

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Ms H

A report for
NHS England, Midlands and East Region

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1. Introduction

Ms H killed her mother, AH. The actual date of the homicide is unclear as her mother was not found for some days. The death was discovered on 5 July 2009 and Ms H was arrested. Ms H and her mother had lived in the same house since 2007. Ms H's clinical notes describe her as a carer for her mother. Her mother was also receiving care from her GP and the district nursing services for dementia.

Ms H suffers from a bipolar affective disorder and had a 20-year history of contact with mental health services at the time of the incident. During that time she was admitted to hospital 17 times. 11 of these admissions were under Section 2¹ or Section 3² of the Mental Health Act 1983. She had no criminal record and her contact with the police was related to her need for hospital admission.

Between her first contacts with services in 1988 until 2007, Ms H was under the care of Sandwell Mental Health NHS and Social Care Trust.

She moved in with her mother in 2007 and her care was transferred to Birmingham and Solihull Mental Health NHS Foundation Trust. Ladywood community mental health team (CMHT) cared for Ms H at the time of the homicide.

Consultant psychiatrist 1, a consultant psychiatrist with Sandwell assertive outreach team described Ms H in 2007 as "an intelligent woman with good insight into her illness and having a strong catholic faith".

Consultant psychiatrist 2 diagnosed Ms H with hypothyroidism (underactive thyroid gland) in June 2009. She was placed on thyroid hormone replacement therapy just over a month before she killed her mother.

Ms H was convicted of manslaughter by reason of diminished responsibility after the homicide and was detained in a medium secure facility on sections 37 and 41³ of the Mental Health Act. Ms H remained in the medium secure unit for four years. At the time of this report, Ms H remains on sections 37 and 41 of the Mental Health Act but has been stepped down in care to a secure hostel.

1.1 Background to the independent investigation

NHS England, Midlands and East Region commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries to independently investigate the care and treatment of Ms H.

¹ Under a Section 2 of the Mental Health Act a person can be detained in hospital for up to 28 days for assessment of their mental health and to get any treatment they might need.

² Under a Section 3 of the Mental Health Act a person can be detained in hospital for treatment for up to six months. Treatment might be necessary because of mental health need, to keep the person safe or for the protection of other people.

³ A Section 37 is a hospital order that is an alternative to a prison sentence. The subject is sent to hospital instead of prison. A crown court judge can add a Section 41 restriction order to this, making the Section a 37/41, if they think a person is high risk and is worried about public safety.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and its updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in section 2 of this report.

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

An independent investigation is normally commissioned following and close to the completion of the Trust investigation but this independent investigation was commissioned and completed five years after Birmingham and Solihull Mental Health NHS Foundation Trust completed a joint internal review into the incident with Birmingham City Council.

1.2 Overview of the Trust

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health care to those people living in Birmingham and Solihull.

The Trust provides services to a population of 1.2 million people spread over 172 square miles. It operates from over 60 sites in a variety of settings, from community based mental health teams to acute wards and day centres. It also provides a forensic service and manages the local regional secure unit.

2. Terms of reference

- Review the trust's internal investigation recommendations and any action plan.
- Compile a chronology of events leading up to the homicide if not already available or review the existing chronology.
- Review the progress that the trust has made in implementing the recommendations and the learning from their internal investigation.
- Review the care, treatment and services provided by the NHS from the service user's first contact with services to the time of their offence.
- Review the appropriateness of the treatment of the service user in light of any identified health needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Examine the effectiveness of the service user care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate.
- Consider if this incident was either predictable or preventable.
- Provide a written report to NHS England that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.

We have outlined the chronology of Ms H's care from when she was first involved with services, but have focused on the Trust's care of her from 2007. A summary chronology of her care prior to 2007 is included in appendix A.

Ms H was an only child and has no children. Her father died in 2002 and her mother was the victim of the homicide. Her clinical records did not indicate any other family involvement. We contacted Ms H's present care coordinator, care coordinator 1, who was not aware of other family involvement.

We conclude at the time this report is published, that there is no family for us to contact. Should Ms H identify family or any of her family members respond to the publication of this report, we will share our findings with them.

3. Approach of the independent investigation

3.1 Background

The first record of contact between Ms H and mental health services was in 1988. She was diagnosed with a bipolar illness in 1991. She suffered multiple relapses of her condition between then and 2005. Most of these relapses required hospital admission. Ms H engaged with assertive outreach services in 2005 in Sandwell, where she was living at the time.

Ms H moved in with her mother in 2007 and her care was transferred to Birmingham and Solihull NHS Trust. The focus of our investigation is the care Ms H received after her transfer to Birmingham and Solihull NHS Trust services in 2007 until the homicide.

On transfer in July 2007 Ms H was eligible for Section 117¹ aftercare under the Mental Health Act. This would have required the involvement of mental health social workers that Birmingham City Council manages. As a consequence, after the homicide, Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham City Council carried out a joint internal review of Ms H's care. This internal investigation resulted in a report published in August 2010 that was delivered to the Trust and the city council.

The report was also presented to the West Midlands Strategic Health Authority. This body commissioned independent investigations into homicides under the Department of Health guidelines referenced above. The Trust told us the inclusion of an independent member on the joint internal review led the West Midlands Strategic Health Authority in 2010 to consider that a full independent homicide review was not needed. This was contrary to the guidance in HSG (94) 27.

NHS England, Midlands and East Regional Team took over the responsibility for commissioning independent homicide reviews in 2013. They decided a full independent review was needed.

A panel of six senior trust and council personnel and an additional service user representative conducted the initial joint internal review. The Trust's medical director led the review. The panel also recruited an independent consultant (not employed by the trust) who is an expert in community mental health care.

The internal review received written and oral evidence from thirteen health professionals involved with Ms H's care. The internal review panel was unable to interview care coordinator 2, Ms H's care co-coordinator in the Ladywood CMHT at time of transfer from Sandwell services. Ms H was also too unwell to be interviewed at the time of the internal review.

¹ Section 117 of the Mental Health Act stipulates that services have a duty to provide aftercare for a person who had been admitted under Section 3 of the Mental Health Act. This can only be rescinded if there is a formal meeting which concludes that aftercare is no longer needed. Ms H had many admission and several under Section 3.

NHS England considered the joint review that Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham City Council carried out into Ms H's care was thorough and took evidence from a wide range of sources. We agreed with the findings from the joint review, but have reservations about the final recommendations.

When commissioning this investigation, NHS England, Midlands and East Region told Verita that the original investigation had been well led and generally of good quality. Verita agrees, with the exception of the recommendations and action plan, which will be discussed later in this report.

The joint internal review identified a number of organisational issues that affected Ms H's care: Key to these were:

- The community mental health team did not have enough care coordinators to serve the size of the population it was overseeing.
- The medical staff in the community mental health teams were spending too much time treating clients with low-level mental health problems.

The homicide happened five years before the commissioning of this report and personnel and services in Birmingham and Solihull Mental Health NHS Trust have changed considerably in that time. Therefore, NHS England, Midlands and East Region and Verita agreed that this investigation would not be able to fully replicate the Trust's internal review of Ms H's care, but would be able to provide assurance about key issues.

NHS England, Midlands and East Region and Verita agreed that this investigation would concentrate on the key themes identified in Ms H's care from the Trust and city council's joint internal review.

3.2 Methodology

NHS England, Midlands and East Region and Verita agreed that the original clinical notes and trust documentation and the joint review contained the information necessary for our investigation and that further interviews of staff involved would not add to the information already available.

Verita held a meeting with the Trust on 13 January 2015 to agree how to proceed with the investigation. A draft methodology was proposed at that meeting which was refined over the following weeks between Verita, the Trust's head of investigations and the team manager of the Ladywood and Handsworth community mental health team.

We did the following to meet the terms of reference.

- A desktop review of Ms H's clinical notes to review her care and provide assurance of the findings of the joint internal review carried out by Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham City Council.

- A review of Ladywood and Handsworth community mental health team's¹ caseload and patient 'Health of the Nation Outcome Scale'² (HoNOS) profiles available on the Trust's dashboard³ to assess the changes taken place since the incident.
- Met the manager of Ladywood and Handsworth community mental health team, team, to clarify details of the care coordinators, their nursing grades and roles in the team.
- We performed a case note review of integrated care electronic records of ten patients in community services who would be considered eligible for assertive outreach services. This review focused on risk assessment, risk management and care planning. This was done to provide assurance on some of the key themes identified in the joint internal review, chapter 13 summarises it.
- Conducted two focus groups – one for medical staff and one for allied professionals. These focus groups examined general capacity and practice in the community mental health services for Ladywood and focused on management of complex high needs clients. The allied professional group included staff from the community mental health teams, assertive outreach teams, and the early interventions team.

The community mental health team asked us during our investigation to conduct a separate group meeting for workers who were in the Ladywood CMHT at the time of the homicide. The Trust agreed to allow us to conduct this meeting so workers affected by the original incident were given a forum to understand the independent investigation and to reflect on changes since the homicide.

The Trust also supplied several other documents pertinent to the themes of the investigation. These are listed in appendix B.

We contacted Ms H during the investigation. NHS England, Midlands and East Region told us that she is now living back in the community.

We advised Ms H to discuss our investigation with her clinical team, which she did. Ms H's clinical psychologist contacted us in July 2015 and told us they had discussed the investigation at some length. Ms H decided she did not want to contribute to our investigation and did not want to receive the final report. We also spoke to her present care coordinator who confirmed Ms H did not want to meet us.

¹ Since the incident in 2009 Ladywood CMHT and Handsworth CMHT have amalgamated into one team – the Ladywood and Handsworth CMHT.

² HoNOS is a scale used by mental health services to measure the health and social functioning of people with severe mental illness.

³ This 'Dashboard' is an up to date electronic record of the caseloads of each care coordinator which can be accessed by team leaders and senior managers. The dashboard contains a breakdown of each care coordinators caseload and gives each client a rating of mental health need derived from their score on the Health of the Nation Outcome Scale.

4. Executive summary and recommendations

Ms H killed her mother, AH. The actual date of the homicide is unclear as her mother was not found for some days. The death was discovered on 5 July 2009 and Ms H was arrested.

Ms H and her mother had lived in the same house since 2007. Ms H's clinical notes describe her as a carer for her mother. Her mother was also receiving care from her GP and the district nursing services for dementia.

Ms H suffers from a bipolar affective disorder and had a 20-year history of contact with mental health services at the time of the incident.

The first record of contact between Ms H and mental health services was in 1988. She was diagnosed with a bipolar illness in 1991. She suffered multiple relapses of her condition between then and 2005. Most of these relapses required hospital admission. Ms H engaged with assertive outreach services in 2005 in Sandwell, where she was living at the time. Ms H moved in with her mother in 2007 and her care was transferred to Birmingham and Solihull NHS Trust.

The terms of reference for this investigation requested Verita to:

“Review the care, treatment and services provided by the NHS from the service user's first contact with services to the time of their offence.”

To fulfil this part of the ToR we have focused on care of Ms H from and including her transfer from Sandwell assertive outreach team to the Ladywood community mental Health team run by Birmingham and Solihull NHS Foundation Trust. This covers the period of 2007 until 2009. We have supplied a chronology of her mental health care prior to this period in appendix A

The homicide happened five years before the commissioning of this report and personnel and services in Birmingham and Solihull Mental Health NHS Trust has changed considerably in that time. Therefore our commissioners agreed that as well as carrying out a desk top review of Ms H's clinical notes, we should seek assurance that the key themes identified in Ms H's care from the Trust and Birmingham city council's joint internal review, have been effectively addressed. This review reported in August 2010 and interviewed all the relevant people involved in MS H's care as well as a number of managers.

Our review had the following components.

- A desktop clinical review of Ms H's clinical notes.
- A review of Ladywood and Handsworth community mental health team's¹ caseload.

¹ Since the incident in 2009 Ladywood CMHT and Handsworth CMHT have amalgamated into one team – the Ladywood and Handsworth CMHT.

- Sought evidence of the make up of the Ladywood and Handsworth community mental health team.
- A case note review of integrated care electronic records of ten patients in community services who would be considered eligible for assertive outreach services.
- Conducted two focus groups – one for medical staff and one for allied professionals, including nursing examining the way that the various community teams were working.

4.1 A desktop clinical review of Ms H's clinical notes

4.1.1 2007

By 2007 Ms H's mental health was stable and she was living with her mother. In March Sandwell assertive outreach team referred Ms H to the Ladywood community mental health team. This was accepted and in June Ms H was seen in out-patients as a new patient. She was seen by senior house officer 1 of the Ladywood community mental health team with the Sandwell assertive outreach worker.

Following transfer, the Sandwell assertive outreach team updated Ms H's records and care plans, shared these with the Ladywell team and maintained regular contact until October. However, there was no multi-disciplinary handover of Ms H's care or a review of her Section 117 aftercare arrangements between Sandwell assertive outreach and Ladywood Community mental health team.

Ms H regularly attended her out patient appointment with senior house officer 1 of the Ladywood community mental health team during which her mental health and risk to self and others was assessed. Ms H was also treated for sleep problems.

In October, psychiatric nurse 1, became Ms H's care coordinator 3 for the Ladywood community mental health team. In November care coordinator 3 began a care plan and risk assessment with Ms H. These were never completed. In December, care coordinator 3 and social worker 1 visited Ms H and her mother to assess Ms H's mother's health but Ms H did not let them talk to her mother.

4.1.2 2008

In February care coordinator 3 saw Ms H and Ms H also attended an outpatient appointment with senior house officer 1. Ms H was stable but having difficulties with sleep and side effects of medication. There were no concerns about her mother.

Ms H was regularly seen by care coordinator 3 until April when social worker 1 became her care coordinator. Prior to handing over, care coordinator 3 completed a care plan for Ms H. The care plan was not signed by Ms H or care coordinator 3.

Ms H was seen by senior house officer 1 in May where she was said to be stable.

Social worker 1 visited Ms H regularly from May until September and Ms H saw senior house officer 1 in outpatients in July. Ms H was generally stable, but her mood was sometimes low. Her risk was assessed by senior house officer 1 and there were no concerns about harm to self or others. Her sleep was normal and she did not complain of side effects of medication.

In September Ms H's care coordinator was changed to community psychiatric nurse 2. In October Ms H was seen in outpatient by senior house officer 1 and said she was feeling low. Her risk was assessed by senior house officer 1 and there were no concerns about harm to self or others.

Psychiatric nurse 2 visited Ms H at home and by November Ms H was stable. Her lithium blood levels were completed and there were no concerns. Ms H said that district nurses were providing home care for her mother.

Psychiatric nurse 2 met Ms H twice in December and there were no concerns.

4.1.3 2009

On 13 January senior house officer 1 saw Ms H in outpatients. Ms H was reasonably stable with slight elation. Senior house officer 1 gave Ms H some extra medication to assist sleep.

Ms H's care coordinator was again changed and psychiatric nurse 3 took over from psychiatric nurse 2. Psychiatric nurse 3 met Ms H on 24 February. Ms H was elated in mood, but said this was normal for her.

Senior house officer 1 saw Ms H in outpatients on 15 April. She was stable in mood. Psychiatric nurse 3 rang Ms H on 27 April and met her on 13 May. She remained stable.

On 14 May Ms H attended clinic for a lithium level blood test. On 28 May the results indicated she had a lithium-induced thyroid problem. Consultant psychiatrist 2 met Ms H on 2 July to discuss this. Consultant psychiatrist 2 offered to stop prescribing lithium, but Ms H wanted to continue. Consultant psychiatrist 2 wrote to Ms H's GP and advised her to see the GP for future help with the thyroid problem.

Psychiatric nurse 3 saw Ms H on 11 June. Ms H was pleasant and stable. Psychiatric nurse 3 saw Ms H's mother during the visit. There were no concerns.

On 5 July Ms H was arrested following the discovery of her mother's death.

We have identified the following themes arising from this chronology:

- transfer of care from Sandwell assertive outreach team to Ladywood community mental health team;
- risk assessment, care planning and the care programme approach;
- risk to Ms H's mother;
- medical care and treatment to Ms H; and
- predictability and preventability.

4.2 Transfer of care from Sandwell assertive outreach team to Ladywood community mental health team

It is clear from the records that when Ms H moved to her mother's home the Sandwell assertive outreach team worked hard to ensure a smooth transfer. They continued to support Ms H and the new team looking after her from June 2007 until 30 October 2007.

Ms H was transferred from an assertive outreach team to a community mental health team which offered less intensive care but it is our view that this was appropriate as Ms H was more stable and could now be stepped down.

4.3 Risk assessment, care planning and the care programme approach

Although we consider Ms H's transfer of care to be appropriate, we would expect to be able to track the change in Ms H's care through a comprehensive record of care planning and risk assessment carried out under the care programme approach. This was not the case.

We found evidence in the records that the Ladywood community mental health team engaged and assessed Ms H's needs and attempted to meet them, but this was not coordinated or monitored as would be expected under the care programme approach. As a consequence, there is no record of risk assessment and management or effective care planning.

4.4 Risk to Ms H's mother

Whilst the records indicate that the Ladywood CMHT had regular contact with Ms H's mother there is no record that they assessed the risk that Ms H may pose to her. Ms H was eligible for a carer's assessment that would have helped determine if she was capable of looking after her mother. This did not happen.

Since these events this trust and nationally safeguarding procedures for vulnerable adults have been put in place and it is likely that if they had been in place then a safeguarding alert would be made. This would lead to an assessment of the risks that her mother faced along with a plan to mitigate the risks.

4.5 Medical care and treatment to Ms H

A client with Ms H's diagnosis and history of non-engagement would normally be expected to be monitored by a consultant psychiatrist. On transfer in 2007, Ms H was not seen by consultant psychiatrist 2, her consultant. Instead she was seen by senior house officer 1, who was a more junior doctor working under the supervision of consultant psychiatrist 2.

Following this, senior house officer 1 appropriately monitored Ms H's mental state and risk to self and others and was diligent in keeping Ms H's GP fully informed of her presentation in out-patient appointments.

Consultant psychiatrist 2 did meet with Ms H in June 2009 when Ms H developed a lithium-induced thyroid problem and provided appropriate care for this.

4.6 Predictability and preventability

In the weeks leading to the homicide, Ms H gave no indications to the Ladywood community mental health team workers that she would be imminently violent.

The team did not consider Ms H's mother to be at risk and there was no indication of risk in the meetings with the community mental health team in the weeks leading up to the incident

4.7 Findings

F1 When Ms H was transferred from Sandwell assertive outreach team to Ladywood CMHT the lack of a formal multidisciplinary handing over of care coordination and review of section 117 was a major error in her care.

F2 The assertive outreach team in Sandwell were able to show that Ms H had 'stepped down' in terms of service provision because she was engaged, with services and compliant with treatment and had not been admitted for two years. The transfer of care of Ms H from Sandwell assertive outreach team to Ladywood community mental health team, thereby stepping down her care level, was appropriate.

F3 The absence of a comprehensive care plan and risk assessment during Ms H's care in the Ladywood community mental health team are significant failures given Ms H's history and presentation.

F4 The records do not always record decisions taken by the clinical team or record when actions agreed have been carried out. This is poor practice and can increase the risk that clients do not get the appropriate support and care they require.

F5 Ladywood community mental health team maintained regular contact with Ms H while she lived with her mother. However, they failed to fully assess if Ms H was a risk to her mother.

F6 We found no evidence that Ms H had a carer's assessment to determine if she was capable of providing the support her mother needed.

F7 Safeguarding vulnerable adult procedures were still in development at the time of the incident and there were no arrangements in place for the team to make a safeguarding alert as is likely would happen now.

F8 The medical care provided to Ms H was appropriate to her needs. Senior house officer 1 oversaw the majority of Ms H's medical care and showed good practice in keeping Ms H's GP fully informed after outpatient appointments. Consultant psychiatrist 2 provided senior medical assistance when Ms H developed a lithium-induced thyroid problem.

F9 It would have been best practice if consultant psychiatrist 2 had seen Ms H at least on transfer from Sandwell assertive outreach team due to her complex history and enduring mental health problems.

F10 We conclude that the homicide of AH could not have been predicted because we found no evidence from Ms H's words, actions or behaviours that could have alerted the professionals that she would become imminently violent.

F11 We conclude it was not possible for community mental health team staff to have prevented the death of Ms H's mother.

F12 The Trust and the council carried out a detailed joint internal review.

F13 The Trust review makes recommendations in both its summary of the themes and again in the action plan. These are not well cross-referenced. The result is that the actions are unclear and there is no process set out to assure that the actions listed have been effectively addressed.

4.8 The work of the Ladywood Community Mental Health Team

In seeking assurance that the themes identified by the Trust and Birmingham City Council review have been effectively addressed we have reviewed the following themes:

- Care coordinator caseloads and distribution of complex cases in the Ladywood and Handsworth Community Mental Health Team;
- Medical input into complex cases;
- Present management of referrals and transfer of care;
- Social work input to CMHT and section 117 monitoring; and
- Care planning and risk assessment.

4.9 Findings

F14 The structure and function of the community mental health teams has changed little since the Ms H incident. The focus of the consultant psychiatrist role is not in line with national models because it does not focus on the care of the most complex clients.

F15 The medical team members of the CMHT are dealing with large caseloads of low need clients consistent with the findings of the internal review. However, this is not isolated to the Ladywood and Handsworth team.

F16 Ladywood and Handsworth community mental health team care coordinators have acceptable caseload sizes.

F17 The community mental health team caseload (excluding medical staff) is made up of 93 percent complex clients with high need.

F18 The small number of lower need clients (not being seen by medical staff) are evenly distributed across the team.

F19 Most clients receiving care under the care programme approach are complex clients with high need.

F20 Unlike other teams in the Trust, Ladywood and Handsworth community mental health teams do not have dedicated sessions for care programme approach meetings.

F21 Ladywood and Handsworth team perform an unofficial practice of double booking outpatient medical appointments.

4.10 Recommendations

R1 The Trust and local authority should provide assurance of their compliance with the legal requirement to review patients subject to section 117 of the Mental Health Act.

R2 The medical director should oversee a major review of the function of Ladywood community mental health teams. This must include a clear definition of the role of the consultant psychiatrist and how this role fits with the care of the most complex clients.

R3 The Ladywood and Handsworth community mental health team should have timetabled sessions dedicated to conducting care programme approach meetings.

R4 The Trust's care programme approach should be multi-disciplinary, include the appropriate consultant psychiatrist and also be used for reviews of clients' community treatment orders and section 117 aftercare arrangements.

5. Chronology of care and treatment of Ms H while under Sandwell Mental Health and Social Care Trust until after the killing of her mother

This chronology is extracted from desktop reviews of Ms H's case notes recorded while she was in the care of Birmingham and Solihull Mental Health NHS Foundation Trust and the report of the joint internal enquiry into Ms H's care.

The case notes contain summary information from Ms H's time under the care of Sandwell Mental Health and Social Care Trust, with information Sandwell assertive outreach services sent to the trust at the time of her transfer in October 2007.

Appendix A contains details of Ms H's care from her first diagnosis until her transfer from Sandwell assertive outreach team to Ladywood community mental health team.

5.1 2007 - Transfer from Sandwell AOT to Ladywood CMHT

Consultant psychiatrist 1 referred Ms H to the Ladywood community mental health team on 27 March 2007. Ms H had sold her house and moved in with her mother, who lived in the area.

In the referral letter, consultant psychiatrist 1 wrote:

“Her psychiatric history goes back to 1988 and she has a diagnosis of bipolar affective disorder. She has had at least 17 admissions, principally in the manic phase but over the past 5 years there have been some depressive phases...She has good insight into her condition and presents as an intelligent woman, who has a strong commitment to her Roman Catholic faith”.

Consultant psychiatrist 1 added that when in a manic phase, Ms H could become physically aggressive, sexually disinhibited and that she had damaged property at least once. Consultant psychiatrist 1 detailed her medication, which was Depakote¹ 1g, twice a day and citalopram² 20mgs twice a day. Consultant psychiatrist 1 noted her relapses were usually associated with non-compliance with treatment.

Consultant psychiatrist 1 sent senior house officer 1 a copy of Ms H's care programme approach³ (CPA) and care plan on 28 March as part of the referral. Ms H and MP, a Sandwell assertive outreach team nurse signed both. The CPA

¹ Depakote is a mood stabiliser used to treat bi-polar disorder. It has less side effects than Lithium.

² Citalopram is an antidepressant and is used to treat depression.

³ The Care Programme Approach (CPA) is how services are assessed, planned, coordinated and reviewed for someone with mental health problems. A person under CPA will be allocated a named care coordinator (usually a nurse, social worker or occupational therapist) to manage their care plan. The care coordinator should ensure the CPA care plan is formally reviewed at least once a year. They should also ensure the care plan is recorded and that the person and relevant carers (both family and professional carers) are given copies. The CPA was introduced in 1991 and became mandatory in 1996

documents say Ms H's needs and the interventions needed to meet them were as follows.

- Monitoring of mental health – assertive outreach team to have weekly contact with Ms H and for Ms H to have 'regular contact' with consultant psychiatrist 1.
- Accommodation need as Ms H had sold her flat and moved to live with her mother – For Ms H to have practical support and be allowed to 'ventilate her thoughts and feelings' about living with her mother.
- Encourage socialising - for assertive outreach workers to encourage Ms H to engage in social activities.
- Benefits – for assertive outreach team to refer to benefits adviser.
- Medication – for assertive outreach team to monitor medication compliance, explain side effect and provide information on medication and to ensure that a psychiatrist reviews medication.
- Ms H as carer – for assertive outreach team to encourage Ms H to "ventilate her feelings" and refer to the carer's team.

Comment

This care plan was written at the point of transfer from Sandwell to Ladywood. The records indicate Ms H continued to receive visits from the Sandwell Team and that her medication was reviewed, we found no record of Ms H being referred to the carers team or getting advice on benefits.

The care plan also shows that the Sandwell team supported Ms H's plan to move in with her mother. We found no record of the Sandwell team considering risks in this move given Ms H's history of mental health problems and her mother's deteriorating health.

The referral is a request from the Sandwell assertive outreach team to the Ladywood community mental health team. In effect, the referral indicates that Ms H is no longer considered as needing the support of assertive outreach as she is engaged with services and is taking her prescribed medication.

Consultant psychiatrist 1 saw Ms H on 9 May in his outpatient clinic after she had experienced a mild manic phase for ten days. Consultant psychiatrist 1 recorded that at times she had been disinhibited and intrusive, although her mental state had improved by the time he met her. Consultant psychiatrist 1 changed Ms H's medication to lithium 800mg daily and quetiapine 200mg twice daily. She was also prescribed chlorpromazine 150 mg nightly for insomnia.

The medical records department of Birmingham and Solihull Mental Health NHS Foundation Trust wrote to Ms H on 30 May to confirm an appointment had been made for her at the Ladywood community mental health team on 7 June.

Ms H saw senior house officer¹ 1 on 7 June as a new client to the Ladywood Community mental health team. Ms H's support time and recovery worker from the

¹ A senior house officer (**SHO**) is a junior doctor undergoing training who is supervised by a consultant. In this case, SC was working under the supervision of consultant psychiatrist 2.

Sandwell assertive outreach team accompanied her. The meeting was recorded as a routine outpatient appointment. Ms H was reported as being mentally stable with no psychotic symptoms. Senior house officer 1 recorded there was 'no risk involved'.

Sandwell assertive outreach team nurse MP completed a threshold assessment grid¹ assessment for Ms H on 2 August. It recorded Ms H had no problems in the following domains; intentional self-harm, unintentional self-harm, risk from others, risk to others, survival (problems with basic amenities, resources or living skills), social (activities or relationships with others). There was only a score of 'mild' recorded for the psychological domain. This is a rating of 'minor disability or distressing problems with thinking, feeling or behaviours'.

Ms H attended an outpatient appointment on 2 August with senior house officer 1 and Sandwell support time and recovery worker. Ms H is recorded as stable with no psychotic symptoms although she complained of sleeping too much. Senior house officer 1 planned to continue all medication apart from diazepam², which was to be reduced and then stopped. Senior house officer 1 reported Ms H did not have 'any ideas of self-harm, harming others or taking overdoses'.

Ms H did not attend her outpatient appointment on 2 October. We found no record of a reason for this. The appointment was rebooked for the following week.

Ms H attended an outpatient appointment with senior house officer 1 on 9 October she remained stable but complained of the side effects of her medication. Senior house officer 1 reported that Ms H has 'no ideas of self-harm, harming others or taking an overdose'. Senior house officer 1 agreed to reduce Ms H's dose of chlorpromazine from 150 mgs to 100 mgs daily.

Care coordinator 3, a community psychiatric nurse from Ladywood community mental health team, wrote to Ms H on 17 October to introduce herself and to arrange to meet Ms H on 30 October for a formal handover of her care from the assertive outreach team to the Ladywood community mental health team.

MP from Sandwell assertive outreach team and care coordinator 3 visited Ms H at home on 30 October. Care coordinator 3 was Ms H's allocated care coordinator. Ms H recognised care coordinator 3 from her incomplete nurse training some years before. Care coordinator 3 recognised that this might cause Ms H some discomfort. Ms H said she was stable but worried about the future and not having direct contact with care coordinator 3, but did not want her to contact her by mobile phone. Ms H requested the out-of-hours³ telephone number for the community mental health team. The meeting ended with a plan for care coordinator 3 to return the following week to complete the care plan and update the risk assessment.

¹ The Threshold Assessment Grid (TAG) is an assessment of the severity of a person's mental health problems designed to identify who would meet the 'threshold' for community mental health services. TAG has seven domains. Scores range from; no problem in that domain to either severe or very severe problems. Ms H's score indicated a low level of need.

² Diazepam is benzodiazepine drug used to treat anxiety disorders,(see page 48 of this report)

³ 'Out of Hours' indicates times when the community mental health team do not provide a service. (i.e., outside of the hours 9am to 5pm). Outside of these hours, patients in crisis are directed to crisis services such as Home Treatment or accident and Emergency liaison teams.

Comment

The Sandwell assertive outreach team and Ladywood community mental health team had jointly seen Ms H from 7 June 2007 until the 30 October 2007 to transfer her care to the Ladywood team. We found no record in that time of a joint review of Ms H's care plan or care programme approach arrangements.

Ms H would have been eligible for aftercare under section 117 of the Mental Health Act, which says services have a duty to provide aftercare for a person who had been admitted under section 3 of the Mental Health Act. Aftercare can only be stopped if a reassessment demonstrates that the service user no longer needs it. The Ladywood team were then providing aftercare for Ms H, but there was no formal aftercare meeting to clarify and record this. The meeting with care coordinator 3 and MP on 30 October 2007 was to introduce of a new care coordinator.

5.1.1 Finding

F1 When Ms H was transferred from Sandwell assertive outreach team to Ladywood CMHT the lack of a formal multidisciplinary handing over of care coordination and review of section 117 was a major error in her care.

Care coordinator 3 rang Ms H with the out-of-hours number that evening but got no reply. The numbers were then posted to Ms H.

Care coordinator 3 went to Ms H's home on 6 November, but there was no reply. She left a card asking Ms H to contact her.

Ms H contacted care coordinator 3 on 8 November and rebooked the appointment for 13 November.

Care coordinator 3 visited Ms H at home on 13 November. Ms H was stable and still taking 50 mg of Chlorpromazine at night for insomnia. Care coordinator 3 planned to meet her at home on 29 November to complete a risk assessment.

Care coordinator 3 visited Ms H at home on 29 November. Ms H said she had been 'high' in the previous week and had experienced tactile and auditory hallucinations that had since stopped. Care coordinator 3 noted Ms H's speech was a 'little bizarre'. Ms H had also been taking erratic doses of chlorpromazine at night for insomnia. Ms H said she had felt she was missing her old assertive outreach team and did not know the workers in the community mental health team yet. Care coordinator 3 discussed referral to the home treatment team (HTT) to help with this but Ms H was ambivalent because she did not know them. Care coordinator 3 noted that Ms H had an outpatient appointment the following week and offered to escort Ms H.

Care coordinator 3 discussed the case with Ladywood community mental health team leader 1 the same day. Team leader 1 advised care coordinator 3 to liaise with

the HTT. Care coordinator 3 contacted the HTT and on the 30 November made a referral to them for a home visit.

Care coordinator 3 began to compile Ms H's risk assessment and care programme approach on 29 November. The record we saw was incomplete; the personal details section has no entry apart from Ms H's name, the box for Section 117 was not ticked and the risk assessment was not completed.

On 30 November, in response to care coordinator 3's referral, Dr H and community psychiatric nurse care coordinator 3 from the HTT visited Ms H at home. She had no abnormal psychomotor activity and no delusions or grandiose thoughts. She had experienced insomnia since reducing her chlorpromazine, so she had increased her dose and was sleeping and feeling better. The HTT workers felt Ms H demonstrated good insight into her illness and was stable in mood. They concluded that HTT input was not required and that Ms H should be referred back to the community mental health team for follow up. They decided that Ms H's lithium and thyroid levels should be checked.

Care coordinator 3 accompanied Ms H to an outpatient appointment with senior house officer 1 on 6 December. Ms H appeared stable and informed senior house officer 1 of her elated mood, which she again attributed to insomnia. She said she had felt better since increasing the dose. Senior house officer 1 reported that Ms H did not have 'any ideas of self-harm, harming others or taking an overdose'. Senior house officer 1 continued Ms H's medication of quetiapine, 200 mg twice a day and lithium carbonate, 800mgs at night, and restarted the dose of chlorpromazine 150mg at night. Senior house officer 1 also discussed and ordered the blood tests needed to check her lithium levels and thyroid function. Ms H was to be reviewed by senior house officer 1 in two months.

The meeting and the planned outpatient appointment were recorded in an entry in the Ladywood community mental health team multidisciplinary team meeting records. An action recorded that care coordinator 3 would visit Ms H and her mother with social worker 1 so that social worker 1 could assess Ms H's mother and refer her to social services. Care coordinator 3 was to inform Ms H of this visit.

Care coordinator 3 and social worker 1 visited Ms H and her mother at home on 19 December. The purpose of this visit was to assess Ms H's mother's needs. Ms H had previously agreed to the visit, but on the day would not let the workers see her mother. Ms H said her mother's GP had recently assessed her mother, but could not remember the GP's name. Care coordinator 3 recorded that she would discuss the situation in the community mental health team multidisciplinary meeting.

The joint internal review accessed the records of the community mental health team multidisciplinary meeting. The record on 21 December says - "[social worker 1] visited, [Ms H], contact GP to inform him that Ms H's mother is at risk of being held hostage. Care coordinator 3 to follow up".

5.1.2 Summary of 2007 care

By 2007 Ms H's mental health was stable and she was living with her mother. In March Sandwell assertive outreach team referred Ms H to the Ladywood community mental health team. This was accepted and in June Ms H was seen in out-patients as a new patient. She was seen by senior house officer 1 of the Ladywood community mental health team with the Sandwell assertive outreach worker.

Following transfer, the Sandwell assertive outreach team updated Ms H's records and care plans, shared these with the Ladywell team and maintained regular contact until October. However, there was no multi-disciplinary handover of Ms H's care or a review of her Section 117 aftercare arrangements between Sandwell assertive outreach and Ladywood Community mental health team

Ms H regularly attended her out patient appointment with senior house officer 1 of the Ladywood community mental health team during which her mental health and risk to self and others was assessed. Ms H was also treated for sleep problems.

In October, care coordinator 3, became Ms H's care coordinator for the Ladywood community mental health team. In November care coordinator 3 began a care plan and risk assessment with Ms H. These were never completed. In December, care coordinator 3 and social worker 1 visited Ms H and her mother to assess Ms H's mother's health but Ms H did not let them talk to her mother.

5.2 2008

Care coordinator 3 rang Ms H on 10 January and planned to escort her to a hospital visit on 16 January for blood tests.

Care coordinator 3 was off sick on 16 January. The team was unable to contact Ms H to arrange an alternative escort. The duty team¹ at Ladywood CMHT left a phone message for Ms H to contact them. Ms H did not contact them. Care coordinator 3 called Ms H on 21 and 22 January but there was no reply. Care coordinator 3 left a calling card on 22 January asking Ms H to contact her and to remind her of her next outpatient appointment on 14 February.

Care coordinator 3 made an unplanned visit to Ms H on 7 February. Ms H's mother was present during the visit and care coordinator 3 described her as 'friendly'. Ms H's mother said Ms H was OK in general though could "fly off the handle" sometimes. The notes record that social worker 1 had made a referral to social services for Ms H's mother to receive 'meals on wheels' and a care package. Care coordinator 3 recorded that the home smelt, strongly, but does not record what it smelt of. Ms H's mother was unable to account for the smell and said that Ms H cleaned the house.

¹ The duty team of the Ladywood CMHT were workers who would deal with day to day referrals to the team and assist with any emergencies.

Ms H failed to attend her outpatient appointment on 14 February. It was rescheduled for 18 February.

Ms H attended her outpatient appointment with senior house officer 1 on 18 February. Ms H told senior house officer 1 she was feeling much better taking the chlorpromazine though she was again experiencing akathisia¹, Ms H described her mood as level and denied experiencing hallucinations or delusional thoughts. Senior house officer 1 planned to continue Ms H on her medication and for care coordinator 3 to continue monitoring her in the community. Senior house officer 1 reported that Ms H did not have 'any ideas of self-harm, harming others or taking overdoses'.

Care coordinator 3 visited Ms H on 12 March. Ms H said she had recently been experiencing tactile and auditory hallucinations nearly every night and sometimes during the day. She was also a little elated. Ms H reported that though she was going to sleep quickly she still felt 'lazy' and was taking a long time to do things. Care coordinator 3 recorded that Ms H should be prescribed procyclidine for the side effects of medication. Care coordinator 3 planned to discuss this with senior house officer 1 so that they could ask Ms H's GP to prescribe it. This was because Ms H's next outpatient appointment was not until April. Care coordinator 3 noted there was a need to complete Ms H's care plan and relapse management plan.

Care coordinator 3 visited Ms H on 20 March. Ms H was feeling OK but a little tired. She had not experienced hallucinations in the previous few nights but said "no doubt they will come back again". Ms H wanted to be prescribed procyclidine for the side effects of her medication.

Care coordinator 3 visited Ms H at home on 10 April, but she was not in. Care coordinator 3 spoke with Ms H's mother and left a message telling Ms H that care coordinator 3 was planning for senior house officer 1 to review Ms H's medication and that arrangements had been made for her to meet with social worker 1. This meeting was necessary because social worker 1 would be taking over as Ms H's care coordinator.

Ms H rang care coordinator 3 on 11 April and asked her not to visit because she was planning to go out that day.

Care coordinator 3 wrote a care plan for Ms H on 17 April. The care plan summarises Ms H's risk to others when unwell and makes reference to an incident in 1994 where Ms H tried to hold her parents hostage. It also says that Ms H occasionally drank alcohol and that:

"while the amount might not be excessive, she is on various treatments for her mental illness and drinking any alcohol may be risky."

The care plan outlined five areas of need and interventions.

¹ Akathesia is a recognised side effect of anti-psychotic medication. It is a movement disorder characterized by a feeling of inner restlessness and a compelling need to be in constant motion. (see page 48 of this report).

- Treatment of bipolar illness – Ms H to be prescribed medication and monitored by her consultant psychiatrist, Dr P.
- Allocation of a care coordinator under the care programme approach – care coordinator 3 to review and manage care plan and risk assessment.
- Contact with mental health team – care coordinator 3 to visit Ms H every two weeks to monitor and provide support.
- For Ms H to obtain a bus pass – for a support worker to help with this.
- For Ms H to have help with social interactions – for a support worker to meet Ms H and plan social activities.

The care plan listed Ms H's early warning signs of relapse. These were primarily changes in sleep, speech and behaviour, which included excessive shopping and feeling elated. These were followed by self-neglect, sexual disinhibition and possibly verbal and physical aggression. The early warning signs section says:

“Please note that Ms H feels that her mother is not in danger from her, but feels that if she did relapse, her mother would need to go into a home if Ms H unwell.”

After this sheet had been printed, the above sentence was changed to say “her mother may need to go into a home if Ms H unwell.” The change is handwritten, but not dated or initialled.

The care plan ends with a contingency plan including contact numbers for the CMHT. The review date for the care plan was April 2009. Neither care coordinator 3 nor Ms H signed the care plan, and there was no record that the care plan was shared with Ms H.

Care coordinator 3 rang Ms H on 18 April to confirm the planned change of care coordinator. Ms H was recorded as accepting the change. Care coordinator 3 and Ms H agreed to visits from the new care coordinator every two weeks and to include trips out for coffee.

Dr 1, a fixed-term special training appointment doctor covering for senior house officer 1 saw Ms H in an outpatient's appointment on 24 April. Ms H was bright and cheerful and “reading books on Islam”. She reported her mood was stable and she had not been experiencing mood disturbances or psychosis. She told Dr 1 that she had been for blood tests earlier that day. Dr 1 said in a letter to Ms H's GP that Ms H's care coordinator, care coordinator 3 was on leave.

Social worker 1, Ms H's new care coordinator 4, visited Ms H on 12 May to discuss her care. They agreed to meet every two weeks so Ms H's mental health could be monitored. Ms H was noted to be stable and she was planning to attend a university course.

Ms H contacted care coordinator 4 on 15 May to say she had not been sleeping for two nights and that she felt 'high'. Ms H was worried she was becoming unwell. Care coordinator 4 agreed she would discuss this with senior house officer 1. We found no record of this discussion in the notes, but there is a record of senior house

officer 1 sending Ms H a prescription for seven days zopiclone¹ 7.5 mg to be taken at night.

Ms H contacted care coordinator 4 on 20 May to tell her she had taken seven zopiclone in five days. Care coordinator 4 advised Ms H that they would not be able to issue more zopiclone without a medical review. Ms H said she felt agitated and was worried about not sleeping. Care coordinator 4 arranged a medical review for the next day.

Ms H attended an appointment with senior house officer 1 on 21 May. When writing to the GP, senior house officer 1 said it was an urgent appointment because Ms H had not been sleeping well and was feeling a 'bit high in mood'. Ms H told senior house officer 1 that she was now OK although she had felt high two days previously. Ms H appeared reasonably stable though her mood had fluctuated. Senior house officer 1 recorded "no concerns at all now" and continued Ms H on her medication with a plan to review her in two months.

Care coordinator 4 visited Ms H at home on 10 June. Ms H said she felt settled in mood and described herself as feeling 'realistic'. She felt more settled than she had a few weeks previously. Care coordinator 4 and Ms H discussed her on-going use of zopiclone and that she might want to reduce her intake in case she became dependent on it. Her GP had prescribed the zopiclone.

Community mental health team support worker KG visited Ms H at home on 17 June to help her complete her bus pass application.

Care coordinator 4 visited Ms H on 25 June. We found no record of this in Ms H's medical notes and we have no details about the visit, which was identified during the initial joint review that the trust undertook.

Care coordinator 4 visited Ms H at home on 8 August. Ms H's mood was slightly low though no further concerns were identified. Ms H was planning activities and discussed giving up smoking.

Senior house officer 1 and care coordinator 4 saw Ms H on 15 July. Ms H appeared to be reasonably stable and her sleep and appetite were satisfactory. Ms H said she had felt low two days before the appointment. Ms H had no psychosis or mood disturbance at that time. She said that she kept herself busy reading, walking and helping her mother with housework. Ms H denied any thoughts of harming herself or others. Senior house officer 1 planned for Ms H to continue her medication and for care coordinator 4 to stay in contact with her. It was agreed Ms H would be reviewed two months later.

Care coordinator 4 met Ms H at home on 22 July after which they went for coffee. Ms H's mood had been slightly low though she had attended church that day, which she enjoyed. Ms H said she had wanted to reduce her medication but accepted senior house officer 1's advice not to. No further concerns were identified.

¹ Zopiclone is a drug commonly used for insomnia. Zopiclone has a risk of dependence and can cause withdrawal symptoms if a patients takes for a long period. For this reason it is used with caution.

Care coordinator 4 visited Ms H's home on 14 August. She was not there so care coordinator 4 left a calling card for Ms H with her mother. Ms H rang care coordinator 4 and they agreed to meet on 19 August.

Care coordinator 4 visited Ms H at home on 19 August. Ms H had again had problems with insomnia and had been taking the zopiclone her GP had prescribed her. Ms H had been given seven days' supply and had four days' worth left. No other concerns with her mental state were identified. Ms H was planning to see a play. She talked about staying well and that not living alone was 'a big factor in her not relapsing'. She also discussed her concerns about when her mother died, which she felt would be difficult for her.

Care coordinator 4 visited Ms H on 2 September and they went for a coffee as planned. Ms H was reported as stable with normal sleep and appetite. She said she had engaged in a few 'day trips', which she had enjoyed.

Care coordinator 4 visited Ms H on 15 September with psychiatric nurse 2, a community psychiatric nurse at the Ladywood community mental health team. Ms H was introduced because psychiatric nurse 2 was taking over her care coordination from care coordinator 4. In the meeting Ms H said she was trying to establish a stable sleep pattern because sleep affected her mental state.

Psychiatric nurse 2 visited Ms H at her home on 30 September. Ms H said she had been feeling low and depressed in the previous three days but now felt better. Ms H had attended a course on bi-polar illness at the weekend and had found it useful. She said she was concerned about her next outpatient appointment, but did not specify her concerns. Ms H also said she had been compliant with her medication and her sleeping and eating habits were good.

Senior house officer 1 and psychiatric nurse 2 saw Ms H on 14 October in an outpatient appointment. She appeared reasonably stable although she said she had been feeling low in the days before the appointment. Her sleep and appetite were fine. No major concerns were reported. She had no thoughts of self-harm or harming others. Senior house officer 1 planned to keep Ms H on her medication and review her three months later. Psychiatric nurse 2 would continue to keep in touch every fortnight.

Ms H attended a clinic on 23 October to have her blood tested for lithium level tests.

Psychiatric nurse 2 visited Ms H at home on 29 October. Ms H was stable. Psychiatric nurse 2 discussed a referral for Ms H's mother to older adult services. Ms H wanted to talk to her GP about home care from district nurses first.

Psychiatric nurse 2 visited Ms H on 12 November and they went out for coffee. Although psychiatric nurse 2 described Ms H as loud, there were no concerns about her mental state. Ms H also discussed that she would wear a scarf to her next appointment with senior house officer 1 to be respectful of senior house officer 1's religious beliefs.

The community mental health team received the lithium level blood test results on 19 November. There were no concerns.

Psychiatric nurse 2 visited Ms H at home on 26 November. Ms H remained stable. Psychiatric nurse 2 told Ms H about her blood results and that there were no concerns. Ms H informed psychiatric nurse 2 that district nurses were then providing care at home for Ms H's mother.

Psychiatric nurse 2 visited Ms H at home on 12 December. She remained stable. She was spending time with friends and walking her dog. Ms H was concerned about an operation planned for her mother. Psychiatric nurse 2 talked to Ms H's mother during the visit. She said she was feeling better and confirmed the district nurses were seeing her.

Psychiatric nurse 2 visited Ms H at home on 18 December and they went out for coffee. There were no concerns. Psychiatric nurse 2 saw Ms H's mother during the visit.

5.2.1 Summary of 2008 care

In February care coordinator 3 saw Ms H and Ms H also attended an outpatient appointment with senior house officer 1. Ms H was stable but having difficulties with sleep and side effects of medication. There were no concerns about her mother.

Ms H was regularly seen by care coordinator 3 until April when social worker 1 became her care coordinator 4. Prior to handing over, care coordinator 3 completed a care plan for Ms H. The care plan was not signed by Ms H or care coordinator 3.

Ms H was seen by senior house officer 1 in May where she was said to be stable.

Care coordinator 4 visited Ms H regularly from May until September and Ms H saw senior house officer 1 in outpatients in July. Ms H was generally stable, but her mood was sometimes low. Her risk was assessed by senior house officer 1 and there were no concerns about harm to self or others. Her sleep was normal and she did not complain of side effects of medication.

In September Ms H's care coordinator was changed to community psychiatric nurse 2. In October Ms H was seen in outpatient by senior house officer 1 and said she was feeling low. Her risk was assessed by senior house officer 1 and there were no concerns about harm to self or others.

Psychiatric nurse 2 visited Ms H at home and by November Ms H was stable. Her lithium blood levels were completed and there were no concerns. Ms H said that district nurses were now providing home care for her mother.

Psychiatric nurse 2 met Ms H twice in December and there were no concerns.

5.3 2009

Senior house officer 1 saw Ms H on 13 January at an outpatient appointment. Ms H said her mood was high and she had not slept the night before, but her appetite was fine and she was keeping herself busy. Senior house officer 1 concluded Ms H was reasonably stable and should continue with her medication. Senior house officer 1 also gave Ms H a short-term prescription of zopiclone to help her sleep. Senior house officer 1 planned to review Ms H three months later.

Psychiatric nurse 2 visited Ms H's house on 28 January for a home visit, but she was not in. Psychiatric nurse 2 had tried to call Ms H for two days before the visit, but she did not answer. Ms H's mother was at home and said Ms H was fine and had gone out for a walk. Psychiatric nurse 2 left a message with Ms H's mother to tell Ms H she was being allocated a new care coordinator who would soon make contact.

Comment

Between 2007-2009 Ms H had four care coordinators. The number of changes in this time was not conducive to building an effective therapeutic relationship with her.

Community psychiatric nurse 3 was allocated as Ms H care coordinator and carried out a planned home visit to Ms H on 24 February. She noted Ms H was engaging and pleasant. Her speech was slightly fast but appropriate and coherent. Ms H said her sleep was a little excessive, which was normal for her. Ms H was planning a trip to Plymouth and felt her mother may have needed a place in a respite home if she went. Psychiatric nurse 3 agreed to explore options. No other concerns were reported and she agreed to see psychiatric nurse 3 every two weeks.

Ms H missed her next planned appointment with psychiatric nurse 3 and it was rescheduled to 23 March.

Psychiatric nurse 3 visited Ms H at home with a student on 23 March. Ms H agreed to be seen with the student but did not go for coffee. Ms H said she was still sleeping too much and continued to use sleeping tablets. Her speech was rapid but she was mentally stable with no evidence of manic symptoms. Ms H said she had previously felt high but this had settled. Psychiatric nurse 3 offered to help with social activities, but Ms H declined. Ms H said she was not planning to go to Plymouth anymore and that psychiatric nurse 3 should not look for respite options for her mother.

Psychiatric nurse 3 visited Ms H at home on 6 April as planned. Ms H was not at home. Psychiatric nurse 3 planned to contact Ms H and rebook.

Senior house officer 1 saw Ms H at an outpatient appointment on 15 April. She appeared stable and her sleep and appetite were fine. She had no psychotic symptoms or mood disturbances. Senior house officer 1 planned to continue Ms H on her medication and review her three months later.

Psychiatric nurse 3 rang Ms H on 23 April but received no reply.

Psychiatric nurse 3 rang Ms H on 27 April. She said she was well, that her mood had lifted since her meeting with senior house officer 1 and she was listening to music to lift her mood. Psychiatric nurse 3 and Ms H agreed to meet on 5 May.

Psychiatric nurse 3 rang Ms H's home and Ms H's mother said she was out.

Ms H rang psychiatric nurse 3 on 6 May and said she had in fact been at home. They rearranged the meeting rearranged for the 13 May.

Psychiatric nurse 3 visited Ms H at home on 13 May. They discussed her past at length, including her marriage. Ms H said she had spent £2000 on jewellery when in a manic phase of her bipolar disorder. Ms H said her sleep and appetite were normal at present. She did not demonstrate rapid speech or thoughts. Psychiatric nurse 3 recorded Ms H appeared rational and mentally stable. Psychiatric nurse 3 agreed to arrange another appointment.

Ms H attended a clinic for a blood test on 14 May.

The community mental health team received Ms H's blood results on 28 May. Ms H's thyroid-stimulating hormone (TSH) level was extremely high. Consultant psychiatrist 2 asked psychiatric nurse 3 to contact Ms H immediately to give her the results and arrange for her to be seen in outpatients. Psychiatric nurse 3 called Ms H at home but received no reply.

Psychiatric nurse 3 rang Ms H again on 29 May but received no reply. Psychiatric nurse 3 went to Ms H's home and delivered a letter asking her to contact the service and telling her about an outpatient appointment for her to see consultant psychiatrist 2 on 1 June. The 29 May was a Friday, so 1 June was the next working day for the community mental health team.

Psychiatric nurse 3 rang Ms H on 1 June. Psychiatric nurse 3 left a message with Ms H's mother as Ms H was not in. Ms H then called her. She agreed to see consultant psychiatrist 2 the next day. Ms H said her GP had also contacted her about the blood results. She had not attended either appointment because she had fallen asleep.

Consultant psychiatrist 2 met Ms H with psychiatric nurse 3 at an outpatient appointment on 2 June. Ms H said her mood was low, she was tired and sleeping more and her weight had increased. Consultant psychiatrist 2 explained that Ms H's thyroxine level was being raised because of her lithium medication. They discussed stopping the lithium but Ms H said she would rather stay on her medication and take thyroid medication. Consultant psychiatrist 2 advised Ms H to see her GP as soon as possible and that another appointment with NP should take place within four weeks. Consultant psychiatrist 2 continued Ms H on lithium carbonate and quetiapine, and reduced her chlorpromazine dose to 100mg.

On 11 June consultant psychiatrist 2 wrote to Ms H's GP about the meeting with Ms H on 2 June.

This is the last written record we found, but the joint internal review interviewed psychiatric nurse 3 and reported that she visited Ms H at home, also on 11 June. She said Ms H was in a pleasant mood and not showing any signs of relapse. She was eating and sleeping well. She appeared well and stable in mood. Ms H's mother was seen during the visit and no concerns were raised.

Police attended Ms H's home on 5 July and found Ms H's mother dead. The police later arrested Ms H for killing her mother. Team leader 1 told us that was unclear precisely when Ms H's mother had died, but it was a few days before her death was discovered.

5.3.1 Summary of 2009 care.

On 13 January senior house officer 1 saw Ms H in outpatients. Ms H was reasonably stable with slight elation. Senior house officer 1 gave Ms H some extra medication to assist sleep.

Ms H's care coordinator was again changed and psychiatric nurse 3 took over from psychiatric nurse 2. Psychiatric nurse 3 met Ms H on 24 February. Ms H was elated in mood, but said this was normal for her.

Senior house officer 1 saw Ms H in outpatients on 15 April. She was stable in mood. Psychiatric nurse 3 rang Ms H on 27 April and met her on 13 May. She remained stable.

On 14 May Ms H attended clinic for a lithium level blood test. On 28 May the results indicated she had a lithium-induced thyroid problem. Consultant psychiatrist 2 met Ms H on 2 June to discuss. Consultant psychiatrist 2 offered to stop prescribing lithium, but Ms H wanted to continue. Consultant psychiatrist 2 wrote to Ms H's GP and advised her to see the GP for future help with the thyroid problem.

Psychiatric nurse 3 saw Ms H on 11 June. Ms H was pleasant and stable. She saw Ms H's mother during the visit. There were no concerns.

On 5 July Ms H was arrested following the discovery of her mother's death.

5.4 Post homicide

Ms H was convicted of manslaughter by reason of diminished responsibility and was detained in a medium secure facility under sections 37 and 41 of the Mental Health Act.

Ms H remained in the medium secure unit for four years. She was then moved to a low secure unit. After a year in the low secure unit she was again moved to a secure hostel in the community and, at present, is a client of an assertive outreach team. At the time of this report, Ms H remains on Sections 37 and 41 of the Mental Health Act and is subject to monitoring from the Home Office.

6. Issues arising

In the following sections we provide comment and analysis of the issues identified during our review of the care of and treatment of Ms H. This is taken from the chronology and as will be discussed later, is in agreement with the key themes identified in the joint internal review.

The themes are:

- transfer of care from Sandwell assertive outreach team to Ladywood community mental health team;
- risk assessment, care planning and the care programme approach;
- risk to Ms H's mother;
- multi-disciplinary team work; and
- predictability and preventability.

7. Transfer of care from Sandwell assertive outreach team to Ladywood community mental health team

Ms H's insight into her mental health problems changed over the time she has been treated by mental health services. After her diagnosis of bi-polar disorder in 1991, she displayed little insight and was difficult to engage with. She was consistently non-compliant with medication between 1991 and 2005 and suffered frequent relapses, often requiring admission to hospital.

Assertive outreach services are specifically designed to assist clients who frequently relapse and who find it difficult to engage in generic community mental health services. The first record we found of Ms H being offered assertive outreach was in April 2004, when she refused. After another relapse and admission in March 2005, Ms H agreed for the Sandwell assertive outreach team to treat her. The assertive outreach team was assisting her by 2006, and she was compliant with medication and attending outpatient appointments with consultant psychiatrist 1 from the Sandwell assertive outreach service. The admission in 2005 is her last recorded admission to an inpatient service until the incident.

Consultant psychiatrist 1 requested a transfer of care to the Ladywood community mental health team in March 2007. This was not a like for like transfer of the service provided to Ms H. A community mental health team is not expected to deliver the same service as an assertive outreach team. Assertive outreach team provides a specialist service reserved for people who have difficulty engaging and who need regular (sometimes daily) visits to facilitate engagement and effective treatment. Consultant psychiatrist 1 was therefore asking to transfer Ms H's care geographically, but also to step her care service down from assertive outreach to generic community services.

Sandwell assertive outreach thought Ms H did not need the same level of care as in 2005. The care plan made on transfer says Ms H was engaged with assertive outreach, was being seen every two weeks and was regularly attending her planned outpatient appointments. Her needs at time were assistance with benefits and help to adjust to living with her mother, who then had a range of physical and cognitive problems. In his referral letter, Consultant psychiatrist 1 added:

“[Ms H] has good insight into her condition and presents as an intelligent woman, who has a strong commitment to her Roman Catholic faith.”

We therefore conclude that the decision to accept Ms H for a step down in services during her transfer was appropriate.

Staff acknowledged in the focus groups we held that there was a waiting list to join the assertive outreach services for Ladywood in 2007 and that there still is now. This means that a like-for-like service transfer would have delayed the transfer. We considered if this unduly influenced the teams in deciding the level of care for Ms H.

We found no evidence this was the case. The Sandwell service continued to engage with Ms H for several months after transfer and could have changed the referral had

they been unduly concerned. In that time Ms H continued to remain engaged and compliant with medication.

Even after Sandwell had withdrawn services, Ms H remained engaged with the Ladywood community mental health team. This service could have also referred her for an assessment from the Ladywood assertive outreach after transfer if they identified a need.

If they had made such a referral, Ms H would not have met the criteria for assertive outreach because she had neither relapsed nor been non-compliant with medication. She continued to engage with workers and to attend outpatient appointments. When she missed her outpatient appointments these were quickly rescheduled and Ms H attended the rescheduled appointments.

7.1 Finding

F2 The assertive outreach team in Sandwell were able to show that Ms H had 'stepped down' in terms of service provision because she was engaged, with services and compliant with treatment and had not been admitted for two years. The transfer of care of Ms H from Sandwell assertive outreach team to Ladywood community mental health team, thereby stepping down her care level, was appropriate.

7.2 Conclusion

It is clear from the records that when Ms H moved to her mother's home the Sandwell assertive outreach team worked hard to ensure a smooth transfer. They continued to support Ms H and the new team looking after her from June 2007 until 30 October 2007. This was good practice.

8. Care planning, risk assessment, and the care programme approach

Although we consider Ms H's transfer of care to be appropriate, we would expect to be able to track the change in Ms H's care through a comprehensive record of care planning and risk assessment carried out under the care programme approach. This was not the case.

The care programme approach is a formal multidisciplinary care plan that should be drawn up to include relapse and risk management plans, a contingency plan, contact details of the care co-coordinator and contact numbers for help out of hours or in a crisis.

The Sandwell assertive outreach team completed a care plan in March 2007 at the point of Ms H's transfer to the Ladywood community mental health service. The care plan outlined how Ms H was to be monitored and supported, and included planned interventions on medication compliance, assistance with benefits and support for her role of caring for her mother.

Ms H attended an outpatient appointment on 7 June with senior house officer 1, a senior house officer working under the supervision of consultant psychiatrist 2. This was Ms H's first recorded meeting with the Ladywood community mental health team. A member of the Sandwell assertive outreach service accompanied her to this meeting. The meeting was not a care programme approach meeting and did not review Ms H's care plans or risk assessment.

Ms H was under the joint care of the two teams between June 2007 and October 2007. The Sandwell team formally disengaged from Ms H's care on 30 October 2007 and care coordinator 3 of the Ladywood community mental health team became her care coordinator. Although care coordinator 3 records the need for care plans and risk assessment we found no record that this was done.

Ms H would also have been eligible for aftercare under section 117 of the Mental Health Act. Aftercare can only be stopped if there is a reassessment demonstrating the person no longer needs aftercare. The Ladywood team were providing aftercare for Ms H, but there was no formal aftercare meeting to review or clarify this.

There is a risk assessment for Ms H dated 30 November 2007, but this was neither complete nor did care coordinator 3 or Ms H sign it.

Care coordinator 3 completed a care plan for Ms H In April 2008, the day before she was due to hand over to a new care coordinator. The care plan outlined five areas of need and the interventions to address them, but named care coordinator 3 responsible. In addition, one of the interventions was to assist Ms H to complete forms for a bus pass. But care coordinator 3 recorded that this action had already been completed. Neither care coordinator 3 nor Ms H signed the care plan.

The care plan listed Ms H's early warning signs of relapse¹. These were primarily changes in sleep, speech and behaviour including excessive shopping and feeling elated. Self-neglect, sexual disinhibition and verbal and physical aggression could follow these signs. The care plan says Ms H was not considered a risk to her mother.

Although the records indicate the Ladywood community mental health team responded to Ms H's early warning signs by monitoring them in their planned meetings and changing her medication when she had changes in her sleep patterns, they did not formally record them in her care plan documents.

Ms H did not meet consultant psychiatrist 2 until one month before the homicide. This meeting was not a care programme review but an emergency meeting due to Ms H's abnormal thyroid results.

8.1 Findings

F3 The absence of a comprehensive care plan and risk assessment during Ms H's care in the Ladywood community mental health team are significant failures given Ms H's history and presentation.

F4 The records do not always record decisions taken by the clinical team or record when actions agreed have been carried out. This is poor practice and can increase the risk that clients do not get the appropriate support and care they require.

8.2 Conclusion

We found evidence in the records that the Ladywood community mental health team engaged and assessed Ms H's needs and attempted to meet them, but this was not coordinated or monitored as would be expected under the care programme approach. As a consequence, there is no record of risk assessment and management or effective care planning.

¹ Developing 'Early Warning Sign' is a recognised psychological intervention with people who have bi-polar disorders. The early warning signs should alert both the person and their care team that an assessment and intervention may be required to prevent a full relapse of the condition.

9. Risk to Ms H's mother

In this section we consider whether the trust adequately evaluated if Ms H was a risk to her mother and if the trust put adequate risk management plans in place for risks identified.

Ms H was transferred to the Ladywood community mental health team when she sold her home and moved in with her mother. Ms H's mother was frail, diagnosed with dementia and receiving healthcare from her local primary care services.

The records from Sandwell hospital from July 1994 note Ms H barricaded herself into her parents' home and 'tried to take her parents hostage'. We found no further information about this incident in the records. We found no record of harm to Ms H's parents. We found no record of subsequent police action, although Ms H was admitted to hospital under the Mental Health Act shortly after the incident. Although the incident correctly remained in Ms H's clinical files as an example of behaviour she was capable of when unwell, because it was not repeated and was over twenty years before the homicide, we conclude that it could not have been used as a predictor of the homicide.

The care plan that Sandwell assertive outreach team made at the time of the move on 28 March 2007 mentioned that 'Ms H acts [as] a carer' for her mother and that they should provide her with the opportunity to 'ventilate her feelings' about this role. We found no evidence that Sandwell assertive outreach services specifically addressed this with Ms H.

Her care plan on transfer did not indicate that the Sandwell assertive outreach team had any concerns about the move, or that Ms H's mother was at risk from Ms H.

A joint visit from social worker 1 and care coordinator 3 was planned in December 2007 because Ms H's mother's health had deteriorated. The visit would have assessed Ms H and her mother. Ms H refused to let the workers see her mother when they attended and said that the GP was dealing with her mother's needs. The team later discussed this in their multidisciplinary meeting and made a plan for care coordinator 3 to contact the GP. We found no record of this happening.

Social worker 1 was interviewed as part of the joint internal review of the homicide. Social worker 1 said Ms H's mother had been referred to the older adult division of Birmingham City Council. Social worker 1 assumed that the older adult division and the community mental health team knew of each other's involvement with the family, but we found no record of this in Ms H's records. Social worker 1 subsequently became Ms H's care coordinator 4.

Care coordinator 4 said during the joint internal review that she felt Ms H's mother would only be at risk if Ms H was suffering a manic relapse of her bipolar affective disorder. We consider this to be a reasonable view because Ms H's previous aggression had been when in a manic phase of her illness. This aggression had not been directed towards her mother and the only record of threat was in 1994 when Ms H took her parents hostage.

Psychiatric nurse 2 became Ms H's care coordinator in 2008 and discussed a referral for Ms H's mother to older adult services. Psychiatric nurse 2 talked to Ms H's mother on 12 December 2008, who said the district nursing team was seeing her.

The last recorded contact with Ms H's mother we found was on 1 June 2009 when psychiatric nurse 3 rang to leave a message for Ms H. We found no record that Ms H's mother had expressed concerns about her safety.

We are mindful of the fact that, if a similar situation arose today, because of Ms H's history of mental health problems and aggression when unwell, safeguarding arrangements would have been in place for Ms H's mother. This would have been particularly relevant because Ms H denied care coordinator 4 access to her mother for a social needs assessment.

However, between 2007 and 2009, safeguarding procedures were in the early stages of development.

The Birmingham safeguarding adults board first published their 'Safeguarding Adults: Policy, procedure and good practice guide'¹ in June 2009. Birmingham and Solihull NHS Mental Health Trust signed up to the policy at the time of publication. This guidance was developed in response to a national drive after the publication of 'No Secrets' in 2000. 'No Secrets' was Department of Health and Home Office guidance published on the adult safeguarding agenda and placed a duty on local authorities to develop a framework to ensure processes were in place to protect vulnerable adults from abuse and neglect.

We have reviewed several documents the Trust provided, including the 2013 quality report presented to the trust board² and the Birmingham and Solihull Mental Health NHS Foundation Trust's Annual Quality Account for 2013/14³. These chart the development of safeguarding procedures in the trust. They show a joint safeguarding group was established in 2011 after the Child and Adult Safeguarding Groups were amalgamated. This group reports to the Trust's clinical governance committee, oversees training and audits safeguarding within the Trust.

These documents show there have been many changes in safeguarding arrangements since the homicide. If these had been in place in 2007, it is probable that Ms H's mother would have been seen as a vulnerable adult and that Ms H denying access would have led to a safeguarding alert.

¹ See <http://www.livingstonehouseuk.org/pdf/Safeguarding%20Adults%20Policy.pdf>

² <http://www.bsmhft.nhs.uk/about-us/trust-documents/board-papers/2013/?assetdet338220=34862&categoryesctl338224=463>

³ This was a report about the quality of trust services which was made available to the public in 2013/4

9.1 Findings

F5 Ladywood community mental health team maintained regular contact with Ms H while she lived with her mother. However, they failed to fully assess if Ms H was a risk to her mother.

F6 We found no evidence that Ms H had a carer's assessment to determine if she was capable of providing the support her mother needed.

F7 Safeguarding vulnerable adult procedures were still in development at the time of the incident and there were no arrangements in place for the team to make a safeguarding alert as is likely would happen now.

9.2 Conclusion

Whilst the records indicate that the Ladywood CMHT had regular contact with MS H's mother there is no record that they assessed the risk that Ms H may pose to her. Ms H was eligible for a carer's assessment that would have helped determine if she was capable of looking after her mother. This did not happen.

Since these events this trust and nationally safeguarding procedures for vulnerable adults have been put in place and it is likely that if they had been in place then a safeguarding alert would be made. This would lead to an assessment of the risks that her mother faced along with a plan to mitigate the risks.

10. Medical care and treatment to Ms H

Here we review the care medical staff of Ladywood community mental health team provided Ms H.

Ms H was transferred from the Sandwell services to Ladywood services in 2007. The two services had a period of working together on her case from March until October 2007. Sandwell services withdrew after October 2007.

The Sandwell assertive outreach consultant psychiatrist, consultant psychiatrist 1, saw Ms H regularly after her referral in 2006.

The Sandwell assertive outreach team consultant wrote a letter of referral to the Ladywood services and Ms H was given an outpatient appointment to facilitate the transfer.

Senior house officer 1 from the Ladywood community mental health team reviewed Ms H in outpatients on transfer. Senior house officer 1 was working under consultant psychiatrist 2. Consultant psychiatrist 2 did not see Ms H until 2009 when her health needed reviewing due to lithium-induced thyroid problems.

We reviewed if medical care was adequate to meet Ms H's needs because she had a serious and enduring bi-polar illness.

Senior house officer 1 first saw Ms H on 7 June 2007 and then saw her regularly on:

2 August 2007;
9 October 2007;
6 December 2007;
18 February 2008;
21 May 2008;
15 July 2008;
14 October 2008;
13 January 2009; and
15 April 2009.

Consultant psychiatrist 2 supervised senior house officer 1. The internal joint review interviewed consultant psychiatrist 2 and she said that senior house officer 1 and consultant psychiatrist 2 each managed some of the outpatients. Our own medical expert advised us that it would have been good practice for consultant psychiatrist 2 to have seen Ms H because of her complex history, enduring mental health problem and being a new patient to the service.

However, senior house officer 1 saw Ms H regularly, provided consistent and appropriate medical care and wrote to her GP to keep them informed of Ms H's assessment. Senior house officer 1 assessed Ms H's mental state, sleep pattern and overall mood during his outpatient appointments. Senior house officer 1 frequently asked her about self-harm and aggression to others and reviewed her medication in response to sleep disturbances and side effects.

Consultant psychiatrist 2 met Ms H in June 2009, when she developed a lithium-induced thyroid problem, and provided appropriate medical care.

The joint internal review found no evidence that the lithium-induced thyroid problem could have contributed to Ms H's violence.

It also found that the overall model of medical input into the care of clients with complex mental health should be reviewed. We discuss this later in this report.

10.1 Findings

F8 The medical care provided to Ms H was appropriate to her needs. Senior house officer 1 oversaw the majority of Ms H's medical care and showed good practice in keeping Ms H's GP fully informed after outpatient appointments. Consultant psychiatrist 2 provided senior medical assistance when Ms H developed a lithium-induced thyroid problem.

F9 It would have been best practice if consultant psychiatrist 2 had seen Ms H at least on transfer from Sandwell assertive outreach team due to her complex history and enduring mental health problems.

10.2 Conclusion

A client with Ms H's diagnosis and history of non-engagement would normally be expected to be monitored by a consultant psychiatrist. On transfer in 2007, Ms H was not seen by consultant psychiatrist 2, her consultant. Instead she was seen by senior house officer 1, who was a more junior doctor working under the supervision of consultant psychiatrist 2.

Following this, senior house officer 1 appropriately monitored Ms H's mental state and risk to self and others and was diligent in keeping Ms H's GP fully informed of her presentation in out-patient appointments.

Consultant psychiatrist 2 did meet with Ms H in June 2009 when Ms H developed a lithium-induced thyroid problem and provided appropriate care for this.

11. Predictability and preventability

Here we consider whether the homicide was predictable or preventable.

11.1 Predictability

Our definition of predictability is as follows:

We consider the homicide would have been predictable if Ms H's words, actions or behaviour at the time could have alerted professionals that she might have become violent, even if this evidence had been unnoticed or misunderstood at the time.

We considered if Ms H's lithium-induced thyroid problems should have alerted the professionals to a risk of increased violence. Lithium-induced thyroid problems are a known side effect of lithium therapy for bi-polar disorder¹. We found no evidence in the British National Formulary 2015 of the Maudsley Prescribing Guidelines that lithium side effects are associated with violence. While the possibility of drug interactions having an idiosyncratic effect on Ms H cannot be ruled out, we would not expect such an effect to be predictable.

The professionals working with Ms H were concerned for her physical health and the possibility of a relapse of her poor mental health. Ms H's previous violence, both in the community and as an inpatient, was linked with episodes of relapse of her bipolar disorder and in particular the manic phase of this disorder.

The assertive outreach team recorded Ms H's early warning signs of relapse when she was transferred from Sandwell services. In this record, sleep disturbance was seen as a particular concern. The Ladywood services team responded to reports of Ms H's sleep disturbance with outpatient reviews and changing dosages of her medication, including chlorpromazine and zopiclone. Senior house officer 1 assessed and monitored her mental state during these meetings and recorded if she had thoughts or ideas of self-harm, harm to others or risk of overdose.

Although the team did not record all meetings and activities with Ms H as expected under the care programme approach, services engaged with her and she engaged with them. She regularly attended outpatient appointments and senior house officer 1 consistently saw her during her transition from Sandwell to Ladywood.

Consultant psychiatrist 2 saw Ms H on 2 June 2009 and noted that she had a low mood, was tired and sleeping more and that she had gained weight. Psychiatric nurse 3 saw Ms H on 11 June, and she was eating and sleeping well and not showing signs of relapse. Ms H's mother was seen during the visit and no concerns were raised. The team did not record or report concerns that Ms H was in danger of becoming manic.

¹ Kibirige D, Luzinda K, Ssekitooleko R, (2013) 'Spectrum of lithium induced thyroid abnormalities: a current perspective', Thyroid Research, Volume 6, 3
<http://www.thyroidresearchjournal.com/content/pdf/1756-6614-6-3.pdf>

Staff who had worked in the community mental health team at the time of the incident voiced a sense of shock about the homicide in the reflective session held during this investigation. The participants who knew Ms H described her as intelligent, with a range of social and artistic skills. They said that since she had been with the service there had been hope for her future.

We found no evidence that should have alerted the team to the possibility of Ms H killing her mother and nothing in her words or actions that would have led the team to believe that this would happen.

Although records show Ms H took her parents hostage, this incident happened in 1994, and we found no record of actual harm to her parents and the incident was not repeated. In the evidence that we have seen, when Ms H was unwell, she was aggressive to professionals, the police and her friends, but we found no further record of threats or actual harm to her mother or father.

11.1.1 Finding

F10 We conclude that the homicide of MC could not have been predicted because we found no evidence from Ms H's words, actions or behaviours that could have alerted the professionals that she would become imminently violent.

11.1.2 Conclusion

In the weeks leading to the homicide, Ms H gave no indications to the Ladywood community mental health team workers that she would be imminently violent.

11.2 Preventability

Our definition of preventability is as follows:

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

If the Ladywell CMHT had complied with the arrangements under the care programme approach, it is likely they would have recorded their interventions more thoroughly. They may therefore have met with Ms H's mother to assist Ms H with her care role, but it is not possible to surmise that this would have affected the eventual incident.

In meetings with the Ladywood community mental health team Ms H freely discussed her mental state and issues and was fully compliant with medication.

When offered the opportunity to stop her lithium on 2 June 2009, she decided to keep taking it.

Although the team were concerned for Ms H's physical and mental health due to the lithium-induced thyroid problems, we found no indication of Ms H having a relapse of her bi-polar illness. Therefore, the team had no reason or opportunity change Ms H's care.

11.2.1 Finding

F11 We conclude it was not possible for community mental health team staff to have prevented the death of Ms H's mother.

11.2.2 Conclusion

The team did not consider Ms H's mother to be at risk and there was no indication of risk in the meetings with the community mental health team in the weeks leading up to the incident.

12. Joint review of Ms H's care

Here we review the trust's joint internal review and the recommendations and action plan that resulted from it.

As mentioned, Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham City Council carried out a joint internal review of Ms H's care. This internal review panel produced a report in August 2010 that was delivered to both the trust board and the city council.

A panel of six senior trust and council personnel conducted the review. The panel members occupied the following posts at the time:

- Medical Director, Birmingham and Solihull Mental Health NHS Foundation Trust.
- Acting Director of Nursing Birmingham and Solihull Mental Health NHS Foundation Trust.
- Director of Strategic Delivery, Adults of Working Age, Birmingham and Solihull Mental Health NHS Foundation Trust.
- Associate Director of Risk management, Birmingham and Solihull Mental Health NHS Foundation Trust.
- Temporary Head of Service/Mental Health, Adults and Communities Directorate, Birmingham City Council.

The panel also included a service user representative and an independent expert in mental health community care who was a professor of psychiatry and consultant psychiatrist.

The Trust solicitor acted as an advisor to the panel. The medical director chaired the panel.

The joint internal review conducted interviews with the following clinical staff involved with Ms H and her mother:

- Consultant psychiatrist 1, consultant psychiatrist Sandwell assertive outreach team;
- Senior house officer 1, associate specialist to consultant psychiatrist 2;
- Consultant psychiatrist 2, consultant psychiatrist Ladywood community mental health team;
- Team leader 1, team manager Ladywood community mental health team;
- Psychiatric nurse 3, care coordinator and community psychiatric nurse, Ladywood community mental health team;
- Care coordinator 4, care coordinator and social worker, Birmingham City Council;
- psychiatric nurse 2, care coordinator and community psychiatric nurse, Ladywood; community mental health team;
- Dr PD, general practitioner for Ms H; and
- Dr KC, general practitioner for Ms H's mother.

The joint internal review also interviewed the following managers who were not directly involved with Ms H's care. These managers provided other information about the community mental health team.

- KJ programme director, Adults of Working Age.
- JB, programme clinical director, Adults of Working Age

The Trust conducted desktop reviews of Ms H's care before officially starting their joint internal review. These focused on the care given to Ms H and her involvement in the care given to her mother.

The internal review received written and oral evidence from health professionals who had been involved with Ms H's care. Care coordinator 3, the care co-coordinator at time of transfer of Ms H was not available for interview. Ms H was also too unwell to be interviewed.

The joint internal review identified six key issues of concern:

- transfer of care from Sandwell assertive outreach to Birmingham and Solihull community mental health team;
- care programme approach issues;
- community mental health team issues;
- medical management;
- assessment of risk to Ms H's mother; and
- documentation and care reviews.

They produced recommendations grouped around four themes:

- transfer of care from Sandwell assertive outreach team to Birmingham and Solihull community mental health team;
- psychiatric management;
- risk posed to Ms H's Mother; and
- structure and function of the community mental health team.

The separate action plan, however, indicated thirty action points. The action points related both to the process of the review itself and actions following the recommendations.

The action points were not referenced to the areas of concern. As a result it has been difficult to correlate areas of concern, themes and action plan.

12.1 Findings

F12 The Trust and the council carried out a detailed joint internal review.

F13 The Trust review makes recommendations in both its summary of the themes and again in the action plan. These are not well cross-referenced. The result is that

the actions are unclear and there is no process set out to assure that the actions listed have been effectively addressed.

13. Assurance of changes following the incident

In this section we consider how the community mental health team functions now and if there is evidence of changes in the function of the team.

Due to the time elapsed between the incident and this investigation, it was agreed with the commissioners and the Trust that this investigation would seek assurance of the themes of the internal review rather than the specifics of the action plan. Because the recommendations were confusing, we have grouped these under the following themes:

- Care coordinator caseloads and distribution of complex cases in the Ladywood and Handsworth Community Mental Health Team.
- Medical input into complex cases.
- Present management of referrals and transfer of care.
- Social work input to CMHT and section 117 monitoring.
- Care planning and risk assessment.

13.1 Ladywood and Handsworth community mental health team introduction

The Trust and city council joint review identified concerns about the capacity of the then Ladywood Community Mental Health team to deliver efficient mental healthcare. These concerns were about:

- the capacity of the care coordinators to provide adequate care given their high individual caseloads at the time; and
- the medical team, including consultant psychiatrists, seeing less complex cases in outpatient clinics. This resulted in the care coordinators having less access to the medical team when managing these cases.

During the present investigation we examined if these factors had improved in the five years since the homicide.

13.2 Methodology

We conducted a caseload audit using the Trust's dashboard system and discussed our initial findings with the team leader 1.

We held two focus groups – one for non-medical staff and one for medical staff.

During these we explored the issues of caseloads and access to consultants and consultant work practice.

Both focus groups had members from two community mental health teams (Ladywood and Handsworth CMHT, Ashton and Nechalls CMHT). The non-medical focus group also had members from assertive outreach and early intervention teams.

13.3 Structure and function of the community mental health team

The joint internal review found two major issues with the structure of the community mental health team that affected the team's ability to care for Ms H.

These were:

- the overall caseload of the team was too large; and
- the majority of the caseload was clients with lower needs who would be better managed in primary care services.

This resulted in the care coordinators in the team having a large number of clients with complex, high needs and on the care programme approach while the medical staff were focused on dealing with clients of lower need and not on the care programme approach.

The next sections will deal with out examination of the practice in the team at the time of our investigation and will end with our findings and recommendations.

13.4 Care coordinator caseloads of Ladywood and Handsworth community mental health team.

The Department of Health *Mental Health Policy Implementation Guide: Community Mental Health Teams* (March 2001) states that, for teams that serve a population between 10,000 and 60,000:

“Each team to have a maximum caseload between 300–350 patients but may be considerably less. Otherwise information exchange becomes unwieldy eroding clinical capacity.” (page 18)

The focus group with the consultant psychiatrists indicated that the Ladywood and Handsworth community mental health team served a population of approximately 45,000 – 47,000, and that this population had very complex clients with high needs. The consultants said that there had been a noticeable reduction in the population since the incident, but had concerns that this may increase in the future with new reconfigurations of services.

On the 4 March 2015, in order to analyse the caseloads of care coordinators in the Ladywood and Handsworth team, we obtained access to the 'dashboard'. The 'Dashboard' is an active and up to date electronic record of all care-coordinators present caseloads. It provides information on a number of metrics such as dates of care programme meetings or reviews.

The dashboard is made available to team managers to monitor care coordinator activity and compliance with trust policies on the care programme approach.

Team leader 1 explained that the team has ten workers whose main role is to work as care coordinator. The team also has two workers who also provide care coordination, but also have other roles that take up more of their working time.

Of the ten dedicated care coordinators, five were full time (or 'whole time equivalent' (WTE) workers) and five were part-time.

The focus groups informed us that the team was expected to maintain care coordinator for clients who were now in forensic care, regardless of how long they were to be there. This was a condition of the client being accepted for forensic care. Of the ten dedicated care coordinators, one has the role of maintaining contact as care coordinator for all clients in forensic services and out of area placements.

One care coordinator is also rostered to work as an approved mental health practitioner on two days a month.

Dashboard records show that these ten care coordinators have a combined caseload of 239 clients on 4 March.

Team leader 1 informed us that two of the ten dedicated care coordinators were agency nurses. They had been working to cover the caseload of two workers who were on long term sick leave.

One of these agency worker had taken on a further four clients in addition to the existing caseload.

As mentioned above, two care coordinators had other roles and small caseloads. One was team leader 1 who had a case load of one client. The other was the recognised duty worker who had a caseload of four clients. The team leader is the operational manager for the team and the duty worker manages all new referrals to the team including initial assessment, planning and communication with referrer. With the nine additional clients (agency workers four plus team leader and duty workers five), the total caseload of the team at time of assessment was 248.

13.5 Caseload sizes of the dedicated care coordinators

There is no national agreed caseload size for a community mental health worker. This is because not all clients are considered 'equal' in the amount of resource and interventions they require to meet their needs. However, Department of Health *Mental Health Policy Implementation Guide: Community Mental Health Teams* states:

“Full time care co-ordinators to have a *maximum* caseload of 35 and part time staff to have their caseload reduced pro-rata.” (page18)

When adjusted for part-time working, the case load sizes for the ten dedicated care coordinators is seen in the shaded column below.

	Band	WTE	Caseload Actual	Caseload Adjusted To WTE	Notes
1	5	1	23	23	
2	6	0.6	20	33	
3	6	1	16	16	Also functions as care coordinator for all out of area and forensic clients
4	6	0.8	20	25	Agency cover for long term sick leave
5	6	0.8	27	34	
6	5	1	27	27	
7	6	1	30	30	
8	6	0.6	19	23	Agency cover for long term sick leave
9	6	1	30	30	AMHP 2 days month
10	5	0.8	27	34	

From this we can see that five of the workers have caseloads of 30 or more and that two are near the maximum level as defined by the policy.

13.6 Overall team caseload

In our analysis we also wanted to examine the level of client need to ensure that most of the clients seen were complex cases.

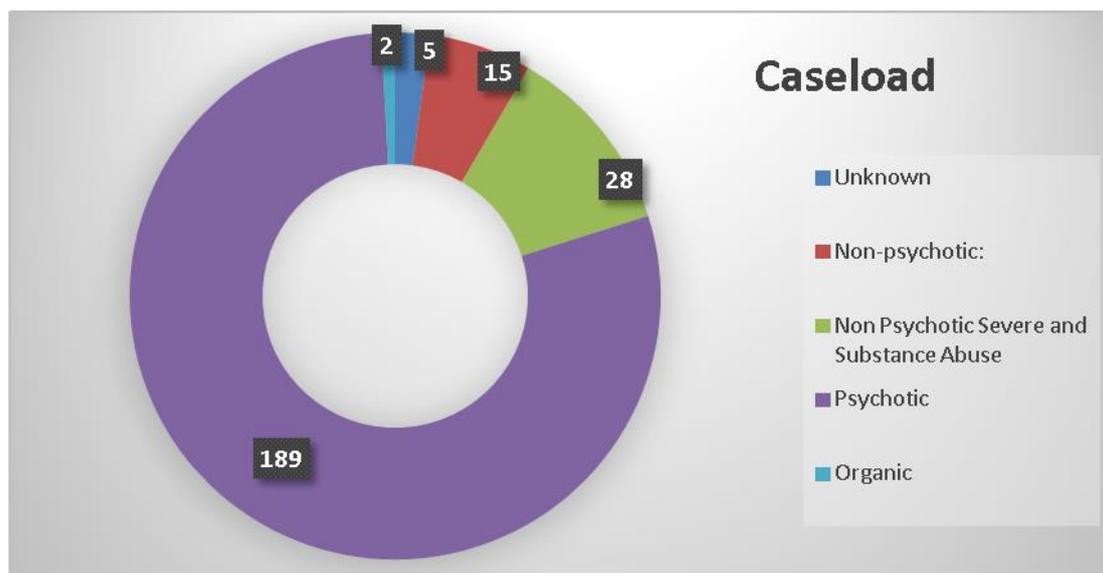
The dashboard contained information on the Health of the Nation Outcome scale (HoNOS) for each client. This rating allows the client to be given a rating indicating their level of illness.

On the 4 March we recorded the HoNOS rating for all the clients of the ten dedicated care coordinators and assigned them to the HoNOS groupings of:

- non-psychotic (e.g. depression or anxiety disorders);
- non-psychotic severe and substance abuse (e.g. severe mood disorders, personality disorder);
- psychotic (e.g. schizophrenia, bi-polar disorder); and
- organic (i.e. dementia type conditions).

Care coordinators (N= 10)

	Clusters	Number
Unknown	n/a	5
Non-psychotic:	1-4	15
Non-psychotic severe and substance abuse	5-9	28
Psychotic	10-17	189
Organic	18-21	2



Community mental health teams should be providing care for complex clients with high need. We have defined complex cases as both 'non-psychotic severe and substance abuse' and 'psychotic' clients.

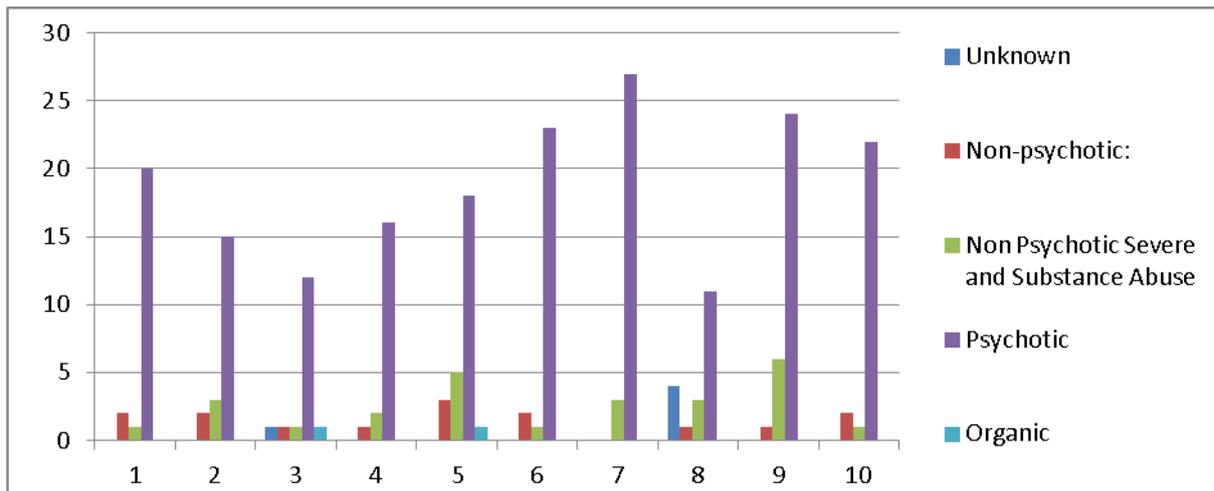
There are 217 complex clients with high need in the total of 239. Discounting the five unknown clients, this is 217 of 234, or 93 percent.

We discussed the small number of low need and the unknown clients with team leader 1. She explained that the ratings can change due to people being reassessed as a lower need cluster than originally considered.

13.7 Distribution of complex clients with high need across the care coordinators.

Although the majority of clients receiving care coordination are of complex clients with high need, we also wanted to ensure that this was evenly distributed across the care coordinators.

To do this we analysed the HoNOS ratings for the clients of the ten dedicated care coordinators, as shown below.



Numbers on caseloads by broad HoNOS Clusters

We also discussed the allocation of clients to care coordinators with team leader 1. She informed us that her team was a mixture of experienced workers and newly qualified workers as well as permanent trust staff and agency workers covering for sickness. Her expectation was therefore that there would be some discrepancy in the distribution of complex clients with high need. She was able to give us a break down of each care coordinator, their individual skill and experience and what cases they were allocated. Care coordinator 1, for example was recently qualified as opposed to case coordinator 7, who was experienced and working to a high level of autonomy.

13.8 Medical input into complex cases

Both focus groups said that medical team in the CMHT's had very large overall caseloads. A figure of 1,300 was given for a locality with a full-time consultant having 650 plus patients.

This is a very high figure for a consultant psychiatrist caseload. As can be seen from the figures above, the vast majority of these clients are not the complex high need clients on the care coordinators caseloads.

This brings into question what is the perceived role of the Consultant psychiatrist in both community mental health teams. The role described by the consultants in the focus group fits the traditional role¹ prior to the national move to new roles outlined in 'New Ways of Working':

“In essence, [New Ways of Working] is about using the skills, knowledge and experience of consultant psychiatrists to best effect by concentrating on service users with the most complex needs, acting as a consultant to multidisciplinary teams, promoting distributed responsibility and leadership across teams to achieve a cultural shift in services. It encompasses a

¹ See Harrison J, 'The work patterns of consultant psychiatrists Revisiting... How consultants manage their time.' *Advances in Psychiatric Treatment* (2007), vol. 13, 470–475
<http://apt.rcpsych.org/content/aptrpsych/13/6/470.full.pdf>

willingness to embrace change and to work flexibly with all stakeholders to achieve a motivated workforce offering a high quality service.” (Care Services Improvement Partnership et al, 2005: p. 5¹).

Our medical expert told us that consultant psychiatrists are the highest clinical expert in the team the more complex and more difficult cases should be their concern. In this the consultant would be expected to carry out assessments on two groups of patients: those new to the services and those who have already been seen and assessed and require a following up and management plan. The consultant has a role to play in both, but only for those who are complex and high need. In this, new cases should either be discharged back to the care of the GP or referred on to other members of the CMHT or to other parts of the services. This frees the consultant to deal with the more urgent referrals, assess the new complex cases and support other members of the CMHT in the follow up of existing complex cases.

Both focus groups described the consultant's role in the CMHTs as very different to this. They told us that medical teams were seeing high need clients on the care programme approach, but also high numbers with lower needs clients, who are not on the care programme approach. The lower needs clients were in receipt of 'care support', which means they do not have access to a non-medical care coordinator. Both the focus groups told us that medical staff spends a lot of time running outpatient clinics or clinics in GP surgeries. Some of these outpatient clinics are run by lower grade doctors under supervision of the consultant (as happened with Ms H) and a recently appointed advanced nurse practitioner will eventually take over some of the monitoring of some clients, but at present the majority of these clinics deal with lower need clients.

The focus group of consultant psychiatrists also said that part of their role was to look after patients who are otherwise not in the system. We were told that if a patient is eligible for the care programme approach but has to wait to be allocated a care coordinator, the consultant automatically takes responsibility for those patients and will increase the number of outpatient clinics until they are allocated a care coordinator.

We were also told of a situation where clients were placed on a consultants caseload 'automatically'. The example given was a care home whose residents were all transferred into the community mental health team due to a boundary change and added to the consultant's caseload.

The situation is also changing as the teams around the CMHT's change. Both focus groups told us that access to forensic services was reducing due to service re-provision and the dual diagnosis service had recently moved due to a restructuring of services. The teams were already experiencing having less support from these specialist teams.

Both focus groups told us that consultant cover for the two community mental health teams has changed over the years. At present Ashton and Nechalls has two full-time consultants and Ladywood and Handsworth has three part-time consultants.

¹ http://eprints.nottingham.ac.uk/788/1/NWW_Psychs.pdf

For the care coordinators in the teams, this difference in consultant input has led to different experiences in accessing medical input within the teams. In the non-medical focus group we were told that the Ashton and Nechalls full-time consultants were more available and integrated into the multi-disciplinary team. In Ladywood and Handsworth, the three part-time consultants are less available and integrated. This was felt to be because of their part-time status, rather than their personalities. We were also told that there were differences in the medical running of Care Programme approach meetings. In Ashton and Nechalls there are timetabled sessions dedicated to care programme approach meetings while in Ladywood and Handsworth a client's care programme approach meeting would happen during outpatient clinics.

The benefits of having a session dedicated to care programme approach meetings are that these can be booked in advance and the focus will be on fulfilling the requirements of the care programme approach and other monitoring such as community treatment orders and section 117 reviews.

The joint internal review into the care of Ms H was clear that "the special tasks inherent in a review require the meeting to be specifically conducted as a CPA review and not a routine outpatient clinic appointment". One consultant informed us that the outpatient clinics had such a high rate of clients not attending that she had taken to double booking clients on occasion. When we asked what would happen if both turned up, we were told "one will be asked to wait".

13.9 Present management of referrals and transfer of care

The joint review identified that the transfer of care neither included adequate documentation of the transfer process, nor an adequate risk assessment or care planning process. Our own review of Ms H's care agrees with this.

In order to provide a thorough examination of the changes in practice, we have looked at these issues for all clients who are stepped down from the assertive outreach team to community services.

Ms H's referral to Ladywood community mental health team was from one consultant to another consultant. The consultant from the Sandwell assertive outreach team wrote to the medical team of Ladywood community mental health team and they accepted this as a transfer of care and arranged an outpatient appointment.

Both focus groups told us the trust now has a different way of processing all transfer and referral requests. All such requests now go to a trust-wide 'single point of access team. This team would then triage and refer or pass the referral on to the relevant trust team for assessment.

Both focus groups were critical of the single point of access system. Because the team do not make face-to-face assessments, the focus groups view was that that referrals are just delayed before they reach the teams. The focus group for medical staff also gave us anecdotal situations where the team received client referrals

outside the single point of access system. An example given was the care of a group of care home residents who were transferred from one team to another after service changes. We discuss this below.

The team's duty worker deals with requests that come to the Ladywood and Handsworth community mental health team. The duty worker either completes the assessment or negotiates with the team manager for a care coordinator to be allocated.

One consultant in the focus group thought there was a waiting list for allocation of a care coordinator in the community mental health teams. All other participants said there was no waiting list.

There is a waiting list for acceptance from the assertive outreach team, who take their referrals from the community mental health teams. These referrals are for complex clients with high risk and need who are in danger of frequent relapse, as Ms H was until 2005. The focus group for clinical workers told us that this waiting list has been as high as 20 patients but at the time of the focus group, was down to six.

In the focus group for medical staff we asked what would happen if they received a request like Ms H's for a transfer from another trust that also indicated a step down in services from the assertive outreach team to the community mental health team. A consultant for the Ladywood and Handsworth team told us that the community mental health team now operated on a 'like for like' service transfer. This means that if the client is with the assertive outreach team, the referring trust would have to step them down before the community mental health team would consider transfer. If they did require the services of the assertive outreach team, the other trust would have to wait until there was capacity in assertive outreach team to take them.

The 'single point of access team' enters client details into the Trust's electronic care record. The Trust also has a 'Dashboard' system for team managers, which is an up-to-date electronic record of the caseloads of each care coordinator. Once a care coordinator is allocated, the team manager monitors the care programme approach meetings through the dashboard.

The focus group for non-medical staff told us that if a client is transferred between services, such as when a client is discharged from inpatient services back to the community, the dashboard assumes that all previous records, such as care plans and assessments are no longer valid.

This means that although there may be an existing risk assessment and care plan from the old service, it is not included in the team's compliance rating for dashboard. The rating will only improve once the community worker has entered their own data following transfer. The focus group workers found this system frustrating, but we find it provides a monitoring system for the new team to update care records and generate their own risk assessments and care plans.

13.10 Social work input to CMHT and section 117 monitoring

Section 117 of the Mental Health Act obliges health and social care services to provide aftercare to clients who have been detained in hospital under certain sections of the Mental Health Act.

The Mental Health Act defines this aftercare as the care required to meet a need relating to the client's mental disorder that will reduce the risk of the person relapsing and being admitted. The obligation to provide this aftercare can only be cancelled if a formal assessment shows that the client no longer needs such aftercare. The recent 2014 Care Act has further defined the obligations of both mental health and social care services.

The non-medical focus group informed us that the mental health teams used to include social workers that the city council employed. Although the focus group was unclear when this changed, they thought it happened in the early 2000's when the city council removed the mental health social workers from the teams and centralised them elsewhere. Dedicated social workers have returned to the early intervention services and assertive outreach services since then, but not the community mental health teams.

Community mental health teams currently have to make a referral to a central duty social work team if they need social work input. This can cause a delay in community mental health team monitoring community treatment orders and section 117 aftercare arrangements. In addition, the groups told us there was an inconsistency in monitoring clients because the social worker was likely to be different each time there is a review.

There is now a new team leader for the social work team who is working to provide more of an interface with the social work service, but the community mental health teams feel that social needs remain hard to address. This is particularly the case with statutory mental health needs such as clients on community treatment orders or those eligible for aftercare under section 117 of the Mental Health Act.

We conducted an analysis of the RiO electronic care records¹. We found the records clearly recorded which patients were under community treatment orders (CTOs) but it was less clear which were eligible for section 117 aftercare. (See Appendix C)

13.11 Care planning and risk assessment.

The joint internal review and our own investigation found that Ms H's care planning and risk assessment did not meet trust or national standards.

We wanted to provide some assurance that the present teams are meeting the required standards the Trust defines.

¹ The 'RiO Integrated Care Record' system has been introduced and embedded in the trust since 2009. It provides an electronic systems for the recording of assessments progress notes and records of and care planning.

At the time of the incident, the Trust was moving from a paper based records system to an electronic integrated care records (ICR) system.

In March 2015 we were given access to the RiO records for a day. Using the care coordinator lists dashboard provided, we identified ten patients who could have fitted the profile for referral to assertive outreach teams. They were complex clients with high mental-health needs.

Once we had identified a suitable client, we examined the RiO records to answer the following questions:

- Is there an up-to date screening of risk on RiO?
- Is there an active risk management plan in the RiO Risk record?
- Has the client had a care programme approach meeting in the past six months and is this recorded in the progress notes?
- Have the care plans been updated since the care programme approach meeting and have these been undated in the Rio Care Plans?
- Is there evidence of recent and ongoing attempts to remain in contact with the client in the progress notes section of RiO?

A detailed summary is contained in Appendix C.

13.12 Conclusions

Apart from one instance of a client having an overdue care programme approach meeting, there was evidence that the Ladywood and Handsworth Community Mental Health Team maintain their records for complex clients with high mental health needs.

One case showed an example of good practice in the communication with police of a high-risk case.

Where risk to the family from the client was indicated, care coordinators had taken these risks into consideration in their risk management plans.

We found evidence that the updating of care plans after care programme approach occurs sometime after the meeting. This may be because the immediate recording of care programme approach meeting is logged in the RiO progress notes section, but the care plans are in a separate section of RiO.

It was clear what arrangements had been put in place to monitor community treatment orders, but the arrangement for section 117 aftercare arrangements were less clear.

13.13 Findings and recommendations

The findings and recommendations from our analysis of CMHT team work are set out below.

Findings

F14 The structure and function of the community mental health teams has changed little since the Ms H incident. The focus of the consultant psychiatrist role is not in line with national models because it does not focus on the care of the most complex clients;

F15 The medical team members of the CMHT are dealing with large caseloads of low need clients consistent with the findings of the internal review. However, this is not isolated to the Ladywood and Handsworth team.

F16 Ladywood and Handsworth Community Mental Health team care coordinators have acceptable caseload sizes.

F17 The community mental health team caseload (excluding medical staff) is made up of 93% complex clients with high need.

F18 The small number of lower need clients (not being seen by medical staff) are evenly distributed across the team.

F19 Most clients receiving care under the care programme approach are complex clients with high need.

F20 Unlike other teams in the Trust, Ladywood and Handsworth community mental health teams do not have dedicated sessions for care programme approach meetings.

F21 Ladywood and Handsworth team perform an unofficial practice of double booking outpatient medical appointments.

Recommendations

R1 The Trust and local authority should provide assurance of their compliance with the legal requirement to review patients subject to section 117 of the Mental Health Act.

R2 The medical director should oversee a major review of the function of Ladywood community mental health teams. This must include a clear definition of the role of the consultant psychiatrist and how this role fits with the care of the most complex clients.

R3 The Ladywood and Handsworth community mental health team should have timetabled sessions dedicated to conducting care programme approach meetings.

R4 The Trust's care programme approach should be multi-disciplinary, include the appropriate consultant psychiatrist and also be used for reviews of clients' community treatment orders and section 117 aftercare arrangements.

This Appendix is a summary of Ms H's early life and her mental health treatment prior to transfer to Birmingham and Solihull NHS Foundation Trust.

Care under Sandwell Mental Health and Social Care Trust

Ms H was raised in Birmingham as the only child of her parents. She left school at the age of 17.

Ms H married in 1983 and moved to Norfolk, returning to the midlands with her husband two years later. In 1988 Ms H started training as a psychiatric nurse.

Also in 1988 Ms H was admitted to Burton Road Hospital in Dudley with what was described in subsequent case summaries as 'acute manic psychosis', although there is no further information in the clinical records about her treatment or aftercare.

She and her husband divorced in 1989. She had no children.

In 1990, while still in nurse training, she took an overdose of Fenfluramine¹. Following this she was alleged to have had an inappropriate relationship with a patient and was dismissed from her nursing course.

On the 14 March 1991 Ms H was admitted to All Saints Hospital in Birmingham. As Ms H had previously been on placement in All Saints Hospital during her nurse training, she was transferred to Burton Road Hospital. She was diagnosed with bipolar affective disorder and treated with Haloperidol². She settled and was discharged on 9 April. On discharge she did not attend follow up appointments arranged.

In May of 1990 Ms H was again elated and sexually disinhibited. She was assessed at home for admission under the Mental Health Act. The medical opinion was that Ms H should be detained in hospital, but she agreed to take medication, so she was not admitted to hospital.

In early 1992 Ms H was again not taking her medication. On 6 February Ms H was informally admitted to All Saints Hospital after attending A&E and asking for an assessment. While in A&E she became physically aggressive to staff, On 9 February Ms H asked to be discharged. She was not detainable under the Mental Health Act and was discharged against medical advice.

¹ Fenfluramine is a drug that regulates appetite and mood. It increases the neurotransmitter serotonin resulting in a feeling of fullness and therefore reduces appetite.

² Haloperidol is an antipsychotic used to treat psychosis. It has a strong sedative effect.

Also in 1992 Ms H started a course in English at University. She was unable to complete the course due to frequent relapses and admission to hospital.

Ms H again failed to attend her follow up appointments. In March she broke into a church and was apprehended by the police. Subsequently, she was admitted to All Saints Hospital under Section 2 of the Mental Health Act on 18 March 1992. Ms H was prescribed Lithium¹ and settled quickly. She was discharged on 6 April 1992 and given an outpatient follow-up appointment.

On 31 August Ms H assaulted a friend and also sustained an injury to her foot when she broke a window. She was taken to accident and emergency and had to be restrained by police officers. Ms H was again admitted to All Saints Hospital under Section 2 of the Mental Health Act. On the ward she was violent towards nursing staff and needed to be sedated. She settled and was discharged on 11 October 1993.

Ms H was informally admitted to All Saints hospital on 7 April 1994. She presented as hypomanic² and experienced paranoid delusions that people were trying to hurt her. This was the first recording of these symptoms. She was again treated with lithium and was discharged on 23 May.

In July 1994 Ms H barricaded herself into her parents' home. Sandwell assertive outreach team handover summary say that she 'had tried to take her parents hostage'. There is no further information on this incident and no record if her parents were harmed. Following this, on 16 July Ms H was admitted to All Saints Hospital under Section 3 of the Mental Health Act. She was treated with lithium. Ms H requested a change of doctors during her admission, which was granted. However, she still failed to engage with the new doctor or care team and did not attend follow up after she was discharged on 23 August.

Ms H was admitted to all Saints Hospital under Section 3 of the Mental Health Act on 2 February 1995. She displayed flight of ideas and paranoid delusions. She settled with lithium and chlorpromazine. She was discharged on 21 March.

Ms H did not have contact with psychiatric services again for 5 years. It is reported than Ms H took her Lithium medication during this period, although it is not clear how she would have been prescribed it, nor if the required blood tests were carried out. During this period of stable mental health, Ms H restarted and completed her English degree.

Ms H was informally admitted to Hallam Street Hospital in West Bromwich on 3 May 2000 after being found by the police wandering the street and knocking on doors. She had not been taking her medication for some time prior to admission. She had stopped taking it when her father became ill. Ms H presented as preoccupied and

¹ Lithium (or Lithium Carbonate) as a medication is prescribed as a mood stabiliser in bi-polar disorder. It is used to reduce mania. The specific biochemical mechanism of lithium in mania is unknown

² Hypomanic means a person has an elevated (euphoric) mood or an irritable mood which is considered less severe than full mania.

guarded but again responded well to Lithium. She absconded from the ward and was discharged in her absence on 8 June.

On 19 August 2000 Ms H was admitted to Hallam Street Hospital under Section 3 of the Mental Health Act. She presented as mute for the first few days. She was subsequently assessed to have paranoid ideas but 'not of a delusional intensity'. Ms H complied with her lithium and steadily improved. She was discharged on 11 November 2000. After discharge she again failed to attend her follow up appointments.

On 8 November 2001 Ms H was detained by the Surrey Police. There is no record in the notes of why she was in Surrey. She was admitted to a local Surrey Hospital before being transferred back to Hallam Street Hospital under Section 2 of the Mental Health Act on 21 November 2001. There, she was prescribed Risperidone¹. Ms H settled and was discharged on 9 January 2002. On discharge Ms H was prescribed Lithium and Risperidone.

On 19 May 2002, Ms H was 'acting strangely in the street' and was detained by the police under Section 136 of the Mental Health Act. She was assessed at Redditch Police station and then admitted to Hallam Street Hospital under Section 2 of the Mental Health Act. This was subsequently converted to Section 3. On admission she isolated herself and was verbally abusive to staff. Blood tests indicated that she had not been taking her Lithium. Ms H complained that her Lithium had made her nauseous and was prescribed Depakote² as a substitute. During her admission Ms H absconded once from the ward and was returned by the police. Ms H was discharged under Section 25³ of the Mental Health Act on 11 September 2002. She was discharged on Risperidone and Depakote medications. When later seen in an outpatients she had gained weight and her Risperidone was changed to Quetiapine⁴.

Ms H's father died in 2002. We found no record of the exact date in Ms H's clinical records.

On 5 December 2003, Ms H was admitted to Hallam Street Hospital under Section 3 of the MHA. On admission she was mute, unresponsive and her personal hygiene was poor. Initially uncooperative, she did eventually comply with medication and became more interactive, although she was also described as aggressive and guarded in her responses to staff. She was discharged on 28 January 2004.

Ms H was admitted again to Hallam Street Hospital under Section 3 of the MHA on 15 April 2004. There was evidence of self-neglect and her personal hygiene was

¹ Risperidone is an antipsychotic drug mainly used to treat schizophrenia, schizoaffective disorder, and bipolar disorder. It has less side effects than Haloperidol but patients do tend to put on weight.

³ Section 25 of the Mental Health Act comes into effect when the nearest relative of a detained patient applies for their discharge from hospital.

⁴ Quetiapine is an antipsychotic similar to Risperidone but does not cause as much weight gain as Risperidone.

poor. She was verbally abusive towards staff and sexually disinhibited and occasionally aggressive. Ms H said she worked for the Devil. She was commenced on Clopixol¹ but this did not reduce her psychotic symptoms. Her medication was then changed back to quetiapine and Depakote. With medication, her psychotic symptoms reduced. Ms H was discharged on 19 August 2004. Her case summary says she did not want to be discharged, but does not say why. On discharge Ms H refused a referral to the assertive outreach Team² and contact with all other services.

On 24 August 2004 Ms H was again admitted to Hallam Street Hospital. She was in an aggressive, isolated state and was initially uncommunicative but found to be euthymic. She did not want to engage with the new team. Ms H was discharged on 1 September 2004. Her medication on discharge was Depakote and quetiapine.

In November 2004 Ms H was arrested by the police after stealing a 'can of drink'. Police detained her under 136 of the Mental Health Act and she was assessed in the police station, but she refused to give any information. On 5 November she was then admitted under section 2 of the Mental Health Act to the psychiatric intensive care unit (PICU) of Queen Elizabeth Psychiatric Hospital Birmingham.

On 8 November 2004 she was transferred from the Queen Elizabeth Psychiatric Hospital to Hallam Street Hospital. Her Section 2 was then converted to Section 3. At Hallam Street Hospital she displayed pressure of speech, was sexually disinhibited and threw water over electrical items. She was again prescribed risperidone and Depakote. When she refused all oral medication, her risperidone was administered as a slow release depot injection. She slowly improved but, when granted leave, refused her medication and relapsed. She also physically assaulted nursing staff. Her risperidone depot dose was increased and she again improved. Ms H then complained of akathesia³ and her risperidone was reduced back to the previous dose.

On 30 March 2005, Ms H was discharged. She was discharged on risperidone, Depakote and diazepam⁴. The risperidone was now given as a depot injection rather than tablets. She was also referred to the assertive outreach Team.

Following this discharge Ms H did engage with Sandwell assertive outreach team. Three months after discharge Dr O, the Special House Office working under consultant psychiatrist 1, writes a summary of Ms H's care to date.

The summary says that Ms H has had no instances of self-harm since her overdose 15 years previously, that she can be physically aggressive to others when unwell,

¹ Clopixol is an antipsychotic medication that is given as a slow release injection known as a 'depot'. Depots are often prescribed to patients who do not take their oral medication.

³ Akathesia is a recognised side effect of anti-psychotic medication. It is a movement disorder characterized by a feeling of inner restlessness and a compelling need to be in constant motion.

⁴ Diazepam is a benzodiazepine drug used to treat anxiety disorders,

which has resulted in injuries and that she is vulnerable due to sexual disinhibition and neglect when unwell.

The summary outlined Ms H's needs as;

- To become familiar with the assertive outreach Team and encourage engagement.
- Continue Risperidone depot 25mg every two weeks, Depakote 1g twice daily and diazepam 5 mg twice daily.
- [Receive] education regarding early warning signs and compliance with medication.
- [Have an] Assessment of current mental state and identification of current needs.
- Identify interests and activities for Ms H.

The next chronological record is a letter to Ms H's General Practitioner from consultant psychiatrist 1 following an outpatient appointment on the 27 February 2006. The letter indicates that there had been a previous outpatient appointment where Ms H was seen 'six months' previously, but we have no record of this in the notes we have seen.

On 27 February outpatient appointment consultant psychiatrist 1 says that Ms H was 'a bit flatter in mood'. She was also complaining of nightmares, weight gain and self-neglect. Ms H was now being prescribed Depakote 1g twice daily and Citalopram 20mg at night by her GP. She is also received 40 mg of Depixol as a depot injection every 2 weeks. Ms H was again complaining of akathisia, so consultant psychiatrist 1 planned to reduce this to 40 mg every three weeks. She was also taking propranolol, but consultant psychiatrist 1 planned to reduce it and for Ms H to stop it in two weeks. Consultant psychiatrist 1 says that the risperidone depot has been discontinued, and that this may have caused the weight gain. Consultant psychiatrist 1 planned to review Ms H in two weeks and said 'there is only a minimal risk of precipitating a manic episode' as she was compliant with medication.

On 16 March 2006 consultant psychiatrist 1 saw Ms H at home with an assertive outreach worker. Ms H had stopped taking her antidepressants (both propranolol and citalopram). Consultant psychiatrist 1 notes that Ms H remained inactive but 'cheerful'. Consultant psychiatrist 1 asked the GP to stop prescribing anti-depressants as Ms H no longer needs them. Consultant psychiatrist 1 also says that Ms H has been on diazepam twice daily for over a year and that it would not be productive to reduce it until Ms H 'is ready to do so' consultant psychiatrist 1 planned to see Ms H in two months' time.

On 3 July 2006 consultant psychiatrist 1 saw Ms H at home with her Support Time Recovery (STR) worker from the Sandwell assertive outreach team. Ms H remained low in mood, but not to the extent of being depressed. Ms H asked for her Depakote medication to be changed back to lithium as she felt this would make her less depressed. Consultant psychiatrist 1 indicates that Ms H had been saying this to the assertive outreach Team workers. Consultant psychiatrist 1 carried out an electro cardio-gram and renal and thyroid function blood tests prior to the meeting and the

results were all normal. Consultant psychiatrist 1 agreed to start Ms H back on lithium and prescribes 400 mg at night with a plan to increase to 800 mg.

On 3 November 2006 consultant psychiatrist 1 saw Ms H urgently with her assertive outreach nurse, team nurse 1. Ms H's primary complaint was akathisia. She wanted to change her medication from depot injection to an oral antipsychotic. Consultant psychiatrist 1 prescribed procyclidine and agreed to review Ms H in a week. Consultant psychiatrist 1 wrote to Ms H's GP;

“There was no evidence of any relapse of her psychotic illness and she is taking her Lithium effectively... certainly no reason why she should not have oral antipsychotics...”

On 10 November 2006 consultant psychiatrist 1 saw Ms H. The akathisia had improved since starting the procyclidine though it had not entirely gone away. They agreed to stop the Depixol depot given that it might be causing her akathisia, and switch to quetiapine. Consultant psychiatrist 1 gave Ms H a two week prescription (Lithium carbonate, diazepam and procyclidine) and asked the GP to continue prescribing after the two weeks.

On 13 December 2006 consultant psychiatrist 1 saw Ms H. Ms H said that she was sleeping poorly though subjectively, her mood felt normal. Her speech and thoughts were normal. Ms H said that she was feeling under pressure due to Christmas and the sale of her house and consultant psychiatrist 1 prescribed Chlorpromazine¹ to help her sleep.

¹ Chlorpromazine was one of the first ever anti-psychotics. In small doses it can also be used to alleviate insomnia.

Documents reviewed during this investigation

- BSMHFT Care Management and CPA Policy
- BSMHFT Care (Health) records management policy : Electronic and Manual
- BSMHFT Trust Board papers for Wednesday 18th December 2013
- Birmingham Safeguarding Adults Board 'Safeguarding Adults: Policy, procedure and good practice guide'

Review of RiO case notes.

On the 21 March 2015, Verita reviewed the RiO case notes for ten clients of Ladywood and Handsworth Community health Team.

Selection of Sample

Using the list of care coordinators for the community mental health team, we randomly screened cases. Clients were selected for the sample as they were complex cases with high need who were (or had been) eligible for assertive outreach. This means that they were:

- Serious and enduring mental health problems
- History of being difficult to engage or maintain in services.
- High risk of relapse and/or need for close monitoring.

Three clients had previously been referred to assertive outreach, but taken off the waiting list when they reengaged with services.

Three clients were presently on community treatment orders¹ and one had recently been an inpatient in a trust forensic service.

Of the ten client selected. Eight had a main diagnosis of psychotic illness, one had an affective disorder with delusional symptoms and one had a personality disorder with psychotic features.

All clients were recorded as difficult to engage.

Review criteria.

The review of the records examined the following:

- Is there an up-to date screening of risk on RiO?
- Is there an active risk management plan in the RiO Risk record?
- Has the client had a care programme approach meeting in the past six months and is this recorded in the progress notes?
- Have the care plans been updated since the care programme approach meeting and have these been updated in the Rio Care Plans?
- Is there evidence of recent and ongoing attempts to remain in contact with the client in the progress notes section of RiO?

¹ A Mental Health Act Community Treatment Order (CTO) is primarily used to address treatment non-adherence. A CTO means that that a client has to keep to certain conditions to stay in the community. If the client breaks the conditions of the CTO or if care team feels they have become unwell again their responsible medical officer (usually their consultant psychiatrist) can order that they are returned to hospital.

Summary of cases.

Client 1

Female client with both psychosis and affective disorder who had been referred to assertive outreach in 2012. Was placed on the assertive outreach waiting list and later removed as engaged with care coordinator. Now on community treatment order. Main risk recorded as suicide.

- Risk screening completed. Management plan in place to maintain contact and monitoring, contact Home Treatment in crisis and support family.
- Care Programme meeting in October 2014 and care plans updated February 2105. Community Treatment Order reviewed as part of this process.
- From progress notes, last contact May 2015

Client 2

Male client with psychosis. Was referred to assertive outreach in 2012. Placed on waiting list and removed as engaged with care coordinator. Now on community treatment order. Main risk harm to others/violence. Risk to family.

- Rick screening completed.
- Management plan in place to maintain contact with client. Given risks, separate contact with at risk family members (sister and mother). Liaison with police about care recorded and showed evidence of good practice. Care coordinator confirmed that police have placed a SIG marker¹ on family home.
- Care programme meeting February 2015 and care plans updated April 2015.
- From progress notes, last contact with police and family May as client not willing to engage.

Client 3

Male client with psychosis. Long history of fluctuating engagement with services and recent relapses requiring home treatment contact. Again relapsing at time of analysis. Main risk violence to others.

- Risk screening completed.
- Management plan in place for recent relapse to include contact and monitoring and referral for home treatment.
- Last care programme meeting in 2103 and therefore overdue. Having said that, care plans completed for management of relapse in May 2015.
- From progress notes, last contact in May 2015

¹ SIG (Street Index Gazetteer) marker is a police monitoring tool where addresses of known concern are recorded on a database and highlighted for rapid response.

Client 4

Female client with a severe affective disorder. Client difficult to engage and high level of family monitoring. Main risk suicide and self-harm with active and ongoing suicidal thoughts.

- Risk screening completed.
- Management plan in place including frequent contact with family as they are closely monitoring client.
- Care Programme meeting February 2015 with care plans updated at same time.
- From progress notes, last contact with family may 2015 as client not willing to be seen.

Client 5

Female client with psychosis and learning disabilities. History of being difficult to engage in service. Presently in supported accommodation. Is at risk of exploitation and disengaging from services.

- Risk screening completed.
- Detailed risk management plan in place to work in collaboration with staff from supported accommodation.
- Last care programme approach meeting in April 2015 with care plans updated one week later.
- From progress notes last contact was an out –patient appointment in April 2015 where client was accompanied by staff from supported accommodation.

Client 6

Female client with psychosis and history of disengaging from services. Presently in community treatment order. Tensions within family and main risk harm to others and self-neglect.

- Risk screening completed.
- Risk managed plan in place to include contact and monitoring and liaison with family.
- Last care programme approach meeting in March 2015 with care plans updated the same day.
- From progress notes, last contact was in May where client was monitored and included liaison with family.

Client 7

Male client with main dual diagnosis of antisocial personality disorder and substance misuse. Some psychotic features in previous presentations. Main risk of harm to others and suicide. Client has a history of being difficult to engage in services and has a forensic history. Client recently relapsed and admitted to forensic inpatient service for assessment and treatment. Discharged from in-patient forensic service in April.

- Risk screening completed.
- Risk management plan in place and updated since relapse, admission and discharge.
- Last care programme approach meeting in the community mental health service in November 2014, just prior to relapse and admission in December. Care plans were updated in March in preparation for discharge.
- Last contact was with forensic follow up service in May.

Client 8

Male client with psychosis and recent admission in 2013 and 2014. In addition, recent referral for home treatment for monitoring. Main risk suicide and self-harm and client difficult to engage.

- Risk screen completed.
- Management plan in place for contact and monitoring of mental state.
- Care programme approach meeting in February 2015 with care plans updated at the time.
- From progress notes, last contact with client in May 2015.

Client 9

Male client with psychosis. Difficult to engage and presently on a community treatment order. Main risk of harm to others. Assessment indicates that high risk when unwell and low when in remission.

- Risk assessment completed.
- Risk management plan in place for maintaining contact and actions if client disengages.
- Care programme approach meeting in March 2015 with care plans updated in April 2015.
- From progress notes, last contact in May 2015. Client currently well and maintained in service.

Client 10

Male client with psychosis. Was referred to assertive outreach in 2014 but removed from waiting list as contact with care coordinator established. Main risk of harm to others. As harm is to specifically identified people, police have been involved in the past.

- Risk screening completed
- Risk management plan in place for maintenance. Plan included police contact details.
- Care programme approach meeting in April 2015 with care plans updated in May 2015.
- From progress notes, last contact in April of 2105. Client now very well and showed some insight into mental health and collaborating with recent care.

Summary of sample against review criteria,

Client	Rio Risk screen complete?	Evidence of risk management plan in RiO	Evidence of CPA in progress notes?	RiO Care Plans Updated following CPA?	Recent contact recorded in RiO Progress notes?
1	YES	YES	YES	YES	YES
2	YES	YES	YES	YES	YES
3	YES	YES	NO	YES	YES
4	YES	YES	YES	YES	YES
5	YES	YES	YES	YES	YES
6	YES	YES	YES	YES	YES
7	YES	YES	YES	YES	YES
8	YES	YES	YES	YES	YES
9	YES	YES	YES	YES	YES
10	YES	YES	YES	YES	YES

Community Treatment Orders and Section 117

Four clients (1, 2, 6 & 9) were on community treatment orders and these were recorded and considered during care programme approach meetings.

Where a community treated order needed to be reviewed, the care coordinator had to request social worker input into the care programme approach meeting.

It was less clear who was eligible for section 117 aftercare arrangements and if these were monitored in care programme approach meetings.

Summary of findings.

Apart from one instance of a client having an overdue care programme approach meeting, there was evidence that the CMHT maintain their records for difficult to engage clients with serious and enduring mental health needs.

One case showed an example of good practice in the communication with police of a high risk case.

Where there was an indication of risk to the family from the client, care coordinators had taken these into consideration in their risk management plans.

There was evidence that the updating of care plans following care programme approach occurs sometime after the meeting. This may be due to the immediate recording of care programme approach meeting being in the RiO progress notes while the care plans are in a separate section of RiO.

It was clear what arrangements had been put in place to monitor community treatment orders, but less clear the arrangement for section 117 aftercare arrangements.

Documents reviewed during this investigation

- BSMHFT Care Management and CPA Policy
- BSMHFT Care (Health) records management policy : Electronic and Manual
- BSMHFT Trust Board papers for Wednesday 18th December 2013
- Birmingham Safeguarding Adults Board 'Safeguarding Adults: Policy, procedure and good practice guide'