of their individual investigation reports were brought together in order for the recommendations to be worked through together.

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- 3. Governance and Learning Organisation Systems.** Mersey Care NHS Trust has modernised its governance systems in recent years. The Trust is also utilising the Oxford Model (the Oxford Model is a Serious Untoward Incident/Complaint rolling review process which is a way of taking forward the lessons learnt from Serious Untoward Incidents/Complaints, and sharing that learning with a broader audience. Each incident/complaint will already have been reviewed, this process provides the possibility of identifying further issues or concerns and also involves staff in the improvement process) in order to disseminate learning following serious untoward incidents. This approach is now embedded into the way that the Trust learns and was found by this Investigation to be notable practice.

- 4. Medical Appraisal.** This Independent Investigation Report has raised issues in relation to the quality of clinical decision making. The Mersey Care NHS Trust has worked to develop a significant model for medical appraisal and revalidation. In 2010 the Trust was selected to become one of ten national pathfinder pilots for medical appraisal and revalidation. Six of the original nine Merseyside Trusts were together successful in a bid to test a revised electronic appraisal system. By the end of the pilot in April 2011, 474 new appraisals had taken place within the Mersey pilot (more than any of the other pilots). This allowed strengthening of the working relationships across the different Trusts in the region and also provided an opportunity for feedback to the independent evaluators. 85 doctors within Mersey Care (out of a possible 100) were able to take part in this pilot. Despite difficulties with the system, participants valued the experience because it increased their awareness of how to successfully undergo appraisal. The approach within Mersey Care NHS Trust has therefore been of moving from the default position of a paper based appraisal process to taking advantage of new approaches, encouraging feedback, and thus ensuring that psychiatrists are able to help influence the development of appraisal. This overall approach also leads to better clinical governance processes by sharing the expectations of revalidation within the Trust.

18. Lessons Learned

1. Adherence to national and local policy and procedure best practice guidance.

National and local best practice policy and procedure guidance is an evidence-based method of ensuring both the quality and safety of the clinical care and treatment provided to service users. If treating teams do not adhere to this guidance then the effectiveness of any treatment programme can be compromised. In the case of Mr. Y it was found by this Investigation that significant departures were made from extant Trust policy and procedure. This had the effect of providing a care and treatment package to Mr. Y that was sub-optimal placing both him and those around him at risk.

Trust policies and procedures were found by this Investigation to be of an excellent standard and the Trust benefitted from having clinical policy authors with national standing. It was unfortunate that members of Mr. Y's treating team chose to ignore this guidance, choosing instead to follow an *ad hoc* and localised way of doing things. A lack of policy and procedure adherence is a common finding in HSG (94) 27 reports of this kind. It is also a common finding that the failure to follow best practice policy guidance leads to the provision of sub-optimal care and treatment delivery.

The lesson to be learned here is that NHS Trusts and the individuals who work within them have a duty of care placed upon them which requires total adherence to policy and procedure guidance unless there are clear clinical indications for a departure in the best interests of the patient. Whilst it is far from unusual to find a lack of policy adherence this is not good practice. NHS Trusts must be mindful of corporate responsibilities and individual practitioners must be mindful of the duty of care placed upon them by their registration bodies. NHS Trusts should develop a culture where there is a zero tolerance of clinical policy and procedure non adherence.

- #### 2. Sub-audit 'blind spots'.
- All NHS Trusts will have clinical governance processes and systems in place in order to ensure patient safety and efficient and effective practice. It is often difficult to understand how a Trust with a sophisticated clinical governance system can still fail to detect poor or unsafe clinical practice.

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It is a fact that many audit processes focus upon compliance rather than quality. In effect this means that increasingly Trust electronic record systems are used to collect basic data. For example, a clinical CPA audit may check whether or not services users have a care plan. It is possible to find Trust audits which show a 100% compliance rate. However when the quality of the care plans are examined it can be seen that the general standard is extremely poor and the implementation, monitoring and review of the care plans is non-existent. This appears to have been situation with Mr. Y's case. It was evident that risk assessment documentation and care plans were developed, however the quality of this work was weak and did not fulfil Trust policy expectations. However to a causal observer it appeared that everything was in order.

Once again when this Investigation considered the documentation available in Mr. Y's clinical record it appears that everything was in order. Documentation included:

- CPA;
- risk assessments;
- Tribunal reports;

However it is a fact that key clinical policies and procedures were paid 'lip service' only. This Investigation concluded that this was a cultural issue which was neither identified nor tackled in a robust manner. Sub-audit blind spots can only be detected and ameliorated by the existence of robust examination and reflection. Clinical audit alone cannot ensure this occurs. Clinical supervision, appraisal and revalidation are essential tools in ensuring that practitioners adhere to best practice guidance and that care and treatment is delivered in an optimal manner. It is only when clinical practice is examined in detail that departures from procedure can be detected.

- 3. Statutory responsibilities.** Ministry of Justice (MoJ) requirements and also those of the Mental Health Act (1983 & 2007) fall under statute. It is never acceptable for practitioners working in specialist services to either ignore or 'bypass' the statutory duty of care placed upon them.

Individuals working in specialist fields cannot use ignorance of policy, procedure or statutory role as any kind of defence for the failure to act appropriately. Each

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individual has a duty of care to ensure that they meet both the requirements of their role and the requirements of the MoJ and the Mental Health Act. NHS Trusts retain a corporate duty of care to ensure that statutory compliance is monitored and upheld. The point of learning here is that individuals should not superimpose their own interpretations, methods or preferred ways of working onto any statutory process. If members of a treating team disagree with a mandated approach then any challenge or concern should be taken up in a formal manner, it is not acceptable for an alternative approach to be taken under any circumstance.

4. Professional and inter agency communication. HSG (94) 27 independent homicide investigations of this kind have consistently found causal factors in relation to homicides perpetrated by mental health service users and failures in levels of professional and inter agency communication. It is common for members of a treating team to know a service user well. It is also common for documentation to not always record all of the pertinent details known about any one individual. When service users are handed over from one treating team to another it is often the case that only partial information is imparted. In the case of Mr. Y a sequence of poor communication occurred:

- at the juncture between Mr. Y being transferred from the Scott Clinic to the Forensic Integrated Resource Team;
- at the juncture of Mr. Y's conditional discharge from the Scott Clinic to Imagine;
- at the juncture of his move from 123 to 133 Moscow Drive.

At each of the three above listed junctures incomplete information was passed on to services.

Inter agency communication was also poor. The failure to communicate with the Police and other statutory agencies served to place both Mr. Y and those around him at risk. Had information about Mr. Y been communicated appropriately a more robust approach to his care and treatment would have been taken. The lesson for learning here is that treating teams have a duty of care to ensure that this essential aspect of care and treatment delivery is always achieved in full.

19. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Mersey Care NHS Trust and Imagine Independence to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

The Independent Investigation acknowledges the fact that the Trust and Imagine internal reviews produced robust recommendations which have been implemented. The recommendations below are provided in addition to those already identified and do not seek to replicate them. The reader is advised to refer to report Sections 15 and 16 which set out previous recommendations. Appendix Two sets out the action plan and progress made to date.

19.1. Mersey Care and Imagine Progress against the Internal Investigation and Recommendations from the Independent Investigation

The Executive Directors of the Mersey Care NHS Trust and Imagine Independence had the opportunity to review the recommendations required for this case at both the preliminary feedback stage and during the factual accuracy checking stage. The Trust and Imagine should be given recognition for the work that it has put into this process and the progress that has already made.

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19.1. Diagnosis

- *Contributory Factor One. There was a failure to understand Mr. Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.*

Trust/Imagine Progress and Commentary

The Multidisciplinary Teams have introduced formulation as a core process to inform treatment and risk management. Diagnostic assessments, which apply accepted diagnostic criteria (ICD-10/or DSM-IV), remain a central part of the evaluation process. However, a more in-depth and specific formulation is developed that takes account of the wide range of psychopathology that may cross diagnostic boundaries. The need to develop sophisticated formulations of understanding has been the focus of a series of presentations and teaching events within the Clinical Business Unit (CBU). The implementation of this approach has been evaluated by the Clinical Director in specific case discussions and more general clinical discussions. In undertaking such assessments there is recognition that symptoms, that may not be considered core to the diagnostic construct or that are present a less obvious degree, may still be important in understanding the case and the related risks. As a result of increased awareness, training and greater access to Psychology resource, more attention is also paid to enduring features such as personality traits. The diagnostic assessment is led by the medical member of the MDT, with active contribution from all team members. The increased availability of Psychology resource has meant that greater attention is paid to the wider formulation based assessment. Again all members of the MDT are involved in this process. Particular attention is paid to aspects of the clinical profile that are associated with risk.

Recommendation 1

A systematic audit of diagnostic practice within the Scott Clinic should take place to provide assurance to the Trust Board and commissioning bodies six months following the publication of this report. The audit should include:

- an audit and assessment of formulation practice to include aspects of clinical profile and potential risk;
- an in-depth case study sample should be audited to check for compliance against accepted diagnostic criteria.

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19.2. Medication and Treatment

- *Service Issue One. The Scott Clinic practiced an unacceptable level of medicines management in the case of Mr. Y. Whilst this cannot be cited as either a contributory or causal factor it demonstrates a lack of medicines management systems and understanding on the part of Scott Clinic clinicians.*
- *Contributory Factor Two. Mr. Y did not receive treatment in line with national best practice guidelines. This represents a missed opportunity that left Mr. Y vulnerable to relapse.*

Trust/Imagine Progress and Commentary

With regard to treatment protocols, there has been an updated review of the National Institute of Health and Clinical Excellence (NICE) guidelines relating to the conditions that fall within the remit of Trust services. Via Governance Forums, Audit Forums and Clinical Meetings the need to adhere to the relevant NICE guidelines has been emphasised. A rolling programme of audits is underway to assess compliance with NICE guidelines. An Audit has been undertaken and presented on medication adherence. The standards from the relevant NICE guideline were audited.

The role of psychological professionals has been reviewed within the Service: all psychologists have three days dedicated time working clinically in the in-patient setting. This enhanced role allows them to undertake individual work with service users and to share their formulation skills with their colleagues. The aim is to ensure that all staff has access to psychological expertise and guidance when assessing and planning care. It was recognised that the client group has gradually changed over time with an increased number of service users having a multiple diagnosis, frequently including the presence of a Personality Disorder. The Trust has appointed an Enhanced Care Psychological Team led by the Clinical Director who work with and advise the staff on the management of this very complex group. The Enhanced Care Team works full time in in-patient services. This has proved very beneficial and gives the staff a resource to gain guidance with which to amend and enhance their practice.

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The Trust also has systems in place to ensure that a statutory process in relation to the rights and needs of carers is met. The Trust is optimising the involvement of carers in all aspects of care, risk and care planning. Currently family interventions *via* Cognitive Behaviour Therapists (Barraclough and Tarrier) can be offered however family therapy as a standard intervention is not routinely offered. The Trust is looking to advice from its Lead Psychologist regarding the need for this level of intervention.

Recommendation 2

The Trust medicines management policy should be reviewed/redeveloped to ensure that service users who have been conditionally discharged are managed effectively in the community. This review should include:

- the clarification of definitions between service user medication adherence and service user medication concordance;
- developing sections that set out the requirements for service user and carer education regarding medication purpose, usage and side effects;
- including the requirement for service users with a history of medication non adherence to have a medicines management care plan which is reviewed on a regular basis.
- sections that set out the requirements for the education and support to be provided to non statutory agencies involved in the care of service users in the community.

The reviewed/redeveloped policy should be audited 12 months after the date of its inception.

Recommendation 3

Service users at the Scott Clinic should receive a broad spectrum of treatment in line with NICE guidance. This treatment should be:

- delivered by therapists experienced and trained in the therapeutic interventions prescribed;
- mindful of the need for family-focused therapy requirements; this to be of particular note if there is a history of either violence or sexual abuse involving family members;
- in keeping with the therapy-service approach to be found in all other parts of the Trust.

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The provision and uptake of psychological therapy approaches in keeping with NICE guidance at the Scott Clinic should be audited within 12 months of the publication of this report.

19.3. Mental Health Act (1983 and 2007)

- *Contributory Factor Three. There were serious failures in the implementation of the terms of Mr. Y's conditional discharge. This meant that the conditions put into place by the Ministry of Justice to protect the public were rendered ineffective.*

Trust/Imagine Progress and Commentary

The Trust/Imagine did not wish to provide a commentary here.

Recommendation 4

The Trust should develop a specific set of clinical guidelines regarding the requirements for treating teams when receiving conditions for discharge on behalf of the patients in their care.

These guidelines should include the need for:

- robust risk assessment;
- consultation and involvement of service users;
- consultation and involvement of carers and family members;
- clear and well communicated care plans;
- the clarification of roles and responsibilities for the implementation, monitoring and review of the conditions of discharge;
- a communication strategy that ensures all partners in care, multi agency personnel, and family members are kept informed and can provide feedback.

19.4. Care Programme Approach (CPA)

- *Contributory Factor Four. It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y worked in silos to the detriment of Mr. Y's overall case management, care and treatment.*

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Trust/Imagine Progress and Commentary

In February 2010 Mersey Care NHS Trust CPA conference launched the CPA documentation to be introduced in April 2010. SaFE Partnerships CBU, although at the time was working within the Care Programme Approach, needed to address these changes in a fashion which not only reflected the different paperwork required, but to ensure that a change in approach was adopted from a quality perspective and was also considered a crucial factor in ensuring high quality care was, delivered, monitored and audited. SaFE Partnerships CBU Medium Secure Unit (MSU) had previously used documentation it devised itself. It was recognised that this option was not in line with Mersey Care NHS Trust CPA Policy.

To ensure effective adherence to the Trust policy it was agreed that the service needed to support the workforce and ensure that a training programme was developed and delivered to potential Care Coordinators to develop the skills and knowledge necessary. The subsequent schedule and delivery of training was based on a training needs analysis, 120 staff were initially identified to complete this training delivered by experienced staff within the CBU. This training has continued to be rolled out and the SaFE Partnerships is confident that appropriate staff has been engaged in this direct learning.

SAFE Partnerships CBU has now commenced the process of assessing the competency of Care Coordinators. The work completed by the National CPA Group for the Department of Health cross referenced Care Coordination Competencies with National Occupational Standards and KSF dimensions. This competency framework has been adopted by SaFE Partnerships CBU.

As SaFE Partnerships CBU provides some regional services it was necessary to develop local guidelines for the MSU to support an effective approach to CPA and to ensure links are made with Secondary Services across Merseyside and Cheshire. The Guidelines for interface between the Forensic Service and Secondary Services were ratified by the Clinical Governance Group initially in 2009 and again following amendments in 2012. This document clarifies expectations of local services in the CPA process during admission to the MSU and for those discharged to the Community Forensic Integrated Resource Team.

Since May 2010 SaFE Partnerships CBU has continued its involvement with Trust focused CPA work and continues to ensure adherence to the Trust Policy.

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Recommendation 5

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding CPA. The Trust should review the effectiveness of its CPA policy at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

19.5. Risk Assessment

- *Contributory Factor Five. Mr. Y was not understood in the context of his full risk profile. Assessments of risk were undertaken in the absence of a robust formulation of the case. Consequently risk management plans and strategies were superficial and non-explicit. This, when taken alongside the failure to abide by the terms of the conditional discharge and decision not to consider MAPPA arrangements, ensured a critical lack of supervision and management. This was to the ultimate detriment of Mr. Y's health, safety and wellbeing and to the continued safety of his mother.*

Trust/Imagine Progress and Commentary

MAPPA

As a result of the Mr. Y incident an extensive specific work stream was undertaken with Mersey Regional Forensic Services (SaFE Clinical Business Unit), primarily in patient and community services to identify and implement systems for MAPPA.

A 'series of scoping exercises' took place from June 2010 with SaFE Clinical Business Unit under the headings of 'MAPPA panels days' when MAPPA coordinators, probation staff, Scott Clinic staff and the criminal justice liaison team (including lead for MAPPA for Mersey Care) came together to discuss specific cases and systems for recording MAPPA arrangements.

Through this forum an extensive MAPPA work stream took place ensuring that the identification and notification of MAPPA eligible service users took place and any service users that needed immediate referral to MAPPA were identified.

This work was undertaken in partnership and in conjunction with multi-agency colleagues from Probation and the Police. There was a series of meetings with the MAPPA coordinators from both Merseyside and Cheshire and with the Partnership Interagency

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Manager (PIM) for the police in the St Helen's area as an immediate response to improve multi agency working.

A police liaison forum was established in August 2010 which meets monthly in conjunction with the Mental Health Police Liaison Officer, local Police, Scott Clinic staff and CJLT. These arrangements have been placed within the Mersey Care NHS Trust governance arrangements. A MAPPA mental health sub group was developed to support MAPPA arrangements across Merseyside and ultimately Mersey Care's MAPPA governance arrangements were developed.

The MAPPA Champions forum was developed in October 2010 which is chaired by Mersey Care SMB Lead and the forum developed the MAPPA governance arrangements and MAPPA framework that Mersey Care adheres to. Senior representatives from all Clinical Business Units attend the Champions group and SaFE Clinical Business Unit is represented by psychiatrists, senior nurses and senior social workers.

A database has been developed which is a fluid document and the mechanism to record all MAPPA eligible offenders, future MAPPA dates and a number of other features. Each CBU has a responsibility to maintain its own database which is available for the SMB lead, CJLT and the MAPPA champions group to consider.

The SMB lead also has regular dialogue with the MAPPA co-ordinator (Probation lead for responsible authorities) and attends an SMB MAPPA mental health sub group.

The Scott Clinic has been an active participant in the MAPPA champions group and led on establishing a SaFE partnership Clinical Business Unit MAPPA guidance document which supports the arrangements for MAPPA.

Conclusion

Mersey Care NHS Trust are at the forefront of development in their current arrangements relating to MAPPA and it is evident from feedback from the SMB and benchmarking against local and North West mental health partners that Mersey Care has guidance which is forward thinking and been held as an example of good practice for other SMBs.

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Throughout this period Scott clinic staff has actively engaged in the process to improve MAPP arrangements and knowledge of MAPPA systems.

