Mr AS independent care and treatment review

Final Report

May 2018

Acknowledgements

We would like to thank Andy's family for their time, patience and candour, and in particular, the invaluable information they provided to us under what can only be considered the hardest of circumstances. We would like to offer our sincere condolences to Andy's family.

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Introduction and background to review

This review looks at the last 12 months of Mr AS, Andy's life, from October 2012 until his death on 4 October 2013.

Andy was a 33 year-old man. He was married to Mrs S with whom he had a son, who was two years old at the time of Andy's death. He was the elder of three children and in regular contact with his family. He was a science graduate, qualified tree surgeon, and a landscape gardener by profession, most recently undertaking jobs on a self-employed basis. He worked throughout his illness.

Andy did well at school and had a natural affinity for sports. He had a promising rugby career which unfortunately was cut short due to a knee injury.

Andy was diagnosed with bipolar disorder when he was 18 years old (this diagnosis was later changed to a schizoaffective disorder during the last 12 months of Andy's life). He experienced difficulties with his mental health throughout his adult life, and, at times could become significantly unwell, which on more than one occasion culminated in an inpatient admission.

Andy's illness could be triggered by a number of factors that included stress and drug and alcohol use. He and his family were familiar with the symptoms of his deteriorating mental health and were aware that he could become unwell quickly. His family were very much in tune with signs of deterioration in his condition and could identify when he needed rapid care. Andy therefore benefitted from – and was receptive to - rapid treatment (e.g. rapid tranquilisation) when he became unwell.

His family were involved in his day to day care, keeping him well and intervening in his care when needed. They wanted to play an active part in his care and treatment and were available to services to provide guidance/being consulted on his management. His wife, Mrs S, qualified in herbal medicine, had a key role in supporting Andy when well and unwell.

Andy's mother had been a consultant in Public Health Medicine; his sister was a doctor and his aunt a psychiatrist. Andy's family were fully versed in management of people with mental health difficulties.

Andy was a dedicated family man, committed to his wife and son. He was an intelligent, funny man, who was friendly and caring towards others when well. In particular he was supportive of the younger members of his family (e.g. siblings and cousins) and was an active member of his community.

When well he held down employment providing for his family and visited and supported his family including developing the garden of his mother who lives in France.

Andy had been under the care of Devon Partnership NHS Trust since May 2010, before which he had been based in Scotland. In the last year of his life, Somerset Partnership NHS Foundation Trust and latterly, Derbyshire Healthcare NHS Foundation Trust also provided care and treatment to Andy. All three Trusts provide mental health, community and learning disability services to their local NHS populations. Andy was also admitted to Cygnet Hospital Kewstoke, near Weston-Super-Mare, four times between 2012 and 2013 because no appropriate NHS beds were available. Cygnet Hospital Kewstoke is an independent mental health facility which also provides private beds to NHS providers who are unable to accommodate patients due to bed demand or patient need.

Between October 2012 and March 2013, Andy – as part of one admission - was transferred seven times between different inpatient facilities. During this time, he was detained under Section 3 of the Mental Health Act for a total of five months. His care at this time was provided by three different organisations, namely: Devon Partnership NHS Trust, Somerset Partnership NHS Foundation Trust and Cygnet Hospital Kewstoke.

Andy and his family moved to Derby in June 2013. Andy was detained by the Police on 13 July 2013 on suspicion of driving under the influence of alcohol but was later released without charge. The next day he was taken by ambulance to A&E at the request of his family because he was suicidal. The assessing team concluded that Andy was not detainable under the Mental Health Act and that he did not need to be admitted. He was discharged and referred to the crisis team. Andy was seen by several members of the crisis team throughout July and August.

Andy was seen by a Specialist Registrar on 14 August. The appointment was treated as a follow-up as opposed to a full assessment.

Andy contacted the community team on 16 August to tell them he was feeling increasingly anxious and was self-medicating with Diazepam. Andy was seen by the crisis team and it was agreed that he would benefit from an admission. The team was unable to locate a bed locally and one was eventually sourced at Cygnet Hospital Kewstoke to which Andy was informally admitted to the next day on 18 August. Andy remained at Cygnet Hospital Kewstoke until 20 September when he was discharged home.

Andy was seen by his Derby care coordinator on 23 September. They agreed he did not need to see the crisis team but that she should undertake a weekly visit to see him. Andy saw his

GP on 24 September for a medication review. His anti-depressant was changed from 10mg Escitalopram to 10mg Citalopram.

Andy's mother contacted the Derby team on 30 September to say that Andy had deteriorated. A social worker undertook a home visit and Andy said he could not keep himself safe and wished to be admitted. Andy was admitted as an emergency to Derbyshire Healthcare NHS Foundation Trust the same day. This was a voluntary admission. He was discharged against medical advice two days later and sadly took his own life on 4 October 2013, two months before his 34th birthday. Derbyshire Healthcare NHS Foundation Trust conducted a Serious Incident investigation[1] into Andy's death which was completed in March 2014.

Andy's family raised their concerns with clinicians about his care during the last 12 months of his life, particularly when he was an inpatient at Somerset Partnership NHS Foundation Trust and when living in Derby. They had serious concerns about the care and treatment he received at Somerset Partnership NHS Foundation Trust. In particular, in November 2012 when he was discharged on Section 17 leave and then recalled in less than 48 hours, and in January 2013, when the police attended the ward and Andy was placed in seclusion. Andy's family submitted three complaints and correspondence to the Trust. The Trust undertook a serious incident investigation – jointly with Devon Partnership NHS Trust - into the events of November 2012 which was not finalised until August 2013.

Andy's family supported him throughout his illness and were in regular contact with his clinicians. After his death, his family identified numerous concerns about the quality and care that Andy received (they also submitted complaints to the police, Crown Prosecution Service, ambulance service and GMC). They submitted a written complaint to Devon Partnership NHS Trust in February 2014 which resulted in two independent investigations (completed in March 2015 and November 2015) into their concerns. The first complaint investigation did not answer the family's questions. Andy's family submitted a complaint in relation to the first report and a second complaint investigation was undertaken in response to these (and the original) concerns.

South Western Ambulance Service undertook an investigation into the events of 14 November 2012.

Derbyshire Healthcare NHS Foundation Trust conducted a serious incident investigation in response to the Senior Coroner's findings that Andy's health records had been altered. This was completed in August 2017 and concluded that Andy's records were amended after his

[1] Serious incident investigations are comprehensive investigations undertaken in instances where the event/incident has significant consequences for the patient, family, staff or organisation and/or there is a potential for learning

death but could not conclude when this happened, or if it was a member of the Trust who had changed the record.

In March 2017 NHS England (Midlands and East) commissioned Mazars to undertake an independent review into the care and treatment that Andy received from October 2012 until his death in October 2013.

Terms of reference

The terms of reference were drafted by NHS England and agreed by Andy's family.

Purpose of the review

"The purpose of this independent review is to fully consider the care and treatment provided to AS in the last 12 months of his life and to make recommendations for further action where appropriate.

NHS England is commissioning this review in response to a complaint from a family member[2] and in the context that AS had contact with multiple care providers during the defined period.

Scope of the review

This independent review is limited to the review of evidence relating to the care and treatment received by a named patient within a defined time period. The review will be required to:

- *Liaise with the family to develop the specific Key Lines of Enquiry for the review, taking into account the inquest Findings of Fact.*
- *Source and review relevant documents to enable the development of a comprehensive chronology of events.*
- *Where necessary, conduct interviews with key personnel.*
- *Undertake an assessment of the care and treatment received by AS.*
- *Produce a summary report of findings and recommendations.*

Objectives

- *To develop a chronology of events relating to the care and treatment of AS in the last 12 months of his life.*
- *To review the existing serious incident investigation reports and associated action plans.*

[2] Andy's mother submitted a letter to NHS England in September 2014 asking that it facilitate an independent integrated investigation into Andy's death.

- *Review the progress that the providers have made in implementing the recommendations and learning from their internal investigations.*
- *To review the care, treatment and services provided to AS by the NHS in the defined time period.*
- *To review the appropriateness of the care and treatment of AS.*
- *Review the adequacy of risk assessments, risk management and care planning for AS.*
- *To involve the family of AS.*
- *Provide a written report to NHS England that includes recommendations for further action where necessary.*

Key questions/issues to be addressed within the review

The review team will be expected to build upon the key questions through the initial engagement with the family. The questions below must be considered in the context of the inquest Findings of Fact.

- *Was the care and treatment provided to AS in the defined time period appropriate for his needs?*
- *Were risk assessments/management plans appropriate to AS's needs?*
- *Has action been taken to address the recommendations arising from the existing serious incident investigations?*
- *Is there further action required in relation to the existing serious incident investigations/recommendations?*
- *Were any opportunities missed to prevent the outcome for AS?*
- *In light of the inquest findings and the outcome of this review, are there any further recommendations for the NHS?"*

Our approach

Mazars Health and Social Care Advisory team is a multi-disciplinary team that provides specialist independent advisory support to health and social care commissioners and providers.

We met Andy's mother and step-father at the beginning of our review to discuss our approach and seek their input about Andy's care and treatment. They provided us with extensive information about Andy, his care and treatment. Leading from this, Andy's mother remained in contact throughout the review, submitting further documentary evidence and answering our questions. We met her again towards the end of our review to discuss our findings. We also spoke to Andy's widow.

We submitted a number of information requests to each of the three NHS Trusts and Cygnet Hospital Kewstoke. Further information and documentation was provided by NHS England (NHSE), Derby and Derbyshire Coroner and the family of Andy. Andy's family gave us permission to review his clinical notes.

We spoke with Andy's (Derby) GP who provided us with his medical notes.

A list of the documents reviewed can be seen in Appendix A.

The volume of information we have been provided in this review has been unprecedented. We received and reviewed nearly 700 documents from the Trusts and Cygnet Hospital Kewstoke. With the exception of the latter, these were provided in extensive PDFs, (in some cases) limited order or structure. The means by which the documentation was provided to us (in terms of order and structure) varied considerably depending on the Trust.

Each NHS Trust should review the manner in which it shares patient information with external investigators. Consideration should be given to the implications of sharing such documentation with other third parties e.g. families and other Trusts. Patient information should be provided in a clear, structured manner that can be easily referenced and navigated.

As a result of the large volume of information we received in relation to the last 12 months of Andy's life, we took a proportional approach to our review that focused on key events in Andy's care and treatment. There have been numerous internal investigations and inquiries into the care and treatment given to Andy, therefore we have sought not to revisit these, rather provide a review of work to date and identify any areas where further inquiry is needed.

We undertook interviews with Trust staff. The purpose of these was to focus on the Trusts' internal investigations, subsequent recommendations and action; and learning to date. All interviews were recorded and transcribed in-line with Mazars internal processes. A list of interviewees can be seen in Appendix B.

The three NHS Trusts and Cygnet Hospital Kewstoke were sent a copy of the draft report to comment on in relation to matters of factual accuracy.

Andy's family were also sent a copy of the report to review for matters of factual accuracy.

The report was subject to Mazars internal quality assurance and review process.

Executive summary and recommendations

This review looks at the last 12 months of Andy's life, (Mr AS) from October 2012 until his death on 4 October 2013.

Andy was a 33 year-old man. He was married to Mrs S with whom he had a son, who was two years old at the time of Andy's death. He was the eldest of three children and in regular contact with his family. He was a science graduate, qualified tree surgeon, and a landscape gardener by profession, most recently undertaking jobs on a self-employed basis. He worked throughout his illness.

Andy's illness could be triggered by a number of factors that included stress and drug and alcohol use. He and his family were familiar with the symptoms of his deteriorating mental health and were aware that he could become unwell quickly. His family recognised signs of deterioration in his condition and could identify when he needed rapid care. Andy benefitted from – and was receptive to - rapid treatment (e.g. rapid tranquilisation) when he became unwell.

His family were involved in his day to day care, keeping him well and intervening in his care when needed. They were actively involved in his care and were available to services to provide guidance on his management. Mrs S had a key role in supporting Andy when well and unwell.

Andy had been under the care of Devon Partnership NHS Trust since May 2010, before which he had lived in Scotland. In the last year of his life, Somerset Partnership NHS Foundation Trust and latterly, Derbyshire Healthcare NHS Foundation Trust also provided care and treatment to Andy. Andy was also admitted to Cygnet Hospital Kewstoke (an independent mental health facility), near Weston-Super-Mare, four times between 2012 and 2013 because no appropriate NHS beds were available.

Between October 2012 and March 2013, Andy – as part of one admission - was transferred seven times between different inpatient facilities. During this time, he was detained under Section 3 of the Mental Health Act for a total of five months.

During his October 2012 admission, ward staff at Devon Partnership NHS Trust called the police to the ward in response to Andy's behaviour. He was subsequently transferred to Cygnet Kewstoke Hospital where he remained until 8 November when he was moved to Holford ward at Somerset Partnership NHS Foundation Trust.

Andy was granted home leave on 13 November 2012. Shortly after Andy went on leave, Mrs S contacted the Devon CRHT to say she thought Andy had breached the conditions of his

leave. Staff at Devon Partnership NHS Trust and Somerset Partnership NHS Foundation Trust agreed that Andy should be recalled to Holford ward at Somerset. The Devon Crisis team would not attend Andy's home address, saying it was too dangerous, and the police were contacted to facilitate his return to the ward on 14 November 2012. The police and local ambulance service attended Andy's address and after some discussion he agreed to be assessed in the ambulance. Whilst in the ambulance the police informed him that he was to be returned to Holford ward in Somerset. A struggle ensued and the police tasered Andy twice. No ambulance staff and/or independent witnesses were present at the time.

Andy was moved to Devon Partnership NHS Trust on 22 December 2012. He took home leave over the Christmas period, but was noted to be irritable and edgy in mood on his return to the ward on 26 December. His behaviour escalated and ward staff again called the police to the ward in the early hours of 27 December.

Andy was transferred to Cygnet Kewstoke (Psychiatric Intensive Care Unit) the same day, (because an NHS PICU bed was not available) where he remained until 2 January when we was moved back to Holford ward in Somerset. Andy gradually became unwell and on 12 January ward staff decided that he presented a high risk to staff and called police to the ward for assistance. The police moved Andy to seclusion but his behaviour escalated a few hours later and the police were again called to the ward. Andy was subsequently transported by the police back to Cygnet Hospital Kewstoke where he remained until he was discharged in March 2013.

Andy and his family moved to Derby in June 2013. He was detained by the police on 13 July 2013 on suspicion of driving under the influence of alcohol but was later released without charge. The next day he was taken by ambulance to A&E at the request of his family because he was suicidal. The assessing team concluded that Andy was not detainable under the Mental Health Act and that he did not need to be admitted. He was discharged and referred to the crisis team. Andy was seen by several members of the crisis team throughout July and August.

Andy contacted the community team on 16 August to tell them he was feeling increasingly anxious and was self-medicating with Diazepam. Andy was seen by the crisis team and it was agreed that he would benefit from an admission. The team was unable to locate a bed locally and one was eventually sourced at Cygnet Hospital Kewstoke (over 150 miles away) to which Andy was informally admitted the next day on 18 August. Andy remained at Cygnet Hospital Kewstoke until 20 September when he was discharged home.

Andy's mother contacted the Derby team on 30 September to say that Andy had deteriorated. A social worker undertook a home visit and Andy said he could not keep himself safe and

wished to be admitted. Andy was admitted as an emergency to Derbyshire Healthcare NHS Foundation Trust the same day. This was a voluntary admission. He was discharged against medical advice two days later and sadly took his own life on 4 October 2013, two months before his 34th birthday.

Themes

Risk assessment and risk management

Andy's risk assessments were updated regularly between October 2012 and March 2013, when he was under the care of Devon Partnership NHS Trust and Somerset Partnership NHS Foundation Trust, but there was not a clear corresponding management plan to address his risk on the ward or in the community.

Andy did not have a comprehensive risk management plan under the care of Derbyshire Healthcare NHS Foundation Trust. The lack of timely risk assessment and a comprehensive management plan meant that after over three months (although Andy was at Cygnet Hospital Kewstoke from 18 August until 20 September 2013) the team was in no better a positon of knowing and working with Andy than after his first appointment. Andy was known to experience suicidal ideation when depressed and had two inpatient admissions in a short period of time yet the team delayed its review of him after his September/October admission, in favour of undertaking a joint team review the following week. The assessments undertaken on 14 July 2013 and 2 October 2013 were missed opportunities to grasp the severity of the risk that Andy's condition presented to his safety.

The risk assessment and risk management plan was inadequate at the time of his death.

Care Planning

Andy was subject to CPA in Devon. He had a care plan in place however we are unclear as to the care plan objectives beyond the March 2013 Section 117 plan. There is evidence that staff were trying to work with Andy – and that he saw his care coordinator regularly - however most goals lacked clarity in terms of long term plans for Andy.

Andy's impending move to Derby may have impacted long-term care planning by the Devon team, but it is our view that throughout his time under the care of Devon Partnership NHS Trust, Andy did not have a long-term psychosocial care plan that took into consideration

factors that included the role his family played in his care, management and recovery. Devon Partnership NHS Trust did not provide comprehensive care planning for Andy.

Andy's nursing (inpatient) care plans at Derby were appropriate for his level of needs and observation and the multidisciplinary assessments were largely satisfactory. Andy's community care plan was in the early stages of development. Andy's Derby care coordinator saw him twice (due to annual leave and sickness) prior to his death. In her evidence to the Coroner, she said that she has been unable to develop Andy's care plan with him because he was unwell. He had not been seen by his consultant prior to his death.

Andy did not have an effective, developed care plan in place at the time of his death in Derby.

In its response to this report, Derbyshire Healthcare NHS Foundation Trust, highlighted the observations of the Coroner's Independent witness in relation to managing and working with Andy. Specifically that Andy's presentation and behaviour, combined with his engagement with different parts of the service, made it *"virtually impossible"* for anyone to have a complete overview of his care. The Trust further highlighted that Andy was admitted to Cygnet Kewstoke between August and September 2013.

There is an element of hindsight to the Trust's point and it does not serve to explain the Trust's own investigation finding that over 30 staff saw Andy yet no one took overall responsibility for Andy's care. Andy still had not been subject to a complete assessment and his care plan remained in development with little documented sign of planned progression, after in excess of three months. Andy's Devon community consultant had written to the Trust at the time of Andy's transfer to Derby, outlining the nature of the difficulties he presented with, and advising that early contact would be *"a useful measure to help prevent problems and ensure stability following his move".*

Carer involvement

Andy's family were actively involved in his care. His wife, Mrs S contributed to his Devon care plan and was his primary carer when he was unwell. She attended ward rounds when he was an inpatient and was in regular contact with the healthcare professionals overseeing his care, both in the community, and on the ward. Andy's risk assessment described her as a 'good barometer' of his illness.

Andy's mother, Dr S, was also in contact with healthcare professionals about his care. For example, she had significant concerns about his recall to Holford ward in November 2012, in terms of both his wellbeing and the actions of staff in accordance with statutory legislation.

Other members of his family, including his sister (also a doctor), were in contact with healthcare professionals about Andy's care.

Healthcare professionals in Devon appear to have involved Mrs S and Dr S in Andy's care however we cannot comment as to the extent to which this influenced/impacted his overall treatment as this was not documented. Mrs S told us that she felt supported by the Devon team. Despite this we note the failure of the Devon CRHT to attend the family home on 14 November 2012. The Somerset serious incident investigation into the events on 14 November highlighted how the team's presence could have deescalated the situation and supported Mrs S.

Andy's family appear to have engaged extensively with healthcare professionals in Somerset - primarily instigated by the family - however we have no way of knowing the extent to which this had an influence over his care. We note that relations between the family and the Trust gradually deteriorated, particularly in terms of their relationship with Andy's Somerset Consultant, who stopped all telephone contact. It is our understanding that this largely stemmed from the events of 14 November 2012 and Andy's subsequent ongoing detention, despite his family's request that he be discharged from the hospital. Mrs S had stopped speaking to Andy's Consultant during the course of his time in Somerset. Andy's mother and wife were critical of healthcare professionals at the Trust, particularly, his Consultant, during their discussions with us.

Mrs S told us that she felt supported by the Cygnet team when Andy was based there, but in contrast, she felt that the Derby team made little effort to get to know Andy and that they didn't support either of them.

The failure of staff in Derby to incorporate the family views – particularly in the absence of Andy's notes - meant they omitted key intelligence from their assessment. Andy's family had detailed experience of his mental health – its impact, the triggers and his maladaptive coping style. In addition, they were a potential source of information about previous treatment.

The Derby team was trying to manage the transition of care of someone unknown to them but with a serious mental illness, and, who by the nature of this illness and his presenting characteristics had a significantly elevated suicide profile. Through proper engagement, listening and working with the family they could have provided a protective environment for Andy on at least two occasions. This did not happen.

Forensic history

Andy was a large, physically strong man who, at times, intimidated staff. When unwell he could be physically aggressive and verbally threatening towards staff. His medical notes often made reference to a history of violence however we found little evidence of actual physical violence, rather that Andy was verbally aggressive towards staff.

We identified eight incidents in Andy's notes between 2012 and 2013 when he was documented as being verbally aggressive and/or physically intimidating– this included the incident on 14 November 2012 when we was tasered by the police. Andy was charged with assaulting a police officer – to which he intended to plead not guilty – but the case had not gone to trial at the time of his death.

It is clear that Andy could be threatening and intimidating towards staff when he was unwell, and that he had broken property. However we note that there is no evidence of him physically hurting staff yet his notes paint a picture of a dangerous individual whom the police were best placed to manage. The records pertaining to Andy were not always accurate in relation to his forensic history.

Crown prosecution service

Andy was charged with assaulting a police officer after the incident on 14 November 2012. His court case was originally scheduled to take place in July 2013, but was postponed at short notice and rescheduled to take place in October 2013.

