INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF Ms Z

JUNE 2017

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1 INTRODUCTION:

1.1 The incident:

1.2 On 9 December 2013, Ms Z attacked the victim with several knives, causing in excess of 70 stabs wounds to her head, face and body, from which the victim later died. The victim and Ms Z had not known each other.

1.3 The background:

1.4 The victim was 70 years old at her death. She lived alone in a cottage.

1.5 Ms Z had a longstanding psychotic illness and persistent poly substance abuse, including opiate dependence. Ms Z received care and treatment from Derbyshire Healthcare NHS Foundation Trust ("the Trust").

1.6 The relevance of Ms Z's harassment charge:

1.7 On 3 September 2013, Ms Z told her Community Mental Health Team (CMHT) that she was jealous of the owner of a successful local café in Derby. In the months leading up to December 2013, Ms Z repeatedly went to this café, where she would shout and swear at the owner.

1.8 Ms Z appeared in Court on 3 December 2013, charged with harassment of this individual, with whom she had attended school, and who had lived in close proximity to Ms Z and her parents as a child.

1.9 The Hearing on 3 December 2013 was adjourned to allow Ms Z an opportunity to speak to a probation officer about arranging a psychiatric assessment. However, Ms Z absconded from Court and walked to the small village in which the victim lived, whereupon she found the victim's cottage unoccupied. The victim was on holiday with a friend at the time. Ms Z broke into the victim's home and proceeded to go about living in the vacant home.

1.10 The homicide:

1.11 When the victim returned to her home from holiday on 9 December 2013, she found Ms Z had unlawfully taken up residence there, and was fatally attacked by Ms Z immediately upon entry. After hiding the victim's body under a duvet in the garden, Ms Z remained at the victim's home and continued using her car, bank cards and changed her phone number.

1.12 On 10 December 2013, the victim's friend grew concerned when he found that he could not contact the victim. He visited the victim's home later that day and discovered Ms Z still living there. She immediately attacked him and chased him out of the house, following which she drove off. The victim's friend then alerted the police. Ms Z was apprehended in Lancashire and remanded in custody on a charge of murder.

1.13 The aftermath:

1.14 Ms Z entered a guilty plea to the manslaughter of the victim on the grounds of diminished responsibility. On 23 January 2015, Ms Z received an order detaining her in hospital in accordance with Section 37 of the Mental Health Act 1983. An order was also imposed in accordance with Section 41 of the Mental Health Act 1983.

1.15 The Independent Investigation Team is aware that during the course of Ms Z's trial, psychiatric expert evidence presented to the Court stated that the cause of the killing was Ms Z's mental illness. In the words of the Court-appointed expert, the Court was told that Ms Z's illness meant she was:

"*Irrational and unable to control her actions…Had she not been mentally ill, I cannot see how this could have possibly happened…with proper medication, there is a low risk of her committing violent offending*[1]*".*

1.16 Without treatment, Ms Z was said to be:

"*Dangerous and…the risk she posed was more connected to her mental illness than her use of illicit drugs…she has behaved in a bizarre, erratic and aggressive manner, making deluded accusations, including threats to kill her parents…she can react in a very unpredictable manner, and satisfies the test of dangerousness. ……but if she takes her medication and doesn't take illicit drugs, she would not present an appreciable risk to the public*[2]*".*

[1] The Psychiatric Expert's opinion, given in evidence at the Trial of Ms Z on 26 January 2015.
[2] The Psychiatric Expert's opinion, given in evidence at the Trial of Ms Z on 26 January 2015.

2 PURPOSE OF REPORT:

2.1 In the period between September 1994 and 7 November 2013, Ms Z was in contact with services delivered by the NHS, including mental health services. As a result, NHS England have commissioned an Independent Investigation in order to unlock learning for the NHS which can improve the delivery of mental healthcare services for individuals such as Ms Z and those connected with them.

2.2 "Hindsight bias":

2.3 "Hindsight bias" is a paradigm that promotes the belief that adverse events were more foreseeable and more avoidable than they *actually* were. Moreover "errors" in the chain of events can assume greater importance with the knowledge of the outcome. To a retrospective observer, all the lines of inquiry can point to the end result, but those individuals who were involved at the time did not have the benefit of foresight.

2.4 In order to ensure that proportionate and meaningful learning is achieved, the Independent Investigation Team has taken into account the notion that knowledge of the outcome can colour ideas of how and why an adverse incident occurred when making its judgements.

2.5 Desired outcome of the report:

2.6 The Independent Investigation Team hopes that this report will allow care providers an opportunity to reflect upon the care which Ms Z received, with a view to making improvements for future service users and those who come into contact with them.

2.7 In this way, it is intended that some benefit can be gained from these tragic events, and a degree of comfort achieved for those whose lives were affected by the victim's death. This is of particular importance to the victim's daughters.

2.8 The Terms of Reference of the Investigation, Team Membership, Methodology and the Chronology prepared during the course of the investigation can be found at Appendices 1 to 4.

3 EXECUTIVE SUMMARY:

3.1 This section is intended to provide an overview of the key findings of the Independent Investigation Team in relation to both predictability and preventability, and in relation to the recommendations made. The detail supporting these findings is contained in the main body of the report which follows.

PREDICTABLE/PREVENTABLE:

3.2 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether the victim's death was "*preventable*" or "*predictable*".

3.3 Many Independent Investigations identify failings, missed opportunities or gaps in the care with which an individual was provided. However, this does not mean that a homicide could have been either *predicted* or *prevented*. The following tests are commonly applied to determine whether a homicide could have been *predicted* or *prevented*.

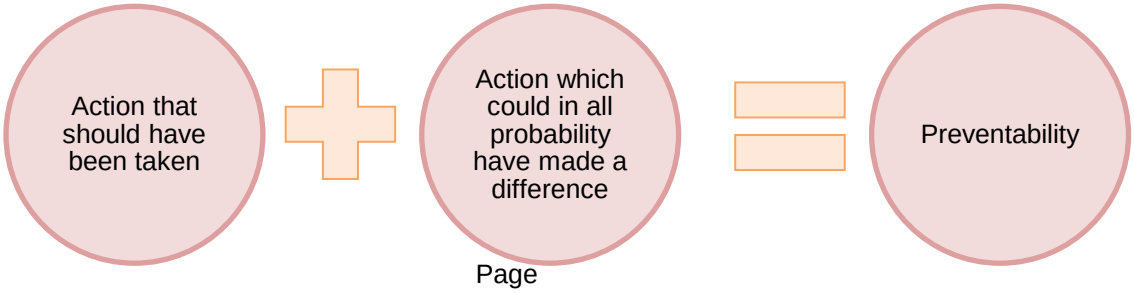
3.4 Predictable:

3.5 A homicide is "*predictable*" if "*there was evidence from the service user's words, actions or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had been un-noticed or misunderstood at the time it occurred*".

3.6 Preventable:

3.7 A homicide is "*preventable*" if "*there were actions that healthcare professionals should have taken, but which they did not take, that could in all probability have made a difference to the outcome*.

3.8 "*Simply establishing that there were actions that could have been taken, or opportunities which were missed would not provide evidence of preventability, as there are always things that could have been done better*".



Comment 1:

Juncture three of this report specifically considers the risks that Ms Z posed when ill, Services' response to these risks, and therein the correlation between those risks and the predictability and preventability of the incident. However, in brief summary:

Predictability - the Independent Investigation Team's view is that it was predictable that Ms Z could have committed a violent attack upon either her mother, or an individual known to her, such as the owner of the local café.

The Independent Investigation Team does not however consider it predictable that Ms Z would have committed a violent attack upon a randomly encountered, previously unknown individual such as the victim.

This is based on the information that the care team had at the time, and the fact that it is the Independent Investigation Team's view that a major issue was not the analysis of the information available to the team at the time, but in fact, by virtue of historic shortcomings in relation to patient records prior to that point, that there was insufficient information available to *make* a full and competent analysis.

Preventability – it is difficult to comment on preventability in any case.

The Independent Investigation Team has considered whether there were "*actions that healthcare professionals should have taken, but which they did not, that could in all probability have made a difference to the outcome*", as per the test of "preventability" as set out at paragraphs 3.7 – 3.8 above.

The Independent Investigation Team considers that even though:

1. *In an ideal service*, *the decline in Ms Z's mental health* may have been preventable from 2006 onwards, had the team then started to have proper, constructive CPAs, and not excluded Ms Z's mother and family; and,

2. Between 2006 and 2011, had the AOT actually reviewed Ms Z's care properly, rather than it being a case of "she's on her medication and not in hospital", had there been better community care, attempts at better control of symptoms with medication, and more assertive attempts at addressing the drug misuse; and,

3. From 2011, when the AOT first mooted a change to the CMHT, but did not involve Ms Z's family or the CDT, and did not actually transfer her for two years, during which time she was in "limbo".

Under the test of "preventability" as above, even if services had performed some, or even all of these actions, the homicide of 9 December 2013 was still not "preventable".

3.9 The deficiencies in consolidating Ms Z's medical records/perform an interim review:

3.10 Ms Z's medical records were lengthy and extensive. However, had comprehensive reviews, pursuant to a meaningful Care Programme Approach (CPA) process, been conducted throughout her care, the risk of important information being absent from the strategic planning of that care would have been reduced. This in turn, would have increased the likelihood that any relevant information actually contained in the records would have been identified.

3.11 The multi-disciplinary team (MDT) working with Ms Z at the time of the incident remain employed with the Trust to this day. They are sensitive to, and aware of, the shortcomings in the process and communication that played a crucial role in the events of this case, and would want to take every step to address the difficulties, but, as this report will show, addressing the various issues is not a "quick fix".

3.12 For example, envisage the case of a service user with an extensive medical history being transferred from one community care team to another as part of service reorganisation. It remains possible for the new team to lack an awareness of the fact that the user's records may well be found split across separate sources and multiple formats. This in turn, could result in crucial information being overlooked, leading to a flawed risk assessment with serious consequences, as has been demonstrated in this case.

3.13 A full solution has not been established by the Trust. Simply put, there remains the potential for an inaccurate risk assessment on this basis in future cases similar to this one.

3.14 Poor shared understanding of risk in the context of Ms Z's illness and the involvement of multiple care teams:

3.15 Shared understanding between services of the risks which Ms Z posed when repeatedly ill in the years leading up to the homicide was inhibited and confused by the above mentioned problems relating to various medical record sources and a flawed approach towards systematically reviewing the records, in order to formulate a treatment plan or risk assessment which was tailored to specifically suit Ms Z's needs.

3.16 This was unsatisfactory. The risk management should have been improved as the historical information indicated the high degree of risk presented by Ms Z when experiencing a relapse. In the absence of systematic review of this data, the treatment plans and risk assessments were incomplete.

3.17 This weakness had an impact not only upon her care at the time, but it also meant that the results of such reviews were not included in her notes. Had a review taken place which pulled together all of the information in the paper and electronic records, that information would have had a greater chance of coming to the attention of those who saw her prior to 9 December 2013.

3.18 The lack of a long term oversight and strategy for Ms Z's care:

3.19 The Investigation Team has reached the view that a significant factor in the events that led to the incident was the absence of a long-term vision of Ms Z's condition throughout the period of her interaction with services over the course of her engagement. Her care appears to have been delivered by multiple teams, with no consistent sharing of information, as a reactive response to individual acute episodes on an *ad hoc* basis, rather than a desire to achieve longer term treatment goals which would improve Ms Z's quality of life whilst she coped with a chronic mental illness.

3.20 This could also have had an adverse impact upon her compliance with her care and treatment, and the inadequate understanding of the risk which she posed to herself and others.

3.21 Contained within Ms Z's medical records is a volume of documentation generated by the CPA process. The Independent Investigation Team readily acknowledges that a substantial amount of time and resource has been applied to comply with trust protocols surrounding completion of these documents. However, Ms Z's records show that whilst the CPA process was (albeit "loosely" and generically) followed, the CPA model of coordinated interagency and multidisciplinary working was not used to provide Ms Z with individualised, specifically targeted or coordinated care.

3.22 The Trust's deficiencies in adhering to the ethos of the Care Programme Approach (CPA):

3.23 There is the fact that there was also no evidence of the various professionals and agencies involved in Ms Z's care acting together in a coherent way to take an over-arching and long-term view about Ms Z's care.

3.24 The Community Drug Team (CDT) and CMHT did not appear to work together to develop a comprehensive management plan which would have addressed relapse prevention strategies, crisis planning and psychological approaches.

3.25 In the opinion of the Independent Investigation Team, neither the CDT nor the CMHT appeared to view the opportunity of a CPA meeting as being an event which could deliver long-term care and potentially avert a crisis. Even if a crisis could not have been averted, a multidisciplinary CPA meeting held at the time of her transfer from the Assertive Outreach Team (AOT) to the CMHT in August 2013 could have better informed those who became responsible for Ms Z's care from August 2013 onwards.

3.26 This in turn could have potentially provided an opportunity for services to explore Ms Z's mental state and background further, pursuant to a thorough, correctly applied CPA strategy as envisaged at the inception of the CPA model, by attempting to utilise her family in her care, as outlined below.

3.27 <u>The Trust's deficiencies in utilising Ms Z's family members in planning her care:</u>

3.28 Throughout Ms Z's illness, she had considerable involvement with her family, particularly her mother. However, involvement of family members in providing mental health services with potentially crucial information regarding service users was not part of the culture of the organisation at this time.

3.29 Ms Z did not live with her family for a number of years. However, they were closely involved during her illness, repeatedly contacting services with increasing frequency and on matters of increasing concern as Ms Z's mental health deteriorated. Services did not properly acknowledge the extent of this involvement in her care strategy.

3.30 The Independent Investigation Team heard that negative and critical statements made by Ms Z about her family at a time when she was clearly unwell were accepted as fact by services, and no attempt was made by those responsible for Ms Z's care to establish the true facts of the situation. Ms Z's comments when acutely unwell were, over time, accepted as an accurate account of the dynamics that existed within the family.

3.31 For example, it appeared to the Independent Investigation Team that services took Ms Z's assertion that she "did not get on" with her family at face value, and formulated the decision not to involve them in understanding Ms Z's illness or behaviour. Services conversely overlooked the significance of the fact that Ms Z's younger son was being cared for by her parents since shortly after his birth.

3.32 This response reflects the problems which NHS service users with long-term disabling conditions face on a national scale in obtaining a long-term approach to their care. The service user remains constant, the family members remain constant, but because the care teams change, such difficulties arise.

3.33 It is of fundamental importance that the professionals who work with individuals with chronic mental health issues take account of the experience and knowledge of family members of the person in their care.

3.34 The reason for this is to ensure that the opportunity which families represent for clinicians (as a resource and means of significant knowledge in relation to the individual who is ill), can be fully utilised in developing meaningful care strategies.

3.35 In performing an inadequate systemic review of the complaints about disharmony within Ms Z's family, clinicians missed a significant opportunity to utilise knowledge that was not reliant on details hidden in copious volumes of case notes, which in turn could have been of diagnostic and therapeutic benefit for Ms Z, her family and services.

4 RECOMMENDED REACTION TO INCIDENT BY HEALTHCARE PROVIDERS:

4.1 In order to provide an insight into the direction of this report at a glance, an overview of the Independent Investigation's Recommendations is as follows:

Recommendation 1 – Consolidating/fully reviewing medical records:

The Trust is required to adopt a strategic response in relation to patient records, i.e. the unification of the paper and digital notes system into one system. The Independent Investigation Team is of the view that this should ideally be an electronic system capable of allowing a care professional to pull up information relating to patients and the status of their risk assessments at a glance.

A strategic response at Board level is required in order to address the practical difficulties which clinicians face when presented with the challenge of accessing a service user's historical records. The loss of information when migrating to electronic service user records is also a risk which must be addressed.

New database packages allow a Care Professional to pull information from their electronic patient record to show the people under a team member's care, and the update status of risk assessments for the last 6 months. This does not address the needs of a patient who has had previous admissions over a period of time. Consequently, a protocol should be developed to ensure a review of paper and electronic records held for service users who have experienced a number of episodes of care.

Accordingly, it is recommended that:

a) The Trust take steps to unify paper and digital patient records. Until such time as the paper and electronic records have been unified, the Trust must implement a protocol to ensure a review of patient's paper and electronic records is undertaken at key stages (admission, CPA Review, discharge and transfer).

b) Following unification of paper and digital record keeping systems, patients' historical records must be reviewed and summarised at key stages in their care (admission, CPA Review, discharge and transfer).

c) The performance of the requirements at 1 and 2 and the adherence to protocol connected to these recommendations needs to be monitored and audited.

d) The findings of these audits are to form part of discussions at regular Quality Assurance Meetings.

Recommendation 2 – Responding to the service user's needs:

"Service-user centred clinical care" is the foundation of CPA care management in delivering services. The essentials of this are contained within the Trust's CPA policy. They include the systemic review and sharing of clinical information to inform clinical decision-making, and involvement of families (or carers where appropriate) in the management of risk.

The Trust's Quality Assurance Programme should ensure that care plans reflect a comprehensive understanding of the ethos of CPA in order that individual service users' current psychiatric, social, family circumstances and risk characteristics are addressed and that service user centred care is delivered.

Accordingly it is recommended that:

a) The ethos of the CPA should be reflected and strengthened in the training programmes which Trust staff are required to attend.

b) Every 6 months, each individual service user's CPA records are audited by the Managers in each service involved in the individual's care with a view to establishing:

1. Whether CPA is being correctly applied and adhered to;

2. Whether all service users' risk assessments are up to date;

3. Whether staff are having regular supervision which includes reference to providing care which recognises the ethos of CPA.

c) Adherence to this recommendation is audited by the Trust on a 6-monthly basis.

Recommendation 3 – Improving long term care:

1. The Trust must conduct regular audits to ensure that its managerial supervision policies and procedures to facilitate supervision are being used to promote the delivery of service user centred long term care.

2. The audit process should include scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the delivery of service user care viewed from a long-term perspective.

Recommendation 4 - Working with family members (and 'carers' where applicable):

1. "Consent to share" information should be updated regularly to promote effective communication between services, the service user and family members/carers. Protocols and policies should be introduced to secure this.

2. Close family members should always be given a contact point to access the mental health system in a crisis. Communication should be established as early as possible.

3. The Trust reviews its "family involvement strategy" to ensure that family members receive appropriate psychological as well as practical support.

4. In order to obtain a comprehensive understanding of the service user's current psychiatric, social and family circumstances and risk characteristics, the Trust's Quality Assurance Programme be revised to ensure that Teams are required to actively seek family members' involvement and views.

5. Collateral histories should be taken from family members and/or carers to secure a greater insight into a service user's situation and those of the family members/carers themselves.

The standard practice of clinical teams in relation to these Recommendations is monitored by periodic audit.

Recommendation 5 – Learning from adverse events:

1. In order to maximise the learning taken from Ms Z's fatal attack upon the victim, approaches to serious incidents should take account of the "bigger picture" of a serious incident. For example, investigating how a crisis has developed should be as a means to identifying learning which can generate improvements in service delivery.

   The Independent Investigation Team recommends that the Trust's framework for investigating serious incidents be reviewed to implement this Recommendation.

2. The Trust takes active steps to ensure that staff and clinicians are supported in relation to serious incidents. In addition to this, the Trust must also take active steps to ensure that information is shared with staff and clinicians in a timely way, and that a longer term view of "support" is taken.

3. The Trust must implement processes to ensure that the learning from adverse incidents and the action points which are generated are drawn to the attention of staff and clinicians involved in the events in order that learning can be embedded in the day to day practices of those responsible for delivering care.

4. The Trust must take steps to demonstrate greater awareness of the knowledge levels of family members of victims, their specific backgrounds and insights, and their interactions.

5 VICTIM IMPACT STATEMENT:

5.1 The death of the victim was a catastrophic event which has had a continuing effect upon those most closely involved with it, and lies at the heart of this Independent Investigation. In order to give her a voice in the Investigation and to allow members of her family to express how her death has had an impact upon their lives, the Independent Investigation Team has asked the victim's daughters to explain their loss.

5.2 They have said:

"*She was our greatest friend and also our Mum. She was anarchic, intellectual, and adventurous, and had an irrepressible sense of fun. She was never boring and never bored - instead she would be busy paragliding, mircolighting, and travelling, as far as Uzbekistan, China and Peru. She was not an old woman; she was the epitome of life. It gushed from her and over those around her*".

5.3 Victim daughter 1:

"*My life has been destroyed. I saw my Mum every Saturday. She was my friend. We went to countryside events, food and craft fairs, walking, cycling and for country pub lunches. I no longer do these things, but I see her everywhere.*

"*My career has been damaged. I successfully applied for a new, national post with my employer, but then had to return to my former post because I simply could not cope. I cannot cope now in my job, and am applying for others that are less stressful.*

"*I live my life now with continual feelings that fluctuate between fear, unease, horror, utter misery and near hysteria. I frequently feel nauseous when I pick up a knife. My family and I now live like automatons to get through the days. I do not value my life and am unsure whether I ever can.*

"*I cannot bear to see the pain that Ms Z has caused to my sisters and family. Strong, bright, and truly good people brought to their knees. Ms Z stole mum's home, her money and her life. And the truth is that she has also stolen mine too*".

5.4 Victim daughter 2:

"*I feel as though I live in two different worlds. There is the everyday life, and then there is the parallel world where Mum was so horrifically attacked. Without the love and support of my family, and closest friends, and the knowledge that my passing would cause still more pain to them, I feel there is a strong chance I would have killed myself. I have had suicidal thoughts many times, and feel at least mildly depressed most of the time.*

“As for my children, I rarely speak of Mum to them, as I am conscious of them worrying that it upsets me, and of it upsetting them. They worry about me anyway, I know, and I about them. I feel that society in general has the attitude that it was a long time ago, and we should have got over it by now, but I can't envision ever "getting over it" in the usual sense regarding a bereavement”.

5.5 The victim’s daughters on the Trust and its response to the incident:

“*It seems like, as a system, there was no motivation to ensure things were done properly with Ms Z, and there was no motivation to deal with us properly as complainants, never mind what happened to mum, we made a complaint and it was dealt with completely inadequately, even though we were pointing out, which is not unreasonable, this is your procedure, can you please follow it. Can you please acknowledge when we write to you...*

“*My belief in the goodness of the majority of people has been deeply shaken by the attitude shown by the Mental Health Trust to our concerns regarding their investigation and the quality of Ms Z’s care. I wonder how many people have been dissuaded from pursuing their concerns when met with a drawn-out process and a defensive manner, especially when trying to cope with a traumatic experience, and maybe lacking the confidence or ability to articulate their concerns.*

“*I am more mistrustful and intolerant, particularly of large organisations, and have developed the opinion that most people are selfish and uncaring, rather than a minority, as I previously believed*”*.*

5.6 The victim’s friend:

5.7 The friend of the victim, with whom she had been on holiday prior to the incident, and who had discovered Ms Z in the victim’s home, had this to say about interacting with the Trust after the incident:

“*My experience of communicating with the Trust was frustrating and extremely stressful and I think contributed to my deterioration in Health in November 2015.*

“*I received the written reply to my 1st complaint of 21 July 2015 during the week I had cancer surgery (in the last week of November). They unreservedly apologised for their actions. As far as I was concerned this was too late I was fighting to overcome cancer and could not address the issues raised in the letter.*

“*The way the trust has treated the family and myself has been appalling. In my case their failure to meet their own deadlines and their failure to be able to offer a date when they would respond to my concerns and complaint was hard to comprehend*”*.*

6 DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST:

6.1 The origins of the Trust:

6.2 Derbyshire Healthcare NHS Foundation Trust was established on 1 February 2011 when Monitor (the independent regulator of health services in England), authorised Derbyshire Mental Health Services NHS Trust to become a "Foundation Trust".

6.3 An overview of Derbyshire Healthcare NHS:

6.4 The Trust provides mental health, learning disabilities and substance misuse services in Derby City and Derbyshire County. It currently employs over 2,400 staff based in 90 locations across Derbyshire. Across the county and the city, the Trust serves a combined population of approximately one million people. It operates within a budget of £132 million and provides 311 inservice user beds.

6.5 The Trust is led by a unitary Board (meaning all participants have equal legal responsibility for the management and strategic performance of the Trust). Since February 2011 when it gained foundation status, the Trust leadership has been in transition, with 3 Chairmen and 3 Chief Executives having held office.

6.6 In relation to Ms Z's care:

6.7 The Junctures later in this report will develop these points in further detail. However, for present purposes, the Independent Investigation Team considers that there remain factors present which would impact on the care of an individual such as Ms Z, with significant consequences.

6.8 Revisiting the Trust's internal investigation:

6.9 The Independent Investigation Team acknowledges that there were a number of positives to be taken from the internal investigation:

- It is comprehensive in its scope.
- It attempted to include the victim's family.
- It contained a timeline.
- It was performed by the organisation.
- It managed to summarise complex records.
- It covered how the teams managed Ms Z, Ms Z's transfer between teams, some healthcare professionals' concerns at the time, as well as investigating whether those healthcare professionals felt people took their concerns in relation to Ms Z seriously at the time.
- It interviewed the staff involved individually and then as a group to discuss the findings and the feelings on ways to improve.

6.10 As mentioned above, the Independent Investigation Team is conscious of the ease with that "hindsight bias" can enter into perceptions of events after the fact, and this has been borne in mind when considering the internal investigation, which came very shortly after the incident.

6.11 The Independent Investigation Team also acknowledges that since the Incident, the situation in relation to service users such as Ms Z has changed on a national level; we now have the Care Act, the Duty of Candour and revised national guidance on serious incident investigations.

6.12 However, it is the findings of the Independent Investigation Team that:

- The staff feel unsupported and unaware of structure of the internal review process.
- The individuals involved, both the staff who worked with Ms Z, and the family members of the victim, did not feel like they were engaging in a process that would ultimately be followed up.
- Whilst the meetings to discuss proposed changes were helpful at the time, the actions on the recommendations for changes to working practices and coordinating care have yet to be implemented.
- A number of the individuals with whom the Independent Investigation Team spoke were all still extremely distressed by the events, and, at the time of the investigation interviews, remained very affected by them.

6.13 The internal investigation process will be discussed throughout the course of this Independent Investigation Report, and at length in the final Juncture in relation to learning.

7 LEARNING FROM PREVIOUS INQUIRIES IN THE NHS:

7.1 In many ways, the manner in which Ms Z presented to mental health services was neither uncommon nor indeed remarkable. What was remarkable however, was the tragic death of the victim.

7.2 The following inquiries are helpful at this point in framing the incident of 9 December 2013 in a broader context of mental health homicide.

7.3 2015 National Confidential Inquiry into Suicide and Homicide:

7.4 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015[3] has calculated that in the years 2003-2013 there were an average of 57 homicides per year, involving 61 victims, committed by individuals in receipt of mental health care.

- 6% of individuals in the period 2005-2013 were under crisis resolution/home treatment teams at the time of the homicide.
- 17% of individuals had been non-adherent with drug treatment in the month before the homicide.
- 29% of individuals with schizophrenia had been non-adherent with drug treatment in the month before the homicide, an average of 5 per year.
- 39% of individuals with schizophrenia missed their final service contact before the homicide, an average of 6 per year.
- In total 57% of individuals with schizophrenia were either non-adherent or missed their final contact with services.
- 89%, (excluding those with an unknown history), had a history of either alcohol or drug misuse or both, an average of 49 homicides per year.

7.5 The Ritchie Inquiry:

7.6 On 17 December 1992, Christopher Clunis killed Jonathan Zito, in an unprovoked attack at a London underground station. Clunis had a long history of psychiatric illness, including previous displays of violent behaviour.

7.7 The NHS sought to learn from the care of Mr Clunis. His care was described as a "*catalogue of failure and missed opportunity*", by the Ritchie Inquiry which was tasked with reviewing his care.

7.8 The Ritchie Inquiry was instrumental in the implementation of the Care Program Approach (CPA), which aims to ensure that there is a coordinated approach to the care and treatment of individuals with long term mental health needs where numerous professionals and agencies are involved. A core purpose of the CPA is to provide a framework for care planning which recognises the needs of the individual.

[3] England, Northern Ireland, Scotland and Wales, July 2015 (University of Manchester).

7.9 The landscape of mental health provision is far more complex than when the Ritchie Inquiry was written. Significant changes have been made to the legal framework governing mental health and there have also been changes in the manner in which services are delivered. However, analysis of mental health homicide reports since the Ritchie Inquiry into Mr Clunis' care show that the issues highlighted in that inquiry remain relevant.

7.10 The Care Programme Approach:

7.11 The CPA was introduced in England in 1991, and by 1996 had become a key component in supporting and facilitating long-term care. It was introduced in order to provide a framework for the delivery of effective mental health care, partly in response to the Ritchie Inquiry.

7.12 The main elements of the CPA are:

a) Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
b) The formation of a care plan which identifies the health and social care required from a variety of providers;
c) The appointment of a "care co-ordinator" to keep in close touch with the service user and to monitor and co-ordinate care; and,
d) Regularly review and, where necessary, agree changes to the care plan culminating in regular CPA meetings between all parties involved, including the service user and their carers[4].

7.13 As will be shown throughout this report, and particularly in Junctures 5, 6 and 7, the CPA was of crucial significance in relation to Ms Z's care and the incident of 9 December 2013.

7.14 The Francis Inquiry:

7.15 The Francis Inquiry report was published on 6 February 2013 and examined the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report made 290 recommendations. Key themes were identified as being important to allow patient centred care to be delivered including:

- Patient-centred values throughout the system;
- Openness and transparency about how the service is performing and candour about harm to patients;
- Strong patient-centred health care leadership; and,
- Accurate, useful and relevant information allowing all to understand how safe, effective and good the service is.

[4] Refocusing the CPA" (DH, 2008).

7.16 The relevance of the above inquiries in Ms Z's case:

7.17 The Independent Investigation Team recognises that the majority of healthcare interactions which are the subject of this report took place prior to the conclusion of the Francis Inquiry. However, both inquiries represent a commitment to greater openness and candour with families involved in incidents, to developing a culture dedicated to learning and improvement that continually strives to reduce avoidable harm.

7.18 The Independent Investigation Team feels the relevance of the Ritchie to Ms Z is that, in contradiction to the legacy of Ritchie, in this case, there was no meaningful and multi-disciplinary CPA involving Ms Z and those involved in her care.

7.19 By contrast, Francis pertains more to the ethos of the Trust. In this case, it is the view of the Independent Investigation Team that there was no clear sense of patient centred values, other than a cursory lip-service to the notion. There was no provision for feedback to those involved as regards the results of the internal investigation; there is the appearance of a division between the Trust leadership and the "shop floor", as will be shown.

7.20 The broader relevance pertains to the cultural shift in the past few years regarding working with families, and being open and accountable to those families.

8 PROFILE OF MS Z:

8.1 Ms Z had a complex mental health and substance use history. It is the view of the Independent Investigation Team that this complexity made it more difficult for mental health services at the time to identify and combat the deterioration in her condition which ultimately progressed until her attack on the victim.

8.2 This chapter will provide an overview of Ms Z's background, her relationship with her family, and her historic interaction with mental health services, to set the scene for analysis in the Junctures of this report.

8.3 Ms Z's background:

8.4 Ms Z was born in Liverpool in 1975. She was the youngest of five half-siblings. Her mother separated from her biological father and married her step-father when she was approximately 3 years old, and at the age of 7, he adopted Ms Z. Her biological father later died (she had minimal contact as a child, and preferred not to have contact with him).

8.5 Ms Z started abusing drugs in secondary school, although she managed to achieve 3 GCSEs before leaving school to commence work in a travel agency. According to her medical notes, her parents informed services that her behaviour and personality underwent a complete change at the age of 18 in the Christmas period of 1993.

8.6 She lost her job with the travel agency shortly thereafter as a result of her "behaviour", and so began her longstanding interaction with mental health services upon her first (informal) admission in September 1994.

8.7 By May 1995, Ms Z was back in employment, working in a supermarket, and involved in a relationship. In June 1995, Ms Z gave birth to her first child. She was studying for an NVQ in catering and hospitality by October 1997, and by November 2000, she had started studies at Derby University. None of these courses were completed, and Ms Z was never in employment again after 1995.

8.8 In December 2001, Ms Z's first son was placed into the care of his father as a result of concerns regarding Ms Z's deteriorating mental health and fear of risk of emotional abuse and neglect.

8.9 Despite this, and her longstanding, tumultuous mental health state, by March 2006 Ms Z was pregnant with her second child, and underwent an induced birth on 12 October 2006. The child was immediately placed on an emergency protection Order and ultimately placed into the care of Ms Z's parents (note, the Trust did not wish the involvement of Ms Z's parents; her parents had to fight for the child).

8.10 Ms Z's relationship with her family:

8.11 Throughout the entire course of Ms Z's interaction with services, her medical records contained references to the nature of the relationship she possessed with her family. According to her medical notes, this was a volatile relationship:

- **September 1994** is the first record of Ms Z's displeasure with her mother, stating that her mother was "*interfering with her financial affairs*".
- On **24 November 1994**, upon her return to the mental health ward on which she was staying from a period of home leave, her mother had stated the leave "*had not gone well*", and that she and Ms Z "*were not getting on*".
- On **2 December 1994**, Ms Z had received a phone call from her mother whilst on the ward, apparently informing her that her mother "*did not want her on the ward and wanted her to come home*".
- On **7 December 1994**, Ms Z's mother called the ward and informed them she "*did not see it as mental health services' responsibility to teach Ms Z living skills and this should be something Ms Z learns at home*".
- On **9 December 1994**, Ms Z's mother met with services and regular contact between her and services was agreed, and the importance of the ways in which she could be involved in Ms Z's care plan was highlighted.
- Following an MDT review meeting on **13 December 1994**, Ms Z's mother was recorded as being "*very lively and forceful in her argument for Ms Z to return home*".
- A letter from services following a home visit dated **4 April 1996** stated that, since her last visit, Ms Z "*had left home after a disagreement with her mother*". Ms Z was recorded as having said she had been "*thrown out of the family home on several occasions*", although the same letter stated that "*[Ms Z's mother] often states that Ms Z should be at home with them*".
- By **October 1998**, problems with her neighbours resulted in Ms Z moving back in with her parents.

8.12 The emergence of violent and threatening behaviour towards her family:

- At a CPA assessment on **13 September 2005**, Ms Z stated that she wished "*no contact*" with her mother.
- On **15 September 2005**, Ms Z's mother called mental health services and informed them the family have been "*dealing with Ms Z's violence through the police*", stating that "Ms Z *had been calling family members at 04.00 and threatening them*", and as a result, "*the family were really frightened of her*". Ms Z's mother informed that Ms Z "*did not want her help*", and she (Ms Z) "*just uses her as a scapegoat and her whipping boy*".

- Ms Z's mother informed services that her relationship with Ms Z "*had broken down to nothing, and the she didn't see or communicate with her any more*". She did also inform services that she was "*still here for her*", and she could be told when she's better that she could contact her.
- On **17 September 2005**, Ms Z's mother spoke with Ms Z on the phone, wherein Ms Z had become hostile and aggressive. Ms Z's mother then called services, concerned about Ms Z's mental state.

8.13 Between 2003 and 2006 the treating psychiatrist and team has ascribed all of Ms Z's behaviour to a personality disorder. The following are instances where Ms Z's mother was potentially noticing this:

- On **9 May 2006**, Ms Z's mother called services seeking an appointment as her behaviour was "*not acceptable by today's standards*".
- On **15 May 2006**, she called again informing services that Ms Z was "*still terrorising the family*", her grandfather had died, and that she had "*threatened to kill her brother's children*". She was stating "Ms Z *needed to be sectioned*".
- On **5 June 2006**, Ms Z's mother called again, and amongst other things, informed services that she "*still cares about Ms Z*" and "*will support her if Ms Z will let her*".
- By **August 2006**, her medical notes recorded her as having been asserting that her step father was responsible for an historic homicide in the area years previously.

8.14 <u>Evidence of possible reconciliation with her family:</u>

- Her medical records indicate that she was having supervised visits with the new born by **January 2007**.
- Ms Z's notes of **9 January 2008** record her mother as having asked Ms Z to live in the house next door to her.
- On **1 December 2008**, Ms Z's medical notes record that she and her mother "*had rowed, but were speaking again now*".
- On **27 April 2009**, her notes record she "*has made friends with her mum*".
- On **21 September 2009**, Ms Z's mother called services and informed them that she was concerned that Ms Z was not taking her mood stabiliser.
- On **7 June 2010**, her notes record her as having had "*a bit of a fall out with her mother over Sunday dinner at her mother's house*".
- **20 August 2010**, her notes record that her relationship with her mother was still "*strained*", although she was planning to visit her on her birthday the following week.
- On **25 January 2011**, services received a call from Ms Z's mother expressing concerns for Ms Z's welfare since her partner moved out.
- On **7 April 2011**, Ms Z's mother called services expressing concerns for her welfare following a series of "*strange telephone calls from Ms Z*".

- On **25 October 2011**, Ms Z's mother called again informing Ms Z had been texting in the early hours of the morning, and spoke at length about her concerns.

8.15 Further breakdown of relationship with her family:

- On **7 December 2011**, Ms Z asked services that they do not disclose her shoplifting offences or the details surrounding them to her mother.
- In an appointment on **20 May 2012**, Ms Z stated that her parents were "*unfit to bring up her son*".
- **14 July 2012**, Ms Z stated she had been making "*nasty*" calls to her father.

8.16 The last known "relationship status" with her family prior to the killing:

- At a home visit on 12 July 2013 recorded "*she does not have much contact with her mum*" (although note that at this point her parents were still caring for her younger son).

8.17 The significance of this "last known relationship status" to Ms Z's care:

8.18 As will be discussed in Juncture Seven of this report, the nature of Ms Z's relationship with her family, and more specifically, services' knowledge of that relationship, would prove to be of crucial importance in her care.

8.19 An overview of Ms Z's contact with mental health services:

8.20 Ms Z's contact with mental health services spanned an extensive time period, from her first ever interaction in the form of an informal admission in September 1994, up until the last contact she had in November 2013, weeks prior to the homicide.

8.21 The full timeline of her contact with services, pursuant to the Independent Investigation Team's Terms of Reference for this report, can be found at Appendix 1.

8.22 However, it is the view of the Independent Investigation Team that an overview of Ms Z's most significant interactions with mental health services would be usefully highlighted below:

8.23 **Ms Z's first contact with mental health services (1994)** – Ms Z first came into contact with secondary mental health services in 1994, when she was 19 years old. She was recognised to be "*actively psychotic, with thought disorder, auditory hallucinations, suspiciousness, perplexity and vagueness*". Her presentation was noted to be "*atypical*".

8.24 Psychometric testing showed deterioration in her cognitive functioning (it is notable that she was less academically successful than her siblings, indicating a potential long prodrome) which was thought to be due to psychotic illness. Drug use was identified as a possible cause, although the only identified drug was cannabis.

8.25 This is significant because patients with schizophrenia show evidence of cognitive impairment and a decline in cognitive functioning. Some of this is thought to be due to the active symptoms of the illness, and can be improved with alleviation of those symptoms.

8.26 Some of this is due to the side-effects of medication, but this is less of a problem on newer, atypical antipsychotics. Finally, some of this impairment and reduced cognitive functioning is thought to be due to the effects on the brain of the schizophrenic process, and may be inevitable.

8.27 By contrast, patients with personality disorder do not show such a decline: the decline is of diagnostic significance when trying to differentiate whether schizophrenia or personality disorder is driving bizarre behaviour.

8.28 Drug misuse is often used as an excuse to ignore psychotic symptoms, labelled as “drug-induced psychosis”. “Drug-induced psychosis” should be short-lived, and should remit once the drug is out of the system, usually within 24 hours. It is more common with stimulants and hallucinogens (cocaine, amphetamine, LSD, ecstasy) than with opiates (heroin). Cannabis can cause psychosis, but it is rare and usually follows prolonged use.

8.29 This factor is therefore significant because it is a misdiagnosis to assert a drug induced illness in situations where urine testing confirms an absence of drugs. In Ms Z’s case, as a result of the relatively low frequency of drug testing performed, the hypothesis of drug induced illness was never challenged.

8.30 Ms Z’s symptoms responded to medication, but her mental health deteriorated rapidly following reduction of the dose or cessation of the medication.

8.31 Between her first interaction with services in 1994, up until the beginning of the most critical period in Ms Z’s care, starting 2011, that forms the focus of this report, Ms Z was involved with services, sometimes sporadically, sometimes frequently, but always constantly.

8.32 <u>The critical period in Ms Z’s care – 2011 – 2013:</u>

8.33 Whilst it is crucial that all of Ms Z’s interactions with mental health services be mentioned and considered given the complexity and longstanding nature of her illness, the most significant period to be considered by this report in terms of her interaction with mental health services is the two years prior to the homicide; the period in her care during which she was in a “limbo” of sorts.

8.34 Ms Z was deemed, on the grounds that she was “no trouble” and taking her medication, to be “stable”, and therefore suitable for transfer from AOT to CMHT. She was informed of this, but then no change of team actually occurred, and it took two years before her care co-ordinator was changed. It is the view of the Independent Investigation Team that alterations in teams have an effect on service users: there emerge anxieties about what will happen, an assumption that they are improved and therefore no longer need the medication, a dropping of the guard of the patient, and ambivalence about the new team/care co-ordinator.

8.35 Although the Independent Investigation Team considers that Ms Z had been “stable” previously, there had not been a thorough and pro-active approach taken to her illness. It was surprising to note that she had been allowed to drift along on low doses of typical antipsychotic medication, whereas someone with longstanding schizophreniform illness should have been asked about behavioural and family interventions, high-dose antipsychotic or, if no response, clozapine[5].

8.36 The whole AOT was re-organised, with the consultant moving to a Community Health Team role, even though Ms Z remained on that consultant’s caseload. The same care co-ordinator also continued being responsible for Ms Z, but in an AOT “role” rather than part of an AOT: an opportunity for a CPA and review of risks was missed.

8.37 Furthermore, the Independent Investigation Team noted that her shoplifting was recorded but not considered, and other symptoms indicative of worsening mental health were not acted upon.

8.38 Between 7 November 2013, and the date of the victim’s death, Ms Z had disengaged from mental health services and so it is not clear from Ms Z’s medical records what occurred next.

8.39 Prior to the victim’s death, Ms Z appeared in Court on 3 December 2013 charged with harassment. Ms Z left Court and failed to return after the Hearing was adjourned for her to speak with a probation officer about a psychiatric assessment.

8.40 It appears that Ms Z returned to her home, packed a few belongings and walked to the victim’s house.

[5] As directed by NICE [CG178 not published until 2014, but CG 82 from 2009 applied].

9 JUNCTURES:

9.1 As has been shown, Ms Z was an individual who had a long involvement with mental health and substance abuse services. Her lifestyle was chaotic and posed a number of challenges for those involved in her care as a result of her significant psychological and social needs. Issues with substances increased both her vulnerability, and the risk which she might have posed, both to herself and others.

9.2 It was recognised at Ms Z's trial that she had a psychotic illness which was a significant feature in her actions towards the victim.

9.3 As mentioned above, the Independent Investigation Team was asked to construct a timeline of Ms Z's care from September 1994, as at Appendix 4.

9.4 The Independent Investigation Team used that timeline and the elements of the CPA to identify a number of "junctures" or transitional points where Ms Z's care could potentially have taken a different path, had organisations/clinicians made different decisions. This is intended to act as a prompt to allow reflective practice and unlock learning.

10 JUNCTURE ONE – THE CONDITION OF MS Z'S MEDICAL RECORDS:

10.1 A contributory factor that led to the tragic events of 9 December 2013 was the condition of Ms Z's medical records during the entirety of her contact with services.

10.2 Simply put, they were not kept as efficiently as they could have been. Furthermore, there was no evidence of a conscious recognition of, and compensation for that deficiency in the approach taken by services to reviewing Ms Z's notes as part of routine care.

10.3 The format of Ms Z's medical records:

10.4 Ms Z's medical records spanned nearly 20 years and were stored in three formats: one paper, and two clinical IT systems. In March 2016, the Trust's patient record system was still in the process of undergoing a period of "migration", which meant that the records of some service users, like Ms Z, were held in the above three separate formats.

10.5 Essentially, this meant that it was not a straight-forward matter for those involved in care delivery to access all the key information about a service user in any of the three formats.

10.6 The detrimental effect on Ms Z's care:

10.7 A key predictor of service user risk is knowledge of their previous history. Accurate service user records are crucial, in order to deliver an appropriate standard of service user care and facilitate assessment of risk.

10.8 The Independent Investigation Team was concerned about the quality and accessibility of Ms Z's records. Aside from the quality of the notes themselves, there were significant difficulties caused by the fact that notes were in three formats, spread across a number of years. This caused important information to become lost or difficult to find without significant effort. The system which operated at the time of Ms Z's care did not allow easy communication of client need, care or risk.

10.9 The Independent Investigation Team recognises that Ms Z had several volumes of records going back over many years. However, no attempt was made to complete a case summary based on those records. Her transfer from AOT to CMHT in August 2013 should have been a trigger for a systematic review of all the notes associated with the case. This did not occur, and had a significant impact upon the manner in which Ms Z's care was delivered.

10.10 The broader concern:

10.11 The issue of access to information contained within service user records is a significant problem across the NHS. The problem is particularly acute in relation to service users such as Ms Z, who may have received care over a number of years and, as a result, have both paper and digital records.

10.12 Whilst procedures had been introduced to make care co-ordinators and/or trainees responsible for ensuring that the new electronic systems used by the Trust were populated with key information from a longstanding service user's files, it was made apparent to the Independent Investigation Team that time pressures may prohibit this transition being fully undertaken.

10.13 During the course of the interviews, it became clear that whilst the Trust had taken steps to try and alleviate the risk of information becoming lost, that risk remained in the opinion of the practitioners who were interviewed as part of the Independent Investigation. The issues repeatedly mentioned were "time pressures" and the need to "free spaces" in the service for new clients.

10.14 <u>Other ways to manage the issues with the notes:</u>

10.15 There were steps that could have been taken by clinicians to reduce the risk of key information not being recognised. This would have involved completing a full review of Ms Z's notes as part of a CPA review.

10.16 However, this would have been a time consuming task taking at least a half day of professional time, which the Independent Investigation Team were repeatedly told by the Trust, employees did not have.

10.17 The Independent Investigation Team acknowledges this concern was raised in the internal investigation and the Trust recognised that having more than one system is very difficult.

Comment 2:

Ms Z's medical records were lengthy and consisted of paper and electronic records. Notwithstanding the fact that it remains the view of the Independent Investigation team, a unification of all patient notes is essential, even with this, had systematic reviews been conducted throughout her care, the risk of important information being absent would have been reduced, and this information would have been captured in the records.

With the passage of time and changes in staff, there had been fundamental flaws in the migration of service users' medical histories that have not been addressed by the Trust in the systems they implement.

A significant factor which lies at the heart of the deficiencies by those involved in Ms Z's care to perform a systematic review of Ms Z's records is that information in past clinical records was not accessed, utilised and shared with the individuals involved in the later stages of her care, who depended on personal recollections, anecdotes, and their general impressions of her functioning. The practical difficulties attached to this task appear to include difficulties in accessing notes in different formats and also time pressures.

In order to obtain a long-term view of a service user, review of information contained in their records is crucial to the delivery of service user centred care and risk assessment. However, the difficulty in doing so is shared by many trusts throughout the NHS.

Recommendation 1 – Consolidating/fully reviewing medical records:

The Trust is required to adopt a strategic response in relation to patient records, i.e. the unification of the paper and digital notes system into one system. The Independent Investigation Team is of the view that this should ideally be an electronic system capable of allowing a care professional to pull up information relating to patients and the status of their risk assessments at a glance.

A strategic response at Board level is required in order to address the practical difficulties which clinicians face when presented with the challenge of accessing a service user's historical records. The loss of information when migrating to electronic service user records is also a risk which must be addressed.

New database packages allow a Care Professional to pull information from their electronic patient record to show the people under a team member's care, and the update status of risk assessments for the last 6 months. This does not address the needs of a patient who has had previous admissions over a period of time. Consequently, a protocol should be developed to ensure a review of paper and electronic records held for service users who have experienced a number of episodes of care.

Accordingly, it is recommended that:

a) The Trust take steps to unify paper and digital patient records. Until such time as the paper and electronic records have been unified, the Trust must implement a protocol to ensure a review of patient's paper and electronic records is undertaken at key stages (admission, CPA Review, discharge and transfer).

b) Following unification of paper and digital record keeping systems, patients' historical records must be reviewed and summarised at key stages in their care (admission, CPA Review, discharge and transfer).

c) The performance of the requirements at 1 and 2 and the adherence to protocol connected to these recommendations needs to be monitored and audited.

d) The findings of these audits are to form part of discussions at regular Quality Assurance Meetings.

11 JUNCTURE TWO – THE DEFICIENCIES IN ADEQUATELY GAINING AN UNDERSTANDING OF MS Z'S ILLNESS:

11.1 It is the view of the Independent Investigation Team that Ms Z was suffering from a "*longstanding, untreated psychotic illness*". However, one of the problems relating to the management of Ms Z was that, throughout the course of her contact with mental health services, her diagnosis was inconsistent with her management.

11.2 Over the course of her nearly 20 years interacting with services, Ms Z's symptoms included:

- Mildly hypomanic;
- Emotional liability (she had some formal thought disorder, and perhaps thought insertion and delusions of persecution);
- Distressed state (talking to unseen/unheard stimuli - brought in by police).
- Visual/auditory hallucinations;
- Responding to unseen stimuli;
- Seeing people with babies and hearing voices;
- Paranoid symptoms including drugs being planted in her house by neighbours;
- She could not link her feelings together and found it very difficult to have a normal chain of thoughts;
- Wandering in the streets wearing only a small vest and leggings (December 2004);
- An overdose (at Christmas 2001, as she had lost the care of her son);
- Bizarre behaviour - Using spray paint on a cat, rummaging through neighbours' dustbins;
- Fluctuating mental state, veering from calm to verbal threats within a day; and,
- Thought disorder, loosening of associations, talking in a very confused manner.

11.3 Ms Z's earlier interactions with and diagnoses by services (1994 – 2003):

11.4 It is the finding of the Independent Investigation team that, for a patient with such a longstanding history of interaction with the NHS as Ms Z, it took a considerable amount of time for services to actually come anywhere near an accurate diagnosis of her condition.

11.5 The Independent Investigation Team considers that the notes for this period of Ms Z's interaction with services are sparse, and may be incomplete. According to the notes, it appears that Ms Z's consultant was off work on sick leave, and there was a series of locums and temporary consultants from 2000 onwards.

11.6 She was diagnosed with post-natal illness and discharged in 2002. It is the view of the Independent Investigation Team that this discharge should not have occurred.

11.7 The 2003 diagnosis change:

11.8 At this point, Ms Z's diagnosis changed. Previously, the working diagnosis was of "*a psychotic illness exacerbated by drug misuse*".

11.9 There were then 3 years when, despite evidence to the contrary, the diagnosis was changed to that of a "*personality disorder*". This diagnosis has set diagnostic criteria. As more information is gathered, the diagnosis can be reflected upon and refined, or altered over time. This "review" did not happen.

11.10 As a result, symptoms were ignored, dismissed as manipulative or disbelieved, with attempts being made to distance Ms Z from the teams (although this was corrected in a 2006 antenatal admission, the tendency to minimise or ignore symptoms indicating relapse, ascribing them to "drug misuse" or "personality disorder", persisted until the time of the index offence).

11.11 The danger that this created was to narrow the range of thinking, and exclude a reflective process concerning Ms Z, or aspects of her presentation, leading to the loss of important diagnostic information.

11.12 By 2005:

11.13 An independent, Court commissioned psychiatric opinion which took place in July 2005 was not followed by any subsequent action, despite there being a Court Order mandating such a review. Ms Z was noted to appear to be responding to unseen stimuli and her ideas involved conspiracies, harassment, betrayal by friends and feeling "*voices and badness*" coming out of friends. However, the Court Appointed expert was unable to elicit delusional beliefs or descriptions of hallucinations.

11.14 It is the view of the Independent Investigation Team, that this inability to elicit delusional beliefs or a description of hallucinations was of relevance; Ms Z was clearly "floridly" unwell, but a competent and unhurried psychiatrist was unable to elicit "typical" symptoms of schizophrenia. It is no surprise therefore, that services could not do so when they assessed her after the depot was discontinued in November 2013.

11.15 Although the Court appointed expert was unable to elicit delusional beliefs or descriptions of hallucinations, he noted incongruity of affect. There was an acknowledgement by Ms Z of longstanding mental health problems, but no understanding of their nature. By this point, Ms Z had been interacting with services for almost 11 years.

11.16 The reviewer concluded that the diagnosis was of recurrent psychotic episodes due to a true mental illness, although with a possible exacerbation due to use of drugs. He noted that when she was being regularly seen by the CMHT, she was more stable and less angry, but when she was more acutely mentally ill, she became aggressive and violent. The reviewer concluded that "*robust management of her mental state would help minimise the risks*".

11.17 The management remained unchanged, and consisted of treating her as though she had a personality disorder with sporadic use of oral antipsychotic medication. She was discharged from the CMHT in April 2006, despite disengagement from services, drug use, threats to kill her mother and non-compliance with medication.

11.18 Ms Z's transfer to perinatal mental health services in June 2006:

11.19 Ms Z came under the care of the perinatal mental health services in June 2006, following a referral by the CMHT as she was 15 weeks pregnant. She did not engage with the services and was eventually admitted to hospital under the Mental Health Act 1983 in August 2006.

11.20 Although recognised as being "floridly psychotic", hallucinations were not a prominent feature of her illness. Delusional beliefs were elicited in response to her behaviour (such as attacking other service users). Her beliefs centred around conspiracies, paedophilia, the removal from her care of her first son and changing of gender.

11.21 In the period September 2002 to 2006, Ms Z was given numerous diagnoses, including:

- Bipolar affective disorder and post-partum depression;
- Emotionally unstable personality disorder, impulsive type;
- Borderline personality disorder; and,
- Feigning of symptoms so that an insurance company would pay off her debts, or she could be supported to change accommodation, or she could have a psychiatric report regarding offences.

11.22 The closest diagnosis:

11.23 The diagnosis of a "*longstanding, untreated psychotic illness*" was recognised, although, as will be shown in later Junctures, it was at this time that the family was excluded from input into her care:

"Ms Z has no social support, her family are not involved in her care, indeed her mother has neither telephoned, nor visited, since Ms Z's admission[6]".

11.24 The baby was induced two weeks before the due date, and taken into the care of the local authority at birth. The child was later transferred into the care of Ms Z's mother.

11.25 Ms Z was appropriately referred to the AOT and was accepted by one Doctor, although by the time she was discharged from hospital, this Doctor had left and the eventual replacement had not been involved in the various previous attempts at referral.

[6] The report for the child protection case conference regarding her unborn child in September 2006.

11.26 Treatment strategy pursuant to these diagnoses:

11.27 **NICE clinical guideline 82: Schizophrenia** (issued March 2009) says that cognitive behavioural therapy (CBT) and family intervention should be offered to individuals with schizophrenia. Counselling and supportive psychotherapy (as specific interventions) can also be offered, although not routinely as service user preferences must be taken into account.

11.28 It is the view of the Independent Investigation Team that services recognised at least the possibility of a schizophrenic element to Ms Z's illness. Ms Z's notes do not include any indication that these treatments were considered.

11.29 **NICE clinical guideline 51: Drug misuse in over 16s:** psychosocial interventions (issued July 2007) is clear that families should be consulted and supported in their interactions with the service user. Brief interventions including motivational interviewing regarding drug use and goals related to substance misuse should also be offered to the client.

11.30 Ms Z's notes indicate that discussions about substitute medication were frequent, but show little evidence of other interventions and no liaison with the family.

11.31 Medication:

11.32 In August 2008, Ms Z was commenced on a depot (40mg flupentixol decanoate every 2 weeks) and supported in attending the community drug services by her care co-ordinator, at that time an occupational therapist.

11.33 Various attempts were made to commence her on a mood stabiliser, but she was poorly compliant with both Lithium and Depakote (Semi-Sodium Valproate). Although she was reviewed prior to commencing her on oral mood-stabilising medication, there was no review when medication was discontinued, and no consideration of increasing the dose of depot medication or considering other treatments for the "schizophrenia" element of her schizo-affective disorder, neither psychological nor pharmaceutical.

11.34 The only assessments of risk between 2006 and 2010 involve the use of illicit and non-prescribed medication.

11.35 CPA in relation to diagnosis of Ms Z's illness:

11.36 The Independent Investigation Team is of the view that had these longstanding difficulties in specifying Ms Z's diagnosis been recognised and reflected in her care under the CPA, this could have provided different options for available treatments and changed her care. This is a point where care could have gone in a different direction.

11.37 It is the view of the Independent Investigation Team that, despite her longstanding interaction with mental health services over the course of many years, the difficulty in proffering an accurate diagnosis for her, and the number of different diagnoses that were applied, even up until the incident itself, provides evidence to support the view that services simply did not have an accurate or realistic understanding of who Ms Z was.

Comment 3:

Psychiatric diagnosis is an active process in which symptoms and behaviour are evaluated against standardised criteria to arrive at a "best match". In complex cases, the information needed to make a diagnosis is often incomplete, or requires a period of longitudinal evaluation. Further, a patient's symptoms or presentation may change over time. Diagnosis, therefore, should be dynamic and be regularly reflected upon, reviewed, and refined. Particular difficulties arise when diagnostic terms are misused in the form of "labels" due to the misplaced assumptions that derive from them.

Labelling" goes beyond diagnostic terms, and represents a shorthand way of categorising an individual without properly formulating their personal circumstances, personal history, and need. This approach, therefore, fails to see the person, as the stigma from labelling is about the blanket application of assumptions about a group of people, rather than exploration of the individual.

As well as adversely influencing decision making with regard to health and social interventions, labelling also acts as a smokescreen to changes in the pattern of a person's difficulties. This was a significant factor in relation to Ms Z.

For example the label of "drug user" was applied to Ms Z. Professionals involved in her care appear to have regarded Ms Z as being in control of this behaviour and that it was in fact, a matter of choice. For example, incidents that could have indicated worsening mental health, such as shoplifting, were ascribed without reflection to acquisitive crime in order to fund drug use.

This could have been viewed differently if the label of "drug user" was recognised as having limitations, and was instead made the subject of a reflective process, which potentially could have led to a greater understanding of the reasons for some of Ms Z's behaviours.

12 JUNCTURE THREE – LACK OF UNDERSTANDING IN RELATION TO THE RISKS MS Z POSED WHEN ILL:

12.1 The correlation between risk, predictability and preventability:

12.2 The Independent Investigation Team has applied the paradigms of predictability and preventability set out at paragraphs 3.4 to 3.8 above to the events of 9 December 2013. It is the view of the Independent Investigation Team that whilst the most notable deterioration in Ms Z's mental health began in 2010 and continued from that point, more proactive work from 2007 would have made a difference.

12.3 The belief that people who suffer from schizophrenia are dangerous is as common and widespread as it is misconceived. The media often depicts mentally ill individuals as violent and out of control which encourages stigmatisation[7]. However, the statistical reality is that most people who suffer from schizophrenia are no more prone to violence than anyone else. Indeed there is evidence to suggest that people who suffer from schizophrenia tend to be socially withdrawn and would rather not engage with others and may be more likely to be a victim of crime[8].

12.4 Predictive factors:

12.5 There are factors which are predictors of violence or may play a role in violent behaviour exhibited by some individuals who are experiencing a serious mental illness such as schizophrenia[9]. These general factors are:

- A history of previous violent behaviour;
- Failure to take medication;
- Disengagement from services;
- Certain types of delusions, particularly ones which are both persecutory and grandiose;
- Command hallucinations which tell them to harm others; and,
- Substance or alcohol misuse or addiction.

12.6 The Independent Investigation Team recognises that if an individual has a history of violent actions then they are more likely to commit violent acts in the future. In most cases, the violence exhibited by an individual is likely to mirror the way in which they had been violent or aggressive before. This includes the group of individuals to whom the violence is directed.

[7] *"Violence and Aggression; Short-term management in mental health, health and community settings"* (Updated edition) - NICE Guideline NG10 2015
[8] Pettit et al., 2013, p21
[9] (Witt et al., 2013)

12.7 A large body of literature exists on risk factors for violence, including in individuals with mental disorders[10]. The largest of these[11] was a systematic review and meta-analysis of risk factors in people with psychosis, providing data from 110 studies and over 45,000 individuals. The authors found that 146 risk factors had been examined in these studies. In line with findings from other studies, criminal history was found to be the strongest static risk factor. Dynamic factors included hostile behaviour, impulsivity, recent drug or alcohol misuse, "positive symptoms" of psychosis and non-adherence with therapy (including psychological and medication)[12]".

12.8 This significance of these particular factors to Ms Z can be shown below in relation to her behaviours in these regards.

12.9 Ms Z's history of "violence" as per her care records:

12.10 The following violent incidents were recorded in Ms Z's care records:

- **December 2001** - attack on mother when visiting ward[13].
- **28 October 2004** – arrested and charged with theft of alcohol from a supermarket, but found to be carrying a lock-knife when in custody (believes charges dropped).
- **December 2004** - cut neighbour's car tyres[14].
- **2004** - Conviction for Battery and Destruction of Property. Hit her son's father and paternal grandmother, and threw a brick through the window of the paternal grandfather's car.
- **26 January 2005** - violent to staff[15].
- **July 2005** - told expert psychiatrist that she had carried a knife since 1999.
- **22 June 2006**: "*harassing a neighbour, accusing her of stealing from her house and having AIDS. The neighbour has been shouted at and called the wrong name over the garden fence. She is fearful as she knows Ms Z carries knives*[16]".
- **August 2006**: Clinician informed the meeting there had been recent concerns expressed to the CMHT, from Ms Z's neighbour, seen slashing or tampering with tyres on neighbours' cars[17].
- **Aug/Sept 2006** - assaulted a fellow service user[18].
- **Aug/Sept 2006** - held a cigarette lighter near the hair of a fellow service user[19].

[10] (Bo et al., 2011; Cornaggia et al., 2011; Dack et al., 2013; Papadopoulos et al., 2012; Reagu et al., 2013; Witt et al., 2013).
[11] (Witt et al., 2013)
[12] Ps58-59
[13] Dr letter of 29 September 2006 to AOT.
[14] Dr letter of 29 September 2006 to AOT.
[15] Letter from Dr to Dr dated 17 Dec 2005.
[16] Letter of 30 June 2006 from CMHT to Dr at General Hospital Psychiatric Unit.
[17] Strategy meeting notes from 4 August 2006.
[18] Dr letter of 29 September 2006 to AOT.
[19] Dr letter of 29 September 2006 to AOT.

- **September 2006** - pushed a service user against a wall in an unprovoked attack, thought to be due to her belief that there was involvement with paedophilia or the removal of her son from her care[20].

12.11 Ms Z's mother's concerns:

- On **15 September 2005**, Ms Z's mother called mental health services and informed them the family have been "*dealing with Ms Z's violence through the police*", stating that "Ms Z *had been calling family members at 04.00 and threatening them*", and as a result, "*the family were really frightened of her*". Ms Z's mother informed that Ms Z "*did not want her help*", and she (Ms Z) "*just uses her as a scapegoat and her whipping boy*".
- Ms Z's mother informed services that her relationship with Ms Z "*had broken down to nothing, and the she didn't see or communicate with her any more*". She did also inform services that she was "*still here for her*", and she could be told when she's better that she could contact her.
- On **17 September 2005**, Ms Z's mother spoke with Ms Z on the phone, wherein Ms Z had become hostile and aggressive. Ms Z's mother then called services, concerned about Ms Z's mental state.
- On **9 May 2006**, Ms Z's mother called services seeking an appointment as her behaviour was "*not acceptable by today's standards*".
- On **15 May 2006**, she called again informing services that Ms Z was "*still terrorising the family*", her grandfather had died, and that she had "*threatened to kill her brother's children*". She was stating "Ms Z *needed to be sectioned*".
- On **5 June 2006**, Ms Z's mother called again, and amongst other things, informed services that she "*still cares about Ms Z*" and "*will support her if Ms Z will let her*".
- By **August 2006**, her medical notes recorded her as having been asserting that her step father was responsible for an historic homicide in the area years previously.

12.12 The significance of the local café owner:

12.13 In the months immediately preceding the killing, Ms Z exhibited obsessive and aggressive behaviour against a former school friend who was, at the time of the killing, the owner of a successful local café. This individual had attended school with Ms Z, and lived across the road from Ms Z while the two were growing up. According to Ms Z's parents, the two were best friends growing up.

12.14 On 3 September 2013, Ms Z attended for her depot, and, as recorded in her service user notes from that meeting;

"*Sounded grandiose in her ideas. She reported that if she wasn't 'stitched' meaning betrayed, she would be running and managing the very upmarket eatery*".

[20] Dr report on Ms Z for Child Protection Conference on expected baby - 12 September 2006.

12.15 Two weeks later, on attendance for a depot on 17 September 2013, her notes reported;

> "*…seemed to be slightly elated in mood with grandiose ideas about owning the cafe. Will discuss with Dr and ask to R/V...*"

12.16 Between September and October 2013, Ms Z went to the café on multiple occasions where she would shout and swear at the owner. She would bang on the window, and was abusive and threatening in this way several times in this period.

12.17 During this period, according to Ms Z's parents, Ms Z also called a luxury car manufacturer and informed them that the café owner intended to bomb their factory. Ms Z's parents said that Ms Z was envious of a lot of her friends that had done things in life she wanted to do. She had ambitions and things she wanted to do, and the illness stopped her. After the homicide, Ms Z told psychiatrists she was "jealous" of the café owner.

12.18 On 19 September 2013;

> "*Message from Care Line (out of hours service) that Ms Z was arrested by Police for harassment (not clear who she harassed). Ms Z phoned to ask if I can organise furniture with Liversege. Asked about the aforesaid incident. Ms Z discussed it stating that it was nothing serious. Asked Ms Z to attend R/V with Dr but she declined*".

12.19 Ms Z was cautioned for threatening to kill the café owner, and then later charged with harassment after making further visits to the café. She was listed at Derby Magistrates Court for Harassment on 11 November 2013, and given Conditional Bail for pre-sentence reports until 3 December 2013. Ms Z did not attend this Hearing, instead absconding to the victim's cottage.

12.20 <u>Instances of services' recognition of the risk Ms Z posed:</u>

12.21 Ms Z had been involved with mental health services since 1994, and had many volumes of psychiatric notes. Several correspondences detailed the risks associated with mental illness, particularly the report for the Court in 2005, and the letter referring Ms Z to the AOT in September 2006.

12.22 Those reports detailed verbal threats and physical assaults (including pushing, the use of weapons and damage to property). The reports detailed links with relapse of illness and aggressive or violent behaviour.

12.23 Indeed, Ms Z's medical records from December 2012 state;

> "*When unwell she is a risk to her mother and wider family, to whom she made threats, to staff members and her children*".

12.24 The Independent Investigation Team found that some healthcare professionals involved with Ms Z in the later stages of care, felt violence was predictable, principally as a result of Ms Z's steadily increasing pattern of offending, in terms of both frequency and severity, as per her continuous involvement with the CJLT. The offences she committed between 2012 and 2013 were an indicator in terms of risk.

12.25 Services' response to these risks:

12.26 The risks, particularly from 2003 to 2006, and then again from 2010 onwards, were noted, but either ignored, minimised, dismissed, disbelieved, ascribed to drug use or ascribed to an ulterior motive, such as wanting to avoid prison. There was no systematic review process, with collation from the notes regarding the risks over the duration of Ms Z's illness.

12.27 It was apparent to the Independent Investigation Team, that in the opinion of some healthcare professionals involved in Ms Z's care, the services who had dealt with Ms Z long term felt they "knew Ms Z better", as they had been involved in her care for years.

12.28 These "concerned" healthcare professionals did not appreciate why the rest of the services could not see the risk Ms Z presented, having considered Ms Z's "Functional Analysis of Care Environments" (FACE) risk assessment in conjunction with previous notes (FACE is a commercial mental health assessment tool designed to assess risk and needs in health and social care to assess an individual's mental capacity).

12.29 It is the finding of the Independent Investigation Team that services' response to these concerns raised was a response of "resignation", and that Ms Z has always presented to services in this way and this is "just the way she is".

12.30 The impact on Ms Z's care:

12.31 The more recent risk assessments did not take account of historical risks, and were based on impressions, labels and the functioning of recent weeks. The family's knowledge of risks and the associations with relapse were either not known (the local café owner) or not acted upon (Ms Z's mother called alleging midnight abusive texts and being "reassured" in April 2011).

12.32 It is conceivable that a CPA meeting at the point at which Ms Z appeared to disengage from the CDT would have allowed the opportunity to perform an immediate Mental Health Act assessment at that stage.

12.33 Conclusions:

12.34 The Independent Investigation Team has concluded that it was predictable that Ms Z would carry out a significant act of aggression towards her mother or former school friend if she was experiencing psychotic symptoms in the absence of medication. This possibility was highlighted in Ms Z's records as early as December 2001, with knowledge of her use of knives being recorded from July 2005. Consequently the Independent Investigation Team believes that a significant attack upon an individual who was known to Ms Z was predictable should Ms Z become psychotic and default from her medication.

12.35 Ms Z was showing signs of relapse in 2010, despite complying with her medication. Her compliance drifted as her mental state worsened; she was already well into a relapse when she stopped attending for her depot.

12.36 However, the Independent Investigation Team is of the view that an attack such as that carried out upon the victim could not have been predicted.

12.37 The Independent Investigation Team believes that had a comprehensive review of Ms Z's care been undertaken, it would have been clear that there was a very real risk that as Ms Z relapsed, she would lose what insight she had, and as a result she could then disengage from services.

12.38 These were not recognised as relapse indicators for her psychosis.

12.39 This disparity between the respective tolerances of the teams involved in the care of Ms Z and the lack of a coordinated adherence to the CPA ethos between them, particularly in relation to indicators of risk will be discussed thoroughly in the next Juncture.

Comment 4:

The Independent Investigation Team has carefully considered the instances of violence committed by Ms Z. The violence was directed at other people with whom she had a relationship, particularly her mother. There is no evidence that her aggression was in the context of dysfunctional or difficult family relationship outside of periods when Ms Z was acutely unwell.

As a result, the Independent Investigation Team considers the violence to be a feature of Ms Z's illness, or directed towards acquiring illicit drugs, rather than a feature of relationships within the family.

13 JUNCTURE FOUR - SERVICE PROVISION AND SERVICE BOUNDARIES:

13.0 During the course of the relevant period, Ms Z was involved with four separate teams within the Trust; the Community Drug and Alcohol Team (CDT), the Community Mental Health Team (CMHT, also known as 'Recovery'), the Criminal Justice Liaison Team (CJLT), and the Assertive Outreach Team (AOT).

13.1 As mentioned in the previous Juncture, it is the opinion of the Independent Investigation Team that these teams did not pursue a common adherence to Ms Z's CPA as best they could, which, in turn, hindered her longer term care and recovery.

13.2 Although they were in separate buildings, the CDT was located comparatively close to the CMHT, and informal liaison between workers was good. However, as will be shown in later Junctures, the lack of a proper CPA or any adherence to its ethos meant that the pre-existing division between the teams ultimately added to the deficiencies in her care that contributed to the homicide.

13.3 Differences between the teams:

13.4 It is the finding of the Independent Investigation Team that differences between the two teams in their responses to Ms Z's presentation and behaviour resulted in miscommunication and an increased risk of behaviour presenting risk (and warranting further investigation and possibly action) being overlooked or downplayed. For example:

- The CDT had a much higher tolerance of shoplifting, minor assaults and harassment than a CMHT would.
- Medication prescribed by the CDT, along with its rationale, was not always clear to the CMHT.
- When Ms Z began to relapse, there was the hope that the CDT would be able to review her: they did, but were not aware of the concerns of the CMHT, did not undertake a more detailed psychiatric assessment, and were not privy to the relapse indicators in the medical notes.
- The Independent Investigation Team found that, after Ms Z had been transferred from AOT to the CMHT, some healthcare professionals in the CMHT were not convinced that Ms Z had stopped using illicit substances, and contacted the CDT to ascertain whether or not they were monitoring Ms Z's usage, via urine and specimen testing – CDT informed that they were not monitoring, but instead were mainly issuing scripts.

13.5 The Independent Investigation Team considers that this testing is something that could have been improved. The effects of illicit drugs on Ms Z's behaviour and the ways in which to address them represented a significant part of the pathway, and therefore proper adherence to the CPA would necessitate at least awareness as to Ms Z's usage. It is the view of the Independent Investigation Team that to simply "take her word" regarding her apparent cessation of illicit drug use, displayed insufficient vigilance and an unwarranted over reliance on her assertions.

13.6 Themes common to both teams:

13.7 It is also the view of the Independent Investigation Team, that both the teams suffered the same weaknesses in several respects:

- Neither team liaised with Ms Z's GP or found out that Ms Z had attended for antidepressants or beta blockers.
- Neither team convened a full, multi-disciplinary CPA.
- Neither team looked at relapse indicators or risk indicators.
- Neither team were aware of the documented risks in the notes.
- Neither team reviewed the notes to provide an improved understanding of her illness and care needs.
- Both provided flexible input, but at the expense of a systematic approach to her care.

13.8 Such processes would be of major importance in cases where the drug services and mental health services are commissioned from different providers, as is the case in many areas across England.

13.9 The movement of Ms Z and the restructuring of the teams:

13.10 Deterioration of Ms Z's condition began in 2010, shortly after Ms Z was told at a CPA that she would be transferred to the CMHT. She may have taken this as a sign that she was well, and either become anxious about the perceived reduction in support, or decided that she did not need to take so much care.

13.11 In the interim, the AOT was disbanded: the exact timing of this is uncertain, but it probably occurred in September 2011. As a result, Ms Z stayed with the AOT nurse, but was transferred to the CMHT administration and management.

13.12 The Independent Investigation Team learned that some healthcare professionals involved in Ms Z's care felt that there needed to be more justification as to why it was felt that Ms Z was ready to be transferred from AOT to the CMHT. She was still a dual diagnosis patient, who was still actively using illicit drugs, still missing appointments, still failing to comply etc. All of these factors (particularly the non-compliance) would suggest that, at the time, Ms Z was still very much an "Assertive Outreach" patient.

13.13 The Independent Investigation Team questions whether or not the decision to transfer Ms Z from AOT to the CMHT was correct.

13.14 Ms Z's transfer from AOT to the CMHT:

13.15 For whatever reason, the transfer did not take place until August 2013, with little forethought, no planning and no CPA (in part, in response to service pressures the Investigation Team heard). By the time the transfer took place, there were clear indicators of relapse, present for over two years.

13.16 The fact that Ms Z missed her depot from 15 October 2013 to 24 October, and that services were unable to respond until 7 November 2013 is a reflection of the service changes: a traditional AOT would have been alerted and responded within 48 hours of the first missed depot.

13.17 The barriers to information between the Criminal Justice Liaison Team and other services:

13.18 Throughout the majority of her interactions with mental health services, Ms Z, by virtue of her repeated and longstanding criminal offending, was also involved with the CJLT.

13.19 The Trust reported that there could have been better communication between the CJLT and the CMHT; the Independent Investigation Team found clear evidence of this.

13.20 For example, on 17 October 2005, Ms Z was charged and convicted for (*inter alia*) an unprovoked attack on a female (unknown to Ms Z) as she walked out of a store in a city centre shopping area[21].

13.21 Such behaviour is not uncommon in service users who do have a serious mental illness. It highlights the importance of liaison between drug and mental health services as the two teams can pool their knowledge of the relapse indicators and risk management of an individual with a "dual diagnosis".

13.22 However, the Independent Investigation Team also consider that the significance of this not being conveyed and recorded is ultimately arguable, because the evidence, presented throughout this report, may suggest that even if the CMHT was aware of this type of incident in Ms Z's prior history, the CMHT, by the time of the killing, was so fixed on the pre disposition that "this was just how Ms Z behaved", that it is feasible that no action would have ensued in any event.

[21] NHS internal report (CJLT records), BBC News website, Ilkeston Advertiser (convictions presented to Nottingham Crown Court at trial).

Comment 5:

The Independent Investigation Team has identified a number of significant concerns about the difficulties which Ms Z experienced in accessing care across the services provided by the Trust.

The Independent Investigation Team acknowledges that the Trust recognises there was no sharing between the CJLTs and CMHTs and that effective use of the CPA process across the Trust would help address these difficulties.

The main concern of the Independent Investigation Team is that all four services, AOT, CMHT, CDT and CJLT were all provided by the same Trust. In future, it is conceivable that different providers may deliver these services.

This would, in turn, raise the question as to the way in which the Trust would respond to the challenges of this. It ought to be via the CPA; however, as this report hopes to show, there is little evidence of that being correctly applied.

14 JUNCTURE FIVE – NON ADHERENCE TO THE ETHOS OF THE CARE PROGRAMME APPROACH:

14.1 It is the view of the Independent Investigation Team that, as a result of systemic inadequacies at a strategic level, resulting in flawed operating practices by the teams actually involved in Ms Z's care, the entire underlying intention of CPA process was simply not sufficiently prioritised, properly implemented or strictly adhered to.

14.2 It is also the view of the Independent Investigation Team that, whilst it is hoped that this report has shown a variety of interconnected factors combined together to create "the perfect storm" (the records, the diagnosis, the disjunct between the teams), the Trust's non-adherence to the ethos of the CPA in Ms Z's case is one of the single most significant factors in the shortcomings in relation to Ms Z's care.

14.3 Simply put, the Independent Investigation Team does not feel that the CPA was followed in relation to Ms Z, and as a result, she showed virtually no improvement or recovery in her condition at any point, and even where she may have, this was short-lived.

14.4 This Juncture will consider the shortcomings in the CPA paradigm applied in Ms Z's case in their own right, but will also highlight the way in which the other Junctures in this report interconnect with that flawed application of the CPA ethos.

14.5 The Care Programme Approach (CPA):

14.6 As mentioned, the CPA is a national framework for mental health services' assessment, care-planning, review, care-co-ordination, and service user and carer involvement focused on recovery.

14.7 If used as it was intended, i.e. to work with service users and carers to make an assessment, establishing care and support needs, it can be a significant asset to the delivery of care. However, if used incorrectly, the CPA can act as a bureaucratic barrier to care delivery, which in turn, can lead to its essential elements and purpose being lost.

14.8 Contained within Ms Z's medical records is a volume of documentation generated by the CPA process which is intended to ensure that the essential aspects of the CPA are included in her care.

14.9 The method of the Care Programme Approach:

14.10 The entire ethos of the CPA is recognition of the fact that in complex individuals, various and multiple services will be needed, and will need to work to the same plan and with the same objective.

14.11 The individual components of the mental health services “orchestra” are not designed to “play solo” – to be effective, they must function “in concert” with each other. The care co-ordinator is supposed to be the “conductor”. The CPA is intended to ensure services have an overview of the patient and the care as a whole, and to ensure that all other components of the care are not simply ticking boxes for the administrative “sake” of ticking boxes, but in fact, acting with the long term goal of actually treating the patient.

14.12 Ms Z’s Care Programme Approach:

14.13 Rather than representing a vehicle for promoting Ms Z’s care and delivering her with a plan and care package designed to meet her individual needs at each stage in that tailored care, the CPA process, as reflected in Ms Z's written records, appears only to deliver plans which were process derived and driven, rather than focused upon Ms Z’s specific needs.

14.14 For example, there is little documentary evidence that the following were discussed and considered as part of the CPA process:

- Review of mental health and symptoms of schizophrenia;
- Review of medication given persistent sub-clinical psychotic symptoms;
- Joint working with the CDT and the CJLT, given that the discovery of an assault conviction that was not in the notes from 2004/2005.
- Engagement with the family and soliciting their views regarding Ms Z’s mental health; and,
- Access to her child.

14.15 Poor adherence to the ethos of the Care Programme Approach in Ms Z’s case:

14.16 It is the view of the Independent Investigation Team that there was a non-adherence to the ethos of the CPA throughout the care of Ms Z.

14.17 Examples of the extant CPA policy that were ignored:

- Involve the person in agreeing and writing the care plan as much as possible.
- Give them an opportunity to sign their care plan.
- Give them a copy of their care plan, review notes etc.
- Ensure that a systematic assessment of the person’s health and social needs is carried out initially, and again when needed (including an assessment of risk and any specialist assessments).
- Be familiar with past and current records about Ms Z, both paper and electronic.
- Ensure that a care plan is produced and sent to all concerned, including Ms Z and G.P. For lead professionals, this will be in a letter.
- Ensure that crisis and contingency plans are formulated, updated and circulated as part of the care plan. For those who do not need CPA, this may be a “contact card”.

- Identify any informal carers providing support, ensure their needs are assessed if necessary, and review this at least annually (see the Carers' Assessment Policy for more information).
- Ensure that carers and other agencies are involved and consulted where appropriate.
- When organising a review, making sure that all those involved in Ms Z's care are told about them, consulted, and informed of any outcomes.

14.18 The lack of a sufficient number of Care Programme Approach meetings:

14.19 One of the essential functions of a CPA meeting is to make a service user feel that their needs are fully understood and the proposed care plan adequately addresses all those needs. The meeting ensures that all those involved in the care plan are aware of their individual roles and responsibilities. In addition, the purpose of a CPA meeting is to ensure a multi-disciplinary approach.

14.20 A CPA meeting with all involved parties therefore could have led to a number of opportunities for Ms Z, her family, her clinicians from the CMHT and the CDT alongside police and probation services to review progress and address concerns.

14.21 However, since 2006 a CPA meeting with all parties involved in Ms Z's care including Ms Z had not been held.

14.22 The effects of the deficient Care Programme Approach in relation to risk in Ms Z's case:

14.23 A key requirement for the effective care and treatment of service users is the need to systematically review the service user's presentation in order to determine an appropriate response by those involved in the service user's care, both in terms of care, but also from a risk management point of view. This requirement is supported by the CPA.

14.24 Such a review should include a review of historical data, examination of the management plan together with an element of contingency/crisis planning which was to apply should a relapse occur.

14.25 This did not happen in relation to Ms Z despite several opportunities being available to do so and as a result, the long-term perspective of Ms Z's illness was lost and her care became responsive in many respects, only to relapse with other issues such as the risk which she posed when she was unwell being unrecognised even when a point of crisis was reached.

14.26 Lack of understanding of the risk of relapse:

14.27 Little work appears to have been undertaken with Ms Z to understand and to either; minimise her risk of relapse; or indeed, make plans for when that relapse occurred.

14.28 Whilst this might have proved problematic in a crisis situation, work was not undertaken with Ms Z when she was well to establish a plan to improve her quality of life and that of the individuals most closely connected with her. Her care essentially revolved around accepting depot medication without any attempt to help her gain insight into the reasons for her diagnosis.

14.29 Other than the very earliest presentation of her illness, Ms Z did not develop classical delusions or hallucinations until late in the course of a relapse. Earlier symptoms included chaotic behaviour, erratic behaviour, concerns about paedophiles, querulousness regarding the loss of custody of her children, harassment of her family, abusive texts and telephone calls and contact with the police of increasing seriousness.

14.30 Whilst it is recognised that some of these symptoms could be due to the need to acquire money for illicit drug use, the combination should have alerted professionals to the reality of her becoming unwell.

14.31 <u>The lack of a systematic attempt to improve Ms Z's long term health:</u>

14.32 Crucially, the Independent Investigation Team could not find any evidence throughout Ms Z's notes or during the course of the interviews which it conducted that demonstrated any systematic attempt to undertake any work with Ms Z which was aimed at preventing relapse, or reducing drug use other than by adjusting her medication.

14.33 Use of oral anti-manic or mood stabilising medication was mooted at various points, but there was no assertive engagement to support the use of that medication, no frequent review to assess effects or side-effects, and no alternative treatment once the medication was unilaterally discontinued by Ms Z. No attempts to increase the depot medication were made: even in the light of subtle relapse indicators and increasing chaos from September 2010 onwards.

14.34 While the prescription of medication for schizo-affective disorder is the first step of treatment for the resolution of an acute episode of psychosis, comprehensive care requires the integration of adjunctive therapies and attention to long-term treatment goals, including relapse prevention and psychosocial rehabilitation, in order to promote recovery.

14.35 There is very little evidence that this took place in the community. A review that systematically examined the risks of the case, and formulated a comprehensive multi-disciplinary management plan that would have included psychological and social elements, as well as concentrating on medication would have been beneficial.

14.36 The consequences of the disjunct between teams on Ms Z's Care Programme Approach:

14.37 It is the finding of the Independent Investigation Team that there was no proper handover when Ms Z was transferred from AOT to the CMHT. There was also no CPA meeting. The CMHT did not regroup as a team and actually consider which (if any) milestones she had reached during her time in AOT. There was no review of the care plans or the risk assessments. Further, before Ms Z was transferred to the CMHT, she had not been seen for over a month previously.

14.38 The process is supposed to work as follows; when a patient is in the AOT and they have reached milestones in terms of their recovery, they are then transferred to the CMHT. Some healthcare professionals involved in Ms Z's care did not feel this transference from AOT to the CMHT was done appropriately or correctly in the case of Ms Z.

14.39 The Trust's investigation notes that the CDT had a high tolerance of risky behaviour, with an acceptance of the increasing contact with the police, from shoplifting, to repeated shoplifting, then on to harassment of the café owner.

14.40 Furthermore, it seems that whilst the CJLT would notify the CMHT when Ms Z had been in Court, they would not receive any notification when she had been bailed.

14.41 The effect of the fragmented notes:

14.42 The effect of records in this format cannot be overstated in relation to patients like Ms Z. Where a service user with an extensive psychiatric history who has been well for a period of time is assigned to a newly appointed team, the team may be unaware that medical records must be accessed in multiple formats. They may not be aware of the involvement of multiple teams, particularly without a CPA, and could be unlikely, given the pressures of service delivery, to be able to review the previous volumes.

14.43 This could result in a flawed risk assessment with serious consequences, as have been demonstrated in this case.

14.44 It is the view of the Independent Investigation Team that the Trust's faith in their electronic medical record as a way of preventing similar confusion in future is misplaced, as has been referenced elsewhere in this document.

14.45 Diagnosis:

14.46 Significant features of the illness included: lack of insight (although she accepted that she had a mental illness, there was no understanding of the *nature* of that illness nor recognition of the symptoms that worried her family as being *due to illness*); relapse leading to failure to accept medication and disengagement with services; chaos, abusive telephone calls, shoplifting and forensic contacts occurring when the illness was relapsing. The accusations and aggression which were aimed at family members, particularly her mother, were not features of Ms Z's behaviour when she was well.

14.47 Ms Z's drug use:

14.48 One of the difficulties which Ms Z presented was that her chaotic lifestyle meant that it was difficult to establish the connection between her drug taking and her psychotic symptoms. However, it is the view of the Independent Investigation Team that those who have a drug induced psychotic episode, even as an intoxication phenomenon, are a group more vulnerable to subsequently developing a psychotic disorder. Whereas this should have pointed towards the need for more vigilance for the possibility of psychosis in future interactions with services, the reverse appears to have been the case.

14.49 An understanding of which drugs Ms Z was using would have been helpful. Liaison with the CDT would have been of assistance in this regard. It is known that some individuals are unclear about what they may have taken, or can, in fact, misreport what quantity of drugs has been taken. Therefore, urine analysis can be very beneficial. Again, this is a feature of substance misuse services that is widely utilised, and could have been exploited by the AOT/CMHT to greater effect.

14.50 The lack of involvement of Ms Z's family in relation to the Care Programme Approach:

14.51 Seeing the implementation of a plan to explore the relationship between Ms Z and her family and supports in a protected and non-judgemental environment as a means to better understanding Ms Z's illness to generate actions which could help her achieve targeted treatment goals would have been encouraging. This would have addressed and hopefully reduced her drug use, simultaneously providing a mechanism for helping Ms Z build strategies for compliance with her medication regime.

14.52 In addition, the family's knowledge of Ms Z's presentation was not hampered by access to records. They could also have been asked for clarification of issues and the context of Ms Z's changes in presentation.

14.53 Absence of the delivery of care from a long term perspective:

14.54 A further significant example of what appears to be a cultural weakness in approaching care from a long-term perspective occurred in the period leading up to the attack on the victim.

14.55 There was no evidence of the various components of the service acting together in a coherent way to take an over-arching and long-term view about Ms Z's care. The GP was copied in to correspondence, but was not consulted: they would have been able to clarify medication changes such as prescriptions of antidepressants and beta blockers in advance of a CPA, even had Ms Z been unable to attend in person.

14.56 This failure to adopt a longer term approach to Ms Z's care will be considered in depth in the next Juncture.

Comment 6:

The acute care components of the service including the CDT and CMHT did not appear to work together to develop a comprehensive management plan as envisaged by the CPA which would have addressed relapse prevention strategies, crisis planning, psychological approaches and support for the family.

It is disappointing that the opportunity of a CPA meeting was not considered as being an event which could deliver long-term care and potentially avert a crisis. Even if a crisis could not have been averted, a full CPA meeting held as early as January 2012, could have better informed those who became responsible for Ms Z's care between then and December 2013.

The volume of documentation generated by the CPA processes is significant in Ms Z's care. However, whilst the procedural requirements of the CPA may have been adhered to, the Independent Investigation Team consider that the evidence provided to them indicates that this did not generate an understanding of how the CPA should form the framework under which care can be planned and structured in order to deliver service user centred care.

Recommendation 2 – Responding to the service user's needs:

"Service-user centred clinical care" is the foundation of CPA care management in delivering services. The essentials of this are contained within the Trust's CPA policy. They include the systemic review and sharing of clinical information to inform clinical decision-making, and involvement of families (or carers where appropriate) in the management of risk.

The Trust's Quality Assurance Programme should ensure that care plans reflect a comprehensive understanding of the ethos of CPA in order that individual service users' current psychiatric, social, family circumstances and risk characteristics are addressed and that service user centred care is delivered.

Accordingly it is recommended that:

a) The ethos of the CPA should be reflected and strengthened in the training programmes which Trust staff are required to attend.

b) Every 6 months, each individual service user's CPA records are audited by the Managers in each service involved in the individual's care with a view to establishing:

1. Whether CPA is being correctly applied and adhered to;

2. Whether all service users' risk assessments are up to date;

3. Whether staff are having regular supervision which includes reference to providing care which recognises the ethos of CPA.

c) Adherence to this recommendation is audited by the Trust on a 6-monthly basis.

15 JUNCTURE SIX – THE ABSENCE OF A LONG-TERM PERSPECTIVE OF CARE:

15.1 Ms Z had a complex presentation which required the involvement of a number of services. The complexity of Ms Z's presentation suggested that her need for care would endure, and that a number of services would need to be involved.

15.2 As has already been discussed in this report, it is the finding of the Independent Investigation Team that services did not place sufficient emphasis on a coordinated, concerted, long term view of her care and treatment goals, instead concentrating more on immediate crisis response.

15.3 The NHS approach to managing "complex" individuals:

15.4 Within NHS provision, individuals with complex health issues may be managed across multiple services throughout their episodes of care. The involvement of multiple teams in the provision of mental health care has increased greatly in recent years with the development of functional teams (e.g. Home Treatment Teams, Acute Inservice User Care Teams and different types of CMHT, including CDT) that focus on a particular stage of the service user's care and treatment.

15.5 Whilst this has advantages, (for example it allows a greater number of service users to receive the appropriate level of specialised care to meet their needs), there is a danger that it can lead to a loss of a long-term, "overview" perspective in care delivery, with each team concentrating on the particular function of that part of the service, and not considering the overall course of care over the endurance of the service user's illness. Simply put, the cog, so busy with its own performance, does not know the overall function or purpose of the machine.

15.6 The additional disadvantage is that information is not brought together in order to allow a "joined up approach" to be taken towards the individual's recovery.

15.7 Ms Z's Care Programme Approach:

15.8 In July 2010 at a CPA, services decided that Ms Z was "stable", and she could be transferred from AOT to the CMHT. The transfer letter notes little input from the AOT over the past year.

15.9 Shortly thereafter, the AOT was disbanded, with the AOT nurses being moved to the CMHT (now renamed "Recovery Teams") but retaining an AOT function.

15.10 The consultant became a CMHT consultant, losing some AOT service users but assuming a caseload of approximately 175 CMHT clients, with a shift of focus from *ad hoc* consultations to running clinics, and no longer reviewing AOT service users every few days, just attending the CMHT allocation meetings every week.

15.11 Ms Z's deterioration from 2011 - 2012:

- **16 March 2011** – Ms Z presented to the CMHT saying that she had problems accessing her children and that she had contacted the police – should have been recognised, given her previous history.
- **7 April 2011** – Ms Z's mother reported to the CMHT that Ms Z was making "*strange telephone calls*" – should have been recognised, given her previous history.
- **20 July 2011** – Ms Z had her depot 2 weeks later than scheduled as a result of her visiting her partner in Nottingham. Noted to be "*not as well, haggard, tired and listening to loud music on headphones*".
- **25 October 2011** – Call from Ms Z's mother regarding distressing texts in the early hours of the morning. Mother contacted the police, provoking a response from Ms Z.
- **26 October 2011** – Home visit, house in a "*total mess*" (unusual; previous notes indicate good housekeeping skills).
- **22 November 2011** – Reported to be buying clothes, wearing them once and throwing them away. Noted to be something she does when ill (from transcript with parents, but not recorded in hospital notes).
- **7 December 2011** – Arrested for shoplifting, three counts. Probation contacted AOT. It is now over 12 months since the last CPA, with "warning lights", IV heroin use, worsening behaviour, contact from parents, police and Courts. The Independent Investigation Team questions the reason why this did not trigger a CPA.
- **29 December 2011** – Depot given over 7 days late.
- **12 January 2012** – FACE risk profile completed; unclear as to whether discussed more widely and not signed by Ms Z.
- **7 February 2012** – Ms Z requested an appointment to reduce her medication. Appointment offered for 27 February 2012, but she did not attend.
- **23 February 2012** – Attended "6 weeks late" for depot (previous dose given 17 January 2012). Told staff she was undertaking "community service" – presumably probation was involved.
- **23 April 2012** – Opportunistic appointment. Complaining of fluctuation in moods, apathy and tiredness. No record of formal mental state, no obvious awareness of concerns highlighted above. Moves made to commence lithium. Spoke of being on or about to start a Drug Rehabilitation Requirement (DRR) Order: again, presumably probation was involved.
- **28 May 2012** – Reported as being rude and abusive in reception, making allegations about doctors taking away her son and healthcare professionals talking about her pregnancy, as well as her parents being unfit to bring up her younger son.
- **6 June 2012** – CDT review. Commenced on Buprenorphine as opposed to Methadone for recent heavy heroin use.
- **11 July 2012** – Informed by CJLT that charged with criminal damage for an offence committed in May 2012.

- **13 July 2012** – Attended for depot, complained of "*feeling high*". Caught shoplifting yesterday, warned may face prison. Referred to Crisis & Home Treatment Team. Reviewed over the weekend due to chaotic behaviour, shoplifting for food and getting caught by the police. Requesting hospital admission, thin and withdrawn.
- **14 – 15 July 2012** – Seen by Crisis Team: superficial cut to wrist on Saturday had been making nasty calls to her father. Not in on Sunday: gone to Nottingham.
- **19 July 2012** – Ms Z wrote about a crime/murder which took place in Derby 10 years ago. Ms Z wrote a letter to the victim's family stating that Ms Z's father was responsible for the murder. She regretted posting it, saying that she was very unwell at the time. Unfortunately that date of letter is not recorded, but presumably recent.

15.12 The Independent Investigation Team is of the view that careful and systematic consideration of each of the examples of behaviour set out in the list above could potentially have constituted a juncture at which point care could potentially have taken a different pathway, had it prompted a CPA review, and their significance had been recognised in the context of Ms Z's long term presentation.

15.13 <u>The lack of an overview in Ms Z's care:</u>

15.14 What was excluded as a result of this lack of an overview was the drawing together of the "bigger picture" of what was happening for Ms Z. By operating within a specific service, gaps in knowledge could not be identified as a holistic picture of Ms Z was not being built up. This *ad hoc* approach meant that CPA meetings were held, without notice or planning, between Ms Z and those involved in delivering her care.

15.15 It is the view of the Independent Investigation Team that the approach of services to Ms Z over the long term seemed to be a case of losing track of her, whilst she then deteriorated, re-establishing contact in the moment of crisis, and then reaction to that crisis, only for the cycle to then begin again, and repeat itself over and over.

15.16 The approach adopted seemed to be a reactive one, focusing on the immediate events and crises in the short term, rather than looking at Ms Z's long term care more longitudinally and implementing and enforcing a strategy to attempt to correctly address her care over a longer period.

15.17 <u>The lack of further review on transfer between teams:</u>

15.18 Once transferred from the inservice user unit to the community teams (AOT → AOT within CMHT → CMHT) her case was never fully reviewed, and no active care plan formulated. Such a plan could have included information, which would have helped those whose responsibility it was to care for Ms Z in a crisis situation. It also meant that the opportunity to work with Ms Z when she was well and potentially more receptive was lost.

15.19 The Independent Investigation Team acknowledges that the management structure of the teams has since changed. The teams are separately managed and they have recruited. There are more staff now than then, so there is more time/less pressure, and therefore things *could* be improved in relation to procedure.

15.20 <u>The exclusion of those close to Ms Z in the management of the CPA:</u>

15.21 It is the view of the Independent Investigation Team that one of the most significant systemic deficiencies of care services which may have contributed to the tragic events of 9 December 2013 was the exclusion of her family members in the management of the CPA, as mentioned in the previous Juncture.

15.22 This exclusion of Ms Z's family, her partner (from 2003 onwards), and the CDT from consideration of Ms Z's presentation during a time when that presentation was deteriorating was absolutely crucial. All had valuable information and insights into her mental state which would have warranted exploration, had that information been elicited. By working within one service only, one perspective was recognised, while the "bigger picture" of what was happening was lost, and with it, a long term perspective on Ms Z's care needs.

15.23 This critical point will be addressed in greater detail in its own right in the next Juncture.

Comment 7:

The Independent Investigation Team reached the view that a significant feature of Ms Z's care was a lack of a long-term view perspective upon of her condition and illness.

The aim of Ms Z's care and treatment in the community appears for her to avoid admission to hospital, rather than a desire to achieve treatment goals which would improve Ms Z's quality of life whilst she coped with a severe and enduring illness presenting in acute crisis. Her care was shared between the CMHT, AOT and the CDT, and was not brought together and systematically reviewed. This could also have had an impact upon her compliance with her care and treatment, and her failure to understand the risk which she posed to herself and others.

The CPA could (and should) have been used as a vehicle to promote service user focused long-term care between all services and the individuals most closely connected with Ms Z. However, there was no evidence of the various components of community services acting together in a coherent way to take an over-arching and long-term view about Ms Z's care.

Good practice:

Services should be commended on the flexibility with which they approached elements of Ms Z's care during this period as appointments were often held opportunistically, as were CPA meetings.

Recommendation 3 – Improving long term care:

1. The Trust must conduct regular audits to ensure that its managerial supervision policies and procedures to facilitate supervision are being used to promote the delivery of service user centred long term care.

2. The audit process should include scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the delivery of service user care viewed from a long-term perspective.

16 JUNCTURE SEVEN - CPA INADEQUACIES IN CONSIDERING THE FAMILY DYNAMICS:

16.1 Tying in with a deficient adherence to the ethos of the CPA and an absence of a long term care perspective was the involvement (or lack of) of her family in Ms Z's care.

16.2 The challenges involved for family members of the mentally ill:

16.3 Close involvement with an individual who has a severe mental illness can be challenging[22].

16.4 Following initial diagnosis, families may be ill-prepared to cope, knowing little about what to expect, except for ideas based on unhelpful and stigmatising stereotypes. They have to learn as they attempt to deal with a variety of services in order to navigate the various pathways which can provide their loved one with the help and care they need[23]. However, this can be a difficult and at times frustrating process. The challenges can prove overwhelming and can be difficult for a family to cope with.

16.5 The role of mental health services in assisting families:

16.6 It is of fundamental importance, that the professionals who work with the families of individuals with chronic mental health issues demonstrate a genuine understanding of what it is like to live with a severe mental illness, and try to connect with this experience when carrying out their duties.

16.7 The reason for this is not simply to prevent families being seen as a problem, but also to ensure that the opportunity which they represent for clinicians as a resource (and means of significant knowledge in relation to the individual who is ill), can be fully utilised.

16.8 The potential value of familial input into a service user's care:

16.9 Family can play an important role in helping in the recovery of a person with psychotic experiences. In particular, the attitude of relatives towards the person, and how they understand and react to the person's experiences are very important.

16.10 There are two important aspects to this. The first is that friends and relatives may find dealing with some of the problems that can be associated with psychotic experiences frustrating and difficult, and therefore require support.

16.11 The second reaction is that families may find the problems experienced by their loved one to be very upsetting, and therefore they try to look after the person intensively. This also creates difficulties for the "carer" and the unwell individual.

[22] NICE guidance CG178 Ch 2.4
[23] NICE guidance CG178 Ch 2.4

16.12 The family dynamic in Ms Z's case:

16.13 In this case, Ms Z's family held vital information about her presentation that clinicians did not have. There was a correlation between declines in Ms Z's mental health, and increased reporting of family disharmony by Ms Z. She reported increased conflict with her mother at times when she was experiencing more psychotic symptoms. Ms Z's relationship with her mother broke down as a result of her deterioration, not the other way around.

16.14 There was no evidence in Ms Z's medical records to suggest that she acted aggressively or violently towards her mother, except when she was ill. This was brought to the attention of clinicians repeatedly, particularly in the early years of involvement with mental health services.

16.15 However, instead of this issue being explored sensitively and systematically, judgements were made, often without any secure foundation, which may have been unhelpful in relation to Ms Z's care and treatment.

16.16 The position taken by services in relation to the involvement of Ms Z's family:

16.17 Throughout Ms Z's illness, it was apparent to the Independent Investigation Team that she received considerable support from her family; however the inclusion of family members (and potentially therefore, *where applicable*, carers) in the care of service users was not part of an embedded culture within the organisation.

16.18 What is striking for the Independent Investigation Team is that by 2006, Ms Z's medical records showed that the family was deemed to be "difficult" and "unsupportive". She had been admitted in a psychotic state whilst pregnant. The report for the child protection case conference regarding her unborn child in September 2006 stated:

"Ms Z *has no social support, her family is not involved in her care, indeed her mother has neither telephoned, nor visited, since Ms Z''s admission*[24]".

16.19 The unborn child was placed on the Child Protection Register, and subsequently placed for adoption. The maternal grandparents subsequently adopted the baby and he now lives with them and has done for several years. There is minimal acknowledgement of this in the records.

16.20 Notes of discussions with Ms Z regarding her parents state that Ms Z did not want her mother to be involved, talk of the mother abusing Ms Z, and take at face value Ms Z's assertions that the relationship with her mother was acrimonious. No mention is made of irregular, though frequent visits by Ms Z to the family home or of contact with her son.

[24] The report for the child protection case conference regarding her unborn child in September 2006.

16.21 Accounts given to clinicians by Ms Z's family of her behaviour and its impact upon their lives were treated with suspicion. Statements made by Ms Z at a time when she was clearly unwell were accepted as fact and no attempt was made by those responsible for her care to establish the true facts of the situation - they were, over time, accepted as the dynamics that existed within the family.

16.22 Despite the records acknowledging that Ms Z accused her family of being murderers and being pre-occupied with paedophiles when unwell, allegations made by Ms Z regarding her relationship with her mother were never questioned; they were accepted at face value as a possible explanation for her mental health problems.

16.23 <u>The potential value of better involvement of Ms Z's family:</u>

16.24 What is clear from a detailed consideration of Ms Z's notes is that after 2006, the focus moved away from the family, with little consideration of their views or documented contact with them.

16.25 Collateral histories are sometimes used to obtain information from family/carers at key points in a service user's care, in order to give clinicians an opportunity to formulate an accurate assessment of the individual's problems. There are no indications that anything other than a brief attempt was made to obtain the views of Ms Z's family concerning her condition, which highlights some of the issues which can arise as a result of an inadequate collateral history.

16.26 If Ms Z's family views had been obtained in late 2012/early 2013, then there would have been more insight into the fact that she was relapsing, clarification of previous relapse indicators and the risks she might have presented as a result.

16.27 In addition to obtaining this practical information, a robust consultation of this nature would have also gone further towards ensuring that the family felt that they had a significant input into Ms Z's care, and that they had had a chance to articulate the strain which they were under, and obtain appropriate offers of support.

16.28 This lack of consideration of family led to subsequent underestimation of the extent of relapse and the level of risk posed by Ms Z, particularly regarding the harassment of the local café owner during September 2013.

16.29 <u>The adverse impact of services' approach to Ms Z's family involvement:</u>

16.30 This appears to have impacted adversely upon how members of Ms Z's family were heard and, indeed, regarded going forward. Given that they held vital information about changes in her behaviour, historical risks and relapse indicators, this was very disappointing.

16.31 The information could have held important insight relevant to her ongoing care and potentially regarding ways to manage the threat which she posed to herself and others could have been managed. It could also have provided information which would have allowed a greater degree of support for Ms Z and her parents as they coped with her chronic illness.

16.32 It is the findings of the Independent Investigation Team following interviews with members of the teams involved in Ms Z's care that, towards the later stages of Ms Z's deterioration, *circa* 2012 – 2013, services had nothing to do with the family because they thought they were out of the picture and Ms Z did not have a "good relationship with her mother".

16.33 There is no evidence that those responsible for Ms Z's care made any attempt to engage with the family as her mental health was deteriorating. This is particularly remiss given that family members had been attacked and threatened by Ms Z on a number of occasions that were recorded, and medical professionals were aware of these incidents.

16.34 <u>Conclusions:</u>

16.35 In this case, Ms Z's family was potentially part of the solution to understanding aspects of Ms Z's presentation. There was a direct correlation between a decline in her mental health, and an increase in disharmony between Ms Z and her family. There is no evidence in Ms Z's medical records to suggest that she acted aggressively or violently towards her family except when she was ill. This was brought to the attention of clinicians repeatedly by Ms Z's family.

16.36 However, instead of this issue being explored sensitively and systematically, judgements were made about family dynamics, often without any secure foundation, which were not helpful.

Comment 8:

In not reviewing the complaints from Ms Z's mother about disharmony in Ms Z's family systematically, rather than judgmentally, clinicians missed a significant opportunity to utilise knowledge which in turn could have been of diagnostic and therapeutic benefit for Ms Z, her family and services.

There is a caveat here in relation to confidentiality and consent to share. It is the view of the Independent Investigation Team that services involved in the care of Ms Z took what she said at face value, and did not include the views of her family. This was because, during her bouts of illness, Ms Z informed services that she and her family were "not close". It may have been the case that services felt they were acting pursuant to her wishes and maintaining confidentiality by not including the family – this will require a very delicate balancing exercise.

Recommendation 4 - Working with family members (and 'carers' where applicable):

1. "Consent to share" information should be updated regularly to promote effective communication between services, the service user and family members/carers. Protocols and policies should be introduced to secure this.

2. Close family members should always be given a contact point to access the mental health system in a crisis. Communication should be established as early as possible.

3. The Trust reviews its "family involvement strategy" to ensure that family members receive appropriate psychological as well as practical support.

4. In order to obtain a comprehensive understanding of the service user's current psychiatric, social and family circumstances and risk characteristics, the Trust's Quality Assurance Programme be revised to ensure that Teams are required to actively seek family members' involvement and views.

5. Collateral histories should be taken from family members and/or carers to secure a greater insight into a service user's situation and those of the family members/carers themselves.

The standard practice of clinical teams in relation to these Recommendations is monitored by periodic audit.

17 RESPONSE TO INCIDENT BY HEALTHCARE PROVIDERS:

17.1 This section will depict the Independent Investigation Team's views on the learning to be gained from this investigation and the extent so far to which the Trust has made changes based on this learning. It will discuss feedback from the individuals interviewed by the Independent Investigation Team.

17.2 Trust response to its own staff following the incident:

17.3 The Independent Investigation Team found that, with the exception of participation in interviews and one joint feedback event, staff involved closely in the care of Ms Z have (as at the time of the interviews) received no contact from the Trust in relation to supervision, "reflection" or updates.

17.4 Interviewees informed the Independent Investigation Team that during the initial internal review, meetings were held with the Trust and staff. However, the Independent Investigation Team found that staff still feel they have not yet seen any changes substantial enough to make an impact. There is a feeling that promises were made that have not yet been delivered upon.

17.5 Eleven members of staff were interviewed in total as part of this Independent Investigation, of which five were directly involved in Ms Z's care The Independent Investigation Team were informed by some of the staff interviewed that staff involved in the care of Ms Z working at service level felt that they did not know what was happening at executive level in terms of the overall strategies and the policies of the Trust in relation to CPA and serious incidents. They were also of the view that the executive level of the Trust did not really know what was happening at service level in terms of day to day workings of the job.

17.6 Three of those interviewees were in tears during the interviews, and informed the Independent Investigation Team that they had not known the outcome of the initial review, the Inquest, or indeed the fact that the Independent Investigation Team would be interviewing them. They were unaware of what had happened as a result of Ms Z's actions. The Independent Investigation Team is therefore concerned that the Trust response at Board Level is not percolating down to the operational level.

17.7 In relation to the staff involved in this case the Trust has now taken the following steps:

"*All staff involved has been sent a letter of apology, stating that we are sorry as a Trust that our response and support was not adequate. We will explain our next actions, how to get support and we will offer a debrief to all staff both internal and external if required*".

17.8 The Trust have informed the Independent Investigation Team that one member of staff involved in Ms Z's care has kindly agreed to be an independent peer support person to talk to staff if they are ever involved in a tragic event such as a mental health homicide so that they have another person to speak with in addition to line managers, professional leads and the staff support service.

17.9 The Trust informed the Independent Investigation Team that they embrace absolutely all learning, and will be adding all recommendations to their internal DATIX and recommendation reporting and implementation process as soon as they receive the final report.

17.10 The Independent Investigation Team recognises that the Trust has given its full cooperation to the Independent Investigation and indeed accepts that a number of changes have been made which could have had a positive impact upon the care which Ms Z received.

17.11 However, the Independent Investigation Team remains concerned that the Trust has not addressed the problem at the heart of the Ms Z case. The Trust can exhibit a great deal of Board level activity. However, it this does not address the level of support given to the responsible clinician or coordinator throughout the course of service user care (rather than after the fact following a serious incident).

17.12 In reaching its conclusion, the Independent Investigation Team recognised that the clinical staff interviewed did not consider it the role of their line managers or professional leads to support them.

17.13 The Independent Investigation Team still has concerns relating to the nature of the immediate response of line managers in the event such a serious incident occurs, and as to the way in which staff directly involved are kept informed of developments in day to day practical terms.

17.14 However, the Independent Investigation Team recognises that steps which have been implemented by the Trust will have a positive impact upon the information and support which staff will receive following an incident, including prompts in the incident recording system and leaflets for staff and managers.

17.15 <u>The continued disjunct between executive team and staff within the Trust:</u>

17.16 The Trust is currently reviewing and improving the effectiveness of its Board. As part of this process, the Trust has taken steps to improve the effectiveness of its leadership by ensuring greater scrutiny of its decisions. Three Executive members of the Board now review all Serious Untoward Incidents occurring within the Trust on a weekly basis. The aim is to allow the Executive Team a full insight in relation to service issues raised by serious untoward incidents.

17.17 The Trust has also informed the Independent Investigation Team that, in addition to the above serious incident reviews, all Board members now visit all clinical and Trust non–clinical services.

17.18 In addition, the Trust is about to introduce a live quality impact assessment tool. The Independent Investigation Team recognises that these measures will play a part in improving communication at a high level.

17.19 However, in order to bridge the perceived gulf between the executive and services the Independent Investigation Team is of the view that there needs to be a higher visibility of the executive level around and amongst service staff. There is also a feeling that the executive team needs provide more reassurance that they care about the service level and the way things are operating “on the ground”.

17.20 Implementing learning arising from the Independent Investigation for staff:

17.21 The Independent Investigation Team did not find that the results of the internal investigation had been adequately fed back to the staff involved.

17.22 However, since receipt of the Draft of the Independent Investigation Team Report, the Trust has informed the Independent Investigation Team that the Trust is scheduling a learning review with all staff involved. The purpose of this review will be to review the Independent Investigation Team’s report, reflect on its findings, and agree shared solutions.

17.23 The outcome of this review will be presented at a Trust event and will be reviewed and managed at the Trust’s Safeguarding Committee. In addition, the Trust has allocated additional senior members of staff to lead the learning review of safeguarding. Staff involved in Ms Z’s care will be present at this event. The resultant plan from this event will be reviewed at Board level and its progression will be monitored.

17.24 The Trust informed the Independent Investigation Team that they plan to share the learning from the Independent Investigation and action plan in their “Spotlight in Leadership” event and in their quality governance structure framework.

17.25 The Independent Investigation Team considers that this is a sound proposal, but also is of the view that this could have been actioned previously.

17.26 Patient records:

17.27 The Independent Investigation Team noted with disappointment that staff involved in the care of Ms Z did not report that anything has changed in relation to systems of recording, communication of information between multiple systems and communication of care or care plans between the teams. There remains no concerted effort to work together for one common, paramount purpose, i.e. to help the service user in their recovery whilst protecting both the service user and others.

17.28 The Trust informed the Independent Investigation Team that they have introduced a “scanning” program so that patients with historical records have key summaries and risk inventories added to their current record on a risk based process.

17.29 The Trust advised the Independent Investigation Team that although they are rolling out a scanning programme in relation to patient records this is not yet completed.

17.30 The Trust have informed the Independent Investigation Team that upon completion of the scanning programme, they will be able to make progress in finding electronic solutions and input information which is available concerning a patient's risk. The Trust states that this will be user friendly and will be able to enable clinicians to fully draw upon historical timelines and older collateral information wherever possible. The Trust states that it hopes that going forward, this will reduce risk in a practical context.

17.31 Whilst the Independent Investigation Team welcomes this development in practice, it is the view of the Independent Investigation Team that in Ms Z's case, this would not have helped. The risk data in Ms Z's case was difficult to locate within the records. It was not clearly set out in one document. The best document relating to Ms Z's risk was an independent psychiatric report prepared for the Court. This was because it was a comprehensive summary prepared by a senior clinician.

17.32 The Independent Investigation Team has a concern in relation to the electronic solution that there is always a high risk of adding additional information without that information being reviewed.

17.33 <u>Trust policies:</u>

17.34 The Independent Investigation also found that staff do not consider the policies to always be straightforward, and do not know whether policies are always enforced, for example, policies relating to CPAs. The policies are very thick documents and sometimes, there is insufficient time, when there is a caseload of 40 – 45 service users, to properly consider these. They are not as "user friendly" as they could be.

17.35 <u>Trust response to victim's families:</u>

17.36 The victim's family in this case, her three daughters, have been diligent and relentless in their pursuit of the facts of the case, in their bid to ensure that "something good for other people" comes from the tragic events that resulted in the death of their mother. One of the daughters has a particularly unique insight into the workings of process by virtue of her work in the CQC, whilst another does herself, work within the NHS.

17.37 They described "*the behaviour of the Trust*" (in dealing with them after the incident) as "*separate to what happened to mum…but deeply appalling….. To get them to respond at all, has been an absolute nightmare…the way that they dealt with the complaint - that is a separate issue to the fact that they did not address things with Ms Z..*"

17.38 The Independent Investigation Team found that a crucial piece of learning that must be taken from this incident relates to the way in which the families of victims are handled by investigating trusts, in accordance with the duty of candour and the developments as a result of the Francis Report.

17.39 This learning must not only be applied to dealing with families in the immediate aftermath of an incident, but also, in the process of, and way in which a trust proceeds to handle the execution and delivery of their internal investigation report.

17.40 The Independent Investigation Team recommends a Trust faced with a similar situation in future must treat the families of victims as individuals, and therein, acknowledge their personal knowledge levels of the case itself, the processes by which the NHS and mental health services operate, and place considerably more onus on the need for understanding and sensitivity to the traumatic events family members with whom they will be interacting in this unfortunate capacity have inevitably endured.

Comment 9:

The Independent Investigation Team notes that the Trust conducted an Internal Investigation concerning the immediate period prior to the death of the victim.

In addition, the Independent Investigation Team is concerned that the Trust did not look more widely in relation to Ms Z's care to determine how that crisis could have been avoided or handled differently and concentrated upon the crisis situation which arose between November and 9 December 2013, rather than to consider why the crisis arose in the first place.

Further, as the Independent Investigation has sought to demonstrate, there is still considerable learning for the Trust arising out of Ms Z's care if a less restrictive view than simply the events of 9 December 2013 are considered.

Recommendation 5 – Learning from adverse events:

1. In order to maximise the learning taken from Ms Z's fatal attack upon the victim, approaches to serious incidents should take account of the "bigger picture" of a serious incident. For example, investigating how a crisis has developed should be as a means to identifying learning which can generate improvements in service delivery.

   The Independent Investigation Team recommends that the Trust's framework for investigating serious incidents be reviewed to implement this Recommendation.

2. The Trust takes active steps to ensure that staff and clinicians are supported in relation to serious incidents. In addition to this, the Trust must also take active steps to ensure that information is shared with staff and clinicians in a timely way, and that a longer term view of "support" is taken.

3. The Trust must implement processes to ensure that the learning from adverse incidents and the action points which are generated are drawn to the attention of staff and clinicians involved in the events in order that learning can be embedded in the day to day practices of those responsible for delivering care.

4. The Trust must take steps to demonstrate greater awareness of the knowledge levels of family members of victims, their specific backgrounds and insights, and their interactions.

GLOSSARY OF TERMS:

1. CPA – Care Programme Approach.
2. AOT – Assertive Outreach Team.
3. CMHT – Community Mental Health Team (also known as ‘Recovery’).
4. CDT – Community Drug and Alcohol Team.
5. CJLT – Criminal Justice Liaison Team.
6. MDT – Multi-disciplinary Team.
7. FACE - “*Functional Analysis of Care Environments*” - a commercial mental health assessment tool designed to assess risk and needs in health and social care to assess an individual’s mental capacity.
8. “*Florid*” – “*The psychosis is the end result of the schizophrenic illness*”.

APPENDICES:

1. Appendix 1 – Terms of Reference of the Investigation.
2. Appendix 2 – Team Membership.
3. Appendix 3 – Methodology.
4. Appendix 4 – Chronology.