The Independent Investigation Team has reviewed evidence to support the progress that the Trust has made and is satisfied with the work that the Trust has undertaken and have no further recommendations to make in this area.

Risk

The Multi Disciplinary Team is taking a more directive approach to Service User involvement in all aspects of care including their engagement in interventions aimed at risk management to maintain therapeutic optimism. Failure for the service user to engage may mean a change of care pathway possibly resulting in long-term hospitalisation.

The use of information obtained by the current risk assessment profile, health and social care reports and other professional information are essential components to contribute to the development of an individual 'Risk Formulation' for each service user.

A risk formulation will be generated for all service users by the MDT based on their completed HCR20 Risk Assessment. This information together with relevant data from Health, Social Care reports and other professional information will be actively utilised, reviewed and updated by the MDT. Each risk formulation should be discussed by MDT members and amended on a regular basis. Risk formulation information should be entered into the E-Pex system by the chair of the meeting. This would demonstrate that risk factors and new information had been actively discussed and considered by the MDT assisting team decision making. This formulation would also guide the individual service users care pathway indicating areas to be addressed by both inpatient and community teams.

The format has been developed to guide staff in conducting MDT's and formulating care plans with the aim of providing staff with guidance on the minimum standards required and the breadth and scope of the work they are required to undertake.

The CPA has been augmented by the standardised use of the HCR20, the formulation template and critical information is directly linked to care plans. This critical information also

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includes the Ministry of Justice conditions are also put into place to ensure efficacy in relation to the public protection.

The service will ensure adherence to the National and Local Standards in relation to Care Programme Approach.

The formulation practices will guide decision making around care pathways and discharge.

Recommendation 6

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding risk management processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

19.6. Referral, Admission and Discharge Planning Processes

- *Contributory Factor Six. The discharge process did not address in sufficient detail either the needs of Mr. Y or the continued safety of the public, with particular reference to Mrs. Y Senior. The process appeared to have been rushed and coordinated poorly. As a consequence the essential safety nets of care were not put into place to the ultimate detriment of the care, treatment and supervision that Mr. Y received up until the time of the killing of his mother.*

Trust/Imagine Progress and Commentary

The Trust/Imagine did not wish to provide a commentary here.

Recommendation 7

Both the Trust and Imagine internal reviews addressed the issues relating to referral, admission and discharge processes in a robust manner. The Trust and Imagine should review the effectiveness of their risk management processes with the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

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19.7. Service User Involvement in Care Planning and Treatment

- *Contributory Factor Seven. Mr. Y's involvement in his care and treatment programme was superficial at best. The treating team placed too much confidence in his ability to work with his recovery programme and consequently failed to put routine protective plans in place to the ultimate detriment of the health and wellbeing of Mr. Y.*

Trust/Imagine Progress and Commentary

The Trust/Imagine did not wish to provide a commentary here.

Recommendation 8

Guidance should be provided to clinical staff as a part of the Clinical Risk and CPA policy documentation which sets out requirements for service user engagement in therapeutic work and long-term care planning. Guidance should be provided in the following areas:

- when taking positive risks;
- when balancing aspects of a recovery programme with an individual service user's choices and wants which may run counter to that person's best interests.

19.8. Carer Assessment and Involvement

- *Contributory Factor Eight. The Scott Clinic failed in its duty of care to Mrs. Y Senior. This left her unsupported and without the protection of risk management plan.*

Trust/Imagine Progress and Commentary

Audit of the service against the standards laid out in the 'Triangle of Care' has enabled the service to identify key areas of action to improve upon the inclusion and involvement of carers in the care planning process. This has been in conjunction with improvements to the Trust wide CPA review and documentation to make the change to a more service user and carer led focus. Specific actions resulting from the audit have included a baseline audit of carer's views and knowledge being sought throughout the assessment and treatment processes for the period between January 2011 – May 2012. This covers the period when the changes were implemented. This has shown an increase in the number of carers who have been invited to attend CPA reviews and their attendance at reviews. All Care Coordinators have been reminded of their responsibility to record the carer's concerns and views within the CPA documentation and this is being monitored. Written consent of the service user is

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routinely obtained with regard to carer involvement. There are always a number of service users who do not provide consent and this is reviewed at each CPA meeting with the service user.

A challenge within the service, and across the Trust, has been the development of Carer Awareness training. This is currently being explored and it is hoped that this will take place with the support of Positive Care Partnerships Clinical Business Unit and Knowsley College within the next six months (autumn/winter 2012).

Work is being undertaken to engage carers more widely across SaFE Partnerships Clinical Business Unit. This has been particularly successful at Rathbone Low Secure Unit with regular 'Friends and Family' meetings and events. A Carer Support event has been held for the Carer's of community service user's which, although poorly attended, was evaluated as helpful to those who attended. Plans are now in place for an event for the carers of inpatient service users. In addition carer's views are being sought in preparation for the annual Forensic Quality Network Peer Review due to take place in November 2012. This will also contribute to enabling the service to benchmark involvement of carers and provision of support to carers.

Monthly complex case reviews are held and chaired by the Lead Consultant where each consultant attends and bring cases for open discussion and analysis. Clinicians are encouraged and supported to accept and respond to change in relation to their practice in a safe and supportive environment.

Recommendation 9

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding carer assessment and involvement processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

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Recommendation 10

When carers or family members are either injured or traumatised by a Trust service user the Trust should make available to the carer or family member a support package that address ongoing needs and the offer of a therapeutic input/counselling etc. if deemed appropriate.

19.9. Housing

- *Contributory Factor Nine. Significant failures to manage Mr. Y's Section 117 aftercare arrangements and terms of his conditional discharge meant that his Supported Living provision was inadequately planned from the outset. This had the effect of creating a degree of instability in the life of a person who required structure and certainty and also prevented realistic protective measures being put into place.*

Imagine/Imagine Progress and Commentary

Imagine staff at all levels, have been empowered to question other organisations and professionals involved in care provision of our service users. Imagine is working with the Mental Health Providers' Forum in developing templates on risk for use across the voluntary sector. This work will produce a set of safety planning principles, templates and tools to support safety, sustainability and quality practices. Best practice, sample policies and procedures will be made available on their website.

The Headline Findings meeting with HASCAS was instrumental in encouraging Imagine to reinforce the message that staff could, and would, question partner organisations appropriately, to ensure the primacy of the safety of clients, staff and the general public. It also encouraged the potential of recognition of specialist services by local funding bodies.

Recommendation 11

The Local Authority, Supporting People, Commissioning Bodies, Imagine and Mersey Care NHS Trust should ensure the following actions take place.

- Contracts must be more robust and reviewed regularly in terms of performance and cost by all agencies involved in the contract and/or the care of the client, at least annually with all agencies present. The principal objective must be to establish the primacy of the safety of clients, staff and the general public.

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- The relationship between funders, social care and residential care providers and mental health care providers must be discussed, agreed and recorded in service contracts.
- Decisions about long-term packages of care for individuals eligible for Section 117 aftercare MUST be based upon clinical assessment and need and MUST not be made by any single agency outside of the appropriate multi-agency arrangements.
- Ministry of Justice requirements must be complied with at all times, specifically in this case residential requirements. The environment at 133 Moscow drive did not contribute directly to this event, however, on reflection some changes to the physical environment may improve the safety and effectiveness of the property.
 - Move the staff flat to the ground floor; this will improve the staffs' awareness of whether residents are in or out of the premises and whether visitors are present.
 - Install an intercom system between the staff flat and the residents' flats to allow residents to call staff or *vice versa*.
 - Modify tenancies to allow staff to retain a copy of residents' keys for use in emergencies e.g. a resident being ill and unable to leave the flat.

19.10. Documentation and Professional Communication

- *Contributory Factor Ten. The standards of clinical record keeping and interagency communication were poor. This made a significant contribution over time to Mr. Y being neither understood nor managed in the full context of his mental illness in a multiagency arena.*

Trust/Imagine Progress and Commentary

The Trust/Imagine did not wish to provide a commentary here.

Recommendation 12

The Trust should conduct a clinical records audit at the Scott Clinic in order to assure both compliance and quality. This audit should include:

- risk assessment and risk care planning documentation;
- CPA documentation;
- ward round discussions;

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- diagnostic and risk formulation;
- rationales for decisions taken;
- evidence of a dynamic approach taken regarding evaluation and review.

Recommendation 13

The minutes of meetings between agencies, e.g. Section 117 planning meetings etc. should be documented clearly within service users' clinical records. A clear audit trail should be created at each juncture on a service users' care pathway where one or more agencies are involved.

With particular regard to Imagine Services the Scott Clinic should:

- be required to make a recording in Imagine notes on every visit;
- ensure clinical risk assessment documentation be clearly separated from social care and support assessments to give clarity of responsibilities to staff from all agencies;
- risk and CPA documentation must be sent out to Imagine at the same time this documentation is forwarded on the GP.

19.11. Adherence to Local and National Policy, Procedure and Clinical Guidelines

- *Contributory Factor Eleven. Policy non adherence made a significant contribution to the poor overall management of Mr. Y's case which was to the overall detriment of his health, safety and wellbeing.*

Trust/Imagine Progress and Commentary

The Medium Secure Unit, is now part of SaFE Partnerships CBU, which also includes low secure and Prison In-Reach services. Each CBU is both clinically and managerially led by a Service Director and Clinical Director.

Clinical and Service Directors are accountable to the Executive Director for Service Development and Delivery for the adherence to care and service delivery standards. An accountability framework is in place which clearly sets out the systems that will be used to identify any gaps in provision.

The Performance Assurance Framework which contains national, local and commissioning indicators is used to direct the work of the Clinical Business Units, monitoring is undertaken monthly and shared with the Accountable Executive Director. Quarterly Governance checks

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which include the key performance indicators and other key targets set by the Trust are facilitated by the Executive Director and her team. Remedial actions are agreed where gaps in provision are identified; the completion of actions and adherence to standards is reviewed by the Integrated Governance Committee a sub committee of the Trust Board.

Following concerns about the performance of SaFE Partnerships CBU the Clinical and Service Directors were replaced in February 2010.

A Consultant Clinical Psychologist was appointed to review the views of staff working in the CBU and this provided a baseline in which the newly appointed Directors could move forward and develop a plan that would specifically change practice and develop a more open culture.

Governance structures within the service have been reviewed with the aim of ensuring that accurate data is used to help clinicians and managers prioritise their work and to ensure that experiences of staff, carers and service users are represented. New arrangements have been put in place to supervise and support staff to ensure that they are provided with every opportunity to meet the standards set.

Recommendation 14

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding governance and policy adherence processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

19.12. Overall Management of the Care and Treatment of Mr. Y

- *Causal Factor One. There was a failure by the Scott Clinic treating team to ensure that best practice clinical policy guidance was applied to the care and treatment of Mr. Y. Consequently Mr. Y's case was managed in an unstructured fashion which placed an over reliance upon 'gut instinct' over and beyond clinical formulation. This was compounded by the weak discharge planning processes that ensued when Mr. Y went to live at Moscow Drive. Protective measures were not put into place in*

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accordance with statutory expectation that could have provided more support for Mr. Y's recovery and a higher level of protection to his mother.

Trust/Imagine Progress and Commentary

Following the Internal Review of Mr. Y, the Clinical Business Unit commissioned a full review of MDT working across SaFE Partnership CBU. The purpose of the review was to provide an opportunity to help inform CBU Directors regarding current and future working practices across SaFE Partnerships CBU.

The review highlighted the different styles and practices used within all the Teams to manage and facilitate MDT meetings and thus provided clear direction for us to establish MDT processes that produce consistency across the whole service. The MDT is recognised as the vehicle for decision making regarding the delivery of high quality care for service users. The changes made in composition of the teams and further efficiency of MDT practices will benefit both service users and professionals.

The MDT review recommended that all meetings have an external professional to chair Multi Disciplinary Team meetings initially as an interim measure to help staff develop systems and enhance their skills in managing meetings and formulating plans of care. The MDT meetings have now been arranged so there is opportunity for a full in-depth discussion around each service users risk formulation, care planning and future planning. Documentation and processes have been enhanced to reflect the above.

This new way of working will effect a change of culture and behaviour and allow people to feel confident in participating fully and effectively in the MDT process. These systems have been piloted, adopted and implemented into MDT and CPA meetings.

Recommendation 15

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding team working and operational processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

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19.13. Progress against Internal Investigation Processes

Trust and Imagine Progress

Both the Trust and Imagine have worked on the recommendations that were developed during the course of their internal review work. This work was largely nearing completion at the time of writing this report. Progress against the work is set out in Appendix Two.

Recommendation 15

The Trust and Imagine action plans should be formally assured and signed off as part of the recommendation action following this HSG (94) 27 Investigation. Any outstanding action should be incorporated into the recommendation action plan developed as a consequence of this current Investigation process.

20. Glossary

Application for Discharge Section 41 (Restriction Order)	A patient cannot be conditionally or absolutely discharged from a restriction order by the Responsible Medical Officer (or the Hospital Managers) without the consent of the Home Secretary. A Mental Health Review Tribunal has the power to discharge such a patient because the president of the Tribunal for a restricted patient will be a legal professional of at least equal standing to the legal member of the Court which made the original detention order.
Approved Social Worker/Clinician	An Approved Clinician (AC) is a health or social care professional who is competent to become responsible for the treatment of mentally disordered people compulsorily detained under the Mental Health Act.
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure that assessment and care planning occur in a timely and user-centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or peoples' own homes.
Care Coordination	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Cognitive Behavioural	CBT is a psychotherapeutic approach that addresses

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Therapy (CBT)

dysfunctional emotions, behaviours, and cognitions through a goal-oriented, systematic process. The name refers to behaviour therapy, cognitive therapy, and to therapy based upon a combination of basic behavioural and cognitive research. CBT is effective for the treatment of a variety of conditions, including mood, anxiety, personality, eating, substance abuse, tic, and psychotic disorders. Many CBT treatment programs for specific disorders have been evaluated for efficacy.

Haloperidol

An Antipsychotic used for Schizophrenia and other mental health problems affecting thoughts, feelings and behaviours.

High Expressed Emotion

Those who are decided to have high expressed emotion are very critical and hostile. They do not know any other way to help support a family member with mental illness because they feel like they are helping. They feel that the illness is internal and can be controlled by this person. The only way they feel that the person will change their behaviour is through criticism which actually causes the relapse.

HoNOS risk assessment

They are 12 simple scales on which service users with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated- say after a course of treatment or some other intervention- and then compared. If the ratings show a difference, then that might mean that the service user's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures. It is not designed to predict risk *per se*.

KGV Kavannagh, Goldberg, Vaughan Scale

The KGV Scale is a clinical tool which measures how severe the symptoms are of someone suffering from a psychiatric illness or disorder such as Schizophrenia or Bipolar Disorder. It is used to evaluate the severity of symptoms in order to incorporate the correct treatment. When using this tool, it is very important that the user is fully trained to a high standard so that an accurate evaluation can be made.

Lorazepam

Lorazepam (Ativan) is in a group of drugs called benzodiazepines and is used to treat anxiety disorders.

LUNSERS

The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) is a well validated and widely used self-rating assessment for measuring the side-effects of anti psychotic medications.

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Multi-Agency Public Protection Arrangements (MAPPA)	Multi-Agency Public Protection Arrangements (MAPPA) is the name given to arrangements in England and Wales for the 'responsible authorities' tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.
Mental Health Act (1983 and 2007)	The Mental Health Act 1983/2007 covers the assessment, treatment and rights of people with a mental health condition.
Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Olanzapine	Olanzapine is used to treat Schizophrenia, moderate to severe episodes of mania in Bi-polar Disorder (manic depression) and prevention of recurrence.
Police National Computer (PNC)	PNC holds details of people, vehicles, crimes and property that can be electronically accessed by the police and other criminal justice agencies.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
PRN	The term "PRN" is a shortened form of the Latin phrase <i>pro re nata</i> , which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Procyldine	Procyldine reduces the effects of certain chemicals in your body that may become unbalanced as a result of disease (such as Parkinson's disease), drug therapy, or other causes.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.

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Quetiapine	Quetiapine is used to help treat Schizophrenia, psychosis and similar conditions.
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
Risperidone	Risperidone is a second generation or atypical antipsychotic. It is used to treat Schizophrenia (including adolescent Schizophrenia), Schizoaffective Disorder, the mixed and manic states associated with Bi-Polar Disorder, and irritability in people with autism.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Section 12 Approved Doctor	A Section 12 approved doctor is a medically qualified doctor who has been recognised under section 12(2) of the Act. They have specific expertise in mental disorder and have additionally received training in the application of the Act. They are usually psychiatrists, although some are general practitioners (GPs) who have a special interest in psychiatry.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
SHO (Senior House Officer)	A grade of junior doctor between House Officer and Specialist Registrar in the United Kingdom.
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.
Wellness Recovery Action Plan (WRAP)	The wellness recovery action plan (WRAP) is a framework which supports the development of an effective approach to overcoming distressing symptoms and unhelpful behaviour patterns. WRAP was developed in conjunction with service users who wanted to work on their own recovery.
Zopiclone	Hypnotic (sleeping tablet) Used for Short-term treatment of insomnia in adults.

