HASCAS
Health and Social Care Advisory Service

Independent Investigation

into the

Care and Treatment Provided to Mr X

by the South Staffordshire & Shropshire Healthcare NHS Foundation Trust

Commissioned by NHS England – April 2015

Investigation Conducted by: HASCAS Health and Social Care Advisory Service
Report Authored by: Dr Androulla Johnstone

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1. Investigation Team Preface

1.1. The Independent Investigation into the care and treatment of Mr X was commissioned by NHS England pursuant to *HSG (94)27.*[1] The Investigation was asked to examine a set of circumstances associated with the death of Ms Y who was found dead on 14 December 2010.

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

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

1.4. This report also addresses current service provision within the Trust and identifies notable practice regarding its present-day work with veterans.

2. Condolences to the Family and Friends of Ms Y

2.1. The Independent Investigation Team would like to extend their condolences to the family and friends of Ms Y. At the time of writing this report it had not been possible to make contact with them.

3. Incident Description and Consequences

Background for Mr X

3.1. Mr X joined the army at the age of 15 and he remained with the army until the age of 30. Mr X saw active service in Cyprus, Northern Ireland and the Falklands and spent his final five and a half years with the Special Forces. Mr X had no history of mental health problems prior to the homicide apart from a brief episode of depression in 1998 due to the separation and subsequent divorce from his wife.

3.2. In the autumn of 2010 Mr X experienced the breakdown of his 10 year relationship with his partner Ms Y. In the months before the breakup Mr X had been irritable and on one occasion had hit Ms Y over something trivial. Ms Y had

1. Health Service Guidance (94) 27

encouraged Mr X to visit the GP to discuss his problems which at this time included nightmares and other symptoms suggestive of Post Traumatic Stress Disorder.

3.3. Following a visit to the GP Mr X was referred to secondary care mental health services. He met with the Team Associate Specialist Psychiatrist 1 on 9 November 2010. During this meeting it was determined that Mr X's mood had been deteriorating over recent months. The diagnoses were that of a depressive episode together with Post Traumatic Stress Disorder. The plan was for Mr X to continue with the antidepressant medication prescribed by the GP, to be referred to Combat Stress and to be followed up by secondary care mental health services again on 15 December.

Incident Description and Consequences

3.4. Mr X was no longer living at his former partner's home and had been sleeping both in his car and on his son's sofa. He decided to try and save the relationship. On 14 December Mr X went to Ms Y's home. It is unclear exactly what happened as Mr X claims not to remember events. However during this meeting he stabbed his former partner to death. He inflicted 28 separate stab wounds upon her at their former home whilst she was decorating a Christmas cake in her kitchen. Apparently Ms Y had wanted to end the relationship as she said she no longer loved Mr X.

3.5. In November 2011 Mr X was convicted of manslaughter with diminished responsibility. He was sentenced to twelve years in prison with a minimum of six years to be served.

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

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

> *"… in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

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

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be

independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

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

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

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

5. Terms of Reference

5.1. The Terms of Reference for this Investigation were set by NHS England.

5.2. *"An external verification and quality assurance review is intended to be a verification of the internal investigation with limited further investigation to enable the review team to fulfil the terms of reference. This may be undertaken via a desktop review.*

1. *Quality assure the Trust's internal investigation, recommendations and any action plan.*
2. *Review the appropriateness of the treatment of the service user in light of any identified health needs.*
3. *Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.*
4. *Focus the investigation on the present day services and current processes.*
5. *Review the progress that the Trust has made in implementing the recommendations and the learning from their internal investigation and other investigations.*
6. *Consider if similar incident/circumstances occurred today would the current Trust policies and procedures prevent a reoccurrence.*

7. *Consider if the current services available for veterans meets the MoD and charitable organisations such as Combat Stress quality standards*
8. *Involve the families of both the victim and the perpetrator as fully as is considered appropriate.*
9. *Review and assess compliance with local policies, national guidance and relevant statutory obligations.*
10. *Consider if this incident was either "predictable or preventable".*
11. *Provide a written report to NHS England that includes measurable and sustainable recommendations.*
12. *Assist NHS England in undertaking a brief post investigation evaluation".*

6. The Independent Investigation Team

Selection of the Investigation Team

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

Independent Investigation Chair

Dr Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service - Chair, nurse member and report author

Investigation Team Members

Dr Liz Gethins	HASCAS Health and Social Care Advisory Service associate and consultant psychiatrist member of the team
Mr Ian Allured	HASCAS Health and Social Care Advisory Service Trustee and veterans' advisor to the team
Mrs Tina Coldham	HASCAS Health and Social Care Advisory Service associate and service advisor to the team

Support to the Investigation

Mr Greg Britton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Mrs Fiona Shipley	Stenography services

Independent Advice to the Investigation

Mr Ashley Irons	Solicitor, Capsticks

7. Investigation Method

7.1. In May 2014 NHS England commissioned the HASCAS Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section five of this report. The Investigation Methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr X and all witnesses to the Investigation.

Communications with Mr X

7.2. On 11 February 2014 Mr X signed a consent form allowing the Investigation access to his clinical records. On 11 July 2014 the Investigation Chair wrote to Mr X advising him that the Investigation had commenced and to offer him a meeting.

7.3. The Investigation Chair and a Senior Officer from NHS England met with Mr X at the prison in which he is detained on 8 October 2014. On this occasion the investigation process was explained to him. Mr X was offered the opportunity to see the investigation report prior to its publication and discuss the findings with the Investigation Chair and NHS England.

7.4. On 10 July 2014 a letter was written to Mr X's son so that communication could be established, support offered and input sought. A second letter was sent in April 2015. At the time of writing this report no contact was established.

Communications with the Family of Ms Y

7.5. The Trust Internal Investigation Team contacted the family and was able to ascertain that there were no issues they wished to have considered by the Trust.

7.6. On 10 July 2014 the Independent Investigation Chair wrote to the family to state that the Investigation was due to commence. The family was invited to make contact with the Investigation so that communication could be established, support offered and input sought. A second letter was sent on 19 March 2015. At the time of writing this report no contact was established.

Communications with the South Staffordshire & Shropshire Healthcare NHS Foundation Trust

7.7. NHS England made contact with the South Staffordshire & Shropshire Healthcare NHS Foundation Trust following the appointment of HASCAS. This communication served to notify the Trust that an Independent Investigation under the auspices of *HSG (94) 27* had been commissioned to examine the care and treatment of Mr X. A formal meeting was held between NHS England, the Investigation Team Chair and the Trust on 19 June 2014. Once the clinical records had been released and the Investigation process commenced. The Trust and GP-held records were released in August 2014.

7.8. The Independent Investigation Team worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished;
- that a briefing opportunity for witnesses was available;
- The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible;
- that interviews on 18 and 19 December 2014 were held at the Trust Headquarters;
- the Investigation Team were afforded the opportunity to interview witnesses and meet with the Senior Managers of the Trust.

7.9. Factual accuracy and headline findings communications were held between the Independent Investigation Team and the Trust in accordance with Investigation best practice.

7.10. The draft report was sent to the Trust for factual accuracy checking in March 2015. Relevant clinical witnesses were also sent key sections of the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

Witnesses Called by the Independent Investigation Team

7.11. Each witness called by the Investigation received an Investigation briefing pack and was provided with an opportunity to speak with the Investigation Chair in advance of interviews taking place. The Investigation was managed in line with national investigation good practice. The team could not call the GP as he was on sabbatical; however the GP practice was liaised with.

Table One
Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
2014	Consultant Nurse: Associate Clinical Director ********** Mental Health Services Director ********** Team Associate Specialist Psychiatrist 1 ********** Veterans' CPN ********** Community Mental Health Team	▪ Investigation Team Chair/Nurse ▪ Investigation Team Psychiatrist ▪ Investigation Team Veterans Advisor

	Leader	
2014	Trust Director of Quality and Clinical Performance and Trust Associate Director of Quality & Risk	▪ Investigation Team Chair/Nurse ▪ Investigation Team Psychiatrist ▪ Investigation Team Veterans' Advisor

Investigation Procedures

7.12. The Independent Investigation Team adopted accepted good practice during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be given the opportunity to review clinical records prior to and during the interview;

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

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

7.14. Prior to the first meeting taking place each clinical team member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference (non-clinical team members received a timeline in lieu of the clinical records to preserve patient confidentiality). It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

First Team Meeting

7.15. The Investigation Team examined and discussed the chronological timeline which had been produced following the receipt of the full clinical records. The Investigation Team decided which staff they wished to interview and agreed the questions they would ask. The list of documents required was made; this consisted of various Trust Policies and Operational Policies together with information about the Trust.

Second Team Meeting

7.16. There was opportunity during the interview schedule which allowed the Investigation Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the organisation and systems of the teams that had contact with Mr X and also management and governance issues.

7.17. Following the witness interviews the Investigation Team received the transcriptions and was able to add to the chronological timeline to reflect upon the additional information. There were also additional policies and procedures sent from the Trust which were examined. The Investigation Team was able to work in a virtual manner in order to complete the Root Cause Analysis methodology and develop the report findings and conclusions.

Other Meetings and Communications

7.18. The Independent Investigation Team Chair maintained communications on a regular basis with NHS England throughout the process. Communications were maintained inbetween meetings by email, letter and telephone.

Root Cause Analysis

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

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

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

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

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

8. Information and Evidence Gathered (Documents)

The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Trust clinical records for Mr X.
2. GP records for Mr X.
3. Trust Internal Investigation Reports and investigation archive.
4. Trust assurance and governance documentation.
5. Secondary literature review of media documentation reporting the death of Ms Y.
6. Independent Investigation witness transcriptions.
7. Independent Investigation witness statements.
8. Trust Clinical Risk Clinical Policies, past and present.
9. Trust Care programme Approach Policies, past and present.
10. Trust Incident Reporting Policies.
11. Trust Being Open Policy.
12. Trust Operational Policies.
13. Healthcare Commission/Care Quality Commission Reports for South Staffordshire & Shropshire Healthcare NHS Foundation Trust.
14. NICE guidance PTSD and also Depression in Adults.
15. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive (2006).
16. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed* (September 2005).

9. Profile of the South Staffordshire & Shropshire Healthcare NHS Foundation Trust

9.1. The Trust provides mental health, learning disability and specialist children's services across South Staffordshire, and mental health and learning disability services in Shropshire and Telford and Wrekin. Some services are also provided on a wider regional or national basis.

9.2. South Staffordshire Healthcare NHS Trust became a Foundation Trust in May 2006 and integrated services from Shropshire in June 2007. The Trust serves a population of 1.1 million over a geography of 2,000 square miles with around 3,500 staff. The Trust turnover is £179 million each year.

9.3. In latter years, since the homicide of Ms Y, the Trust has provided a service to Veterans. This service is available to anybody who has been in the British Army, Royal Navy or Royal Air Force for at least one day in either the regular or reserve forces. The service outcomes are to:

1. Provide a seamless fast-track care pathway for veterans with mental health needs.
2. Refine the care pathway for veterans.

3. Facilitate training and education around the cultural needs of military personnel.
4. Provide a Mental Health clinical lead to champion and facilitate enhanced services for veterans.
5. Monitor the flow of veterans through the care pathway ensuring seamless transition between services.
6. Ensure the co-ordination of assessments.
7. Provide logistical support to enable referrals from third sector organisations to be shared quickly with appropriate colleagues within the NHS.
8. Ensure existing providers support veterans' mental health as a vulnerable group resident in the local community.
9. Follow up with providers the treatment options and outcomes for patients.
10. Provide a one-stop service for NHS, social care and 3rd sector professionals for information on mental health services in the West Midlands.
11. Provide engagement and support to existing veteran Mental Health Services provided by other organisations in the region (West Midlands).

9.4. The expected outcomes are:

1. Better patient satisfaction of healthcare services; provided by:
2. Better Mental Health outcomes.
3. Reduction in mental health morbidity.
4. Better utilisation of healthcare resources (community and hospitals) by patients.
5. Improved engagement with veterans.
6. Increased carer and staff satisfaction.
7. Promotion of the needs of veterans with mental disorder.
8. Raised awareness of the importance of mental health.
9. To promote the routine assessment of veteran mental health.
10. A reduction of stigma.

9.5. Referrals into the service can be from GPs, Community Mental Health Services, Crisis Home Treatment Teams, self referrals, Defence Medical Services, inpatient wards, primary care, and third sector organisations. All requests for initial assessments will be responded to within three working days. All requests for assessment will be allocated within four weeks of the referral being made. The assessment can be undertaken in a location agreed by all parties.

9.6. Discharge from the service occurs following a discharge summary which details any future care plan in keeping with the principles of 'Recovery'. All discharge planning occurs with service user and carer involvement and agreement.

10. Chronology of Events

This Forms Part of the RCA First Stage

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

10.2. Mr X was born on **3 March 1952**. He joined the army at the age of 15 immediately after leaving school. He has been diagnosed with PTSD and depression which was thought by the Court to be a factor in the killing of his former partner. However Mr X has always had problems with his temper and with fighting, long before joining the army.

10.3. In **September 1998** Mr X referred himself to the Shropshire Mental Health Team as he was suffering from depression. He was offered an appointment which he did not keep and was subsequently removed from the caseload. The depression was due to his separation from his wife. At this time Mr X described himself as desperate; it was recorded in the GP record that he had no former psychiatric history.[2]

10.4. On **19 October 2010** Mr X visited his GP surgery. Two weeks previously he had separated from his long-term partner, Ms Y, and was living in his car. He had been in touch with the council regarding future accommodation and he was feeling emotional.[3]

10.5. On **27 October 2010** Mr X's GP referred Mr X to secondary care mental health services. Mr X had been admitted to the Royal Shrewsbury Hospital the previous Sunday after taking an overdose of sleeping tablets and Co-codamol. Mr X's partner had recently left him after a 15 year relationship. She had been the person that supported him and he found it very difficult to cope without her. Mr X denied the overdose was a suicide attempt; rather he described it as an attempt to get some sleep to escape emotional pain. The GP had commenced Mr X on Mirtazapine 30mg at night, however he also felt that Mr X needed some additional support and made the referral. At this stage Mr X had not been assessed as having *"a mental health issue as such"* but a reactive depression. It was noted that Mr X said he no longer drank alcohol.[4]

10.6. Mr X was seen by secondary care mental health services on **9 November 2010**. Team Associate Specialist Psychiatrist 1 ascertained that Mr X had served in the army from the time he left school (aged 15 years) up until the age of 30. Five a half years of this time was spent with the Special Forces. The assessment concluded that Mr X was suffering from Post Traumatic Stress Disorder. This made it difficult for him to hear loud percussive sounds such as firework displays and he had also been suffering from nightmares. Two of the recurring themes in his nightmares were having a friend die in his arms in the Falkland's and listening to the screams of children being raped in Cyprus during a 12 hour ordeal. His mood had been deteriorating over recent months and he had been becoming irritable and had hit his partner, Ms Y, in a rage over something trivial. This was out of character for him and he left to sleep on his son's sofa which he was continuing to do. Mr X was trying to make amends with his partner and needed some help in order to move forward, but the relationship with Ms Y had broken down. He was however speaking to her again and she had encouraged him to seek help from the GP. Mr X said he had received counselling in **1998** at his GP surgery when his marriage broke down due to his wife being unfaithful. Mr X's current medication was listed as being:

- Mirtazapine 30mg at night;

2. GP records p 51
3. GP records p 5
4. clinical records pp 8 – 10 and p 88

- Medication for angina.

10.7. Mr X's mental state was described as depressed with poor sleep. His appetite was poor and he had lost a stone in weight. He was free from suicidal thoughts and psychotic symptoms. The diagnoses were:
- depressive episode;
- post traumatic stress disorder.

10.8. Mr X was assessed as being a low risk to himself and others and he was not deemed to be a risk to Ms Y. The plan was to continue with the medication, to refer to Combat Stress and to review Mr X again on **15 December**. A letter was sent to the GP detailing this information and copied Combat Stress and a referral was also made on this day.[5]

10.9. On **14 December 2010** Mr X stabbed his former partner to death. He inflicted 28 separate stab wounds upon her at their former home.

10.10. On **17 December 2010** Mr X was assessed by secondary care mental health services and an entry was made in the clinical record (he was not detained in a mental health facility). Mr X had killed Ms Y and then tried to hang himself before the arrest. He was low in mood but said he was not suicidal although it was thought that his risk of suicide remained high.[6]

10.11. Mr X was assessed on **20 December 2010** by a Forensic Psychiatrist; Mr X index offence was listed as *"murder".* It was recorded that Mr X had already hit his partner *"once"* and had been sleeping on his son's settee. It was recorded that Mr X had depressive episodes with PTSD. He had started Mirtazapine and it was noted *"referral to Combat Stress active".*

10.12. Whilst in the army Mr X had been told to imagine his mind to be like a locker where he could lock up all the *"the bad stuff".* When he re-joined *"Civvy Street"* Mr X described having a bad temper and that he had punched his first boss. Mr X said he had calmed down as he grew older but that he would occasionally experience a low mood, anxiety and racing thoughts. More recently his temper had become a problem and he had become angry at small *"silly things".* Mr X was described as being very emotional and tearful which was not usual for him as he normally kept things *"under wraps".* His sleep pattern was disrupted and he only managed to cat nap at night. He was using Zopiclone 7.5mg to help him sleep but he was still waking with thoughts racing around his head. Mr X was well kempt and was eating *because "staff encourage".* He stated that he wanted to be with *"his lady".* This was explored but there was no evidence that Mr X was contemplating taking his life. He said he was disappointed that the police stopped him (presumably from self harming) and he thought he should be dead. His next Court appearance was listed as being **21 December 2010**. The biggest question Mr X had was *"why"* he had this in him.[7]

10.13. It was noted that Mr X was currently on remand for the unlawful killing of his partner of ten years. It was recorded that Mr X had four adult children and 11 grandchildren. There was no evidence of severe or enduring mental illness. After

5. clinical records pp 78 -80
6. clinical records pp 109 - 111
7. clinical records pp 15 – 26

killing his partner Mr X had planned to end his life with a ligature but the police arrived before he could use it and because the overdose he had taken had made him too drowsy to use the ligature.[8]

10.14. On 21 February 2011 during an assessment in prison Mr X said that he had a history of drinking heavily. In recent times he had tried to limit this to social drinking but admitted he would drink heavily at weekends although he had not kept alcohol in the house.[9]

10.15. In November 2010 Mr X was convicted of manslaughter with diminished responsibility. He was sentenced to twelve yeas in prison with a minimum of six years to be served.

11. Identification of the Thematic Issues

11.1. Thematic Issues

11.1. The Independent Investigation Team identified eight thematic issues that arose directly from the Terms of Reference. These thematic issues are set out below.

1. Diagnosis.
2. Medication and Treatment.
3. Clinical and Risk Assessment.
4. Referral Processes.
5. Interagency Working.
6. Service User Involvement in Care Planning and Treatment.
7. Documentation and Professional Communication.
8. Adherence to Local and National Policy and Procedure, Clinical Guidelines**.**

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

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

- serious incident reported = serious injury to limb
- immediate cause = wrong limb operated upon (ask why?)
- wrong limb marked (ask why?)
- notes had an error in them (ask why?)
- clinical notes were temporary and incomplete (ask why?)

8. clinical records pp 27 - 28 and 35 - 39
9. clinical records pp 104 - 105

- original notes had been mislaid (ask why?)
- (because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

12.2. Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. The Court convicted Mr X of manslaughter with diminished responsibility and sent him to prison. No connection was made between his mental state at the time of the homicide and the care and treatment he received.

RCA Third Stage

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

1. Areas of practice that fell short of both national and local policy expectation.
2. Causal, contributory and service issue factors.

12.4. The terms 'causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

12.5. **Causal Factors:** in the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used to describe any act or omission that had a direct causal bearing upon the failure to manage a mental health service user effectively and a consequent homicide. None were found by the Investigation.

12.6. **Contributory Factors:** the term is used to denote a process or a system that failed to operate successfully thereby leading an Independent Investigation Team to conclude that it made a direct contribution to the breakdown to a service user's mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party. None were found by the Investigation.

12.7. **Service Issue:** the term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Ms Y need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made. None were found by the Investigation.

Findings Relating to the Care and Treatment of Mr X

12.8. The findings in this chapter analyse principally the care and treatment given to Mr X. The reader is referred to the narrative chronology for supporting information. Mr X's contact with mental health services was fleeting as he killed Ms Y shortly after his first contact. It should be remembered that Mr X was seen by his GP in October 2010 on two occasions in relation to his mental health, and secondary care mental health services saw him only once on 9 November 2010. This means that any analysis into the quality of the care and treatment Mr X received can only be based upon the limited contact that he had.

Diagnosis

Context

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

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

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

Depression

12.12. NICE guidance states that:

> *"Depression is a common mental health problem – it affects nearly one in six people in the UK. The main symptoms of depression are losing pleasure in things that were once enjoyable and losing interest in other people and usual activities. A person with depression may also commonly experience some of the following: feeling tearful, irritable or tired most of the time, changes in appetite, and problems with sleep, concentration and memory. People with depression typically have lots of negative thoughts and feelings of guilt and worthlessness; they often criticise themselves and lack confidence. Sometimes people with depression harm themselves, have thoughts about suicide, or may even attempt suicide. Occasionally a person with severe depression may have hallucinations and delusions. People with depression may have feelings of anxiety as well".*[10]

Post Traumatic Stress Disorder

12.13. The National Institute for Health and Clinical Excellence (NICE) quick reference guide for Post Traumatic Stress Disorder states that:

> "*PTSD can develop in people of any age following a stressful event or situation of an exceptionally or catastrophic nature...symptoms often develops immediately after the traumatic event but the onset of symptoms may be delayed in some people (less than 15%)... Assessment can present significant challenges as many people avoid talking about their problems."*[11]

12.14. The NICE quick reference guide lists the following symptoms associated with PTSD:

- *"Re-experiencing – flashbacks, nightmares*
- *Avoidance - avoiding people, situations or circumstances associated with the event*
- *Hyperarousal - hypervigilance for threat, sleep problems and irritability*
- *Emotional numbing-lack of ability to experience feeling*
- *Depression*
- *Drug or alcohol misuse*
- *Anger*
- *Unexplained physical symptoms".*[12]

Findings

Findings of the Trust's Internal Investigation

12.15. The internal investigation found that Team Associate Specialist Psychiatrist 1 was formulating diagnoses of a depressive episode and a post traumatic stress disorder (PTSD). The diagnoses were supported by the clinical presentation, mental state examination and social history.

10. http://www.nice.org.uk/guidance/cg90/ifp/chapter/depression
11. National Institute for Health and Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26 P 5
12. National Institute for Health and Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26 P6

12.16. The Independent Investigation concurs with this finding.

Findings of the Independent Investigation

12.17. Mr X presented to his GP on 19 October 2010, he was emotional, and the contextual issues identified were that he had broken up with his long term partner and was homeless. The GP saw Mr X again on the 27 October 2010, the contextual factors noted on this occasion were that Mr X had been treated for an overdose the previous weekend (Mr X denied suicidal ideation) and was having difficulty coping with the end of the relationship. It was also noted that Mr X no longer drank alcohol. This was important in that Mr X had used alcohol to excess in the past. As Mr X was presenting with what the GP felt was a reactive depression, he was commenced on antidepressant (Mirtazapine) and referred to the mental health services for extra support.

12.18. Mr X was sent an appointment letter two days later (29 October 2010) and was seen by the team Associate Specialist Psychiatrist on 9 November 2010 – 13 days after the initial referral. Mr X attended that appointment and the clinical records demonstrate that a thorough history was taken which included details of Mr X's social situation, his army background and trauma experiences which were an active part of his psychological presentation, his relationship history, the recent overdose and his emotional state. Mr X was noted to present as depressed with weight loss and poor sleep, but with no suicidal ideation and evidence of some hope for the future. There was no evidence of psychosis.

12.19. Mr X was noted to be insightful, open, remorseful for his actions (he had previously hit his partner), had demonstrated taking some control and responsibility for his situation (moving out of the house and going to stay with his son and avoiding alcohol) and while he was emotional, it was thought that his armed forces background gave him skills in emotional containment. There was no evidence that he presented a risk to himself or to his ex-partner.

12.20. The diagnosis after initial interview was that of depression (reactive to his current social circumstances) with co-morbid symptoms of PTSD – it was noted that he did not have flashbacks or hyperarousal symptoms. As Mr X's GP had already commenced him on an antidepressant, he was advised to continue taking this, he was referred to Combat Stress for assessment and psychological support, and he was to be reviewed again on 15 December 2010 to review his progress and further explore his depression, his coping strategies and his trauma symptoms. Mr X stabbed his ex-partner to death on 14 December so this review never took place.

Conclusions

12.21. The Independent Investigation agrees that Mr X's primary presentation was that of a reactive depression. The Investigation also agrees that Mr X was presenting with symptoms of PTSD secondary to his historical army experiences. We agree that this diagnosis needed further exploration and clarification, and the intention was to do this at the next out-patient appointment.

Medication and Treatment

Context

12.22. The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

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

12.24. Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and / or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders. In prescribing medication there are a number of factors that the doctor must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

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

12.26. The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly / monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

12.27. The NICE quick reference guide for PTSD recommends the following action be taken:

- *"Assessment should be comprehensive and should include a risk assessment, assessment of physical, psychological and social needs*
- *Give PTSD sufferers sufficient information about effective treatments and take into account their preference for treatment*

- *Provide practical advice to enable people with PTSD to access appropriate information and services for the range of emotional response that may develop*
- *Identify the need for social support and advocate for the meeting of this need*
- *Familiarise yourself with the cultural and ethnic backgrounds of PTSD sufferers*
- *Consider using interpreters and bicultural therapists if language or cultural differences present challenges for trauma-focused psychological interventions"*[13]

12.28. Additional recommendations include:

- ensure sufferers understand the emotional reactions and symptoms that may occur;
- respond appropriately if a PTSD sufferer avoids treatment;
- keep technical language to a minimum;
- only consider providing trauma-focused psychological treatment when the patient considers it safe to proceed;
- ensure treatment is delivered by competent individuals;
- where depression is present consider treating the PTSD first, unless the depression is severe;
- prioritise any high risk of suicide or risk of harming others.

Findings

Findings of the Trust's Internal Investigation

12.29. The internal investigation found that Mr X had been prescribed Mirtazapine by his GP and that it was clinically appropriate for the Associate Specialist Psychiatrist to recommend that this be continued in order for it to take effect. The treatment plan for Mr X was found to be in keeping with NICE guidelines for depression.

12.30. The Independent Investigation concurs with this finding.

Findings of the Independent Investigation

12.31. The Independent Investigation found that the care and treatment pathway pursued by Mr X's GP and the Associate Specialist Psychiatrist were appropriate. This was treatment with an antidepressant and provision of support. The Investigation had a discussion about medications recommended by the NICE guidelines in the context of treating PTSD and whether or not Mr X should have been commenced on a different antidepressant. However the primary focus for treatment at the time was Mr X's depressive symptomatology, and in our view the prescription and continuation of Mirtazapine was entirely appropriate.

12.32. The Investigation also found that Mr X was presenting with symptoms of PTSD secondary to his historical army experiences. This diagnosis needed further exploration and clarification, and the intention was to do this at the next out-patient appointment planned for the 15 December. However enough information had been obtained as to make it clear that Mr X would need some specialist intervention, and the Investigation found that the referral to Combat Stress (with whom the Trust have positive working relationships) was appropriate in this case.

13. National Institute for Health and Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26. PP. 8-10

Conclusions

12.33. The Investigation concluded that secondary care mental health services responded promptly and efficiently to the GP's request for intervention. This was good practice. Whilst national guidelines suggest PTSD is treated before depression, the Investigation concluded that Mr X's depression required immediate attention and this was managed well. Mr X's clinical care and treatment for the short time that he presented to primary and secondary care services was appropriate and met the requirements of national clinical guidelines.

Clinical and Risk Assessment

Context

12.34. Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

12.35. The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

12.36. It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

> *Best Practice in Managing Risk* (DoH June 2007) states that *"positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed".*[14]

12.37. As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

12.38. Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others,

14. Best Practice in Managing Risk; DoH; 2007

or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

NICE Guidelines for Depression – Assessment and Review

12.39. The NICE guidance for follow up reviews states that:

> *"The review period should be determined by the risk of suicide and the need to assess the tolerability and effectiveness of any treatments started or changed. In general, for people not considered to be at an increased risk of suicide:*
>
> - *Arrange an initial review: Within 1 week for people less than 30 years of age who have been started on an antidepressant.*
> - *Within 2 weeks for other people.*
> - *Arrange subsequent reviews every 2–4 weeks for the first 3 months and if the response to treatment is good, longer review intervals can be considered".*[15]

Findings

Findings of the Trust's Internal Investigation

12.40. The internal investigation found that the Associate Specialist Psychiatrist explored the fact that Mr X had hit his partner, Ms Y, a month earlier. It was considered that this act of violence had occurred in the context of an argument and was out of character. Mr X appeared to show genuine remorse and said he had taken steps to prevent a similar situation from happening again. The Psychiatrist had anticipated concluding the initial assessment of risk when he next saw Mr X and if appropriate ask some more searching questions in relation to his experiences and past behaviour. The risk assessment conducted on 9 November 2010 was considered by the review team to be acceptable, sufficient and proportionate to Mr X's presentation.

12.41. The Independent Investigation concurs with this finding in general.

Findings of the Independent Investigation

12.41. The NICE guidance for PTSD requires that a detailed risk assessment be undertaken at the first opportunity. It is evident from reading the clinical records, and from the interview the Independent Investigation held with the Associate Specialist Psychiatrist, that a detailed and thorough clinical and risk assessment was conducted. It is also evident that Mr X was perhaps economical with the truth regarding his drinking which later forensic reports showed to be out of control; however without the benefit of hindsight this could not have been known to either the GP or the Associate Specialist Psychiatrist in November 2010.

12.42. The Associate Specialist assessed Mr X's risk of suicide and harm to others. He thought that at the time of the assessment Mr X's risk on both counts was low. However he also understood that the assessment would need to be continued at the next review. This was set for the 15 December 2010 representing an interval of five

15. http://cks.nice.org.uk/depression#!scenario

weeks and one day. NICE guidance for newly diagnosed depression recommends (for an individual presenting in the way that Mr X did) a shorter interval of time for the second follow up review. A period of no longer than two weeks is recommended.

Conclusions

12.43. The Independent Investigation concluded that without the benefit of hindsight the clinical and risk assessments conducted in November 2014 were thorough and detailed based upon was what known at the time about Mr X. It would have been good practice to have followed Mr X up within a shorter interval of time in keeping with NICE guidelines for depression especially as he had also been assessed as suffering from PTSD. However this omission can not be seen as either a causal or contributory factor in the homicide of Ms Y. The Independent Investigation has identified this, in the interest of learning, as a service issue for the Trust's consideration.

- ***Service Issue 1. NICE guidance was not adhered to in relation to follow up intervals.***

Referral Processes

Context

12.44. Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

Findings

Findings of the Trust's Internal Investigation

12.45. The internal investigation found that the GP referral was processed by the secondary care mental health community team. The decision was made that the referral required the assessment of an Associate Specialist Psychiatrist. The internal investigation found this to be an appropriate decision as the Psychiatrist had the appropriate skills and experience in assessing and treating individuals with Post Traumatic Stress Disorder.

12.46. The Independent Investigation concurs with this finding.

Findings of the Independent Investigation

12.47. The Independent Investigation found the initial GP referral to be made in a timely manner. Secondary care mental health services picked the referral up quickly and Mr X was assessed by a Psychiatrist with the appropriate skills and experience. Mr X was referred on to Combat Stress and this was an appropriate thing to do. Whilst Mr X waited to be seen by Combat Stress a care and treatment plan was developed; this was good practice.

Conclusions

12.48. The Independent Investigation concluded that referral processes followed good practice and were managed in an appropriate and timely manner.

Service User Involvement in Care Planning and Treatment

Context

12.49. The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:
"… the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

12.50. In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"… people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. It also stated that it would *"… offer choices which promote independence".*

Findings

Findings of the Trust's Internal Investigation

12.51. The internal investigation did not examine this aspect.

Findings of the Independent Investigation

12.52. The Independent Investigation found that Mr X received care and treatment that was sensitive and person-centred. It was evident that he was able to build up a rapport with the Associate Specialist Psychiatrist who was himself a veteran.

Conclusions

12.53. The Independent Investigation concluded that the care and treatment Mr X received was in keeping with NICE good practice guidance in relation to first contacts for service users with depression. Mr X was consulted fully and supported in making an informed decision about his future care and treatment pathway.

Documentation and Professional Communication

Context

Documentation

12.54. The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance.

12.55. The GMC states that:
"Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without

reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off".[16]

12.56. Pullen and Loudon writing for the Royal College of Psychiatry state that: *"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised".*[17]

Professional Communication

12.57. *"'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion".*[18]
Jenkins *et al* (2002)
Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. Interagency communication when working effectively should take place in a service user-centric manner.

12.58. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.[19]
The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

Findings

Findings of the Trust's Internal Investigation

12.59. The internal investigation did not examine this aspect.

Findings of the Independent Investigation

12.60. The Independent Investigation found the clinical documentation in both primary and secondary care to be of a good standard. Professional communication between primary and secondary care was clear, detailed and timely.

Conclusions

12.61. The Independent Investigation concluded that documentation and professional communication adhered to both local and national good practice guidance.

Adherence to Local and National Policy and Procedure

Context

12.62. Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients".*[20] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

16. http://www.medicalprotection.org/uk/factsheets/records
17. Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) pp 280-286
18. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy,* (2002) p121
19. Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)
20. Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p 328

12.63. **Corporate Responsibility:** policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored below.

12.64. **Team Responsibility:** clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

12.65. **Individual Responsibility:** all registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

Findings and Conclusions

Findings of the Trust's internal Investigation

12.66. The internal investigation found that the Associate Specialist Psychiatrist worked within both local and national best practice guidelines.

Findings of the Independent Investigation

12.67. Based on the limited contact Mr X had with both primary and secondary care services in relation to his mental health the Independent Investigation concurred with the findings of the internal investigation.

13. Summary Conclusions Regarding the Care and Treatment Given to Mr X

Care and Treatment

13.1. The care and treatment that Mr X received in 2010 from primary and secondary care services was in keeping with both local and national good practice guidance. It was apparent to the Investigation that Mr X was managed in a compassionate and sensitive manner by health care professionals who were suitably experienced and qualified.

13.2. Mr X's referrals were managed in a timely manner and the initial assessments and care and treatment plan were entirely in keeping with Mr X's presentation. The Investigation considered whether or not a more detailed risk assessment should have been undertaken in relation to Mr X's self reported irritation and temper and the fact that he had hit his partner. However it was evident from reading the clinical record, and from interviewing Associate psychiatrist 1, that a detailed mental state

examination had been conducted and that in balance Mr X's risks as they were assessed at the time were managed appropriately. It was identified that Mr X:

- had self-presented to his GP seeking help and support;
- had good insight into his feelings and behaviour;
- stated his recent overdose was not a suicide attempt - he had only wanted to sleep for a while to forget his problems and that he did not want to die;
- had no previous history of mental health problems, apart from a short depressive episode several years earlier;
- was taking steps to remove himself from his partner and was living with his son;
- had stopped drinking;
- showed remorse and said that he acted uncharacteristically when he hit his partner and that he would never do this again;
- was amenable to medication and treatment and was fully compliant with this;
- would contact services if he felt he needed more emergency assistance before his next review.

13.3. The Investigation found that there was one aspect of Mr X's care and treatment that could have been managed differently and that was the interval of time between the first consultation with Associate Specialist Psychiatrist 1 on 9 November 2010 and the planned second review for 15 December 2010. It would have been good practice to have followed him up within two weeks of the initial consultation in line with his newly diagnosed depression, PTSD and medication regimen (NICE guidance). However it cannot be determined whether or not an earlier review would have prevented the death of Ms Y.

Summary

13.4. Mr X was convicted of manslaughter with diminished responsibility. He was sentenced to twelve years in prison with a minimum of six years to be served. Whilst his depression and PTSD were accepted as mitigation Mr X was not deemed to be suffering from a severe or enduring mental illness at the time of the homicide or directly thereafter.

13.5. The Investigation was asked to determine whether or not the killing of Ms Y was either predictable of preventable.

13.6. The Investigation concluded that Mr X had a newly diagnosed depression and symptoms compatible with PTSD. He had taken an overdose shortly before his referral to secondary care mental health services and had hit his partner in an uncharacteristic outburst. On face value another incident of *some kind* could have been predicted. However on careful examination by Associate Psychiatrist 1 on 9 November 2010 Mr X appeared to have reflected on his past behaviour and was convinced that he would not repeat either another self harm attempt or act of violence. As has already been mentioned above, it would have been good practice to have followed Mr X up within a shorter interval of time in order to re-assess and monitor Mr X's progress. This was not done. However based on what was known about Mr X at the time (bearing in mind he had told no one about his heavy drinking and had in fact denied this when asked about his alcohol intake) an act of homicide could not have been predicted and in all probability could not have been prevented.

14. South Staffordshire & Shropshire Healthcare NHS Foundation Trust Response to the Incident and Internal Review

The Trust Serious Untoward Incident Process

Initial Reporting of the Incident

14.1. The homicide was reported to the Trust on the 15 December 2010 and an incident form was completed and a Strategic Executive Information System (STEIS) incident reported.

The Trust Internal Investigation

The Internal Investigation Review Team personnel

14.2. The Trust internal investigation team was comprised of a:

- Consultant Psychiatrist, General Psychiatrist with expertise in providing mental health care for veterans;
- Consultant Nurse/Associate Clinical Director, Mental Health Services (Lead Investigator).

The Terms of Reference

14.3. *"This report is concerned with the circumstances of a Serious Incident whereby … [Mr X], who had been in the process of receiving care from mental health services of Shropshire, is alleged to have killed his partner. … [Mr X] is currently remanded to Prison.*

14.4. *The purpose of this report is to review the care and treatment provided to … [Mr X] leading up to the incident.*

14.5. *The process is essentially one of examining systems and process within the organisation. The review team appraise the care provided in order to determine if there are any underlying causes and contributory problems and to establish whether there are any lessons that can be learnt which may minimise a recurrence of similar incidents. Additionally care delivery is evaluated against Trust policy and relevant national guidance and professional standards. The process will establish if any failing occurred in the care or treatment afforded to the deceased. Finally the review will identify good practice and make recommendations for the future actions by the directorate and Trust.*

14.6. *In the event of any matters arising out of the review that are unrelated to the incident these will be shared with the appropriate Director".*

Methodology

14.7. The internal investigation used Root Cause Analysis (RCA) methodology and the Trust's Serious Incident investigation proforma.

Key Findings, Analysis and Conclusions

14.8. There were no causal, contributory factors or care and service delivery problems identified. The internal investigation found that the assessment conducted by the Trust was of the expected standard and that interventions were in line with National Guidance. The internal investigation made no recommendations.

Being Open

14.9. The Trust Lead Investigator contacted the families of both Ms Y and Mr X; the contact details were negotiated via the Police Family Liaison Officer. Ms Y was survived by her daughters, one of whom was living in Germany at the time of her death. The family of Ms Y was sent a letter of condolence and offered a meeting with the Trust. In the event communication was limited to telephone conversations. The family of Ms Y did not require any ongoing support and identified no specific issues that they wanted the internal investigation to pursue. Ms Y's family was also given a copy of the Trust internal investigation report.

Staff Support

14.10. The Associate Specialist Psychiatrist advised the Independent Investigation that he had been supported throughout the Trust internal investigation process. The community team were debriefed at the time of the homicide and this process was led by senior clinical team members.

Independent Investigation Team Feedback on the Internal Investigation Report Findings

14.11. The Independent Investigation found the Trust internal investigation to have been managed in a competent manner by suitably experienced and qualified individuals. We concur with the findings of the internal review team. Of particular note is the contact made to the families of both Mr X and Ms Y. The Trust was proactive in making contact with them and tried to involve both families fully with the investigation process. The Trust sought to share the report findings with the families and offered a consistent level of communication and support. This was good practice.

14.12. The Trust is to be commended for its serious incident handling. All serious incidents are discussed in Directorate quality groups. Within these groups investigation findings are discussed and practical solutions are often generated to improve patient safety in a timely manner. Another area of good practice is the 'serious incident clinic' which supports the work of investigation officers and ensures the quality of the investigation process from inception to completion.

14.13. The Independent Investigation noted that there were no lessons for learning identified in the internal investigation report. However we asked members of the Trust Governance Team how lessons for learning were disseminated following other kinds of Serious Incident Investigations. We were told that the Trust has recently set up a 'Start and Finish Group' to ensure that investigation processes are managed in a systematic manner and to ensure that all lessons are learned and disseminated throughout the organisation. Key recommendations from investigations are also managed on an electronic system called Performance Plus. This system tracks progress and ensures that actions are not 'lost'. The Trust holds annual learning the lessons events and this is now supplemented by a learning the lessons bulletin. Where there are repeated incidents and the emergence of themes a 'Red Top Alert' goes to all teams across the service to ensure the immediate dissemination of the actions required to prevent further incidents. When relevant, lessons for learning are linked to local policy and NICE guidelines to reinforce good practice, also when relevant local policies are amended to incorporate lessons for learning and investigation recommendations. In addition, to aide the management of risk, quarterly risk reports are completed and made available to all managers of service.

15. Notable Practice and Current Trust Services

15.1. The South Staffordshire and Shropshire Healthcare NHS Foundation Trust currently provides care and treatment services to veterans. It should be noted that the care and treatment Mr X received from the Trust in 2010 pre-dated the development of these services. The Terms of Reference for the investigation requires an examination of current service in order to determine *"if the current services available for veterans meets the MoD and charitable organisations such as Combat Stress quality standards".* This Chapter is supported by Appendix One which sets out the Trust's current practice in relation to PTSD and veteran services.

Veterans

Background

15.2. In 1953 a War Pension was introduced for veterans with physical health disabilities and mental health disorders. The NHS was involved in providing healthcare once a veteran had left the army, although many such veterans also attended the three Combat Stress facilities for both medical and social needs.

15.3. Combat Stress is a registered charity that was set up in 1919 just after the First World War. At the end of the War there were thousands of men returning from the front suffering from shell-shock. Many were confined in Mental War Hospitals under Martial Law - with the risk of being sent on, without appeal, to asylums. Today Combat Stress works with more than 5,600 Veterans who suffer mental ill-health. It's residential and community treatment programmes support Veterans with severe PTSD, anxiety and depression. Combat Stress also works in partnership with other organisations to support the welfare of Veterans within their communities.

15.4. In 1997 the arrangements with the NHS were expanded and veterans no longer needed to have a War Pension to gain access to mental healthcare provided the GP considered that the individual was suffering from a mental illness. This arrangement was relatively 'fast track' with a target set so the individual could receive NHS support within 17 weeks of being referred to the appropriate service. In more recent years guidance has been developed which sets out the responsibilities of the NHS and the Ministry of Defence (MoD) and what is expected of an effective service for Veterans.

The Military Covenant

15.5. The NHS document *No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages* was published in February 2011. This provided the basis for government policy aimed at improving the support available to the armed forces community. Mental health services have a key role to play in fulfilling this covenant. Ways to provide additional help were explored through six joint MoD/NHS mental health pilots which had been established by HASCAS Health and Social Care Advisory Service, the MoD and the NHS. The findings assisted other mental health services to make special provision for veterans during 2011/2012. The South Staffordshire and Shropshire Healthcare NHS Foundation Trust was one of the HASCAS, NHS and MoD Pilot sites.

15.6. Section 15 of the Health and Social Care Act 2012, gives the Secretary of State the power to require NHS England to commission certain services instead of clinical commissioning groups (CCGs). These include services or facilities for members of the Armed Forces or their families. These regulations define the scope of responsibility as being for any serving member of the Armed Forces stationed in England and any family dependents who are registered with Defence Medical Services (DMS). In addition, reservists who require NHS health services while mobilised will be the commissioning responsibility of NHS England. Those stationed overseas who return to England to receive health services are the responsibility of NHS in England and the outcome will depend on what service is needed and where.

15.7. For family members, primary healthcare may be provided by the MoD in some cases (for example when accompanying service personnel posted overseas). They should retain their relative position on any NHS waiting list, if moved around the United Kingdom due to the service person being posted. Veterans receiving their healthcare from the NHS should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in Service, whether physically or mentally, should be cared for in a manner which reflects the Nation's moral obligation to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of the Armed Forces culture.

15.8. The MoD, when considering veterans' health issues, including mental health needs, relies on the NHS in England and the Devolved Administrations to ensure that the services that it provides to veterans, as a specific group in the general population, are appropriate. The changes to the NHS commissioning arrangements in England introducing Clinical Commissioning Groups (CCGs), should enable CCGs

to provide services tailored to their local community; with the expectation that CCGs with a large number of veterans in their patient community will commission more services for veterans than CCGs where there is a smaller population. This is supported by the proposal that there should be a GP champion for veterans in every CCG. All of this supports the aims of both MoD and Department of Health to encourage service leavers to identify themselves as a veteran when they register with an NHS GP/GP Practice after leaving the Armed Forces to ensure that their needs are recognised.

Fighting Fit - mental health plan for servicemen and veterans

15.9. There are four principal recommendations within the *Fighting Fit* document. These are:

- *"incorporation of a structured mental health systems enquiry into existing medical examinations performed whilst serving;*
- *an uplift in the number of mental health professionals conducting veterans outreach work from Mental Health trusts in partnership with a leading mental health charity;*
- *a Veterans Information Service (VIS) to be deployed 12 months after a person the Armed Services;*
- *trial of an online early intervention service for serving personnel and veterans".*

15.10. Some of the above recommendations were necessary as the actual numbers of servicemen and veterans attending the six pilot sites was relatively small, and more publicity or signposting was deemed necessary, hence the inclusion of mental health in more routine medicals.

NHS England's Responsibility to the Armed Forces

15.11. The 'Mandate' to the NHS from the Government for April 2014 to March 2015 includes a sentence which states that the NHS will demonstrate progress against the Government's priorities which includes *"upholding the Government's obligations under the Armed Forces Covenant*". In the past 12 months new ways of working for the MoD and the NHS have been developed. NHS England has a dedicated team of Armed Forces healthcare commissioners. For the first time, a single, national organisation is commissioning the majority of services required by the Armed Forces community, which includes mobilised reservists and some families. This duty is carried out by NHS England's National Support Centre and its three lead area teams: North Yorkshire and Humber (North); Derbyshire and Nottinghamshire (Midlands and the East); and Bath, Gloucestershire, Swindon and Wiltshire (South, including London).

15.12. As well as these teams, NHS England has been working with other partners, including a full range of service supporting charities and the Department of Health (DH) and the Local Government Association (LGA), to improve the services available to veterans and raising awareness of veteran's health and mental health issues within ex-service communities. This is all part of helping to connect other parts of the health system for this population, notably with CCGs, local authorities, providers and health and wellbeing boards.

Current Services within the South Staffordshire and Shropshire Healthcare NHS Foundation Trust

15.13. In latter years, since the homicide of Ms Y, the Trust has provided a service to Veterans. This service is available to anybody who has been in the British Army, Royal Navy or Royal Air Force for at least one day in either the regular or reserve forces. The service outcomes are to:

1. Provide a seamless fast-track care pathway for veterans with mental health needs.
2. Refine the care pathway for veterans.
3. Facilitate training and education around the cultural needs of military personnel.
4. Provide a Mental Health clinical lead to champion and facilitate enhanced services for veterans.
5. Monitor the flow of veterans through the care pathway ensuring seamless transition between services.
6. Ensure the co-ordination of assessments.
7. Provide logistical support to enable referrals from third sector organisations to be shared quickly with appropriate colleagues within the NHS.
8. Ensure existing providers support veterans' mental health as a vulnerable group resident in the local community.
9. Follow up with providers the treatment options and outcomes for patients.
10. Provide a one-stop service for NHS, social care and 3rd sector professionals for information on mental health services in the West Midlands.
11. Provide engagement and support to existing veteran Mental Health Services provided by other organisations in the region (West Midlands).

15.14. The expected outcomes are:

1. Better patient satisfaction of healthcare services; provided by:
2. Better Mental Health outcomes.
3. Reduction in mental health morbidity.
4. Better utilisation of healthcare resources (community and hospitals) by patients.
5. Improved engagement with veterans.
6. Increased carer and staff satisfaction.
7. Promotion of the needs of veterans with mental disorder.
8. Raised awareness of the importance of mental health.
9. To promote the routine assessment of veteran mental health.
10. A reduction of stigma.

15.15. Referrals into the service can be from GPs, Community Mental Health Services, Crisis Home Treatment Teams, self referrals, Defence Medical Services, inpatient wards, primary care, and third sector organisations. All requests for initial assessments will be responded to within three working days. All requests for assessment will be allocated within four weeks of the referral being made. The assessment can be undertaken in a location agreed by all parties.

15.16. Discharge from the service occurs following a discharge summary which details any future care plan in keeping with the principles of 'Recovery'. All discharge planning occurs with service user and carer involvement and agreement.

15.17. The veteran population that the Trust serves is described by the Trust as being small but significant. The Trust has developed services for veterans in the population (and for staff who may also be veterans) that are as accessible and easy to access as possible. The aim is to educate all services in the Trust to be responsive to the needs of Veterans so that this culture is embedded within the Trust as a whole. To this end the Trust has a Veteran's led nurse, a Consultant Psychiatrist with specialist knowledge and experience and a part time Consultant Psychologist.

15.18. The new clinical recording system created an opportunity for the development of veteran service. The generic screening tool for all service users who are referred to the Trust includes two questions:

- have you ever served in the Armed Forces?
- would you like to be seen and/or contacted by the Veterans' lead nurse?

15.19. This process ensures that every potential service user is screened immediately and that all veterans can be identified quickly and specialist assessment offered to them. The electronic system has been a vast improvement on the old paper-based system. Referrals made to the Veterans' lead nurse can be proceed within five working days and therefore provides a timely and responsive service.

15.20. Veterans' mental health needs are generally the same as the general population. Veterans who come through to the lead nurse are traditionally referred from secondary mental health care teams, and that is where in the past there has been a gap. In the past, when Veterans were referred by primary care to a secondary care team there was a risk that their needs would not be identified in a timely manner. The Veteran lead nurse can 'latch on' to that community mental health team to provide help and advice and can also provide a fast track specialist assessment service.

15.21. The Trust Veteran service is aware that mental health needs cannot be seen in isolation form social inclusion issues such as employment and housing. The service is integrated within the British Legion, Help for Heroes and the Princes Trust and can signpost Veterans in order to gain a wider access to support.

15.22. To support the work that is being done with Veterans a lifestyle and wellness research project is being launched with the University of Worcester looking at what else veterans need in order to integrate back into society and maintain their mental health.

15.23. The Trust Veterans Service was established and fully deployed in 2012 and offers and assessment and treatment service for veterans across all mental health specialities. The service has dedicated professionals Lead Nurse, CBT Therapist, Consultant Psychologist and Consultant Psychiatrist allocated to the needs of veterans. There is local contact with Combat Stress Outreach services that are able to access local NHS provision if clinically indicated. The Regional Lead for Veterans (West Midlands) continues to forge links with CS and all service related charities. Local initiatives from the Trust have promoted other third sector providers such as 'CHANGES' a local social enterprise who are able to with Veterans on a non medical peer support based model and they seek to develop a veterans support service.

Further work is currently being undertaken with 'Action for Hearing loss' Royal National Institute for the Deaf.

15.24. The Trust Veterans service aims to engage and provide a treatment plan within four weeks of referral to the service. The Trust also provides outreach to those service users in others mental health speciality areas. The primarily focus is providing a veterans input to all the former service population.

Summary

15.25. The Investigation found that services within the Trust were alert to, and aware of, the needs of Veterans. There are well integrated services within the Trust that are robust and fit for purpose. If another service user such as Mr X was to be referred to the Trust today then we are confident that assessment, care and treatment would be timely and meet good practice local and national guidance.

Internal Investigation Practice

15.26. During the interview process the Independent Investigation Team was able to establish the work achieved by the Trust in relation to its internal investigation progress. In December 2014 the Trust reviewed its Serious Incident Investigation processes using Virginia Mason LEAN methodology (Rapid Process Improvement Workshop). As a result of this review a number of improvements have been made to the Trust's investigation process that have further strengthened the learning from serious incidents and the timeframes taken to complete an investigation and share learning. The Trust now routinely uses Significant Event Analysis Reviews as the method for investigating and learning from incidents. Clinical teams have found that this fosters a learning environment and enables key learning and service improvements to be identified and embedded sooner. It has also enabled the organisation to complete serious incident reviews within a quicker timeframe, meaning that commissioners receive reports well within the 45 working day timeframe.

16. Recommendations

16.1. The Independent Investigation conducted a comprehensive review of the services within the Trust relating to veterans (see appendix one). Mr X was seen on a single occasion by the Trust and no contributory or causal factors were identified relating to any act or omission on the part of the Trust and the death of Ms Y. One service issue only was identified. This forms the basis of the single recommendation made by the Independent Investigation.

Recommendation One

The Trust will ensure that all operational policy documentation provides clear instruction about NICE guidance in relation to the intervals of time that should be allowed to elapse between initial contact/diagnosis and follow up in the case of depression.

17. Glossary

Associate Specialist	An Associate Specialist ranks below a consultant and is always nominally accountable to one, but as associate specialists do not count as junior doctors they are able to have their own clinic lists and see patients independently. Associate specialists are often (but not always) on the specialist register of whichever field of medicine in which they practice, and can be specialists in any field. Promotion from staff grade or specialty doctor was normally on experience rather than qualification, although an associate specialist is free to sit any required exams and apply for a consultant post (often without having to have been a specialist registrar first) if they wish. An associate specialist can sit for an exam at any time.
Combat Stress	A registered charity that provides mental health care, support and treatment to Veterans.
Mirtazapine	An antidepressant used to treat depressive disorders.
National Institute for Health and Care Excellence (NICE)	NICE was originally set up in 1999 as the National Institute for Clinical Excellence, a special health authority, to reduce variation in the availability and quality of NHS treatments and care.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
Service User	The term of choice of individuals who receive mental health services when describing themselves.