Andy's family told us he was extremely worried about the court case. He was concerned about the severity of the charge, and the implications of this in terms of a potential custodial sentence. Dr S told us he deeply feared going to prison.

Andy's notes detail he shared his concerns with health care professionals. The notes do not detail whether healthcare professionals gave consideration to the implications of the impending court case on his mental health. At the time of his death the prospect of a court case had been in Andy's life for nearly a year yet we found little evidence to suggest that this had been explored with him in terms of whether it was affecting his wellbeing and his thoughts about the future.

Police involvement and Tasers

There were four occasions when the police were involved by Trust staff in the management of Andy: October, November and December 2012, and January 2013.

The Somerset serious incident investigation report and Devon's independent (second) complaint both highlighted concerns in relation to ward staff opting to involve the police (on the ward and in the community) in managing Andy. In particular, the latter highlighted the lack of Trust policy. There is little doubt that staff felt intimidated when they called the police to the ward however it seems that each situation escalated relatively quickly and there is little evidence of action taken to deescalate the situation prior to calling the police.

Devon Partnership NHS Trust did not have a policy in relation to the presence of police staff on the ward therefore it is difficult to comment as to the actions of those involved – as there is limited information documented in the notes. The situation appears to have escalated with remarkable pace from Andy lying on the floor talking to a member of staff, to being restrained by seven police officers. Based on the limited information available, we do not consider this to meet the criteria of 'proportionate to harm or the least restrictive option' available to Trust staff.

Andy could be aggressive and threatening when unwell – this is not in dispute. His consultant in Devon described Andy when unwell in his letter to Derby as *"very challenging, verbally and physically hostile and obstructive, and undoubtedly there is considerable risk attached to this."* Staff appear to have been quick to involve the police rather than attempt to manage the situation themselves. For example, on 13-14 November, the community team who knew Andy well did not attend his home or make an attempt to assess the situation before involving the police.

It is documented in Andy's notes that he could become unwell quickly and that staff needed to act promptly in such situations.

Relatively speaking, little is known about the long term impact of being Tasered. Most research has been conducted in America and there is little UK-based data available. There is no statutory requirement for healthcare providers to report Tasers being used on their wards. In 2016, the Rt Honourable Norman Lamb, MP, sought to amend the Policy and Crime bill to ban the use of Tasers in psychiatric hospitals.

It is the police – not ward staff – who ultimately take the decision whether to discharge a Taser on the ward, but it is undoubtedly the responsibility of the ward staff to ensure the wellbeing of the patient thereafter and take into account the possible effect of such action on a patient's physical and mental health.

Continuity of care

Andy was admitted and/or transferred 11 times between October 2012 and October 2013. Andy changed hospital and healthcare provider seven times between October 2012 and March 2013. All but one move was to another county or hospital (he also transferred wards at Cygnet Hospital Kewstoke in February 2013). Andy's notes were not always available to healthcare professionals at the time of his transfer, and equally staff (e.g. his care coordinator) were not always given adequate notice that he was being moved and/or discharged. The distances Andy's family had to travel in order to see him were at times significant (in particularly from Derby to Cygnet Hospital Kewstoke) and presented a challenge in terms of seeing him regularly and maintaining contact.

Andy was under the care of five consultant psychiatrists between October 2012 and October 2013. He was also seen by a number of other consultants and medics during this time.

The inconsistent manner in which Andy's transfers were managed and communicated by healthcare providers undoubtedly had a negative impact on his care and treatment. We have previously highlighted the lack of effective care planning - which was likely exacerbated by the number of transfers Andy experienced. Information was not shared in a timely manner the upshot of which being ward staff essentially had to start again with Andy, in terms of gathering information and building a relationship with him.

We were left with a sense that healthcare professionals were largely 'firefighting' in terms of addressing Andy's immediate needs (e.g. when he was in crisis). Andy saw at least 20 different medical staff (and numerous nursing staff) in both inpatient and community settings during the last 12 months of his life. At least 12 of these medical staff (including three at Cygnet) were seen following his move to Derby in June 2013.

NICE guidance highlights the importance of a continued relationship between the patient and clinician. Andy had few enduring relationships with healthcare professionals other than with his Consultant in Devon, who he had seen for a number of years, and his Devon care coordinator. Andy's Devon care coordinator was clearly involved in his care, trying to ensure everyone was kept informed. However, information was not routinely communicated by the inpatient wards to this care coordinator in a timely fashion. We were left with a sense that no one specific individual was actively seen as central to Andy's care in terms of managing his overall care plan and long term treatment. The continuously changing nature of Andy's inpatient arrangements meant that no substantial plans could ever be effectively implemented.

The Derby team did not provide Andy with continuity of care. Andy moved to Derby in June 2013, yet at the time of his death, over three months after his transfer, he did not have an

established relationship with his care coordinator, having met her twice (due to annual leave and sickness). He had not met his consultant psychiatrist, and a clear, effective care plan had not been developed.

There is no evidence that Andy's care and treatment plan had evolved – or that healthcare professionals knew him any better - from his admission to Devon Partnership NHS Trust in late October 2012 through to his final (voluntary) emergency admission to Derby in October 2013.

Pharmaceutical care

We engaged a Deputy Chief Pharmacist from another Mental Health NHS Trust to consider:

- The medication Andy was prescribed;
- any variation in dose;
- the length of each prescription; and,
- the potential impact of combining antipsychotics and antidepressants.

Andy's mother also had a number of questions, specific to his medication which we also asked be addressed – these are set out in the main body of the report.

Three areas of concern were identified in relation to Andy's pharmaceutical care:

1) The escalation of the dose of Citalopram prior to discharge. This fell below accepted care levels.

2) There are further questions that need answering in relation to the monitoring of Blood pressure and pulse prior to discharge from Ward 36 on 2 October 2013. We are unclear if an ECG was requested and undertaken.

3) The doses of Benzodiazepines prescribed between March 2012 and July 2013 were higher than would be expected in an outpatient setting.

The plan for a medication review at Cygnet Hospital Kewstoke was appropriate, due consideration should have been given to a longer time frame for the changes to occur in a more gradual and stepwise fashion.

Trust(s) internal investigations

Each of the three Trusts involved in Andy's care during the period of this review produced an investigation into significant events. Two of these were Serious Incident (SI) reports:

- In March 2013, Somerset Partnership NHS Foundation Trust produced a level 2 investigation report (jointly with Devon Partnership NHS Trust) looking at the breakdown of Andy's leave home (the review was commissioned in December 2012). The action plan was not finalised until over 2 years later in April 2015.
- In March 2014, Derbyshire Healthcare NHS Foundation Trust produced a Serious Incident Investigation 6 months after the death of Andy.
- In March 2015, Devon Partnership NHS Trust produced two Independent Investigating Officer's reports following a formal complaint about Andy's care submitted by his mother in February 2014. She listed a range of concerns. The first report was of poor quality, poorly evidenced and judgemental of Andy. A second report was completed in August 2015.

We note the significant period in which reviews and investigations were undertaken in relation to Andy's care and treatment. This work did involve three healthcare providers, but taken cumulatively, the first review was commissioned in December 2012 and the last report was completed in August 2015. Leading from this, we note that each Trust is still undertaking work in relation to its action plan and that there is a need for further monitoring and evaluation of changes made.

We also note that the lengthy time in which investigations have been undertaken has had a significant impact on Andy's family.

Final reflection capturing family thoughts shared with us through the review

We engaged extensively throughout this review with Andy's family – and in particular his mother. We were asked by Andy's mother to reflect their feelings throughout his care in relation to their experience.

Andy was a loving, committed family man who was central to his family. He was much loved and is very much missed.

Andy's family have always maintained that a number of healthcare professionals (e.g. his Devon-based care coordinator and consultant) were supportive of Andy and tried to help him when he was well and unwell. In particular they were complimentary about the care and respect shown to Andy when he was an inpatient at Cygnet Kewstoke hospital. However they also highlighted to us their sense of indifference from some healthcare professionals, a failure to listen to them and Andy, and above all, a lack of compassion.

Andy's family wanted us to draw attention to the lack of compassion he and themselves sometimes experienced and the negative impact it had on all of them. Leading from this, they wanted to highlight the value and difference it made to Andy and themselves when they did experience kindness and compassion; and how even small actions could have a positive effect. They consider this a wider learning point for all healthcare professionals.

Recommendations

1. Each NHS Trust should review the manner in which it shares patient information with external investigators. Consideration should also be given to the implications of sharing such documentation with other third parties e.g. families and other Trusts. Patient information should be provided in a clear, structured manner that can be easily referenced and navigated.

2 All healthcare professionals should take into consideration the implications of criminal proceedings on a service user as part of any broader assessment of mental health and well-being.

3 Somerset Partnership NHS Foundation Trust and Devon Partnership NHS Trust should review and ratify a Taser policy for their Trust that covers:

- Immediate aftercare
- Patient monitoring (physical and psychological)
- Escalation criteria (e.g. further medical review)
- Recognition of the impact and possible effects (including psychological effects)

4 Each Trust should set out a programme of evaluation and assessment, revisiting all aspects of their action plan to ensure that changes have been implemented and are monitored.

As part of this process we recommend that particular attention be given to:

- The role of families/carers in developing risk assessments, risk management plans and care plans
- Developing, clarifying and/or ratifying policies in relation to:
    - Section 17 leave
    - The use of Tasers on NHS premises and the aftercare of patients who have been subject to an event involving a Taser
    - The involvement of police on wards (e.g. liaison, individual roles and responsibilities, when to escalate and involve the police on the ward, and, how this should be managed, minimised and situations de-escalated)
- Pharmaceutical oversight of transferred patients with a history of severe mental illness
- The role of the responsible clinician in patient transfers between Trusts/provider services.

Taking into account the time that has passed since each action plan was developed, we advise that this work be completed within six months. This should include a clear programme of monitoring and evaluation going forward.

A description of Andy by his mother

Andy's mother submitted the following description of him to his Inquest in 2016. She asked that we include it in this report.

"It is really important to me that during this inquest some evidence is heard about what my son was like. There were so many amazing and brilliant things about him. Yes, he had a serious mental illness, just as some people have lifelong physical illnesses, but he lived his life fully.

He was a good, caring, thoughtful, clever, funny and well-loved person, who is bitterly missed every day by his family and all his friends. He was a loving husband, father, son, brother and cousin and nephew and grandson. He was a part of his community.

I remember all the minutiae of his life - the happy times and the sad times.

I find it difficult to reduce down all the information I have in my head, but this is an attempt to give you a picture of my son and the pattern of his illness until the last year of his life.

He was my eldest son, he had a sister 2 years younger and a brother 3 years younger. He was born in Yorkshire and we moved to Dorset when he was 9 years old. His father was a captain in the Merchant Navy and I was a consultant in public health medicine. When Andy was a baby he travelled round the world on the ship with us. Andy was popular and did well at school, not just academically but also in art and sport. He was captain of the rugby team, practised judo, and was an active member of the school cadet force.

His first admission to psychiatric hospital in Dorset was as an emergency on Mother's Day; he was 18 years old and admitted under s.2. He was in hospital for about 6 weeks and was diagnosed with Bipolar Affective Disorder. His psychiatrist stated he had been taking drugs to self-medicate to relieve his symptoms and that this was very common. My son was started on lithium as a mood stabiliser and it worked well for him.

After leaving hospital he enrolled at the local agricultural college and trained as a tree surgeon whilst also learning practical skills through working full time with a local tree surgery firm. He gained his qualifications in the spring of 1999. However, he had a second psychiatric admission for a hyper manic episode in June 1999 to the same Dorset hospital. He had stopped taking his lithium tablets as he was experiencing a lot of side effects; also, he thought he was ok. While he was in hospital he had time to understand more about his illness and the treatment he needed. He was stabilised on lithium again and discharged at the end of July 1999 with support from his community psychiatric nurse and psychiatrist, both of whom he saw regularly.

After leaving hospital then he just lived an ordinary life and was generally well for over 8 years. In August 1999 he established his own self-employed business of Tree Surgery & Landscaping. The Prince's Trust gave him support in the form of a grant and a mentor. He employed 3 other people in his business and it was successful. At the same time, he took further part-time courses at the local Agricultural College. During all this time he saw his consultant and community psychiatric nurse regularly. He also started a long-term relationship with his girlfriend.

In 2001 my son applied to Stirling University and was successful in gaining a place there as a mature student on a 4-year course in Environmental Science with economics and philosophy. He was stable, well and enthusiastically looking forward to his studies. He moved with his girlfriend to live in Alloa, near the university in Scotland. Whist studying, he did part-time work to support himself such as tree work, landscaping and teaching and used the profits from his previous business too. He was referred to the Community Mental Health Team in August 2001 and was seen for follow-up by the respective community consultant at the time. He remained well taking his prescribed medication and with regular outpatient follow-up. His long-term relationship with his girlfriend ended suddenly in spring 2004, but in the summer of 2004, while doing voluntary work in the Brazilian Rain Forest, he met his future wife. Shortly afterwards she moved from America to Scotland to live with him and enrolled on a degree course in herbal medicine.

My son meanwhile completed his own BSc honours course gaining a first with the highest marks in his year. He was offered an opportunity to study for a masters but declined as he wished to work. During his last year at university he started up a property business in Scotland; buying houses to renovate to let or sell. This did well and in early 2007 the business owned 26 properties and employed 2 people.

In 2006 they married, and it was a very happy time. In 2007 the stress of managing the business increased considerably because of the changes in the property market. My son's third hospital admission took place in Scotland in October 2007 being discharged in early November 2007. He again had the same signs and symptoms and delusional beliefs that had occurred on his two previous admissions. After he left hospital Andy was depressed for a long time. Despite this he gained an excellent job as an environmental scientist specialising in climate, carbon change & carbon credits and forestry. He gave presentations at the Scottish Parliament.

Meanwhile, I had moved to France my son gave us a lot of help moving and fixing our home and garden. He split his time successfully between working in France and Scotland. He helped to organise the wedding and probably became too tired as he became ill immediately on his

return from France. He was alone in Scotland and no-one with him to notice his relapse signs as his wife, was visiting her seriously ill grandfather in the States. His fourth admission was to hospital in Scotland from 23rd August 2009 to 9th September 2009 and he was then followed up by the Intensive Home Treatment Team. After this admission he again had an extended period of depression.

His wife passed her degree in 2009 and in May 2010 they moved to Tiverton in Devon so she could set up a business as a herbal medicine therapist and also make her own beauty products to sell. He supported her in this and worked as a landscape gardener and making items from wood for her market stall.

His community psychiatrist in Clackmannanshire referred him directly to her equivalent in Devon and arranged an emergency appointment. My son saw the Devon community psychiatrist in June 2010 as he was very depressed and new adjunct medication was given. My son immediately developed an acute reaction to the new medication (sodium valproate), and was admitted to The Royal Devon and Exeter Hospital with acute liver failure of such severity that initially a liver transplant was being considered. He eventually made a complete recovery from this but was physically weak and unable to work for at least 6 months. This was the first time that he had to claim benefits. He had always been very independent and lived on his earnings and had been able to provide independently for his family. Financial worries were therefore an additional stress for him.

His fifth admission to psychiatric hospital was 16th October 2010 in Exeter when he and his wife realised he was relapsing into a manic phase. It was a voluntary admission initially though soon after admission, he was detained under s.3 Mental Health Act 1983, and was then transferred to a Psychiatric Intensive Care Unit at Cygnet Kewstoke Hospital, Weston-Super-Mare as there were no suitable services locally. He was transferred back to The Cedars, Exeter following improvement in his mental state and discharged home via staged leave.

My son was then given a recovery care coordinator from the Home Treatment Team based in Tiverton and saw his community psychiatrist regularly. His medication was supplemented with another mood stabiliser, Lamotrigine, and he responded well. His son was born in September 2011 and the family were very happy. He developed a good relationship with his consultant and recovery care coordinator and could contact them easily if he was unwell. A carer's support worker was allocated to his wife.

My son was on the waiting list to see a psychologist individually for the whole of the three years he lived in Tiverton, but the waiting list was long, and he wasn't successful. He really wanted psychological care. After his admission in 2010 he read the evidence about the positive impact of mindfulness on mental health (recommended by NICE). He attended a few

sessions with a private mindfulness counsellor, who trained him in the technique. He made time to practice mindfulness every day. He also attended a psychology course run by Devon Partnership Trust for people experiencing psychosis and following this was then asked by the psychologist to be a co-facilitator for this group. He made this a priority in his life and valued the interaction and the opportunity he had to share his experiences of mindfulness.

He was seen by his care co-ordinator and all was recorded as ok on 24th October 2012. But my son became unwell and on 27th October 2012 admitted himself as a voluntary patient onto The Cedars, Devon Partnership Trust. As with previous times, he deteriorated very quickly and he was placed in seclusion the night of 27th October and the next day he was detained under Section 3.

His health care for the last year of his life did not follow his usual care."

Chronology

The following chronology focuses on the last 12 months of Andy's life until his death on Friday 4 October 2013. The chronology serves to provide a summary of the events and incidents that occurred in the 12 months prior to Andy's death. It is based on his clinical notes, Trusts serious incident reports and investigations and correspondence. There are a number of episodes for which his family dispute the detail/interpretation of events. We explore this further in our analysis of themes.

Andy was a 33 year-old man with an extensive mental health history since the age of 18. He had a diagnosis of bipolar affective disorder, although this was later changed to schizoaffective disorder. Andy had a history of aggressive behaviour when unwell, and experienced psychotic symptoms during manic episodes. He was also known to abuse alcohol and drugs. Andy had said his substance use was an attempt to manage his symptoms, which conversely tended to exacerbate them.

October 2012

Andy attended a planned CPA meeting with his wife, Mrs S, and his care coordinator, Care coordinator 1, on 24 October. It was recorded in the notes that Andy was doing well and wasn't using alcohol on occasions that he felt stressed. It was agreed that Care coordinator 1 would contact Andy a few weeks later to check he remained well. Both Andy and Mrs S were advised to contact Care coordinator 1 (who worked part time) if they had any concerns.

Mrs S contacted the Devon Crisis Resolution Home Treatment Team (CRHTT[3]) three days later on Saturday 27 October. She said Andy had started to show signs of mania and she was concerned he was relapsing. His symptoms included not sleeping, impulsive behaviour, some irritability and grandiosity. It was recorded in his notes that Andy had a history of rapid relapse that required prompt admission. The referral was accepted and the team undertook a home visit the same day. Andy agreed that he should be voluntarily admitted to Delderfield[4] ward (Devon) and attended in the early evening of 27 October.

Andy was noted to be calm, but showing variable behaviour, during his mental state exam (MSE) undertaken by Medical Staff 1 and Staff Nurse 1 on Delderfield ward at 2230hrs. Andy was described in the notes as sometimes appearing friendly and pleasant, but that he was quick to withdraw his cooperation and appeared to be trying to physically intimidate staff. Nursing staff were due to undertake a physical assessment (as part of Andy's admission) of

[3] CRHTT's offer support to patients in the community who are in crisis. They also support patients who need an inpatient admission and those who are to be discharged from hospital.
[4] Delderfield was a male mental health ward located at the Ceders, Exeter, in Devon Partnership NHS Trust

Andy but this was cut short when Andy refused to participate until cannabis he had brought onto the ward – which had been confiscated – was returned to him. Andy claimed that the cannabis had been stolen from him and he wanted this reported to the police. The staff told Andy that he was in a hospital and that they could not return it to him. He told the staff they could not leave the room until this happened. The admitting staff were of the opinion that Andy would use physical force to retrieve the cannabis and therefore gave the cannabis back to him. The admitting staff contacted the on-call registrar (Registrar 1) who agreed that Andy needed a full Mental Health Act (MHA) assessment and advised that he should be placed on a section 5(2)[5] of the MHA. Andy's cannabis was later picked up by ward staff off the floor – he was unaware it was in their possession. We have no record as to whether ward staff contacted the police to report the presence of cannabis on the ward.

Andy had a number of escorted cigarette breaks in the later hours of Saturday 27 October and into the morning of 28 October. At approximately 0130hrs on 28 October Andy requested a cigarette. When told this would not be possible he entered the staff office to collect his cigarettes and lighter. His notes say he told staff that they should give him what he wanted if they didn't want to be hurt. The notes also record that he told a female member of staff to leave if she didn't want to be part of a 'bloodbath[6]'. Andy left the office to smoke a cigarette he had taken. It was recorded in the notes that he "*appeared aroused* [with] *some tremor[7] of adrenalin"*. The unit's "Control and Restraint" (C&R) team[8] were called to the ward but it was considered likely they would be injured if they tried to restrain him. Andy subsequently calmed and spoke with a nurse, assuring her that he would not hurt her. Nursing staff decided Andy no longer posed a risk to staff and the C&R team was dismissed. He then settled for a few hours during which time he was noted to be either on the ward or sleeping.

The notes say that at approximately 0515hrs, Andy and another patient kicked down the door of the small male (patient) lounge and attempted to barricade themselves in. Both were smoking cigarettes and ignored staff requests to stop. They were told the C&R team would be recalled to which Andy reportedly said there would be a 'blood bath'. It was recorded in the notes that "[Andy] *was too powerful and determined to be restrained by the available restraint staff without serious risk of injury to* [Trust] *staff*". Ward staff then contacted the police

[5] Section 5 (2) is a temporary hold (up to 72 hours) of a voluntary/informal service user in a mental health unit until a MHA assessment can be arranged.
[6] Andy's family told us that he was a keen rugby player in his youth and that his use of the term 'blood bath' stemmed from that. They do not consider that he meant serious harm towards ward staff. Equally Andy wrote in his statement about his illness and care, that he used the phrase 'blood bath' in a similar context to the rugby term 'blood bin', and that he would only use it in the context of him being on the receiving end of violence/aggression – not that he would harm to others.
[7] Andy's family told us that tremors were a side effect he experienced when taking Lithium
[8] Control and Restraint (C&R) is a term that was used to describe de-escalation and management of aggression techniques. Staff trained in these techniques would make up a C&R Team. Since 2012 the term used to describe these staff is "Prevention of Violence and Aggression", but we have retained the older term.

who attended the ward at approximately 0610hrs. Andy was lying on the floor (the notes do not detail his mental state other than to say he was talking to a member of the ward staff and ignored the police; Andy later explained that he had been meditating) and two officers held him by his arms and wrists, making him stand. Andy refused to move and shrugged the officers away. He was subsequently forced to the floor by the officers who were assisted by C&R trained Trust staff. Andy was handcuffed and five more police officers became involved, restraining him and applying leg restraints. He was carried to the seclusion room by seven police officers and left in seclusion at 0630hrs.

The on-call registrar, Registrar 1, conducted a MHA assessment through the door of the seclusion room (staff felt it was unsafe to enter seclusion) at approximately 1100hrs on 28 October. Registrar 1 recorded in the notes that Andy's presentation was consistent with hypomanic relapse. Registrar 1 wrote that Andy had indicated he would be happy to remain an informal admission, however Registrar 1 did not think this was feasible in view of Andy's recent aggressive and unpredictable behaviour, and continuing threats to staff. Registrar 1 and ward staff concluded that Andy should be placed on a Section 3[9] of the MHA and transferred to a psychiatric intensive care unit (PICU[10]). Shortly after the MHA assessment eight Restraint team members entered seclusion to give Andy 200mg Lamotrigine and PRN[11] 10mg Diazepam. Andy complied with staff requests and accepted the medication. Andy remained in seclusion until approximately 1500hrs on 28 October whilst arrangements were made to transfer him to Nash ward, a PICU at Cygnet Hospital Kewstoke[12] the same day.

October/November 2012

Andy was transferred to Nash Ward (PICU) on the afternoon of 28 October. Whilst on the PICU Andy remained in contact with his care coordinator, Care coordinator 1. Andy remained at the PICU until 8 November when he was transferred to Holford Ward, a PICU at Somerset Partnership NHS Foundation Trust[13]. Care coordinator 1 recorded in the notes on 8 November that he did not know why Andy had been moved:

[9] Section 3 of the MHA pertains to the detention of a service user in a mental health setting to administer treatment (http://www.legislation.gov.uk/ukpga/1983/20/section/3)
[10] A psychiatric intensive care unit (PICU) is a locked ward that has more security than an acute mental health admission ward. PICU's only take patients who are deemed very acutely unwell and detained under a section of the mental health act.
[11] '*Pro re nata'* – medication prescribed as required
[12] Devon Partnership NHS Trust did not have a PICU facility at the time of Andy's admission. Any patients requiring intensive psychiatric support had to be transferred to PICU beds as and where they were available. The Trust had a Service Level Agreement (SLA) with Somerset Partnership NHS Foundation Trust that it would provide PICU beds for Devon Partnership NHS Foundation Trust.
[13] The Trust SI report said that Andy was moved from Kewstoke Hospital to Holford as part of the Trust's SLA to provide PICU beds for Devon.

"*I heard late yesterday from Cygnet (Kewstoke) that* [Andy] *is being transferred today to Holford Ward, Bridgwater. I'm not sure of the reasons for this – whether it was just cost or some other reasons. The ward were unclear as* [Andy] *had settled well and seemed to be much calmer with no significant incidents.* [Andy] *had rung me yesterday to ask if I could mobilise the CRT to support a discharge home and I agreed to talk to his Consultant at Kewstoke. It was unfortunate that I knew nothing of the transfer to Holford Ward when talking to* [Andy]*. I can see nothing on RiO. It would be very helpful (I would suggest crucial) that the IPP* [Individual Placement] *Panel communicate such moves to the Care Co-ordinator"*

Consultant 1, the consultant psychiatrist for Holford ward, Somerset Partnership NHS Foundation Trust, saw Andy with Deputy Ward Manager 1 on Thursday 8 November. Andy told them that he was feeling better than he had been. He said he would not hurt anyone unless in self-defence. It was agreed that Andy could take half an hour of escorted leave on 9 November and then two half hour slots of escorted leave from 10 November.

Care coordinator 1 emailed Consultant 1[14], on 8 November 2012, to advise that a member of the Devon team had seen Mrs S the day before and, though she had some concerns about a return home, she wished for Andy to be discharged soon (he himself had seen her on 8 November 2012). Care coordinator 1 advised against this in his email to Consultant 1, recommending "[Andy] *is not discharged until things have settled a bit and you've got to know him a bit. I think he covers* [his illness] *quite well. I suggest leave be considered on a graded basis – starting with some time off the ward and building up to some time at home before he is discharged".* Care coordinator 1 emailed Consultant 1, Deputy Ward Manager 1, and Consultant 2 (Andy's community psychiatrist in Devon) the next day to advise that Mrs S had told him on 8 November 2012 that she thought Andy had been stockpiling Sertraline[15] (it is unclear if on the ward or at home) and had been taking more than he was prescribed.

GP 1 contacted the ward on 9 November to inform staff of Andy's medication history in the community.

On 13 November a Section 117[16] discharge planning meeting was held. The meeting was attended by Consultant 1, Care coordinator 1, the nurse on duty (Nurse 2) and Andy. Mrs S was not present[17] at the meeting but had emailed Care coordinator 1 the day before to give her views about Andy's potential discharge from the ward (she felt he should return home as

[14]We are unclear if Consultant 1 saw Care coordinator 1's email before he met Andy. Consultant 1 did reply to Care coordinator 1 the same day to say he had seen Andy and asked if Care coordinator 1 could attend the next ward round on 13 November.
[15] An antidepressant.
[16] Section 117 aftercare refers to the rights of a patient to access Mental Health services as part of their discharge from inpatient services (https://www.mind.org.uk/information-support/legal-rights/community-care-and-aftercare/aftercare-leave-and-guardianship/#.WbarA9KourQ)
[17] Andy' mother told us that Mrs S had been told she could not attend the meeting, despite wanting to do so.

opposed to a series of graded visits which she felt would be difficult for their young son). It was agreed Andy should have seven days Section 17[18] leave[19] to his home. There were a number of actions agreed as part of Andy's leave which included a follow-up with the Devon CRHTT, that Mrs S contact the ward every evening to confirm Andy was coping, and that Andy avoid street drugs and alcohol. Care coordinator 1 and the Devon CRHTT team were to be the primary contacts for Andy. It was agreed Care coordinator 1 would make an appointment for Andy to see Consultant 2 at the earliest opportunity. Care coordinator 1 recorded in the notes the same day that Consultant 2 couldn't see Andy until 19 December (unless there was a cancellation).

CRHTT nursing staff 1, CRHTT, tried to contact Andy on his mobile on 13 November however a recording stated the recipient was driving and unable to take the call. CRHTT nursing staff 1 subsequently called Andy's landline and spoke to his wife who advised Andy had driven into town to buy paint. CRHTT nursing staff 1 called Andy again at 1830hrs. She told Andy that he should not be driving[20]. CRHTT nursing staff 1 contacted Holford ward (Somerset) to let them know what had happened and it was agreed that any further incidents would warrant Andy being recalled to the ward (the notes do not suggest that this was communicated to Andy or Mrs S at this time).

Mrs S contacted Devon CRHTT approximately an hour later to report that she had found and disposed of cannabis she suspected Andy had purchased in Exeter earlier that day. Upon learning what she had done, Andy left the home again and took the car. Mrs S suspected this was to buy more cannabis. CRHTT nursing staff 2, who took the call, told Mrs S that the police would have to be informed because Andy had breached his leave conditions (to avoid illicit substances). The decision was taken by the CRHTT to recall Andy. The CRHTT subsequently called the police (via 999) to give details about Andy's presentation and car. Andy's mother, Dr S, told us that the family advised Mrs S to contact the CRHTT for advice and support; they had not anticipated that he would be recalled to hospital or that the police would be contacted.

CRHTT nursing staff 2 contacted Holford ward to advise it was likely Andy would be recalled due to a breakdown in community care. He then called Mrs S to update her – she told him she never felt at risk from Andy. Mrs S called the CRHTT at approximately 2030hrs to let

[18] Section 17 leave allows a service user to leave inpatient services for an agreed period of time despite being detained under the MHA (https://www.mind.org.uk/information-support/legal-rights/community-care-and-aftercare/aftercare-leave-and-guardianship/#.WbarA9KourQ)

[19] The Section 117 leave and Section 17 meeting were combined with the thinking that if the latter went well, Andy might be discharged long-term. However at the time of the meeting Andy was subject to 7 days Section 17 leave only.

[20] We have found no evidence in the notes that not driving was a condition of Andy's leave

them know Andy remained out and she was concerned he might be resistant if the police tried to return him to the ward. Dr S told us that Andy was in contact with her and his stepfather via his mobile whilst he was out.

Holford ward (Somerset) contacted Devon CRHTT the morning of Thursday 14 November to advise that Andy had not returned to the ward. Devon CRHTT subsequently called Mrs S who said that Andy was at home asleep. She said that Andy needed to be back in hospital but she would prefer if the police were not involved in his recall.

It is recorded in the notes that Devon CRHTT had a team discussion and a separate discussion with Holford ward, for which it was concluded *"The potential risk* [from Andy] *to others is too high to warrant Crisis Team review or alternative to requesting the police. Holford ward requested that I* [CRHTT staff member] *contact Devon and Cornwall Police regarding the recall."* A call was subsequently placed to Devon and Cornwall Police who advised that Holford ward would need to contact Avon and Somerset Police (due to the geographical boundaries) who in turn would have to submit the recall request to Devon and Cornwall Police. Holford ward agreed to do this. Devon CRHTT recorded in the notes *"We have not alerted the household to the recall arrangements as this may undermine the plan"*.

Mrs S contacted Devon CRHTT at 1100hrs to ask that the CRHTT attend the home to settle the situation. The CRHTT declined to attend saying it would exacerbate the situation – Mrs S disagreed with this but the call was cut short by her because she thought Andy was entering the room. Andy contacted Devon CRHTT at 1300hrs to ask when they would be visiting him. CRHTT nursing staff 3 who took the call, wrote in the notes that he had advised he was unsure what the recall plan was and would contact Andy once this was established. Mrs S called the team ten minutes later to say she thought Andy was lying about being well and expected him to be recalled immediately. CRHTT nursing staff 3 contacted Devon and Cornwall Police (having confirmed with Holford ward that Somerset Police had been informed) who advised that they did not have officers available at the time. CRHTT nursing staff 3 wrote in the notes that he'd asked the police to contact Mrs S to advise when they would be attending the family home.

Mrs S telephoned Holford ward (Somerset) on the afternoon of 14 November. She spoke to Holford nursing staff 1, telling him that Andy's mood was becoming unstable. Holford nursing staff 1 spoke to Andy to advise that there would be consequences if he did not return to the ward. Andy reportedly said he had not done anything wrong and would not return quietly.

Mrs S phoned the ward again at 1500hrs to advise that she had barricaded herself and son into her bedroom and that she could see Andy outside with chainsaws and axes getting ready

for the police to arrive[21]. Devon and Cornwall Police contacted the ward at 1530 to advise that they were at Andy's address and that he was "*abusive and aggressive, and is threatening the police with chainsaws[22]"*.

Initial police attendance was undertaken by unarmed officers. However, when they became aware that Andy had access to tools they requested an armed response, negotiator and helicopter. The police escorted Mrs S and her son from the house.

The police escorted Andy to South Western Ambulance Service (SWAS) ambulance. Ambulance staff advised Andy he should attend A&E for further assessment but he declined. It was then decided that the police should return Andy to Holford ward. The police asked the ambulance staff to leave the ambulance and informed Andy he would be taken back to hospital. A struggle ensued in the ambulance during which Andy was tasered twice by police. One officer sustained an injury to his face during the struggle and Andy was bruised. No ambulance staff and/or independent witnesses were in the ambulance at time of the incident. Andy was returned to Holford ward under the escort of eight police officers, without ambulance staff[23].

Upon admission to the ward, Andy agreed to a urine drug screen (UDS), the result for which was negative. He complained of a number of physical pains including a painful knee and blood in his faeces. The medical team noted that Andy had bruises on his wrists and back, and there was evidence of petrol inhalation, possibly from the chainsaw.

The police contacted Holford ward on 15 November to advise they would be pressing charges against Andy in relation to the alleged assault of a police officer. Dr S, Andy's mother contacted the ward the same day to ask staff to photograph and record the bruises he sustained in the ambulance; she was told this was not the job of ward staff.

Andy told ward staff on the 16 November that the police had beaten and kicked him when he was tasered in the ambulance. He was concerned that he might have a brain bleed and wanted to go to hospital (something endorsed by his mother and sister, both of whom are doctors). Andy was not taken to hospital, but seen by a member of the medical team and monitored on the ward.

[21] Andy's family told us that they had advised her to barricade herself in her room to protect herself and son from the police/events escalating. Mrs S had the family dog in the room with her whom she was concerned would try to defend Andy and attack the police. When we spoke to Mrs S she told us she had never been scared of her husband. Her statements provided to healthcare professionals at the time of the incident reinforce this.
[22] This statement was later revised to say that Andy had chain saws but there was no evidence he was in fact threatening police.
[23] Andy' family submitted a complaint to SWAS which led to the service undertaking an investigation into the incident on 14 November 2012. The report details conflicting accounts as to what the ambulance staff saw happen in the ambulance between Andy and the police.

Andy was seen by Consultant 1, Holford psychiatrist, six days later on 20 November during ward rounds. Andy said he was fine on the ward and had been taking his medication. He told staff that his memory of the incident on 14 November was hazy because he had been tasered. He added that he hadn't broken the conditions of his leave and that he had chosen to work in his shed when Mrs S told him the police were coming, and consequently put a warning sign on the outside door as per health and safety laws (e.g. when using chainsaws). Consultant 1 agreed that Andy could have escorted leave twice a day and that he should meet with Mrs S to discuss Andy's care plan.

Consultant 2 emailed Consultant 1 on 21 November to advise that he had spoken to Andy's GP about recent events and they had some concerns in relation to Mrs S' wellbeing and asked that this be borne in mind in relation to any leave arrangements made for Andy.

Consultant 1 saw Mrs S and spoke to Andy's mother over the phone on 22 November. Andy's mother, Dr S, told Consultant 1 she was unhappy with his leave arrangements and the lack of contact by the Devon crisis team, particularly in relation to his recall to hospital. Leading from this Dr S believed the incident with the police on 14 November could have been avoided. Dr S felt that Andy should not be in hospital but if he was to remain, he should be transferred back to Devon. Dr S asked Consultant 1 why Andy was not taking his mood stabiliser, Lamotrigine. She felt that his mood had been stabilised in the community when he was taking 100mg Lamotrigine, but Consultant 1 had prescribed 25mg Lamotrigine on 22 November 2012.

Care coordinator 1 phoned Andy on 22 November. He wrote in the notes that Andy had said that he had bought cannabis[24] when on leave 13/14 November, but denied he had broken the conditions of his leave because he did not take it.

Consultant 1 contacted the Devon team the same day to ask for a copy of Andy's notes and ask that they organise a forensic referral for Andy. Care coordinator 1 contacted Consultant 3 (consultant forensic psychiatrist) to request a forensic assessment. Consultant 3 advised that the team would need to contact Assistant 1 (the business assistant for secure services) who was subsequently contacted by both Care coordinator 1 and Consultant 2. Assistant 1 agreed to arrange a forensic assessment but said she would need a formal referral from a psychiatrist. Care coordinator 1 replied that Consultant 2 would submit this[25].

[24] Dr S told us that Andy was always clear that he had not purchased cannabis when he was on leave. She said that Care coordinator 1 may have misinterpreted what Andy had told him.
[25] The Forensic report dated 20 December 2012 says that Consultant 1 (not Consultant 2) referred Andy on 30 November 2012.

In parallel with this, Devon information governance team advised that they would need consent from Andy if they were to release his notes to Consultant 1.

Consultant 1 saw Andy during ward rounds on 27 November. It was recorded in the notes that Mrs S had submitted a written request, asking that Andy be discharged from his section and hospital. Andy asked for leave to help Mrs S run their business.

Andy gave written consent on 28 November for Consultant 1 to access his notes. Deputy Ward Manager 1 wrote in the notes the same day that Consultant 1 was to make a decision as to whether Andy could be discharged from his section. Holford ward received a 'nearest relative discharge' request from Mrs S which Consultant 1 barred (on 29 November). A hospital managers' hearing was arranged for 6 December.

Consultant 1 telephoned Consultant 2 on 28 November to discuss Andy's diagnosis, background, risk assessment and management. Consultant 2 wrote in the notes "*In summary my view shared with him* [Consultant 1] *is that a conservative approach with careful assessment as part of a cautious graded approach to discharge is the only realistic option in light of recent events which it seems to me were the result of a complex combination of mental ill-health, possibly drug use, impulsive actions with whatever psychological and possible symptom drivers, and interpersonal relationship factors all of which resulted in a catastrophic misjudgement on* [Andy]' *part…"* Consultant 2 wrote that Consultant 1 was to seek a forensic component to Andy's risk and care plan.

Mrs S phoned the ward on the evening of 28 November to arrange a visit with her son to see Andy when he was on leave. She was asked to call in the morning to discuss with ward staff.

Consultant 1 saw Andy on 29 November. Consultant 1 agreed Andy could have section 17 leave [26]with Mrs S under staff escort. Consultant 1 wrote to Assistant 1 on 30 November to request a forensic assessment.

December 2012

Andy was seen by Consultant 1, Junior doctor 1 and Deputy Ward Manager 1 (Holford) on 4 December. Andy's mother dialled into part of the meeting. Dr S queried the lack of planning involved in Andy's discharge from hospital and the Trust recall process. Andy's Lamotrigine[27] was increased to 50mg. Andy started taking unescorted leave on 4 December, initially for 30 minutes, and gradually increased.

[26] Andy was permitted one hour's escorted leave, twice a day
[27] Lamotrigine is an anti-convulsant and mood stabiliser used in the treatment of bipolar disorders and epilepsy.

A Hospital Managers Hearing[28] took place on 6 December. Consultant 1 wrote in his report to the hearing, dated 4 December, that Andy was complying with treatment and remained stable but did not fully accept responsibility for his behaviour. Consultant 1 added that he had requested a forensic assessment for further risk assessment. Consultant 1 concluded *"If he were to be discharged prematurely my concern is that his level of risk has not been totally identified and he may therefore present a risk to others. I am therefore concerned about his health and safety of other* [sic]". Andy's detention was upheld and he remained on Section 3.

Care coordinator 1 was asked to follow-up the forensic assessment with a view to discussing transferring Andy to an open unit closer to home. Care coordinator 1 emailed the forensic team (Consultant 14) to ask when it intended to undertake the assessment and highlighted its urgency in view of planning Andy's leave/discharge arrangements. Consultant 2 emailed Care coordinator 1, Consultant 1 and Consultant 14 the same day to advise caution in giving Andy any more escorted leave until a forensic assessment had been completed. Consultant 2 wrote *"I am increasingly concerned that we don't have the full info re what exactly happened between* [Andy] *and the police…. I just think we have to sort all this out first before he goes out, as otherwise we risk repeating the whole thing. It is essential… to understand what really happened before a proper analysis of risk can be made"*.

Consultant 1 saw Andy during ward rounds on 11 December. Andy was told that he would not be transferred to Devon until he had a forensic assessment (scheduled for 17 December). It was recorded in the notes that the responsible Consultant for Devon agreed with this decision and wanted Andy to be assessed before a transfer.

Senior Registrar 1 (Devon forensic psychiatrist, senior registrar) conducted Andy's forensic assessment on 17 December as part of ward rounds. SHO 1 (SHO psychiatry to Consultant 1) gave a written summary to Senior Registrar 1 as part of this process. It said, "*Since his return to Holford ward his mental state has remained remarkably stable. He is showing no signs* [of] *hypomania or other abnormalities in thinking or perception… He continues to maintain a low profile on the ward and is not a management problem. However, he often attempts to be controlling of staff and insist on getting* [his] *way…* [Risks] *Historically harm to himself and other when unwell"*

Andy said during the forensic assessment that the cannabis Mrs S found in November was old and that she had falsely accused him. Dr S told us that Andy had been anxious about this assessment because he was on his own without a relative or advocate.

[28] A Hospital Managers' Hearing is the process by which detained patients have their detention reviewed.

Senior Registrar 1 wrote in the notes that he had consulted Consultant 4, a Devon Partnership Trust consultant forensic psychiatrist (and joint Medical Director), about Andy and she advised that more information should be gathered from Mrs S and in relation to any previous convictions – *"she* [Consultant 4] *took particular notice of the fact that* [Andy] *did not show any early warning signs before the incident with* [sic] *the police happened on 13-11-2012. She also wanted to make sure that we have a clearer idea regarding any potential risk to wife or child through collateral history".*

It was subsequently recorded in the notes that Consultant 4 spoke to Consultant 1 and that she asked that Andy's move to Cedars[29] in Devon be put on hold until the forensic team could complete its assessment (e.g. speak to Mrs S, obtain Andy's PNC record).

Consultant 1 asked the Somerset staff to start making arrangements to transfer Andy to Cedars. A bed request was submitted to which Devon staff advised the ward to call daily to get a bed/check availability.

Consultant 1 saw Andy during ward rounds with Deputy Ward Manager 1 and SHO 1 on 18 December. Andy said his mood had improved which he attributed to the Sertraline (originally started because Andy's mood had become depressed) he had been taking.

The Devon forensic report (by Senior Registrar 1) was submitted by Consultant 1 to Holford on 20 December. The report confirmed that Andy could be transferred to an open ward/low secure ward. Andy was transferred to Ceders (Coombehaven ward) on 22 December, Andy's birthday. He was assessed by Doctor 1 and granted overnight leave the same day. Andy was seen by Consultant 5 (consultant psychiatrist) and Doctor 1, during ward rounds on 24 December. Andy was granted overnight leave on Christmas day and returned to the ward the evening of Boxing Day.

Upon his return to Cedars, Andy was noted by nursing staff to be irritable and edgy in mood. It was recorded in the notes that Andy had become intimidating and aggressive when found smoking on the ward with another patient in the early hours of 27 December. He was described as non-compliant and making threats to staff if they did not let him leave the unit – reportedly telling staff there would be 'consequences'. Ward staff took the decision that the level of risk Andy presented (*"unpredictable behaviour, agitated, threatening violence"*) meant the police should be asked to intervene[30]. As a result, ten police officers attended the ward. It was recorded in the notes that Andy initially refused to comply with the police, however

[29] Ceders is a dedicated mental health unit in Devon that provides inpatient psychiatric care. There are two wards: Coombehaven and Delderfield. (http://www.nhs.uk/Services/clinics/Overview/DefaultView.aspx?id=109093)

[30] In its complaint response to Dr S, the Trust advised that the ward had one Registered Nurse (RN) on duty as opposed to two.

reportedly noticed a number had their Tasers drawn, and entered seclusion as directed. The police had to leave the ward and Andy was unmedicated (this was recorded as an incident by ward staff) as staff did not feel safe to enter seclusion without the police. A doctor subsequently attended the ward and prescribed medication. Staff took steps to transfer Andy back to a Nash ward (a PICU ward at Cygnet Hospital Kewstoke). Dr S told us that the ward did not give any information to the family in relation to the incident and that she had to contact the Trust for details.

Andy slept intermittently until 0900hrs (in seclusion) at which point he became aggressive and threatening[31] towards staff. He reportedly head-butted the seclusion room viewing pane and spent 20-30 minutes trying to kick his way through the door. Andy was transferred to Nash ward the afternoon of 27 December.

January 2013

Andy remained on Nash ward (where the decision had been taken to stop his Sertraline in increments of 50mg a week) until 2 January 2013 when he was moved back to Holford Ward, Somerset. Andy had not stopped taking Sertraline when he was moved. Mrs S contacted Holford ward on the 2 January to voice her concerns about Andy returning to the ward, particularly given that she felt he did not get on well with Consultant 1 and the ward contained a number of disturbed patients. However she did not feel he was well enough to return home.

Deputy Ward Manager 1 described Andy in the notes as 'pleased' to be back on Holford and that he did not mind Consultant 1 being his consultant. Dr S told us that Andy was unhappy to find that some of his possessions – including his diary - were missing but eventually located. It was noted that Andy had been unaware of the impending transfer until lunchtime that day – he had been given little warning (one hour) of his move back to Somerset.

Consultant 1 saw Andy on 3 January. Andy denied that he had been smoking cannabis on Nash ward or when on leave. It was agreed that feedback would be sought from the Devon Forensic team, Andy would continue on his medication and that Consultant 1 would review his leave. Consultant 1 spoke to Senior Registrar 1 who in turn spoke to the Clinical Director for Secure Services at Devon about recent events.

Senior Registrar 1 revised his forensic report (in view of the incident in Devon on 27 December 2012), recommending that Andy initially be assessed in a medium secure setting before being transferred to a low security setting. He added that Consultant 1 should cancel Andy's unescorted leave.

[31] The notes do not describe the alleged threating/aggressive behaviour.

Consultant 1 explained to Andy the recommendation of the Forensic team the same day in relation to a medium secure assessment. Andy said he was unwilling to be transferred to another ward and would contact his lawyer. As a result of the Forensic team input and Andy's response to the news, Consultant 1 took the decision to not grant Andy any section 17 leave at that time.

Senior Registrar 1 emailed Consultant 2 on 3 January, saying "*…due to the failure in the step-down to Cedars,* [Andy]'s *increasing substance misuse and the intimidating behaviour he exhibited in an open ward, he requires a secure Forensic admission"*

Whilst on the ward Andy became unwell and his behaviour became uncooperative and intimidating at times. Andy's sister contacted the ward on 6 January to ask about his behaviour. She said she had observed (when she had seen him) some of the typical symptoms of him being high that include grandiose statements and flight of ideas[32]. Ward staff advised that there hadn't been any changes to Andy's medication. Andy's mother contacted the ward on 7 January to advise that her daughter was concerned he was becoming manic. She also asked if blood tests had been taken (Dr S told us this was to check Andy's Lithium levels – if they were less than 0.6 then they were not effective. She said she was told his levels were ok). Mrs S also contacted the ward to advise that Andy had been smoking cannabis since he was discharged from Holford ward on 22 December and consuming high energy drinks; she was not surprised his mental state was deteriorating. Andy continued to express grandiose ideas and odd religious beliefs.

Consultant 2 emailed the community team and Consultant 1 on 7 January. He wrote that he thought Consultant 1 was right to seek the guidance of the forensic team and *"my view is that a) he is not functioning as he does when he is well and b) that he needs a period of stability to a safe setting, to allow his problems to be properly understood and his condition treated adequately – this might well mean rethinking his medication and will certainly require a careful risk management plan, and is not a quick fix".* Consultant 2 added that he supported Consultant 1's decision making and pathway.

Consultant 1 saw Andy at ward rounds on 8 January. No cause for concern was identified, though it was recorded in the notes that Andy was not taking responsibility for his actions[33], but said his behaviours were the result of psychotic symptoms.

Andy was told on 9 January that his Mental Health Tribunal scheduled to take place on 11 January had been cancelled[34]. Consultant 1 saw Andy during ward rounds on 9 January.

[32] Accelerated, continuous speech, that switches topic rapidly
[33] Dr S has contest this assessment, noting that her son was unwell at the time.
[34] No explanation for the cancellation was recorded in the notes.

Andy's uncle attended the ward round. It was agreed that Andy could start taking escorted leave either with his uncle or wife. It was recorded in the notes that staff were awaiting a decision from the Devon forensic team as to next steps for Andy's treatment.

Nurse 3, mental health nurse, undertook a mental health assessment of Andy on 9 January at the request of Consultant 1 who wanted a second opinion in relation to risk management, diagnosis and further management. She recommended[35] a full psychology assessment be undertaken to assess whether Andy had a dissocial personality disorder. She added that Andy's diagnosis should be revisited given that there was *"a consensus*" that a schizoaffective disorder should be considered.

Andy was noted at various times between 10 and 12 January to have acted in an intimidating manner towards staff and that he pushed a male patient to the floor on 10 January. Dr S told us that this was indicative of him becoming increasingly unwell.

Andy's mother contacted the ward on Saturday 12 January to say she felt he was paranoid and was becoming manic. She asked that a doctor review him. The same day, Andy asked for some cola however he had already received his daily allowance as directed by his care plan re caffeinated drinks. He became argumentative and staff thought he was trying to intimate them. Deputy Ward Manager 1 had a "one to one" planned meeting with Andy however he curtailed this because he felt threatened. The nursing team held a group discussion in which it was decided that Andy presented a very high risk to staff and that the police should be contacted to move Andy from the communal area to seclusion. He was described in the notes as repeatedly issuing threats and *"appearing increasingly hostile, verbally aggressive, threatening posture, intimidating manner".*

Ward staff contacted the police (via 999) at 1500hrs. The police returned the call at 1530hrs to say they did not have the resource available to attend the ward and that mental health services should manage the situation. Ward staff reiterated the risk Andy posed to staff at that time and repeated their request for police support. They were advised the police would seek advice from their Sergeant and contact the ward. The ward did not hear from the police and called 999 again at 1600hrs. The police Sergeant contacted the ward at 1630hrs to advise it was not in their remit to attend the ward. Deputy Ward Manager 1 voiced his disappointment at the lack of timely support from the police given what he considered to be a serious situation. The Sergeant initially advised that they might be able to send a response at 1700hrs subject to resource, however four officers became available during the call and attended the ward (armed with Tasers and shields) at 1700hrs. Andy was moved to seclusion without force or

[35] Dr S told us she believed the report was full of inaccuracies.

restraint, but was reportedly described by one of the officers as 'unsafe and unpredictable'. The police left the ward. Andy's family contacted the ward (and Devon) a number of times during the day, asking to speak to a doctor and/or qualified staff. Dr S told us they had been trying to avoid another incident.

Andy was given his evening medication at 2115hrs. Shortly after he started to kick the seclusion door. He broke the window of the door shortly after and staff left the area, locking the surrounding doors. The police were contacted again and attended the ward at 2200hrs. Arrangements[36] were made for Andy to have a PICU bed at Cygnet Hospital Kewstoke and following some debate, with ward staff, the police agreed to transport Andy to the hospital if the ward paid for the service.

Andy was transported by the police and was readmitted to Nash ward at Kewstoke hospital on 12 January. His family asked that he remain at the hospital (specifically Nash ward) until his Mental Health Tribunal took place (scheduled for early February). Ward Manager 2 (clinical ward manager, Holford) emailed Care coordinator 1 to advise that there currently weren't any beds available in Somerset and asked that Devon confirm its position in relation to Andy and any plans for transfer in order to achieve a consistent approach across the two Trusts.

The (Cygnet) nursing report prepared for Andy's Mental Health Tribunal, dated 15 January, recommended that Andy spend time in a low secure rehabilitation unit and that a stay might *"contribute to lowering the risk of relapse and therefore re-admission"*

It was agreed at a Devon bed managers meeting (the forensic team was in attendance) on 17 January that Andy should stay at Kewstoke hospital. The reasoning for this was to reflect the wishes of his family (who had written to the Senior Forensic Consultant explaining the situation; Andy's sister had also telephoned), a medium secure bed was not available and there was a belief that Andy could be treated in a low secure setting.

Care coordinator 1 spoke to a member of staff at Kewstoke on 23 January to discuss Andy's progress. It was reported that Andy had been quite pleasant and there hadn't been any violent incidents, however he was also described as quite delusional, paranoid and very assertive at times. The Kewstoke member of staff thought Andy would benefit from a medication review.

Care coordinator 1 emailed Consultant 6 (consultant forensic psychiatrist, Kewstoke) on 23 January to say he would be willing to attend ward rounds though Andy had recently requested a new care coordinator (Andy later changed his mind). Care coordinator 1 outlined

[36] Dr S submitted a complaint to the Trust (on Andy's behalf) in relation to its management of Andy's transfer. She told us her concerns were never fully addressed.

that the Devon forensic team and out of county placement team believed Andy needed to be treated in a low secure setting (the forensic report[37] recommending a medium secure setting).

Care coordinator 1 and the Trusts individual patient placement (IPP) team started exchanging emails on 24 January to discuss where Andy should be placed once he left Nash ward at Cygnet Hospital Kewstoke. The general consensus was that he would need a low secure placement. Redhill ward (a low secure ward at Kewstoke) was identified as the appropriate placement.

Care coordinator 1 attended ward rounds at Kewstoke on 31 January. Mrs S was also in attendance. He noted Andy to be tense and challenging at times, concluding that he did not appear well. It was agreed at the ward round that a move to Redhill would be appropriate. It was also agreed that a detailed risk assessment was needed and that Andy needed support for his substance misuse. Consultant 6 (also present) told Andy that he would not support his discharge at the forthcoming Mental Health Tribunal and that a move to Redhill was appropriate.

February 2013

Consultant 2 wrote to Care coordinator 1 on 4 February to advise that a graded approach should be taken to Andy's discharge which should include escorted leave that graduated to home leave. Consultant 2 endorsed the consensus that Andy would benefit from not being moved to another hospital. He added that he did not think a community treatment order[38] (CTO) would help Andy, but endorsed a Clozapine[39] trial, ideally whilst Andy was still an inpatient. Consultant 2 asked that his views be taken into account and shared with Consultant 6.

Kewstoke emailed the Devon IPP team on 6 February to advise that Redhill ward did not think Andy was suited to the ward and that he would benefit from a medium secure placement. Consequently steps were to be taken to arrange an assessment for eligibility for care in a medium secure unit before a final decision was made.

Care coordinator 1 spoke to Nurse 4 (nurse, Nash ward) on 6 February to discuss a possible Clozapine trial (Consultant 6 was not available). Nurse 4 relayed that any decision in relation to a trial was being delayed because it was thought Andy would be transferred imminently.

[37] Andy's family dispute the accuracy of the Forensic report, and describe it as being based on hearsay and inaccuracies.
[38] A community treatment order is part of the MHA. It is used to treat patients in the community who require ongoing support. They are granted leave subject to their adherence to the conditions of the order e.g. take medication.
[39] Clozapine is an antipsychotic medication. It has rare but dangerous side effects and patients have to be closely monitored when taking it. This includes regular blood tests.

Consultant 2 and Consultant 6 had a phone call on 7 February during which they discussed a possible Clozapine trial and the need for a stable ward environment to facilitate this.

Consultant 6 interviewed Andy on 8 February for his Mental Health Tribunal psychiatric report. Consultant 6 recommended that Andy continue to be detained under Section 3 of the MHA and that eventual transition to the community be carefully considered by the hospital and community teams collaboratively.

Consultant 7, consultant psychiatrist and neuropsychiatrist, assessed Andy for a medium secure placement on 8 February. Consultant 7 concluded:

"…I am not confident to argue that [Andy] *satisfies the criteria for detention in their entirety… I do not think he is a candidate for a medium secure setting. He probably needs to be observed in a less restrictive setting gradually moving to an open ward and has further risk assessments and management plan prior to community leave and eventual discharge… a CTO is not indicated"*

A Section 117 meeting took place on 11 February. This happened in advance of the Mental Health Tribunal in case Andy was discharged from his section. Andy did not attend[40]. A number of recommendations were made at the 117 meeting which included (prior to Andy being discharged), an ongoing period in hospital during which he gradually tested returning home. Care coordinator 1 advised that he and Consultant 2 did not think a CTO would be helpful.

Andy's Mental Health Tribunal was delayed until a later date (to take place within four weeks) because not everyone - including Andy, his solicitor and the medical representative of the Tribunal – had seen the forensic risk assessment report. The Tribunal also requested a brief report from Consultant 2 (Consultant 6 provided this in his revised report on 4 March).

The police attended Nash ward on 17 February to formally charge Andy with assaulting a police officer in November 2012. Andy refused to see the police and reportedly unsettled the ward by telling other patients the police were coming to the ward.

It was agreed at a multi-disciplinary team (MDT) meeting on 21 February that Andy should be placed on Redhill ward. Andy moved to Redhill ward on 25 February. During his time on the ward Andy was noted to engage with therapies and appeared settled in mood.

[40] The notes do not say why Andy did not attend the Section 117 meeting

March 2013

Andy's Mental Health Tribunal took place on 25 March at Kewstoke Hospital. Andy's solicitor had obtained the police statements and that of Consultant 1 (in relation to the incident); this was the first time this information had been available to them. Andy submitted an extensive handwritten statement to the Tribunal, outlining his care and treatment, previous admissions and what he had learnt. The Tribunal decided that Andy should be discharged from his section on 28 March. It was agreed that the draft care plan drawn up during the Section 117 meeting (held on 11 February) could be implemented. The care plan outlined a number of interventions that included short term support from the CRHTT, medication, substance misuse support (e.g. attend AA), CPA meetings and an outpatient appointment with Consultant 2 (scheduled to take place on Monday 8 April 2013).

Andy was discharged from Kewstoke on 28 March. He had been in inpatient settings for five months.

Andy was referred to the East and Mid Devon CRHTT (as part of his Section 117 care arrangements) who saw him on 30 March. The team planned a brief period of intensive interventions to support Andy's Section 117 care plan. The team also contacted Andy's GP (GP 1) in relation to his prescriptions.

April 2013

Andy attended support groups (e.g. AA and Relate) as directed by his care plan in April.

Consultant 2 saw Andy with Mrs S and their son on 8 April. Andy appeared pleasant and focussed. They discussed Andy's treatment and medication. They agreed that in the event of becoming unwell, Andy should be treated quickly with medication and potentially an inpatient stay – preferably a PICU. Andy felt that he had repeatedly encountered difficulties on open[41] wards when he was unwell.

Andy and Mrs S told Care coordinator 1 on 17 April that they were considering moving to Sheffield where Mrs S had been accepted onto a nursing course. Andy was discharged from the CRHTT case load (in preparation for his move) on 18 April[42]. He remained on CPA and under the care of Consultant 2 and Care coordinator 1 of the CMHT.

Andy saw his GP, GP 1, on 24 April. GP 1 subsequently contacted Consultant 2 to report that Andy was doing quite well but had called the surgery after his appointment asking for

[41] Consultant 2 wrote in the notes that Andy referred to 'open wards' – we assume this means acute admission wards

[42] The CRHTT's support of Andy (as per the Section 117 care plan) was on a short term basis which was to decrease gradually, as agreed with Andy.

Lorazepam. GP 1 was reluctant to give this and it was agreed with Consultant 2 that Andy should remain on Clonazepam for another 1-2 weeks before considering a planned reduction. Consultant 2 wrote in Andy's notes that he continued to hold the view that Clozapine would offer Andy a fundamental improvement but Andy remained against the idea because his family tell us he did not want to become addicted to it.

Care coordinator 1 saw Andy and Mrs S on 30 April. Care coordinator 1 told Andy that he had received an email from Kewstoke earlier in the day advising that a summons had been sent for Andy to Redhill ward from Devon and Cornwall Police to attend court on 3 May in relation to the alleged assault of a police officer on 14 November 2012. Andy rang his solicitor and told Care coordinator 1 that he would enter a 'not guilty' plea.

May 2013

Care coordinator 1 saw Andy on 8 May. Andy said that Mrs S had been offered a place on a nursing course in Derby and they had decided to move there as opposed to Sheffield. Andy said he thought his court hearing would be in July, and that he found this stressful. Care coordinator 1 wrote in the notes *"He* [Andy] *has little or no insight into his responsibility for anything that happened* [on 14[43] November 2012]*".*

Andy emailed Care coordinator 1 on 28 May to tell him that he and his family would be moving on 12th June to Derby. He asked for an earlier appointment (the date previously offered was 13 June) with Consultant 2 and Care coordinator 1.

June 2013

Consultant 2 saw Andy with Mrs S and their son on 5 June. Andy had stopped taking the Clonazepam and Zopiclone[44] because he was concerned he would start becoming addicted. Consultant 2 wrote in the notes that Andy was understandably preoccupied with his impending prosecution. Andy's mood was noted to be euthymic (non-depressed/stable). Andy told Consultant 2 he would share the details of his new (Derby) GP with Consultant 2 at the first opportunity. Consultant 2 intended to write to Andy's new consultant psychiatrist once this individual was identified.

Care coordinator 1 saw Andy and Mrs S on 6 June. They assured Care coordinator 1 that they would provide Andy's GP details at the first opportunity and understood the importance of transferring Andy's care to Derby mental health service – which Care coordinator 1 would initiate. Andy's court appearance had been confirmed for 12 July.

[43] Care coordinator 1 was not present at the incident on 14 November 2012. He was not working that day.
[44] Zopiclone is a medication often given to help with sleep. It is addictive and should only be used for a short time.

Consultant 2 wrote to the local consultant psychiatrists, Consultant 8 and Consultant 9, in Derby (Derby City Recovery Teams 1 & 2) on 10 June asking that Andy be reviewed. In his letter, Consultant 2 provided details of Andy's diagnosis (historically bipolar disorder but now schizoaffective disorder), mental health history, recent admissions, family background and medication. He provided information about Andy's impending court hearing and attached Andy's recent care plan and risk assessment. He added that there was some debate in relation to Andy's diagnosis, but that he himself did not believe Andy to have a personality disorder. Consultant 2 wrote that he believed Andy would benefit from taking Clozapine in terms of controlling his *"residual but definite psychotic symptoms, helping stabilising his mood symptoms, and reducing his risk of reverting to drug and alcohol use…".* He wrote that Andy had previously resisted this treatment option but was now prepared to consider it as an alternative to Olanzapine. Consultant 2 wrote that though Clozapine is prescribed for treatment resistant schizophrenia, this was not Andy's diagnosis.

Consultant 2 wrote to Andy the same day to advise him he had written to the Derby team and shared a copy of his referral letter.

Mrs S emailed Care coordinator 1 on 20 June to give Andy's GP surgery details. She said she would provide the GP's name once she had it. Andy saw GP 2 on 21 June. Andy's records were updated on 25 June to include the name of GP 2[45] (as provided by Mrs S). Consultant 2 sent the Derby team Andy's GP (GP 3 – from the same surgery) details on 27 June. Consultant 2 wrote to GP 3 on 27 June, providing a copy of the letter he sent on 10 June to the Derby consultants, with a view to providing GP 3 with context and information about Andy's medication.

July 2013

Consultant 2 faxed his referral (dated 10 June) to Recovery team 2 in Derby on 3 July. The team discussed Andy at the Derby City recovery team sector meeting on 4 July. It was agreed a letter would be sent to Consultant 2 letting him know that Consultant 10 (consultant psychiatrist, recovery team 2) and Care coordinator 2 (care coordinator) would be responsible for Andy's care.

Andy saw GP 2[46] on 5 July.

Consultant 8 wrote to Consultant 2 on 10 July to advise that he and Consultant 9 were the wrong people to contact in relation to Andy. He added that his secretary had sent Consultant

[45] It was later recorded in Andy's notes that GP 4 was his GP
[46] Andy contacted his surgery a number of times in July by telephone

2's original letter to the Derby Pathfinder service, Consultant 10, the community link psychiatrist for Andy's GP surgery.

A letter was sent to Andy on 11 July to advise that an outpatient appointment had been arranged to take place a month later on 14 August.

Andy's court case was cancelled on 11 July. He was detained by the police on 13 July on suspicion of drink driving but later released without charge. The next day he was taken to A&E by ambulance at the request of his family because he was suicidal. He had told Mrs S that he wanted to kill himself and she had found him with empty packets of Lorazepam and Clonazepam. A MHA assessment was undertaken. Andy admitted to drinking alcohol the night before and said that he had fallen over his dog which accounted for grazes to his forehead and nose. The assessing team spoke to Mrs S on the phone who told them that he had threatened to kill himself with a chainsaw that morning. She told the team that she did not want Andy to return home and that they should look at his history.

It was recorded in the assessment that Andy's notes detailed that he had suicidal thoughts and could be aggressive when unwell. The assessment concluded that on the basis of his presentation, Andy did not need to be admitted and was not detainable under the Mental Health Act, but should have ongoing crisis support at home. Andy was therefore discharged and referred to the crisis team. The MHA assessor wrote in the notes: *"Drs* [A&E Doctor 1 and A&E Doctor 2] *and I felt that given his* [Andy's] *responses to questions, hospital admission was not required. However, we felt that support from the crisis team pending allocation to workers from CMHT would be helpful and* [Andy] *agreed with this".* It was recorded in the notes that Andy's family were unhappy with this decision and it was likely they would submit a complaint to the Trust.

Andy was seen by the crisis team on 15 July after the weekend. He appeared calm and showed no sign of mania or depression, though smelt strongly of alcohol and appeared intoxicated. He appeared to have limited insight into his illness and its associated risks, particularly in relation to his alcohol use. He walked out of the assessment meeting twice when he didn't agree with the proposed treatment plan. The assessors concluded that Andy's presentation was in keeping with a hypomanic state. They agreed a number of actions that included the home treatment team assuming responsibility for Andy and that he should have an urgent medical review on 17 July. They also took steps to bring forward his outpatient appointment with Consultant 10. They added that if Andy disengaged, deteriorated or became non-compliant he should be urgently assessed by the crisis team and a Mental Health Act assessment should be considered. Andy's mother contacted the crisis team on 15 July to tell them she feared he was unwell and was suicidal.

Care coordinator 2 forwarded a copy of the crisis team assessment and outcome to Consultant 10 on 15 July. She sent the crisis team a number of documents (e.g. risk assessment) received from Devon on 16 July. Consultant 10 wrote to Consultant 2 on 16 July advising that Andy had been offered an appointment on 14 August and allocated a care coordinator from Recovery team 2.

The crisis team undertook further home visits on 16, 18, 21 and 22 July. Care coordinator 2 also attended on 22 July (having telephoned and spoken to the crisis team on 17 July 2013). Andy said he had been feeling anxious since his court case was postponed and asked for more medication. The crisis team agreed to arrange a medical review for Andy.

Andy was seen by Consultant 11 (consultant psychiatrist, Derby City Crisis Resolution and Home Treatment Team) on 23 July. Mrs S was also present. Andy told Consultant 11 that the Lorazepam and Clonazepam had 'lost their sting' and that he wanted more medication. Consultant 11 suggested that both be stopped and replaced with Diazepam. They discussed the dosage – Consultant 11 suggesting 5mg three times a day, whereas Andy wanted 5mg four times a day. Andy told Consultant 11 that he needed Benzodiazepines until after his court case otherwise he would self-medicate. Consultant 11 told Andy that the team could not keep prescribing Benzodiazepines and that he would liaise with the community team psychiatrist. He added that Andy should "take some responsibility"[47] for his substance misuse. The meeting deteriorated and Andy left saying he did not agree to switch to Diazepam and he would order Benzodiazepines from the internet. Mrs S told Consultant 11 that Andy was upset but might agree with the plan in due course[48]. Consultant 11 asked Mrs S that they consider possible changes to Andy's medication and made no changes to Andy's medication in the interim[49].

Andy attended his GP surgery on 24 July and was seen by GP 4. Andy requested Benzodiazepines. GP 4 declined to prescribe more medication and contacted Consultant 10 who agreed with this decision. Consultant 10 said he/she would speak to the crisis team consultant about Andy's medication.

The crisis team undertook a home visit on 27 July.

Mrs S contacted the crisis team on 30 July to advise that she thought Andy wasn't taking his medication as prescribed and she was worried he was going to relapse. The team offered to

[47] This wording is taken from Consultant 11's letter to Andy's GP4.
[48] Andy contacted Consultant 11's office on 24 July to apologise for being disagreeable during the assessment.
[49] Consultant 11 advised in his statement to the Coroner that Andy changed his mind the next day about taking Diazepam and that Consultant 11 subsequently contacted his GP as a result. We have seen this letter dated 1 August 2013. We have also seen a letter from Consultant 11 dated 2 August 2013 in which he states he has not made any changes to Andy's medication.

contact Andy to make an appointment however Mrs S said he was at work at that time and it would be easier if he contacted them.

Mrs S also contacted the Derby City team on 30 July to say she was concerned that Andy was missing doses of his medication and that he had been discharged from the crisis team. Care coordinator 2 contacted the Derby crisis team who confirmed Andy's planned discharge and that they wanted to undertake a joint home visit with the city team to facilitate this. She advised the team that she would be on leave until 27 August and that Andy had an outpatient appointment on 14 August. Care coordinator 2 wrote in the notes *"Informed* [crisis team worker] *that when I met* [Andy] *he was a little guarded and his history indicates high risk of relapse".*

The crisis team contacted Andy on 31 July to arrange a home visit. Andy said there was little sense in meeting unless they would be bringing him medication. A visit was not scheduled.

August 2013

The crisis team contacted Andy on 1 August to arrange a visit. They spoke to Mrs S who told them Andy was at work. The team told Mrs S that Consultant 11 wanted Andy to stop taking his lorazepam and clonazepam and to start taking diazepam. They told her that he had faxed this message to Andy's GP and she/Andy should make arrangements for an appointment as soon as possible. The crisis team asked that Andy contact the team to arrange a visit for the next day.

A home visit was undertaken by the crisis team on 5 August (they had tried to arrange an appointment for the previous day but had been unable to get hold of Andy). Andy seemed fine though said he was angry with Consultant 11 and the crisis team for not believing he was mentally unwell.

The crisis team undertook another home visit on 7 August at 1800hrs. They were met by Mrs S who told them Andy had gone to bed and did not want to see anyone from the team at present. Mrs S told them he asked that they undertake two phone calls a week and a possible home visit if he felt up to it.

A member of the crisis team spoke to Consultant 11 on 9 August to say that Andy was not engaging with the team and that his care coordinator was on annual leave until the end of August. They agreed the crisis team should arrange a home visit to discharge Andy from the service and that he should attend his outpatient appointment with Consultant 10 on 14 August.

Specialist registrar 1 (ST4 to Consultant 10) reviewed Andy on 14 August. He recorded in the notes that it was a follow-up appointment. Specialist registrar 1 did not have a copy of Andy's

section 117 care plan or risk assessment at the appointment. Andy appeared relaxed, his mood euthymic. Andy said he was anxious about his impending court case that had been postponed until October. He admitted that he had purchased additional Diazepam over the internet and from other patients. Andy told Specialist registrar 1 he had fleeting thoughts of suicide but no intention of acting on these. Specialist registrar 1 wrote to Andy's GP detailing the meeting and asking that Andy's medication continue but his Diazepam[50] be gradually reduced with the aim of stopping it over the upcoming weeks. Specialist registrar 1 wrote that Andy would remain under the care of the crisis team until a joint meeting with Specialist registrar 1, Care coordinator 2 and the crisis team took place. Specialist registrar 1 concluded in his letter "*I remain concerned about* [Andy]'s *self-medication and the harmful impact on his underlying mental health. He has a history of volatility and aggression in the past and at times has not engaged appropriately. He was well and agreed with the above* [enclosed] *plan".* A follow-up review was scheduled to take place six weeks later.

Andy contacted the community team the morning of 16 August asking to speak to Specialist registrar 1. Specialist registrar 1 was unavailable at the time but later called Andy back. Andy told Specialist registrar 1 that he had been feeling increasingly anxious and that he was self-medicating with additional diazepam. He said that he was experiencing increasing suicidal ideation but was able to keep himself safe because his wife was with him. Specialist registrar 1 spoke to Mrs S who confirmed that Andy was increasingly agitated and taking more Diazepam.

Specialist registrar 1 contacted the crisis team asking them to visit Andy that day. Mrs S contacted the crisis team at 1650hrs to tell them that Andy was making plans to commit suicide. The team spoke to Andy who said he was willing to meet. He was seen by the crisis team at the Radbourne unit (a male inpatient psychiatric service) at 1930hrs on 16 August. He told them he had been feeling suicidal and was taking excessive Cocodamol to replace alcohol. He told them he had also taken Lorazepam and Clonazepam which he had bought over the internet. The team concluded that Andy was at an increased risk of accidental self-harm (i.e. accidental overdose) and would benefit from an admission.

The Derby crisis team called Andy at 2200hrs to advise that a bed was not available. They agreed with Andy that they would contact him when a bed became available (as opposed to calling every couple of hours), or would give him an update in the morning. A bed was eventually sourced at Cygnet Hospital Kewstoke and steps were taken to arrange transport for Andy.

[50] This is the first confirmation that Andy was taking Diazepam as prescribed by Consultant 11.

The Derby team referred Andy to Cygnet Hospital Kewstoke on 17 August. He was informally admitted the morning of 18 August and discharged from the Derby crisis team the same day.

Andy settled at Cygnet Hospital Kewstoke and attended various support groups. He appeared stable during his admission. Some changes were made to Andy's medication during his admission (we discuss Andy's medication further under 'themes'). He was commenced on Escitalopram[51] on 20 August and a trial of Clozapine on 23 August.

September 2013

Andy remained settled on the ward in September. Consultant 6 saw Andy during the ward round on 18 September. He was noted to be well and it was decided he could be discharged the next day.

Care coordinator 2 contacted Kewstoke hospital on 18 September, asking to be told when Andy was discharged. Staff at Kewstoke contacted Andy's local Clozapine clinic to advise of his impending discharge and faxed a copy of his prescription chart. Andy was discharged from Kewstoke hospital on 20 September to home.

Care coordinator 2 (Derby) undertook a home visit on 23 September. She noted that Andy had lost weight. He said that his mood had dropped since his discharge from Kewstoke hospital and that he had experienced suicidal thoughts. Care coordinator 2 wrote in the notes that she talked through Andy's care plan with him and left contact cards. Care coordinator 2 and Andy agreed that Andy did not need the crisis team, but that Care coordinator 2 would visit on a weekly basis.

Andy saw another GP, GP 5, at his local surgery on 24 September for a medication review. GP 5 changed Andy's anti-depressant, switching from 10mg Escitalopram to 10mg Citalopram[52].

Andy's mother contacted the Derby team[53] at 1030hrs on 30 September to tell them that Andy had deteriorated; his mood was low and he was suicidal. She spoke to Social Worker 1, a social worker and approved mental health professional (AMHP), who agreed to undertake a home visit at midday.

[51] Escitalopram is an antidepressant
[52] Citalopram is an antidepressant
[53] Andy's mother also contacted Kewstoke hospital on 30 September. She said that Andy's mental health had deteriorated in the past week and he was feeling suicidal. She said his doctor had changed his prescription, changing Escitalopram to Citalopram, and she was concerned he was not getting enough antidepressants. Staff at Kewstoke recommended that she take him to A&E for assessment and that he might need to be admitted.

Social Worker 1 visited Andy as planned. He told her he was feeling very low in mood and had constant thoughts of committing suicide. He had made plans to either take an overdose or cut his own wrists. Andy told Social worker 1 that he could not keep himself safe and wanted to be admitted. He added that he felt his medication was wrong and that he should be taking Escitalopram as opposed to Citalopram; the dose of which he did not feel was therapeutic. Andy's mother echoed this view.

Social worker 1 told Andy that she would refer him to the crisis team and update him at the first opportunity. She subsequently called the team at 1300hrs and 1415hrs but they were in handover and then a meeting, respectively, and unavailable. She received a call from a bank nurse at 1440hrs. Social worker 1 gave the bank nurse details for Andy's referral, explaining that Andy needed to be seen that day and was at high risk of self-harm. She was told it was unclear when the team meeting would end. Social worker 1 contacted Mrs S at 1445hrs to outline the situation and to advise she would keep them informed. Social worker 1 contacted the crisis team again at 1550hrs. She spoke to a member of the team who said the team would visit Andy but could not give a specific time. Social worker 1 asked the team member to liaise directly with Andy and Mrs S. Social worker 1 called Mrs S to advise that the crisis team would be in contact to make arrangements for a visit.

Andy was seen by Nurse 5 at 1930hrs on 30 September. Nurse 5 wrote in the notes that Andy had been experiencing suicidal thoughts and had gathered eight codeine tables and a Stanley knife. Andy said he had recently been drinking heavily and that alcohol made him more at risk of suicide and aggression. Nurse 5 concluded that Andy would benefit from an informal admission to the Radbourne unit – to which Andy agreed - and made arrangements for him to be admitted.

Andy was informally admitted to Radbourne the night of 30 September. He was assessed to be depressed. Andy's admission plan was that bloods be taken, level 3 (continuous) nursing observations conducted, and both his medication and risk assessment and management be reviewed.

October 2013

Andy's mother contacted the ward on 1 October to discuss his recent admission and her concerns that his relapse was due to a recent change in medication from Escitalopram to Citalopram. Andy's blood was tested to check his Clozapine levels[54]. Ward staff contacted Mrs S to let her know and advise that Andy would stay on his current medication but the Citalopram had been increased to an equivalent dose of Escitalopram.

[54] The results were not recorded in the nursing notes.

Andy was seen by Consultant 12, locum consultant psychiatrist, CT1 A and Nurse 6 on 1 October. The meeting was treated by the inpatient team as an introduction to Andy and a full review would take place the next day in the ward round. Andy told them he felt his main issue was depression. He denied any suicidal thoughts or psychosis. Andy had been taking Escitalopram, however it is not prescribed in Derbyshire and was stopped, therefore his Citalopram was increased to 40mg to accommodate this. It was also intended that his Amisulpride[55] be gradually reduced.

Consultant 12[56] saw Andy again during ward rounds on 2 October. CT1 A, Nurse 6, Nursing staff 1, two members of the Inreach team and Mrs S were present. Andy denied any suicidal ideation, paranoid thoughts, delusions or hallucinations. It was recorded in the notes *"*[Andy] *requesting discharge, encouraged to take level 4* [home leave] *or leave.* [Andy] *to be discharged against medical advice, crisis team will visit daily"*. Mrs S was noted to be *"very apprehensive"* about Andy returning home given the circumstances and suicidal thoughts that had led to his admission. She was also concerned about his alcohol consumption and felt he should stay in hospital. It was recorded in the notes that the team did not think Andy was detainable. The team discussed alternatives to discharge (e.g. leave) however Andy wished to be discharged. He presented as stable and said he was 'past the point' of committing suicide. The team asked Andy to stay in hospital for further assessment and treatment but Andy said he wanted to be discharged. It was therefore decided that he be discharged against medical advice. Andy did agree to the crisis team being contacted and that they would see him daily to assess, that his dose of Amisulpride would be reduced to 300mg BD and that the crisis doctor would see Andy within the next week with a view to a further medication review.

The inpatient team made a number of calls, leaving a message for Care coordinator 2 to say that Andy had been discharged against medical advice and asking that she contact the crisis team. The team also contacted the Clozapine clinic to advise that Andy was being discharged. Arrangements were also made for him to have the required blood test to monitor his Clozapine levels and side effects in the following week. The team tried to contact Consultant 11 (consultant psychiatrist, Radbourne unit) however there was no answer. They contacted Consultant 10 who advised them that it was Consultant 11 that they needed to speak to and they subsequently left a message asking that he call the ward.

[55] Amisulpride is an antipsychotic.
[56] In his statement to the Coroner, Consultant 12 confirmed that he did not have access to Andy's notes at the time of his admission.

Consultant 11 called the ward later in the day however the doctor he spoke to, having not attended the ward round earlier, was unaware of Andy and unable to provide any information. CT1 A tried to call Consultant 11 back but there was no answer.

Andy was discharged on 2 October. His discharge care plan advised that he abstain from alcohol, take his medication, speak to his wife if he was struggling and contact identified professionals if he relapsed.

The crisis team called Andy on 3 October at 1350. They spoke to Mrs S who told them that he was sleeping and that his mood had been 'interactive' that morning. She asked the team to undertake a home visit.

Andy was seen with his wife and son during a home visit by Nurse 7 the evening of 3 October. Andy said he had been mindfully meditating that day and felt ok, though still had some general thoughts of hopelessness. He denied any thoughts of self harm or intention to harm himself. Nurse 7 wrote in the notes that Andy appeared *"a little flat with a somewhat glazed expression"*. They agreed Andy should have a medical review the next day.

CT1 A called Consultant 11 at 1000hrs on 4 October to discuss Andy. Consultant 11 wrote in the notes that he had received feedback about Andy's presentation and had a brief conversation with CT1 A, both of which led him to conclude that the home treatment team should not undertake Andy's medical review on its own. Rather, he intended to review Andy in a week with the sector team. Consultant 11 wrote that Andy had a complex presentation and his care plan needed to be addressed by both teams together[57].

Enablement worker 1, enablement worker for CRHTT, undertook a home visit at 1030hrs on 4 October[58]. She recorded in the notes that Andy had slept well but was still feeling depressed. He denied any thoughts of self-harm or suicide. Mrs S told Enablement worker 1 that Andy's mood as *"very up and down"*. It was agreed that another home visit would be undertaken the next day and that Enablement worker 1 would confirm the date of Andy's outpatient appointment scheduled to take place the next week.

Andy sadly took his own life later the same day.

[57] Consultant 11 contacted Consultant 10 on 4 October to ask that they undertake a joint review of Andy on 9 October.

[58] Enablement worker 1 wrote in her statement to the coroner that she had felt a 'little uneasy' about visiting Andy given he had discharged himself from hospital and that she had asked Consultant 11 to document in the notes his decision to delay reviewing Andy

Risk assessment, risk management and care planning

Risk assessment and risk management
The Department of Health[59] (2009[60]) describes risk assessment as:

"…working with the service user to help characterise and estimate each of these aspects. Information about the service user's history of violence, or self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that's available, and their more general social contacts could all be relevant. It is also relevant to assess how a service user is feeling, thinking and perceiving others not just how they are behaving."

It defines risk management as:

"… developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. Risk management must include a set of action plans, the allocation of each aspect of the plan to an identified profession and a date for review."

Each of the Trusts had a risk assessment and risk management policy in place at the time of Andy's admission(s).

October 2012 – March 2013

Andy had regular risk assessments between October 2012 and March 2013. The following dates were primarily recorded in the Devon Partnership NHS Trust notes:

- 27 October 2012 (Devon Partnership NHS Trust)
- 28 October 2012 (Devon Partnership NHS Trust)
- 9 November 2012 (Somerset Partnership NHS Foundation Trust)
- 21 November 2012 (Devon Partnership NHS Trust)
- 13[61] December 2012 (Devon Partnership NHS Trust)
- 23 December 2012 (Devon Partnership NHS Trust)
- 29 January 2013 (Devon Partnership NHS Trust)
- 2 February 2013 (pre-leave risk assessment, Cygnet Hospital Kewstoke)

[59] https://www.gov.uk/government/publications/assessing-and-managing-risk-in-mental-health-services
[60] This is the most recent Department of Health publication available.
[61] We note that Andy was based at Somerset Partnership NHS Foundation Trust (and taking leave) on the day that this assessment was recorded in the Devon Partnership NHS Trust
Trust notes. This was recorded by Care coordinator 1 in the notes but there is no evidence to indicate that he saw Andy on 13 December 2012.

- 2 March 2013 (Cygnet Hospital Kewstoke)
- 27 March 2013 (Devon Partnership NHS Trust)

Andy risk profile and risk screen was regularly updated when he was an inpatient in Somerset (e.g. on Holford ward). The risk screen was routinely updated in November, December 2012 and January 2013 when it was consistently recorded that Andy had a significant long-term risk of 'violence/harm to others'. It was also regularly recorded that he had an acute risk of 'violence/harm' to others. Deliberate self-harm and/or suicide were not identified as risks to Andy. However, we did not find a corresponding inpatient risk management plan to address the management of any risks identified.

The risk assessments provide information about Andy's mental health history and details incidents of note e.g. 14 November 2012. Andy's last risk assessment was undertaken by Care coordinator 1 in March 2013. It did not identify Andy as a risk to himself but noted he could be a risk to others when unwell. It was said:

"Although [Andy] *agrees to admission he appears to be unable to comply with hospital rules and behave in a considerate manner when deteriorating. He has a history of assaultive behaviour towards staff. Careful consideration needs to be given, in the event of any future deteriorations, as to whether an informal admission is feasible or safe even if he agrees to an informal admission"*

The risk assessment highlights the involvement of the police (in recall and on the ward) on November 2012, 27 December 2012 and 13 January 2013. It recorded that Andy's relapses and admissions have typically been precipitated by an increase in stress and/or major life events. The risk assessment concluded:

"[Andy] *has a diagnosis of Bi-polar affective disorder.* [Andy] *generally takes a responsible attitude towards his illness and relapse prevention. However during relapse* [Andy]'s *mental state quickly deteriorates and his ability to make reasonable choices around risk becomes diminished."*

The risk assessment summary recorded that Andy experienced suicidal ideation when depressed and had a history of rapid relapse.

Andy moved to Derby in June 2013. Care coordinator 1 updated the risk summary on 3[62] July 2013. He recorded that Andy's overall risk rating was 'high'. Risk factors identified were driving/road safety, unsafe use of medication, absconding/escape, damage to property and

[62] Andy was living in Derby at this time. It is assumed that Care coordinator 1 updated the Risk summary for the Derby team, but did not see Andy as part of this process.

phone calls. Consultant 2 highlighted the availability of this information in his referral/introductory letter to the Derby team.

Andy's risk assessments were updated regularly between October 2012 and March 2013 but there was not a clear corresponding management plan to address his risk on the ward or in the community.

June – October 2013 (Derby)

Andy was subject to risk assessments at Cygnet Hospital Kewstoke. A FACE[63] risk profile was completed for Andy on 18 August 2013.

Dr A, an independent consultant psychiatrist, reviewed Andy's Derby assessments and care plans in his report submitted to the Coroner[64] on 22 February 2016. Our independent advisor agreed with the assessment of Dr A, and in particular, the findings of the Derbyshire serious incident report (in relations to risk assessment and risk management). We highlight below the key findings of these reports.

Dr A considered Derby's risk assessments of Andy. Dr A wrote:

"… I do not consider that there has been any particular failure in the assessments provided during [June to October 2013] *this planned, and, one feels, in general, quite appropriate community health care delivery"*

Dr A noted healthcare professional assessments and discussions to be appropriately documented and appropriate. There were two exceptions to this. One, Andy's assessment in A&E on 14 July 2013 when he was discharged. Noting the nature of Andy's admission to A&E (i.e. that his family had called an ambulance and said he was suicidal), his earlier arrest by the police, and that Mrs S had advised the AMHP that Andy had threatened to injure his neck with a chainsaw and was very concerned about his return home; and that the team did not have all of his records, Dr A wrote:

"I take the view that it would have been more appropriate for [Andy] *to have been offered either informal admission to an in-patient psychiatric ward, or else in fact it may have been appropriate to initiate compulsory admission to hospital for at least a period of assessment (Section 2 Mental Health Act 1983) given the account by the family, the concerns expressed by his wife, and the fairly chequered and serious significant mental health history, including*

[63] Functional Analysis of Care Environment, FACE, is a risk profile assessment tool used in health and social care.
[64] Dr A compiled the report at the request of the Senior Coroner for Derby and Derbyshire Coroner's Area. Dr A was instructed to provide an expert witness report about the death of Andy.

discharge by a Mental Health Review Tribunal only a few months earlier that year in March 2013."

Whether the outcome of this Section 136 assessment on the 14 July 2013 would have more than minimally contributed to [Andy's] *eventual death on 4 October 2013 is perhaps a rather complex matter to address… However it is the case that had his clear (so it would appear) need for more intensive and likely inpatient care been identified on 14 July 2013 then his continuing, rather chaotic, and somewhat disastrous later mental health issues may have taken a different course"*

We explore the Trusts involvement of Andy's family in his care under 'Carer Involvement'.

The second assessment of concern in Dr A's view was that which resulted in Andy's discharge from an inpatient setting on 2 October 2013. Dr A concluded:

"… not only the Consultant Psychiatrist but other members of the multidisciplinary team appear to have formed the conclusion that [Andy] *was making an entirely capacitous decision to refuse the continuing in-patient care he clearly required on that day. Therefore, this assessment has, in my view, likely been rather inappropriate..."*

The Derby Coroner concluded in his Findings of Fact:

"[Andy] *could and should have been detained under the Mental Health Act on the 2nd of October and not have been allowed to take his own discharge. I would also find as a fact that there is a direct causal link between the failure to detain* [Andy] *on the 2nd October 2013 and his death on the 4th October 2013."*

The Derbyshire serious incident investigation described Andy's FACE Risk assessment dated 30 September 2013 as "unsatisfactory" and the associated mental state examination failed to capture the severity of Andy's symptoms.

The Derbyshire serious incident investigation also identified a third occasion – 14 August 2013 - in which risk assessment was deemed to have been inadequate. It concludes:

"The risk assessment did not reflect the true risks posed by the service user's illness and was not informed by the extensive risk information which had been sent from Devon. The follow up was not timely; it was not arranged for 3 months. There were no plans for the assessing doctor to participate in an early CPA review".

Our clinical advisor highlighted the inadequacy of the August A&E assessment, noting the reliance of practitioners on the FACE risk profile to be contrary to NICE guidance on managing suicide[65]. Staff also failed to take into account the views of Mrs S, his wife.

We conclude that Andy did not have a comprehensive risk management plan under the care of Derbyshire Healthcare NHS Foundation Trust. The risk assessment and risk management plan was inadequate at the time of his death. The lack of timely risk assessment and a comprehensive management plan meant that after over three months (we note Andy was at Cygnet Hospital Kewstoke from 18 August until 20 September 2013) the team was virtually in no better a positon of knowing and working with Andy than after his first referral. Andy was known to experience suicidal ideation when depressed and had two inpatient admissions in a short period of time yet the team delayed its review of him after his September/October admission, in favour of undertaking a joint team review the following week[66]. We consider the assessments undertaken on 14 July 2013 and 2 October 2013 were missed opportunities to grasp the severity of the risk that Andy's condition presented to his safety.

Care Programme Approach (CPA) and care plans

The Care Programme Approach (CPA[67]) is a method by which a service user's mental health care is planned and managed. If a patient is under CPA they should have a care coordinator who agrees their care plan with them, and supports them to coordinate and manage their care. Andy was under CPA and had a care coordinator in Devon (Care coordinator 1) and in Derby (Care coordinator 2), however he only met the latter twice (between June and October 2013) due to annual leave and staff sickness.

Each Trust had a CPA policy in place at the time of treating Andy.

A care plan outlines how a service user's care and support needs will be met. Creating a care plan should be a collaborative process between the service user and the healthcare team (typically overseen by a care coordinator). A care plan should be documented – the service user should be given a copy – and be subject to regular review.

NICE guidance (2011)[68] recommends that the community teams develop care plans jointly with the service user and:

[65] https://www.nice.org.uk/donotdo/do-not-use-risk-assessment-tools-and-scales-to-predict-future-suicide-or-repetition-of-selfharm
[66] An appointment had been arranged for 9 October 2013.
[67] http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx
[68] https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#community-care

- *"include activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependents*
- *Provide support to help the service user realise the plan*
- *Give the service user an up-to-date written copy of the care plan, and agree a suitable time to review it"*

NICE guidance[69] in place at the time of Andy's care highlighted the importance of psychological interventions (e.g. family intervention, group or individual interventions) for treating people with psychosis.

We have found few examples of written care plans for Andy:

- A care plan was updated by Care coordinator 1 on 11 June 2013
- A crisis, relapse and contingency plan which was updated by Devon Partnership NHS Trust 30 April 2013 (previous updates occurred on 21 November 2012 and 6 August 2012).
- A Section 117 community care plan updated by Devon Partnership NHS Trust on 28 March 2013.
- A care plan dated 10 March 2013 (Cygnet)
- A recovery care plan for when he was an inpatient on Holford ward. It was updated 9 January 2013.

Somerset Partnership NHS Foundation Trust acknowledged in a letter dated 3 April 2013 to Dr S that Andy did not have a written care plan at the time of his Section 17 leave in November 2012

Andy's care plan for Devon Partnership NHS Trust typically reflected interventions when he was on the ward e.g. recognise the detrimental impact of cannabis' (dated 21 November 2012). We have not seen a holistic community based care plan in Devon other than the Section 117 plan for post discharge.

NICE guidance outlines that a crisis plan should be developed for service users at risk of crisis. It should include early warning signs of crisis, detail support available and outline where the service user would like to be admitted if hospitalised.

Andy's crisis, relapse and contingency plan updated by Care coordinator 1 on 30 April 2013 outlined that he felt he could become unwell rapidly and that he needed to be treated

[69] https://www.nice.org.uk/guidance/CG178/chapter/1-Recommendations#how-to-deliver-psychological-interventions The original guidance was published in 2002 and updated in 2009. It was updated again in 2014.

aggressively – he believed that delays in care could lead to extended inpatient stays. The plan highlighted that the police should only be involved in managing Andy as a last resort – and that if engaged, it was likely to have a negative impact.

Andy was subject to CPA in Devon. He had a care plan in place however we are unclear as to the care plan objectives beyond the March 2013 Section 117 plan. There is evidence that staff were trying to work with Andy – and that he saw his care coordinator regularly - however most goals lacked clarity in terms of long term plans for Andy. For example:

- **"*to provide structure and opportunity to 'let off steam'***
- ***To ensure* [Andy] *gets the services/help he needs to try and prevent a return to hospital";*)**
- ***To ensure* [Andy's] *care is well co-ordinated and reviewed"***

Andy's impending move to Derby may have impacted long-term care planning by the Devon team, but it is our view that throughout his time under the care of Devon Partnership NHS Trust, Andy did not have a long-term psychosocial care plan that took into consideration factors that included the role his family played in his care, management and recovery.

We conclude that Devon Partnership NHS Trust did not provide comprehensive care planning for Andy.

Dr A found the Derby nursing (inpatient) care plans to be appropriate for Andy's level of needs and observation and that multidisciplinary assessments appeared to be largely satisfactory. Dr A notes however that Andy's Derby care coordinator saw him twice (due to annual leave and sickness) prior to his death. Dr A does not attach criticism to the care coordinator for these absences. In her evidence to the Coroner, Care Coordinator 2 said she had been unable to develop Andy's care plan with him because he was unwell. Dr A commented:

"*Mr* [Andy] *was likely already becoming significantly mentally disordered in the days and weeks after moving to Derby and even before she* [Care coordinator 2] *first saw him, there was little therefore she could do to influence matters much in any other sense given the rapid and rather concerning developments between June and October 2013"*

We note that the Derby CRHTT had not agreed a community care based care plan with Andy. It was in the early stages of development.

Derbyshire NHS 'Care Programme Approach and Care Standards Policy and Procedures' (2009[70]) says the care coordinator or lead professional is responsible for developing the care plan. The Policy says: the care plan should be based on a needs assessment and include evidence-based interventions; should include aims or goals; interventions; identified risks and contingency arrangements that includes a crisis plan. It adds that the care plan should be detailed enough that other members of staff can carry it out, if required

Andy's care plan was last updated on 11 June 2013 by Care coordinator 1 (Devon) in advance of his move to Derbyshire. A formal care plan had not subsequently been agreed between Andy and his Care coordinator in Derby.

Andy was assessed by the Derbyshire CRT on 15 July 2013 (after his discharge from A&E). The assessment summary (dated 24 July 2013 in a letter to GP 4) advised that it should be reviewed in conjunction with the comprehensive notes submitted by Consultant 2 to the Trust. The assessment set out nine points to a crisis plan that included:

- Andy be taken on to the Home Treatment Team case load
- Andy to be allocated a care coordinators and Recovery team worker
- Andy to have an urgent medical review.

It also said that his appointment with Consultant 10, scheduled for 14 August, should be brought forward. The assessors wrote that Consultant 10's secretary was arranging this.

Andy's outpatient appointment with Consultant 10 was not brought forward. He was seen by Specialist registrar 1 (the ST4 to Consultant 10) on 14 August 2013. We found no evidence the care plan set out by the CRT was used to formulate a long-term plan for Andy. We note the reference the assessment made to the value of Consultant 2's notes, but again, there is no evidence that these were subsequently used by healthcare professionals to underpin any long-term plan for Andy.

Andy's care plan from Ward 36 at Derbyshire Healthcare NHS Foundation Trust (dated 2 October 2013) set out four points:

- "*Abstain from alcohol misuse*
- *To take medication at correct times*
- *Inform identified professionals in case of relapse*
- *Talk to wife if struggling"*

[70] We asked each NHS Trust to provide us with the policies that were in place between October 2012 and 2013. The policy provided by Derby (known as Derbyshire NHS Mental Health Services NHS Trust) was due for review in October 2011.

We do not consider this an adequate care plan for a patient who has experienced two recent inpatient emergency admissions, and whose wife was clearly stating he was a risk to himself, and that he should not be discharged from the ward.

The Derby Serious Incident report concludes:

"The service user had over 30 people, not including ward staff, involved in his assessment and/or care. The manner in which this case was handled meant that no one took continuous overall responsibility for his care; not only did this mean that the clinical picture was fragmented and without continuity, which was a major contributing factor in the failure to develop a comprehensive care plan, even though the information, provided by [Consultant 2, Devon], *contained a detailed programme of care and relapse profile, but it also meant that the service user did not develop any meaningful therapeutic relationship".*

We are in agreement with the findings of Derbyshire Healthcare's investigation. Andy did not have an effective, developed care plan in place at the time of his death in Derby.

In its response to this report, Derbyshire Healthcare NHS Foundation Trust, highlighted the observations of Dr A in relation to managing and working with Andy. Specifically that Andy's presentation and behaviour, combined with his engagement with different parts of the service, made it *"virtually impossible"* for anyone to have a complete overview of his care. The Trust further highlighted that Andy was admitted to Cygnet Kewstoke between August and September 2013.

Though we note the above, there is an element of hindsight, and it does not serve to explain the Trust's own Investigation finding that over 30 staff saw Andy yet no one took overall responsibility for Andy's care. Andy still had not been subject to a complete assessment and his care plan remained in development with little documented sign of planned progression, after in excess of three months. Consultant 2 wrote to the Trust at the time of Andy's transfer to Derby, outlining the nature of the difficulties he presented with, and advising that early contact would be *"a useful measure to help prevent problems and ensure stability following his move".*

Carer involvement

In this section we consider whether healthcare professionals appropriately involved Andy's family, in particular his wife (in her capacity as his carer), sister and mother, both of whom are doctors, in his care. We also consider the support offered to Andy's family.

NICE guidance[71] (2011) highlights the importance of mental health services working in partnership with service users and their families. It says that if a service user wishes for their carer or family to be involved in their care, staff should:

- *"negotiate between the service user and their family or carers about confidentiality and sharing information on an ongoing basis*
- *explain how family or carers can help support the service user and help with treatment plans*
- *ensure that no services are withdrawn because of the family's or carers' involvement, unless this has been clearly agreed with the service user and their family or carers"*

It adds that the family and/or carer should be given written and verbal information about:

- *"the mental health problem(s) experienced by the service user and its treatment, including relevant text from NICE's information for the public*
- *Statutory and third sector, including voluntary, local support groups and services specifically for families and carers, and how to access these*
- *Their right to a formal carer's assessment of their physical and mental health needs, and how to access this"*

In relation to discharge it says:

- *"Before discharge or transfer of care, discuss arrangements with any involved family or carers."*

Mrs S was actively involved in Andy's care. She contributed to his Devon care plan and was his primary carer. Leading from this, she attended ward rounds when Andy was an inpatient (e.g. at Cygnet Hospital Kewstoke) and was in regular contact with the healthcare professionals overseeing his care, both in the community, and on the ward. In particular there is evidence that Mrs S was in regular contact with Andy's Devon care coordinator (including during his admissions). Andy's risk assessment described her as a 'good barometer' of his

[71] https://www.nice.org.uk/guidance/cg136/chapter/1-Guidance

illness. It added that she should be fully involved in any discussions regarding leave or discharge.

The Somerset notes indicate that Mrs S supported Andy's discharge in November 2012[72]. She was also in regular contact with staff after his recall and met with Consultant 1, Andy's consultant on 22 November. Consultant 1 wrote in his notes about their meeting that he had advised Mrs S to resist discharging Andy from hospital without a proper discussion with medical staff. He wrote that she agreed with this but that she felt she was in a difficult position as his nearest relative. Equally she wished for Andy to be discharged before Christmas.

Andy's mother (Dr S), was also in contact with healthcare professionals about his care. Dr S had significant concerns in relation to Andy's recall to Holford ward in November 2012, in terms of both Andy's wellbeing and the actions of staff in accordance with statutory legislation.

Leading from this, Dr S, Mrs S (and other members of Andy's family) made a number of calls to the ward in December in relation to Andy's Manager's hearing and the subsequent decision to uphold his Section. It was recorded in the notes on 2 January 2013 that Consultant 1 was no longer willing to receive phone calls from Andy's family but would see them by appointment only.

Taking into account that Dr S, Andy's mother, was based in France and unable to physically attend appointments, Consultant 1 was essentially cutting off 'live' communication. The Trust has indicated that there were challenges in relation to the volume and tone of some contact made by Andy's family; but this is not detailed in the notes and we cannot comment. We note that Andy's mother had been a consultant in Public Health and his sister was a doctor; both were arguably well placed to comment on his care and treatment.

There is extensive evidence that Mrs S and Dr S were both in contact with healthcare professionals on a regular basis and with increased frequency when Andy was unwell. For example, both contacted Holford ward on 12 January 2012 to voice concerns that his mental health was deteriorating and that he needed medication. However, the effects of this communication are unclear. There is no documented evidence to indicate that the wider team was made aware of his family's concerns and their view that he was becoming unwell. The police were called to the ward later that day and Andy was placed in seclusion.

[72] The Somerset SI identified that Andy's wife may have unduly influenced the decision for her husband to have a longer period of Section 17 leave than he had previously as this would be less unsettling for their son.

Healthcare professionals in Devon appear to have involved Mrs S and Dr S in Andy's care however we cannot comment as to the extent to which this influenced/impacted his overall treatment as this was not documented. As previously noted, the Devon team considered Mrs S to be a good judge of Andy's mental health. Mrs S told us that she felt supported by the Devon team. Despite this we note the failure of the Devon CRHTT to attend the home of Andy and Mrs S on 14 November 2012. The Somerset SI into the events on 14 November highlighted how the team's presence could have deescalated the situation and supported Mrs S.

Andy's family appear to have had ample opportunity to engage with Healthcare professionals in Somerset - primarily instigated by them - however we have no way of knowing the extent to which this had an influence over his care. We note that relations between the family and the Trust gradually deteriorated, particularly in terms of their relationship with Consultant 1, who stopped all telephone contact. It is our understanding that this largely stemmed from the events of 14 November 2012[73] and Andy's subsequent ongoing detention, despite his family's request that he be discharged from the hospital. Andy's mother and wife were critical of healthcare professionals at the Trust, particularly, Consultant 1, during their discussions with us. Mrs S had stopped speaking to Consultant 1 during the course of Andy's time in Somerset.

June 2013 onwards

A recent analysis (2016) of suicides over a 10-year period finds suicide risk especially acute in first two weeks after leaving hospital.[74] The National Confidential Inquiry into Suicide and Homicide found that mental health patients are at the highest risk of taking their own lives in the first two weeks after being discharged from hospital, and that the first three months after discharge was a time of "particularly high" suicide risk. Professor Louis Appleby, Director of the National Confidential Inquiry, said: "*This increased risk has been linked to short admissions and to life events so our recommendations are that careful and effective care planning is needed including for patients before they are discharged and for those who self-discharge."*

[73] Andy's family (Dr S) made a complaint about Consultant 1 to the Trust in relation to the incident on 14 November 2012 and his subsequent communication with the police (e.g. a breach of confidentiality). In its response to Dr S (dated 6 June 2013), the Trust said that Consultant 1's actions were in line with GMC guidelines and permissible in the circumstances. There was further correspondence between the Trust and Dr S in relation to her concerns (with additional points) which culminated in a final response from the Chief Executive on 6 August 2014 in which he wrote that the Trust considered it had concluded local efforts to resolve Dr S' complaint.
[74] http://www.communitycare.co.uk/2014/07/16/experts-warn-heightened-suicide-risk-mental-health-patients-post-discharge/

Cygnet Hospital Kewstoke noted the role of Andy's family in his care. It was recorded in the August 2013 FACE risk profile;

"[Andy's] *wife is his primary carer and she is aware of relapse signs as is his mother who continues to be very supportive of* [Andy]"

In contrast to Devon, Somerset (initially) and Cygnet Hospital Kewstoke, Derby does not seem to have taken the views of Andy's family into account. On both occasions when Andy was in crisis - 14 July and 3 October 2013 - his family were clear that he first be admitted (via A&E) in the first instance and, remain on the ward in the second. On both occasions healthcare professionals noted but did not act on this.

It is clearly documented in the Derby notes that Mrs S did not think Andy should be discharged from the ward on 3 October 2013. The clinical team who reviewed Andy on 3 October 2013 later acknowledged in their statements for Andy's Inquest that Mrs S was very unhappy at the prospect of Andy being discharged, however they did not believe Andy to be at significant risk and discharged him against medical advice.

We have previously explored this under 'risk assessment, risk management and care planning' however, the failure of staff to incorporate the family views – particularly in the absence of Andy's notes - meant they omitted key intelligence from their assessment. Andy's family had detailed experience of his mental health – its impact, the triggers and his maladaptive coping style. In addition, they were a potential source of information about previous treatment. Mrs S told us that she felt supported by the Cygnet team, but in contrast, she felt that the Derby team made little effort to get to know Andy and that they didn't support either of them.

The Derby team was trying to manage the transition of care of someone unknown to them but with a serious mental illness, and, who by the nature of this illness and his presenting characteristics had a significantly elevated suicide profile. Through proper engagement, listening and working with the family they could have provided a protective environment for Andy on at least two occasions. However, this did not happen.

Andy's forensic history and the Crown Prosecution Service (CPS)

Forensic history

Andy was a large, physically strong man who, at times, intimidated staff. When unwell he could be physically aggressive and verbally threatening towards staff. His medical notes often made reference to a history of violence however we found little evidence of actual physical violence, rather that Andy was verbally aggressive towards staff.

In this section we consider Andy's forensic history and if this was accurately represented and subsequently managed by health care professionals.

The NICE Clinical Guideline (2005) on the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments[75] states that *any form of physical interventions must always be in line with NICE clinical guideline CG25*[76] *and should be:*

- *Necessary, justifiable and proportionate*
- *Conducted by appropriately trained and competent staff*
- *Combined with strategies to continuously de-escalate*
- *Carried out using the least restrictive interventions*
- *Used for the minimum amount of time*
- *Done so as to enable staff to continually monitor the patient for signs of medical or physical distress*
- *Formally recorded as soon as possible after the event.*

Examples of de-escalation (i.e. defusing) techniques include respectful communication with the service user and moving them to a less stimulating area in order to calm the situation.

If a person is in hospital and detained under the Mental Health Act 1983, staff are entitled to exercise a degree of containment over that person, for example preventing that person from leaving the hospital or requiring them to leave a public area of the hospital. Force may be used to achieve this if it is necessary to maintain safety or ensure treatment, but it must be reasonable and proportionate.

[75] NICE Clinical Guideline 25: 2005: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments www.rcpsych.ac.uk/PDF/NICE%20Guideline%202005.pdf
[76] CG25 was updated in in May 2015. It is now NICE guideline NG10 https://www.nice.org.uk/guidance/ng10

Physical restraint is not defined in the Mental Health Act but the key guidance on use of restraint and detained patients is in the Code of Practice (2005) to the Act[77]. The Code of Practice says:

"Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for it likely to suffer harm unless proportionate restraint is used."

Andy received a caution for tendering counterfeit currency in 1997. He was convicted of drinking driving in 1998. He was charged with assault in 2009 but the charge was later dropped.

We set out below details of Andy's verbal or physical aggression recorded in his medical notes between 2012 and 2013:

- 25 September 2009[78] an incident occurred in which Andy was initially charged with assaulting a nurse however the charge was later dropped.
- 27 October 2012 Andy was verbally threatening to staff telling them they should give him what he wants (cigarette[79] and lighter) if they did not want to get hurt.
- 28 October 2012 Andy and another patient broke the small lounge door and attempted to barricade themselves in. The police were subsequently called to the ward and moved Andy to seclusion.
- 14 November 2012 Andy was returned to the ward (as a result of an incorrect Section 17 recall) by Devon and Cornwall Police. During the transfer Andy was tasered twice and a policeman's eye was injured. Andy was later charged with assaulting an officer.
- 26 December 2012 Andy returned to the ward and was noted to become increasingly intimidating and threatening towards staff, culminating in the police being called 27 December 2012 to the ward. The police escorted Andy to seclusion without event.
- 9 January 2013 Andy pushed a patient to the floor. He later apologised.
- 10 January 2013 Andy was found standing over a patient in an intimidating manner.
- 12 January 2013 Andy became threatening and verbally aggressive to ward staff. The police attended the ward and escorted him to seclusion.

[77] *www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpgacop_20050009_en.pdf*. Please note that this was revised in 2015.

[78] This incident falls outside of our terms of reference however we have included it given it was referenced in his nursing notes by staff more than once.

[79] The ward was a 'smoke free' environment. Anyone wishing to smoke had to ask to go outside.

Devon recorded three of the above events on its Trust incident system. Somerset recorded the events of 14 November 2012 on Datix.

The above illustrates that Andy had a history of threatening staff when he was unwell however there is no evidence of significant physical violence between October 2012 and October 2013.

We mention occasions when the police were called to support Trust staff in Devon and Somerset. We discuss this further under 'Police and Tasers'.

It is clear that Andy could be threatening and intimidating towards staff when he was unwell, and that he had broken property. We note that there is no evidence of him physically hurting staff yet his notes paint a picture of a dangerous individual whom the police were best placed to manage. However the records pertaining to Andy were not always accurate in relation to his forensic history. A Devon incident report detailing the events of 14 November 2012 contained a number of inaccuracies:

"[Andy] ***drove*** **[his]** ***car despite instruction not to… Patient armed themselves*** **[sic]** ***with a chainsaw and other offensive weapons. Nearest relative had to barricade themselves in the home with children for fear of safety"*****.**

The conditions of Andy's leave did not specify he was not to drive. It is also understood that Andy owned a chainsaw for his work as a landscape gardener, but there is no evidence that he was 'armed' in response to the police attending his home or that he was using other offensive weapons[80]. In her letter to Holford ward on 4 December 2012, Mrs S said Andy had never threatened her or their son, and that on the 14 November she had gone to the bedroom to keep the family dog out of harms' way. We accept that it may have taken time for this information to reach Devon – and there is no question that the events on 14 November were serious - but the incident record should have been clarified to reflect the facts and Mrs S's account of the situation to ensure staff going forward had an accurate account of events.

Leading from this, such clarification would have avoided the inaccuracies being passed on and perpetuated. For example, when Andy was admitted to Somerset in January 2013, the admission clerk wrote "*Forensic history: many arrests for assault, drink driving"*. We cannot quantify 'many', but this statement is misleading and incorrect. Andy had a single historical conviction for drink drinking and a historical charge of assault which was later dropped.

[80] One of the officers who attended Andy's home described in his written record a chainsaw being started at intervals in the shed and the sound of items being cut.

Crown Prosecution Service (CPS)

Andy was charged with assaulting a police officer after the incident on 14 November 2012. Consultant 1 provided a statement to the Police in relation to the incident – this was not shared with Andy at the time and he only learnt of it at a later date. Dr S, Andy's mother, submitted a complaint to the Trust about Consultant 1's engagement with the Police. We do not revisit the detail of the complaint here, but the Trust investigation concluded that though there were some learning points for Consultant 1 in relation to following procedures in relation to the wider incident (which the Trust said had been addressed), Consultant 1 had acted in his professional capacity when he submitted a statement to the police.

Andy's court case was initially scheduled to take place in July 2013 but was postponed at short notice (on 11 July 2013) and rescheduled to take place in October 2013. Shortly after learning the case had been postponed in July, Andy was arrested by the police for drink driving, but released without charge. The next day he was admitted to A&E at the request of his family because he was suicidal.

Andy's family told us he was extremely worried about the court case. His notes detail he also shared his concerns with health care professionals (e.g. Consultant 11 references it in his letter to GP4 on 2 August 2013). Consultant 2 submitted at Andy's Inquest that he was preoccupied with his impending court trail.

Andy's family told us he was concerned about the severity of the charge, and the implications of this in terms of a potential custodial sentence. Dr S told us he deeply feared going to prison.

Andy's notes do not detail whether healthcare professionals gave consideration to the implications of the impending court case on his mental health. At the time of his death the prospect of a court case had been in Andy's life for nearly a year yet we found little evidence to suggest that this had been explored with him in terms of whether it was affecting his wellbeing and his thoughts about the future.

Dr S has always refuted the content of Consultant 1's statement to the police (as per her complaint to the Trust) and it is her belief that the CPS should have dropped the case against Andy because he was unwell at the time of the incident (something Consultant 1's statement did not support). We have not investigated the Trust's investigation into Dr S' complaint as outlined above. It is difficult to comment beyond noting the differing opinions of the Trust and Andy's family, and leading from this the importance of the role healthcare providers have in ensuring the police have an accurate understanding of the patient and their risks.

We have not explored engagement with the CPS in depth and have limited information in relation to Andy's case. However we recommend all healthcare professionals should take into consideration the implications of criminal proceedings on a service user as part of any broader assessment of mental health and well-being.

Police involvement and Tasers

In this section we explore how ward – and community based – staff managed Andy when he was unwell, particularly in relation to involving the police.

A Home Affairs Committee (July 2014) highlighted concerns about the use of police in managing mental health patients, noting that their involvement can at times be to support an under resourced service. It added that the police become involved at the point of crisis when earlier intervention might have averted such a need.

The police do not have specific powers to restrain a patient for the purposes of medical treatment regardless of whether the treatment is in the patient's best interests. However, research by MIND in 2013[81] revealed there is significant variance in the extent to which healthcare providers call the police for support around restraint and restrictive practices.

NICE guidance (2005[82]) recommended:

"Local protocols should be developed to ensure that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between different agencies. Such policies should set out what constitutes an emergency requiring police intervention"

There were four occasions when the police were involved by Trust staff in the management of Andy:

- 28 October 2012 - police attend the ward (Devon)
- 14 November 2012 - police attend Andy's home and return him to the ward (at the request of the Devon team). He is tasered twice during this incident.
- 26 December 2012 – police attend the ward, drew their Tasers (Devon)
- 12 January 2013 – police attend the ward (Somerset)

We asked each Trust whether it had a policy (at the time of Andy's care) or agreement with the police in relation to managing patients and their attendance to wards. We asked if they had a policy for using Tasers on the ward.

[81] MIND: June 2013; Mental health crisis care: physical restraint in crisis - A report on physical restraint in hospital settings in England

[82] NICE Clinical Guideline 25: 2005: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments www.rcpsych.ac.uk/PDF/NICE%20Guideline%202005.pdf

Devon

- Aftercare of those who have been exposed to PAVA (CAPTAR) spray or Taser devices (see below)

Devon Partnership Trust told us that initial discussions about the need for further guidance about Taser use started in late 2011, but there was no specific guidance in place prior to May 2015. There was nothing specific in place at the time of Andy's care. The 2015 policy has not been ratified.

Somerset

- Supervised community treatment (community treatment order[83]) policy (October 2010[84])
- Detained patients absent without leave policy (September 2012[85])

Derby

- Taser policy and procedure (October 2012[86])
- The trust provided a number of joint policies pertaining to Section 136, absent patients and (undated) terms of reference for a police liaison group.

Taking into account that staff in Devon[87] and Somerset[88] involved the police in the management of Andy we have focused on the policies in place available to staff at the time.

Devon does not (at the time of writing) have a clear policy for involving the police in the recall of patients. Somerset 'detained patients absent without leave[89]' policy (2012) says:

"The police have the power to return the patient to hospital but should only be requested to assist if absolutely necessary. They are under no obligation to assist."

Andy's Section 117 care plan (updated in March 2013) included a crisis plan which outlined that Andy could become unwell quickly, during which time he wished to be treated aggressively with medication. The crisis plan said that the police should only be involved in managing Andy as a last resort:

[83] Andy was not subject to a Community Treatment Order
[84] This policy was scheduled for review in October 2012
[85] This policy was due for review in July 2015
[86] This policy was updated in December 2015
[87] twice to the ward and once to the community
[88] once to the ward
[89] Andy was not AWOL at the time of incident on 14 November 2014.

"Police assistance to be used as a last resort if [Andy] *is refusing admission and other de-escalation techniques have failed.* [Andy] *has had traumatic experience of police involvement in the past and this needs to be acknowledged and should influence any decisions taken. Police assistance, whilst it may be needed, may well create a negative impact"*

The Devon (second) independent complaint review commented in relation to the propensity of staff to involve the police in the management of Andy:

"The difficulty seems to have been that in the absence of any overarching agreement and protocol between the Trust and the police, and the absence of effective risk management and care planning, calling the police seemed to become the default position in managing his [Andy's] *behaviour, in order to ensure the health and safety of staff."*

The independent complaint review goes on to put the actions of Devon staff in context but concludes:

"It is noteworthy that [Andy] *never actually attacked any members of staff in Devon Partnership NHS Trust, and all of his behaviour which challenged was due to a deterioration in his mental* [health]. *His extensive record of involvement with the police, was primarily the result of calls made by NHS staff for assistance, and there is no evidence that he was dangerous in a community setting when well. Nonetheless, from my reading of the records, I believe that staff in Devon Partnership Trust during this period up to 2013 were acting in good faith when seeking to minimise the risk of violence, and they were behaving in a way that would not have been deemed exceptional by professionals elsewhere at that time. However, they were not fully acting in accordance with the Mental Health Act Code of Practice, the Mental Capacity Act, and NICE guidelines…"*

Somerset SIRI (Serious Incidents Requiring Investigation) report and Devon's independent (second) complaint both highlight concerns in relation to ward staff opting to involve the police (on the ward and in the community) in managing Andy. In particular, the latter highlights the lack of Trust policy available to Trust staff. There is little doubt that staff felt intimidated when they called the police to the ward however it seems that each situation escalated relatively quickly and little was done to deescalate Andy prior to calling the police.

It is documented in Andy's notes that he could become unwell quickly and that staff needed to act promptly in such situations.

We detail below the events that culminated in the police being called to the ward on 28 October 2012:

- Admitted circa 1930hrs 27 October.
- Mental health deteriorating (2330hrs) and staff agreed he should be put on a Section 5(2). It was recorded in the notes that it would be '*appropriate to prescribe rapid tranq*[utilisation] *and use seclusion if necessary'*.
- At 0005hrs on 28 October it is recorded Andy had been given rapid tranquilisation and also told he was now detained under a section of the Mental Health Act.
- Andy becomes confrontational and aggressive on the ward at 0130hrs, demanding that he be given his cigarettes. He tells a female nursing assistant that she should leave if she does not want to be part of a 'blood bath'. Control and restraint trained staff are called to the ward but Andy has left the office and is calmer when they arrive.
- Andy has an escorted cigarette break (recorded in the notes at 0148hrs)
- Andy sleeps between 0300-0400hrs.
- At 0515hrs Andy and another patient kick down the door to the male lounge and attempt to barricade themselves in. When told that control and restraint staff have been called, Andy replies that there will be 'blood bath'.
- Ward staff contact the police at 0530hrs. The nursing staff assess that Andy is *"too powerful and determined to be restrained by available trained staff without serious risk of injury to staff".*
- Police attend the ward at 0610hrs. Andy is lying on the floor speaking to a member of staff. Andy refuses to stand and the police help him to stand. Andy refuses to move and attempts to 'throw off' the officers holding him. Andy is moved back to the floor by the police and two Trust staff. The police handcuff Andy and apply leg restraints. He is moved to the seclusion room by seven police officers.
- Andy is placed in seclusion at 0630hrs.

The above timeline illustrates Andy's fluctuating mood. Staff were clearly concerned that if they challenged Andy he would become aggressive however at the time of the police attending the ward he was lying on the floor and talking to a member of staff.

Devon Partnership NHS Trust did not have a policy in relation to the presence of police staff on the ward therefore it is difficult to comment as to the actions of those involved – as there is limited information documented in the notes - but we note the situation appears to have escalated with remarkable pace from Andy lying on the floor talking to a member of staff, to being restrained by seven police officers. Based on the limited

information available, we do not consider this to meet the criteria of proportionate to harm or the least restrictive option available to Trust staff.

We detail below events of 13 and 14 November 2012.

On 14 November 2012 CRHTT staff in Devon took the decision to recall Andy as he was considered by them to have breached the conditions of his leave. However, Andy was to be recalled to a Somerset ward (that which he was originally on Leave from). The Devon team decided it was too dangerous to enforce Andy's recall with health staff. Following agreement with the Somerset team about the situation, and a dialogue with both Devon and Cornwall Police and Avon and Somerset Police (there was initially confusion as to which police force should undertake the recall), Devon and Cornwall Police facilitated Andy's recall.

We have not seen any documented risk assessment undertaken by the Devon (or Somerset) team as to why it was decided that attendance to Andy's home was too dangerous. It is unclear how Andy could be viewed as such a risk when he had only spoken to individuals briefly on the telephone and had not been seen and assessed in person.

The events and actions of staff on 13 and 14 November 2012 have been explored by the Somerset SIRI and Devon Partnership (second) independent complaint review therefore we do not revisit them here but note the following:

- The SIRI was critical of the decision by Devon staff not to attend the home of Andy because they deemed it too dangerous yet did not implement any safeguarding protocol for Andy's wife or child who were already in the home.

The Trust SIRI does not provide a view as to whether the team's assessment of Andy's risk itself was appropriate. The (second) Devon complaint report notes *"it is unclear on what basis this* [risk assessment] *was made, looking at* [Andy's] *presenting needs during 13th and 14th November 2012, given that he was described as calm and settled on the ward and well enough to be considered for a weeks* [sic] *home leave which had only just begun. The subsequent escalation of events… could be seen to have been triggered in part by the involvement of the police"*

The (second) Devon report describes the failure of community staff to engage with Andy over 13 and 14 November as a 'missed opportunity' to alter events and we agree with this assessment.

We detail events below the events that culminated in the police being called to the ward in Devon on 27 December when Andy became verbally abusive and threatening. We set out below the timeline of events:

- Andy is irritable and edgy in mood (1937hrs, 26 December)
- Noted to be intimidating and threatening; a risk of setting fires (midnight, 27 December).
- Andy tells staff there will be 'consequences; if they do not let him leave the ward (0145hrs)

Shortly after this time ward staff decided:

"With [Andy's] *forensic history and the current risks he posted, it was felt necessary that he should be moved into seclusion… unpredictable behaviour, agitated, threatening violence. Police contacted."*

Ten police officers – some of whom drew their Tasers - attended the ward to move Andy to seclusion.

As we have previously outlined, Andy did not have an extensive forensic history. Rather, he had a history of being physically and verbally intimidating and threatening. Andy did not have a history of setting fires – there is nothing in the notes to suggest this – yet this was considered one of the cumulative risks that resulted in the police being called to the ward.

Clearly staff felt that they were at risk but we found no evidence in the notes that anything was done to de-escalate Andy other than give him medication. There are various de-escalation techniques ward staff could have used prior to calling the police, but we have found no evidence in the notes that anything was attempted. Again, emphasis was placed on Andy's alleged forensic history which in reality did not exist – or certainly not to the extent ward staff assumed.

Andy could be aggressive and threatening when unwell – this is not in dispute. Consultant 2 described Andy when unwell in his letter to Derby as *"very challenging, verbally and physically hostile and obstructive, and undoubtedly there is considerable risk attached to this."* Staff appear to have been quick to involve the police rather than attempt to manage the situation themselves. For example, on 13-14 November, the community team who knew Andy well did not attend his home or make an attempt to assess the situation before involving the police.

It was documented in the notes that Andy could become unwell quickly and staff needed to act rapidly. Devon logged an incident (with a major risk rating) on 27 December 2012 that detailed that Andy was not given PRN and (potentially) rapid tranquilisation when needed. As we have outlined, events consequently culminated in ten police officers attending the ward.

Devon has since overhauled its approach to patient engagement on the ward as part of its Four Steps programme – we discuss this further under 'Serious incident reports and Action Plans'

The use of a Taser

Devon's (undated) procedure policy defines a Taser as:

*"**'Tasers'** are hand-held devices that propel two barbs at an individual which discharge a temporary high-voltage low-current electrical discharge to override the body's muscle-triggering mechanisms. The recipient is immobilized via two metal probes connected via metal wires to the electroshock device. The recipient feels pain* [policy emphasis]*, and can be momentarily paralyzed while an electric current is being applied. It is reported that applying electroshock devices to more sensitive parts of the body is even more painful. The maximum effective areas for stun gun usage are upper shoulder, below the rib cage, and the upper hip. High voltages are used, but because most devices use a high frequency alternating current, the skin effect* [policy emphasis] *prevents a lethal amount of current from traveling into the body. The resulting "shock" is caused by muscles twitching uncontrollably, appearing as muscle spasms."*

The College of Policing[90] outlines a number of side effects that may be experienced when a Taser has been discharged. These include convulsing, intense pain and an inability to maintain posture. Leading from this, the recipient may be unable to respond to verbal commands after being tasered, appear confused or disoriented and is likely to feel exhausted. There are documented reports of Tasers having an impact on respiratory and cardiac function.

We have previously outlined NICE clinical guidance in relation to the short-term management of disturbed/violent behaviour. The guidance did not extend to the use of Tasers on the ward.

There were two occasions in Devon when police were called to the ward and at least one where they drew Tasers (January 2013).

[90] https://www.app.college.police.uk/app-content/armed-policing/conducted-energy-devices-Taser/#effects

Andy was twice in quick succession on 14 November 2012 in an ambulance outside his home. Andy said in his statement after the event that he thought the officer involved was a troll attacking him and that if he did cause him injury, it was accidental. Andy was charged with assaulting the officer – for which he intended to plead not guilty - however the case did not go trial[91] before Andy died.

Andy was reviewed by the duty doctor on the ward in Somerset. No significant injuries or concerns were recorded in the notes. Andy asked to see the ward doctor on 16 November. He said he had noticed some blood in his stool and urine and was also bleeding from his right ear. He told the doctor he had been beaten and kicked by the police; and was concerned that he had a bleed on the brain. He added that his mother and sister – both doctors – thought he should go to hospital. The results of the examination were normal and Andy was not sent for further assessment.

Somerset does not have a policy regarding the aftercare of patients who have been tasered. There is no guidance available to staff in relation to both the immediate after care of a patient who has been tasered, or in the days that follow. Equally the (undated) Devon policy does not consider aftercare beyond the immediate event.

Relatively speaking, little is known about the long term impact of being Tasered. Most research has been conducted in America and there is little UK-based data available. There is no statutory requirement for healthcare providers to report Tasers being used on their wards. In 2016, the Rt Honourable Norman Lamb, MP, sought to amend the Policy and Crime bill to ban the use of Tasers in psychiatric hospitals.

It is the police – not ward staff – who ultimately take the decision whether to discharge a Taser on the ward, but it is undoubtedly the responsibility of the ward staff to ensure the wellbeing of the patient thereafter.

We recommend as a priority that Somerset Partnership NHS Foundation Trust and Devon Partnership NHS Trust should review and ratify a Taser policy for their Trust that covers:

- **Immediate aftercare**
- **Patient monitoring (physical and psychological)**
- **Escalation criteria (e.g. further medical review)**

[91] The first court date in July 2013 was delayed. At the time of his death the revised court date had not been confirmed.

- **Recognition of the impact and possible effects (including psychological effects)**

Continuity of care

In this section we consider the number of care episodes Andy experienced, including inpatient admissions, and the number of clinicians involved in his care.

The NICE Quality standard QS14 (2011) sets out the quality statement in relation to continuity of care:

"People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship"

NICE guidance[92] (2011) stresses the importance of working in partnership with service users, their family and/or carer. As part of this process, time is needed to build a supporting, non-judgemental, trusting relationship. In this context, emphasis is placed on the role of the community team, but any inpatient team also has a responsibility to build up a clinical relationship with the service user. Leading from this, in the event of hospital admissions, or a change in care, the guidance sets out a number of points to consider in relation to discharge and transfer of care. The guidance says steps should be taken to ensure:

- *"such changes* [e.g. the end of treatment, transfer to another service]*, especially discharge, are discussed and planned carefully beforehand with the service user and are structured and phased*
- *The care plan supports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis"*

The guidance also says healthcare professionals should:

"Agree discharge plans with the service user and include contingency plans in the event of problems arising after discharge…Before discharge or transfer or care, discuss arrangements with any involved family or carers"

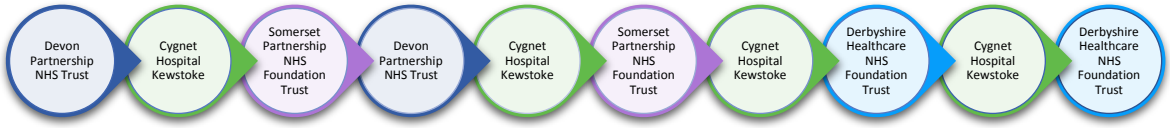
[92] https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#assessment-and-referral-in-a-crisis

Andy was admitted and/or transferred 11 times between October 2012 and October 2013.

Andy's hospital admissions and/or transfers (T)

Date	Ward/Trust/Private facility
27 October 2012	*Delderfield ward, Exeter, Devon*
28 October 2012 (T)	*Nash ward, Cygnet (Weston-Super-Mare)*
8 November 2012 (T)	*Holford ward, Somerset*
Granted Section 17 leave on 13 November	
14 November 2012	*Holford ward, Somerset*
22 December 2012 (T)	*Delderfield ward, Devon*
27 December 2012 (T)	*Nash ward, Cygnet (Weston-Super-Mare)*
2 January 2013 (T)	*Holford ward, Somerset*
12 January 2013 (T)	*Nash ward, Cygnet (Weston-Super-Mare)*
25 February 2013 (T)	*Redhill ward, Cygnet (Weston-Super-Mare)*
Discharged 28 March 2013	
19 August 2013	*Sandford ward, Cygnet (Weston-Super-Mare)*
Discharged 20 September 2013	
30 September 2013	*Radbourne Unit, Derby*
Discharged 2 October 2013	

We set out a summary of Andy's transfers and moves below:



Andy changed hospital and healthcare provider seven times between October 2012 and March 2013. All but one move was to another county or hospital (he transferred wards at Cygnet Hospital Kewstoke in February 2013).

The Somerset SIRI incident report was critical of both Cygnet Hospital Kewstoke and Devon Partnership NHS Trust for not providing documented information about Andy to Holford ward prior to his move there in November 2012.

The (second) independent complaint investigation commissioned by Devon Partnership NHS Trust referenced NICE clinical guidelines 38[93] in the management of bipolar disorders and the importance of continuity of care in primary and secondary care. The review described moving Andy to Holford ward in January 2013 – taking into account the lack of consultation with his family and his complaint about the care he had received there – as (with hindsight) *"ill judged"*. The review went on to say:

"The Participation principle in the Mental Health Act and Code of Practice was not respected. Decisions to move [Andy] *to Holford ward in 2012 and 2013 were made without prior consultation with the nearest relative or family. It is not known to what extent* [Andy] *was consulted, although there is a note on RIO on 2/1/13 which demonstrates he was asked by ward staff at Holford after the move whether he was happy to be there.*

Each of these moves necessitated a change in consultant and nursing team. There were delays in relevant nursing notes being made available to maintain continuity of care, although the care coordinator, Care coordinator 1 from the community team, was very active in ensuring communication was maintained with all parties[94]."

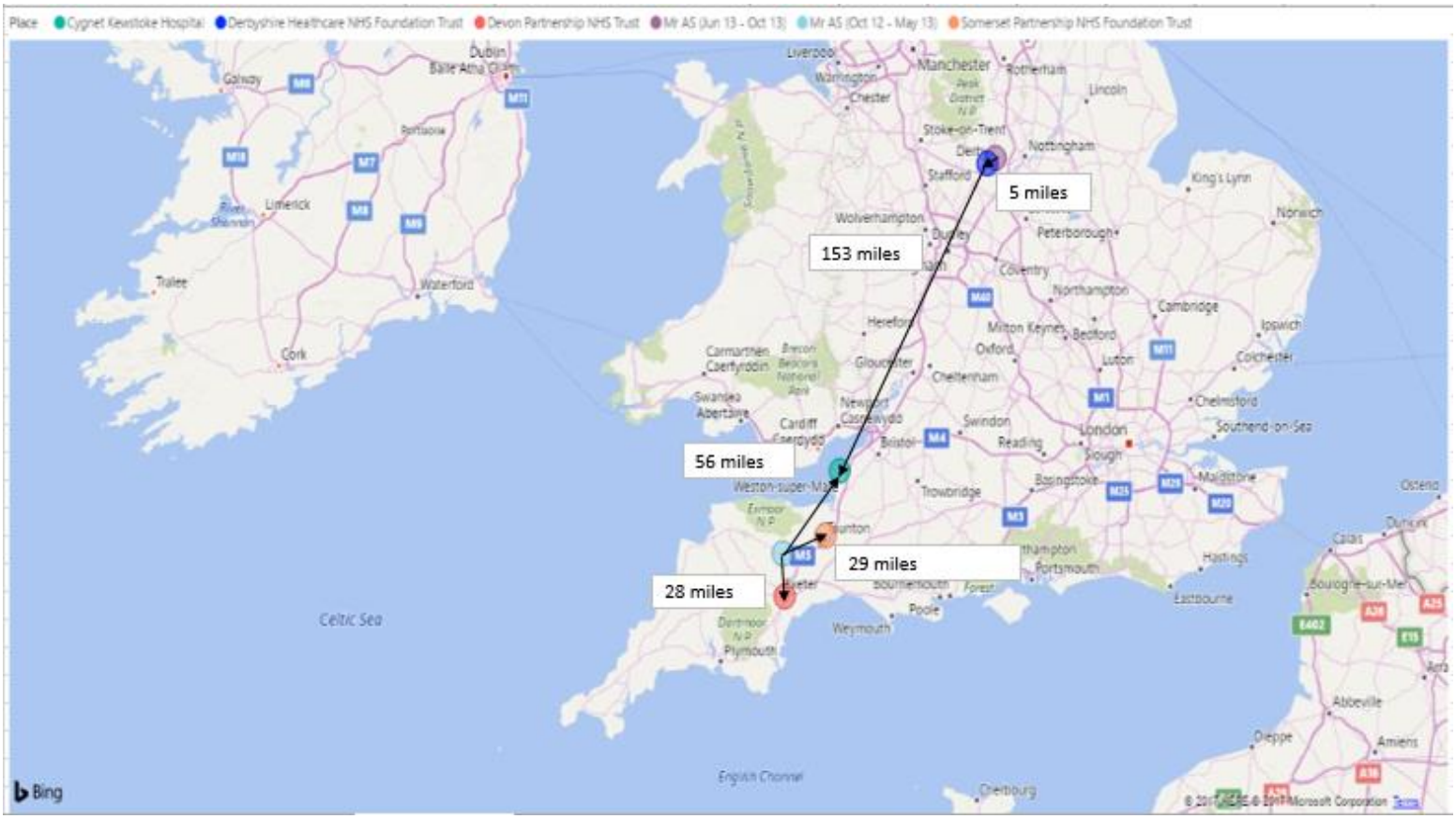
Equally Andy's care coordinator was not always told when he was being moved. In November 2012 Care coordinator 1 was given one days' notice that Andy was being transferred from Cygnet Hospital Kewstoke to Holford ward in Somerset.

Care coordinator 2 was given limited notice that Andy was being discharged home from Cygnet Hospital Kewstoke in September 2013. The independent expert report was critical of communication between Cygnet Hospital Kewstoke and Andy's Derbyshire care coordinator, noting the former to have not kept the latter informed in a timely manner about Andy's discharge and resultant healthcare needs (e.g. community based Clozapine monitoring).

The decision to transfer Andy was not always communicated to him or his family in a timely fashion. In January 2013, Andy was given an hour's notice that he was being moved from Cygnet Hospital Kewstoke to Somerset. His family disagreed with the move but were unable to stop it.

We set out below a visual representation of the distances that Andy (and his family) travelled when he was transferred between providers, first when living in Devon between October 2012 and May 2013, and then when living in Derby from June 2013 onwards:

[93] This guidance has since been updated to CG185 (2014) https://www.nice.org.uk/guidance/cg185
[94] Andy's family were also instrumental in ensuring information was shared.



Both Devon Partnership NHS Trust and Somerset Partnership NHS Foundation Trust were nearly 30 miles from Andy's Devon home. Cygnet Hospital Kewstoke was nearly 60 miles away. When Andy moved to Derby, the distance to Cygnet Hospital Kewstoke was over 150 miles. These are not insignificant distances and we note the challenge this may have presented to Andy's family in terms of seeing him regularly and maintaining contact. Equally Andy's final transfer to Cygnet Hospital Kewstoke in the summer of 2013 took him a number of hours' drive away from his family which undoubtedly would have impacted the frequency in which they could see him.

Andy was under the care of five consultant psychiatrists between October 2012 and October 2013; Consultant 1 (Somerset), Consultant 2 (Devon community), Consultant 5[95] (Devon inpatient), Consultant 6[96] (Cygnet Hospital Kewstoke) and Consultant 10 (Derby). Andy was also seen by a number of other consultants and medics between October 2012 and October

[95] Consultant 5 was recorded in the notes at being Andy's responsible clinician when he was an inpatient in Devon but the notes suggest that Andy was actually seen by a number of other clinicians; not Consultant 5.
[96] Andy's discharge summary named Consultant 13 (consultant forensic psychiatrist) as his responsible clinician however it is Consultant 6 who gave a statement to Andy's inquest. Speciality Doctor 2 wrote the discharge summary.

2013 but we view the five aforementioned Consultants as Andy's principle (responsible) clinicians.

The table below summarises when Andy was seen by consultants and/or medics:

Date	**Location**	**Consultant/medic**
28/10/12	Delderfield, Devon	Registrar 1, on-call registrar
28/10/12-8/11/12	Cygnet Hospital Kewstoke	Consultant 6
8/11/12	Holford, Somerset	Consultant 1, consultant psychiatrist & SHO 1, SHO psychiatry to Consultant 1
17/11/12		SHO 1
20/11/12		Consultant 1 and SHO 1
27/11/12		Consultant 1
29/11/12		Consultant 1
4/12/12		Junior doctor 1, junior doctor
11/12/12		Consultant 1
12/12/12		SHO 1
17/12/12		Senior Registrar 1, Forensic psychiatrist, senior register, Devon
22/12/12	Delderfield, Devon	Doctor 1
27/12/12		CT1 B
27/12/12 – 02/01/13	Cygnet Hospital Kewstoke	Consultant 6
03/01/13	Holford, Somerset	Consultant 1 & SHO 1
08/01/13		Consultant 1
12/01/13 – 28/01/13	Cygnet Hospital Kewstoke	Consultant 6, Consultant & Speciality Doctor 1, ward doctor
08/02/13		Consultant 7, consultant psychiatrist and neuropsychiatrist
08/04/13	Devon[97]	Consultant 2
05/06/13		Consultant 2
21/06/13		GP 2, GP
05/07/13		GP 2, GP

[97] AS also saw his GP, GP 1, when back in Devon

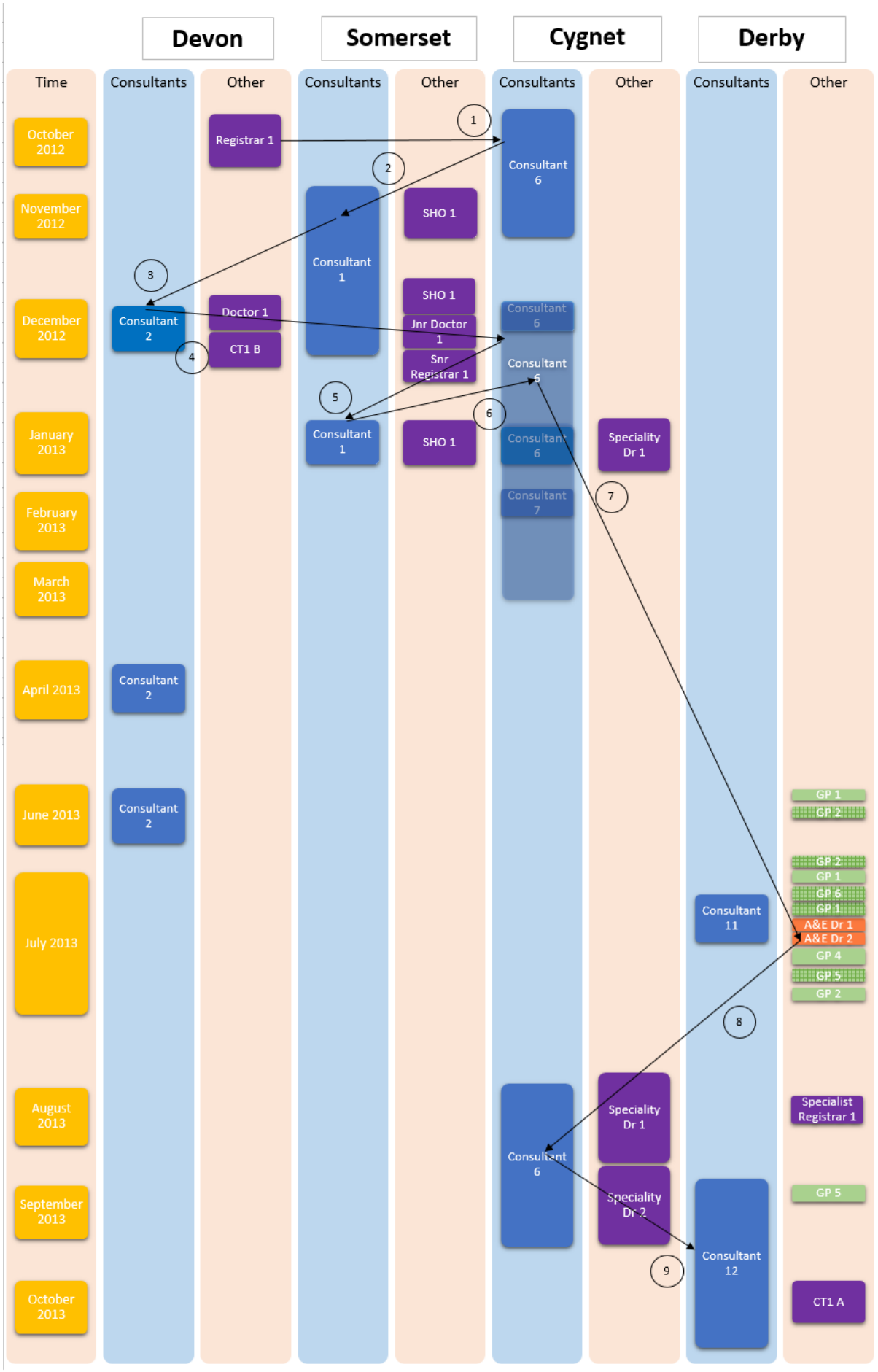
13/07/13	Derby	A&E Doctor 1 & A&E Doctor 2 (A&E)
23/07/13		Consultant 11, consultant psychiatrist, Derby City CRHTT
24/07/13		GP 4, GP
14/08/13		Specialist registrar 1, ST4 to Consultant 10
18/08/13-20/09/13	Cygnet Hospital Kewstoke	Consultant 6, Speciality Doctor 1 and Speciality Doctor 2 (speciality doctor is in psychiatry)
24/09/13	Derby	GP 5, GP
01/10/13	Radbourne unit, Derby	Consultant 12, locum consultant psychiatrist and CT1 A (CT1)
02/10/13		Consultant 12 and CT1 A

.

We have seen clear evidence that Consultant 2 was communicating with other healthcare professionals; the independent coroner report highlighted the '*prompt and appropriate referral*' by Consultant 2 at Devon Partnership Trust to Derby, describing it as *'significantly informative'.* Equally there is evidence that Consultant 1 was communicating with Consultant 2 in relation to the events on 14 November 2012 and Andy's Mental Health Tribunal. Specialist registrar 1 (ST4 for Consultant 10) sent a summary assessment[98] to Andy's GP on 19 August 2013. Speciality Doctor 2 (speciality doctor in psychiatry to Consultant 6) wrote Andy's discharge summary (retrospectively[99]) on 1 October 2013.

We set out below a visual representation of Andy's moves/transfers between healthcare providers and engagement with consultants and medics:

[98] Dr S described this assessment as inaccurate.
[99] Andy had been discharged from Cygnet Hospital Kewstoke on 19 September 2013.


Devon
Somerset
Cygnet
Derby
Time
Consultants
Other
Consultants
Other
Consultants
Other
Consultants
Other
October 2012
November 2012
December 2012
January 2013
February 2013
March 2013
April 2013
June 2013
July 2013
August 2013
September 2013
October 2013
Registrar 1
Consultant 2
Doctor 1
CT1 B
Consultant 1
SHO 1
SHO 1
Jnr Doctor 1
Snr Registrar 1
Consultant 1
SHO 1
Consultant 6
Consultant 5
Consultant 6
Consultant 7
Consultant 6
Speciality Dr 1
Speciality Dr 1
Speciality Dr 2
Consultant 11
Consultant 12
GP 1
GP 2
GP 2
GP 1
GP 6
GP 1
A&E Dr 1
A&E Dr 2
GP 4
GP 5
GP 2
Specialist Registrar 1
GP 5
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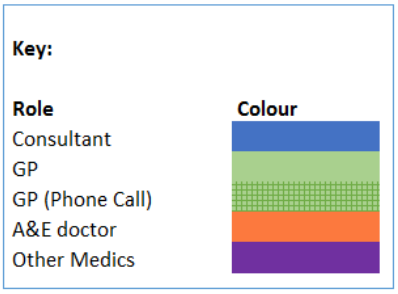

The chart illustrates the numerous transfer and changes in clinician that Andy experienced between October 2012 and October 2013.

The inconsistent manner in which Andy's transfers were managed and communicated by healthcare providers undoubtedly had a negative impact on his care and treatment. We have previously highlighted the lack of effective care planning - which was likely exacerbated by the number of transfers Andy experienced. Information was not shared in a timely manner (e.g. Consultant 1 had to request copies of Andy's notes in November 2012 and January 2013) the upshot of which being ward staff essentially had to start again with Andy, in terms of gathering information and building a relationship with him.

We were left with a sense that healthcare professionals were largely 'firefighting' in terms of addressing Andy's immediate needs (e.g. when he was in crisis). Andy saw at least 20 different medical staff (and numerous nursing staff) in both inpatient and community settings during the last 12 months of his life. At least 12 of these medical staff (including three at Cygnet) were seen following his move to Derby in June 2013.

NICE guidance highlights the importance of a continued relationship between the patient and clinician. Andy had few enduring relationships with healthcare professionals other than with Consultant 2, who he had seen for a number of years, and Care coordinator 1, his Devon care coordinator.

Andy's Devon care coordinator was clearly involved in his care, trying to ensure everyone was kept informed. However, information was not routinely communicated by the inpatient wards to this care coordinator in a timely fashion. We were left with a sense that no one specific individual was actively seen as central to Andy's care in terms of managing his overall care plan and long term treatment. The continuously changing nature of Andy's inpatient arrangements meant that no substantial plans could ever be effectively implemented.

There is no evidence that Andy's care and treatment plan had evolved – or that healthcare professionals knew him any better - from his admission to Devon Partnership NHS Trust in late October 2012 through to his final (voluntary) emergency admission to Derby in October 2013.

Specialist registrar 1's plan in August 2013 included arranging a joint meeting with Care coordinator 2 and the crisis team. This meeting did not take place, in part due to care coordinator 2's absence, and because Andy was admitted to Cygnet Kewstoke on 18 August 2013 (Andy's discharge from Cygnet in September 2013 was described in the Coroner's Findings of Fact as a *'failed discharge'*). Consultant 11 intended to arrange a joint meeting with the crisis and home treatment teams in early October 2013. This meeting did not take place before Andy's death.

The Derby team did not provide Andy with continuity of care. Andy moved to Derby in June 2013, yet at the time of his death, over three months after his transfer, he did not have an established relationship with his care coordinator, having met her twice (due to annual leave and sickness). He had not met Consultant 10, his consultant psychiatrist, and a clear, effective care plan had not been developed.

Andy's mother, Dr S, told us that lack of continuity of care took its psychological toll on Andy. She told us that he felt increasingly helpless as he met each new healthcare professional and essentially had to 'start again' with each one, yet a long-term plan in relation to his care and treatment failed to materialise. She told us that he had initially been optimistic about the move to Derby, but was soon struggling to get mental health services to engage with him in a timely manner. Mrs S told us that she too had sought to engage healthcare services for Andy in Derby, but she felt they had received little support in a timely manner.

A further point Dr S raised with us in relation to Andy's continuity of care, was the accuracy of his records. She told us that a lot of his records are incorrect and/or contain inaccuracies – we have seen evidence that this was something she raised with the Trusts (e.g. she submitted a complaint to Somerset) during the last year of Andy's life and after his death. She added that healthcare professionals often relied on information that was collected second-hand (e.g. no healthcare professionals were present during the incident on 14 November 2012 therefore there isn't a first-hand account of what happened, yet it is frequently referred to in Andy's notes). The terms of reference do not focus on the accuracy of Andy's records, but we have previously commented that Andy's notes refer to a forensic history, when he did not have one. The lack of continuity of care meant that any inaccuracies in Andy's records could

unknowingly be passed to another provider/healthcare professional, further diminishing the prospect of identifying and correcting any such mistakes, with each transfer. As previously mentioned there was no one health care professional central to Andy's care who would have assumed responsibility for ensuring his records were accurate and that the correct information was being shared.

Pharmaceutical care

In this section we consider the medication that Andy was prescribed between October 2012 and October 2013. We engaged a pharmacist, Mr Abiola Allinson, Deputy Chief Pharmacist from a large Mental Health NHS Foundation Trust to consider:

- The medication Andy was prescribed;
- any variation in dose;
- the length of each prescription; and,
- the potential impact of combining antipsychotics and antidepressants.

In addition to the above, Dr S, Andy's mother had a number of questions specific to Andy's medication which we asked be addressed too. She submitted a number of documents as part of this process. