An independent investigation into the care and treatment of a mental health service user (Mr T) in Lincolnshire

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Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1 Executive summary

1.1 NHS England, Midlands & East commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr T. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2] The terms of reference for this investigation are given in full in Appendix A.

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

1.5 Mr T killed his grandson, Alex, when visiting Alex's mother Ms J (also Mr T's daughter) on 23 December 2014. Mr T was subsequently arrested and charged with murder. We would like to express our condolences to Alex's family who have asked that his named is used in our report. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr T.

Mental health history

1.6 Mr T had a long history of involvement with mental health services dating back to 1991.

1.7 He had been admitted to a mental health inpatient unit a number of times, including units provided by Lincolnshire Partnership NHS Foundation Trust (to be known as the Trust hereafter). Most of the admissions appear to have been for short periods of time ranging from one day to two weeks.

1.8 Mr T had been assessed by forensic psychiatrists on at least three occasions when he had been on remand awaiting trial. Those assessments indicated that alcohol was a significant factor in Mr T's offending behaviour and that Mr T had associated mental and behavioural disorders.

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[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidents. https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

1.9 Mr T spent ten months in a mental health rehabilitation unit between May 2011 and February 2012, when he was discharged to live in supported housing. At that time, it appears that supported housing staff reported that he was confrontational, aggressive and argumentative towards staff and other tenants. Mr T's mental health care and treatment was provided by a community mental health team at this time.

1.10 In October 2013 Mr T was discharged from specialist mental health services, following a review by his consultant psychiatrist Dr C. Dr C discharged Mr T into the care of his GP and recommended that Mr T's GP continue to prescribe Mr T's current medications.

1.11 Mr T appeared to be settled for about six months until in April 2014 his GP advised him that they were no longer able to obtain one of his medications, clomipramine,[3] because it had been discontinued by the manufacturer. Mr T's GP sought advice from the community mental health team about a suitable alternative medication. The GP records show that the advice was to prescribe venlafaxine[4] until Mr T could be seen in the outpatient clinic. However, the Trust records show that the advice given was that no alternative should be prescribed, and that Mr T should be seen in the outpatient clinic as soon as possible. There is no evidence that an outpatient appointment was offered to Mr T.

1.12 Mr T's mental health deteriorated over the following weeks and towards the end of June he saw his GP complaining of low mood. His GP made a referral to the older people's community mental health team but in the meantime Mr T's mental health deteriorated further and at the end of July he contacted the general adult community mental health team because he was in crisis.

1.13 Mr T was seen at home by the crisis and home treatment team on 28 July and staff noted that his home was in a very poor state. Arrangements were made for him to be seen by a consultant psychiatrist, Dr C, the following day. At the assessment on 29 July Dr C found that Mr T was severely depressed and arranged for him to be admitted to Connolly Ward, one of the Trust's mental health wards.

1.14 Following admission Mr T was generally compliant with his care and treatment plan but told staff on many occasions that he felt he needed to live in a residential home because he was unable to function on his own. He later told staff that he felt he should be detained in a maximum-security hospital, such as Rampton or Broadmoor, because he had a personality disorder.

1.15 In September ward staff had discussions with community mental health team staff about the allocation of a community mental health nurse to Mr T for when he was discharged from inpatient care. However, within three days of this discussion Mr T was transferred to Maple Lodge, a rehabilitation unit. There is no evidence of any discussion about or rationale for this transfer within Mr T's

[3] *Clomipramine is a type of antidepressant medication.* https://www.nhs.uk/conditions/antidepressants/

[4] *Venlafaxine is a type of antidepressant medication.* https://www.nhs.uk/medicines/venlafaxine/

clinical records and he was informed of the transfer the day before it took place.

1.16 On 17 September Trust staff were contacted by the police because they were concerned about Mr T's welfare. It appeared that Mr T's housing provider had expressed concern that his property seemed empty and had contacted the police who in turn had contacted the Trust and Mr T's GP surgery.

1.17 Mr T's GP surgery had noted that he had not collected his medication that had been prepared for him and had missed appointments with clinical staff. Despite being aware that Mr T had been admitted to hospital, Mr T was later (25 September) removed from his GP surgery's patient list.

1.18 On 22 September Mr T was seen by Dr A because he wanted different medication to deal with the pressure in his head. Mr T told Dr A that he wanted to be locked up. Dr A discussed arranging some tests prior to changing medication but Mr T became frustrated that Dr A appeared not to be listening to him and told Dr A that voices were telling him to hurt people. Mr T then attacked Dr A and tried to strangle her. He was restrained by other clinical staff and the police were called. Mr T was then taken to the Section 136 suite by police for an assessment to be done under Section 136 of the Mental Health Act (MHA)1983.[5] He was then taken back to Connolly Ward. Dr S, consultant psychiatrist was later asked to provide clarity on whether Mr T had capacity at the time of this incident and could be held accountable for his actions. Dr S confirmed that it was his view that Mr T did indeed have capacity and that in his view charges should be brought against Mr T.

1.19 An assessment was completed by an Approved Mental Health Act Professional (AMHP)[6] and Section 12 MHA approved doctors[7] and the conclusion was that Mr T did not need to be detained because he had agreed to an informal admission to Connolly Ward.

1.20 Ward staff liaised with community mental health team staff and Mr T's family (former wife, Ms A and daughter, Ms J) about cleaning his property and planning discharge for when his property had been sorted out.

1.21 Mr T was not eligible for social care funding in order for his property to be deep cleaned and he refused to agree to fund this himself. Therefore, Ms J and Ms A agreed to clean the property for him but told staff that it would take them some time to do so, because they both worked, and Ms J had young children to care for.

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[5] *Section 136 MHA 1983 allows a police officer to remove a mentally disordered person to a place of safety without a warrant. http://www.legislation.gov.uk/ukpga/1983/20/section/136*

[6] *An Approved Mental Health Professional is a person who is warranted, or authorised, to make certain legal decisions and applications under the Mental Health Act 1983.*

[7] *A doctor trained and qualified in the use of the Mental Health Act 1983, usually a psychiatrist.*

1.22 Mr T was keen to move to the Lincoln area so that he could be closer to his family so ward staff arranged for the housing officer to meet with him to help him to complete the relevant paperwork.

1.23 Mr T refused to go on planned leave on a number of occasions between September and December however he did agree to go on leave on 22 November. Ms A transported Mr T between the ward and his home but when it was time to return to the ward Mr T had refused to return and stated he wanted to stay with his daughter. Ms A and Ms J told staff they were concerned that Mr T would "*up the anti [sic] to get his own way*". Later Mr T left the ward and staff were contacted later by Ms J to stay that Mr T had arrived at her home and that she was happy for him to stay one night but that he had to return to the ward the following day.

1.24 Mr T was returned to the ward by Ms A and Ms J the following day, both of whom were distressed because of Mr T's behaviour. They expressed concern about Mr T hurting someone and said they felt frightened about what he might do if he arrived at their homes. Shortly afterward Mr T became very agitated and attempted to punch ward staff. The police were called, and Mr T was arrested and taken to the police station for questioning. He was later returned to the ward.

1.25 On 8 December Mr T refused to go on home leave and asked for it to be delayed.

1.26 The following day (9 December) Mr T was reviewed by Dr H when she agreed that Mr T should have shorter periods of leave at home prior to discharge at some point in the future. Mr T was encouraged to go on leave the following day and return the day afterwards.

1.27 On 10 December Mr T attempted to assault a member of the nursing team stating he was not going to go on leave that day. The situation escalated, and Mr T stated that he could not go home and that he should be taken away. Another senior member of the nursing team "*threatened*" to discharge Mr T immediately if he continued to threaten staff. Staff informed Ms A that Mr T had assaulted a member of staff and advised her not to take Mr T on his planned leave that day. Police were contacted and although they attended the ward they advised ward staff that Mr T could not be charged with any offence because ward staff had successfully de-escalated the situation. Later that day Mr T became agitated and aggressive again and when staff stated they would get the police involved Mr T stated that he wanted to go to prison. A member of the nursing team noted that Dr S had attended the ward and stated that Mr T should be discharged the following day.

1.28 Mr T was not informed of the plans to discharge him from the ward. Ward staff arranged for police to attend and escort Mr T from the ward, which they did the following day (11 December). He was provided with seven days medication and advised to see his GP for further medication. Arrangements were made for Mr T to be reviewed by the community mental health team and it was noted that Mr T would be asked to attend the team base (rather than receive a home visit) because of the risk to staff.

1.29 On 12 December Ms J contacted the community mental health team to advise that Mr T had arrived at her home the following day. She had allowed him to stay one night but he then refused to leave. Ms J sought advice about what to do as she felt unable to manage Mr T in her own home. Ms A later offered to allow Mr T to stay with her on a temporary basis and arrangements were made for a home visit to be made on 18 December to Ms A's property to complete a review following discharge.

1.30 Following this appointment Mr T was discharged from the Louth crisis and home treatment team and his care was handed over to the Lincoln crisis and home treatment team. After Mr T's care was handed over attempts were made by the crisis and home treatment team staff to contact him by telephone on 18 December and 21 December. It appears that no attempts were made to contact Ms J during this time.

1.31 Crisis and home treatment team staff were able to speak to Mr T on 22 December when he reported that things were going okay and that he planned to stay with Ms J over Christmas. Mr T stated he was too busy to see staff and said that he was not a risk to himself or other people. Because of this information the crisis and home treatment team closed the referral to their team and noted they would accept a self-referral if Mr T made contact over the Christmas and New Year period.

1.32 This decision left Mr T with no healthcare professional having responsibility for oversight of his care and treatment.

1.33 The next contact was on 26 December when ward staff were contacted by mental health nursing staff at HMP Lincoln asking for information about Mr T.

Offence

1.34 Mr T killed his grandson Alex on 23 December 2014. Mr T was staying with his former wife, Ms A, after he had been suddenly discharged from a long stay in hospital.

1.35 Mr T should have returned to his home address some miles away but wanted to be with his former wife (Ms A), and near his daughter (Ms J) and her children.

1.36 On 23 December Ms A and Ms J went shopping with Ms J's daughter. Ms J's son, Alex wanted to stay at home, so they left him in the care of Mr T.

1.37 While they were out Mr T locked the doors, ran a bath, walked Alex into the bathroom and drowned him.

1.38 When Ms A and Ms J returned from shopping Mr T told Ms J that he had drowned Alex. Ms J attempted to resuscitate Alex but was unable to do so.

Sentence

1.39 Mr T initially pleaded not guilty to murder on the grounds of being mentally ill, but he changed his plea during the trial.

1.40 The judge, Mrs Justice Thirlwall DBE, sentenced Mr T to a life sentence with a minimum term of 22 years.

Internal investigation

1.41 The Trust undertook an internal investigation that was chaired by a non-executive director with senior management and senior clinical input.

1.42 The report made 37 recommendations across nine themes:

- Use of the fast track protocol.
- Risk assessment and procedure.
- Care pathway, treatment and care plans.
- Staff management.
- Performance management.
- Ensuring performance compliance (audit, monitoring and supervision).
- Raising policy awareness.
- Amendments to policy.
- Pharmacy and medical advice.

1.43 The Trust also commissioned a further specialist serious incident report that identified five concerns:

- Turnover of staff and lack of continuity of care on the ward.
- Lack of a clear policy of how to manage the potential for criminal justice proceedings if patients are violent.
- Lack of contact with Mr T's family, during his inpatient stay and at the decision to discharge him.
- Confusion about who was in charge of his care.
- Lack of clarity about what might change a clinical decision if something happens between the decision to discharge and discharge actually taking place.

1.44 The Trust developed an action plan that we have reviewed and commented upon. The majority of the actions have been properly implemented; however,

it is our view that the Trust should provide itself and its commissioners with greater assurance about the effectiveness of the changes that have been made.

Independent investigation

1.45 This independent investigation has reviewed the internal process, associated action plan and progress. We have also studied clinical information, witness statements, interview transcripts and policies.

1.46 The team has also interviewed senior staff who are responsible for the management of community and inpatient services, and organisational governance. We have undertaken a review workshop with staff who now work in the inpatient unit and in the community teams and we have interviewed the two consultants who were responsible for Mr T's care and treatment on Connolly Ward. We have also spoken to the GP practice.

1.47 We have provided an assessment of the internal investigation and associated action plan.

Conclusions

1.48 It is our view that although Mr T had been threatening towards his family and Trust staff, and had actually assaulted Trust staff, it would not have been possible for Trust staff to have predicted that Mr T's behaviour would escalate to the degree that it would cause the death of his grandson, Alex.

1.49 We do however consider that there were actions that Trust staff could have taken that might have avoided Mr T killing Alex.

1.50 Mr T's discharge from the ward was rushed, there is no clearly documented rationale or discussion leading to the sudden decision to discharge him. The community mental health team had refused to allocate a care coordinator in accordance with the policy covering Care Programme Approach and staff felt that Mr T was too high risk for staff to visit him at home. Whilst staff may have felt that Mr T was unwilling to engage in support mechanisms that staff felt would benefit him whilst he was on the ward, he had clearly articulated that he wanted to be fully looked after when he was in the community. In addition, the inpatient team had recorded their view that Mr T needed an "*enhanced package of care*".

1.51 Although community mental health team staff did contact Mr T by telephone nobody saw him for a face to face assessment after he was removed from the ward on 11 December until 18 December. At this time staff noted that Mr T had "*approximately a week's worth*" of medication, however he had been provided with seven days medication seven days earlier and therefore should have run out of his medication by the time of this appointment. A lack of medication, and no registration with a GP surgery in order to obtain more medication would have contributed to a decline in his mood.

1.52 Mr T was discharged in an unplanned and unstructured way, without the appropriate enhanced package of care in place and with his concerns about his accommodation remaining unresolved. He should not have been discharged without the enhanced package of care being properly planned and implemented. Had his discharge been conducted in accordance with the plan described by Dr H it would have been less likely that Mr T would have demanded that his family look after him and therefore less likely for him to have been in the same property as his grandchildren.

Recommendations

1.53 This independent investigation has made 13 recommendations for the Trust and two recommendations for the local clinical commissioning groups to address in order to further improve learning from this event.

1.54 The recommendations have been arranged in four themes:

- family engagement.
- discharge and transfer.
- clinical response and engagement; and
- risk assessment.

1.55 These have been given one of three levels of priority:

Priority One: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

Priority Two: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients but identifies important improvement in the delivery of care required.

Priority Three: the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Priority One: Family Engagement

Recommendation 10a

The Trust must ensure that when:

- family members are either expected to play a key role in a patient's care and treatment; and/or
- have previously expressed concern about their own safety in relation to the patient

those family members are involved in the decision making about discharge and informed about the patient's discharge prior to it taking place.

Recommendation 11

The Trust must assure itself and its commissioners that involve patients and their families (where appropriate) in decisions about transferring patients to other units.

Priority One: Discharge and transfer

Recommendation 10b

The Trust must ensure that any plans for discharge from an inpatient unit are planned with the patient, GP and all relevant community services. There must be a clearly documented structured plan which sets out roles, responsibilities and timescales.

Recommendation 12

The GP practice must ensure that when the practice is informed that a patient has been admitted to hospital, a review of that patient's appointments and repeat medications is undertaken.

Recommendation 13

The GP practice must ensure that prior to removing a patient from a surgery list, the surgery has considered all information in their possession regarding the possible whereabouts of that patient and that they clearly document in the records the basis or rationale for that removal with details and/or a copy of the information upon which the decision is based.

Priority Two: Clinical Response and Engagement

Recommendation 5

The Trust must ensure that appropriate action is taken when a clinician has advised that a review of a patient's medications is required.

Recommendation 6

The Trust must assure itself and its commissioners that medications are prescribed in accordance with best practice and that timely reviews of the ongoing appropriateness of the dose are undertaken.

Recommendation 7

The Trust must ensure that there is a clear rationale provided when changing a diagnosis and that the appropriate associated treatment plans are described and implemented.

Recommendation 9

The Trust must ensure that the correct registered GP details are held on file, regularly checked and updated (where required) and present on discharge documentation.

Recommendation 15

The Trust must ensure that a clear focus is maintained on the reasons and purpose of admission throughout any internal ward transfers.

Priority Three: Risk assessment

Recommendation 1

The Trust must ensure that staff complete incident forms at the earliest opportunity and that staff are clear about when this is.

Recommendation 2

The Trust must ensure that guidance is in place for staff completing serious incident investigation reports that they use plain English and that the templates include section numbering, page numbering and a table of contents.

Recommendation 3

The Trust must assure itself and its commissioners that recommendations in internal reports are fully implemented and that the actions provide sufficient evidence of the effectiveness of the changes made.

Recommendation 4

The Trust must assure itself and its commissioners that staff use every opportunity to triangulate information about clients from all reasonably available sources.

Recommendation 8

The Trust must ensure that a communication protocol with the police is developed and implemented when the police are involved in a patient's management.

Recommendation 14

The Trust must ensure that service changes are properly monitored in the post-implementation phase. Analysis should include governance success indicators, staff satisfaction assessments, patient experience scores and overall performance rates.

Post publication of this report

1.56 This report will be published accompanied by action plans developed by organisations for whom we have made recommendations. Progress and implementation of those action plans will be monitored by NHS South Lincolnshire Clinical Commissioning Group & South West Lincolnshire Clinical Commissioning Group and NHS England.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

2.2 The terms of reference for this investigation are given in full in Appendix A.

2.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.

2.4 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

2.5 The investigation was carried out by Naomi Ibbs, Senior Associate for Niche, with expert advice provided by Dr Ian Davidson, Clinical Advisor and Consultant Psychiatrist and Kate Jury, Governance and Assurance specialist.

2.6 The investigation team will be referred to in the first-person plural in the report.

2.7 The report was peer reviewed by Dr Carol Rooney, Associate Director, Niche.

2.8 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.

2.9 NHS England wrote to Mr T at the start of the investigation but did not receive a response. A decision was therefore made that requests to access Mr T's healthcare records would be made to the relevant Caldicott Guardians.[8]

2.10 We used information from:

- Lincolnshire Partnership NHS Foundation Trust (the Trust hereafter).
- GP records received from Marsh Medical Practice.

2.11 As part of our investigation we interviewed:

- Non-Executive Director, Chair of Internal Investigation Panel.
- Medical Director.

[8] *A Caldicott Guardian is a senior person within a health or social care organisation who makes sure that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained.* https://www.ukcgc.uk/manual/role

- Director of Nursing, Allied Health Professionals and Quality.
- Associate Director of Nursing, Allied Health Professionals and Quality.
- Divisional Manager.
- Consultant Psychiatrist, Internal Investigation Panel.
- Service Manager – Older Adults, Internal Investigation Panel.
- Local Security Management Specialist.
- Former Local Security Management Specialist.
- Chief Pharmacist.
- Non-Executive Director, Chair of Quality Committee.

2.12 We also sought to interview two consultant psychiatrists who were responsible for Mr T's care and treatment whilst he was an inpatient. We contacted one consultant psychiatrist directly and held a telephone interview. The other consultant psychiatrist was contacted via the GMC and we were also able to hold a telephone interview with them. We also conducted a telephone interview with the acute care nurse who was assaulted by Mr T and had documented the discussion with Dr S about discharging Mr T.

2.13 A full list of all documents we referenced is at Appendix B.

2.14 The draft report was shared with NHS England, the Trust, the Clinical Commissioning Group, and the GP surgery. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with Alex's and Mr T's family

2.15 We met with Alex's mother (Mr T's daughter) and father who were accompanied by an advocate from the charity Hundred Families.[9] We discussed the terms of reference for the investigation and specific questions and concerns that Alex's parents had about Mr T's care and treatment.

2.16 Following discussion with NHS England it was agreed that the terms of reference would be amended so that Alex's family's concerns were specifically referenced. The terms of reference at Appendix A include these revised terms.

2.17 Alex's family had three main areas of concern:

[9] *Hundred Families is a charity that provides support to families bereaved by homicide.* http://www.hundredfamilies.org/

- Why was Mr T's medication not fully reviewed on admission to hospital in July 2014?

- Why were Mr T's daughter or ex-wife not informed that he was being discharged from hospital in December 2014?

- Who was responsible for the decision to discharge Mr T?

2.18 In addition, Alex's family were very keen for us to interview the two consultant psychiatrists who were involved in Mr T's care and treatment whilst he was an inpatient. Alex's family had three specific questions that they wanted us to post to the two doctors:

- Who took the decision to discharge Mr T?

- How did the discharge actually happen?

- How do you explain the differences in the various accounts of the discharge arrangements?

2.19 We have endeavoured to provide answers to these concerns and questions and our analysis can be found in Section 8, Specific family questions.

2.20 We met with Alex's family in November 2018 after they had received a copy of the draft report. We discussed our findings, conclusions and recommendation and they broadly satisfied with these. We received further feedback via the family's advocate which we have either addressed or provided reasons why we are unable to do so. We met Alex's family again in December 2019 to gather further comments on the final draft.

Contact with the perpetrator

2.21 We wrote to Mr T at the start of the investigation, explained the purpose of the investigation and asked to meet him. We did not receive a response, so we wrote to him again via the relevant prison Governor. We still did not receive a response, so we were unable to seek Mr T's views about his care and treatment.

2.22 We offered the opportunity to meet with us prior to publication of the report, writing both to Mr T and the relevant prison Governor. Letters were sent in June 2019, and we did not receive as response.

Structure of the report

2.23 Section 3 provides some background to Mr T's life and forensic history.

2.24 Section 4 sets out the relevant details of the care and treatment provided to Mr T. We have included an anonymised summary of those staff involved in Mr T's care for ease of reference for the reader at Appendix C.

2.25 Section 5 examines the issues arising from the care and treatment provided to Mr T and includes comment and analysis.

2.26 Section 6 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.27 Section 7 sets out our overall analysis and recommendations.

3 Background of Mr T

3.1 We have used information provided by Mr T's daughter and her mother and obtained from clinical records to provide a summary of Mr T's background. These were the only sources of information available to us because Mr T did not respond to our requests to meet him.

Personal history

3.2 Mr T had described to clinical staff that he had a happy childhood and that he left school at the age of 15 years with no qualifications. Mr T told clinical staff that his father used to suffer from depression and was an alcoholic.

3.3 Mr T started drinking at the age of 16 or 17 years. He described his drinking to clinical staff as a major problem of his life but that in 2012 he had abstained from alcohol for two years.

3.4 After leaving school Mr T worked in engineering for 24 years, followed by 20 years of taxi driving and other driving jobs. It is reported that he had time off work because of drinking binges that appear to have been prompted by having money from driving. Mr T told staff that he "*used to binge for a few days and work for a few days"*, but he never drove whilst under the influence of alcohol.

3.5 Mr T was first married in 1972 but that ended in divorce because of his drinking problem. There were no children from this marriage.

3.6 Mr T married Ms A in 1978 when he was 28 years old and she was 22 years old. Mr T described Ms A as his carer, although at the time of the report their marriage had ended. Staff noted that Mr T had described his 12-year relationship with Ms A as "*good, but marred by his drinking*".

3.7 Mr T and Ms A had a child, Ms J who in 2012 was reported as being 34 years old. Mr T reported that Ms J had two children.

Forensic history

3.8 Mr T has an "*extensive offending record*" with approximately 75 offences and 36 convictions (as reported in 2012). His offences included:

- offences against the person.

- two offences against property.
- four public disorder offences.
- nine offences relating to police.
- one firearm offence.
- more than 50 theft and kindred offences.

3.9 Mr T told clinical staff that his convictions were mostly alcohol related and were for theft or threatening behaviour. He also reported having been in prison six or seven times (as reported in 2012) and that at that time his longest prison sentence was six months.

4 Care and treatment of Mr T

2013

4.1 Although Mr T had many years of care and treatment by mental health services, it was agreed with NHS England that this investigation would focus on the care and treatment of Mr T in the 20 months before Alex's death. Mr T had been under the care of Dr C, consultant psychiatrist for the community mental health team in Louth, Lincolnshire.

4.2 On 24 October 2013 Dr C wrote to Dr P, GP at Marsh Medical Practice with a summary of Mr T's review the previous day. Dr C noted that there was a "*significant degree of diagnostic uncertainty*" in Mr T's case and that there had been a number of different diagnoses made over time, including:

- anxiety.
- recurrent depression.
- personality disorder.
- bipolar affective disorder.

4.3 Dr C stated that it was clear that all the diagnoses had been made in the context of Mr T's alcohol dependence from which he had abstained for a long time. Dr C indicated that Mr T should continue to take his medication at the existing doses: quetiapine[10] 200mg twice daily; clomipramine 150mg once daily, ferrous sulphate[11] 200mg twice daily, simvastatin[12] 40mg once daily,

[10] *Quetiapine is used to treat bipolar disorder and schizophrenia*

[11] *Ferrous sulphate is a medicine used to treat and prevent iron deficiency anaemia.*

[12] *Simvastatin belongs to a group of medicines called statins, which is used to lower cholesterol.*

thiamine[13] 100mg once daily, "*VitBCoStrong*"[14] two tablets twice daily. Dr C advised Dr P that he should consider specific annual blood tests given that Mr T was taking an atypical antipsychotic medication. Mr T had not reported or presented with any problems consistent with affective or psychotic problems, nor any self-harm or "*suicidal/homicidal ideation*". Mr T was living in settled and secure warden-controlled accommodation and reported having "*reconciled with his family*". Dr C stated that given Mr T's progress he was being discharged back into the care of his GP and that it had been agreed that he would have a 'fast track' arrangement (self-referral back to the team in the case of being in crisis) in place for one year.

April to July 2014

4.4 On 14 April Ms S2, from the community mental health team received a telephone call from Marsh Medical Practice (Mr T's GP surgery) to say that they were no longer able to obtain clomipramine. The GP surgery asked that a doctor within the community mental health team be consulted to advise an alternative medication. Ms S2 noted that Dr C was away; she therefore had sought advice from Dr B (another psychiatrist who was in clinic during Dr C's absence). Trust records indicate that Dr B advised that no alternative should be prescribed at that time and Mr T should be given an appointment with the community mental health team as soon as possible. Ms S2 noted that because Mr T had been discharged the previous year on 'fasttrack', an appointment would be arranged with Dr Z who was then responsible for patients registered at that GP surgery. There is no corresponding entry within Mr T's GP records reflecting this discussion.

4.5 Two days later Ms C from the community mental health team received a call from Mr T expressing concern that he had been informed his prescription for clomipramine had been discontinued. Mr T was concerned because he felt he had "*got on well with the medication*" and that his GP had not told him that the medication would be discontinued. Ms C contacted the GP surgery and spoke with a receptionist who said that she would check with the pharmacist and contact Mr T directly to explain. Ms C noted that that at the time of these actions she had not read the previous entry. The GP records for this date (16 April) indicate that the GP surgery manager spoke to Dr B's secretary who stated that Dr B had advised that Mr T could "go onto venlafaxine…if he wished to do so until he got a review appointment". Venlafaxine 75mg was prescribed the same day. There is no record in the Trust notes that indicates that Dr B changed his advice and recommended prescribing venlafaxine whilst Mr T waited for an urgent appointment.

4.6 There is no indication that any action was taken regarding an appointment with the mental health team for Mr T's medication to be reviewed.

4.7 On 21 July Mr T contacted his GP surgery because he was feeling increasingly depressed. Mr T's GP offered him an appointment that afternoon,

[13] *Thiamine is used to treat vitamin B deficiency.*

[14] *Also used to treat clinical vitamin B deficiency*

but Mr T chose to attend the following morning when his support worker would be with him.

4.8 The following day Mr T was seen by a GP who noted that Mr T's medication had been changed from clomipramine to venlafaxine because clomipramine was not available. The GP noted that Mr T should be reviewed two weeks later and that a referral to the older people's mental health team would be arranged. This referral was actually sent on 23 July.

4.9 On 24 July the older adult community mental health team received a referral and it was noted that the team needed to arrange an appointment.

4.10 On 28 July Mr T telephoned the crisis and home treatment team in distress. Mr J, crisis and home treatment team worker, noted that rapport over the telephone was difficult and arranged to see Mr T at home that day. Mr T presented as unkempt, dirty, agitated and depressed. Mr J arranged an appointment the following day with Dr C and noted that the team would help Mr T with his travel arrangements. Mr J also noted that he would refer Mr T for a social care assessment and that the crisis and home treatment team would stay involved in his care to help prevent admission to hospital.

29 July 2014 – admission to Connolly Ward

4.11 On 29 July the crisis and home treatment team collected Mr T and took him to his appointment with Dr C. Dr C diagnosed a "*severe depressive episode without psychotic symptoms*" and noted that Mr T was not on Care Programme Approach at that time. Mr T was already prescribed quetiapine 200mg twice daily, venlafaxine (Mr T was unable to recall the dose), ferrous sulphate 200mg twice daily, and simvastatin 40mg one daily. Dr C recommended that Mr T immediately be admitted as an informal patient to Connolly Ward. Dr C also recommended a full physical examination, ECG and chest x-ray, review of his medication, a comprehensive assessment of his cognitive abilities and a social care review regarding his housing situation. Dr C noted that he considered Mr T to present a "*significant risk of further self-neglect and, potentially, completed suicide*" that could only be managed through inpatient admission. Dr C provided a summary of this appointment in a letter to Dr P, Mr T's GP, the following day.

4.12 On admission to Connolly Ward at about 5.45pm Mr T was seen by Dr C2, the on-call doctor. Dr C2 informed nursing staff that Mr T should be managed on 15-minute observations and escorted if he went off the ward. It was also noted that Dr S would review him. Staff noted Mr T's forensic history to be:

- 2013 – threatened a woman with a knife.
- spent periods in HMP Lincoln.

4.13 The electronic patient record shows that Dr S changed Mr T's Care Programme Approach level on 29 July to "*CPA*". This has previously been noted as "*receiving care but not on CPA*".

4.14 A ward round was completed on 30 July at which it was noted that Mr T was a new admission and although "*no current medical concerns*" were noted diagnoses of bipolar disorder and depressive episode were recorded. An observation care plan was completed that indicated staff should observe and monitor Mr T's mental state every 15 minutes. It is unclear at what point this level of observation was changed because the record of the ward round on 6 August notes that Mr T was on general observations.

4.15 At a ward round meeting on 30 July Mr T reported feeling depressed and "*worn out*" and that his concerns about his physical health had affected his mental health. Present were Dr S, Ms L (nurse) and Dr S2. During the meeting Mr T became aggressive towards Dr S, accusing him of lying, and it "*seemed to be*" because Mr T felt staff were not taking him seriously. Ward staff noted that they would invite Louth crisis and home treatment team staff and the warden for Mr T's accommodation to the ward review meeting the following week.

4.16 Also, on 30 July, Mr T's GP surgery received a request for information about Mr T's medications. Staff at the GP surgery noted that a medication summary was faxed to Lincoln Hospital. Despite this information being present in Mr T's GP records, the next entry (also on 30 July) indicates that Mr T's usual weekly medication was prepared in a dosette box ready for him to collect. The medication prepared was:

- Ferrous sulphate 200mg – 14 tablets.
- Quetiapine 200mg – 14 tablets.
- Simvastatin 40mg – 7 tablets.
- Thiamine 100mg – 7 tablets.
- Venlafaxine 37.5mg – 7 tablets.
- Venlafaxine 75mg – 7 tablets.
- Vitamin B compound strong – 28 tablets.

4.17 The following day staff noted that Mr T's dementia screening blood test results had been received and all were within normal limits. Mr T scored 27 out of 30 in an MMSE[15] undertaken by Dr J and Ms K. Scores between 25 and 30 are considered normal. Mr T complained of painful swollen ankles and staff noted he had difficulty walking even short distances. Ward staff examined Mr T's ankles and feet and found no evidence of infection or callouses. Surgical stockings were prescribed, and Mr T was given lifestyle advice regarding smoking, exercise and diet.

4.18 On 2 August Mr T stated he felt that he needed to live in a residential home because he could not function living on his own. Mr T reported that he lived "*in*

[15] *Mini-Mental State Examination (MMSE) is a commonly used set of questions for screening cognitive function*

the middle of nowhere" and that other than going to the single shop he saw no one for days at a time. Mr T said that although there was a communal lounge in his warden supported bungalow it was rarely used by other residents.

4.19 On 5 August Mr T did not attend his follow up appointment with his GP. This was obviously because he had been admitted to an inpatient ward.

4.20 At the ward round meeting on 6 August Mr T's case was discussed. Present were Dr S, Ms J (care coordinator), Ms L (nurse), and another doctor (we are not able to decipher the name). It was noted that Mr T had been referred to adult social services because his home was "*dishevelled*" and needed to be cleaned prior to his discharge. Mr T stated he was unhappy to return to his bungalow because there was not much for him to do in his village, leaving him feeling lonely and having no motivation. The plan was for staff to chase a number of assessments, make referrals for chiropody input, extra support from social services, and support from a care coordinator.

4.21 Also, on 6 August, Mr T was seen by the Stop Smoking Advisor, at his own request. Mr T said he was not ready to completely stop smoking but asked for something to help him to cut down. A carbon monoxide reading was reported as indicating that Mr T was still smoking 20 cigarettes per day.

4.22 On 7 August a referral to the integrated community mental health team was completed. The referral noted that Mr T was known to the Louth community mental health team but that at that time he was not allocated a community mental health nurse. Community support was requested in order to help Mr T in his recovery and social inclusion.

4.23 During one-to-one time on 8 August Mr T presented as "*jovial and humorous*". He stated that he believed that in the future people would be "*shot if they do not recover from mental illness quicker*" and described himself as "*barmy*".

4.24 On 11 August Mr T complained of a headache and described it as a "*crushing feeling across the front of his head*". He reported that it had started about four weeks previously and that it was constant. Dr J examined Mr T and found no visual changes or neurological problems and concluded it was a tension headache. Dr J prescribed paracetamol as required.

4.25 Later that day a housing support worker contacted Louth community mental health team to discuss the progress with Mr T's house as requested by Dr S. A member of staff from the community mental health team advised that Ms L was involved and organising for the bungalow to be cleaned but was not in the office that day.

4.26 Also, on 11 August, Mr T's GP surgery noted that he had not collected his last batch of medication and queried whether he had moved away.

4.27 On 12 August Dr S2 conducted a physical health review for Mr T in response to concerns raised by nursing staff that he appeared to be quite breathless, particularly when walking to and from the smoking area, and that he struggled with the stairs. Mr T said he felt short of breath only on exertion and that his

morning cough produced clear sputum most mornings. Dr S2 noted Mr T's shortness of breath was as a result of him not being a fit man and queried underlying heart failure or chronic obstructive pulmonary disease. Dr S2 gave Mr T advice about exercise, weight management and smoking.

4.28 Later that day ward staff noted that Mr T had admitted smoking in the ward toilets because his physical health made it difficult to get to the smoking area.

4.29 On 13 August Dr C noted that following discussion about Mr T's case at the Louth community mental health team meeting it had been decided that Ms L would attend the ward round meeting the following day to discuss Mr T's care and treatment further.

4.30 Later that day Dr J noted that Mr T was still complaining of being short of breath, but Dr J could find no change in Mr T's condition when he examined him. Dr J referred Mr T for a repeat chest x ray.

4.31 On 14 August Mr T reported that he "*felt rough*" both physically and psychologically. He reported having trouble with his legs and that he was finding it difficult to walk any distance. Mr T said that he felt he would be better off living in a residential care home so that he had support 24 hours a day.

4.32 Mr T was later offered one-to-one support with Ms M2 who noted that Mr T was feeling low and hopeless and talked about ending his life but feeling frightened to do so. Mr T said that he felt very weak and was fed up of fighting his illness, which he had to do all his life. Mr T spoke of stressors at home and feeling frightened of being discharged back to his home where he did not have enough support.

4.33 Dr S2 conducted a physical health examination and noted that Mr T was still short of breath on exertion and that he was complaining of long-standing pain in his knee. Dr S2 also noted that Mr T's toenails were "*very overgrown*" and asked nursing staff to refer him to podiatry.

4.34 Mr T's case was later discussed at a ward round meeting. Present were Dr S, Dr J, Ms L, Ms S (acute care nurse), two medical students and Mr T. It was noted that Mr T had been settled on the ward, but he continued to complain of sore legs and being short of breath. Mr T reported feeling worried about being discharged and expressed thoughts of ending his life. Dr S felt that this was because of the anxiety around his discharge. There was a discussion about the state of Mr T's home and consideration of a placement with increased levels of support. Mr T felt he was eligible for social care to clean his home, staff explained that he had to live at home for a while before Mr T could "*arrange assisted living*".

4.35 On 15 August Dr S2 reviewed Mr T's notes from Lincoln County Hospital because of Mr T's complaints of being short of breath and question about previous cardiac arrest. Dr S2 noted that Mr T had been admitted in:

- 2009 for chest pain, there had been no real evidence of ischaemic heart disease and Mr T had discharged himself.

- December 2010 following an overdose and at that time the only previous medical history that had been noted was removal of appendix and previous depression.

4.36 Dr J later reviewed Mr T's chest x ray and noted that it appeared unchanged from a previous x ray taken four years previously. Dr J planned to try Mr T on treatment for chronic obstructive pulmonary disease and arrange lung function tests.

4.37 On 17 August when collecting his morning medication Mr T said he wished staff would lock him up because he was ready for the "*knacker's yard*". Staff gave him reassurance.

4.38 On 19 August Ms A and Ms J came to visit Mr T but he refused to see them and stated he had already told them not to come to see him. Mr T did give staff permission for them to discuss his health with Ms A and Ms J.

4.39 On 21 August Mr T's case was discussed at a ward round meeting. Present were Dr S, Dr J, medical students and Ms D (a ward nurse). It was noted that Mr T did not want his family to see him as he was and that he was still complaining of leg pain and he was very short of breath. Staff noted "*will have to work with social worker to arrange longer term plans*". Plans were for staff to chase the social worker and social services, encourage Mr T to attend group activities and discuss with the Louth community mental health team about leave prior to cleaning the bungalow so that Mr T could identify the items he wanted to keep. The record of the meeting was taken by Dr J.

4.40 On 22 August Mr T commented that he wanted to be transferred to Rampton because he thought that it was a knacker's yard. Staff explained that Rampton was a hospital.

4.41 On 24 August staff noted that Mr T had been smoking in the ward toilets again. Staff informed Mr T that it was not acceptable to do this and that it was a "*criminal offence*".

4.42 On 26 August Mr T reiterated to staff that he wanted to live in a residential home.

4.43 The following day Ms L visited Mr T and noted that his mood was "*okay*", but he appeared unkempt. Referral and assessment and consent forms (for financial assessment) were signed by Mr T. Ms L discussed the possibility of Mr T contributing towards the cost of deep cleaning his home plus the cost of any subsequent home care staff put into place. Ms L noted that Mr T agreed to this.

4.44 A nursing assistant later reported to Ms S (acute care nurse) that Mr T had been rude and abrupt to another patient on the ward. Ms S approached Mr T to discuss this but Mr T instantly became hostile and shouted that he was entitled to his own opinion and that the other patient should be in a nursing home. Mr T continued to shout and swear at staff even when they approached

him later to inform him that he had a telephone call, which he refused to take. Staff noted "*no evidence of acute mental illness*".

4.45 On 27 August Mr T's case was discussed at a ward round meeting. Present were Dr S, Dr S2, Ms L2 and two medical students. It was noted that Mr T had alternately been bright in mood and verbally hostile towards staff and patients. Mr T had not been keen to attend the ward round meeting and there were no concerns noted from nursing staff. The record of the meeting was taken by Dr S2.

4.46 On 30 August Ms K (occupational therapist) met with Mr T and discussed healthy eating and lifestyle. Mr T said he would like to engage in occupational therapy to look at healthy eating and meal planning. Later ward staff noted that although Mr T was pleasant when staff interacted with him, but the only subject Mr T wanted to discuss was the fact he wanted to go into residential care.

4.47 The following day Ms L3 had some one-to-one time with Mr T who remained focussed on moving into residential accommodation. Mr T said he felt he needed to stay in hospital for at least another two weeks but was unable to explain why.

4.48 A ward round meeting took place on 1 September to discuss Mr T's case. Present at the discussion were Dr S, Dr J and ward nurse Ms K. It was noted that Mr T wanted to go to "*Rampton or another institution where he can be cared for long term*". Mr T's hygiene remained poor and he was still struggling with breathing. The discussion section of the form noted "*feels he is getting better…knows he has to go home and wants to go…understands that being on ward/nursing home can make him worse*". The plan was for staff to chase the community mental health nurse regarding the deep clean and a "*short term nursing home*" and to encourage Mr T to join in groups. The document was signed by both Dr S and Dr J.

4.49 The following day Ms S contacted Ms L asking her to contact the ward to discuss Mr T's discharge plan.

4.50 On 5 September Mr T was seen by a physiotherapist about his leg pain. The physiotherapist noted that Mr T had degenerative knee pain and "*mild trochanteric bursitis".*[16] The physiotherapist taught Mr T some stretches and sitting/lying positions to help with his breathlessness.

4.51 On 7 September Ms M (acute care nurse) met with Mr T who presented as anxious about returning to his bungalow. Mr T was aware that staff were still waiting to hear when the planned deep clean would go ahead and that he still needed to collect some of his possessions beforehand. Mr T reported that he felt less anxious after the conversation.

[16] *Trochanteric bursitis is inflammation of the bursa (a small, cushioning sac located where tendons pass over areas of bone around the joints), which lies over the prominent bone on the side of your hip*

4.52 On 9 September Ms L3 spent some one-to-one time with Mr T who said that he felt he should be in a maximum-security hospital like Rampton or Broadmoor because he had a personality disorder. Ms L3 asked if Mr T meant a residential home to which Mr T responded, "*yes that would be better as long as I'm locked up*". Mr T also talked about the bumps on his head and that he had suffered in the past and abused alcohol.

4.53 At the ward round meeting on 10 September Mr T's case was discussed by Dr S, Dr J and Ms L3 (acute care nurse). It was noted that Mr T was having "*passing thoughts*" about suicide but there was no evidence of intent. Mr T reported that he was not sure if he was ready to go home and complained of pain in his legs and chest. He also reported that he was not getting on well with his family. Plans were noted as "*chase deep clean*" and "*chase CPN*". Dr J completed the record of the meeting. It was also noted that there would be no change to Mr T's medication.

4.54 Ms L3 met with Mr T after the ward review because he was upset as he thought he was being discharged. Ms L3 reassured Mr T that no discharge date had been set and that staff were waiting for confirmation that his bungalow had been properly cleaned and that a community mental health nurse had been appointed. Mr T reported that he felt better after the conversation.

4.55 On 11 September a member of staff (Mr C) noted that Mr T was at "*Maple Lodge for rehabilitation*".

4.56 On 12 September Mr A received a call from Ms J who asked for information about Mr T's care. Mr A told Ms J that he needed to seek permission from Mr T to share information with her. Mr T gave permission for staff to talk to Ms J but said he did not want to talk to her himself. Mr A also noted that he received a call from Maple Lodge to advise that they had a bed for him, and that transfer had been arranged for the following day. Maple Lodge is an inpatient unit that provides rehabilitation support for people with mental illness.

4.57 Ms M later spent some one-to-one time with Mr T to inform him of the planned transfer to Maple Lodge the following day. Mr T stated he was "*very shocked*" but pleased, anxious and excited about moving on from the ward. Staff organised seven days' of medication for Mr T to take with him the following day. Ms M also noted that she received a call from Ms J and that this made Mr T angry and told staff that he did not want them to disclose any information to her. Mr T also asked that staff did not inform Ms J of his transfer to Maple Lodge. Ms M informed Ms J of Mr T's wishes. Ms J became upset and tearful and was advised to call back the following day and staff would see if Mr T would be prepared for them to share any information then.

4.58 Ms J did call back the following morning however Mr T still refused to talk to her and said that he did not want staff to share any information.

13 September 2014 – transfer to Maple Lodge rehabilitation unit

4.59 On 13 September 2014 Mr T was transferred from Connolly Ward in Lincoln to Maple Lodge for a period of rehabilitation. Maple Lodge staff noted that they had received Mr T's medication from Connolly Ward staff but that no paper notes were available. Although Maple Lodge was managed by the Trust, it appears that not all services were using electronic patient records at this time.

4.60 An inpatient medical and nursing assessment was started that noted diagnoses of generalised anxiety disorder and depression; however no information was recorded in the sections for past psychiatric history, background history, other findings, current medication, risks, observation level, or therapeutic goals. It appears that the staff did not chase up the missing information from Connolly Ward. The document was signed by a junior doctor (CT2). It was noted that Mr T was an informal patient and was not detained under the Mental Health Act.

4.61 Mr T signed a confidentiality statement that indicated he was happy for staff to share relevant information with his family. Mr T stated that he did not know his daughter's telephone number and would provide it to staff in due course. Mr T reported a pain in his head that became more prominent when moving or standing. Staff noted this in the doctor's diary for the ward round meeting.

4.62 On 15 September Ms N (role unknown) called Louth community mental health team to speak to Ms L but she was not available. The member of staff with whom Ms N spoke advised that Mr T was not on Care Programme Approach and had not been for about a year. Ms N noted that because Mr T was an inpatient again he needed a care coordinator from the community team who could attend a Care Programme Approach meeting in the unit, either 8 or 15 October.

4.63 The following day Mr K (role unknown) called Ms L to discuss the issue of a care coordinator. Ms L advised that Mr K would need to contact her manager, Mr J, about allocating a care coordinator. Mr K did so and was advised by Mr J that because Mr T was already receiving input from Ms L and that his problems were "*social*" Mr T did not require a care coordinator. (It is unclear from the notes why Mr T's problems were considered as social rather than mental health issues.) Mr K therefore invited Ms L to attend a Care Programme Approach review on 15 October.

4.64 On 17 September Maple Lodge staff received a telephone call from the police who reported that they were concerned about Mr T's welfare. It appears that this was prompted by concerns expressed by Mr T's housing provider about his welfare. The housing provider had contacted Mr T's GP surgery and they advised that Mr T had been admitted as an inpatient to the Peter Hodgkinson Centre (where Connolly Ward is based). Although by this time Mr T had been transferred to Maple Lodge, it appears that the GP surgery had not yet been informed of this.

4.65 On 19 September Dr S3 reviewed Mr T because he had "*increased suicidal thoughts*". Mr T told Dr S3 that he planned to take any tablets he had with alcohol in order to end his life. Mr T asked for different medication and said he was not interested in talking therapy. Dr S3 attempted to get more information from Mr T about his sleep but he became irritable and said, "*more and more questions*". Dr S3 spoke to nursing staff who reported that Mr T had displayed similar behaviour during his previous admission i.e. threatening to end his life and "*demanding*" different medication. Dr S3 noted that she would pass the information to Dr A (consultant psychiatrist) but that there would be no change to Mr T's medication at that time and that he should be escorted when leaving the ward.

4.66 Dr A later spoke to nursing staff and advised that if staff felt that Mr T's risks increased they should contact the crisis and home treatment team for an assessment for admission to an acute ward (such as Connolly Ward). Dr A advised that he would discuss medication with Mr T at the next multi-disciplinary meeting.

4.67 On 21 September Mr T stated he wanted to see the doctor the following day about the constant "*pressure*" in his head. Mr T told staff it was a "*physical thing*" and that it would not go away. Mr T reported that he was having "*bad thoughts*" all the time about harming himself and other people. Staff discussed this further with Mr T who said that he did not want to kill himself but that he did not know what was stopping him from acting on his thoughts. Mr T said he wanted to be locked up and that he might "*hurt someone*" if he was not locked up. Staff attempted to discuss Mr T's housing, but he said he did not want to talk about his.

22 September 2014 – assault and urgent transfer back to Connolly Ward

4.68 On 22 September Mr T was seen by Dr A2 (a junior doctor). Mr T described the pressure in his head and said that he wanted different medication. He repeated his statement about wanting to be locked up. Dr A2 discussed organising some blood tests and ECG and MRI scans to check there were no physical problems before reviewing his medication. Mr T stated that he did not want these tests but did want his medication changed. Mr T told Dr A2 that she was "*not listening*". Dr A2 discussed again why Dr A wanted the tests to be done but Mr T said the "*voices are telling me to hurt people*". Dr A2 attempted to discuss this further with Mr T but he jumped from his chair and put both hands around her throat. Ms R (role unknown) pulled her alarm and attempted to de-escalate the situation. Mr K attended and both he and Ms R pulled Mr T away from Dr A2. Mr T was offered and accepted lorazepam[17]1mg. Mr T also said to Dr A2 "*I wanted to kill you*" and then "*the voice told me to kill you*". It is unclear from Ms R's entry what time the incident happened, but it was recorded at about 6:00pm.

[17]*Lorazepam is part of a group of medicines called benzodiazepines or anxiolytics. It is used for short-term treatment of severe and distressing anxiety and sleeping problems. https://www.nhs.uk/conditions/generalised-anxiety-disorder/treatment/*

4.69 The police were called and attended Maple Lodge. The police spoke to Dr A2 and Mr T, they explained that they would remove him from Maple Lodge and take him to the Section 136 suite.

4.70 During the evening Mr T was assessed by an AMHP[18], Mr M, and Dr U (section 12 doctor). It was incorrectly noted that Mr T was living in a "*residential home*", (Maple Lodge is an inpatient rehabilitation unit), and that he had "*put his hands around the throat*" of a female psychiatrist treating him. Mr T's Nearest Relative was recorded as his daughter but no information about her is recorded because Mr T refused to provide it. Mr M noted Mr T's psychiatric history (all of which is in line with information we have already reported in this report). Mr M recorded that Mr T appeared unkempt and refused to shake hands with the assessing doctor. Mr T had also been reluctant to engage with the assessment and answer questions, repeatedly rubbing his face and looking at the ceiling. Mr T asked the doctor and Mr M to take him to a "*secure unit*". Mr T referred to voices and negative thoughts and indicated that he did not feel that his medication (quetiapine) was working. Mr T's medications were noted as:

- Quetiapine 200mg twice daily.
- Venlafaxine 75mg once daily.
- Simvastatin 40 mg once at night.
- Ferrous sulphate 200mg once in the morning.
- Thiamine 100mg once in the morning.
- Vitamin B twice daily.
- Lorazepam as required.
- Paracetamol as required.

4.71 Mr M recorded that Mr T was "*unrepentant about assaulting*" the doctor earlier that day and later asked whether the assessing doctor and Mr M would like him to jump on them. Mr T accepted informal admission to Connolly Ward so although a Mental Health Act assessment was undertaken, an application to detain him under the Mental Health Act was not required.

4.72 Dr R assessed Mr T on arrival at Connolly Ward. Dr R recorded a possible diagnosis of bipolar disorder and noted "*change antipsychotic/ antidepressant*" medication. Dr T stated Mr T should be on 30-minute observations and that he should be escorted for breaks from the ward. Dr R completed an inpatient healthcare assessment document. On this document

[18] *Approved Mental Health Professional (AMHP) – a mental health professional who has been approved by a local social services authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating a patient's assessment and admission to hospital if they are detained under the Mental Health Act.*

Dr S noted the reason for admission as "*review of antipsychotics/assessment*".

4.73 At the ward round meeting on 23 September Mr T's case was discussed by Dr S, Dr J and Mr A, acute care nurse. It was noted that Mr T had been admitted following an attempt to strangle a doctor at Maple Lodge and that he had alleged that "*voices*" told him to do it. Risks were recorded as "*no thoughts of harm to self or others*". (It is unclear whether this meant that Mr T was no longer reporting thoughts of harm, even so it should have been recorded as recent high risks.) During discussion it was noted that Mr T was complaining of pressure in his head and had requested different medication to stop the tightness that he described a feeling like a band around his head. The plans were for staff to chase the social worker about the bungalow, "*restart quetiapine*", stop lorazepam and zopiclone[19], for staff to impose strict boundaries and follow up the incident at Maple Lodge and "*make them aware that should they wish to pursue charges then [Mr T] has capacity*". It was also noted that Mr T was on general observations, but it is unclear when this change was made. On review by the duty medical officer 12 hours earlier Mr T was on 30-minute observations. The written record of the discussion was completed by Dr J, the electronic entry was completed by Mr A.

4.74 The crisis and home treatment team then wrote to Mr T's GP to inform him that Mr T had been assessed under the Mental Health Act and had been re-admitted as an informal patient to Connolly Ward. The crisis and home treatment team advised that Mr T was being discharged from their service.

4.75 On 24 September Mr T was found smoking in the ward toilet and said that he had done so because he was desperate for a cigarette and could not wait to be escorted. He was reminded of the hospital policy about smoking. Later that evening Mr T approached nursing staff and asked for some medication to help with his anxiety. Staff spent time with Mr T "*looking at alternative ways of dealing with anxiety*" but this did not appear to help so Mr T was given haloperidol[20] 2mg "*to good effect*".

4.76 The same day the crisis and home treatment team wrote to Mr T's GP to inform him of Mr T's transfer to Connolly Ward from Maple Lodge.

4.77 On 25 September Mr T's GP surgery recorded that they had received a notification to remove Mr T from their list of registered patients (the entry reads "*GP deduction request – left area, gone away*"). We have been unable to clarify exactly why this action was taken. There are no documents within Mr T's GP records that indicate that he had registered with a different GP surgery and when we spoke to the Operations Manager at the surgery she told us that although it was some time ago she believed that the surgery was informed that Mr T had moved away.

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[19] *Zopiclone is used to treat insomnia.* https://www.nhs.uk/medicines/zopiclone/

[20] *Haloperidol is used to treat psychotic symptoms.* https://bnf.nice.org.uk/drug/haloperidol.html

4.78 On 28 September Mr J2 spent some one-to-one time with Mr T. Mr T reported that he still had pressure around his head and that he was finding it difficult to deal with. Mr J2 noted that the doctors were continuing to investigate it. Mr T said that he struggled with motivation and had to be encouraged to look after his personal hygiene and wash his clothes.

4.79 Dr V saw Mr T at the request of nursing staff because Mr T was complaining of pressure on one side of his head. Mr T described it as being related to something broken in his head and that he was really concerned about it and that it was not pain but pressure. Dr V attempted to examine Mr T, but he refused a full physical examination, so Dr V commented only on Mr T's neurological observations which were all within normal limits. Dr V noted the plan would be to continue to observe Mr T.

4.80 Later that day Dr V was asked to review Mr T's prescription chart because a member of nursing staff had identified a medication error. Dr V amended Mr T's prescription to thiamine 100mg once daily and nursing staff submitted an incident form.

4.81 On 29 September (the following day) Mr T was still complaining of a pressure in his head and staff noted it as a tension headache. Ms J came to the ward to see Mr T, but he refused to speak to her. However, Mr T was happy for staff to talk to his daughter.

4.82 Later that day Ms L also visited Mr T to discuss the outcome of the financial and benefits assessment. Mr T stated he felt low and that he had "*that tension*" in his head. Ms L explained that Mr T had been assessed as being able to make a contribution of £69 per week towards the cost of any ongoing care. Ms L discussed the implications of this with Mr T and agreed that the best option would be for Mr T to pay privately for a cleaner to come for two to three hours per week to help him keep on top of his cleaning. Ms L noted that whilst Mr T appeared to accept this he stated he was still not ready to go home and wanted to go into a residential home. Ms L explained that Mr T did not meet the criteria for residential care. Ms L was informed by ward staff that Mr T had given his consent for Ms J to be updated about his care plans and therefore Ms L called Ms J. Ms L also called a local cleaning company to arrange for someone to meet Mr T at his bungalow to provide a quote for the deep clean.

4.83 The following day Ms L called Connolly Ward to advise that arrangements had been made with a cleaning company to meet at Mr T's bungalow the following Tuesday.

4.84 On 1 October Ms G (acute care nurse) noted that staff from Maple Lodge had called regarding the assault charges against Mr T. It was noted that staff at Maple Lodge were unsure what was happening because the doctor was still on sick leave due to her injuries. That evening Mr T was reported as being quiet and subdued and he had talked about the pressure in his head.

4.85 On 7 October Ms L arrived at Connolly Ward to collect Mr T to take him to meet with the cleaning company at his bungalow. However, Mr T told Ms L

that he no longer wanted to go ahead with the deep clean and that he had spoken with his daughter who had agreed to do the deep clean for him. Mr T said that Ms J also planned to visit him more regularly when he was discharged and to help him stay on top of the cleaning and other household chores. Ms L had been trying to get hold of Ms J for about a week and tried again to call her but again did not get an answer on the landline number she had for Ms J. Ms L discussed the idea of Mr T moving closer to Lincoln and he said that he wished to do so. Ms L noted she would seek support from the team's housing officer to help Mr T to complete the necessary forms.

4.86 Later that day Mr P (role unknown) spoke with Dr S and then with Mr C (security management advisor) regarding the progress of the assault charge against Mr T. Mr C advised that although the member of staff wished to press charges they were off sick and therefore little progress had been made.

4.87 On 8 October Ms J called Connolly Ward seeking an update on the incident that occurred at Maple Lodge. Ms J spoke to Ms K who advised that nursing staff had not been informed of anything at that time.

4.88 On 10 October Ms L referred Mr T to the housing officer for the community mental health team, Ms H. Ms L also tried to contact Ms J again but was unable to speak to her. Ms L therefore rang Connolly Ward to ask staff there to pass her number to Ms J if she called.

4.89 On 12 October Mr T complained of feeling pressure in his head which he said had been present for weeks.

4.90 The following day Mr A and a student nurse met with Mr T who described an ongoing feeling of depression and pressure in his head. Mr T talked about his work as an engineer, how he had been married 20 years previously and that he had no friends at that time.

4.91 On 14 October Ms L again tried to contact Ms J but was unable to speak to her or leave a message. Ms L2 (ward staff) received a call from Mr T's sister asking after him. Ms L2 advised that there were no changes to his care plan.

4.92 At the ward round meeting on 14 October Mr T's case was discussed by Dr S, Dr J and Mr A, a ward nurse. The nursing report noted that Mr T did not engage with the nursing team, although he was polite and appropriate in his communication. Although the record indicates that Mr T showed no signs of aggression or violence on the ward, he had "*expressed thoughts of aggression towards others in the ward*". Mr T told staff that he had attacked the doctor because of the "*pressure in his head*". Staff also noted that Mr T had previously said that if the doctor didn't do what he wanted he would attack them and that he should have had help when he was 18 years old. The paper record of the discussion was completed by Dr J, the electronic record of the discussion was completed by Mr A.

4.93 On 17 October Mr J2 received a telephone call from Dr S who advised that formal action was going to be taken against Mr T in relation to the assault on

the doctor at Maple Lodge. Dr S advised that Mr C was leading on this and that Mr T was not to be informed at that time.

4.94 Shortly afterwards Ms J and Ms A arrived at Connolly Ward and asked to speak to staff about Mr T's care plan. Mr T gave his permission for "*basic information"* to be given to them but did not want to see them, he also gave permission for them to attend the ward round meeting on 23 October. Mr T asked that his family be seen separately from himself at the meeting. Ms A and Ms J advised that they felt that Mr T's housing was a major factor in his mental health.

4.95 Ms H contacted staff at Connolly Ward regarding support for Mr T to move to Lincoln. Ms D (role unknown) informed Ms H that ward staff had decided it would be more appropriate for Mr T to return to his home first and then find alternative accommodation. Ms D advised Ms H that she did not have capacity to support Mr T with this matter and therefore Ms H would have to do so.

4.96 On 19 October Mr T told staff that he was worried about his family attending the ward round meeting that week, but he still agreed for them to attend. During the afternoon Mr T approached staff asking if he could discharge himself from the ward because he was bored. Mr J2 (role unknown) suggested that Mr T should wait until the following day so that he could be seen by the ward doctor, be prescribed appropriate medication and staff could arrange the necessary support. Mr T agreed to stay for that night.

4.97 On 23 October Mr T was discussed at the ward round meeting. Present were Dr S, Mr A (ward nurse), a medical student, Ms J and Ms A. It was noted that Mr T was settled and had spent some time off the ward that had gone well. Although Mr T had wanted to discharge himself at the beginning of the week, he had not mentioned this to staff since. No risks were identified to himself or others, but a discussion did take place about Mr T's attack on a doctor at Maple Lodge, however there is no record of the outcome of that discussion. It was noted that Mr T's family were supportive and that they would visit him when he was in the community. Mr T told staff that he wanted to live with Ms A however Ms A explained this would not be possible as she would not be able to cope. The plan was for the social worker to discuss an appointeeship[21] and for Mr T to continue on existing medication.

4.98 On 25 October Mr T asked to go into the seclusion room so that he could shout and vent some frustration. He would not discuss his feelings with staff. He lay down on the mattress and said it was better because it was quiet but after a short while he said that the police were required because he was not well, and he should not have been on the ward. Mr T swore at staff and became angry and hostile shouting that staff did not understand him. Mr T was given oral haloperidol 2mg.

[21] *An appointee is a person who has been chosen by the Department of Work and Pensions (DWP) or local authority to receive welfare benefits on behalf of someone.*

4.99 Later that day ward staff noted mobile telephone numbers for both Ms A and Ms J.

4.100 On 27 October Ms L called Ms J and left a message asking her to call Ms L. The following day Ms L called Ms J again but did not get an answer.

4.101 On 29 October ward staff received a call from Lincolnshire Police regarding the assault on the doctor at Maple Lodge. The police asked whether Mr T had capacity at the time of the attack. Nursing staff discussed the matter with Dr S who advised that Mr T "*has capacity and [Dr S] will put this in writing*" if required. Nursing staff contacted the police to advise them to contact Dr S's secretary.

4.102 On 30 October Ms L was able to speak to Ms J. Ms L advised that Mr T had told her that Ms J would clean his bungalow prior to his return home. Ms J stated that she had not agreed to this and it had only been in the last few days that Mr T had allowed her to visit and talk to him. Ms J said she would do her best to clean the bungalow but as she didn't drive she would be reliant upon her mum (Mr T's ex-wife Ms A) to take her there. Ms J expressed concern because she had not seen the condition of the bungalow and therefore did not know how long it would take to clean it. Ms J said that she would call Mr T to discuss the matter but pointed out how important it was for Mr T to be closer to Lincoln to be nearer family support. Ms L explained that when Mr T had been discharged from hospital Ms H, the housing support worker, would work with him to help him to find accommodation closer to Lincoln.

4.103 At the ward round meeting on 30 October Mr T's case was discussed in the ward round meeting by Dr S, Dr J, Ms L, a ward nurse and a medical student. Mr T reported that his daughter would help to clean his bungalow but when Ms L spoke with Ms J she knew nothing about the arrangement, however she said she was happy to help. Mr T had refused to pay the service user fee, so staff were unable to arrange for the house to be deep cleaned. Dr J noted that if Mr T's family were not happy to clean the property Ms L would discuss the possibility of the Trust funding it. It was also noted that Mr T planned to move closer to Lincoln in the "*longer term*" and that he was still complaining of "*tightness*" in his head.

4.104 On 1 November Mr T reported to Mr B2 that he still felt depressed and was experiencing "*tightness*" in his head. It was noted that Mr T gave permission for staff to talk to his family when they attended the ward that afternoon to collect his keys.

4.105 On 5 November ward staff noted that Mr T continued to talk about a pressure in his head, referring to it as "*something more sinister*" than a headache. Mr T continued to repeat this statement so staff suggested he discuss it with a doctor, but Mr T declined saying nothing could be done.

4.106 Later that day Ms J called Ms L to say that she and Ms A had started cleaning Mr T's home but that due to work commitments, they would not be able to return to complete the clean until the following week. Ms J advised that Mr T had no food supplies and asked that if Mr T were to be discharged it would be

helpful if it could be arranged for a day when either she or Ms A could support him.

4.107 On 6 November Mr T was reviewed by Dr S, also present were Dr J, Mr J (acute care nurse) and Ms O from the Louth crisis and home treatment team. It was noted that Mr T continued to spend most of his time in the bed area with little engagement with staff. It was noted that Mr T's daughter had reported that his bungalow should be ready for him by 15 November. Mr T was feeling brighter despite not having left the ward to help his daughter and ex-wife to clean his house the previous Saturday. Mr T indicated he felt his improved mood was linked to renewed contact with his daughter and ex-wife. It was noted that Mr T was still complaining of pressure in his head and that he was sleeping badly as a result of this. The plan was for Mr T to be discharged from the ward once his home was clean, daily crisis visits to be in place, the crisis and home treatment team to identify a care coordinator, chase an outcome on the possible prosecution for assault on the doctor at Maple Lodge, for Mr T to go home the following Tuesday to help with the cleaning.

4.108 On 7 November crisis and home treatment team staff spoke with Ms L and discussed the outcome of the ward round meeting the previous day. It was noted that the crisis and home treatment team would support Mr T when he was discharged from the ward and would be responsible for completing the seven day follow up appointment. Ms L noted that the crisis and home treatment team would review whether Mr T needed an allocated community mental health nurse and would refer him to the integrated community mental health team if necessary. Ms L planned to visit Mr T when he was at home in order to introduce him to the housing support officer who would work with Mr T to help him move closer to Lincoln.

4.109 On 8 November Ms L2 (a ward nurse) contacted Ms J who reported that the cleaning of Mr T's home would be completed on 11 November and that Ms A would collect him on 15 November.

4.110 On 9 November Connolly Ward staff reported that Mr T was presenting as "*extremely anxious*" and when staff tried to support him he reported a "*pressure in his head*" and that his "*head was damaged*" but was unable to elaborate further. Dr H (junior doctor) saw Mr T and prescribed him haloperidol 2mg after which Mr T asked to sit in the de-escalation room. Later Mr T continued to seek assurance and complained of "*thinning*" in his head that made him feel unwell and suicidal. Mr T reported that he thought he might feel this way because of his previous heavy alcohol use or that he had inherited it from his father.

4.111 Mr B2 recorded that he had discussed Mr T's care plan with him, and that Mr T had said he was happy with it and signed it.

4.112 On 11 November Dr S2, a junior doctor, recorded that Mr T continued to report a pressure like sensation in his head. Dr S2 offered Mr T the opportunity to discuss it further in clinic and to examine him but Mr T declined.

4.113 On 15 November Mr T reported that his home leave would have to be cancelled because his daughter was ill but refused to provide more details. Mr B2, recorded that he had no way of verifying the information. Mr T continued to state that his brain was damaged and appeared to be in distress.

4.114 A further review took place on 18 November at which Dr S, Ms K (a nurse) and Dr J were present. Mr T continued to report heavy pain/pressure in his head and that he was unable to focus as a consequence, it was noted that he had been examined on "*numerous occasions*" but the outcome of those examinations is not noted. Mr T said he felt he needed to be "*shut away*". There had been no change to his mental state and Mr T continued not to engage in any one to one time with staff. It was noted that Mr T was keen to return to his bungalow now that his family had cleaned and tidied it for him. The plan was for Mr T to be allocated a care coordinator, to have two night's leave after crisis follow up had been organised, and for his leave to be discussed with the social worker.

4.115 On 19 November Ms L spoke to staff on Connolly Ward who advised that Mr T would be going on home leave from Saturday to Monday and that the crisis and home treatment team had agreed to provide support to him over the weekend. Ms L stated that the community mental health team had discussed the ward's request for a care coordinator to be allocated for Mr T. Ms L's manager would allocate a community mental health nurse the following week.

4.116 On 20 November Mr T continued to say that he had pressure in his head and that his head was damaged. Mr T was advised to use distracting techniques and stated he would do so.

4.117 On 21 November Mr T spent some one-to-one time with Ms K, an acute care nurse. Mr T spoke about the tension in his head, described it as "*locked*". Ms K queried whether this was a consequence of stress, but Mr T was not convinced. Ms K discussed the leave that Mr T was due to take the following day, but Mr T did not appear positive about it. However, Ms K discussed the activities he could do such as contacting his family and seeing his daughter Mr T said that would be good. Mr T stated he had done "*lots of bad things*" but did acknowledge that he had done some good things too.

4.118 On 22 November Mr A reported that Mr T appeared bright in mood that morning and that he had collected his leave medication, expressing no concerns about going home for a while. Mr A noted that Ms A had collected Mr T who had left the ward to meet her, however Mr T refused to leave the building and complained that his head was pulsing. Mr A spoke to Mr T who said that he no longer wanted to go on leave. Mr A explained that it would be in Mr T's best interests to go on leave as this would enable staff to identify his needs when at home so that appropriate support could be provided. Mr T said he could not cope on his own, that he would struggle to sleep and said he just wanted to stay with Ms A. Mr A explained that it would be no different at Ms A's home because she had to work nights and then sleep during the day and that it was not her job to look after Mr T. Mr T responded by saying that Ms A could return him to the ward that evening. Mr A told Mr T that he had the opportunity to go on leave at the weekend but did not take it and if staff "*kept*

changing the boundaries on already agreed leave it would have a negative impact on his long term mental health". Mr A said that it was better for Mr T to "*face his house now whilst he has support rather than be discharged back to the house and the support offered…isn't the right support*". Mr A recorded that Mr T "*reluctantly accepted*" this and left with Ms A. Louth crisis and home treatment team was informed.

4.119 At about 4:00pm Ms S3 from Louth crisis and home treatment team called Mr T at home. Mr T reported that he had got home okay and that he had eaten. Mr T said that he was okay and that if he needed to talk to anyone that evening he would call the crisis and home treatment team.

4.120 On 23 November Ms S3 and Ms U, both from Louth crisis and home treatment team visited Mr T at home. Mr T reported he was anxious, and staff noted this was evident because he was physically shaking and breathing heavily. Mr T reported that the reason for his anxiety was that the quetiapine had damaged his head and that his head felt tight and damaged. Staff noted that Mr T's home was tidy and that he was returning to the ward the following day. Mr T told staff that he should be on the ward all the time because there were people around 24 hours a day.

4.121 On 24 November in the morning Ms J called Connolly Ward to express concerns about Mr T being discharged. Ms J felt that Mr T was not well enough and that he would require a lot of input in the community. Staff reassured Ms J that any discharge would be planned and discussed fully prior to discharge taking place.

4.122 At about 12:30 Mr T returned from leave and stated it had gone "*poorly because of the pressure in his head*". He said that he wanted to stay at his sister's house because he would then have someone with him. Dr J informed Mr T about community groups near his home but Mr T was not keen to join them. Mr T asked to go into town to do some shopping and Dr J told him he would discuss the request with Dr S. The nursing entry made by Ms L3 noted that Ms A and Ms J accompanied Mr T on his return to the ward and that Ms A and Ms J reported that Mr T had initially refused to return and that they had to pull him out of his home. Mr T continually asked to stay with Ms J for a few days, but she repeatedly told him that she did not have room for him. Ms A and Ms J expressed concern that Mr T might "*up the anti to get his own way*" and it was noted they commented that he preferred to be in hospital rather than his bungalow. The family's recollection of this conversation was that they were trying to say that Mr T did not feel right and wanted to stay in hospital.

4.123 Ms L noted that Dr S was aware and asked that Louth community mental health team be contacted about a support and care package for Mr T for when he returned home. The family say they were worried about plans for discharge, and that staff told them that they "*would cross that bridge when we come to it*", which the family did not find helpful.

4.124 At about 4:40pm that day Mr A noted Mr T had left the ward earlier stating he was getting a taxi into town. Mr A later received a telephone call from Ms J saying that Mr T had arrived at her home and said he wanted to stay the

night. Ms J said she was happy for him to stay and would return him to the ward the following morning.

4.125 On 25 November, whilst Mr T was still on leave Ms K (an occupational therapist) completed a weekly review. Ms K noted that Mr T would benefit from occupational therapy interventions, but he had chosen not to engage in these. Ms K had observed Mr T whilst on the ward and could see that he had the ability to complete some activities of daily living but lacked the motivation to complete them. Ms K planned to "*continue to engage*" Mr T in occupational therapy.

4.126 At around lunchtime on 25 November Mr T returned from leave, accompanied by Ms A and Ms J. Mr T was shaking and appeared angry, and Ms A and Ms J appeared distressed. Staff asked Ms A and Ms J to leave and return later. Dr S2 attempted to discuss Mr T's leave with him and noted that Mr T appeared to be increasingly agitated, "r*estless, clenching and unclenching fists*" and threatened to harm "*someone*". Dr S2 terminated the conversation at that point and sought out nursing staff to provide some medication at which point Mr T assaulted a nursing assistant (the nature and details of the assault are not provided). Mr T shouted that he was "*deranged*" and threatened to hit staff and his family. He was angry that no one believed he was mentally unwell, and he was annoyed with his family that they did not believe he was unwell and that he could behave appropriately if he chose to. Mr T was given 2mg oral lorazepam with no effect and then 5mg oral haloperidol with minimal effect. Police attended and arrested Mr T and took him to police custody.

4.127 Dr S2 then had a discussion with Ms A and Ms J who expressed "*real concerns*" about Mr T hurting someone whilst on leave and that he had previously threatened to hurt others with a knife. They reported being frightened about what Mr T might do if he arrived at one of their homes and stated that Ms J had two young children aged five and nine years old. However, Ms A and Ms J stated that they did not believe Mr T would hurt his grandchildren. They expressed concern about the vulnerability of other residents at Mr T's sheltered accommodation. Dr S2 noted that Ms A and Ms J were aware of the earlier assault on the nursing assistant and that it would be a police matter. Dr S2 noted that Ms A and Ms J asked about a previous assault on a member of staff but Dr S2 indicated that it was also a police matter and she was unable to provide an update.

4.128 Ms S called the police later in the evening and spoke to PC F who reported that Mr T had been calm and cooperative whilst in police custody. PC F stated that the police planned to return Mr T to the ward in the following hour. Concerns were raised regarding staff safety and PC F advised that if there was further violence staff should dial 999. PC F also advised that there was insufficient evidence to charge Mr T at that time (for the assault on the nursing assistant mentioned at paragraph 4.126) however he stated that any staff who responded to the staff alarm should get in touch to provide a statement..

4.129 Mr T was returned to the ward at about 9:00pm and reported that he still had the pressure in his head. It was noted that Mr T was on police bail until 4 January 2015.

4.130 On 25 November Mr T was again reviewed on the ward. The review notes do not indicate who was present for the discussion. It was noted that Mr T had spent some time on leave and that Mr T had reported it had not gone well because of the pressure in his head. Clinical staff noted no changes to Mr T's presentation and that he spent "*long periods of time sleeping*" in his bed space on the ward.

4.131 On 26 November staff noted that police officers wished to speak to a nursing assistant regarding the incident with Mr T the previous day (mentioned at paragraph 4.126).

4.132 On 29 November Mr T told staff that he was looking forward to his discharge but that he could not understand why he had not been seen in ward round the previous week. Mr B2 reassured Mr T that he would be reviewed that week and a decision would be made regarding discharge and leave.

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4.133 Mr T was discussed in a ward round meeting on 2 December. Present for the discussion were: Dr S; Dr J (junior doctor), Ms K (nurse) and a student nurse. The nursing report notes: "*Stating he is looking forward to discharge. Spending time in bed space for long periods*". Risks identified noted as "*No thoughts of harm to self of others, self-care still improving. Keen to go on leave.*" The discussion section shows that Mr T still believed that the pressure in his head was due to the quetiapine medication, but Mr T's records show that the feeling of pressure had been present for a number of years. Mr T told staff that he was able to look after his flat whilst he was on leave and did not know why the flat got so bad prior to his admission. Mr T told staff that he punched the member of staff because the pressure was "*driving him mad*". The plan from the meeting was for Mr T to have home leave for four nights, daily crisis contact, staff to chase a community mental health nurse, staff to encourage Mr T to participate in activities on the ward, staff to arrange a discharge Care Programme Approach meeting. The record of the meeting was completed by Dr J.

4.134 On 3 December Mr T approached ward staff to ask for leave from the following Monday. Mr T was advised that this could be arranged but staff noted he remained quite isolated during the afternoon with minimal engagement with staff.

4.135 On 4 December the Louth crisis and home treatment team received a call from Connolly Ward advising that Mr T was due to go on leave from 5 to 9 December and would require daily face to face contact from the crisis and home treatment team.

4.136 On 5 December (Friday) Ms L noted that she had received a call from Connolly Ward advising that although Mr T had been due to go on leave that day, he had stated he didn't want to go until the Monday (8 December). Ms L was unclear at that time how long the leave would be arranged for and asked that the ward contact her again when this had been decided.

4.137 On 7 December Mr T was offered one to one time with Ms M but he declined it. Ms M asked if he would be going on leave the following day and Mr T responded saying he would think about it. Ms M advised that leave was considered part of treatment, but Mr T did not appear to be convinced. Mr T continued to express concerns regarding his head to Mr B2 and reported that he may have been taking the wrong medication. Mr B2 noted that Mr T had been seen on many occasions loitering in the corridor and looking at the clock. Ms A visited Mr T and they sat on a sofa together. Mr B2 noted that Ms A had not expressed any concerns to staff.

4.138 On 8 December Mr T approached Mr A and stated he did not want to go on leave that day and asked for it to be delayed. Mr A explained that he would be arranging transport as soon as possible and that Mr T had to go on leave. Mr T kept asking and Mr A kept repeating his answer, however it appears that due to the "*ward environment*" Mr A was unable to arrange leave for that day and it was postponed until the following day.

4.139 On 9 December a clinical review took place on the ward for Mr T. The record of that review indicates that it was a "*subsequent MDT clinical review*" and a "*pre-discharge planning*" meeting. The primary diagnosis was recorded as emotionally unstable personality disorder, the secondary diagnosis was recorded as harmful use of alcohol. Present for the discussion were Dr H, Dr I, Ms K and Ms L. It was noted that Mr T had not gone on leave at the weekend and that he had told staff he wanted to defer the leave until the Monday. Ms L advised that she was doing a financial assessment for Mr T and a housing support worker had been assigned because he wanted to move closer to his family in Lincoln. Ms L had liaised with Ms J who had cleaned Mr T's property. It is also noted "*she thinks his difficulties are more related to poor coping strategies, rather than a mental problem*". It is unclear whether this is reported as Ms L's belief or Ms J's belief. The need for Care Programme Approach was discussed and Ms L advised that she would ask the community mental health team to allocate a worker. Mr T continued to believe that quetiapine, vitamin B and simvastatin may be causing the sensation in his head. Dr H explained that none of the reported side effects of the medications were consistent with the feeling that Mr T had reported. Risks were reported as low or moderate (relating to neglect). The plan was for Mr T to be encouraged to go on leave the following day and return to the ward on Friday. Dr H noted that because Mr T was "*highly resistant*" to being discharged, he would need "*assertive reintegration*" into the community and this would require the support of the community mental health team.

4.140 A telephone call was later received from the team manager of the community mental health team stating that Mr T did not require Care Programme Approach. Dr H clearly noted that the Connolly Ward team did not share that view for the following reasons:

- Mental disorder with a high degree of complexity, necessitating an inpatient admission as he needed intensive support and was unmanageable in the community.

- Referred for rehabilitation as a result of this and there he severely assaulted a doctor and has since assaulted one of the nursing staff.
- Family were concerned as he had previously made threats towards them, adding to his risk of violence.
- Harmful use of alcohol.
- Unsettled accommodation and under multiple service provision from different agencies.
- Poor social support.
- Current and past history of severe distress and instability.

4.141 Also, on 9 December, a 'working with risk' documented Mr T's risks at the time of the assessment. The only risks identified at that point were Mr T's risk of physical impairment (related to the pressure in his head and a tremor in his left arm) and challenges to services (wanted to stay an inpatient for ever and non-compliant with some prescribed medication).

4.142 Between about 7:30pm and 8:00pm Ms K noted that Mr T had stated he would not be able to organise his own transport for leave starting the following day. Ms K therefore contacted the Louth crisis and home treatment team to enquire whether they would be able to help Mr T. Ms K then received a call from Ms J and informed her of the plan agreed at the meeting that day. Ms J stated that Ms A would be able to transport Mr T home the following day but would not be able to return him on the Friday. Ms K therefore noted that ward staff should contact the Louth crisis and home treatment team the following day to ask if they could transport Mr T back to the ward on Friday.

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4.143 At around 11:00am Mr T attended the clinic room for his medication and said "*I'm not getting discharged today*". Mr A attempted to reassure him, but Mr T's behaviour quickly escalated and he shouted "*I'm not going*" and pushed the medicine trolley out of the way. Mr T then clenched his fists and said he was not going to leave. Mr A activated his alarm and then Mr T approached Mr A in an aggressive manner. Mr A recorded that he had to grab both of Mr T's wrists to prevent him from attacking him. Mr O and Ms S attended, and restrained Mr T. Ms S talked to Mr T who "*kept stating that he was not ready for discharge*". Ms S informed him that his behaviour was not acceptable, that it was not a symptom of his mental health and that he was responsible for his own actions, therefore the police would be informed. Mr T agreed and stated "*I need to be taking [sic] away, I can't go home*". Mr T's behaviour then escalated again. However, when Ms S "*threatened*" him with immediate discharge if he continued to threaten staff Mr T quickly calmed down. Mr T was advised that nursing staff would speak to the doctor about leave and discharge. Ms A attended the ward to collect Mr T for his planned leave, however staff updated her regarding the earlier event and advised her not to take Mr T on leave because last time Mr T presented in that way he attempted

to attack her. Ms A agreed. Mr A then contacted the police to inform them of the incident, they were advised that Mr T "*had capacity…was informal…due to be discharged and had leave gone well*". PC N rang the ward and stated she would attend and speak to Mr T but that she would not be able to arrest him because he had not actually committed an assault. It was reported by ward staff that PC N spoke to Mr T and warned him again future behaviour and explained he could be banned from the unit if he continued to behave in that way. Mr A then contacted Mr C, Trust security management advisor to seek advice about pressing charges against Mr T. It appears that Mr C sought advice from a legal advisor who stated that the incident "*may be charged as common assault or assault by apprehension or attempted assault*". It also appears that Mr A informed the police control centre of this information and was advised that they would speak to PC N and ask her to contact the ward.

4.144 At about 12:15pm Ms K recorded a weekly occupational therapy review. She noted that Mr T continued to display outbursts of aggression that "*from observation*" appeared to be "*more behavioural*". Mr T had poor coping mechanisms, but he was unwilling to explore this and did not accept change readily. Ms K noted that there was no identified need for occupational therapy intervention on the ward, but Mr T would benefit from this when back at home.

4.145 At about 2:15pm Mr T approached Mr A and asked for a "*30 minute chat*". Mr A explained that he would talk to Mr T shortly but that he would ask another member of staff to stand outside the door because of Mr T's earlier aggression. Mr A noted that he decided that talking with Mr T "*would be better than refusing to engage with him*". Mr A was accompanied by a nursing assistant (Mr H) and another member of staff (Mr B) stood outside Mr T's room. During the conversation Mr T stated that he "*needs to be locked up*" or he would hurt people again. Mr A asked why he felt the need to hurt people and Mr T stated "*because of the pressure in my head*". Mr A explained that this reason was not acceptable, and the only time Mr T behaved in that way was when the team were discussing discharge from the ward. Mr A offered to work with Mr T's anxiety if that was the reason, but he became angry and the third member of staff came into the room to help to verbally deescalate the situation. However, Mr T became agitated and attempted to throw the table, however staff intervened and physically restrained him. Mr T stated he wanted to be arrested because of the pressure in his head and repeatedly stated he wanted to go to prison. Mr A asked the nursing assistant to find another member of staff to speak to Mr T. Ms S then arrived and the conversation "*followed a similar pattern*" to the one Mr A had just held with Mr T. Mr T eventually accepted that he would not go anywhere that day and that he would "*behave*" himself and go to his room. Mr A recorded that Dr S attended the ward and "*stated that we should push for discharge tomorrow and arrange transport and arrange aftercare*" with Louth crisis and home treatment team. Mr A informed Ms S of this information and noted that Mr T had not been informed.

4.146 Between about 3:15pm and 4:30pm Ms S recorded that Mr A had informed her that he had liaised with the police and that they would "*facilitate*" taking Mr T home the following day. The police had advised that they would send a

police van and two to three officers to remove him from the ward and that if Mr T became aggressive he would be arrested for breach of the peace. Ms S called Ms L to inform her of the situation. Ms L advised that the crisis and home treatment team should do the seven-day follow up, but she would continue to provide support. Ms S then called the Louth crisis and home treatment team and again provided an update on the situation. Ms S was advised that the crisis and home treatment team would discuss Mr T's case and contact the ward regarding the plan.

4.147 Ms C from the Louth community mental health team received a call from Ms S on Connolly Ward at about 5:15pm who stated that Mr T would be discharged at lunchtime the following day. Ms S advised that the team would have a discussion the following day about how to facilitate the discharge and would contact the community mental health team the following morning to let them know.

11 December 2014 – discharge from Connolly Ward

4.148 Dr I (Dr H's trainee doctor) completed a discharge notification form. The form noted Mr T had been admitted on 13 November (this date was incorrectly stated, Mr T was actually admitted on 22 September) and his diagnoses as anxiety, depression and personality disorder. It also noted that Mr T's medication on discharge was thiamine 100mg once daily, simvastatin 40mg once at night, vitamin b co strong tablets twice daily, ferrous sulphate 200mg once daily, quetiapine 200mg once daily, venlafaxine 75mg once daily.

4.149 A risk assessment was completed by Ms S. The document includes information provided on previous dates when Mr T's risk was assessed, and it appears that staff added to the risk assessment each time risk was reviewed. On this date the only risks identified were:

- Risks to others: "*Following a discussion with the MDT it was decided that [Mr T] should be discharged from the ward due to the number of violence incidences towards staff when leave from the ward or discharge is discussed, [Dr H] states the incidences are not due to his mental health. There is no concerns [sic] with regards to [Mr T's] capacity and there has been no evidence of acute mental illness during [Mr T's] admission to Connolly Ward.*"

- Risk of neglect: Poor personal hygiene.

- Risk to children: no risk evident.

- Challenges to services: "…*he has attacked several member of staff when leave from the ward has been discussed and planned. [Mr T] has refused to go on all periods of leave that has [sic] been planned*…".

- Significant known history: evidence provided in this section is as reported in risks to others and challenges to services, with the addition of "*The police was [sic] contacted and attended the ward to remove [Mr T] from the unit*".

- Risk management plan: Mr T was given seven days' worth of medication and was made aware that he could obtain further medication from his GP. Louth crisis and home treatment team had been informed and they planned to contact Mr T to ask him to attend their unit the following Monday for his seven-day follow-up appointment. The community mental health team had also been informed and it was noted that they planned to continue input with Mr T.

4.150 There are a number of diagnoses in the electronic clinical record effective on this date, but entered on 15 December, all with Dr S as the diagnosing clinician:

- Other anxiety disorders, generalised anxiety disorder – primary diagnosis.
- Personal history of self-harm – secondary diagnosis.
- Mental and behavioural disorders due to use of alcohol, dependence syndrome – secondary diagnosis.
- Mental and behavioural disorders due to use of tobacco, harmful use – secondary diagnosis.
- Depressive episode, moderate depressive episode – secondary diagnosis.
- Specific personality disorders, unspecified – secondary diagnosis.

4.151 At about 10:25 Ms S called Lincolnshire Police who stated that the next available officers would attend the ward to escort Mr T off the premises. No information had been recorded regarding why the police were asked to attend.

4.152 Ms S, a ward nurse made an entry between 11:16 and 11:33. Ms S stated that a police officer had attended the ward that morning as planned and that she and a nursing assistant had approached Mr T to inform him that because of the violent incidents towards members of staff on the ward, he was being discharged. Mr T stated he should have leave from the ward prior to being discharged, but staff explained that "he had several opportunities to go on leave" and that he had not cooperated with these. This combined with the "*number of attempts to harm staff*" had resulted in the multi-disciplinary team agreeing that he should be discharged. Mr T was advised that a police officer had arrived to escort him from the premises and ensure he could get home. It appears that staff emptied Mr T's locker and Mr T then packed his belongings. Mr T was given seven days' medication and was advised that he could obtain further medication from his GP. Ms S called Louth crisis and home treatment team and spoke to Ms S3 who stated that Mr T would be asked to attend their base on 15 December for his seven day follow up appointment, because of the risk to staff. Ms S attempted to speak to Ms L at Louth community mental health team but was unable to do so, so Ms S sent Ms L an email asking her to contact the ward as soon as possible and provided an update on the situation. It later transpired that Mr T asked police to drop him off in the centre of Lincoln, rather than take him home, but ward staff were unaware of this at the time.

4.153 On 12 December Ms L received a call from Ms J who stated that Mr T had arrived at her home the previous day asking to stay with her. She had allowed him to stay overnight but he was then refusing to leave. Ms J was unsure what to do because she had her own family and work responsibilities and did not feel she could manage Mr T in her home. Ms L agreed to speak with the crisis and home treatment team and try to come up with a plan. Mr J from the crisis and home treatment team later called Ms J who stated that Mr T was still refusing to leave her home. Ms A had offered to let him stay with her from the following day, but she was not sure whether Mr T would cooperate. Mr T refused to speak to Mr J on the telephone and Ms J was unable to persuade him to do so.

4.154 On 14 December Mr J called Ms J who advised that Mr T would be staying with Ms A on a temporary basis. Contact details for Ms A were provided and noted in the clinical record. Mr J then spoke with Ms A and Mr T. Mr T remained of the view that he was not willing to return to his own home and Ms A said that she was willing to support him "*for the time being*". Mr T agreed to receive follow up support from the community mental health team and the crisis and home treatment team and arranged a visit for the following afternoon.

4.155 On 15 December Ms L spoke with Mr J from the Louth crisis and home treatment team and arranged to visit Mr T at Ms A's home the following day. Ms L noted that she would call Ms A the following day to arrange a suitable time.

4.156 When Ms L called Ms A the following day to arrange a home visit for that day, Ms A explained that she was out with Mr T and that they were then going to visit Ms J that day. However, they would be at home all day the following day. Ms L then spoke with Mr J and they agreed to visit Mr T at Ms A's address two days later. Ms L called Ms A to discuss the plan and Ms A said she and Mr T would be at home and that she was happy with the plan.

4.157 On 18 December Ms L and Mr B from the Louth crisis and home treatment team visited Mr T at his ex-wife's home (Ms A) in Lincoln where he was staying. The notes record that Ms J (Mr T's daughter) was also present, but she is clear that she was not there. Mr T was quiet and low in mood and had a noticeable tremor in his left hand. Ms A explained that she was happy for Mr T to stay with her over Christmas but that he could not stay indefinitely. Ms A also said that she would like Mr T to move closer to Lincoln because she felt he was too isolated in the village and too far away from the family support that she and Ms J could provide. Mr T was asked his view of this and "*all he could say was that he wants to stay with his ex-wife for good*". Staff did not challenge Mr T on this view because his behaviour had escalated when challenged previously. Ms L said that she would ask the housing support officer to support Mr T to find alternative accommodation closer to Lincoln. Mr T had approximately a week's supply of medication and Mr B suggested that he register as a temporary resident with a local GP surgery in order to obtain a repeat prescription whilst staying with Ms A. Staff gave Mr T and Ms A the telephone number for the Lincoln crisis and home treatment team

and Mr B agreed to contact them to make them aware of Mr T and that he would be staying in Lincoln during the Christmas period.

4.158 Mr B later called Lincoln crisis and home treatment team to handover Mr T's care during Christmas. It was noted that staff needed to read the recent clinical history in particular for the alerts relating to Mr T's risks. Following this review, it was noted that home visits should be made by two members of staff. Mr M2 from the Lincoln crisis and home treatment team attempted to call Mr T to arrange a visit, but Mr T did not answer his phone.

4.159 On 21 December two different members of staff attempted to contact Mr T to arrange a home visit. Neither member of staff could get through and they were unable to leave a message.

4.160 On 22 December Ms L3 called Mr T as planned. Mr T reported that things were going okay and that he planned to stay at his ex-wife's over Christmas. Mr T refused to see the crisis and home treatment team "*claiming he was too busy to see*" them over the Christmas period. It is recorded that he denied any risk to himself or others and that he was aware how to access the team as needed. Ms L discussed the situation with "*ACM*" Mr G, and it was agreed it was appropriate to close Mr T to the crisis and home treatment team and accept a self-referral if Mr T made contact over the Christmas or new year period.

4.161 On 26 December Ms K received a call from a nurse at HMP Lincoln asking for information about Mr T. After undertaking the necessary checks to establish the nurse's identity Ms K provided information about Mr T's admission and discharge to both Connolly Ward and Maple Lodge. It was not noted in Mr T's record why Mr T was at HMP Lincoln at this point.

4.162 On 29 December Ms L received a telephone call from Ms J, who was "*very angry*" and wanted to know how staff could have thought it was acceptable to leave Mr T at his ex-wife's house over Christmas. Ms L expressed her condolences and advised Ms J that an investigation would take place and that Ms L could therefore not comment on the case. Ms L called Louth crisis and home treatment team to make them aware of Ms J's contact and was advised to inform the complaints department. When Ms L contacted the complaints department she was advised to put the information in an email and to complete an incident form.

5 Internal investigation

5.1 The Trust commissioned both an internal investigation and a specialist serious incident report. We deal with each of these reports separately.

Terms of reference and process

5.2 The Trust commissioned an internal investigation that was chaired by a Non-Executive Director. There were two other panel members: a consultant psychiatrist for adult services; and a head of service for older adult services.

5.3 The investigation focussed on the period of care from 27 July to 23 December 2014.

5.4 The internal report states that the Trust was contacted by the police on 23 December advising that Mr T had been questioned in connection with the death of his grandson. However, we are not able to find this information within Mr T's clinical records, so we are unclear how this information was obtained by the internal review team.

5.5 It is clear that ward staff were aware of Alex's death as early as 26 December, at the point when ward staff were contacted by healthcare staff at HMP Lincoln. However, it appears that it was not until Ms J contacted the community mental health team staff on 29 December that an incident form was completed. And then, only after the social worker had contacted the complaints team. See our Recommendation 1.

5.6 It is unclear when the investigation was commissioned, however we can see that a representative of the panel met with Ms J and Ms A on 27 April 2015. The purpose of that meeting was to provide the family with the opportunity to put forward their views and concerns in relation to the incident. The internal report notes that the questions and concerns raised during the meeting were incorporated into the Terms of Reference that were:

Table 1 - Internal investigation terms of reference and family concerns

Terms of reference and family concerns	
1	Whether medication and prescribing practice and monitoring was appropriate. Associated concerns from family: • Why were Mr T's medications not looked into during his period of admission? (Mr T was only supplied with about a week) • Mr T was only supplied with about a week's worth of medication on his release, which was not enough to last him over the Christmas period. • There was a failure to ensure Mr T had access to medication following discharge which left him and his family extremely vulnerable.

Terms of reference and family concerns	
2	Whether the risk assessments of the service user were timely, appropriate and following by appropriate action. Associated concerns from family: • Ms A reports that staff was [sic] apparently so concerned about Mr T's potential for violence that they advised her not to travel in the same vehicle as Mr T, for fears for her personal safety. • Mr T was released from hospital when clearly unwell, against the advice of the family, and with no effective aftercare in place. • The family was so concerned that they expressly told mental health staff "if you let him out now, he will do something dramatic". • The family's concerns were not taken seriously and a doctor just told them "We'll cross that bridge when we come to it". o This was a clear abdication of the Trust's responsibilities of care, both to Mr T and to Ms A and Ms J, and left the family and their young children extremely vulnerable. • When Mr T was released, completely unable to cope, he turned for help to Ms A and Ms J (who had two young children) – this was a totally foreseeable outcome. • The family reports they had extreme difficulty in getting any information about Mr T's care. • They contacted the Peter Hodgkinson Centre initially; no information was given to them about his release.
3	Whether the delivery, monitoring and review of care plans including standards of documentation and comprehensive records were adequate. Associated concerns from family: • There was a failure to plan and coordinate aftercare, which left Mr T and his family extremely vulnerable. • The family report they had extreme difficulty getting any information about Mr T's care. • The family say that it was only after Mr T began to acknowledge the family's presence at care meetings that his discharge was planned without any consultation with them. • There appeared to be an expectation that the family were capable and willing to look after a seriously sick patient, although no discussion or assessment took place about their capacity or willingness to do so.

Terms of reference and family concerns	
4	Whether the liaison and communication between different health professionals and agencies involved in the care of the service users were adequate, including adequacy of transfer/discharge. Associated concerns from family: • The family was not consulted, or informed, of Mr T's release/discharge. • The family reports that they had extreme difficulty in getting any information about Mr T's care. • Mr T was discharged from hospital with limited medication when he was seriously unwell and extremely disoriented, with the expectation he could get himself back to his flat, some two hours, and two bus rides away. • There was a failure to plan and coordinate aftercare, which left Mr T and his family extremely vulnerable.
5	What management and supervision arrangements were in place and whether any issues were raised in relation to the care and treatment in this incident.
6	To identify any safeguarding issues (e.g. neglect or organisational abuse). Associated concerns from family: • Repeated, clear, official guidance around safeguarding of children and vulnerable people appears to have been completely ignored by MH staff responsible for Mr T's care and aftercare, which placed the family in an extremely vulnerable position. • The family was so concerned that they expressly told mental health staff "if you let him out now, he will do something dramatic." • The family's concerns were not taken seriously and a doctor just told them "We'll cross that bridge when we come to it." • This was a clear abdication of the Trust's responsibilities of care, both to Mr T and to PW and PD, and left the family and their young children extremely vulnerable.

5.7 Ms J and Ms A had made a request to see the draft report before it was finalised. Although the Trust agreed it in principle, it was noted that the Trust solicitor would have to agree because of the ongoing criminal proceedings.

5.8 The internal investigation panel interviewed 14 members of staff from the community team in Louth and inpatient staff from Connolly ward. Staff were informed that they could bring someone with them to provide personal support. All interviews were recorded, and a copy was provided to everyone who was interviewed.

5.9 The internal report was not signed off until September 2015.

Findings

5.10 The investigation identified ten findings that were presented in a way that clearly linked them to the relevant item in the terms of reference. The findings are presented in the executive summary and main body of the report,

however some of the findings are worded differently. The findings we have represented below were taken from the executive summary.

Table 2 - Findings from internal investigation

Finding	
1a	That there was a breakdown in the process of medication review by LPFT following a change in availability of Mr T's medication regime and that a required Consultant outpatient appointment (by CP2) for the purpose of medication review that never occurred. That due to the resultant change in medication regime that this omission potentially contributed to a decline in Mr T's clinical presentation and the onset of the clinical episode which led to the care-episode under investigation. Further, that at the point of admission that LPFT details of Mr T's current anti-depressant medication regime were inaccurate, resulting in Mr T not being prescribed and/or receiving the current prescribed dosage.
1b	That the review and management of Mr T's antidepressant medication whilst an in-patient did not reflect the diagnosis of severe depression identified pre-admission. Further, that the diagnosis of severe depression/depressive state was not considered/accepted as clinically valid by the in-patient team. That the recommendation to review Mr T's medication based on this diagnosis was not sufficiently followed through by the ward team(s) and that no suitable rationale was provided with regards this decision in relation to either the expressed concerns of both the patient (Mr T) and family [Ms J and Ms A] or the presenting clinical state as documented in the clinical noting. That this omission could have contributed to the on-going noted clinical presentation and further LPFT staff-related incidents associated with Mr T's view that his views with regards his treatment were not being taken account of.
2a	That the framework, process and content of risk-assessment did not sufficiently or accurately reflect the actual presenting needs and/or risks. That as a consequence key triggers and opportunities for more detailed and specialist assessment were missed and that the shortfalls in the quality of content/formulation of risk were perpetuated down through the care-pathway. These shortfalls in-turn appeared to impact upon the quality and accuracy of associated care-planning, inter-service communication, liaison and service-provision access and engagement decisions. Further, that they also appeared to undermine informed and accurate clinical decision-making processes and potentially contributed to triggers and opportunities for on-ward referral (for specialist and/or multi-agency engagement and risk assessment) that could potentially have provided beneficial clinical input and overview into Mr T's care-pathway. That a practice of descriptive and non-collaborative risk assessment processes undermined the quality and content of risk-assessment used to inform clinical decision-making particularly within Conolly ward and to a lesser degree within Maple Lodge at this period in time. That the core skills and professional competencies required to support comprehensive clinical decision making and deliver evidence-based practice were not broadly demonstrated within these settings at the time under review.

Finding	
3a	That whilst Mr T was registered as being under CPA the care and treatment provided to Mr T during his in-patient care was not aligned to or consistent with the requirements of the CPA process. That there was an inconsistent view/uncertainty within the in-patient and community care teams as to whether Mr T was under CPA or not. Whilst no firm conclusions could be drawn, that this lack of clarity/uncertainty potentially impacted upon the quality of assessment, review and care-coordinator allocation at point of discharge. That there was a clear disconnect in the status of CPA application between acute and rehabilitation in-patient care.
3b	Whilst a named nurse model/ethos is present within Conolly ward, the standards of practice and process appeared to be inconsistent and failed to provide the continuity of care required of the role (as either lead professional if non-CPA or care-coordinator if CPA). That as a possible consequence, clear processes or responsibility for coordinating, reviewing and progressing patient assessment and care planning were absent. Further, that the CPA standards relating to/required for these processes did not appear to have been met. That collaborative care planning and timely review was not evident and that a current and relevant single plan clearly aligned to clinical need was absent.
3c	That there was a clear absence of robust and coordinated processes to support the provision of quality nursing information into/to inform the Multi-Disciplinary Team (MDT) patient reviews process. That as a consequence information presented in the MDT did not accurately reflect events, incidents and aspects of clinical presentation clearly recorded and identified in the clinical records. That the absence of a clear and organised system of allocation and associated clarity of responsibility undermined the quality of patient information presented which in turn undermined the review and clinical decision-making process within the MDT setting.
4a	That there was a clear and significant breakdown in communication within and between the treating/ward team members in relation to the decision to discharge Mr T and associated care requirements to ensure a safe discharge for Mr T. Herein, that documented and agreed plans/decisions with regards Mr T's discharge plan and support requirements made by the RC-led MDT were over-ridden/not considered at the point of actual discharge. That there was a clear failure to engage and/or inform either Mr T or his family with regards the decision to discharge and that the risks associated with these omissions were not considered or acted upon as required (see Finding 2a). That there were clear and repeated inconsistencies in the stated lines of decision making and accountability with regards the authorisation of Mr T's discharge. That there were inconsistencies and uncertainties with regards who was the accountable Responsible Clinician (RC) for both Mr T and the broader ward in the period leading up to and at the actual point of Mr T's discharge.

Finding	
4b	That there was a breakdown in both the quality and process of liaison and communication within and between services at key decision and transition points of Mr T's care; that fell short of those set out in Trust policy & procedure standards. That issues with patient CPA status and the quality of risk and care assessment/information (as per Findings 2a, 3a, 6a) potentially undermined the processes of liaison and engagement between services. That there was an absence of clear line-management/hierarchical checks and measures in terms of key clinical decisions at clinical team level. That due to these shortfalls potential opportunities for re-assessment were missed (with particular reference to the admission to the 136 suite) and that as a consequence, opportunities for on-ward referral for specialist and/or multi-agency engagement and review that may have altered Mr T's care pathway were missed. That Mr T's family were neither sufficiently included, communicated with and/or supported at points of service transition and especially at the point of discharge and that as a consequence plans and service actions taken to support and monitor the discharge process were not optimally informed.
5a	The panel identified an overarching issue of a lack of clear and visible clinical team level managerial leadership, support and hierarchy in terms of both core and key decision-making processes and clinical pathways. That these impacted upon the broader processes and quality of staff and clinical service performance in relation to Mr T's assessment and decision management within his care-pathway. Herein, it is the panels opinion that the shortfall of effective and robust management overview and supervision of service quality and decision-making processes contributed in-part to the impact of un-checked shortfalls seen to be compounded through Mr T's care-pathway (e.g. risk assessment, care-plan, CPA status etc.). **Note:** The majority of the individual recommendations associated with Standard 5 are included in the body of the other findings and recommendations and will not be repeated herein.
6a	The panel identified clear failings with regards to the standards and requirements of LPFT's Safeguarding Policy & Procedures (Policy 11), with specific reference to procedures and responsibilities for Safeguarding Children on both a ward-team and individual basis. That triggers and associated opportunities to review the levels of risk presenting were not taken at both an individual and team level and that as a consequence associated safeguarding processes, line-management escalation, or consulting with the Trust's Safeguarding Team as per the Safeguarding policy were not undertaken and associated opportunities for escalation for multi-agency engagement and review were missed. *Due to the nature of the issues there is considerable overlap with the issues of Finding 2a – risk assessment (please also refer to and cross-reference with this section for broader context).

5.11 The report stated that none of the findings could be individually identified as the root cause of the incident.

Recommendations

5.12 The internal investigation made 37 recommendations. Nearly all the recommendations had a focus on the practice and performance of individual members of staff. The analysis in our view failed to consider the organisational or system factors that might have contributed to the behaviour of staff.

5.13 The recommendations are presented in different ways. In the executive summary they are presented in themes but in the main body of the report they are listed individually. The recommendations we have represented below have been taken from section 11 of the main body of the report.

Table 3 - Recommendations from internal investigation

Recommendations	
1	A review of the Fast Track protocol and process to ensure that its triggers and response cascades to patient and/or GP contact are robust and that they allow effective return to service, with the inclusion of controls and safeguards to ensure that medication reviews are undertaken in a timely manner (see also recommendation 5).
2	That within the Fast Track process the service should develop a protocol that supports the provision of timely access for Consultant telephone advice in relation to medication-based/prescribing enquiries.
3	That all in-patient staff confirms their awareness of the requirements of the Trusts Assessment and Care Planning policy, that plans or statements of care or 'treatment' must be created collaboratively with the service user and derived from an appropriate assessment process. Further, that all reviews of treatment and care plans must give the service user the opportunity for full involvement and that where service and service-user treatment statements/decisions are not aligned that a clear clinical rationale is recorded within the MDT record.
4	That an audit of MDT review process/entries is undertaken within 2 months of the report to ensure that the following standards are met. • Clinical rationale recorded in cases of where there is a non-alignment of service and service-user care and treatment indicators and associated treatment. • Clear inclusion of formal review of medications.
5	That the review of Fast Track discharge process (see also Finding 1) ensures that a process is in place for service users, who are discharged under fast track, and return directly to acute/in-patient services are reviewed for care-coordinator/lead professional allocation to support the in-patient episode (and provide pre-admission continuity of care). [Ensuring that patients return to the same care team wherever possible.]
6	That the role and/or processes of routine pharmacist review and/or presence in relationship to review of patient medications at point of assessment and thence within the clinical MDT decision making process be reviewed.

Recommendations	
7	That at the point of transfer from community to in-patient care there needs to be explicit evidence in the clinical notes with regards cross-team discussions/agreement of: • The clinical reason and objectives for/of the admission • Confirmation of robust confirmation of current medication regime • Where a differing clinical opinion with regards the patient's admission needs/condition/objectives is present that a cross-service discussion/review occurs to agree upon the care-plan.
8	It is Trust policy that all staff must review current risk assessment documentation and update whenever there is a change to risk level or circumstances. That the in-patient Consultant(s), Team Leader(s), CRHT Team-leader and the Ward Managers (Conolly Ward and Maple Lodge) ensure, through management supervision, that all staff fully understand and meet the required standards to continuously review and update risk assessments in line with Trust policy and best practice.
9	That a detailed quality impact review and action with regards of risk assessment process and quality is carried out within 2 months of this report. That they work collaboratively with the ward team to develop and action plan addressing the identified issues, and that this is clearly linked to the embedding and delivery of risk assessment within the Trusts new risk formulation risk assessment framework (see also recommendation 14).
10	At present the Trust process for MAPPA referral and access do not appear to be universally known, understood and/or embedded across services. The recommendation of the panel is that the alignment and management of the MAPPA process be reviewed to see how it can be better embedded as a cross-organisational issue to improve service awareness, access and use.
11	That performance and conduct/practice issues related to the quality of/response to and/or failure to follow required risk processes, pathways and actual incidents be considered through performance management and/or disciplinary process.
12	That risk assessment should be MDT/Responsible Clinician led. For the Ward Consultants, Team Leader and Ward Manager to ensure that appropriate forums for discussing clinical risk such as Ward MDTs and CPA Reviews take account of the perspectives of all relevant parties (including patient/family/carers). Further, that a shared understanding and formulation of risk is explicitly recorded and clearly disseminated through MDT discussions.
13	That Trust policy, with regards the standards of Clinical Risk Screening (section 10.5 of the Clinical Care Policy) and Reviewing Clinical Risk Assessment (section 10.8 of the Clinical Care Policy) be reviewed and amended to ensure that service specific review of risk must occur at the key transition points of transfer and discharge and from services (with particular reference to transition between in-patient and community services). Further, that all in-patient and community staff confirm their awareness of this aspect of the amended policy.

Recommendations	
14	For the Consultant(s), Team Leader, Ward Manager and identified Risk Champion for Conolly Ward to engage fully in the roll out of the Trusts new Clinical Risk programme* and associated 2015/16 CQUIN. That: All clinical staff on the ward are trained and supported to adopt the new processes and ways of thinking about risk assessment New processes for recording clinical risk assessment formulation are implemented and embedded fully into practice on the ward Staff are skilled to record and use all the available information to support clinical decision making at key points on the patient journey e.g. sending someone on leave/ discharge. Staff are trained to use an explicit five P's approach to risk formulation which would support a clinical analysis and formulation of the patient and support decision making Team Consultant, Leader/Ward Manager ensure a process of local monitoring of the quality of risk assessment processes is implemented through the management supervision of those acting as named nurses.
15	It is evident that care-coordination of Mr T's care was not present in line with the CPA and Trust policy. To this end it is the recommendation of the panel that conduct and/or performance issues with regards staff who did not follow Trust policy in relation to CPA standards be considered through performance management and/or disciplinary process.
16	That the Trust Policy for Assessment and Care Planning (including CPA) should be re-issued with a lessons learnt report requiring all in-patient staff to confirm their awareness of the policy requirements and standards and associated clinical systems requirements of CPA status allocation and review, and that all admissions to secondary care in-patient services be under CPA.
17	That the ward Consultants/doctors, Team Leader and ward manager ensure that all relevant ward staff are compliant with CPA training and have a clear understanding of the application of the CPA process including; • Clinical decision making around CPA classification & recording a clinical rationale • Recording processes for CPA/non-CPA • Responsibilities of the named nurse & CPA • Patient involvement • Reviews & Transfers of care
18	That patients deemed to be of a level of complexity to be accepted/admitted into acute care should have their care assessed, reviewed and delivered within a framework that reflects the level of complexity and provides safeguards to ensure comprehensive and holistic assessment of sufficient standard to identify complex issues and risks. For the assessment pathways in acute care wards to include the use of validated/standardised condition specific formal assessments to support clinical opinion (see also Recommendation 24).

Recommendations	
19	That ward Consultant(s)/doctors, and manager(s) assure that a robust process of recording multi-disciplinary meetings, including ward rounds and CPA Reviews, is embedded in ward processes. That these processes ensure that information is clearly recorded and completed in line with Trust policy to clearly evidence the clinical decision making of the MDT. That the templates developed to support these processes are standardised and supported by Silverlink.
20	That the process and function of the Named Nurse system/model as applied within an acute MH ward setting is reviewed against alternative individual and team nursing models with a view to determining and implementing best practice/based on National Bench Marking evidence.
21	That the Team Leader, ward manager and Modern Matron ensure a process of local monitoring of the quality of assessment and care planning process is implemented and recorded through the management supervision of those staff acting as named nurses – or alternate model if decided (see Recommendation 20).
22	That performance issues related to the management, monitoring and completion and quality of required assessment and care-planning standards in accordance with identified Trust Policies be considered through performance management and/or disciplinary process.
23	That a review of the process and protocol of MDT ward review is undertaken to better enable earlier identification of patients for review so as to better support the attendance and engagement of significant and required external parties. That an audit/review is undertaken within 2 months of the report to ensure that the following standards are met (see also Recommendation 4).
24	That the Acute Service Medical & Management Team review and develop a clear and robust ward-review pathway/protocol/process that aligns with the named nurse model utilised to support clinical continuity. That the quality and content of information sources/assessments required for and presented within the ward review in order to support safe and effective clinical decision making are reviewed and that the evidence base of clinical decisions is clearly evident in ward-review summaries (see also Recommendation 18). As per Recommendation 18 this needs to include/be supported by empirical data/formal assessment outcomes specific to the presenting clinical diagnosis and associated need.
25	The named consultant responsible for a patient's care should be clearly identified and known to the patient and ward staff at any given time – this would include AL cover, locum cover and at points of staff exit and/or transfer of care.
26	That the professional/medical leave policy and process for the arrangement and agreement of leave is reviewed and formalised. That the formalised process/policy is broadly disseminated down all management and clinical lines.
27	That the medical cover arrangements for Conolly Ward are reviewed and the required levels of robust cover required to maintain safe practice/Trust standards is in place at all times.

Recommendations	
28	That practice and performance issues related to management, monitoring and undertaking of discharge and liaison standards in accordance with both best-practice and Trust Policy be considered through performance management and/or disciplinary process.
29	That all in-patients (at the point of admission) are classified as falling under CPA status and associated processes. That for an in-patient to be re-classified as non-CPA that they have to undergo assessment and review, within the CPA-review format.
30	That the care-pathway and associated referral and transfer pathway requirements and standards between LPFT Acute and Rehabilitation services be reviewed and that all patients transferred from acute services to rehabilitation services must have an appropriate clinical assessment prior to transfer. That service medical and management be assured that the agreed standards are being implemented and actively reviewed and that breaches of the agreed standards are reported and reviewed.
31	That the care/referral pathway between Acute care and ICMHT is reviewed to ensure that a robust and standardised process is in place and fully embedded within operational/clinical practice; with particular reference to patients not under care-coordination/ICMHT at the point of admission and/or not meeting the requirements of CPA care at the point of pre-discharge planning.
32	That the LPFT Clinical Care Policy sections 11 (Discharge/Transfer Procedure) and section 9.11 (Timescales and Transfer to/from CPA) be reviewed and that additional text is added to ensure that the duties of the employee at points of internal discharge/transfer includes an explicit requirement for a detailed verbal handover supported by a written document.
33	That section 7.8 of the LPFT Clinical Care Policy (Admission Procedures) be extended to make explicit reference to the requirements of a detailed verbal and written summary by the admitting team including the agreed clinical reason and objectives for/of the admission (see also Recommendation 7).
34	That the Community Mental Health Team (CMHT) Operational Policy is reviewed and revised to: • To ensure that it fully aligns to the LPFT Clinical Care Policy (with particular regards to recommended amendments within this report) • Clearly identify the service eligibility criteria and access requirements/referral processes • That the referral process and routes for internal referral from in-patient services is clearly agreed and stated in section 3.0 of the CMHT Policy (Access to the Service) and that the role of ICMHT representative as ward MDT's is clarified (i.e. is direct referral accepted or do all referrals require a formal ICMHT referral form) • That the ICMHT referral form is included in the CMHT Policy • That information on the interface with in-patient services is added to section 7.0 (Service Interfaces) of the CMHT Policy • Ensure these are broadly and robustly agreed and disseminated between in-patient and community services.

Recommendations	
35	Given the issues identified around overall coordination, review and management of the patient care and management processes (i.e. CPA, named nurse, discharge & transfer, MDT) the service should look to appoint a substantive ward manager as soon as possible, in order to provide a strong, visible and stable leadership and management presence.
36	Robust Safeguarding pathways and processes are already in place within LPFT but were not followed by the staff as identified in this report. Therefore, that performance issues related to the management, monitoring and completion and quality of required Safeguarding standards in accordance with identified Trust Policy be considered through performance management and/or disciplinary process.
37	That the ward(s) medical and management team ensure that all staff are up to date with their safeguarding mandatory training requirements and that all staff are aware of and have read the Trust safeguarding policy.

5.14 The consequence of recommendations being presented differently in the same report is that it leaves readers open to place their own interpretation of the content. There is no clear correlation between the recommendations in the two different formats and it leaves readers unclear about which set of recommendations should flow through to the action plan.

5.15 National Patient Safety Agency guidance indicates that recommendations should:

- be clearly linked to identified root cause(s) or key learning point(s) (to address the problems rather than the symptoms).
- address all of the root causes and key learning points.
- be designed to significantly reduce the likelihood of recurrence and/or severity of outcome.
- be clear and concise and kept to a minimum wherever possible.
- be Specific, Measurable, Achievable, Realistic and Timed (SMART) so that changes and improvements can be evaluated.
- be prioritised wherever possible.
- be categorised as:
- those specific to the area where the incident happened.
- those that are common only to the organisation involved.
- those that are universal to all and, as such, have national significance.

5.16 The internal report is written in a way that is challenging for a lay person to follow. It does not use plain English and as such the author(s) has (have) not

considered how the report would be received and digested by family members.

5.17 The first paragraph of the executive summary contains inaccurate information about when Mr T arrived at his daughter's home. Whilst this detail has no impact on the findings it is nevertheless an incorrect statement and one that Alex's family has indicated rankles with them.

5.18 The format of the report was set out by the Trust (rather than it being the investigation team's choice) and we were told that the investigation team found the format difficult to follow. We understand that the Trust has changed the format of serious incident reports since 2015.

5.19 However, we strongly recommend that the Trust assures itself that the language and format of internal reports are fit for purpose for families whilst also identifying learning. If a lay person can understand the content, then so can a member of staff. See Recommendation 2.

Clinical commissioning group oversight

5.20 The clinical commissioning group has provided us with extracts of minutes from two meetings when this incident was discussed.

5.21 The first meeting was 11 November 2015 when a review of the incident investigation report took place and it was noted that there were many issues noted about the Trust within the report. It was agreed to support the formal request to suspend the investigation pending the outcome of the court hearing the following month.

5.22 On 8 December it appears that the meeting reviewed an executive summary of the incident report and that no root cause had been identified. It was agreed to keep the incident open pending the outcome of the inquest.

6 Action plan

6.1 In developing the action plan to respond to the recommendations the Trust has used the recommendations as they were set out in the executive summary of the internal investigation report. There is therefore a risk that some of the intent has been lost.

6.2 There are nine recommendations listed in the action plan and the Trust has advised that the associated actions deal with the detailed recommendations as set out in Table 4 below.

Table 4 - Alignment of specific recommendations against themes

Action plan recommendation	Recommendations from main body of report
1 Fast track protocol There is a thorough review of the Fast Track Protocol and process to include: - Ensuring trigger and response cascades are robust - Allowing effective return to service for service users - Adequate controls and safeguards to ensure medication reviews are undertaken as required - A provision for timely access to consultant advice - A process for identifying a care coordinator (lead professional), for previously discharged service users returning under fast track going directly into acute/in- patient services.	1, 2, 5
2 Risk assessment and procedure i. For the ward consultant, team leader, ward manager and identified risk champion for Conolly Ward to fully engage in the roll out of the Trust's new clinical risk assessment training programme and associated CQUIN. ii. In-patient consultants, team leaders, the CRHT leaders and ward managers of Conolly and Maple Lodge ensure, through management supervision, that all staff fully understand and meet the required standards of the new Trust Clinical Risk Assessment Protocol. iii. For ward consultants, team leaders and ward manager to ensure appropriate forums for discussing clinical risk, such as ward MDTs and CPA reviews, take account of perspectives of all relevant parties: patient, family, carers. There needs to be a shared understanding of formulation of risk, explicitly recorded and disseminated. iv. For these teams there is a detailed quality impact review of the new risk assessment process within 2 months of this report. Ensuring key issues and actions are completed and the new procedure fully embedded.	3, 4, 8, 9, 12, 13, 14, 15, 19, 23, 24, 35
3 Care pathway, treatment, care plans i. The acute service medical and management team review and develop a clear and robust ward review pathway/protocol/process, aligned with the named nurse model. The quality and content of the information presented must: - Support safe and effective clinical decision making - Be clearly documented in the clinical record	7, 17, 18, 30, 31, 32

Action plan recommendation	Recommendations from main body of report
- Include/be supported by empirical data/formal assessment outcomes, specific to clinical need - Reflect the level of clinical complexity at presentation, using standardised condition specific assessments when indicated - Record a clear clinical rationale where service user statements/decisions are not aligned to their care plan ii. That at service transition points, there is clear evidence in the clinical notes with regards to cross team discussion/agreement. Specifically: - At admission - At transfer to rehabilitation services - At discharge to CMHTs to include reasons for admission/discharge/transfer, and differing clinical opinions. iii. That all patients, at admission, are classified as requiring CPA and associated processes. To be reclassified as non-CPA a formal review must be undertaken. iv. That the full care pathways between Trust acute, rehabilitation and CMHT are fully reviewed. Specifically: - All patients are clinically assessed prior to transfer - Service and medical management to be assured that stated standards are being met.	
4 Staff management i. That the named nurse model, as applied to acute MH ward setting is reviewed against alternative current best practice nursing models based on national benchmarking evidence. ii. A named consultant responsible for a patient's care should be clearly identified and known to the patient and ward staff at all times. To include annual leave and locum cover, and points of transfer. iii. That the professional/medical leave policy and process is reviewed, formalised and disseminated through all management and clinical lines; and that medical cover arrangements on Conolly Ward are reviewed and the required levels of cover provided to maintain safe practice, at all times.	20, 24, 25, 26, 27

Action plan recommendation	Recommendations from main body of report
iv. For Conolly Ward to have a substantive ward manager appointed as soon as possible, to provide strong, visible and stable leadership and management presence.	
5 Performance management Formal performance management and/or disciplinary processes should be considered in issues relating to failures in the following domains: - Clinical risk assessment processes - Trust policy in relation to CPA standards - Discharge and liaison standards - Safeguarding pathways and processes	11, 15, 22, 28, 36
6 Ensuring performance compliance (audit, monitoring and supervision) i. That ward consultants, team leader and ward manager ensure all staff are compliant with CPA training. ii. Team leader, ward manager and medical manager ensure a process for monitoring the quality of assessment and care planning is recorded through management supervision of named nurses (or equivalent). iii. That there is an audit of MDT review entries within 2 months of this report to ensure standards are met, specifically: • Clinical rational recorded where there is non-alignment between service user and care plan • Inclusion of formal reviews of medication iv. There is a review of the MDT ward review process to ensure earlier identification of service users for review, to better support full attendance and engagement of external parties. This review is audited after 2 months of this report to ensure issue is addressed.	4, 12, 13, 15, 16, 17, 19, 21, 23, 24, 29, 30
7 Raising policy awareness i. All in-patient staff confirm their awareness of the requirements of the Trust's Assessment and Care Planning Policy and, specifically: • Care plans are created collaboratively • Care plans are derived from appropriate assessments. ii. The full MAPPA process to be reviewed and embedded to improve service awareness, access and use. iii. That the Trust's policy for Assessment and Care Planning (including CPA) is re-issued in	3, 10, 16, 36, 37

Action plan recommendation	Recommendations from main body of report
a lessons to be learned learnt report across the Trust. iv. Ward consultants/doctors and ward managers ensure that recording of MDT meetings, including ward rounds and CPA review, is done in line with Trust policy. v. All ward staff are up to date with mandatory safeguarding policy.	
8 Amendments to policy The following Trust policies are reviewed: - **Clinical Care Policy** (5.11) discharge/transfer procedure (7.8) admission procedures (9.11) timescales for CPA transfer (10.5) clinical risk screening (10.8) reviewing clinical risk assessment to ensure service specific review of risk occurs at key transition points. All in-patient and community staff to confirm their awareness of the amended policy. - **CMHT Operational Policy** is reviewed and revised to ensure: • Alignment with Clinical Care Policy • Service eligibility criteria for teams are clear • Internal referral processes and routes are agreed and stated • The ICMHT referral form is included in the policy • Information on service interface is added – section 7 • These are agreed and disseminated between all in-patient and community services	8, 13, 32, 33, 34
9 Pharmacy/medical advice The role of routine pharmacist in relation to MDT decision-making is reviewed.	6

6.3 We asked the Trust to provide us with evidence of completion of the action plan. We asked them to provide evidence for each of the 37 recommendations and also evidence that impact had been effective. We have themed our evidence in accordance with the themes used in the executive summary of the internal report and the action plan.

Analysis of implementation of fast track protocol recommendations

Trust recommendations 1, 2 and 5	
1	A review of the Fast Track protocol and process to ensure that its triggers and response cascades to patient and/or GP contact are robust and that they allow effective return to service, with the inclusion of controls and safeguards to ensure that medication reviews are undertaken in a timely manner (see also recommendation 5).
2	That within the Fast Track process the service should develop a protocol that supports the provision of timely access for Consultant telephone advice in relation to medication-based/prescribing enquiries.
5	That the review of Fast Track discharge process (see also Finding 1) ensures that a process is in place for service users, who are discharged under fast track, and return directly to acute/in-patient services are reviewed for care-coordinator/lead professional allocation to support the in-patient episode (and provide pre-admission continuity of care).

6.4 The Trust has advised that the Fast Track Protocol was reviewed by a task and finish group in 2016 and that the revised protocol was implemented in early 2017.

6.5 The new protocol states that fast track is designed to provide a safety net for clients who have been discharged from the caseload of community mental health teams. The safety net is in the form of quicker access to community mental health team functions via self-referral or referral by a relative/carer, rather than requiring re-referral from another health professional. The self-referral route can be arranged for up to one year and prior to discharge the process and timeframe is agreed with the client. It is however unclear how staff know whether a client is entitled to access services via a fast track route.

6.6 Telephone or face to face advice can be provided under the protocol. Telephone advice is usually provided by the duty worker for the relevant team. However, if the enquiry relates to a medication issue that cannot be dealt with by a GP, the protocol states that the duty worker should discuss the issue with the team psychiatrist and liaise directly with the client and/or their GP within two working days.

6.7 In the event that a client is accepted by the crisis and home treatment team or admitted as an inpatient, the duty worker will arrange an assessment of the client's needs within 48 hours and allocate a care coordinator.

6.8 It is unclear from the evidence provided by the Trust what audits are in place to monitor the compliance or effectiveness of this new protocol. We suggest that the Trust undertakes further work to assure themselves that:

- clients understand what support they are entitled to under this protocol.
- staff are following the protocol when clients or their families/carers attempt to activate the protocol.
- implementation of the protocol improves patient experiences and outcomes.

6.9 We have addressed this issue in our Recommendation 3.

Analysis of completion of risk assessment and procedure recommendations

Trust recommendation 3
That all in-patient staff confirm their awareness of the requirements of the Trusts Assessment and Care Planning policy that plans or statements of care or 'treatment' must be created collaboratively with the service user and derived from an appropriate assessment process. Further, that all reviews of treatment and care plans must give the service user the opportunity for full involvement and that where service and service-user treatment statements/decisions are not aligned that a clear clinical rationale is recorded within the MDT record.

6.10 The Trust has advised that the compliance matrix (the list of required training for different groups of staff and the frequency of updates) has been reviewed. Care Programme Approach, assessment and care planning training is considered an essential skill for key groups of staff, particularly those working as care coordinators, lead professionals and named nurses. Staff should update their training every three years and compliance with this should be monitored through supervision. Central reports on training compliance are run twice a year and reminders sent out to teams with low levels of compliance. The Trust has not indicated what the expected target threshold is nor how low compliance levels have to be before reminders are circulated.

6.11 The Trust has reviewed its audit processes and has moved away from individual team or ward audits to a more trust wide audit that covers a wide range of issues including:

- risk.
- care planning.
- safeguarding.
- records management.
- mental capacity.
- restrictive interventions etc.

6.12 A group of subject specialists undertook this for each division in late 2017. The results will be fed back to the relevant division and via the Trust Patient Safety and Experience Committee.

6.13 From a Care Programme Approach perspective, this audit not only looks at the presence and currency of key components including risk and needs assessment, care planning and review, but also considers more qualitative measures such as evidence of involvement and personalisation.

6.14 We have been provided with a sample audit report[22] and a copy of the audit standards for the Trust[23]. However, neither document has been completed and therefore we are unable to comment upon the outcomes of any audit.

Trust recommendations 4, 19, 23 and 24	
4	That an audit of MDT review process/entries is undertaken within 2 months of the report to ensure that the following standards are met; • Clinical rationale recorded in cases of where there is a non-alignment of service and service-user care and treatment indicators and associated treatment. • Clear inclusion of formal review of medications.
19	That ward Consultant(s)/doctors, and manager(s) assure that a robust process of recording multi-disciplinary meetings, including ward rounds and CPA Reviews, is embedded in ward processes. That these processes ensure that information is clearly recorded and completed in line with Trust policy to clearly evidence the clinical decision making of the MDT. That the templates developed to support these processes are standardised and supported by Silverlink.
23	That a review of the process and protocol of MDT ward review is undertaken to better enable earlier identification of patients for review so as to better support the attendance and engagement of significant and required external parties. That an audit/review is undertaken within two months of the report to ensure that the following standards are met (see also Recommendation 4).
24	That the Acute Service Medical & Management Team review and develop a clear and robust ward-review pathway/protocol/process that aligns with the named nurse model utilised to support clinical continuity. That the quality and content of information sources/assessments required for and presented within the ward review in order to support safe and effective clinical decision making are reviewed and that the evidence base of clinical decisions is clearly evident in ward-review summaries (see also Recommendation 18). As per Recommendation 18 this needs to include/be supported by empirical data/formal assessment outcomes specific to the presenting clinical diagnosis and associated need.

6.15 We have been advised that because the manager in post at the time no longer works for the Trust no evidence has been located to provide assurance that this action was completed within 12 months of the internal report being completed.

6.16 The Trust has stated that the new management structure for inpatient services has ensured that a full review has since been conducted. The output from this was a ward round template[24] that is now used on all three acute admission wards.

6.17 The Trust has provided a copy of the new MDT form as evidence for recommendations 4,19, 23 and 24. However we have not been provided with any evidence that the Trust has sought assurance that use of the revised

[22] *Evidence 24 – clinical governance visit example.doc*

[23] *Evidence 24 – Trust wide audit standards*

[24] *Evidence 25 – MDT blank*

template has addressed the recommendation 4 from the internal report. We suggest that this is done. See our Recommendation 3.

Trust recommendations 8, 13 and 14	
8	It is Trust policy that all staff must review current risk assessment documentation and update whenever there is a change to risk level or circumstances. That the in-patient Consultant(s), Team Leader(s), CRHT Team-leader and the Ward Managers (Conolly Ward and Maple Lodge) ensure, through management supervision, that all staff fully understand and meet the required standards to continuously review and update risk assessments in line with Trust policy and best practice.
13	That Trust policy, with regards the standards of Clinical Risk Screening (section 10.5 of the Clinical Care Policy) and Reviewing Clinical Risk Assessment (section 10.8 of the Clinical Care Policy) be reviewed and amended to ensure that service specific review of risk must occur at the key transition points of transfer and discharge and from services (with particular reference to transition between in-patient and community services). Further, that all in-patient and community staff confirm their awareness of this aspect of the amended policy.
14	For the Consultant(s), Team Leader, Ward Manager and identified Risk Champion for Connolly Ward to engage fully in the roll out of the Trusts new Clinical Risk programme* and associated 2015/16 CQUIN. That: All clinical staff on the ward are trained and supported to adopt the new processes and ways of thinking about risk assessment. New processes for recording clinical risk assessment formulation are implemented and embedded fully into practice on the ward. Staff are skilled to record and use all the available information to support clinical decision making at key points on the patient journey e.g. sending someone on leave/discharge. Staff are trained to use an explicit five P's approach to risk formulation which would support a clinical analysis and formulation of the patient and support decision-making. Team Consultant, Leader/Ward Manager ensure a process of local monitoring of the quality of risk assessment processes is implemented through the management supervision of those acting as named nurses.

6.18 The Trust has provided us with a copy of the presentation used at Care Programme Approach and care coordination training[25]. The stated aims of the training are:

- *"To understand the nature & purpose of the CPA process.*
- *To understand the role of the CPA Care Co-ordinator.*
- *To reflect on current themes & emerging research in assessment & care planning processes."*

6.19 Staff are reminded to review risk assessment and management plans whenever there is a change in a client's level of risk or circumstances.

[25] *Evidence 23 – Care Programme Approach training*

6.20 The training takes staff through four case studies and emphasises the importance of including the client and their family/carer in reviewing their care and treatment. The Trust provides three routes for staff to achieve Care Programme Approach competence:

- attendance at one of the monthly half day sessions (usually recommended for new starters).
- completion of a short Virtual College eLearning as a refresher.
- on site team refresher training from the Trust Team Coordinator for Assessment and Care Planning.

6.21 The Trust is reviewing a number of the different training subject areas, also in the context of the risk training, defensible decision making and Care Programme Approach training, to look at utilising the EQUIP[26] training on which a number of members of staff were recently trained. The Trust has indicated that this would offer a more combined approach, but also support the need to embed more recovery focused and person-centred approaches to care.

6.22 The Trust revised the Clinical Care Policy in 2017 to set out the frequency of risk assessments and reviews. These are minimum intervals and the policy clearly states that they are not limited to these examples:

- upon referral.
- when care is reviewed e.g. ward round, outpatients, Care Programme Approach.
- following any changes in circumstances or risk factors, e.g. serious incidents.
- known high risk times, e.g. post discharge or significant anniversaries.
- when a transition occurs between services (e.g. transfer between teams or professionals such as admission and/or discharge from hospital).

6.23 We have not seen any evidence that the Trust is monitoring the impact of the training. We suggest that the Trust undertakes an assessment of this. See our Recommendation 3.

6.24 The Trust has also provided a copy of the supervision tool used. We can see that this tool addresses the frequency, completeness and quality of risk assessments and concludes with an action plan for any issues that the supervisor has identified.

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[26] EQUIP (Enhancing the quality and purpose of care planning in mental health services). The aim of the programme is to improve service user and carer involvement in care planning in mental health services.

6.25 However, we have not been provided with any evidence that the Trust is monitoring the impact of use of the supervision tool. See our Recommendation 3.

6.26 The revised sections of the Clinical Care Policy (sections 10.5 and 10.8) provide detailed information about what a clinical risk assessment should reference. It also states that a risk management plan should be linked directly to the risk and protective factors. A tiered risk assessment model is described and the importance of involving the client in a clinical risk assessment is emphasised.

6.27 The Trust has also implemented clinical risk framework training[27] and has developed an accompanying guide for staff[28].

6.28 The training started in July 2015 and by the end March 2016 95% (649 of the 685 clinical staff identified as requiring the training) had completed it.

6.29 We can see that staff completed a number of other training sessions, however the evidence we have seen is transactional and does not provide assessment or assurance of the impact or effectiveness. See our Recommendation 3.

Trust recommendation 9	
9	That a detailed quality impact review and action with regards of risk assessment process and quality is carried out within 2 months of this report. That they work collaboratively with the ward team to develop and action plan addressing the identified issues, and that this is clearly linked to the embedding and delivery of risk assessment within the Trusts new risk formulation risk assessment framework (see also recommendation 14).

6.30 The Trust has advised that Recommendation 9 was superseded during 2015-16 because all registered staff were trained in the use of the Trust Clinical Risk and Formulation Framework.

6.31 We are advised that this was supported by the development of a local CQUIN that can provide evidence of the completion of staff training and achievement of the stated outcome: a reduction in the number of serious incidents that identify poor risk assessment as a contributory factor. See our Recommendation 3.

6.32 We have not been provided with the CQUIN information in order to be able to assess the impact of this action.

[27] *Evidence 34 – Clinical risk framework training*

[28] *Evidence 34 – Clinical risk a new way of thinking*

Trust recommendation 12

That risk assessment should be MDT/Responsible Clinician led. For the Ward Consultants, Team Leader and Ward Manager to ensure that appropriate forums for discussing clinical risk such as Ward MDTs and CPA Reviews take account of the perspectives of all relevant parties (including patient/family/carers). Further, that a shared understanding and formulation of risk is explicitly recorded and clearly disseminated through MDT discussions.

6.33 The Trust provided us with a copy of the new MDT form that is being used on at ward round on all wards.

6.34 However, we have not seen any evidence that the Trust has assured itself of the effectiveness of the new form. See our Recommendation 3.

Trust recommendation 15

It is evident that care-coordination of Mr T's care was not present in line with the CPA and Trust policy. To this end it is the recommendation of the panel that conduct and/or performance issues with regards staff who did not follow Trust policy in relation to CPA standards be considered through performance management and/or disciplinary process.

6.35 The Trust has provided us with the following statement:

"It is of note that the management team at the time of the incident made the decision that they would not discipline any members of staff. None of the management team from the time of this incident are still in post within [the Trust]."

6.36 The Trust has also advised us that the new management team ensures that all staff are aware of the expectations of them regarding standards of care and that staff performance is managed accordingly if the need arises. The Trust advised us that performance management is seen as the last resort and supportive interventions are considered and acted upon first.

6.37 The Trust must now assure itself that the new management team is able to demonstrate that all staff performance is being managed accordingly, and that both formal and informal supervision is available to staff at the appropriate time.

6.38 See our Recommendation 3.

Trust recommendation 19

Given the issues identified around overall coordination, review and management of the patient care and management processes (i.e. CPA, named nurse, discharge & transfer, MDT) the service should look to appoint a substantive ward manager as soon as possible, in order to provide a strong, visible and stable leadership and management presence.

6.39 The Trust undertook a divisional restructure in 2015 that resulted in an entirely new senior management team for the adult inpatient division.

6.40 A substantive ward manager was appointed in October 2016 and was allocated a coach/mentor for six months. The Trust has reported that "*this has*

proven to be invaluable" but has not provided any evidence to support this statement nor the basis upon which they are measuring the effectiveness of this approach. See our Recommendation 3.

Analysis of completion of care pathway, treatment and care plans recommendations

Trust recommendation 7

That at the point of transfer from community to in-patient care there needs to be explicit evidence in the clinical notes with regards cross-team discussions/agreement of:

- The clinical reason and objectives for/of the admission
- Confirmation of robust confirmation of current medication regime

Where a differing clinical opinion with regards the patients admission needs/condition/objectives is present that a cross-service discussion/review occurs to agree upon the care-plan.

6.41 The Trust has advised that the current process is for the receiving team to:

- have a verbal handover from the referring team.
- examine clinical care records.
- examine clinical risk.

6.42 We understand that the team is "*working towards a full review after 72 hours to complete a formulation meeting*" and that the referring clinician will be part of this meeting. It is not clear at what point the Trust plans to have this 72-hour review in place, nor whether it will be the process across all inpatient units or just Connolly Ward. See our Recommendation 3.

6.43 The electronic patient record is used to review outpatient appointments, discharge summaries etc if the patient is known to the Trust. The pharmacy team will contact the patient's GP and obtain details of current prescribed medication. If the patient is transferred from another inpatient unit within the Trust then the existing prescription chart will be sent with the patient. This would mean that on transfer between Connolly Ward, Maple Lodge and back to Connolly Ward, the prescription chart would be sent with the patient.

6.44 The Trust has reported not having a formalised process or protocol if teams have different views regarding the appropriateness of admission. We understand that case reviews or a professionals meeting is held to discuss the most appropriate outcome for the patient and that outside of normal working hours the on-call manager has the overall decision.

6.45 It is our view that the absence of a formalised process to deal with clinical differences is not helpful for staff. We suggest that the Trust addresses this issue. See our Recommendation 3.

Trust recommendation 17

That the ward Consultants/doctors, Team Leader and ward manager ensure that all relevant ward staff are compliant with CPA training and have a clear understanding of the application of the CPA process including;

- Clinical decision making around CPA classification & recording a clinical rationale.
- Recording processes for CPA/non CPA.
- Responsibilities of the named nurse & CPA.
- Patient involvement.
- Reviews & Transfers of care.

6.46 The Trust has provided a worksheet[29] that shows that there are 12 members of staff on Connolly Ward that should be compliant with Care Programme Approach training.

6.47 Of these 12 members of staff three (25%) are not up to date with the training. The Trust has advised that at the time of sending the information, two members of staff were "new starters" and one member of staff was about to complete the training.

6.48 All the staff listed are either nurses or the ward manager. It appears that no doctors have completed this training module. We therefore do not consider that the Trust has fully completed this recommendation and suggest that further work is undertaken to ensure that all appropriate staff are trained, in accordance with the recommendation. See our Recommendation 3.

Trust recommendation 18

That patients deemed to be of a level of complexity to be accepted/admitted into acute care should have their care assessed, reviewed and delivered within a framework that reflects the level of complexity and provides safeguards to ensure comprehensive and holistic assessment of sufficient standard to identify complex issues and risks. For the assessment pathways in acute care wards to include the use of validated/standardised condition specific formal assessments to support clinical opinion (see also Recommendation 24).

6.49 The Trust has provided us with links to two online presentations developed by the Clinical Director. These provide information on:

- Adult inpatient care pathway.
- Adult inpatient care journey.

6.50 Whilst these do provide evidence of work being undertaken to ensure that staff have access to information and learning, it does not provide evidence that:

[29] *Evidence 37 – training worksheet*

- the assessment pathways in acute care wards include the use of validated/standardised condition specific formal assessments to support clinical opinion.

- the Trust has assured itself that the impact has been effective.

6.51 See our Recommendation 3.

Trust recommendation 30	
30	That the care-pathway and associated referral and transfer pathway requirements and standards between LPFT Acute and Rehabilitation services be reviewed and that all patients transferred from acute services to rehabilitation services must have an appropriate clinical assessment prior to transfer. That service medical and management be assured that the agreed standards are being implemented and actively reviewed and that breaches of the agreed standards are reported and reviewed.

6.52 The Trust did not provide us with information about the referral and transfer pathway requirements in place in 2014. Neither were we provided with a single document that described the transfer pathway in place now.

6.53 However, the Trust did advise that there is a daily morning meeting to discuss potential referrals for patients needing rehabilitation. Referrals are managed by the bed managers who also attend this meeting.

6.54 Once a patient has been accepted for rehabilitation and a bed becomes available the referring ward will contact the rehabilitation ward to arrange a suitable time to transfer the patient. The referring ward is responsible for organising the patient transport.

6.55 The Trust expects that the referring ward will update clinical risk information to reflect the current circumstances and change of environment and send any relevant Mental Health Act paperwork, informing the Mental Health Act office of the transfer.

6.56 If the patient is not considered to have a need for rehabilitation, then the referring ward is informed, and alternative suggestions are made. It is unclear who takes responsibility for managing a difference of clinical opinion. See our Recommendation 3.

6.57 It is also unclear what action the Trust has taken to ensure that referral and transfer pathway requirements and standards between acute and rehabilitation services have been reviewed, and that all patients transferred from acute services have an appropriate clinical assessment prior to transfer. See our Recommendation 3.

Trust recommendations 31 and 32	
31	That the care/referral pathway between Acute care and ICMHT is reviewed to ensure that a robust and standardised process is in place and fully embedded within operational/clinical practice; with particular reference to patients not under care-coordination/ICMHT at the point of admission and/or not meeting the requirements of CPA care at the point of pre-discharge planning.
32	That the LPFT Clinical Care Policy sections 11 (Discharge/Transfer Procedure) and section 9.11 (Timescales and Transfer to/from CPA) be reviewed and that additional text is added to ensure that the duties of the employee at points of internal discharge/transfer includes an explicit requirement for a detailed verbal handover supported by a written document.

6.58 The Clinical Care Policy[30] has been revised and was provided by the Trust as evidence that this recommendation had been met. The Trust directed us to Section A – Care and treatment, sub section 12, discharge and transfer.

6.59 The policy makes it clear that discharge planning should start at the point of admission to inpatient services and that patients should be fully involved in decisions about care, support and treatment.

6.60 Section 12.6 deals with inpatient discharge, stating:

"A pre-discharge meeting must be organised by the named nurse in liaison with the nominated community based co-ordinator/lead professional. This meeting should include the service user, their relative/carer if appropriate and all members of the multi-disciplinary team involved in the inpatient care as well as the nominated community based care co-ordinator/lead professional. The meeting details should be recorded on the review screens of the Wellbeing Plan so that relevant parties, including the service user/carer to have a copy."

6.61 This section also directs staff to consider eligibility for Section 117 (aftercare) of the Mental Health Act.[31] We believe that this was particularly relevant in Mr T's case because he had been detained for treatment in the 1980's but his ongoing aftercare entitlement does not appear to have been considered by the team.

6.62 The policy provides guidance on actions to take for internal transfers (section 12.7), "*when a service user moves from one [Trust] team or setting to another [Trust] team or setting*". It is stated that the Interface Meeting is the forum for decision making on internal referrals.

[30] *Evidence 9 – Clinical care policy 2016*

[31] *Section 117 of the Mental Health Act - If you have been compulsorily detained for treatment in a psychiatric hospital, any "mental health aftercare" that you may need when you leave hospital should be provided free of charge. This free aftercare is given to try to prevent your condition getting worse and you needing to be re-admitted to hospital. https://www.nhs.uk/conditions/social-care-and-support/mental-health-aftercare/*

6.63 We suggest that the Trust provides itself and its commissioners with the necessary assurances that clinical disputes are being appropriately escalated and managed through this route. See our Recommendation 3.

Analysis of completion of staff management recommendations

Trust recommendations 20, 24, 25, 26 and 27	
20	That the process and function of the Named Nurse system/model as applied within an acute MH ward setting is reviewed against alternative individual and team nursing models with a view to determining and implementing best practice/based on National Bench Marking evidence.
24	That the Acute Service Medical & Management Team review and develop a clear and robust ward-review pathway/protocol/process that aligns with the named nurse model utilised to support clinical continuity. That the quality and content of information sources/assessments required for and presented within the ward review in order to support safe and effective clinical decision making are reviewed and that the evidence base of clinical decisions is clearly evident in ward-review summaries (see also Recommendation 18). As per Recommendation 18 this needs to include/be supported by empirical data/formal assessment outcomes specific to the presenting clinical diagnosis and associated need.
25	The named consultant responsible for a patients care should be clearly identified and known to the patient and ward staff at any given time – this would include AL cover, locum cover and at points of staff exit and/or transfer of care.
26	That the professional/medical leave policy and process for the arrangement and agreement of leave is reviewed and formalised. That the formalised process/policy is broadly disseminated down all management and clinical lines.
27	That the medical cover arrangements for Conolly Ward are reviewed and the required levels of robust cover required to maintain safe-practice/Trust standards is in place at all times.

6.64 The Trust has advised that a named nurse and associate nurse system is now in place and has provided us with an anonymised image of the ward board[32] for 14 November 2017.

6.65 From this information we can see that across ten members of staff, responsible for 20 patients (on this occasion), each member of staff is identified as either the named nurse, associate nurse or 1:1 staff member. Some staff are identified across these three roles on ten or 11 occasions, some are identified as few as three or four times. 12 of the 20 patients have the same nurse identified in two of the three roles.

6.66 On admission each patient is allocated a named nurse and an associate nurse. This information is recorded on the admission template.

6.67 We cannot see any evidence that the Trust has assessed the effectiveness of this change. See our Recommendation 3.

[32] *Evidence 40 – Ward board*

6.68 The Trust has also advised that each ward uses a board to identify which consultant is responsible for each patient.

6.69 Medical staffing for the ward was reviewed during 2015-16 and the output was that there are now two consultants for each ward, in addition to the junior doctor workforce. The Trust has advised that nursing staff have a clear route of escalation to the Clinical Director and Divisional Manager should there be any concerns about medical staffing.

6.70 Consultants have a monthly medical meeting to discuss issues about workforce, divisional development and leave cover.

6.71 We have not been provided with a copy of the medical leave policy in place at the time, or currently. However the Trust has provided us with a statement of the process in place.

6.72 The process for organising cover remains the same, i.e. that the consultant requesting leave has to have identified a consultant colleague who has agreed to provide cover. This continues to be recorded by the medical human resources team when the leave is approved. For annual leave this is an electronic process.

6.73 The same process applies for special leave for work related learning activities or study leave.

6.74 The Trust has indicated that the issue in this incident was that there were different understandings regarding whether leave was taken or agreed (some people believed the leave had been agreed, and others believed it had not been applied for). The new process is designed to ensure that there is no confusion in future.

6.75 If this process is not written into a leave policy we recommend that the Trust rectifies this. See our Recommendation 3.

Performance management

Trust recommendations 11, 15, 22, 28 and 36	
11	That performance and conduct/practice issues related to the quality of/response to and/or failure to follow required risk processes, pathways and actual incidents be considered through performance management and/or disciplinary process.
15	It is evident that care-coordination of Mr T's care was not present in line with the CPA and Trust policy. To this end it is the recommendation of the panel that conduct and/or performance issues with regards staff who did not follow Trust policy in relation to CPA standards be considered through performance management and/or disciplinary process.
22	That performance issues related to the management, monitoring and completion and quality of required assessment and care-planning standards in accordance with identified Trust Policies be considered through performance management and/or disciplinary process.

Trust recommendations 11, 15, 22, 28 and 36	
28	That practice and performance issues related to management, monitoring and undertaking of discharge and liaison standards in accordance with both best-practice and Trust Policy be considered through performance management and/or disciplinary process.
36	Robust Safeguarding pathways and processes are already in place within LPFT but were not followed by the staff as identified in this report. Therefore, that performance issues related to the management, monitoring and completion and quality of required Safeguarding standards in accordance with identified Trust Policy be considered through performance management and/or disciplinary process.

6.76 The Trust has stated:

"It is of note that the management team at the time of the incident made the decision that they would not discipline any members of staff. None of the management team from the time of this incident are still in post within [the Trust]."

6.77 The Trust has advised that the new management team ensures all staff are aware of the expectations regarding standards of care. Staff performance is managed accordingly if the need arises, however this is seen as a last resort and supportive interventions are considered and acted upon first.

6.78 We have not seen any indication that the Trust has sought assurance of the effectiveness of the new management team. See our Recommendation 3.

6.79 We have been provided with a copy of the supervision template and have been advised that clinical notes are examined as part of managerial supervision.

6.80 We have been provided with a copy of the supervision template, but the Trust has not provided us with any evidence of seeking assurance of the effectiveness of this approach. See our Recommendation 3.

Analysis of ensuring performance compliance (audit, monitoring and supervision) recommendations

Trust recommendations 4, 12, 13, 15, 19, 23, and 24	
4	That an audit of MDT review process/entries is undertaken within 2 months of the report to ensure that the following standards are met; • Clinical rationale recorded in cases of where there is a non-alignment of service and service-user care and treatment indicators and associated treatment. • Clear inclusion of formal review of medications.

Trust recommendations 4, 12, 13, 15, 19, 23, and 24	
12	That risk assessment should be MDT/Responsible Clinician led. For the Ward Consultants, Team Leader and Ward Manager to ensure that appropriate forums for discussing clinical risk such as Ward MDTs and CPA Reviews take account of the perspectives of all relevant parties (including patient/family/carers). Further, that a shared understanding and formulation of risk is explicitly recorded and clearly disseminated through MDT discussions.
13	That Trust policy, with regards the standards of Clinical Risk Screening (section 10.5 of the Clinical Care Policy) and Reviewing Clinical Risk Assessment (section 10.8 of the Clinical Care Policy) be reviewed and amended to ensure that service specific review of risk must occur at the key transition points of transfer and discharge and from services (with particular reference to transition between in-patient and community services). Further, that all in-patient and community staff confirm their awareness of this aspect of the amended policy.
15	It is evident that care-coordination of Mr T's care was not present in line with the CPA and Trust policy. To this end it is the recommendation of the panel that conduct and/or performance issues with regards staff who did not follow Trust policy in relation to CPA standards be considered through performance management and/or disciplinary process.
19	That ward Consultant(s)/doctors, and manager(s) assure that a robust process of recording multi-disciplinary meetings, including ward rounds and CPA Reviews, is embedded in ward processes. That these processes ensure that information is clearly recorded and completed in line with Trust policy to clearly evidence the clinical decision making of the MDT. That the templates developed to support these processes are standardised and supported by Silverlink.
23	That a review of the process and protocol of MDT ward review is undertaken to better enable earlier identification of patients for review so as to better support the attendance and engagement of significant and required external parties. That an audit/review is undertaken within 2 months of the report to ensure that the following standards are met (see also Recommendation 4).
24	That the Acute Service Medical & Management Team review and develop a clear and robust ward-review pathway/protocol/process that aligns with the named nurse model utilised to support clinical continuity. That the quality and content of information sources/assessments required for and presented within the ward review in order to support safe and effective clinical decision making are reviewed and that the evidence base of clinical decisions is clearly evident in ward-review summaries (see also Recommendation 18). As per Recommendation 18 this needs to include/be supported by empirical data/formal assessment outcomes specific to the presenting clinical diagnosis and associated need.

6.81 The above recommendations have already been discussed under the section on Risk assessment and procedure. See paragraphs 6.15 to 6.17, 6.18 to 6.29, and 6.33 to 6.34. We will therefore not repeat our analysis here.

Trust recommendation 16
That the Trust Policy for Assessment and Care Planning (including CPA) should be re-issued with a lessons learnt report requiring all in-patient staff to confirm their awareness of the policy requirements and standards and associated clinical systems requirements of CPA status allocation and review, and that all admissions to secondary care in-patient services be under CPA.

6.82 The Trust has advised that learning is communicated through lessons learned bulletins and has provided us with copies of five bulletins from 2015, 2016 and 2017[33].

6.83 We have also seen a Quality Improvement and CQC Visit bulletin that reminds staff that Trust policies, operational protocols, strategies and reports are available on the Trust intranet.

6.84 The Trust provided us with a copy of the presentation given at the safeguarding and mental capacity and risk champions learning event, delivered in response to the findings of the serious case review.

6.85 The presentation covers the safeguarding considerations that staff should have given in this case and discusses the role of MAPPA at length. It is unclear to us whether MAPPA would have been an appropriate route through which to manage Mr T's risk and therefore we are unclear about the reference to it in this context.

Trust recommendations 17 and 30	
17	That the ward Consultants/doctors, Team Leader and ward manager ensure that all relevant ward staff are compliant with CPA training and have a clear understanding of the application of the CPA process including; • Clinical decision making around CPA classification & recording a clinical rationale. • Recording processes for CPA/non-CPA. • Responsibilities of the named nurse & CPA. • Patient involvement. • Reviews & Transfers of care.
30	That the care-pathway and associated referral and transfer pathway requirements and standards between LPFT Acute and Rehabilitation services be reviewed and that all patients transferred from acute services to rehabilitation services must have an appropriate clinical assessment prior to transfer. That service medical and management be assured that the agreed standards are being implemented and actively reviewed and that breaches of the agreed standards are reported and reviewed.

6.86 The above recommendations have already been discussed under the section on care pathway, treatment and care plans (paragraphs 6.46 to 6.48 and 6.52 to 6.56.

Trust recommendation 21
That the Team Leader, ward manager and Modern Matron ensure a process of local monitoring of the quality of assessment and care planning process is implemented and recorded through the management supervision of those staff acting as named nurses – or alternate model if decided (see Recommendation 20).

6.87 The Trust has advised that Connolly Ward completes weekly nursing care audits to ensure that patients have person centred care plans that are written

[33] *Evidence 16 – Learning lessons Feb 15; Nov-Dec 15, Mar- Apr 16, May-Jun 16, Jan-Feb 17*

in collaboration with each patient. When a patient is happy with their care plan they are asked to sign it and a copy is kept in the nursing office. These are sent to ward Manager and Deputy Ward Mangers to monitor and action if required.

6.88 During supervision it is the responsibility of the supervisor to examine the care plans and ensure that these are of a high standard. It is expected that any issues are raised and addressed.

6.89 The Ward Manager reviews each supervision session to view what has been discussed and ensure that they are aware of any issues.

6.90 We have not been provided with data from the weekly nursing care audits. Neither is it clear where the weekly audit outcomes are reported. We are not assured that the Trust is maintaining appropriate oversight of the effectiveness of this approach.

6.91 The inference in many of the Trust's responses is that Mr T and his family were let down by the former divisional management team. We have not seen any evidence that the Trust is assuring itself that human factor failings cannot go unnoticed or unaddressed in future.

Trust recommendation 29

That all in-patients (at the point of admission) are classified as falling under CPA status and associated processes. That for an in-patient to be re-classified as non-CPA that they have to undergo assessment and review, within the CPA-review format.

6.92 The Trust has directed us towards the Care Programme Approach section of the new Clinical Care Policy[34] as evidence of this recommendation being implemented.

6.93 The policy states

"Ordinarily, individuals admitted to the Trust's inpatient beds will receive care and treatment through the CPA process. This includes anyone detained under the Mental Health Act. There will be exceptions to this, for example, a service user who is briefly admitted suffering from a drug induced psychosis would not require a classification of CPA. The CPA classification may be reviewed during the inpatient stay or as part of discharge planning by the multi-disciplinary team and should take account of the service user's presentation, the characteristics contained within the national CPA guidance as reflected in Appendix 9.1, as well as a service user's current clinical risk formulation."

6.94 It also states that the additional support of Care Programme Approach should not be withdrawn without:

- *"An appropriate review or handover which involves all the relevant people*

[34] *Evidence 49 – Care Programme Approach section of clinical care policy*

- *An exchange of appropriate information with all relevant people, including carers*
- *Plans for ongoing support and follow-up, including plans for future review*
- *A clear understanding about the action to be taken in the event of relapse to minimise the negative impact on the person's well-being e.g. a completed crisis & contingency plan*
- *A formal review of any elements of the care plan provided through an entitlement to after-care provided under Section 117 Mental Health Act 1983"*

6.95 We have not been provided with any evidence that these standards are being audited in order to provide assurance to the Trust and its commissioners. See our Recommendation 3.

Analysis of completion of raising policy awareness recommendations

Trust recommendations 3, 16, and 36	
3	That all in-patient staff confirms their awareness of the requirements of the Trusts Assessment and Care Planning policy > that plans or statements of care or 'treatment' must be created collaboratively with the service user and derived from an appropriate assessment process. Further, that all reviews of treatment and care plans must give the service user the opportunity for full involvement and that where service and service-user treatment statements/decisions are not aligned that a clear clinical rationale is recorded within the MDT record.
16	That the Trust Policy for Assessment and Care Planning (including CPA) should be re-issued with a lessons learnt report requiring all in-patient staff to confirm their awareness of the policy requirements and standards and associated clinical systems requirements of CPA status allocation and review, and that all admissions to secondary care in-patient services be under CPA.
36	Robust Safeguarding pathways and processes are already in place within LPFT but were not followed by the staff as identified in this report. Therefore, that performance issues related to the management, monitoring and completion and quality of required Safeguarding standards in accordance with identified Trust Policy be considered through performance management and/or disciplinary process.

6.96 Recommendation 3 has already been discussed under the section on risk assessment and procedure (paragraphs 6.10 to 6.14 above). We will therefore not repeat our analysis here.

6.97 Recommendation 16 has already been discussed in paragraphs 6.82 to 6.85 under the section on ensuring performance compliance (audit, monitoring and supervision). We will therefore not repeat our analysis here.

6.98 Recommendation 36 has already been discussed under the section on performance management (paragraphs 6.76 to 6.80 above). We will therefore not repeat out analysis here.

Trust recommendations 10 and 37	
10	At present the Trust process for MAPPA referral and access do not appear to be universally known, understood and/or embedded across services. The recommendation of the panel is that the alignment and management of the MAPPA process be reviewed to see how it can be better embedded as a cross-organisational issue to improve service awareness, access and use.
37	That the ward(s) medical and management team ensure that all staff are up to date with their safeguarding mandatory training requirements and that all staff are aware of and have read the Trust safeguarding policy.

6.99 The Trust has reviewed where responsibilities for MAPPA sit within the organisation. The safeguarding team now hold this responsibility and additional training has been provided for safeguarding champions.

6.100 The safeguarding and mental capacity assessment team attend the ward every fortnight to review safeguarding pathways and processes relating to individual cases.

6.101 The Safeguarding Policy and Procedures[35] was reviewed in July 2017. We can see that the information about the MAPPA process and Trust responsibilities are set out in sections 4.10 and 4.11.

6.102 All new clinical Trust staff are required to attend the following training within six weeks of induction:

- Children's safeguarding;
- Adult safeguarding;
- Domestic abuse;
- Prevent;
- Mental Capacity Assessment and Deprivation of Liberty Standards.

6.103 The Trust has produced a leaflet that details what statutory training each member of staff is required to undertake, and the frequency of update training. This clearly states that it is the responsibility of each member of staff to identify their own training requirements, book themselves onto required courses, and ensure that training dates are on the health roster.

6.104 Compliance with training is monitored by administrative staff within the learning and development centre and a monthly report is generated identifying non-compliance. This report is sent to all managers in the Trust.

[35] *Evidence 30 – SG Policy v.11*

6.105 The Trust has not provided us with any comparable data so we are unable to assess whether this approach has improved the uptake of statutory training. See our Recommendation 3.

Analysis of completion of amendments to policy recommendations

Trust recommendations 8, 13 and 32	
8	It is Trust policy that all staff must review current risk assessment documentation and update whenever there is a change to risk level or circumstances. That the in-patient Consultant(s), Team Leader(s), CRHT Team-leader and the Ward Managers (Conolly Ward and Maple Lodge) ensure, through management supervision, that all staff fully understand and meet the required standards to continuously review and update risk assessments in line with Trust policy and best practice.
13	That Trust policy, with regards the standards of Clinical Risk Screening (section 10.5 of the Clinical Care Policy) and Reviewing Clinical Risk Assessment (section 10.8 of the Clinical Care Policy) be reviewed and amended to ensure that service specific review of risk must occur at the key transition points of transfer and discharge and from services (with particular reference to transition between in-patient and community services). Further, that all in-patient and community staff confirm their awareness of this aspect of the amended policy.
32	That the LPFT Clinical Care Policy sections 11 (Discharge/Transfer Procedure) and section 9.11 (Timescales and Transfer to/from CPA) be reviewed and that additional text is added to ensure that the duties of the employee at points of internal discharge/transfer includes an explicit requirement for a detailed verbal handover supported by a written document.

6.106 Recommendations 8 and 13 have already been discussed under the section on risk assessment and procedure (paragraphs 6.18 to 6.29 above). We will therefore not repeat our analysis here.

6.107 Recommendation 32 has already been discussed under the section on risk assessment and procedure (paragraphs 6.58 to 6.63 above). We will therefore not repeat our analysis here.

Trust recommendation 33
That section 7.8 of the LPFT Clinical Care Policy (Admission Procedures) be extended to make explicit reference to the requirements of a detailed verbal and written summary by the admitting team including the agreed clinical reason and objectives for/of the admission (see also Recommendation 7).

6.108 The clinical care policy has been reviewed in accordance with this recommendation.

6.109 However, we have not seen any evidence indicating that the Trust has sought assurance that revised policy is being followed. Neither have we seen any evidence that the Trust has assessed the impact of the change to the policy.

6.110 We suggest that the Trust assures itself and its commissioners that the change is being adhered to and is being effective.

6.111 See our Recommendation 3.

Trust recommendation 34

That the Community Mental Health Team (CMHT) Operational Policy is reviewed and revised to:

- To ensure that it fully aligns to the LPFT Clinical Care Policy (with particular regards to recommended amendments within this report).
- Clearly identify the service eligibility criteria and access requirements/referral processes.
- That the referral process and routes for internal referral from in-patient services is clearly agreed and stated in section 3.0 of the CMHT Policy (Access to the Service) and that the role of ICMHT representative as ward MDT's is clarified (i.e. is direct referral accepted or do all referrals require a formal ICMHT referral form).
- That the ICMHT referral form is included in the CMHT Policy.
- That information on the interface with in-patient services is added to section 7.0 (Service Interfaces) of the CMHT Policy.
- Ensure these are broadly and robustly agreed and disseminated between in-patient and community services.

6.112 In August 2016 the Trust noted that the community mental health team operational policy was "*undergoing a full review*" in line with transformation work that was being undertaken in the division.

6.113 In November 2017 the Trust reported that the policy was still under review as part of the transformation project and that planned policy revisions had been delayed because of the divisional restructure in 2015.

6.114 The Trust has advised that the new policy will reflect the transformation work that was still being undertaken.

6.115 Despite this information the action is marked as completed on the action plan.

6.116 We are unable to provide assurance that actions for this recommendation have been completed. See our Recommendation 3.

Analysis of completion of pharmacy and medical advice recommendation

Trust recommendation 6

That the role and/or processes of routine pharmacist review and/or presence in relationship to review of patient medications at point of assessment and thence within the clinical MDT decision making process be reviewed.

6.117 The Trust has advised that "due to staffing issues and regularity of ward rounds it was not possible" for pharmacy staff to attend every ward round.

6.118 The pharmacist provides weekly drop in sessions on Connolly Ward and these are available to every patient and their carers.

6.119 We have not seen any evidence that the Trust has sought to assure itself that this action is being effective in patients or their families/carer feeling heard when they have concerns about medication. See our Recommendation 3.

Clinical commissioning group oversight

6.120 We have not seen any evidence that the clinical commissioning group has scrutinised the action plan and provided the Trust with any feedback.

7 Specialist serious incident report

7.1 The Trust also commissioned a specialist serious incident report from an independent consultant forensic psychiatrist, Dr M.

7.2 The instructions provided by the Trust were:

"To identify any lesson to be learnt given the further information that came to light following the internal Level 2b Trust Report, primarily the additional independent forensic psychiatry expert opinions."

7.3 A consultant forensic psychiatrist from Rampton Hospital completed the specialist report.

7.4 The specialist report has not been completed in the spirit of an incident report in that it includes staff and client names, however it has been shared with Alex's family.

7.5 Dr M had access to the following information in order to complete the report:

- Letter from the Trust dated 7 January 2016 in which the report was commissioned;
- Internal investigation report;
- Report of an independent consultant forensic psychiatrist #1, dated 12 April 2015;
- Report of an independent consultant forensic psychiatrist #2, dated 17 September 2015;
- Interim report of an independent consultant forensic psychiatrist #3, dated 17 September 2015;
- Addendum report of an independent consultant forensic psychiatrist #3, dated 27 October 2015;
- Interim report of an independent consultant forensic psychiatrist #4, dated 3 November 2015;
- Court transcript of the evidence of Mr T, dated 24 November 2015;
- Copy of Mr T's psychiatric records from 1998 to December 2014;
- List of 16 questions prepared by Ms J.

7.6 Dr M noted that Mr T had received a number of diagnoses over the years including:

- Alcohol dependence syndrome;
- Dissocial personality disorder;
- Borderline personality disorder;
- Emotionally unstable type;
- Anxiety disorder;
- Recurrent depressive disorder.

7.7 Dr M noted that the most consistent primary diagnosis was that of personality disorder, although the sub-type had been variously reported as emotionally unstable, borderline or dissocial.

7.8 The second diagnosis is recurrent depressive disorder. Whilst on remand Mr T presented as so severely depressed that two of the four independent consultant forensic psychiatrists considered Mr T to be unfit to plead. However, when Mr T was subsequently admitted to a medium secure mental health unit "*it very quickly became apparent that there was no evidence of severe depression*". The view appears to be that Mr T's presentation in prison had primarily been aimed at gaining admission to hospital to get away from prison where he was unhappy. It is unclear from Dr M's report whether this was his view or the view of the forensic psychiatrist at the medium secure unit.

7.9 Dr M stated that this response "*almost exactly*" mirrored Mr T's admission to hospital in July 2014 when he presented as severely depressed but "*as soon as he was admitted to hospital, his symptoms disappeared*". Dr M further stated that "*there is no evidence that these maladaptive behaviours were related to a mental illness but did clearly relate to him not getting his own way*".

7.10 Dr M also correctly noted that Mr T had been treated with both antidepressant and antipsychotic medication. When Mr T was discharged from Dr C's community mental health team caseload in October 2013, he was prescribed an antipsychotic - quetiapine 200mg twice daily and clomipramine 150mg once daily.

7.11 Dr M stated that when Mr T was admitted to hospital in July 2014 (three months after clomipramine became unavailable and his medication was changed to venlafaxine), Mr T "*was by then on an adequate treatment dose of venlafaxine*". We disagree with this statement, our analysis can be found at paragraphs 8.5 to 8.15 below.

7.12 We spoke to Dr M who told us that he believed the additional review had been commissioned in order for the Trust to identify any additional learning from information that had come to light during Mr T's trial.

7.13 Dr M was clear that his concerns were:

- Staff turnover and lack of continuity on the ward.
- Lack of clarity about how patients are dealt with (from a criminal justice perspective) if they are violent whilst on the ward.
- Lack of contact with Mr T's family, both during his inpatient stay and at the point of discharge.
- Confusion about who was in charge of his care.
- Lack of clarity about where responsibility sits for reviewing a discharge decision if there is a change in presentation or risk between the decision and actual discharge.

7.14 Dr M told us that he would have expected the Trust to have developed a further action plan following his review. However, it is our understanding that no further actions were identified by the Trust following receipt of Dr M's review.

8 Arising issues, comment and analysis

8.1 It is our opinion that there was a key change in Mr T's presentation from the point at which clomipramine became unavailable. Although Mr T was subsequently prescribed an alternative antidepressant, venlafaxine, the two drugs work in different ways.

8.2 Each person's reaction to any antidepressant is unique to them. Clomipramine and venlafaxine have different effect and side effect profiles. It cannot therefore be assumed that if one was working well and was stopped, the other will work as well, or at all. Venlafaxine also has a wide dosing range, so titration of the dose is more complicated to achieve the best balance of benefit versus side effects. 75mg daily is the minimal effective adult dosage but range goes up to 375mg daily.

8.3 It is clear from multiple documents that Mr T was considered to have a personality disorder with an overlying depressive illness that was sometimes a more prominent feature in his presentation.

8.4 We cannot find any evidence to indicate that Mr T's personality disorder was assessed in the context of treatability and therefore it appears that Mr T was offered no specific treatment to treat his personality disorder.

Medication

8.5 Mr T was prescribed clomipramine 150mg once daily at the time it became unavailable in April 2014. It appears that the GP surgery was unable to source clomipramine because of manufacturing issues. He was also prescribed citalopram 200mg twice daily.

8.6 Clomipramine is used to treat depression and the British National Formulary (BNF)[36] recommends that adults are started initially on 10mg daily, then increased if necessary to a range of 30mg to 150mg daily in divided doses, or a single dose at bedtime. The maximum recommended dose is 250mg per day.

8.7 Mr T's GP surgery called Louth community mental health team to seek advice about a suitable alternative and nursing staff spoke to the doctor on duty, because Dr C was on holiday. The duty doctor's advice was that no alternative should be prescribed, and that Mr T should be given an appointment in clinic as soon as possible. We can see no evidence that this appointment was ever arranged.

8.8 By the time Mr T was admitted in July 2014 we can see from the Trust clinical records that he was prescribed venlafaxine 75mg and quetiapine 200mg.

8.9 However, this does not correlate with the information about the dose of venlafaxine in Mr T's GP records. We can see from those records that he was prescribed 37.5mg (modified release) to be taken in the morning and 75mg (modified release) to be taken at bedtime. We know that this information was available to Dr S because we initially found it within the Trust records. We also know that the Trust contacted Mr T's GP surgery to obtain a medication summary at the time he was admitted to the ward. It remains unclear to us why Mr T's dose of venlafaxine was reduced from 112.5mg to 75mg on admission to hospital.

8.10 Quetiapine can be used to treat psychosis or depression in people who have bipolar disorder. It can also be used as an additional medication for patients who have major depression. The dose varies dependent on the reason for prescribing, we have set out the different doses in Table 5 below.

[36] *British National Formulary (BNF) is a reference book that provides information about prescribed medications including doses, and potential side effects,*

Table 5 – BNF recommended doses for quetiapine

Reason for medication therapy	Recommended doses
Schizophrenia	25mg twice daily increasing over time to a usual dose of 300-450mg daily in two divided doses, maximum 750mg daily. For modified release medicines: 300mg once daily increasing over time to a usual dose of 600mg once daily under specialist supervision, maximum 800mg daily.
Treatment of depression in bipolar disorder	50mg once daily increasing over time to a usual dose of 300mg once daily, maximum 600mg daily. The recommendation is the same for modified release medicines.
Prevention of mania and depression in bipolar disorder	Continue at the dose effective for treatment of bipolar disorder and adjust to lowest effective dose, usually dose 300-800mg daily in two divided doses. The recommendation is the same for modified release medicines.
Adjunctive treatment of major depression	For modified release medicines: 50mg once daily increasing over time to a usual dose of 150-300mg once daily.

8.11 Venlafaxine can be used to treat major depression, generalised anxiety disorder or social anxiety disorder. Again the dose varies dependent upon the reason for prescribing, we have set out the difference doses in Table 6 below.

Table 6 – BNF recommended doses for venlafaxine for adults

Reason for medication therapy	Recommended doses
Major depression	Initially 75mg daily in two divided doses, increased if necessary over time up to 375mg daily, maximum 375mg daily. The recommendation is the same for modified release medicines.
Generalised anxiety disorder	Initially 75mg daily in two divided doses, increased if necessary over time up to 225mg daily, maximum 225mg daily.
Social anxiety disorder	Initially 75mg daily in two divided doses, increased if necessary over time up to 225mg daily, maximum 225mg daily.
Adjunctive treatment of major depression	For modified release medicines: 50mg once daily increasing over time to a usual dose of 150-300mg once daily.

8.12 The court transcript shows that Dr S stated that Mr T was prescribed quetiapine 200mg twice a day and venlafaxine 75mg once daily when he was admitted to Connolly Ward in July 2014. We have found no evidence that this was the case.

8.13 When Mr T was admitted back to Connolly Ward in September 2014 the reason for admission was noted as "*review of antipsychotics/assessment*". We can see no evidence that there was a focussed review of Mr T's medication at subsequent ward round discussions.

8.14 We have provided a summary below of the documented multi-disciplinary discussions about medication that followed Mr T's readmission to Connolly Ward.

Date	Prescribed medication for mental health disorder/s
13 September 2014	Quetiapine 200mg twice daily Venlafaxine 75mg once daily
23 September 2014	Restart quetiapine Stop lorazepam and zopiclone
9 December 2014	Mr T believed that the quetiapine, vitamin B and simvastatin may be causing the sensation in his head. Dr H explained the known side effects that were not consistent with Mr T's reports. Regular and as required medication remained appropriate.

8.15 When clomipramine was discontinued by the manufacturer in 2014 his medication should have been reviewed in a more planned and focussed way. Whilst it may have been appropriate for an alternative to have suggested by the consultant covering the community clinic, the Trust should have taken responsibility for ensuring that Mr T was offered suitable monitoring of the efficacy of the new medication (venlafaxine) and alternatives if appropriate. See our Recommendation 5.

8.16 There is nothing in Mr T's records to indicate that during his admission the appropriateness of venlafaxine was considered or alternative medications properly discussed with him.

8.17 The dose of 75mg of venlafaxine was prescribed at a starting dose level and was only increased briefly by Mr T's GP prior to being admitted to hospital in July 2014.

8.18 Our Recommendation 6 deals with both of these issues.

Diagnoses

8.19 Table 7 below details the recorded diagnoses for Mr T from October 2013.

Table 7 - Recorded mental health diagnoses

Date	Diagnosing clinician	Diagnoses
24 October 2013	Dr C, Louth community mental health team	"*It is clear that there is a significant degree of diagnostic uncertainty with mention made, over time, of a variety of psychiatric diagnoses including anxiety, recurrent depression, personality disorder, and latterly, bipolar affective disorder. What is very clear is the fact that all the above diagnoses were made in the context of [Mr T's] alcohol dependence from which, fortunately, he is now in long-term abstinence.*"
29 July 2014	Unknown, Connolly Ward	Bipolar disorder
30 July 2014	Mr C, Louth community mental health team	Severe depressive episode without psychotic symptoms
13 September 2014	Dr ??, Maple Lodge	Known diagnosis of: Generalised anxiety disorder Depression
22 September 2014	Dr S3, Maple Lodge	Severe depression without psychotic symptoms Anxiety Personality disorder
9 December 2014	Dr H, Connolly Ward	Emotionally unstable personality disorder (primary) Harmful use of alcohol (secondary)
11 December 2014	Dr H, Connolly Ward	Anxiety Depression Personality disorder

8.20 In Mr T's recent mental health history personality disorder first appeared as a diagnosis after Mr T was transferred to Maple Lodge in September 2014. We can find no evidence that the diagnosis of personality disorder was based on a clear formulation to help staff understand his presentation. This remained the case during Mr T's brief stay at Maple Lodge and after his transfer back to Connolly Ward, when there was a period of nearly 12 weeks before Mr T's sudden discharge into the community.

8.21 The diagnosis of emotionally unstable personality disorder given by Dr H on 9 December is a significant change from previous diagnoses, including the diagnosis given on admission to Connolly Ward in July 2014. It is also very unusual for emotionally unstable personality disorder to be first diagnosed when the patient is older. There is no clear rationale given in Mr T's records for this diagnosis. The behaviours described by staff around this time (early December) could fit with another diagnosis previously ascribed (agitated

depression). Changing the diagnosis to emotionally unstable personality disorder had a large impact on what type of care and treatment might be needed and we would expect to see greater justification for the new diagnosis at that point.

8.22 We asked Dr H whether she was aware of whether treatment was considered for this diagnosis. Dr H advised that given that the plans were for Mr T to move towards discharge, she did not consider it appropriate to review his treatment plan.

8.23 Our Recommendation 7 deals with both of these issues.

Risk assessments

8.24 The risk assessments completed for Mr T were sparse.

8.25 We can find a number of references to risk in a variety of documents, but of the following references to risk:

- Inpatient screening document dated 29 July 2014. "*Risk of harm to self*" noted in significant risk factors.
- Ward round dated 30 July 2014. "*[Mr T] says he feels safe to go unescorted to the smoking area*".
- Observation care plan dated 30 July 2014 detailing enhanced observations due to "*risk to self*". Mr T was to have been observed every 15 minutes.
- Ward review dated 6 August 2014. Risk identified as "*dependency/self neglect*".
- Ward review dated 14 August 2014. Risks identified as Mr T being worried about discharge and expressing thoughts of ending his life. "*No thoughts of harming others.*"
- Progress note dated 24 August 2014. Noted that Mr T had been smoking in the toilets and staff advised him to stop, citing that it was a "*criminal offence*". N.B. it is of note that it is NOT a criminal offence to smoke in the toilets.
- Ward review dated 10 September 2014. Mr T was having "*passing thoughts about suicide*" but no plans or intent.
- Inpatient screening documents dated 22 September 2014, completed after Mr T was transferred back to Connolly Ward from Maple Lodge after the assault on the doctor. Significant risk factors noted as "*others* ++".
- Ward review dated 23 September 2014. "*No thoughts of harm to self or others.*"

- Ward review dated 14 October 2014. "*Expressed thoughts of aggression towards others on the ward but no plans/intent.*"

- Working with Risk (1) document dated 9 December 2014. Risks identified as physical impairment and challenges to services (Mr T wanted to remain on the ward "*forever*" and was non-compliant with "*some medication*").

8.26 There is no detailed summary of Mr T's risk history and we can find no review of risk profile or management following occasions when Mr T presented as aggressive or violent.

8.27 The Trust policy in place at the time (Clinical Care Policy 2013) states that where clinical risk has been identified, a more detailed risk assessment (such as Working with Risk Part 2) should be considered. Where a service user is identified as having complex needs an "*additional risk assessment*" will be completed within four weeks of the initial risk screening being conducted.

8.28 Responsibility for determining the frequency at which clinical risk should be reviewed is described as sitting with the lead professional or care co-ordinator who has responsibility for the service user. In the case of Mr T we consider that individual to have been:

- Whilst in the community – Ms L (Louth community team)

- Whilst an inpatient – Dr S

8.29 The policy states that "*it is likely*" that a review of clinical risk assessment would take place in the following circumstances:

- *"Admission, discharge or leave from service.*

- *At a point of referral and transfer between services.*

- *Change of nominated practitioner responsible for service user care, i.e. care co-ordinator.*

- *Significant life event i.e. suicide attempt, non-compliance to treatment, loss of contact with service.*

- *Mental health deterioration or change in legal status.*

- *Change in treatment plan, recovery plan, medication etc.*

- *Increased hostility to others or property.*

- *CPA or other reviews."*

8.30 Mr T did not have a simple diagnosis and was inconsistent in his response to clinical interventions. Crucially, he was resistant to discharge from the ward. Therefore, we would have expected a more detailed review of his clinical risk assessment to have taken place at least as frequently as:

- on admission to Connolly Ward on 29 July 2014;
- on transfer back to Connolly Ward on 13 September 2014 after he assaulted the doctor;
- on arrival back to Connolly Ward after being arrested for assaulting a nursing assistant on 25 November 2014;
- on decision to discharge him on 11 December.

8.31 There are a number of occasions when staff have made entries indicating "*no concerns*". It is unclear exactly what that means, given that some of those entries follow incidents of aggression or complaints about Mr T's physical or mental health.

8.32 The way in which staff classified risk (using low, medium, high) is not only unreliable but it provides false assurance. Mr T's risks in early December 2014 (including in recent history) were very considerable. At best it might be said that Mr T's risks were reduced with the care plan in place at that time. We are not saying that this would or should have led him to stay in hospital, but it might have influenced how the community team viewed Mr T's case, amongst other patients on their caseloads.

8.33 Whilst we do not wish to increase the burden on an already stretched police force, we are concerned at the response that the police would not be able to arrest Mr T following the attempted assault on Mr A. We are not suggesting that arrest was legally appropriate, as this is clearly outwith our remit, however it adds to the picture of a man:

- with known risks;
- who was actively volatile with aggressive threatening outbursts;
- who required direct intervention but seemingly beyond the ability of health, social care or the criminal justice system managing him to prevent further harm.

8.34 As we have reported in Section 5 and Section 6, the internal investigation team identified a lack of risk assessments and there are a number of recommendations dealing with various aspects of this. We have therefore not made a further recommendation about changing clinical practice. However, we have recommended that the Trust takes the necessary action to provide robust assurance that changes to clinical practice have delivered the necessary changes. See our Recommendation 3.

Care plans

8.35 The Trust Care Programme Approach policy in place at the time (Clinical Care Policy 2013) states that all service users who are admitted to an inpatient bed will receive care and treatment through the Care Programme Approach process.

8.36 The same policy states that care plan should be written in a way that the service user, carer and staff involved have a clear understanding of the service user's agreed care and treatment. The care plan must detail all of the interventions and plan, including arrangements for managing crisis and promoting choice and be created collaboratively with the service user (and carers, if appropriate). If a service user is unwilling or unable to be involved in the development and agreement of their care plan, the reason for their non-compliance should be explored. Where the service user's non-compliance cannot be overcome, the reason should be recorded in the healthcare record.

8.37 We can find no care plans for Mr T that meet the required standard set out in the Trust policy. The only care plans we can find are dated:

- 6 August 2014 – addressing Mr T's knee pain, breathing difficulties and support to stop smoking;
- 13 September 2014 – addressing Mr T's accommodation needs, motivation and confidence, medication, psychological health dealing specifically with issues of depression and anxiety, diet and self-care, discharge planning and his own safety;
- 9 November 2014 – addressing Mr T's psychological health, his own safety and the safety of others, medication, knee pain, discharge planning.

8.38 They do not provide a holistic picture of how Mr T's care needs would be met and appear in random order within Mr T's electronic record. The first care plan addressing his mental health needs was not written until he had been in inpatient care for six weeks.

8.39 At the ward round meeting conducted shortly after Mr T's admission on July 2014 staff noted that Mr T had "*no current medical concerns*". We consider this to be a meaningless statement. Given that he was in hospital, by definition there had to be medical concerns, otherwise he would have been considered fit for discharge. There were very serious medical concerns noted the previous day that had led to his admission and therefore this statement makes no sense. If staff meant that Mr T had no current physical health concerns, this statement is still difficult to justify, given his presentation the previous day and the list of medication Mr T was prescribed. We accept that the statement may have meant that staff felt that the concerns were being adequately reviewed and managed at that point, but staff cannot correctly say that there were no concerns at all.

8.40 Mr T had a number of physical healthcare needs including:

- shortness of breath;
- difficulty walking short distances;
- chest pain;
- knee pain;

- overgrown toenails;
- chronic obstructive pulmonary disease

8.41 Mr T complained of these problems on numerous occasions and more than once staff noted that Mr T felt that he was not being taken seriously.

8.42 However staff responses when he did complain of ailments lends support to Mr T's opinion that he was not taken seriously.

8.43 The first care plan on 13 September 2014 was written when Mr T was transferred to Maple Lodge. This care plan addressed Mr T's accommodation, psychological and physical health, medication and discharge planning.

8.44 On 9 November Mr B2 recorded that he had discussed Mr T's care plan with him and that Mr T had signed it. The care plan we have seen provides no indication that Mr T contributed to it, saw it, or signed it.

8.45 We believe that the final care plan was created after Dr H conducted her first review of Mr T after taking over responsibility as his consultant.

8.46 The Trust has already identified the lack of care plans in Mr T's care and treatment and it has been addressed in the action plan. We have however made a further recommendation that the Trust provides itself with the appropriate assurance that the actions taken have addressed the issues identified. See our Recommendation 3.

Discharge from inpatient care and treatment

8.47 It was clear from Dr S's long-term plan and Dr H's review on 9 December that the intention had been to move Mr T towards successful discharge from inpatient care and treatment. Dr H had noted that it appeared that Mr T had found trial leave of three or four days difficult to manage and therefore had reasonably suggested that trial leave of shorter periods of time (one or two days) might work better for Mr T.

8.48 Dr H's plan following her review meeting had been entered into Mr T's clinical record in a timely fashion and was available for all ward staff to review. Nowhere in Dr H's plan did it indicate that should Mr T become violent again, he should be removed from the ward.

8.49 In order to try to identify exactly who made the decision to discharge Mr T we have spoken to:

- Mr A – a nurse on duty on the day of the decision to discharge Mr T (10 December) who made the clinical entry stating that Dr S had told staff that Mr T should be discharged the following day;
- Dr H – the consultant who had just taken over responsibility for Mr T's care and treatment;

- Dr S – the consultant who had been responsible for Mr T's care and treatment for the vast majority of his inpatient stay and who had just handed over responsibility to Dr H.

8.50 Mr A is clear that Dr S agreed with him that discharge should happen the following day, after Mr A had spoken to Dr S on the ward following Mr T's attempt to assault Mr A.

8.51 Dr H was not on duty on the ward from the time she went off duty on 9 December after reviewing Mr T's care plan, until the afternoon of 11 December. Dr H told us that she had clearly stated in her records of that review meeting that Mr T should be given short periods of trial leave to see if he could manage those better than the longer periods of leave that he had been having.

8.52 Dr H told us that she was not on duty on the ward on 10 December because she was at a meeting in London. She also told us that prior to taking up her position she had agreed with Dr S, the Associate Medical Director and a human resources manager that Dr S would provide consultant cover to the ward on that day.

8.53 Dr S told us that he was in the process of handing over responsibility to Dr H as the incoming consultant. During the week that included 10 December Dr S was finishing off some of his management tasks and told us that he was contacted by the ward to say that there were no doctors around. Dr S recalled that he thought the ward's main concern was that there were patients booked in for a ward review with a junior doctor. Dr S told us that he agreed to go to the ward to review those patients because he knew them. Dr S said that he felt comfortable reviewing the patients in Dr H's absence because patients that were booked in for a more junior doctor to review would be those patients who required "*…more standard assessments…perhaps the longer term patients who had a treatment plan fully up and running…*".

8.54 Dr S told us that (contrary to the clinical entry by Mr A) he did not make the decision to discharge Mr T on 11 December and was not involved in any clinical discussions to do so. However Dr S recognised that the plan for Mr T was moving towards discharge. Dr S told us that he felt he had "*suitably relinquished my consultant responsibilities*" for the patients on the ward.

8.55 Mr T was not informed of his discharge from the ward until the police had arrived at the unit to escort him from the premises. Staff packed Mr T's belongings, emptied his locker and provided seven days of medication, and the police then escorted him from the building. The community mental health team were informed that Mr T had been discharged and they noted that community staff would ask him to attend their base (rather than visit him at home) due to risk to staff.

8.56 There appears to have been no protocol covering the expectations of clinical staff of the police staff being asked to be involved in the execution of Mr T's care and treatment. As such the police officers who transported Mr T from

Connolly Ward were under no requirement to inform ward staff that Mr T had not been taken to his home address. See our Recommendation 8.

8.57 A discharge form was completed by Dr H's junior doctor on 11 December. All the information on the form was completed except for Mr T's GP details. There was no evidence of this form in Mr T's GP records that we received (as we would expect given he had been removed from the list of patients at the GP surgery by this time). It is therefore clear that no GP was aware of his discharge from inpatient care and treatment. One consequence of this was that Mr T would have found it more difficult to obtain the correct medication when in the community. No GP would have had oversight of Mr T's diagnoses, care and treatment plan or risks. See our Recommendations 9 and 10b.

Information sharing with Mr T's family

8.58 On 25 November Mr T returned to the ward having spent a night at his daughter's home. Mr T was shaking and appeared angry and distressed. Ms A and Ms J had accompanied Mr T on his return to the ward but staff asked them to leave and return later, so that staff could focus on Mr T's needs. After Ms A and Ms J left, Mr T assaulted a nursing assistant and threatened to hit other members of staff and his family, because he felt that his family did not believe he was unwell and that he could behave appropriately if he chose to do so. The police later attended the ward and arrested Mr T, taking him to the police station for several hours.

8.59 Ward staff expressed concerns about their safety to the police. Police advice was that if there was further violence, staff should dial 999.

8.60 Dr S spoke to Ms A and Ms J and noted that they expressed "*real concerns*" about Mr T hurting someone, and that he had previously threatened to hurt other people with a knife. Both Ms A and Ms J reported that they were frightened about Mr T arriving at their homes and Ms J stated that she had two young children. Although Ms A and Ms J stated that they did not believe that Mr T would hurt his grandchildren, staff should have properly considered the risks to Ms A and Ms J, as well as Ms J's children, at this point. At the very least, it should have been central to the thinking of the ward team that both Ms A and Ms J should be informed of the potential risks and how to keep themselves safe when Mr T was discharged.

8.61 Trust records show that ward staff had informed Ms A and Ms J about the assault on the nursing assistant and the fact that it would be a police matter. Trust records also show that Ms A and Ms J asked about a previous assault on a member of staff but they were told that the member of staff could not provide an update and that it was a police matter.

8.62 Despite these concerns being recorded, when the police removed Mr T from the ward (at the request of ward staff) on 11 December ward staff did not inform Ms A or Ms J. For three reasons it is of concern to us that staff did not consider it important to let both Ms A and Ms J know that this action had been taken:

- Staff knew of the concerns expressed by Ms A and Ms J about Mr T's risks of being violent;

- Ms A and Ms J had been identified as key contributors to Mr T's ongoing care whilst in the community;

- Community staff were not happy to visit Mr T at home because of the risks to staff in doing so.

8.63 See our Recommendation 10a.

Transfer to Maple Lodge

8.64 Maple Lodge is a rehabilitation inpatient ward. It has a multi-disciplinary team consisting of specialist nurses, psychologists, occupational therapists, social workers, and a range of support staff.

8.65 The Trust states:

"Rehabilitation teams provide tailored therapeutic programmes to empower individuals to take decisions about their future needs, maximise their independence, and increase their overall participation in community life. All programmes are individualised and are based on activities of daily living and social integration. This may include group work, skills development, goal setting and confidence building. There is access to a range of psychological therapies and physical therapies."

8.66 We can find little evidence of multi-disciplinary team discussion about the benefits of a transfer to Maple Lodge. There is an action from a ward round meeting held on 1 September for ward staff to chase the community mental health nurse regarding a "*short term nursing home*" placement. However there is no evidence of any discussion following this that led to Maple Lodge being considered as appropriate for Mr T's treatment pathway.

8.67 The first mention of Maple Lodge or rehabilitation in Mr T's records is on 11 September when it was noted that he was at Maple Lodge for rehabilitation. The following day ward staff were advised by Maple Lodge that a bed was available for Mr T and that transfer had been arranged for the following day (13 September).

8.68 Mr T was informed of the plan later that same day and he stated he was "*very shocked*" about the planned transfer but was also pleased, anxious and excited.

8.69 We can find no evidence of the intended purpose of Mr T's transfer and no evidence that he was told why he was being transferred.

8.70 The Trust Clinical Care Policy in place at the time states:

"Care must be organised around the needs of individual service users and carers; and staff should ensure that the transfer between services includes negotiation, agreement and that the process is well managed."

8.71 We asked Dr S if he recalled what led to the decision to transfer Mr T to a rehabilitation unit. Dr S told us that his recollection was that the social environment of Connolly Ward was not really benefitting Mr T. Dr S said that he recalled that when the move happened it was "*quite quick*".

8.72 A sudden transfer to an alternative inpatient based service, with less than 24 hours' notice and no prior discussion about the possible benefits of such a transfer does not fulfil the requirements of the Clinical Care Policy. See our Recommendation 11.

8.73 It is clear that some staff and external agencies were confused regarding the status of Maple Lodge, hence some entries describing it as a residential home. It is our view that this contributed to the decision to take Mr T to a Section 136 suite, rather than assessing Mr T on the ward at Maple Lodge and then transferring directly to Connolly Ward from there.

8.74 Information about Mr T was not transferred properly to staff at Maple Lodge and there appeared to be lack of recognition that Mr T had one long admission (July to December) in two different wards. It is our view that this contributed to the purpose of his admission becoming unclear. The importance of keeping a clear focus on the reasons and purpose for admission through any internal ward transfers during an inpatient stay must remain at the centre of patients' care pathway. See our Recommendation 15.

Allocation of care co-ordinator

8.75 When Mr T was admitted to Connolly Ward on 29 July his Care Programme Approach status was amended from "*receiving care but not on CPA*" to "*CPA*".

8.76 The Trust policy covering Care Programme Approach, the Clinical Care Policy states:

"If a service user who is admitted to an inpatient bed has not previously be supported by CPA, the named nurse will act as the CPA Care Coordinator until a decision is made whether or not care under CPA is required on discharge (Appendix 9.1). However, it would be seen as good practice to continue the support from CPA following discharge until review indicates this is no longer required. A CPA review must be undertaken within one month of discharge from an inpatient area."

8.77 The refusal by the community mental health team to accept Mr T as requiring Care Programme Approach and the failure to allocate a care co-ordinator is not in line with this policy statement.

8.78 We consider that the lack of a consistent and assertive approach to supporting Mr T after his sudden discharge from inpatient care was a contributory factor in the death of Mr T's grandson.

Update of GP records

8.79 Mr T's GP referred him to the older age community mental health team on 23 July. However, during the period between then and when Mr T was offered an appointment his mental state declined further and he contacted the crisis and home treatment team on 28 July. Mr T was seen by the crisis and home treatment team the following day and was admitted to Connolly Ward that evening. Mr T was never seen by the older adults community mental health team. However when Mr T was admitted to Connolly Ward Dr C (the adult community mental health team psychiatrist) spoke with a consultant psychiatrist for the older adults community mental health team. Following that discussion, it was agreed that if a transfer to the older adults inpatient ward was considered to be in Mr T's best interests, the older adults consultant would support it.

8.80 On 30 July Mr T's GP received a request for information about Mr T's current medications. On the same day Dr C wrote to Mr T's GP to advise that he had assessed Mr T and that Mr T had been admitted to Connolly Ward.

8.81 We have been unable to locate a copy of this letter in Mr T's GP records, however there are several entries made in the first two weeks of August that indicate that the GP surgery had received the letter, these are set out in Table 8 below.

Table 8 - GP record entries relating to letter from Dr C

Date of entry	Intervention date	Entry
5 August 2014	29 July 2014	*Summary to North Somercotes*
7 August 2014	29 July 2014	*Seen in psychiatry clinic* *Severe depressive episode without psychotic symptoms*
15 August 2014	29 July 2014	*Seen in psychiatry clinic*

8.82 On 30 July the surgery faxed a summary of Mr T's medication to Lincoln Hospital as requested.

8.83 Mr T did not attend a booked appointment with his GP on 5 August and did not collect his medication prepared on 30 July.

8.84 On 11 August the GP surgery noted that the medication due to be prepared on 13 August had not been prepared because the last box of medication had been returned, and queried whether Mr T had moved away.

8.85 On 1 September the GP surgery noted that Mr T had not attended for an appointment.

8.86 On 17 September the GP surgery were contacted by Mr T's housing provider. They and the police had attended Mr T's property and asked if the GP surgery knew where he was. The entry in Mr T's GP records states: "*…Advised recent advice from [the Trust] for [Mr T] to become an inpatient at Peter Hodgkinson Centre*". Trust records show that the police had contacted Maple Lodge because they were concerned about Mr T's welfare. The police were informed that Mr T was at that time an inpatient at Maple Lodge.

8.87 The GP surgery had known since 5 August that Mr T had been admitted to Connolly Ward and yet they failed to use that information to ensure that:

- their own resources were used effectively by cancelling Mr T's planned appointments at the surgery;
- NHS resources were used effectively by suspending Mr T's prescriptions and medications;
- correct information was shared with other agencies (Mr T's housing provider) when approached about his whereabouts.

8.88 See our Recommendation 12.

8.89 On 25 September the GP surgery removed Mr T from their list noting he had "*…left area, gone away…*". It is not clear from within the records, nor could the Operations Manager recall, where that deduction request came from.

8.90 This meant that when Mr T was discharged from Connolly Ward at short notice on 11 December, he was not registered with a GP in order to be able to obtain further medication. Also that ward staff were unable to inform a GP of Mr T's discharge. The discharge form completed on 11 December by Dr H's junior doctor is not addressed to any doctor and we can see no evidence that ward staff checked where the discharge form should be sent. See our Recommendation 10b.

8.91 The Operations Manager at the GP surgery has indicated that she believes she recalls that Mr T's "*sister*" called the surgery asking for medication for him, some weeks later. Staff at the surgery advised her that because Mr T was staying in Lincoln, he would have to register with a GP surgery there.

8.92 It is of concern that the GP surgery removed Mr T from their list, despite knowing that he was being treated as an inpatient at that time. See our Recommendation 13.

Specific family questions

8.93 Ms J asked that we provide answers to three specific family questions:

1. Who took the decision to discharge Mr T?
2. How did the discharge actually happen?

3. How do you explain the differences in the various accounts of the discharge arrangements?

Who took the decision to discharge Mr T?

8.94 We have been unable to determine with any degree of certainty who took the decision to discharge Mr T. We have spoken with Dr S, Mr A and Dr H to try to establish clarity on this matter.

8.95 Mr A told us that Dr H was not on duty on the day when Mr T attempted to assault him. Therefore, Mr A had spoken to Dr S about what had happened and that Dr S "*agreed with me that discharge should happen the next day*". Mr A said that Dr S had attended the ward briefly, that he didn't recall that Dr S had seen anyone face-to-face but had come onto the ward for a "*brief handover of things*".

8.96 Mr A said that he had felt frustrated with the police because he had wanted to press charges against Mr T for the attempted assault on him, but the police had refused. The police rationale appears to have been that Mr T had not actually assaulted anyone that morning (10 December) because ward staff had intervened appropriately to prevent it.

8.97 Mr A is certain that he did indeed have the conversation with Dr S about Mr T and another patient and that he would not have documented it had it not taken place. Mr A also said that he was not on duty when Mr T was removed from the ward, his shift started later in the day on 11 December and by the time he arrived for work Mr T had been discharged.

8.98 Dr H had reviewed Mr T on 9 December and had suggested that given previous trial leaves of three or four days had not gone well, it might be better to have trial leave of just one or two days. However, Dr H was clear that discharge was not imminent.

8.99 Dr H was Mr T's named consultant at the point he was discharged from the ward, however Dr H was not on site on the day of the decision to discharge him (10 December). Dr H believed that Dr S was covering her duties, as agreed by telephone prior to her taking up her post at the end of November. Dr H was in London attending a meeting at the Royal College of Psychiatrists. The meeting was a quarterly commitment for Dr H and formed part of her job plan.

8.100 Dr H told the internal investigation team that that when she was in London, prior to the start of her meeting, she rang the ward (before 9am) to get an update on the progress of a different patient who had been placed in supervised confinement the previous day. Dr H advised that whilst she was on the telephone with a member of ward staff the conversation was interrupted by the alarms going and she was told that the member of staff had to go, because Mr T had just done something.

8.101 Dr H said she then called Dr S's secretary to ask Dr S to call her when he got into the office. Dr S did call Dr H shortly afterwards and Dr H asked Dr S to go

to the ward to find out what support the staff needed and what they needed him to do as the consultant covering the ward that day.

8.102 Dr H said she did not arrive on the ward until the afternoon of the following day because she was scheduled for duties off the ward during the morning. However Dr H recalled that between 11:30 and 11:45 she received a call from the ward to inform her that Mr T had been discharged. Dr H told the internal investigation team that she was surprised at this action but she did not question the member of staff because she felt it was not appropriate to challenge the messenger. Dr H said that she remembered saying "*oh my god, the ward have just discharged [Mr T] this morning*" but that she didn't have opportunity to look into it until she returned to the ward later that afternoon. There is no evidence in the records that Dr H followed this up.

8.103 Dr H told us that planned discharges should always take place with the full consent of the consultant, unless a patient who was not detained under the Mental Health Act wished to leave the ward. Dr H was confident in her belief that ward staff would never discharge a patient without first seeking the view of the consultant.

8.104 Dr S told us that he was in the process of handing over responsibility to Dr H as the incoming consultant. During the week that included 10 December Dr S was finishing off some of his management tasks and told us that he was contacted by the ward to say that there were no doctors around. Dr S recalled that he thought the ward's main concern was that there were patients booked in for a review with a junior doctor. Dr S told us that he agreed to go to the ward to review those patients because he knew them. Dr S said that he felt comfortable reviewing the patients in Dr H's absence because patients that were booked in for a more junior doctor to review would be those patients who required "*…more standard assessments…perhaps the longer-term patients who had a treatment plan fully up and running…*".

8.105 Dr S told us that he has no recollection of the incident between Mr T and Mr A and that he does not remember being involved in discussions about the incident from a clinical perspective. Indeed, Dr S told us that he only became aware of the incident after Alex's death.

8.106 We discussed Mr A's entry into Mr T's clinical records concerning the conversation Mr A reported he had with Dr S. Dr S told us he was aware of that entry but reiterated that he was not "*aware of any clinical discussion I had concerning [Mr T]*". Dr S was clear with us that he had not reviewed Mr T that day and that he would find it "*highly unusual after working with the patient for a number of weeks and months with a clear plan of structured discharge why I would suddenly change my mind and demand he is discharged immediately*". Dr S told us that he could not support Mr A's entry into Mr T's notes that referred to Mr A's discussion with Dr S.

8.107 We have three clearly articulated versions of the discussions that key members of staff were involved in prior to the decision documented on 10 December to discharge Mr T the following day.

8.108 All of the accounts agree that Dr H was not on the ward at the time the decision was documented, although Dr H and Dr S provide differing accounts regarding the arrangements in place for consultant cover to be provided in her absences.

8.109 Mr A and Dr S have provided significantly different accounts of any interaction they had following Mr T's attempted assault on Mr A. Although Mr A told us that Dr S had "*agreed with him*" regarding the fact that Mr T should be discharged. It is therefore possible that Mr A implied from Dr S's response that he agreed with Mr A's view about Mr T being discharged, without that agreement being explicitly given.

8.110 We cannot give greater weight to one person's evidence over another person's evidence without the presence of independent corroborating evidence.

How did the discharge actually happen?

8.111 Ward staff did not inform Mr T that his discharge from the ward had been planned overnight. This appears to have been an active decision by nursing staff. Ward staff had liaised with the police who had agreed to send a van with two or three officers the following day to remove Mr T from the ward. Staff had noted that if Mr T were to become aggressive the plan was for the police to arrest him for breach of the peace.

8.112 Ward staff informed the community mental health team in Louth of the plans to discharge Mr T, but no contact was made with Mr T's family.

8.113 A police officer attended the ward on the morning of 11 December and a nurse and nursing assistant informed Mr T that because of the recent incidents of violence toward staff he was being discharged. Mr T stated that he should have leave first, but ward staff advised him that he had not cooperated with attempts to trial leave and therefore had lost his opportunity. Staff informed Mr T that the police were in the building waiting to escort him off the premises and ensure he was able to get to his home address.

8.114 It later transpired that Mr T had asked the police to drop him off in the centre of Lincoln, rather than take him to his home address. Had the police done as ward staff had requested, Mr T may not have subsequently gone to his daughter's home. It is also our view that the police should have informed ward staff that they had left Mr T in the centre of Lincoln and not taken him home.

8.115 That said, it is our view that using the police to transport patients from a ward to their home address is not appropriate. Whilst it may have been appropriate for the police to be present to escort him from the building, it should have been staff from the community team that transported Mr T to his home and ensured that he was safe.

How do you explain the differences in the various accounts of the discharge arrangements?

8.116 We have not been able to identify reasons for the differences in the accounts of the discharge arrangements. We do not dispute Dr H's account of events; however, it has not been possible to provider any further evidence that gives weight to, or supports, either Mr A's or Dr S's assertions.

Governance and assurance at the time of the incident

8.117 At the time of the incident the organisation had a number of systems, processes and controls in place to mitigate against adverse incidents and to learn when things go wrong. Particularly, the organisation utilised an early warning trigger tool (EWT), or, 'heatmap' that aimed to provide periodic assessments of individual service directorates against the core Care Quality Commission domains. In November 2014 this 'heatmap' was highlighting particular issues around:

- staff sickness rates (which had risen to above 5%).
- challenges associated with the delivery of staff training.

8.118 In January 2015 a 40% drop in performance across all sites, had been noted on the heatmap. This was attributed in large part to an increase in the incidence of bank and agency use. In short reflection, the organisation was, at the time of the incident, experiencing a significant degree of operational pressure.

8.119 Despite these challenges, between November 2014 and January 2015 the Board received positive assurance in relation to the application of organisation controls from Quality Committee and in Board papers and we must now question how the Board applied judgements on levels on assurance at that time. Whilst we must credit the Trust with the use of the early warning trigger tool and their determination to identify early downturns in performance, some issues were clearly either not being escalated effectively or being acted upon in a sufficiently robust way at the time.

8.120 The Board, at that time, must also have taken further positive assurances from two recent CQC inspections (November 2014):

- Acute wards for adults of working age.
- Forensic inpatient/secure wards.

8.121 Both reports made overwhelmingly positive observations about the services inspected and the only improvement areas noted were in relation to the Trust's absence of a psychiatric intensive care unit and inconsistent approaches to the updating of risk assessments and care plans.

8.122 In addition to positive CQC assurance there were other positive reinforcing factors in relation to governance at around the time of this incident including:

- The Trust had a Monitor (now NHSI) continuity of service rating of 4, which was positive, and demonstrated a strong financial position.
- They were meeting all regulatory targets (including full CQC compliance).
- Operational performance indicators were rated as green in 95%+ of cases.
- The Trust had undertaken a quality governance review which provided positive assurance on the strength of systems and processes; and
- During 2014 the organisation had also been chosen as a pilot site for the new NHSI 'Well-led' Inspection regime that could be seen to be an affirmation of their current good standing.

8.123 It is clear that at the time of this incident the Trust was seen to be 'high-performing' and a perceived exemplar in relation to governance, quality, finance and performance. Whilst we cannot make a complete assessment on the levels of Board vigilance and capability at the time, it is clear from the number of findings made within both the Trust's own internal report that there were in fact material deficiencies in relation to governance and quality. To this end, we must question the efficacy of the systems processes and controls, leadership, insight and scrutiny at that time. In high-performing organisations there is always a risk of 'confirmation-bias in relation to how both good and poor performance is calibrated.

Board oversight at the time of the incident

8.124 In November 2014 the Board had three key executive level roles as non-substantive (interim). These were:

- the Medical Director;
- the Director of Nursing and Quality;
- the Director of Operations.

8.125 This is a significant degree of Board-level churn that would usually trigger concerns around portfolio continuity and executive team leadership stability. This must be noted as a potential contributory issue at the time of the incident.

Operational framework changes

8.126 The new Director of Operations commenced post in January 2015 and by February 2015 significant changes were underway in relation to the Trusts operational governance structures. Notably, the Trust had previously been divided into two key divisions and this was then expanded into four. The make-up and complexity of a Trust's operational governance structure is always a cause for debate and there is no ideal structure, particularly when considering the geographic and operational span of most mental-health organisations. That said, two divisions may seem unusually insufficient for a trust of this size and local oversight may have been an issue. A four-way

divisional structure is more usual and was the model that the Trust developed in the period following the incident.

More recent governance related activity

8.127 Under the CQC's newer inspection regime the Trust was given an overall rating of 'good' in June 2017 but was identified as having some significant governance deficits. In 2019 however the Trust overall rating remained as 'good' but the category of 'well-led' was rated as 'outstanding'. There was detailed commentary which included that acute wards for adults of working age were rated as 'good', having been rated as 'requires improvement' in 2017.

8.128 The 2019 rating had improved because (most notably):

- The trust responded in an extremely positive way to the improvements they were requested to make following the CQC inspection in April 2017. At the November 2018 inspection, significant improvements in the core services were noted inspected and an '*impressive ongoing improvement and sustainability of good quality care across the trust as a whole'*. The senior leadership team had been '*at the fore front of delivering quality improvement and there was a true sense of involvement from staff, patients and carers towards driving service improvement across all areas'*.

- Staffing numbers had been calculated across wards, and staffing levels were adjusted daily to meet patient needs. Teams included a range of specialists required to meet the needs of patients. The trust was supporting some nursing assistants to undertake nurse training. Qualified nurses were encouraged to attend additional training and conferences.

- Wards appeared clean, had appropriate modern furnishings, and patients had somewhere safe to store possessions.

- Staff were responsive to the individual needs of patients. Staff said they could raise concerns about any discriminatory, disrespectful or abusive behaviour or attitudes towards patients, without fear of reprisal. Staff maintained the confidentiality of patients. Sensitive conversations with patients took place in private. Staff were mindful of other patients being in communal areas and ensured that any conversations about patients between staff could not be overheard by others.

- Managers had the skills, knowledge and experience to perform their roles. ward managers were visible, attended multidisciplinary meetings, patient meetings, and were available generally for staff and patients.

8.129 Whilst it is accepted that between the inspections carried out in 2017 and the inspections reported in 2015 the CQC inspection criteria was rebased; the above findings indicated a worsening position in relation to areas of the Trust's - local compliance with the CQC through the materiality of their assessment. It is difficult to say exactly why this may be and is likely attributable to a range of factors including increased activity and increasing

acuity (generally seen nationally in similar services). Any large divisional restructure may also create significant challenges within services, and we are unclear on the processes that the Trust adopted to ensure stability within the post-reconfiguration phase (usually up to two years). See our Recommendation 14.

8.130 The Trust Board has continued to monitor the CQC action plan, and the November 2018 CQC inspection recognises that significant changes have been made across the senior leadership team. The January 2019 report notes that '*the building of a continuous quality improvement and innovation culture has enabled the trust to move from a top- down organisation to a system where staff were empowered to make decisions for improvement for the benefit of services to patients. The delivery of innovative and continuous quality improvement was central to all aspects of the running of the service'.*

Other changes made

8.131 Since this incident, the Trust has made a number of other important incremental changes which are aimed at ensuring good local and Board level governance, these include:

- The quality assurance process around investigations have now been improved. Investigating officers from different trust divisions are now used and level two investigations are now routinely outsourced to an independent team.

- Investigations review panels now allocate a professional chair, replacing the previous Non-Executive Director Chair. Non-Executive Directors continue to maintain oversight of investigations, providing additional challenge.

- All of the non-executive directors have now done root cause analysis training, and where previously investigations training was sporadic, a law company has now been commissioned to deliver this training. Notably, commissioners have also been invited to attend these training sessions.

- The organisation has done significant amounts of work on 'human factors' training as well as a large programme of work around early intervention training.

- Governance has now been significantly reinforced at a divisional level. Each division now has a dedicated quality and assurance lead, these staff have combined to form a peer group where lessons are shared between divisions. Board oversight on the divisions has increased through the Quality Committee and the clinical management meetings. Incidents are now also routinely said to be discussed at Executive Team meetings and problem sharing is said to be much more open.

- The Trust early warning tool has been reviewed and is being developed to increase the focus upon quality outcome monitoring and improved

triangulation with existing management knowledge to provide a more holistic view on services.

8.132 More detailed actions are covered in other areas of this report, however, primary actions in relation to governance do appear to have been well progressed by the Trust.

Residual or ongoing issues and risks

8.133 The Trust is continuing to progress significant clinical quality improvement workstreams which cover:

- care planning;
- risk assessments;
- mental capacity act;
- clinical supervision;
- the governance of processes relating to these.

8.134 These are reported through the Quality Committee that in turn provides the Board with summary updates on the progress against these areas.

8.135 All risks identified within the Trust are recorded and categorised as an organisational, divisional or locality risk. Risks escalated to the Board on the 'Organisational Risk Register' contain stratified operational and clinical risks and the Board also receives a Board Assurance Framework which provides a Board-level strategic risk profile.

8.136 The Board Assurance Framework indicates that Board level churn is still challenging and determines a turnover rate of around 50% in one year. The Board has put mitigation plans in place although additional caution should be employed around the impact upon leadership teams and portfolios.

8.137 Whilst work is being currently undertaken, the Trust continues to experience difficulty in meeting its agency cap (particularly medical agency) and Care Programme Approach seven-day follow-up in some areas (following discharge from inpatient care). In other respects, the Trust continues to perform well in most areas, particularly around the NHSI Single Oversight Framework (SOF) where they maintain a segmentation of one (the highest of four potential ratings); through which they are devolved maximum regulatory autonomy (i.e. they are deemed to require the least amount of regulatory oversight).

9 Overall analysis and recommendations

Predictability and preventability

9.1 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[37] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it[38].

9.2 Prevention[39] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

9.3 There is evidence that Mr T had been threatening towards his former wife and his daughter, however Trust records show that both Ms A and Ms J told staff that they did not believe he would harm his grandchildren. There is also evidence that Mr T had been threatening towards staff and had actually assaulted staff in the weeks prior to being removed from the ward. However, we consider that it would not have been possible for Trust staff to have predicted that Mr T's behaviour would escalate to the degree that it would cause the death of his grandson, Alex.

9.4 We do however consider that there were actions that Trust staff could have taken that might have might have avoided Mr T killing Alex.

9.5 Mr T's discharge from the ward was rushed, there is no clearly documented rationale or discussion leading to the sudden decision to discharge him. The community mental health team had refused to allocate a care coordinator in accordance with the policy covering Care Programme Approach and staff felt that Mr T was too high risk for staff to visit him at home. Whilst staff may have felt that Mr T was unwilling to engage in support mechanisms that staff felt would benefit him whilst he was on the ward, he had clearly articulated his desire for intensive support when he was in the community.

9.6 The Trust relied upon police officers to transport Mr T to his home address. Mr T did not want to go to his home and so asked police the officers to drop him off in Lincoln centre. Ward staff had not asked the police to let them know where Mr T had been dropped off, so were unaware that Mr T actually remained in Lincoln. Had ward staff asked community staff to transport Mr T to his home address, they would have been able to ensure that he had arrived

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[37] *http://dictionary.reference.com/browse/predictability*

[38] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*

[39] *http://www.thefreedictionary.com/prevent*

safely. If the risks to community staff were considered to have been so high, the police officers could have escorted the community staff to Mr T's address.

9.7 Although community mental health team staff did contact Mr T by telephone nobody saw him for a face to face assessment after he was removed from the ward on 11 December until 18 December. So, the seven day follow up standard was at its limit. When staff did see him on 18 December they noted that Mr T was quiet and low in mood with a noticeable tremor. Staff noted that Mr T had "*approximately a week's worth*" of medication, however he had been provided with seven days medication seven days earlier and therefore should have run out of his medication by the time of this appointment. A lack of medication, and no registration with a GP surgery in order to obtain more medication would have contributed to a decline in his mood.

9.8 Mr T was discharged in an unplanned and unstructured way, without the appropriate enhanced package of care in place and with his concerns about his accommodation remaining unresolved. He should not have been discharged without the enhanced package of care being properly planned and implemented. Had his discharge been conducted in accordance with the plan described by Dr H it would have been less likely that Mr T would have demanded that his family look after him and therefore less likely for him to have been in the same property as his grandchildren.

Recommendations

9.9 This independent investigation has made 13 recommendations for the Trust and two recommendations for the local clinical commissioning groups to address in order to further improve learning from this event.

9.10 The recommendations have been arranged in four themes:

- family engagement.
- discharge and transfer.
- clinical response and engagement; and
- risk assessment.

9.11 These have been given one of three levels of priority:

Priority One: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

Priority Two: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients but identifies important improvement in the delivery of care required.

Priority Three: the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Priority One: Family Engagement

Recommendation 10a

The Trust must ensure that when:

- family members are either expected to play a key role in a patient's care and treatment; and/or
- have previously expressed concern about their own safety in relation to the patient

those family members are involved in the decision making about discharge and informed about the patient's discharge prior to it taking place.

Recommendation 11

The Trust must assure itself and its commissioners that involve patients and their families (where appropriate) in decisions about transferring patients to other units.

Priority One: Discharge and transfer

Recommendation 10b

The Trust must ensure that any plans for discharge from an inpatient unit are planned with the patient, GP and all relevant community services. There must be a clearly documented structured plan which sets out roles, responsibilities and timescales.

Recommendation 12

The GP practice must ensure that when the practice is informed that a patient has been admitted to hospital, a review of that patient's appointments and repeat medications is undertaken.

Recommendation 13

The GP practice must ensure that prior to removing a patient from a surgery list, the surgery has considered all information in their possession regarding the possible whereabouts of that patient and that they clearly document in the records the basis or rationale for that removal with details and/or a copy of the information upon which the decision is based.

Priority Two: Clinical Response and Engagement

Recommendation 5

The Trust must ensure that appropriate action is taken when a clinician has advised that a review of a patient's medications is required.

Recommendation 6

The Trust must assure itself and its commissioners that medications are prescribed in accordance with best practice and that timely reviews of the ongoing appropriateness of the dose are undertaken.

Recommendation 7

The Trust must ensure that there is a clear rationale provided when changing a diagnosis and that the appropriate associated treatment plans are described and implemented.

Recommendation 9

The Trust must ensure that the correct registered GP details are held on file, regularly checked and updated (where required) and present on discharge documentation.

Recommendation 15

The Trust must ensure that a clear focus is maintained on the reasons and purpose of admission throughout any internal ward transfers.

Priority Three: Risk assessment

Recommendation 1

The Trust must ensure that staff complete incident forms at the earliest opportunity and that staff are clear about when this is.

Recommendation 2

The Trust must ensure that guidance is in place for staff completing serious incident investigation reports that they use plain English and that the templates include section numbering, page numbering and a table of contents.

Recommendation 3

The Trust must assure itself and its commissioners that recommendations in internal reports are fully implemented and that the actions provide sufficient evidence of the effectiveness of the changes made.

Recommendation 4

The Trust must assure itself and its commissioners that staff use every opportunity to triangulate information about clients from all reasonably available sources.

Recommendation 8

The Trust must ensure that a communication protocol with the police is developed and implemented when the police are involved in a patient's management.

Recommendation 14

The Trust must ensure that service changes are properly monitored in the post-implementation phase. Analysis should include governance success indicators, staff satisfaction assessments, patient experience scores and overall performance rates.

Post publication of this report

9.12 This report will be published accompanied by action plans developed by organisations for whom we have made recommendations. Progress and implementation of those action plans will be monitored by NHS South

Lincolnshire Clinical Commissioning Group & South West Lincolnshire Clinical Commissioning Group and NHS England.

Appendix A – Terms of reference

This case has been the subject of an internal investigation, a further specialist serious incident report and a Serious Case Review.

The independent investigation should build on the previous investigations and utilise the intelligence from all of them.

- Review the trust internal investigation and assess the adequacy of its findings, recommendations and action plan
- Compile a comprehensive chronology of events leading up to the homicide if not already developed
- Review the appropriateness of the care, treatment and services provided by the NHS, local authority and other relevant agencies from the service user's first contact with services to the time of their office, identifying both areas of good practice and areas of concern
- Review the appropriateness of prescription and monitoring of medication
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves [sic] or others
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family and involve the relatives in the investigation as fully as considered appropriate
- Comprehensively review the arrangements surrounding the service user's discharge from the ward, the plans in place for the service user's support in the community, family involvement, and the appropriateness of discharge
- Review the Trust Safeguarding procedures when discharging patients both during periods of leave and at discharge
- Review and assess compliance with local policies, national guidance and relevant statutory obligations
- Consider if this incident was either predictable or preventable
- Review the progress that the trust has made in implementing the action plan
- Provide a written report to the investigation team that includes measurable and sustainable recommendations
- Assist NHS England in undertaking a brief post investigation evaluation
- Undertake an assurance follow up review 6/12 months after the report has been published to assure that the report's recommendations have been fully implemented
- Produce a short report that may be made public

Appendix B – Documents reviewed

Lincolnshire Partnership NHS Foundation Trust documents

- Mr T's clinical records
- Terms of reference for the internal investigation
- Internal investigation witness statements
- Statement from Dr H provided to the internal investigation team
- Internal investigation report
- Action plan
- Additional clinical review
- Clinical Care Policy v2014
- Clinical Care Policy v2017
- Supervision Policy v2014
- Current Supervision Policy
- Clinical risk framework
- Clinical risk training guide
- Pocket Ps and mental health guidelines
- Clinical risk managerial supervision support tool
- Lessons Learnt Bulletin May/June 2015
- Multi-disciplinary team ward review record sheet (2014)
- Multi-disciplinary team ward review record sheet (2017)
- Community mental health team policy – awaiting review
- Safeguarding Policy 2014
- Fast track protocol
- Care Programme Approach audits
- http://mentalhealthact.weebly.com/pathway-ac.html
- http://mentalhealthact.weebly.com/acute-inpatient-pathway-app.html

Other documents

- Marsh Medical Practice clinical records for Mr T

Appendix C – Professionals involved

Pseudonym	Role	Team and organisation
Dr A	Consultant Psychiatrist	Maple Lodge, LPFT
Dr A2	Role unknown	Maple Lodge, LPFT
Dr B	Consultant Psychiatrist	Louth CMHT, LPFT
Dr C	Consultant Psychiatrist	CMHT, Louth, LPFT
Dr C2	On call doctor	Connolly Ward, LPFT
Dr H	Locum Consultant Psychiatrist	Connolly Ward, LPFT
Dr H	Junior doctor	Connolly Ward, LPFT
Dr I	Junior doctor	Connolly Ward, LPFT
Dr J	Junior doctor	Connolly Ward, LPFT
Dr J	Junior doctor	Connolly Ward, LPFT
Dr M	Consultant Forensic Psychiatrist and author of independent report	Author of independent report
Dr P	GP	Marsh Medical Practice, North Somercotes
Dr R	Role unknown	Connolly Ward, LPFT
Dr S	Consultant Psychiatrist, Clinical Director	Connolly Ward, LPFT
Dr S2	Junior doctor	Connolly Ward, LPFT
Dr S3	Junior doctor	Maple Lodge, LPFT
Dr U	Section 12 doctor	Team unknown, Organisation unknown
Dr V	CT1 on call doctor	Connolly Ward, LPFT
Dr Z	Consultant Psychiatrist	Louth CMHT, LPFT
Mr A	Nurse	Connolly Ward, LPFT
Mr B	Role unknown	Louth CRHT, LPFT
Mr B2	Role unknown	Connolly Ward, LPFT
Mr C	Security management advisor	LPFT
Mr C	Role unknown	Team unknown, LPFT
Mr G	Acute care manager	Team unknown, LPFT
Mr H	Nursing assistant	Connolly Ward, LPFT
Mr J	Role unknown	Louth CRHT, LPFT
Mr J	Team manager	Louth CMHT, LPFT
Mr J2	Role unknown	Connolly Ward, LPFT
Mr K	Role unknown	Maple Lodge, LPFT
Mr L	ACT	Connolly Ward, LPFT
Mr M	AMHP	Lincolnshire County Council
Mr M2	Role unknown	Lincoln CRHT, LPFT
Mr O	Acute care nurse	Connolly Ward, LPFT

Pseudonym	Role	Team and organisation
Mr P	Role unknown	Team unknown, LPFT
Ms C	Role unknown	Louth CMHT, LPFT
Ms C2	Role unknown	Louth CMHT, LPFT
Ms D	Senior acute care nurse	??, ??
Ms D	Nurse	Connolly Ward, LPFT
Ms D	Role unknown	Connolly Ward, LPFT
Ms G	Acute care nurse	Connolly Ward, LPFT
Ms H	Housing support officer	Louth CMHT, LPFT
Ms K	Ward staff	Connolly Ward, LPFT
Ms K	Acute care nurse	Connolly Ward, LPFT
Ms K	Occupational therapist	Connolly Ward, LPFT
Ms L	Social worker	Integrated CMHT, LPFT
Ms L2	Nurse	Connolly Ward, LPFT
Ms L3	Unknown	Lincoln CRHT, LPFT
Ms L3	Role unknown	Connolly Ward, LPFT
Ms M	Nurse	Connolly Ward, LPFT
Ms M2	Role unknown	Connolly Ward, LPFT
Ms N	Role unknown	Maple Lodge, LPFT
Ms O	Unknown	Louth CRHT, LPFT
Ms R	Role unknown	Maple Lodge, LPFT
Ms S	Acute care nurse	Connolly Ward, LPFT
Ms S2	Role unknown	Team unknown, LPFT
Ms S3	Role unknown	Louth CRHT, LPFT
Ms U	Care coordinator	Louth CRHT, LPFT
PC F	Police officer	Lincolnshire Police
PC N	Police officer	Lincolnshire Police