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Appendix One

Timeline for Mr. Y Appendix One

Mr. Y Timeline

Date	Event
22 February 1972	Mr. Y was born.
26 September 2001	Mr. Y was involved in a road traffic accident whilst working as a taxi driver.
7 March 2003	Mr. Y visited his GP. He was feeling shaky and had not worked since the road traffic accident the previous July. He was described as tense and described hallucinatory experiences. Mr. Y said he talked to himself and read meanings into what people said to him. He reported that he thought people knew what he was thinking. The GP reached no diagnosis but suspected that Mr. Y was bordering on psychosis. The GP asked Mr. Y to write down some of his experiences over the weekend.
10 March 2003	It was recorded in the GP record. " <i>RX = Risperidone Tablets 1mg: mental illness referral.</i> " Mr. Y had recorded the preceding weekend that he felt as though he was being monitored as a taxi driver and felt that people knew him and were influencing his behaviour. The GP also referred Mr. Y for a biochemical test [not specified].
14 March 2003	Mr. Y was seen by his GP again. He was asked if he had found any situations threatening recently and Mr. Y described how being in the library had led him to believe that people were influencing him and that he was being monitored by the taxi office he used to work for. As a consequence he had turned his television and video to face the wall at his home. Mr. Y appeared to be anxious.
18 March 2003	Mr. Y was seen by his GP. He described himself as feeling " <i>not too bad</i> ". Mr. Y was still not sleeping. The plan was to continue the medication.
25 March 2003	It was entered into the GP record that Mr. Y had an appointment with Moss House " <i>on Friday</i> ".
28 March 2003	Mr. Y was seen in Consultant Psychiatrist 1's clinic on the 28 March 2003. The provisional diagnosis was " <i>a psychotic illness, paranoid schizophrenia</i> ". There was a reluctance to " <i>label</i> " him until he had been assessed at the Day Hospital. Mr. Y was not currently taking his Risperidone as he thought it was affecting his testicles. The plan was to admit him to the Day Hospital; an inpatient admission was not thought to be necessary at this stage.
1 April 2003	It was recorded in the GP record that Mr. Y was awaiting Day Hospital placement. Mr. Y reported feeling angry as people " <i>knew</i> " him and were trying to influence his behaviour. He admitted to swearing at motorists and passers by.
15 April 2003	It was recorded in the GP record " <i>has stopped medication, not yet heard re day hospital placement</i> ". It was also recorded that medication had been issued to Mr. Y for stress and anxiety.
15 August 2003	A 'Standard Care Plan Medication Review' was recorded. It was noted that Mr. Y came to Moss House to see Care Coordinator 1 twice a week and Consultant Psychiatrist 21's clinic as required. The plan was to clarify the diagnosis and to stabilise his mental state. It was also hoped that Mr. Y's insight would improve and that he would accept antipsychotic medication. The Contingency/Crisis Plan was for Mr. Y or his carer to contact Care Coordinator 1, the Crisis Team, his GP, or the Accident and Emergency Department if in crisis.
18 August 2003	Mr. Y was discharged from the Arundel Day Hospital. His GP was sent a communication to state that Risperidone Caplets 2mg had been prescribed with immediate effect.

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	<p>A risk assessment was conducted by Care Coordinator 1. It was noted that Mr. Y experienced delusions of reference and persecution. It was also noted that he had paranoid ideas about his neighbours and members of his family. His psychosis was untreated at the time of the assessment and the diagnosis was not clear. Mr. Y had some suicidal ideas, but no plans. He also had limited insight into his situation.</p> <p>It was noted that Mr. Y had a supportive family and that he was being monitored by Moss House. The summary of the risk assessment was as follows:</p> <ul style="list-style-type: none"> • <i>“Risk of aggression/violence – low</i> • <i>Risk of suicide – low/moderate</i> • <i>Risk of self neglect – low/moderate</i> • <i>Other risks – low”</i> <p>Mr. Y did not think he had any risk factors and he did not want his mother involved in a care plan <i>“so opinion not sought”</i>.</p>
<p>30 October 2003</p>	<p>It was recorded in the GP record that Mr. Y spent most of his time in his room at home avoiding the television. He thought people could <i>“make him think and they can hear everything he says”</i>. Mr. Y was visited by a Nurse and Psychologist on this day but Mr. Y felt sceptical about the outcome of such input.</p>
<p>31 October 2003</p>	<p>A CPA review was held. Mr. Y was noted as being on Standard CPA. Those present were:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 2: Consultant Psychiatrist • Care Coordinator 1: Community Mental Health Nurse; • Mr. Y. <p>Those listed as requiring notification of the outcome were listed as:</p> <ul style="list-style-type: none"> • GP; • Clinical Psychologist 1; • a Trainee Clinical Psychologist. <p>Mr. Y complained that people were <i>“trying to wind him up”</i>. He wanted someone to talk to, but did not want medication or a hospital admission. It was the view of the clinical team that Mr. Y needed antipsychotic medication and that his mental state had deteriorated over the past four weeks. It was agreed that urgent talking therapy would be provided to Mr. Y to which he agreed. It was noted that Mr. Y’s care plan did not require revision.</p> <p>His HoNOS score was:</p> <p>Aggressive 0 Self injury 0 Drinking/Drugs 0 Cognitive 0 Relationships 3 Daily living –</p>

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	<p>Physical 1 Hallucinations/Delusions 3 Depressed 1 Occupation/Activities – Other Mental/Behaviour 0 Living Conditions 0</p>
18 November 2003	<p>Consultant Psychiatrist 2 wrote to the GP. Mr. Y had been avoiding engagement with mental health services. He had not attended the Clinic on the 25 September and on the 7 November. Consultant Psychiatrist 2 had conducted a joint assessment with Care Coordinator 1, CPN, three weeks previously. The assessment took place at Mr. Y's home. His mother had answered the door. Mr. Y was described as being well kempt. He maintained the view that people were monitoring him and could read his thoughts. Mr. Y had been avoiding the mental health team as he believed that the people who were monitoring him would be able to know about the content of the meetings. Mr. Y had ideas of reference and believed that people were sending him messages through switching on and off their house lights.</p> <p>It was reported in this letter that the Psychologist, had visited Mr. Y the previous Thursday but could not get anyone to let him into the house. He planned to visit again the following week. It was thought that Mr. Y was not detainable under the Mental Health Act (1983) at the time. However it was proving difficult to get him to engage with the service. The plan was to continue to try and build a rapport with him and for Care Coordinator 1 to continue to work with him.</p>
2 December 2003	<p>A home visit took place by Consultant Psychiatrist 2 and Care Coordinator 1. Mr. Y was paranoid. The assessment was <i>"incomplete as poor rapport"</i>. It was recorded in the GP record <i>"CPN: Care Coordinator 1. Clin Psychol: visiting"</i>.</p>
28 January 2004	<p>Consultant Psychiatrist 2 telephoned the GP surgery to say that Mr. Y had <i>"florid psychosis, not taking medication. Not going out as he used to"</i>. Consultant Psychiatrist 1 felt that the situation could not be allowed to continue and that an assessment under the Mental Health Act (1983) should be considered. The plan was to seek Social Worker involvement and to discuss treatment options.</p>
7 February 2004	<p>The GP was invited to attend a CPA review on the 7 March 2004.</p>
16 February 2004	<p>Consultant Psychiatrist 2 and an Approved Social Worker visited Mr. Y at his home. The reason for the visit was to discuss informally with Mr. Y the possibility of an informal admission to hospital.</p> <p>The meeting had been arranged with Mr. Y's mother and she was present throughout the entire interview. She mentioned that Mr. Y went to the Day Hospital and that it <i>"made him a hundred times worse"</i>. She also felt that as the medication made him like a <i>"zombie"</i> that it was not the answer to his problems. Mr. Y did not mind his mother being present. He said that people were monitoring him and people in the library were winding him up. At this point in the interview Mr. Y's mother appeared to understand the seriousness of his illness and joined with the staff in explaining why a short inpatient admission would be important.</p> <p>It was made clear to Mr. Y and his mother that the situation could not continue as it was as his mental state was deteriorating. The need for a Mental Health Act (1983) assessment was also discussed and the Social Worker arranged to visit him again the following day.</p> <p>A letter was sent to the GP.</p>

Mr. Y Investigation Report

	FIRST HOMICIDE AND ATTEMPTED HOMICIDE
19 February 2004	<p>Mr. Y and his father had an argument about money. Mr. Y became angry and smashed some ornaments. His father told him Mr. Y would have to pay for the damage. They resolved the argument and his father comforted him and stated that he would have to go the inpatient unit and then <i>"things would improve"</i>. However following this Mr. Y retrieved a <i>"hammer/spanner"</i> and hit his father around the head until he fell to the ground. His mother was unaware of the attack and came down the stairs as she had been packing Mr. Y's belongings for a hospital admission. His mother then sustained a broken wrist and fingers and a fractured skull. She was able to reason with Mr. Y who stopped the attack and went upstairs. His mother called for the Police. Mr. Y made no further attempts of resistance or violence.</p> <p>The Social Worker had telephoned the house to arrange Mr. Y's admission for 10.00am. A Police Officer answered the telephone to say that Mr. Y had murdered his father and injured his mother.</p> <p>A telephone call was made by the Social Worker at Moss House to the GP surgery to say that Mr. Y had attacked his parents. His father had been fatally injured and his mother was also in hospital. Mr. Y had been due for an informal admission to Calder Ward at 10.00 hours that morning.</p> <p>Mr. Y was admitted to the Scott Clinic under Section 2 of the Mental Health Act (2007). He had been due to be admitted onto the Broad Oak Unit on this day prior to the incident occurring. He was remanded on bail.</p> <p>A nursing referral assessment form was completed at the Scott Clinic. It was noted that Mr. Y had <i>"12 months of untreated psychosis?"</i>. During the assessment it was noted that Mr. Y was suspicious and had poverty of speech. The Police had felt that Mr. Y was mentally ill and should go to hospital following his attack on his parents. It was noted that he had killed his father, hurt his mother and was considered to be at high risk of self harm.</p> <p>Mr. Y was transferred to the Scott Clinic at 9.30 pm. It was noted that his health had been deteriorating over a period of some 12 months. He had experienced persecutory delusions and ideas of reference. A home visit had taken place on the 16 February when it had been decided that Mr. Y required hospital admission. He was due to have an informal admission on the 19 February. Mr. Y was admitted onto Ward 2 under Category A on 1:1 observations and he was commenced on Olanzapine and PRN Lorazepam. A scan of his head was required to assess any possible damage to his head following the injury that he sustained in a road traffic accident in 2002.</p>
20 February 2004	<p>Mr. Y was described as being very quiet and timid. He became tearful at one point. The plan was reduce to level three observations once reviewed by Consultant Psychiatrist 3. He was duly placed on level three observations and commenced on Olanzapine Velotabs 10mg at night.</p>
21 February 2004	<p>Initially Mr. Y appeared to be settled. Mr. Y declined his medication and his diet. It was explained to Mr. Y where he was and that he was on a Section of the Mental Health Act (1983), however he still refused his medication.</p> <p>Mr. Y became agitated later in the day rocking and hitting his head into a wall. His agitation increased and he was restrained, Control and Restraint techniques were used. Lorazepam 2mg IM was given as he refused oral medication.</p> <p>As the day progressed Mr. Y asked how his mother was. He was reluctant to eat. He was confused and low in mood. He stayed up late. He was reluctant to interact with staff, but eventually drank some milk and had a banana.</p>

Mr. Y Investigation Report

22 February 2004	Mr. Y appeared to be very anxious. He appeared to be disorientated. He refused lunch. As the day continued he continued to be confused and came into the day room in his underpants whereupon he stood on the day room table. Once back in his room he continued to be confused and tried to remove all of his clothing. He did accept his medication but would not eat or drink. He continued confused and tried to remove his clothes once more. He said he would " <i>cut his balls off</i> ".
23 February 2004	Mr. Y continued to decline food and drink and did not wish to communicate with staff.
24 February 2004	Mr. Y continued to be " <i>suspicious and perplexed</i> ". He felt he should be in prison. He continued to be reluctant to eat, but ate two sandwiches and two cups of tea that night.
25-29 February 2004	On the 25 th Mr. Y saw his solicitor and was noted to laugh and joke at his humorous remarks. He was noted to be sullen and difficult to engage with. In the early hours of the 26 th Mr. Y was noted to have broken a toothbrush (no explanation for this is recorded in the notes). The plan was to continue level 3 observations and to increase the Olanzapine to 20mg with Mr. Y's consent.
1 March 2004	Mr. Y had escorted Section 17 leave for his Court appearance. It was noted that Mr. Y was " <i>warmer</i> ". However it was noted that his interactions were limited.
9 March 2004	Mr. Y's solicitors wrote to the GP notifying him that he may be required to provide medical reports for the Court.
15 March 2004	Mr. Y was Commenced on Section Three of the Mental Health Act (1983). This was renewed on 14 March 2005. A clinical meeting was held on this day. The medication was noted as being: <ul style="list-style-type: none"> • Zopiclone 7.5mg pm (max at night); • Haloperidol 5 – 10mg pm (max 30mg daily); • Lorazepam 1 – 2mg pm (max 4mg daily); • Procyldine 5mg pm (max 30mg daily); • Olanzapine 20mg at night; • Senna two tablet pm (max at night). He continued on level three observations.
16 March 2004	Mr. Y was due to appear at Liverpool Magistrates Court on this day. He was remanded on bail.
22 March 2004	A Care Programme Approach (CPA) Review was held on this day. The following people attended: <ul style="list-style-type: none"> • Consultant Psychiatrist 3 (Scott Clinic); • Consultant Psychiatrist 2 (Moss House); • Senior Psychiatric Registrar; • Clinical Psychologist 2; • Social Worker 1; • Nurse Therapist; • Care Coordinator 1: Community Mental Health Nurse; • Social Worker (Scott Clinic); • Probation Officer.

Mr. Y Investigation Report

	Mr. Y was on level three observations. He had tried to remove his testicles.
25 March 2004	A letter was sent to the GP. The letter confirmed that Mr. Y had been charged with the homicide of his father and the attempted homicide of his mother. A review into Mr. Y's care and treatment was due to take place and copy of his GP records was requested.
1 April 2004	Mr. Y's uncle telephoned the ward as he and Mr. Y's mother were worried that he had been released on bail. They were worried that he might try and return home.
22 April 2004	<p>A Care Programme Approach (CPA) Review was held on this day. The following people attended:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3 (Scott Clinic); • Consultant Psychiatrist 2 (Moss House); • Social Worker 1; • Care Coordinator 1: Community Mental Health Nurse; • Social Worker (Scott Clinic); • Probation Officer. <p>Other people noted as requiring notification of outcomes were listed as:</p> <ul style="list-style-type: none"> • Staff Nurse Ward 2; • Nurse Therapist; • Clinical Psychologist 2; • Care Coordinator (?). <p>Mr. Y was present at the review. He said that he wanted to see his mother and he complained about being sedated by his medication. It was noted that Mr. Y's family had yet to be interviewed.</p> <p>At this time Mr. Y was detained under Section 3 of the Mental Health Act (1983) following the murder of his father and the attempted murder of his mother on the 19 February 2004. He was currently unfit to attend Court on 16 March 2004 or to appear on the 11 May 2004.</p> <p>Mr. Y was prescribed Olanzapine Velotabs 20mg at night. He was on continuous 1:1 observation. The ward staff were trying to build up a rapport with him; they had also noted sexually inappropriate behaviour. Mr. Y had recently broken a tooth brush which he said he wanted to use to remove his testicles in order to cut off his testosterone supply and thereby his aggression. Further assessments were required and it was decided to split Mr. Y's medication into two doses, one in the morning and one at night.</p>
23 April 2004	The GP surgery was sent a copy of Mr. Y's CPA review documentation. The GP was listed. Mr. Y was listed as being on Enhanced CPA and eligible for Section 117 aftercare.
11 May 2004	Mr. Y was remanded on bail at Liverpool Magistrates Court to live and sleep at the Scott Clinic.
9 June 2004	Mr. Y appeared at Liverpool Crown Court where he was remanded on bail to the Scott Clinic.
14 July 2004	Mr. Y applied for a bail application. Bail was granted conditionally that he lived and slept each night at the Scott Clinic.
	Social Worker 2 made a visit to Mr. Y's mother's home. Mr. Y's mother felt better able to talk on this occasion. She mentioned that Mr. Y had always had a loving relationship with his father, that he liked history and keeping fit. She also said that Mr. Y had never been an aggressive person and had never been in fights. Mr. Y had recently written a letter to his mother. The letter was reported to have been full of love for his

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	<p>mother and regret for killing his father. Mr. Y had requested that his mother visit him. At this stage Mr. Y's mother felt that she could not visit him, but may be able to do so in the future. She said her sister would probably visit him.</p>
18 July 2004	<p>Mr. Y's uncle and aunt visited him. Mr. Y was reported as being "<i>warm in response</i>". There was no physical contact between them. Mr. Y asked if his mother was going to visit, he was told that it was too soon.</p>
23 July 2004	<p>A Psychiatric report on Mr. Y was prepared by a Locum Consultant Forensic Psychiatrist. At this stage Mr. Y was charged with the murder of his father and the attempted murder of his mother. The report noted that it appeared Mr. Y's mental health problems began after his care had been 'rear ended' whilst he sat in traffic. From this time he was suspicious of people at work and he thought that he was driving with an open microphone and that everyone could hear what he was saying. Mr. Y self reported that he was not very sociable and preferred solitary pursuits such as jogging.</p> <p>The Locum Forensic Consultant Psychiatrist had been asked to visit Mr. Y at the Police station following the offence on the 19 February 2004. On this occasion Mr. Y had appeared to be confused and withdrawn and he had refused to answer questions. The diagnosis was made of schizophrenic illness. The main concern was of his risk of suicide.</p> <p>The report noted that Mr. Y had been transferred to the Scott Clinic later on the day of the 19 February under Section 2 of the Mental Health Act (1983). He was placed on 2:1 observations due to the concerns about his suicide risk. He was possibly responding to auditory hallucinations. His mood was abnormal and he was extremely distressed. He was commenced on Olanzapine 10mg at night. There was a degree of sexual inappropriateness and on the 26 February he attempted to remove his testicles.</p> <p>This presentation remained unchanged throughout May and June and his Olanzapine was increased to 20mg at night. Following this there was evidence of a 'warming' of his mood. Mr. Y told the Locum Forensic Consultant Psychiatrist that he had been feeling strange the week before the incident and that he had given away a great of money (£7,000 in total) and that he had not been sleeping.</p> <p>At the time of the report Mr. Y was described as presenting with an abnormal affect. He was markedly flattened with little facial expression. He accepted that some of his behaviours were abnormal. It was noted that Mr. Y suffered for Paranoid Schizophrenia. It was thought that he would be likely to relapse if he was in hospital to receive ongoing treatment.</p> <p>Mr. Y's Social Worker made a visit to his mother's home to collect some of Mr. Y's belongings. Mr. Y's aunt and her twelve-year old granddaughter were present. Mr. Y's mother was also present; she was still trying to come to terms with events.</p>
2 August 2004	<p>At a ward clinical meeting it was noted that Mr. Y was still not engaging with staff or patients. He did not appear to be distressed. His medication was Olanzapine 20mg at night.</p>
9 August 2004	<p>At the Indictment at the Crown Court in Liverpool Mr. Y was charged as follows:</p> <p>Count 1: murder, contrary to common law. Particulars of the offence: Mr. Y on the 19 day of February 2004 murdered his father.</p> <p>Count 2: attempted murder. Particulars of the offence: Mr. Y on the 19 day of February 2004 attempted to murder his mother.</p> <p>Count 3: causing grievous bodily harm. Particulars of the offence: Mr. Y on the 19 day of February 2004 caused grievous bodily harm to his mother with intent to do her grievous bodily</p>

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	harm.
18 August 2004	The preliminary hearing date was set for this day.
24 August 2004	<p>A renewal of authority for detention was made. Consultant Psychiatrist 3 stated that the patient was suffering from a mental illness which it appropriate for him to receive his treatment in hospital and that such treatment was likely to alleviate his condition.</p> <p>It was stated that Mr. Y remained guarded and withdrawn and that he was charged with serious violence in the context of his mental illness and that he required further treatment and rehabilitation.</p>
31 August 2004	Mr. Y attended Liverpool Crown Court for a review of his case. He remained calm and fully cooperative throughout.
6 September 2004	<p>A Social Work Report for the Enhanced Care Coordination Review was prepared. It was noted that Mr. Y was a little warmer and more settled. He still had a tendency to isolate himself from others.</p> <p>It was noted that apart from the index offence there was no history of violence towards others. According to his mother Mr. Y had always avoided confrontation.</p> <p>Mr. Y understood that he had a mental illness and recognised certain symptoms and behaviours that were evident prior to admission, e.g. giving away his possessions.</p> <p>The Carer perspective was: that Mrs. Y Senior was grieving for her husband, but at the same time had lost her son for whom she could not grieve. She felt it would have been better if her son had killed her as well. She could not feel sorry for her son, nor sympathise, as she was still trying to come to terms with what had happened. Mrs. Y Senior said that she had not been informed about her son's mental illness in the past or about his signs and symptoms. Any perceived non-compliance on her part in the past was "<i>done in complete ignorance.</i>"</p>
September 2004	<p>[Precise date uncertain]. Mr. Y was referred to Clinical Psychologist 2, by his clinical team. The Psychologist met with Mr. Y and also with his mother on two occasions. She also met with the treating team.</p> <p>Mr. Y was described as quietly spoken with a flattened affect.</p> <p>Mr. Y's mother said that as a young child, he periodically held his breath until he went blue in order to get his way. Upon starting school she described him as anxious not wanting to be separated from herself or travel on the school bus. Mr. Y had expressed feelings of jealousy about his younger brother.</p> <p>Mr. Y had a close relationship with his mother; however he described her as being an anxious woman who was "<i>interfering, controlling and critical</i>". He said that her intrusiveness had undermined his confidence. As a consequence he withdrew and bottled up his feelings. Shortly after leaving school he had left home, but his mother had "<i>ordered him to return home</i>".</p> <p>Mr. Y had become unemployed a year prior to the index offence. This had led to arguments between him and his father. On the 19 February 2004 Mr. Y killed his father and attacked his mother. Acts for which Mr. Y expressed remorse, although this could not be discerned by the Psychologist during the assessment. Mr. Y suggested that eventually he would return to live at home without realising how inappropriate this would be. It was noted that both Mr. Y and his mother were "<i>poor self-reporters of their own history</i>". The Psychological opinion debated:</p>

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	<ul style="list-style-type: none"> • Were Mr. Y's presentation and psychological difficulties defences in order to cope? • Had there been any neurological damage as a result of anoxia? • Did his presentation warrant a diagnosis of Asperger's Disorder? <p>The recommendations were:</p> <ul style="list-style-type: none"> • to share the information about diagnosis with Mr. Y; • to refer him to the Asperger's Team; • to commence neurological testing.
<p>15 September 2004</p>	<p>A Psychiatric Report was prepared on Mr. Y by Consultant Psychiatrist 3. This had been requested by the CPS Merseyside. The report was similar in content to that prepared on the 23 July 2004. The additions included the fact that Consultant Psychiatrist 3 thought that at the time of the offence Mr. Y was suffering from Paranoid Schizophrenia which "<i>could be considered to be an abnormality of mind</i>". It was view of Consultant Psychiatrist 3 that Mr. Y suffered from an abnormality of mind and he respectfully suggested that if convicted of manslaughter then the Court should consider disposal by way of a Section 37 Hospital Order under the Mental Health Act (1983). It was conformed that a bed was available at the Scott Clinic with immediate effect.</p>
<p>20 September 2004</p>	<p>A Psychiatric Report was written. It was noted that Mr. Y was detained on a Section Three of the Mental Health Act. His RMO was Consultant Psychiatrist 3 (who wrote the report), and that he was on Hawthorn Ward at the Scott Clinic. It was recorded that Mr. Y had been admitted to the clinic from the Belle Vale Police Station on the 19 February 2004. He had been seen by the Medical Examiner and believed to be psychotic. On examination he had appeared to be perplexed and anxious, paranoid and guarded.</p> <p>A review of the clinical notes showed that Mr. Y's mental condition had appeared to deteriorate over the past 12 months. The diagnosis of Paranoid Schizophrenia had been made and he had been commenced on antipsychotic medication. It was noted that Mr. Y had not always attended appointments or been compliant with medication.</p> <p>The homicide of his father had resulted as the culmination of an argument between them initiated by financial disagreements. He recalled going into the garage to find a hammer and a spanner in order to kill his father. Mr. Y had intended to kill his father outright so that he would not suffer and hit him a few times on the head.</p> <p>As his mother came down the stairs he hugged her so she would not see her husband on the floor and then hit her over the head. He denied being angry towards his mother, although he agreed he had meant to kill her. He had no explanation why he stopped himself from killing her.</p> <p>Mr. Y's mother had said that on the morning of the 19, when he was due to be admitted into hospital, he had begun to go about money. He "<i>went mad and started shouting</i>" which was unlike him. His father wrote him a cheque but Mr. Y thought it was for the wrong amount and said he wanted cash. He started to smash ornaments. He appeared to calm down. Mr. Y's mother had gone upstairs. When she came downstairs Mr. Y hugged her and asked her go upstairs with him, when she declined he started to hit her over the head with the hammer. He eventually stopped the attack.</p> <p>Mr. Y's progress on admission into the Scott Clinic: Mr. Y was described as being perplexed and suspicious on admission. He appeared to be experiencing hallucinations, although he denied this when questioned directly. On the 26 February he was observed to break a toothbrush with which he had intended to remove his testicles.</p>

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	<p>At the time the report was written he remained compliant with his oral medication and continued to be detained under Section Three of the Act. It was thought that the introduction of antipsychotic medication had improved his condition. It was noted that he remained isolative and did not engage with the other patients on the ward.</p> <p>The Opinion was that Mr. Y suffered from Paranoid Schizophrenia.</p> <p>It was noted that Mr. Y was due to stand trial in November 2004 and whilst there had been some improvement his condition merited detention in hospital.</p>
<p>29 September 2004</p>	<p>A nurse report was made. It was noted that Mr. Y's trial was due to commence on the 1 November 2004. This was potentially identified as increasing his stressors. His behaviour was described as isolative. He was engaging in a psychology assessment. He no particular distress or psychotic symptoms. He was on Olanzapine Velotabs 20mg daily.</p> <p>It was the opinion of the nurse that Mr. Y required further assessment.</p>
<p>4 October 2004</p>	<p>An Enhanced Care Coordination (ECC) Review was held. Present were:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3; • the Deputy Ward Manager; • Social Worker 2 (Social Supervisor 1); • Named Nurse; • Clinical Psychologist 2; • Occupational Therapist; • Care Coordinator 1: CPN; • Mr. Y also attended. <p>It was noted:</p> <p>Mental State: remains generally isolative. No obvious psychotic symptoms. Level one observations were required. Not expressing suicidal thoughts. Compliant with medication.</p> <p>Assessment: HoNOS - 7. HoNOS Secure - 15. Lunsers completed.</p> <p>Medication: Olanzapine 20mg at night.</p> <p>Outside Agencies: it was noted that Mr. Y was due to attend Court on 18 October 2004, a recommendation for Section 37 and a restriction Order was considered likely.</p> <p>Therapeutic Interventions: psychological assessment ongoing, Social Worker continuing to liaise with mother and aunt.</p> <p>It was also noted that Mr. Y was due to attend Court on the 18 October 2004, "<i>recommendation for Section 37, likely restriction order</i>".</p>

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	<p>Risk Management: <i>“Secure environment. Graded exposure to risk areas. Medication. Psychological input. SPECT scan of brain normal.”</i></p> <p>Issues were raised regarding ongoing family dynamics and Mr. Y’s unpredictable behaviour.</p> <p>Carer Issues: the Social Worker and Psychologist had visited Mr. Y’s mother in order to assist in his assessment. At this stage she did not wish to visit or contact him at this stage.</p> <p>Current Situation: Mr. Y’s mental state was stable. He was still very withdrawn and isolative. He undertook a moderate engagement in activities and was compliant with medication and psychological input.</p> <p>Mental State Examination: on admission Mr. Y had been confused, suspicious, paranoid, with <i>“bizarre monologues on wars and unusual behaviour similar to standing on table, on bed, hitting head on wall (briefly).”</i> He was currently described as <i>“warmer”</i> although his engagement was limited. He reported no anxiety, depression or delusional beliefs.</p>
5 October 2004	A Review by the Hospital Managers took place. The RMO was Consultant Psychiatrist 3 the Named Nurse attended with a Social Worker. The Renewal form stated that Mr. Y was on a Section 37 and that it was due to expire on the 14 September 2004. It was noted as being an Uncontested Renewal Hearing.
11 October 2004	Mr. Y was entered onto the severe mental illness register at the GP surgery.
18 October 2004	<p>A Hospital Order was made at the Liverpool Crown Court. Documentation stated that Mr. Y had been convicted of manslaughter and causing grievous bodily harm with intent. His diagnosis was given as Paranoid Schizophrenia. He was to be detained at the Scott Clinic under Section 41 of the Mental Health Act (1983).</p> <p>On this day Mr. Y was formally discharged from his detention under Section Three of the Act.</p> <p>Mr. Y was commenced on a Section 37/41 of the Mental Health Act (1983).</p> <p>Mr. Y appeared in Court to face charges concerning the death of his father and serious injury to his mother. He was convicted of manslaughter and causing grievous bodily harm with intent. Section 37/41 was imposed by the Court. Mr. Y was returned to the Scott Clinic.</p> <p>Mr. Y was anxious in Court, but flattened in affect afterwards. He said he felt like crying, <i>“yet he did not appear to be tearful”</i>.</p>
22 October 2004	<p>A Social Circumstances Report for the Managers Hearing was written by Social Supervisor 1, the Forensic Social Worker. It was noted that if Mr. Y was regarded to informal status under the Act that he would be remanded to prison. The Social Worker had spoken to Mr. Y’s mother and two aunts on several occasions. Mr. Y’s mother described him as a quiet person who was outgoing. She was devastated by what had happened and was not yet ready to meet with her son. She made it clear she did think she would not be able to support Mr. Y at home in the future.</p> <p>The conclusions and recommendations pointed out that Mr. Y had been in the Scott Clinic for six months and that he had made progress. However it was felt that he required further assessments and treatment. It was thought that he did not pose a risk to others, but that he might continue to be a risk to himself. The recommendation was that Mr. Y remained on Section under the Act for his own health and safety.</p>
22 November 2004	Mr. Y was granted escorted Section 17 leave in the grounds for half an hour each day. Initially with two members of staff. The plan was to reduce

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	<p>this down to a single escort in December 2004.</p> <p>Issues regarding absconding and harm to others were considered pertinent for highlighting as part of the risk assessments.</p>
30 November 2004	<p>The Social Worker spoke to Mr. Y's mother who was happy about the Section 117 arrangements. She planned to visit Mr. Y before Christmas with his aunt as they had bought presents for him. Mr. Y was pleased with this information.</p>
18 December 2004	<p>Mr. Y was visited on the ward by his mother, aunt and uncle. The visit went well. After the visit staff reported that Mr. Y became tearful.</p>
28 February 2005	<p>Consultant Psychiatrist 3 wrote to the Home Office to propose that Mr. Y could have escorted leave in the local area. The purpose was to support Mr. Y's rehabilitation. His mental state appeared to be stable. The risks to his mother appeared to be low as he had met with her on the ward on two occasions without incident. No concerns were thought to be present regarding her safety at this time.</p>
7 March 2005	<p>A Routine Enhanced Care Coordination Review took place. Those present were:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3; • Hawthorne Ward Nurse; • Specialist registrar; • Social Supervisor; • Clinical Psychologist 2; • Care Coordinator 1: CPN; • Mr. Y's mother and aunt also attended. <p>Therapeutic interventions had been provided through psychological assessment with one-to-one work with both Mr. Y and his family. Neurological and 'theory of mind' assessment followed. Mr. Y's insight was limited.</p> <p>Mr. Y was having escorted leave for periods of two hours three times a week. The plan was to increase to full unescorted leave. Mr. Y wanted to be able to pursue running in the grounds as this was a major coping strategy of his.</p> <p>The discharge planning identified that Mr. Y required a small group home with staff experienced in autistic spectrum disorder.</p> <p>Actions that were required included the Psychologist meeting with Mr. Y's mother and aunt, and for the occupational Therapist to provide sessions around expression and emotion and to reduce his isolation.</p> <p>Carer issues: Mr. Y's mother and aunt attended the review. They expressed no specific views, but requested clarification of Mr. Y's progress. <i>"His mother is clear she would not wish for him to return to live with her"</i>.</p>
13 April 2005	<p>Mr. Y was referred to the Asperger's Team. Mr. Y's psychological report was enclosed. It was noted that whilst Mr. Y continued have reduced interactions with people at the Scott Clinic this had improved since admission. Mr. Y was willing to be seen by the Asperger's Team. Mr. Y had expressed concerns that his mother would not provide objective information about his early childhood and suggested one of his aunts be contacted.</p> <p>Mr. Y thought that he had a normal childhood developing friendships and playing football. He expressed an interest in history. During his school life it had been suggested that he had developed a routine around his lunch breaks. The Asperger Team was requested to read the full</p>

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	psychological report written in September 2004.
13 May 2005	Mr. Y was to have escorted leave in the local area for up to two hours three times a week and escorted leave in the grounds at the staff's discretion. The conditions of leave were identified as " <i>comply with escorting staff</i> ". His risks in all areas were deemed to be low.
17 May 2005	Mr. Y was referred to the Asperger's Team on the advice of the Psychologist. It was noted on the referral form that Mr. Y had developed a psychotic illness and killed his father and seriously injured his mother. Following his admission to the Scott Clinic it had become apparent that he had problems with social functioning and interpersonal skills. The Psychologist thought that he might have Asperger's Syndrome. The Asperger's Team were ultimately to find Mr. Y not eligible for their service.
4 July 2005	Mr. Y was to have escorted leave in the grounds at the staff's discretion and to also have escorted leave in the local area for up to two hours three times a week. His risks in all areas were deemed to be low.
18 July 2005	Mr. Y was to have escorted leave for up to two hours three times weekly. His risk was deemed to be low in all areas.
26 July 2005	Consultant Psychiatrist 3 wrote to the Home Office to report the outcome of Mr. Y's leave. It was noted that Mr. Y continued to do well with his leave. His mental state was described as settled.
8 August 2005	<p>A neuropsychological assessment report was written. The referral had been made because of Mr. Y's presentation and psychological difficulties. The main concern prompting the referral was Mr. Y's breath-holding activities as a child and the concern that this may have caused neurological damage.</p> <p>It was noted that Mr. Y had not presented with any management problems since being in the Scott Clinic. He did isolate himself and spent most of his unstructured time in his bedroom.</p> <p>Mr. Y's mother had stated he had displayed some unusual behaviour from an early age. He did not like being held or hugged and would sometimes hold his breath until he turned blue on these occasions. Previous tests administered included:</p> <ul style="list-style-type: none"> • Rivermead Behavioural memory test, and subtests from the Wechsler Adult Intelligence Scale (March 2005); • Reading the Mind in the Eyes Test, Benton Verbal Fluency Test, Hayling subsection from the Hayling and Brixton Task (March 2005); • Theory of Mind Assessment- the picture sequencing task (May 2005); • Theory of Mind Assessment – verbal stories (May 2005). <p>The neurological assessment utilised the tests set out below with the following results:</p> <ul style="list-style-type: none"> • Rivermead Behavioural Test (this test is difficult for subjects with acquired brain damage): Mr. Y's scores which suggested he had a poor memory range. • Similarities, Picture Arrangements and Comprehension Subtests from WAIS III (this tool assesses cognitive functions): Mr. Y scored within the normal range. • Informal Orientation and Memory Questions: Mr. Y performed well. • Test of Comprehension and Divided Attention: Mr. Y performed well. • Benton Verbal Fluency Test: Mr. Y's results were within normal ranges. • The Hayling Brixton Test (designed to test damage to frontal lobes of the brain): Mr. Y's results were in the 'moderate/average' range. • The Reading the Mind in the Eyes Test: the results suggested that Mr. Y may have difficulties in feeling/recognising compassion for example.

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	<ul style="list-style-type: none"> • The Picture Sequencing Task: Mr. Y performed well. <p>The conclusion was that it was unlikely Mr. Y had incurred any numerological damage due to breath holding as a child. However it was noted that he had a long-standing deficit in theory of mind functioning. It was noted that Mr. Y had difficulties with social functioning and that this could cause difficulties in the future if was to feel under threat as he had limited coping strategies. Mr. Y had <i>“severe difficulties in stepping outside of his own perspective and feelings in order to consider and understand how and why other people might behave in social situations”</i>.</p> <p>The recommendation was that Mr. Y learning basic theory of mind skills in order to recognise his own emotions in both himself and in others, and that he develop coping strategies. It was also noted that Mr. Y’s future accommodation needs would be best placed in a small home in a structured and predictable environment.</p>
<p>5 September 2005</p>	<p>A Routine Enhanced Care Coordination Review took place. Those present were:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3; • Deputy Ward Manager; • Occupational Therapist; • Social Supervisor 1; • Clinical Psychologist 2; • Mr. Y’s mother and aunt also attended. <p>It was noted that Mr. Y had been mentally stable for 12 months in terms of his acute psychosis. He was being nursed on a low-dependency ward on level one observations utilising unescorted leave in the grounds. Mr. Y was also having escorted leave in the local area for two hours three times a week.</p> <p>Discharge planning identified Mr. Y’s need for a small group home in a predictable environment with staff experienced in autistic spectrum disorder.</p> <p>Planned actions were for the treating team to meet with Mr. Y’s mother and aunt and for <i>“Occupational Therapy sessions around expression and emotions”</i>.</p> <p>Carer issues: Mr. Y’s mother wanted to understand the progress he was making. She was clear that she did not want him to return and live with her again.</p> <p>The Multidisciplinary Assessment described Mr. Y’s behaviour as <i>“very settled”</i>. He continued to have minimal contact with his family members.</p> <p>A Risk Assessment was conducted. The factors listed as contributing to the index offence were listed as being:</p> <ul style="list-style-type: none"> • acute psychosis with marked persecutory delusions; • heightened arousal and fear; • disengagement with psychiatric services;

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	<ul style="list-style-type: none"> • difficulty in complying with medication; • relationship issues with parents; • issues regarding money following unemployment; • difficulty in anticipating the emotions of others; • suppression of anger and the difficulty in recognising the emotions of others; • deterioration in social functioning; • lack of routine and increasing isolation; • personality issues/developmental disorder; • expressed needs through avoidance or defiance; • misreads the behaviour of others when he felt under threat, which escalated his risk of violence. <p>Long-term management problems were identified as being: family dynamics; personality issues; psychotic illness; requiring psychological input and neurological assessment. The summary was:</p> <ul style="list-style-type: none"> • <i>“Concerns re: unpredictability and of violence to others although less so with stabilisation of mental state</i> • <i>Risk of harm to self should also be considered low</i> • <i>Risk of absconding - low</i> • <i>Risk of self neglect - low”.</i> <p>The main risk was deemed to be that to his parents. It was noted that Mr. Y did not want to talk about the death of his father and displayed limited discernible remorse.</p> <p>It was noted that future offending/relapse indicators could be precipitated by non-compliance with medication, the use of alcohol or drugs, relationship and personality issues.</p> <p>Mental State Examination: a KGV assessment was completed on the 11 August 2005. Mr. Y scored 0 in all areas. Mr. Y denied any psychotic symptoms but had been heard laughing in his room. He was warm on approach. No problems had been identified regarding his cognition. His behaviour was described as <i>“very settled”</i>. It was noted that although Mr. Y joined in ward activities he remained isolative.</p>
<p>19 September 2005</p>	<p>Consultant Psychiatrist 3 wrote to the Home Office to request escorted leave for Mr. Y three to four times a week. It was proposed that he would be able to use the bus. It was noted that his mental state was stable and that he used regular unescorted leave in the ground with no problems apparent. He had never tried to abscond.</p>
<p>10 October 2005</p>	<p>Mr. Y’s medication was reduced to Olanzapine 10mg at night.</p>
<p>26 October 2005</p>	<p>The Home Office wrote to Consultant Psychiatrist 3. Mr. Y was to be allowed escorted leave at the RMO’s discretion. He would not be allowed</p>

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	to use this leave to visit his mother or to go to his mother's address. A report was required within three months. The leave was not to place either Mr. Y or others at risk and if he failed to return to the hospital then both the Police and the Home Office were to be notified.
1 November 2005	Mr. Y was given escorted day leave and allowed to attend unit trips. He was to be allowed to visit the pub and drink a maximum of one pint. He would not be allowed to visit his mother or go to her home. He was deemed to be a low risk in all areas.
21 November 2005	Mr. Y went on a ward trip to Blackpool.
3 January 2006	Consultant Psychiatrist 3 wrote to the Home Office to request unescorted leave for Mr. Y. It was noted that the focus was to begin to consider move-on plans for him. Unescorted leave was planned in order to further his rehabilitation and improve his physical fitness. Mr. Y's mental state was described as being stable. It was thought that he presented a low risk to others. He had expressed remorse for killing his father and saw his mother regularly. Previous escorted leave in the community had taken place without incident. The request was supported by all members of the clinical team.
6 February 2006	<p>A Routine Enhanced Care Coordination Review took place. Those present were:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3; • Specialist Registrar; • Deputy Ward Manager; • Occupational Therapist; • Social Supervisor 1; • Clinical Psychologist 2; • Care Coordinator 1: CPN; • Advocate; • Mr. Y's mother and aunt were presented. Mr. Y did not wish to attend. <p>It was noted that Mr. Y was on level one observations and continued to deny symptoms of psychosis. Mr. Y utilised his leave well and used exercise as a coping mechanism. Mr. Y noted to be engaging well on the ward. His behaviour was described as being settled. His family stated that they were happy with his progress.</p> <p>Mr. Y had a care plan to increase his unescorted leave. Overall it was thought that Mr. Y was managing well on Olive Ward.</p> <p>A Risk Assessment was conducted. It was noted that prior to the homicide of his father Mr. Y had given all of his possessions away and had marked persecutory ideas, he had also disengaged from the service and not was compliant with medication. Mr. Y was also noted to suppress his emotions and had difficulty in expressing his feelings. He also misread the behaviour of others when he felt under threat which had previously escalated his risk of violence.</p> <p>Mr. Y was currently compliant with his medication and was on level one observations. He had been able to build up therapeutic relationships with staff and was developing coping strategies.</p> <p>Long-term risk management was thought to depend upon the outcome of neurological assessment. "<i>Poor theory of mind issues ongoing</i>" was also recorded. It was thought that Mr. Y would need nursing staffed accommodation which was able to provide support and monitoring in the future.</p>

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	<p>The risk assessment summary included:</p> <ul style="list-style-type: none"> • <i>“Concerns re: unpredictability and of violence to others although less so with stabilisation of mental state</i> • <i>Risk of harm to self should also be considered low</i> • <i>Risk of absconding - low</i> • <i>Risk of self neglect - low”.</i> <p>Risk was thought to be confined largely to the dynamic Mr. Y had with his parents.</p> <p>Future work was to focus on helping Mr. Y recognise his own emotions and those of the people around him and to develop coping strategies.</p> <p>Relapse indicators were identified as being: persecutory beliefs; withdrawal; non-compliance; relationship issues; physical violence.</p> <p>Mr. Y wanted a copy of his care plan. In summary Mr. Y was happy with his treatment and ultimately hoped to be discharged.</p>
27 February 2006	A request was made to the Home Office for full escorted day leave. He was to be allowed to visit the pub and drink a maximum of one pint. He would not be allowed to visit his mother or visit her home. He level of risk was deemed to be low in all areas.
29 March 2006	The Consultant Psychiatrist wrote to the Home Office with the annual statutory report for Mr. Y. It was noted that Mr. Y’s mental state had stabilised over the past 12 months.
6 May 2006	A Routine Enhanced Care Coordination Review took place.
19 May 2006	The Home Office wrote to Consultant Psychiatrist 3 giving permission for Mr. Y to have unescorted leave on the condition that he did not visit his mother or visit her home. A full report was required within two months. The leave was sanctioned provided that the patient did not present a risk to wither himself or to others. The Home Office required notification if the patient failed to return to hospital from leave.
24 May 2006	Mr. Y was granted unescorted leave in the locality for up to three hours, three times a week. The condition was that he did not visit his mother.
5 June 2006	The GP was invited to attend a CPA review that was due to be held on the 24 July 2006.
5 June 2006	Mr. Y was granted unescorted leave in the locality for up to half a day up to Prescott and St. Helens on a daily basis. The condition was that he did not visit his mother.
24 July 2006	<p>A Routine Enhanced Care Coordination Review took place. Those present were:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3; • Community Practitioner; • Occupational Therapist; • Social Supervisor 1; • Clinical Psychologist 2; • Mr. Y’s mother and aunt were presented. Mr. Y did not attend. <p>Mr. Y was on level one observations and a low-dependency ward. He was increasingly able to articulate his needs/emotions and was mentally stable with no suicidal ideation.</p> <p>Early warning signs work was ongoing with his Named Nurse to develop a relapse plan. Mr. Y was on Olanzapine 10mg at night. He was taking</p>

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	<p>regular unescorted day leave from the ward. Mr. Y's physical health was good and planning was underway to identify a staffed placement at Moscow Drive in the community. The date of the next review was set for the 22 January 2007.</p> <p>The care plan was for a Mental Health Review Tribunal to be pursued and for Social Supervisor 1 to arrange a visit to Moscow Drive.</p> <p>Mr. Y's mother and aunt were recorded as being happy with the plan and the progress that he was making.</p> <p>The Multidisciplinary Assessment summarised priorities as being:</p> <ul style="list-style-type: none"> • <i>To continue with the relapse and prevention work</i> • <i>To continue emotional work with Occupational Therapy</i> • <i>To engage in self-catering and budgeting whilst on Olive Ward</i> • <i>Progress regarding future accommodation</i>". <p>Risk Assessment: Summary as follows:</p> <ul style="list-style-type: none"> • <i>Concerns re: unpredictability and of violence to others although less so with stabilisation of mental state</i> • <i>Risk of harm to self should also be considered low</i> • <i>Risk of absconding - low</i> • <i>Risk of self neglect - low</i>". <p>Concerns regarding "<i>his personality and theory of mind difficulties</i>" were noted. It was also noted that Mr. Y may misread social situations and could react impulsively if he considered there to be a threat against him. Previous coping strategies were to be used e.g. jogging, and one-to-one work was to focus on Mr. Y recognising both his emotions and those of others and developing coping strategies.</p> <p>Mr. Y's potential for violence was thought to be specific to the relationship he had with his parents. Mr. Y's relapse indicators were identified as being: persecutory ideas; withdrawal; non-compliance; relationship issues; and physical violence.</p> <p>The risk management strategy involved:</p> <ul style="list-style-type: none"> • <i>Review his mental state</i> • <i>Unescorted leave in community</i> • <i>Medication</i> • <i>Engage in gym and other activities</i> • <i>Psychological assessment</i> • <i>Build therapeutic relationship</i> • <i>Occupational Therapy input</i>".
28 July 2006	Consultant Psychiatrist 3 wrote to the Home Office to state that Mr. Y had taken the opportunity to take his leave on a regular basis with no problems being identified.
24 August 2006	Mr. Y visited Moscow Drive with his Social Supervisor 1. Mr. Y liked it and said that he would like to live there when he was discharged.
11 September 2006	Section 17 day leave was arranged. The condition was that he would not visit his mother at her home.

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	<p>Consultant Psychiatrist 3 wrote to the Home Office to state that Mr. Y was being monitored whilst on leave and that he had shown no evidence of any physical or verbal aggression since very early on in his admission to hospital. It was stated that Mr. Y was no longer considered to have been a risk to others, either people in general or to his mother. It was noted that Mr. Y had taken unescorted leave for some time without incident.</p>
28 September 2006	<p>The Social Supervisor visited Mr. Y's mother. She was confused about the forthcoming Tribunal and what it would mean. Moscow Drive was not far away from her home and did not feel she could bear Mr. Y coming back into the house. It was clear that members of the extended family had very strong negative feelings about Mr. Y.</p>
30 September 2006	<p>Social Supervisor 1 wrote a Social Circumstances Report. It was noted that the City of Liverpool would be responsible for the Section 117 arrangements.</p> <p>It was noted that Mr. Y had improved "<i>on many levels</i>" and that he had been on the pre-discharge ward for 16 months and had continued to progress towards discharge. It was recorded that following Mr. Y's discharge he would be allocated a CPN from the Moss House CMHT and that he would continue to receive support from the Scott Clinic Outpatient service. Social Supervisor 1 was to continue as his Social Supervisor and she noted that she was confident that Mr. Y should be recommended for discharge.</p>
11 October 2006	<p>Consultant Psychiatrist 3 wrote a report for the Mental Health Tribunal. It was recorded that Mr. Y had been detained in the interests of the safety of both himself and of others. However his insight and condition had now improved with antipsychotic medication and he had no psychotic symptoms. Mr. Y had been placed on Olanzapine 10mg at night and had experienced no symptoms. It was noted that there was an ongoing risk of violence to other given his theory of mind issues, although some improvement had been noted. The management was to ensure a regular review of his mental state, to ensure compliance with his medication, to ensure Mr. Y engaged in activities and to ensure he lived in a supervised environment. It was recommended that Mr. Y received a conditional discharge to live in the community.</p> <p>A Section 117 planning meeting was also to be arranged.</p> <p>Concerns remained about the unpredictable nature of Mr. Y's risk of harm to others, especially if his mental state began to deteriorate. All other risks were considered to be low, especially in his current environment. However the risk assessment information was not completely accurate.</p>
23 October 2006	<p>Section 17 day leave was arranged. The condition was that he would not visit his mother.</p>
24 October 2006	<p>The statement for the Home Secretary for the consideration of the Tribunal stated that whilst he was pleased to note Mr. Y's progress he would not be prepared to support his discharge at this time and that he needed to stay in hospital in order to receive treatment for both his own health and safety and for the protection of others.</p>
7 November 2006	<p>The Social Worker visited Mr. Y's mother to explain about his pending discharge. She was happy for him and said she would visit him at Moscow Drive. She needed to understand the conditions of the Section 41.</p>
9 November 2006	<p>The Home Office Mental Health Unit wrote to Consultant Psychiatrist 3 to say that under Section 41 of the Mental Health Act (1983) Mr. Y was to be granted overnight leave to 123 Moscow Road. On the condition that he did not visit his mother at her home.</p>
27 November 2006	<p>An Effective Care Coordination Pre Discharge Review was held. Those present were:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3; • Staff Nurse; • Social Supervisor 1; • Mr. Y's mother and aunt were present. Mr. Y also attended.

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	<p>A gradual transition to community accommodation was planned “<i>in terms of Theory of Mind difficulties</i>”. Liaison with the family was also required. Mr. Y was due to move to Moscow Drive supported living accommodation. He was due to commence overnight leave in advance of “<i>MHRT</i>”. Early warning signs of relapse were identified as thinking people were talking about him and a lack of energy and feeling tired.</p> <p>Mr. Y’s mental state was assessed as being stable. The new Key Worker (Care Coordinator) was to be liaised with. Mr. Y’s medication was Olanzapine 10mg at night. The HoNOS summary was - 2. The HoNOS Secure - 2.</p> <p>A Post Discharge Effective Care Coordination meeting was to be held if Mr. Y achieved Conditional Discharge.</p> <p>The Care Plan stated that an overnight leave was to be pursued. Liaison was to be achieved with the new Key Worker and a Social Supervisor was to be allocated.</p> <p>Mr. Y’s family were recorded as being happy with the prospect of Conditional Discharge. There was a plan for a Mental Health Review Tribunal on the 15 December 2006. CAB was to organise benefits.</p> <p>A Risk assessment was conducted. The summary was as follows:</p> <ul style="list-style-type: none"> • “<i>Risk of harm to self - low</i>” • <i>Risk of absconding - low</i> • <i>Risk of self neglect - low</i> • <i>Risk of suicide - low</i>”. <p>Concerns remained regarding Mr. Y’s personality and theory of mind difficulties in that he misinterpreted situations and could act impulsively when he perceived a threat against him. He needed to be able to recognise both his emotions and those of others and to develop coping skills.</p> <p>It was recorded that Mr. Y’s potential risk of violence “<i>appeared to be very specific to the interaction and the dynamics in his relationship with his parents</i>”. Future risk factors were identified as being:</p> <ul style="list-style-type: none"> • “<i>Medication non compliance</i>” • <i>Acute illness</i> • <i>Alcohol/drugs</i> • <i>Relationship issues</i> • <i>Misinterpretation of social situations and of threat towards him</i>”. <p>“<i>Observable indicators of repetition</i>” were recorded as being: persecutory beliefs; withdrawal; non compliance; relationship issues; and physical violence. The plan was to monitor Mr. Y and to provide support and restrict his visiting and access to his mother’s address.</p> <p>Long-term risk: will require nursing staff accommodation which is able to support and monitor. Monitoring and support through Conditional Discharge.</p>
<p>28 – 30 November</p>	<p>Mr. Y went on day leave to Moscow Drive. There were no problems and Mr. Y enjoyed himself. Because Mr. Y was not yet signed up as a tenant</p>

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2006	he could not stay for the night.
2 December 2006	<p>It was agreed that Mr. Y would have Section 17 leave from 9.00am until 6.00pm on the 3 December 2006. The conditions of the leave were that Mr. Y would not visit his mother or attend the close in which she lived. The relapse indicators were noted as being a lack of energy and having feelings that he is talked about.</p> <p>His risks in all categories were noted to be low.</p>
15 December 2006	<p>Mr. Y was to be discharged subject to the conditions below:</p> <ul style="list-style-type: none"> • The discharge was to be deferred until the Tribunal was satisfied that the necessary arrangements were in place. • Mr. Y was to attend appointments with his CPN (Care Coordinator). • Members of the Moscow Drive staff were to be notified of any face-to-face meeting with his mother. • Mr. Y was to reside at 123 Moscow Drive. • Mr. Y was to permit access to any members of staff caring for him and to have face-to-face contact with staff on a daily basis. • Mr. Y was to comply with all aspects of treatment. • Mr. Y was to attend all appointments with his RMO. • Mr. Y was also required to attend all appointments with his Social Supervisor. • Mr. Y was not to go within 200 metres of his mother's address. <p>The Tribunal did not reclassify Mr. Y. The reasons the Tribunal gave for the discharge was that Mr. Y had responded to medication since being at the Scott Clinic, he had enjoyed extensive unescorted leave and had not psychotic symptoms. It was thought that Mr. Y was compliant with his medication and had a genuine insight into his condition. It was noted that he still had "<i>personality difficulties</i>" but that these pre-dated and were quite distinct from his mental illness.</p> <p>An identified area of risk was that presented to his mother. Mr. Y had been seeing her regularly; however she expressed concerns about his visiting her at home. It was to be a condition of his discharge that he did not go within 200 metres of her home. The Tribunal was confident that Mr. Y would comply with the conditions of his discharge. It was noted that Consultant Psychiatrist 3 and the treating team were unanimous in the decision that Mr. Y no longer required detention in "<i>conditions of security</i>" and that he could be safely treated in the community subject to the conditions imposed.</p>
18 December 2006	<p>Consultant Psychiatrist 3 wrote to Imagine. It was noted that Mr. Y was on Section 37/41 and had been conditionally discharged at Mental Health Tribunal. He was to be followed by Consultant Psychiatrist 3, the Social Supervisor and the Care Coordinator. In addition Mr. Y was to have access to the Crisis Intervention Team. The plan was to discharge Mr. Y to Moscow Drive which was a 24-hour staffed facility. It was stipulated that he was not to go within 200 metres of his mother's address, and that any meeting with his mother was to be notified to the care staff.</p> <p>A brief history of Mr. Y was given. The plan was to review him at Outpatients on the 11 January 2007.</p> <p>Mr. Y was discharged from the Scott Clinic on this day.</p>
20 December 2006	Mr. Y was discharged from the Scott Clinic to 123 Moscow Drive.
11 January 2007	The Home Office Mental Health Unit wrote to Consultant Psychiatrist 3 to say that they had used their powers under section 73(2)/74(2) of the

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	<p>Mental Health Act (1983). The conditions were those set out above under 15 December 2006 entry. Powers of recall were set if required. Mr. Y was written to in order to inform him of his discharge. It was confirmed that the power to recall the patient rested with the Home Secretary.</p>
<p>11 January 2007</p>	<p>Enhanced Care Coordination Review Risk Assessment. Post Discharge. Signed by Consultant Psychiatrist 3 on the 25 January 2007.</p> <p>Those present were:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3; • Care Coordinator 2; • Social Supervisor 1; • Mr. Y was present. <p>CPA: it was noted that Mr. Y was living in supported accommodation in the community at Moscow Drive. Signs of relapse were noted as being feeling as though he was being talked about and feeling tired with a lack of energy. The crisis plan consisted of an early review by the Care Coordinator and Responsible Medical Officer, increase support and review medication and access to crisis intervention. The Contingency plan was to admit to the Scott Clinic. At this stage his mental state was stable. Mr. Y was to see his Care Coordinator weekly and his Social Supervisor two-three weekly. His medication was Olanzapine 10mg at night.</p> <p>Risk Assessment: It was noted that prior to the index offence Mr. Y had an acute psychosis with marked persecutory delusions. He had given away all of his personal belongings and had heightened arousal and was fearful. There had been issues with disengagement from services, compliance with medication, and relationship issues with his parents.</p> <p>Mr. Y was noted to have difficulty in anticipating and recognising emotions in others, and that he suppressed his anger and could not express his feelings. Deterioration in his social functioning had been observed. It was noted that Mr. Y could be at risk of violence when he felt under threat because he was prone to misread the behaviour of others. This escalated his risk of violence.</p> <p>It was also noted that Mr. Y had previously been a heavy drinker and had admitted to using cocaine in the past. He was currently compliant with his medication, had a stable mental state and therapeutic relationships with staff.</p> <p>Long-term management options were identified as:</p> <ul style="list-style-type: none"> • <i>“Poor theory of mind issues ongoing. Staffed accommodation which is able to provide support and monitoring. Monitoring and support through Conditional Discharge”.</i> <p>Summary of risk assessment:</p> <ul style="list-style-type: none"> • <i>“Concerns re: unpredictability and of violence to others although less so with stabilisation of mental state</i> • <i>Risk of harm to self should also be considered to be low</i> • <i>Risk of self neglect - low</i> • <i>Risk of suicide - low”.</i> • <p>There were concerns regarding his personality and theory of mind difficulties. It was recorded that Mr. Y may misread social situations and</p>

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	<p>could act impulsively upon misinterpretation of threats against him. The plan was to help Mr. Y recognise his emotions, the emotions of others, and develop coping strategies.</p> <p>In summary the risk of his behaviour reoccurring (in the context of the current risk management strategy) was deemed to be low.</p> <p>The Plan: Mr. Y was to be monitored especially when major changes to his environment were made. A stable and supportive placement would be required in the community. Mr. Y would have to be discharged on condition that he avoided his mother's address. His mother was to be liaised with to ensure her continued safety. The likelihood of violence was considered to be low, but it would depend upon his continuing mental stability.</p>
22 February 2007	<p>The Scott Clinic CMHT Manager wrote to the Park Lodge CMHT Manager, with a formal request for Mr. Y to be accepted onto the caseload. It was noted that Mr. Y had been referred to the Scott Clinic three years previously following the homicide of his father and the attempted homicide of his mother. Mr. Y had been stabilised on medication and had made good progress at the Scott Clinic under the care of Consultant Psychiatrist 3. Social Supervisor 1 had been able to arrange a placement at the Imagine house at 123 Moscow Drive and she was currently acting as Social Supervisor.</p> <p>Mr. Y had been given a Conditional Discharge under Section 41 when his appeal had been heard on the 15 December 2006. His GP was based at the Green Lane Surgery. The plan was for the Scott Clinic to work jointly with a community team with a view to handing over the case at a later date.</p> <p>Whilst Mr. Y was at the Scott Clinic he had been visited by a Care Coordinator from Moss House (Care Coordinator 1) until she left the service the preceding year. It was now thought that Mr. Y needed continuing support from the local CMHT.</p>
13 March 2007	<p>The Park Lodge CMHT Manager wrote to the Scott Clinic CMHT Manager. It had been decided that Mr. Y would be transferred to the Park Lodge CMHT once the Scott Clinic was ready to discharge him.</p>
19 April 2007	<p>It was not recorded who was present, however Care Coordinator 1, CPN Moss House, was recorded on the invitation confirmation list. An Effective Care Coordination review took place. Mr. Y attended the review, no family members were present. Mr. Y did not express any concerns and was happy with his current placement at Moscow Drive supported by Imagine. His mental state remained stable. He had developed a routine which was quite isolative and was spending quite a lot of time on his own. The plan was for Mr. Y's plan to remain with no changes made.</p>
1 November 2007	<p>Mr. Y attended for his routine ECC (CPA) review with Consultant Psychiatrist 3. A worker from Imagine, and Care Coordinator 2 were present. Mr. Y was also present. His CPN visited him weekly and his mother visited him six weekly at Moscow Drive. At this stage Mr. Y did not wish for a more independent kind of living arrangement. He was noted as being currently stable in the community. Mr. Y was compliant with his medication. Mr. Y was to continue with his supported living and CPN support. If required he was to access 24-hour crisis intervention. No changes were required to the care plan.</p> <p>The GP was written to.</p>
7 February 2008	<p>Consultant Forensic Psychiatrist 3 reviewed Mr. Y at an Outpatient appointment. He was still living at Moscow Drive and was seeing his CPN on a weekly basis. His Social Supervisor was due to leave and a replacement was being sought. Mr. Y was compliant with his medication and no concerns were identified. The GP was written to.</p>
3 April 2008	<p>Mr. Y attended for his routine ECC (CPA) review with Consultant Psychiatrist 3. Mr. Y was visiting his mother every six weeks and was commencing self medication. The new Social Supervisor met with him every fortnight. HoNOS was completed during the meeting. No concerns</p>

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	<p>had been expressed by the staff at Moscow Drive. Care Coordinator 2 was visiting Mr. Y on alternate weeks to the Social Supervisor.</p> <p>The Care Plan was reviewed. The care plan noted the following: Signs of relapse: feeling that he is being talked about, irritated by those around him, feeling tired. Crisis Plan: early review by CPN/Social Supervisor, RMO, increase support, review medication. Contingency Plan: to admit to the Scott Clinic. Summary of Risk Intervention: mental state was stable, Mr. Y was living in 24-hour supported accommodation, weekly support and monitoring of mental state was occurring. Medication: Olanzapine 10mg at night prescribed by GP. Plan: to see CPN fortnightly and the Social Supervisor fortnightly on alternate weeks. To see the Consultant three monthly and to be reviewed six monthly.</p> <p>The GP was written to.</p>
15 July 2008	<p>Consultant Psychiatrist 3 wrote to the GP following a review of Mr. Y. Prior to the meeting the Doctor had discussed the case with the Social Supervisor. They were in agreement that Mr. Y was engaging well, continued to have contact with his mother and was compliant with his medication.</p>
26 August 2008	<p>An Imagine Support Plan was developed. It was noted that Mr. Y was a very private person and that he needed support to interact with people. Mr. Y wanted to work with his Keyworker (Imagine) to develop his fitness. He was to be encouraged to work to his Occupational Therapy plan and to engage with others. Mr. Y was working positively to gain more independence. He liked to visit the library and cook his own meals.</p>
1 September 2008	<p>An Essential Lifestyle Plan assessment was conducted. It was recorded that Mr. Y must have privacy and that people must knock on his door prior to gaining access. Mr. Y was also described as needing to run at around 7.30 in the morning and that he liked to have 1:1 time with his Keyworker. It was recorded that Mr. Y must have contact with his uncle, aunt and mother at least once a fortnight. Mr. Y had been noted as self medicating and being compliant with this for six months. He was described as liking to keep himself clean and presentable. Mr. Y still preferred to keep to himself, was pleasant and polite and felt that he was ready to move into a flat on his own.</p>
3 September 2008	<p>The GP was invited to attend a CPA review that was due to be held on the 18 September 2008.</p>
18 September 2008	<p>An Enhanced CPA Care Plan was developed by the Care Coordinator. Mr. Y was subject to Section 117 aftercare arrangements. The focus of the plan was to monitor Mr. Y for paranoid thoughts and to support him. Mr. Y was to remain in 24-hour supported accommodation and to remain on his Olanzapine 10mg at night. The CPN was to continue to make two weekly visits and to liaise with the Imagine staff. The Imagine staff were to contact the Forensic Team if they had any concerns. Mr. Y was to access the 24-hour Crisis Service if the need arose.</p> <p>Early signs of relapse were listed as being feeling tired and feeling watched and talked about. More well-developed signs were irritability, preoccupation and the feeling that others could hear his thoughts, depression and poor self care.</p> <p>It was noted that Mr. Y's current mental state was stable. His risk of self harm was deemed to be low. There were some concerns regarding his lack of predictability. It was noted that the risk of violence was "<i>specific to the interaction and the dynamics in his relationship with his parents.</i>" There was an ongoing risk of violence towards others. It was noted however that he had been able to utilise coping strategies since his discharge.</p> <p>Consultant Psychiatrist 3 reviewed Mr. Y (CPA) the meeting was attended by the Social Supervisor and the Care Coordinator from the Forensic</p>

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	<p>Integrated Resource Team. It was noted that Mr. Y appeared to be well. He was to be followed up in Outpatients in three-months time on the 12 March 2009.</p> <p>The Effective Care Coordinator Review paperwork was completed. It was noted that Mr. Y was not on a supervision register, that it had been considered, but not thought necessary. It was noted that he was on a Section 41. Mr. Y continued to be monitored for paranoid thoughts. Both the CPN and the Social Supervisor were to continue to work with Mr. Y and liaise with Imagine staff. Early signs of relapse were identified as being feeling tired and thinking people were watching him and talking about him. More serious indicators included being irritable, preoccupied, withdrawn and giving his belongings away. It was noted that his mental state was stable and his risk was low.</p> <p>The risk assessment for this period noted that the only condition placed on Mr. Y was that he was not to go to his mother's address.</p>
1 November 2008	<p>An Imagine risk assessment was conducted. The reason was that it was a "periodic" assessment. It was noted that Mr. Y was at risk of isolation. The only person thought to be at risk was Mr. Y. His risk fell into the "medium" category. Staff were to make contact with him twice each day. He was to be encouraged to join in Home activities.</p>
30 November 2008	<p>An Imagine Support Plan was developed. It was noted that Mr. Y was a very private person who needed a structured programme to broaden his social skills. It was also noted that Mr. Y had spent the past three months increasing his fitness, that he went on runs with his Support Worker and had joined the Leisure Centre. Staff were to carry through the Occupational Therapy Support Plan. Mr. Y had the goal to run a marathon and staff were supporting him to do this.</p> <p>Mr. Y also said that in the long term he would like to go back and be a taxi driver. Mr. Y also said that he would like to work towards having his own flat. Mr. Y had been at Moscow Drive for 18 months and he had been working towards his independence, he was positive and seen to be working in the right direction.</p>
18 December 2008	<p>Consultant Psychiatrist 3 reviewed Mr. Y at an Outpatient appointment. It was noted that he continued to do well. He was in regular contact with his Care Coordinator (CPN), and his Social Supervisor. He had met up with his mother since the last Outpatient meeting and was compliant with his Olanzapine 10mg at night. There were no specific concerns and the plan was to review Mr. Y again in three-months time.</p>
11 February 2009	<p>Imagine emailed the FIRT to say they had been requesting Mr. Y's up-to-date risk assessments and ECC documentation for a period of some months. It was noted that some of the paperwork was seriously overdue, some at least six months old. The response was that CPA and risk reviews were not always conducted six monthly and that these were sometimes done on an annual basis. A worker from FIRT emailed back to say to say that Imagine should have copies of reviews, especially if they attended and would "sort something out".</p>
13 February 2009	<p>The GP was invited to attend a CPA review that was due to be held on the 5 March 2009.</p>
3 March 2009	<p>The GP was invited to attend a CPA review that was due to be held on the 28 March 2009.</p>
2 April 2009	<p>Mr. Y attended for a routine CPA review with:</p> <ul style="list-style-type: none"> • Consultant Psychiatrist 3; • A Worker from Imagine; • Care Coordinator 2; • the person who was due to take over the role of CPN in a couple of week's time. <p>The Social Supervisor sent her apologies. Mr. Y was well and compliant with his Olanzapine, which he self-medicated, and was considering pursuing his GCSEs. His next CPA review was set for six months time and he was scheduled to be followed up by Consultant Psychiatrist 3 in</p>

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	three-months time. The GP was written to.
7 April 2009	A letter was sent to the GP advising him that Mr. Y was to be entered, following a referral, into the Trust Wellbeing Support programme which would encourage physical wellbeing and lifestyle changes. At this time it was noted that Mr. Y was prescribed Olanzapine 10mg once daily and that his diagnosis was Schizophrenia.
1 June 2009	A Support Costings Summary was completed/ it was noted that Mr. Y was receiving funding from Supporting People, Housing Benefit and from the PCT.
2 July 2009	Mr. Y attended for his routine Outpatient appointment with Consultant Psychiatrist 3. Mr. Y was well kempt and relaxed and living at Moscow Drive. Mr. Y had been talking to his solicitor about an Absolute Discharge. The Doctor said it may be a little early to discuss this. Mr. Y seemed "content" with the discussion. The plan was to review him again in six-months time.
24 September 2009	Mr. Y was seen for a routine CPA review. Consultant Psychiatrist 3, a Worker from Imagine, the Social Supervisor and the new Care Coordinator were present. Mr. Y was due to move into a new flat that was managed by Imagine. He continued to be well. The Consultant planned to see him again on the 10 December 2009.
28-29 September 2009	Mr. Y moved into his new flat. He appeared to settle in well and was reported to be relaxed. He was reminded that he was expected to spend at least an hour a day with the staff.
1-7 October 2009	Mr. Y appeared to have settled in well and was socialising with one of the other residents well.
8-9 October 2009	Mr. Y was reported to be in his flat with his mother. His uncle was checking in on them. Everything to be OK.
1 November 2009	A risk assessment was prepared as Mr. Y was about to move to a new flat. The required activities/task were listed as being: <ul style="list-style-type: none"> • staff must ensure daily contact; • tenant was safe to use all equipment; • tenant was storing medication correctly; • tenant ensured the importance of turning everything off at night; • tenants to ensure foodstuffs are kept in date. <p>The potential hazards were noted as being fire and self neglect. Mr. Y's risk rating was medium. The risk assessment had no review date.</p>
10 December 2009	Consultant Psychiatrist 3 reviewed Mr. Y at an Outpatient appointment. He appeared to be physically and mentally well. Mr. Y had recently moved into a self-contained flat with staff support throughout the day. Mr. Y was compliant with his Olanzapine medication. He was being seen regularly by Care Coordinator 3 and his Social Supervisor from the Forensic Integrated Resource Team. No concerns had been raised. The Consultant followed Mr. Y up on a three-monthly basis.
7 February 2010	It was recorded in the Imagine notes that Mr. Y was coming around to the idea of moving out of Moscow drive. Someone was due to come and talk to him about a long-term tenancy elsewhere. The worker was due to visit the following day.
9 February 2010	The GP was invited to attend the CPA meeting set for the 11 March 2010. Mr. Y was written to inviting him to his CPA review. Imagine was also invited to this meeting.
23 February 2010	Mr. Y expressed his concerns to his Keyworker about perhaps having anti-social neighbours when he moved. He was reassured that this would not happen.
24 February 2010	Mr. Y told his keyworker that his CPN had not called in to see him as expected.
25 February 2010	Mr. Y was reminded that someone was due to call in the following day to arrange his moving on.

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26 February 2010	A Worker met with Mr. Y. He explained about the flat he could move to, the removal process, rent and the neighbours.
4 March 2010	Mr. Y was said to be getting used to the idea of a move. He appeared well in himself and there were no changes to his mental state.
5 March 2010	Mr. Y appeared to be well. He told his Care Coordinator that he was looking forward to looking at the new flats.
7 March 2010	Mr. Y had been to view a flat the previous day. He seemed to be pleased with the location of the property.
11 March 2010	<p>Consultant Psychiatrist 3 wrote to inform the GP that Mr. Y had attended for his routine CPA review. The meeting had also been attended by a Worker from Imagine, the Bridge Builder from Imagine, and the Social Supervisor. The focus of the meeting was to try and move Mr. Y into a more independent mode of living. He was maintaining his flat and had good daily living skills. Mr. Y was also receiving support from CPN services.</p> <p>The plan was to review Mr. Y in three-months time on the 24 June and the next CPA review was scheduled for the 23 September.</p>
12-22 March 2010	It was recorded in the clinical records that Mr. Y continued much the same. His mental state appeared to be normal and he seemed to be relaxed and happy with the idea of a move.
23 March 2010	Mr. Y was told that there was a possibility of a flat coming up soon in the local area and that he could view it if he wished the following day.
24 March 2010	Mr. Y went to visit the flat. He appeared to be pleased with the location and how quiet it was. He was told that he could have the tenancy on a long-term lease if he wished.
25 March 2010	Mr. Y said that he did not want to move into the flat that he had visited recently as it was too far away. He said that he would prefer to wait for a flat closer to Moscow Drive.
30 March 2010	<p>A Worker from Imagine contacted the FIRT Team as Mr. Y had given away his television to another service user. This was noted to be one of his risk indicators. The Social Supervisor went to visit Mr. Y, but he was not there. It appeared that Mr. Y was not unwell and that he had loaned the television to another service user.</p> <p>Mr. Y was having lunch with his mother, which was usual. The Social Supervisor told a Worker from Imagine to contact her if she had any concerns. At 19.45 hours Mr. Y returned he spent some time with the staff talking about Scrabble and then went to his flat stating he was going to listen to music.</p> <p>At 22.30 hours a neighbour of Mr. Y's mother called Moscow Drive stating that his mother had not returned home, he subsequently called back to say that the mother's house was on fire. Mr. Y was arrested at the scene. His mother's body was found in his flat at Moscow Drive.</p> <p>The Imagine notes record that staff had a discussion with him about loaning his television to another service user. Mr. Y asked the staff if they thought he was becoming unwell, and he said that he did not feel unwell. He was asked by staff if he had anything on his mind, especially about the move. He said that he would rather stay at Moscow Drive as he had only recently moved to his current flat. The Team Leader was informed about Mr. Y's behaviour. The Team Leader telephoned Mr. Y's mental health team who said that they would send someone out later that day to speak to him.</p>
	There were no indications in the GP record a third move was being planned.
	POST SECOND HOMICIDE
31 March 2010	At approximately 0.15 hours Police in the company of an Imagine Worker entered Mr. Y's flat where they found his mother dead on the floor. Mr. Y was in custody following his arrest near the vicinity of his mother's home.

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	Mr. Y was arrested on suspicion of killing his mother at his flat in Liverpool. He was initially arrested in connection with an act of arson at his mother's home address. Following his arrest her body was found at his flat. He had killed her with a kitchen knife. He was initially seen by Consultant Psychiatrist 3 at the Police station who determined that he was fit for interview and detention. The Consultant Psychiatrist could find no evidence of any acute psychotic symptoms in the forms of delusions and hallucinations.
1 April 2010	Mr. Y refused to move from his cell and had to be carried to Court. He was distracted and pre-occupied and incongruous in that he exposed his genitals. Consultant Psychiatrist 3 assessed Mr. Y. On this occasion he did not appear to be distracted but was guarded. Mr. Y <i>"appeared quite brittle and menacing in his presentation"</i> . Consultant Psychiatrist 3 felt that he was not fit for interview and the decision was made to detain him under Section 3 of the Mental Health Act (2007) at the Scott Clinic.
28 April 2010	The Opening Inquest Decision Notice and Direction was held.
24 May 2010	An Ashworth Hospital Social Work pre-admission report was prepared by. Mr. Y's clinical history was given. It was noted that Mr. Y stated from the outset that he had committed two crimes. He denied any delusions or particular beliefs. He had told Consultant Psychiatrist 3 that he taken up his mother's house keys and just decided to <i>"destroy my mum's home"</i> . He denied any thoughts of wanting to cause harm to other people. The report summarised that the recent incident had <i>"come as a shocking surprise for which there had been no warning signs"</i> . He had been assessed five days before the incident at CPA review <i>"in which risk of serious physical harm was rated as low"</i> .
26 May 2010	The Consultant Psychiatrist Consultant Chair Admissions Panel, wrote to Consultant Psychiatrist 3 acknowledging receipt of a letter sent on the 29 April 2010. The letter requested a high secure assessment for Mr. Y with a view to admission at Ashworth Hospital. A Consultant Forensic Psychiatrist conducted the assessment on the 12 May 2010. The Admissions Panel met on this day and agreed that Mr. Y suffered from a mental disorder that required a period of assessment and treatment in hospital. Given his history and his current offence it was agreed he should be admitted to Ashworth Hospital. Consultant Psychiatrist 3 was asked to liaise with the Mental Health Act Office to arrange the admission.
7 June 2010	Mr. Y was discharged from his Section 3 and recalled under Section 37/41 to Ashworth Hospital.
16 November 2010	A Court hearing was held on this day. Mr. Y did not appear and had been detained in hospital. The treating Psychiatrist at Ashworth, had produced a report that indicated diminished responsibility was an aspect of the case. The trial was listed for the week commencing 28 March 2011. It was anticipated that it would be a two-week trial.
28 March 2011	Mr. Y was found guilty of manslaughter and attempted arson. He was sentenced to life imprisonment with a 20-year determination. He was detained at Ashworth Hospital.

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Appendix Two

**Trust Action Plan Produced in Response to the Review into the Care Treatment of Mr. Y
December 2011**

Time Line of events:

Date	Action/Event	Person Responsible	Evidence Log
1 April 2010	Post Incident Review	Service Director	Item 1a
March 2011	Service Director and Clinical Director received the Report relating to the care and treatment of Mr. Y received		Item 1b
Spring 2011	Key Finding and recommendations presented across SaFE Partnerships Clinical Business Unit (referred to as CBU in the following action plan)	Clinical Director	Item 1c
13 April 2011	Clinical Director presented recommendations from Mr. Y investigation and next step for Directors was to agree action plan, presentation to Trust Board in September 2011. Agreed to set up SaFE action plan group (Evidence Item 28) – Quality and Effectiveness Meeting 13 April 2011		
20 April 2011	Further presentation of Mr. Y Report (Evidence Item 34)		
11 May 2011	Group met up to address recommendations and produce an action plan in response. Membership included representatives from all disciplines and Managers within SaFE Partnerships CBU	Service Director	Version 1 action plan produced
13 July 2011	Updated CPA Guidelines at Quality and Effectiveness Meeting (Evidence Item 29) – Minutes from Quality and Effectiveness Meeting		
27 July 2011	Service Director provided the group with the action plan produced in response to Mr. Y recommendations (Evidence Item 30) Minutes from Quality and Effectiveness Meeting.		
28 September 2011	Action plan presented at Adverse Incidents Sub Group SaFE CBU (Evidence Item 31) minutes.		

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Recommendation (1)

The management arrangements and working practices of multidisciplinary teams at the Scott Clinic should be reviewed to ensure a consensus approach to decision making. The outcomes should be reflected in an operational procedure governing the working of MDTs

Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
To conduct a formal review of the working of the multidisciplinary teams throughout SaFE Partnerships Clinical Business Unit (CBU) with a focus on decision making processes and evidence of collaborative working within the team	Clinical Director/ Service Director	October 2011	Offender Health Lead MCT commenced a thorough investigation into Multi disciplinary team approaches in May 2011. Review completed July 2011	Item 2 TOR for the review See Evidence Log item 3 Report-Outcome of the review	
Feedback the outcomes and recommendations	Offender Health Lead MCT	October 2011	28 recommendations. 15 noted as priorities. Presented to a wide audience across SaFE Partnerships CBU	Item 4 presenation	
Implementation of MDT Action Plan	Clinical Director	December 2012	Action plan completed December 2011	Item 5 Action Plan	

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Recommendations (2)

A review of the arrangements in place for carers of service users admitted to the Scott Clinic should be undertaken

Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
<p>Service to carry out an audit using the Self assessment audit tool for carer engagement within The Triangle of Care. (National Mental Health Unit, Princess Royal Trust for Carers)</p> <p>http://www.acutecareprogramme.org.uk/silo/files/triangle-of-care-carers-included.pdf</p> <p>SaFE Partnerships to agree an action plan based on the finding to support the 'Key elements to achieving a Triangle of Care' as described outlined in this document.</p> <p>Action Plan to be devised</p>	<p>Service User and Carer lead SaFE Partnerships CBU</p>	<p>January 2012</p>	<p>Meeting arranged for 19.12.11. Audit and Action Plan to be completed.</p>	<p>Item 6 Carer Action Plan</p>	
<p>Following the review of existing MSU guidelines for CPA it was identified that all carers should be offered a carer's assessment</p> <p>For existing Service Users each Carer in the community or inpatients is to be offered Carers assessment. This will be recorded on E-Pex (Mersey Care Trust electronic recording system) as a contact and recorded in the CPA Care Pathway section: CPA Care Assessment part 2 as per Trust CPA Policy</p>	<p>FIRT Manager</p>	<p>July 2011</p>	<p>A section has been included in the MSU CPA guidelines document to advise all staff of future arrangements. (Page 3). The Guidance is explicit in stating the role and responsibility</p>	<p>Item 7 MSU CPA revised guidelines</p>	

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Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
			<p>of staff in ensuring Carers are involved in the CPA Process.</p> <p>A letter has been sent to the relevant carer / relative to offer opportunity to speak with the clinicians from the Scott Clinic has. This details the opportunity for communication with the potential for referral for a full Carers' assessment.</p> <p>This has been completed for all Community service Users and has commenced for all inpatients</p>	<p>Item 8 Letter to Carers</p>	
<p>Evidence that carers/family members have been invited to participate in the process and the process audited to</p>	<p>FIRT Manager Head of</p>	<p>October 2011</p>	<p>With regards to Carers/family</p>	<p>Item 9 Sample database</p>	

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Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
ensure this happens	Administration		involvement in discharge planning, where appropriate (i.e. where the service user have maintained contact with family) they are invited to the CPA reviews which will include discharge planning, evidence of participation and involvement will be tracked through CPA documentation and recorded centrally in a database manually.		

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Recommendation (3)

Arrangements for the risk assessment, management and discharge of service users should be reviewed at the Scott Clinic. This review should include:-

- a) An overall assessment of the quality of information provided to the Ministry of Justice and relevant partners involved with ongoing care responsibilities and identification of associated actions for improvements.
- b) A set of criteria to be drawn up to clarify the reasons why service users are, or are not, considered suitable for discharge from inpatient care in a medium secure unit. This should include details of what a service user must achieve before they are considered suitable for discharge and information on what alternative provision needs to be made if the criteria are not, or cannot be met.

Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
Recommendation 3a). A review of information has been conducted and the Ministry of Justice has produced templates of standardised documentation	Mental Health Act Administrator	May 2011	Completed by the deployment of these templates	Items 10-18 (inclusive)	
Recommendation 3b). The Clinical Director to review existing approach to risk formulation and to oversee changes that increase the focus on formulation and understanding of index offence	Clinical Director	November 2011	The risk assessment work sheet has been amended to include prompts for consideration of the index offence and risk formulation. This information will take into account readiness for discharge of the service user. Work sheet will focus on historical and contemporary views on recidivism, response to treatment, protective factors against noted risk factors and clinical progression. It will also consider information from clinical assessment in structuring the judgment of the MDT when developing a bespoke pathway for each service user. The draft document is for review within the	Item 20 Violence Risk Worksheet.	

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Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
			Quality and Effectiveness Governance group.		
Recommendation 3b). Clinical and Service directors to consider risk assessment tools used within the MSU	Clinical Director/ Service Director	20 July 2011	The Clinical Director and Service Director have met to discuss risk assessment issues, quality and appropriate assessment tools and advised Nurse Consultant to review inclusion of HCR20 risk assessments as a standard.		
Recommendation 3b). The service to review the staff available to give advice and offer specialist intervention on formulation of risk and plan additional HCR20 training sessions	Nurse Consultant		In addition to existing staff, a further 18 people have received HCR20 Training in October 2011. The concept of risk formulation has been added to the standard training package. Service has ensured the adherers to Trust guidance in relation to risk assessments.	Item 33 minutes 14 September 11 Quality and Effectiveness Meeting. Item 32 letter to heads of departments June 2011.	
Recommendation 3b). Raise staff awareness around broader responsibilities of Risk Management beyond diagnosis.	Clinical Director		Sessions have been arranged to raise staff awareness around broader responsibilities of Risk Management beyond diagnosis. Dates already completed with FIRT September 2011 Occupational Therapy Department completed 10 th November 2011 Further dates confirmed for presentation to, Medics, Psychology and Nursing. The aim is to ensure the service is optimising the link between risk assessment and risk	Item 22 Presentation Risk Formulation	

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Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
			<p>management by the emphasis on drawing together assessment findings in a risk formulation has commenced and has been incorporated into a presentation that has been delivered across disciplines and will continue to be rolled out as a longer term aim.</p> <p>This is an ongoing discussion/topic with in the Quality and Effectiveness sub group of Governance.</p>		
<p>Recommendation 3b) Identify community cases that are considered high risk and explore current risk management. Criteria for identification:</p> <p>Offences that include previous conviction of the following; Murder, Attempted Murder, Manslaughter and sexual offences</p> <p>And</p> <p>Current risk assessments that indicates high risk of future violence of offending</p>		<p>Commenced May 2011</p>	<p>Monthly meetings currently take place between key clinicians working with in patients and in the community. 25 cases identified.</p> <p>The focus of these meetings is mainly to look at all homicide cases and to review/agree the formulations. This relates to in-patients and people in the community to develop a robust formulation process</p> <p>The first step is understanding the index offence(s)/risky behaviour. The following are considered:</p> <p>What was the <u>rationale</u> for the offence: Cognitive - what were they trying to achieve Emotional – what feelings drove the offence Why did they commit the offence against this</p>	<p>Item 23 dates of risk formulation meetings.</p>	

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Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
			<p><u>victim:</u> What were the <u>disinhibiting/facilitating</u> factors Why didn't the patient resist the urge/feeling?</p> <p>What were the <u>contextual</u> factors - What was happening in their life that made it more likely that: The patient wanted to achieve the particular goal at this time The patient experienced the emotion(s) at this time This victim was attacked at this time The patient did not resist the urge/feeling at this time</p> <p>The next steps involve determining to what degree the above are related to underlying mental health issues agreeing what interventions may be indicated to deal with those mental health issues. Focus will also be to agree whether specific offence related work is required; agreeing what has changed in the above areas and what that means about current risk and agreeing what needs to be in place to manage the risk.</p>		
<p>Recommendation 3b). Identifying and adopting good practice for the management of other service users eligible for conditional discharge into the community is supported by the above actions and provides evidence of future formulation of risk and practitioners understanding.</p>					

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Recommendation (4)

Working arrangements with partner/non-statutory organisations require immediate review

Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
<p>Ensure community partners and service providers Care Plans are incorporated into Mersey Care NHS Trust; this is the responsibility of the Care Co-ordinator.</p> <p>Existing MSU CPA guidance should reflect this.</p>	FIRT Manager	July 2011	<p>All FIRT Care Plans have been reviewed and now include details of what care is provided, whose responsibility this is and how many hours of care and support is provided each week. This sets out exactly who is responsible for meeting different areas of need.</p> <p>Existing MSU CPA guidance now includes a section to ensure staff are aware of their responsibilities to ensure that appropriate questions are asked of service providers and that they are able to contribute more thoroughly to CPA reviews.</p>	Item 6 CPA Guidelines MSU/FIRT	
<p>CPA Reviews – Care Co-ordinators must ensure that providers are invited to CPA's. Service providers will be asked to complete a pro forma prior to the CPA review to give an update on progress or any notes of concerns etc. This can be discussed prior to the CPA. This will be typed and saved on E-Pex in patient documents.</p>	FIRT Manager	July 2011	<p>A standard template for providers to complete prior to each CPA has been devised and included in MSU CPA guidelines.</p> <p>A CPA review prompt sheet has been devised for inpatients and out patients. A section has been included in the MSU/FIRT CPA Guidelines.</p> <p>Providers have also been contacted and arrangements are being made with larger</p>	Item 6	

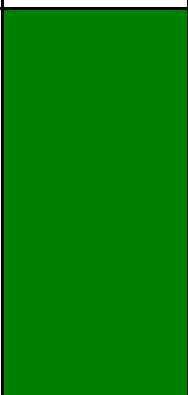
Mr. Y Investigation Report

Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
			<p>providers for them to attend meetings with the FIRT team on a 3 monthly basis to ensure good communication.</p> <p>In July 2011 four team leaders from Imagine met with the Forensic Integrated Resource Team to discuss service users open to both teams.</p>	<p>Item 24 minutes of meeting with Imagine</p>	
<p>The Forensic Integrated resource Team should ensure that all service providers have copies of all current CPA.</p>	<p>FIRT Manager</p>		<p>All current care plans and CPA documentation have been printed and sent with the Care Co-ordinator and given to the provider. A section has been included in the MSU/FIRT CPA Guidelines and revised Care Plans. This has ensured that roles of professionals and service providers are explicit and that providers and service users are well informed and understand roles.</p>	<p>Item 35 Team meeting minutes.</p>	
<p>Handover of clinical care</p> <p>Risk and early Warning signs information should be shared with providers in the community prior to discharge into the community.</p>	<p>FIRT Manager</p>	<p>July 2011</p>	<p>Staff from Scott Clinic will meet with providers and discuss early warning signs and CPA risk assessment documentation and support the provider with the development of their Care Plan to manage any risks.</p> <p>A section has been included in the MSU/FIRT CPA guidelines document. This has also been incorporated in to the guidelines for interface between Mersey Forensic Psychiatric service and secondary services</p>	<p>Item 25 Scott Clinic Guidance for the Interface with Secondary and Third Sector Services.</p> <p>Item 36 Team meeting minutes of providers attendance.</p>	

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Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
<p>The Forensic service should support identified training needs of staff at Imagine.</p> <p>In addition the service should consider developing a package of training that is available on to request to all services providers working with community service users discharged from Scott Clinic.</p>	Head of Education and Training	October 2011	A package of appropriate training for providers has been devised and has been delivered to staff at Imagine.	Item 21 Programme of training delivered to Imagine	
<p>Links between Scott Clinic, CJLS, and involvement in MAPPA need to be robust and guidelines developed to support staff to ensure the service adheres to national and local policy and guidelines.</p> <p>Develop guidance for services within SaFE Partnerships CBU</p>			<p>Guidance for Scott Clinic and the FIRT has been developed with support from Mark Sergeant MAPPA lead (Mersey Care NHS Trust).</p> <p>Guidelines have now been agreed. This includes PNC Markers, MAPPA and E-Pex warnings and is tied into the CPA process and medical reviews.</p> <p>A PNC and MAPPA review sheet has been developed. For practitioners to use at CPA and Medical reviews and is included in the guidance.</p> <p>A section has also been included in the MSU FIRT CPA Guidelines to ensure consistency.</p>	Evidence item 26 MAPPA Guidance	

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Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
<p>Clear protocols re arrangements with partners should be included in existing interface guidelines between secondary and third sector services.</p>	<p>FIRT Manager</p>	<p>July 2011</p>	<p>Section has been included in Scott Clinic/FIRT Interface Guidelines. Document currently covers interface with secondary statutory services. An additional section covers third sector interface and the responsibility of our service to share early warning signs.</p> <p>Section 4.10 has been added to the reviewed Interface Guidance for MSU/FIRT and other services.</p>	<p>Item 25 Scott Clinic Guidance for the Interface with Secondary and Third Sector Services.</p>	

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Recommendation (5)

The Mersey Forensic Psychiatry Service should routinely participate in benchmarking exercises against other medium secure units with regard to both operational and management arrangements

Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
Benchmark service against other similar service providers	Consultant Forensic	December 2011	<p>The Forensic Quality Network already exists and the Mersey Forensic Psychiatry Service, Scott Clinic, is part of this network. The network looks at benchmarking, quality and learning outcomes across all MSUs.</p> <p>Mersey Forensic Psychiatry Service to approach Reaside Clinic, Birmingham, to engage in an additional benchmarking exercise</p> <p>Following an approach to Reaside Clinic, the Regional Secure Unit covering the West Midlands, a meeting was held there on 10 October 2011. This was an opportunity to discuss a variety of issues including risk assessment and formulation, use of leave, the processes around these decisions and management of serious untoward incidents. It was clear that there was little difference in the general approaches and outcomes for the two services. Although routinely using the HCR-20 to guide risk management, it was apparent that Reaside Clinic did not focus on the formulation-driven approach that we are currently moving towards. Reaside Clinic used leave slightly differently, with service users going out less often but for longer.</p>		

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Recommendation (6)

The Governance arrangements integral to the Scott Clinic need to be reviewed, strengthened and aligned with the corporate processes and system adopted by all services in Mersey Care NHS Trust. The review should ensure that all the safety regulations are being met as part of the registration requirements of the Care Quality Commission and detailed assurance provided to the Board of Mersey Care NHS Trust that the requirements have been satisfied.

Action	Person Responsible	Timescale	Progress/Current Position	Evidence Log	RAG rating
Review of SaFE Partnerships CBU Governance arrangements.	Clinical Director Service Director		<p>The governance arrangements have been reviewed and developed in line with Mersey Care NHS Trust corporate processes and systems.</p> <p>The new leadership arrangements and clear responsibility for Governance arrangements will support this.</p>	Evidence item 27. Governance Structure.	

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Recommendation (7)

That the Trust ensures that robust systems are in place to give assurances that all Trust wide policies are implemented and adhered to throughout Mersey Care and that audit arrangements evaluate compliance

Action	Person Responsible	Timescale	Progress/Current Position	Evidence	RAG rating
<p>Procedures to include a section outlining the approach to evaluating compliance and the effectiveness of the corporate procedural document. The outcomes of this process will be presented to the Integrated Governance Committee as assurance of compliance with policy standards.</p> <p>The Corporate Procedural Document Review Group has been allocated responsibility for ensuring and monitoring all corporate policy implementation plans. The Compliance Analyst seeks assurance reports from policy authors on compliance with implementation plans and reports to the group accordingly. The outcomes of this process are reported to the Integrated Governance Committee as required.</p>	Trust Secretary	Completed	<p>Following appropriate lead times for implementation of relative policies.</p> <p>Completed</p>		

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Recommendation (8)

The Trust Board considers the need for any further action it may wish to take following receipt of this report.

Action	Person Responsible	Timescale	Progress/Current Position	Evidence	RAG rating
The report has been sent to the Trust Board and the actions will be monitored by the Integrated Governance Committee.					

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Appendix 3

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Membership

The Committee shall be appointed by the Board and will consist of four Non-Executive Directors, one of which shall be appointed Chair of the Committee. The Trust's Chairman shall not be a member of the Committee.

At least one Committee member will be a member of the Clinical Governance Committee.

The membership of the Committee will be disclosed in the annual report.

3. Quorum

A quorum shall be three members.

4. Attendance

Non-Executive Directors may attend without invitation (but will not retain the rights of full members when attending).

The Executive Director of Finance and Performance; Executive Director of Nursing and appropriate Internal and External Audit representatives shall normally attend meetings. At least once a year the Committee should meet privately with the External and Internal Auditors.

The Chief Executive and other Executive Directors should be invited to attend, when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.

The Trust Secretary shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Committee Chair and Committee members.

Required attendance is at least 3 meetings per year.

Priority is to be given to attendance at these meetings. Deputies are permitted in the event of a Committee member being unable to attend, but must be a Non-Executive Director. Identified deputies will retain the full rights of members when attending.

The Committee Chair will nominate an appropriate Deputy Chair (Non-Executive Director).

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5. Frequency

Meetings shall be held six times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

6. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and will utilise this authorisation rigorously should the need arise.

The Committee is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Duties

The Audit Committee will act as the central means by which the board is assured that effective internal control arrangements are in place and provide a form of independent check upon the executive arm of the board. It will achieve this by:

7.1 Governance, Risk Management and Internal Control

- 7.1.1 Concluding upon the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
- 7.1.2 Reviewing the adequacy of all risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with Standards for Better Health), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- 7.1.3 Reviewing the adequacy of underlying assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements within the organisational priority areas of:
 - 7.1.3.1 Authentic Engagement;
 - 7.1.3.2 Patient Experience;
 - 7.1.3.3 Workforce Development;
 - 7.1.3.4 Governance and Public Accountability;
 - 7.1.3.5 Finance;
 - 7.1.3.6 Estate and Environment;
 - 7.1.3.7 Service Transformation;
 - 7.1.3.8 Business Development;
 - 7.1.3.9 Creativity and Innovation.
- 7.1.4 Reviewing policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; as well as policies for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.
- 7.1.5 Reviewing Committees of the Board in meeting their terms of reference, and supporting the delivery of strategic objectives.

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- 7.1.6 Reviewing the effectiveness of the organisational risk management function as a whole system.
- 7.1.7 Reviewing systems to ensure compliance with the requirements of the Auditors Local Evaluation (ALE) standards taking particular note of assurances relating to the organisational approach to its use of resources and ensuring value for money.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.2 Internal Audit

Ensuring an effective internal audit function is established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- 7.2.1 Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- 7.2.2 Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- 7.2.3 Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- 7.2.4 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- 7.2.5 Annual review of the effectiveness of internal audit.

7.3 External Audit

Reviewing the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

- 7.3.1 Consideration of the appointment and performance of the External Auditor, as far as the Audit Commission's rules permit;
- 7.3.2 Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy;
- 7.3.3 Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
- 7.3.4 Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

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7.4 Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Healthcare Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.). As a Mental Health Trust the Committee will seek to take specific note of assurances relating to Mental Health Act compliance arising from the work of the Mental Health Act Commission.

In addition, the Committee will review the work of other board committees, whose work can provide relevant assurance to the Audit Committee's own scope of work. The committee will satisfy itself that its work and that of other committees are co-ordinated to avoid duplication or omission. In reviewing issues relating to clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

7.5 Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

7.6 Financial Reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- 7.6.1 The wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee;
- 7.6.2 Changes in, and compliance with, accounting policies and practices;
- 7.6.3 Unadjusted mis-statements in the financial statements;
- 7.6.4 Major judgemental areas;
- 7.6.5 Significant adjustments resulting from the audit.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

8. Reporting

The (draft) minutes of Audit Committee meetings shall be formally recorded by the Trust Secretary and submitted to the Board, supported by a Chairs Report highlighting:

- i. key risks identified through the work of the Committee;
- ii. the impact of assurance reports received relating to existing risks in the Corporate Assurance Framework;
- iii. any issues that require disclosure to the full Board, or require executive action.

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The Committee will report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Standards for Better Health.

The Committee will outline the work of the Committee to the Board through an annual work plan and will formally report progress against the work plan by means of bi-annual monitoring reports. Any amendments to the work plan will be discussed and approved by the Board.

The Committee will provide assurance to the Trust Board of compliance with the requirements of these terms of reference through the development and presentation of an Audit Committee Annual Report, presented at the end of the financial year.

There are no board sub-Committees which report to the Audit Committee.

9. Other Matters

The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- i. agreement of agenda with Chairman and attendees and collation of papers;
- ii. taking the minutes & keeping a record of matters arising and issues to be carried forward;
- iii. advising the Committee on pertinent areas;
- iv. ensuring the committee receives sufficient resources to undertake its duties;
- v. management of the Audit Committee work plan;
- vi. identifying and agreeing new ways of working to enable the committee to meet the wide range of responsibilities set out in these terms of reference;
- vii. support existing and new members to meet the knowledge and skills requirements for their role within the committee;
- viii. to collate the annual report of the Committee.

Any proposed amendments to these Terms of Reference must be agreed by both the Audit Committee and the Trust Board.

10. Date of Review

These Terms of Reference are to be reviewed annually. Date for review March 2010.

Appendix 4

**Clinical Governance Committee
Terms of Reference**

1. Constitution

The Board hereby resolves to establish a Committee of Board to be known as the Clinical Governance Committee (The Committee). The Committee is an assurance Committee of the Board and has only those powers specifically delegated in these terms of reference. The Committee reports directly to the Trust Board.

2. Membership

The membership of the Clinical Governance Committee shall be appointed by the Trust Board from amongst the Non-Executive Directors and Executive Directors. Membership will consist of:

- i. four Non-Executive Directors (including a member of the Audit Committee);
- ii. Medical Director/ Deputy Chief Executive;
- iii. Executive Director of Nursing and Care;
- iv. Executive Director of High Secure Services;
- v. Executive Director of Service Development and Delivery;
- vi. Director of Workforce.

The Medical Director is the appointed Chair of the Committee, the Executive Director of Nursing and Care is the appointed Deputy Chair.

3. Quorum

A quorum shall be four members, of which two shall be Executive Directors or their representatives and two shall be Non-Executive Directors.

4. Attendance

Non-Executive Directors may attend without invitation. The following will normally attend the meeting:

- i. Risk Manager;
- ii. Governance Manager;
- iii. Chief Pharmacist;
- iv. Assistant Chief Executive – Complaints Claims and Incidents;
- v. Infection Control Nurse Manager;
- vi. A Service User or Carer;
- vii. Director, Service Users and Carers;
- viii. A staff representative;
- ix. Trust Secretary.

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Any manager may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that manager.

Required frequency of attendance is at least 80% of meetings a year.

Priority is to be given to attendance at these meetings. In the event of a Committee member being unable to attend nominated deputies will be permitted. Deputies attending will not retain the voting rights of committee members.

5. Frequency

Meetings shall be held no less than six times a year.

6. Authority

As a Committee of the Trust Board, the Committee will

- i. make recommendations to the Board;
- ii. develop and approve policy;
- iii. monitor and hold to account;
- iv. identify key risks which require inclusion in the Corporate Assurance Framework;
- v. enhance controls and assurances of clinical risks identified in the Corporate Assurance Framework;

The Board delegates the above functions to the Committee. The Board also delegates decisions that are not of a significant nature. In practice, what is significant will depend upon the judgment of members but the Committee must refer the following types of issue to the Trust Board:

Any matter which will:

- i. change the strategic direction of the Trust;
- ii. conflict with strategy obligations;
- iii. contravene National policy decisions or Governmental directives;
- iv. have significant revenue implications;
- v. have significant governance implications;
- vi. are likely to arouse significant public or media interest;
- vii. any other issue the Board reserves to itself under the Statement of Reservation and Delegation.

7. Duties:

The committee will provide assurances to the Trust Board through delegated responsibilities that the safety, quality of care, treatment and services provided by the Trust and the experiences of Services Users, Carers and Staff are of a high standard by establishing and maintaining standards. It will achieve this by:

- 7.1 Developing and overseeing the implementation of an organisational Clinical Governance Strategy (incorporated into the Integrated Governance Strategy).

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- 7.2 Ensuring organisational and Clinical Business Unit level compliance with all externally defined standards relating to:
 - 7.2.1 Standards For Better Health;
 - 7.2.2 NHS Litigation Authority;
 - 7.2.3 Information Governance and Caldicott requirements;
 - 7.2.4 Research Governance.
- 7.3 Ensuring and reviewing Clinical Governance arrangements operating at all health and social care bodies with which Mersey Care has a contract or partnership and in areas where there is a cross organisational service.
- 7.4 Developing and monitoring improvement measures/ quality improvement and target performance measures in the areas of PPI; Clinical Risk Management; Adverse Incident Reporting; Complaints; Claims; Staffing and Staff Management; Education and Training; CPD and the Use of Information.
- 7.5 Monitoring and developing the service user and carer involvement strategy.
- 7.6 Ensuring an appropriate PALS service and utilising information arising from this function to develop and improve services.
- 7.7 Ensuring the effective provision of information relating to treatments, services and facilities to service users and carers.
- 7.8 Developing and approving policies in the areas of: Service Administration; Information Management, Technology and Governance; Service Delivery; Infection Control; Mental Health Act and Mental Capacity Act.
- 7.9 Approval and monitoring of the outcomes of the annual organisational clinical audit programme.
- 7.10 Receiving and monitor progress against reports from external agencies such as the Care Quality Commission, professional bodies etc.
- 7.11 Ensuring action is taken as a result of external guidance e.g. NICE; National Confidential Enquiries, NPSA etc; and receive reports justifying any proposal to continue clinical practice within the Trust contrary to the guidance.
- 7.12 Ensuring that nationally and (locally) agreed best practice is taken into account when planning and delivering care.
- 7.13 Developing and overseeing the implementation of an organisational Research and Development Strategy.
- 7.14 Ensuring compliance with Research Governance standards.
- 7.15 Receiving and monitoring the outcomes of the annual staff and service user survey.
- 7.16 Monitoring and ensuring the delivery of mandatory learning and development.
- 7.17 Developing and overseeing the implementation of a knowledge management strategy.
- 7.18 Ensuring the quality in prescribing and medicines management within the Trust.
- 7.19 Ensure effective systems and processes for the protection of children and vulnerable adults.
- 7.20 Monitoring and ensuring appropriate action for lapses in quality identified through the systems of complaints, claims and incidents and make recommendations for improvements.

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- 7.21 Providing a forum within which health community wide clinical quality issues and governance issues can be identified and responded to.
- 7.22 Ensure compliance with the National and Local requirements for improvements in patient safety.
- 7.23 Seek assurance of compliance with legislative requirements in relation to the Mental Health Act; Health and Safety; Infection Control; Drugs and Therapeutics; Research Governance and Information Governance through oversight of the following sub-committees:
 - 7.23.1 Mental Health Act Managers Committee;
 - 7.23.2 Health and Safety Committee;
 - 7.23.3 Infection Control Committee;
 - 7.23.4 Drugs and Therapeutics Committee;
 - 7.23.5 Research Governance Committee;
 - 7.23.6 Information Governance and Caldicott Committee.

8. Reporting

The (draft) minutes of the Clinical Governance Committee meetings shall be formally recorded by the Trust Secretary and submitted to the Clinical Governance Committee, supported by a Chairs Report highlighting:

- i. key risks identified through the work of the committee which are recommended for inclusion in the Corporate Assurance Framework;
- ii. the impact of assurance reports received relating to existing risks in the Corporate Assurance Framework;
- iii. any enhanced controls related to existing risks in the Corporate Assurance Framework;
- iv. any issues that require disclosure to the full Board via an exception report.

The work of the Committee will be outlined to the Trust Board through an annual work plan (updated bi-annually) and will formally report progress against the work plan by means of an Annual Report. The Committee Chair is responsible for the development of the Annual Report.

9. Other Matters

The Committee may set up permanent groups or time-limited working groups to deal with specific issues and report back to it. Precise Terms of Reference for these shall be determined by the Committee and approved by the board. However, the Clinical Governance Committee is neither entitled to further delegate its powers to other bodies nor establish additional sub-committees unless expressly authorised by the Trust Board. Authorised sub-committees include: Mental Health Act Managers Committee; Health and Safety Committee; Infection Control Committee; Drugs and Therapeutics Committee; Research Governance Committee; Information and Caldicott Guardian Committee.

The Clinical Governance Committee will as a minimum annually review the Terms of Reference of its sub-committees, agree their annual objectives and receive their Annual Reports. It will ensure that these groups are able to report to the Governance Committee and through them to the Board, significant risks or other issues of concern.

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The Committee shall be supported administratively by the Trust Secretary, whose duties in this respect will include:

- i. agreement of Agenda with the Chairman and attendees plus collation of papers;
- ii. taking the Minutes and keeping a records of Matters Arising and issues to be carried forward;
- iii. advising the Committee on pertinent areas;
- iv. ensuring that the Committee received sufficient resources to undertake its duties;
- v. development and management of the annual Clinical Governance work plan;
- vi. identify and agree new ways of working to enable the Committee to meet the wide range of responsibilities set out in these Terms of Reference;
- vii. to support new and existing members of the Committee to meet the knowledge and skills requirements for their role within the Committee;
- viii. to collate the Annual Report of the Committee for presentation to the Trust Board.

The Committee will provide assurance to the Trust Board of compliance with the requirements of these terms of reference through the development and presentation of a Clinical Governance Committee Annual Report.

The Committee Chair is responsible for the development of the Annual Report, which will be presented to the Trust Board for consideration at the end of the financial year.

Any proposed amendments to these Terms of Reference must be agreed by both the Clinical Governance Committee and the Trust Board.

10. Audit Committee Review

The chair will ensure that the committee supports the requirements of the Audit Committee in its annual review of effectiveness of the Clinical Governance Committee in meeting these Terms of Reference.

In addition the committee will take note of the Audit Committee terms of reference to avoid duplication of effort or omission of coverage.

11. Date of Review

The Terms of Reference are to be reviewed annually. Date for review February 2008.

Updated July 2008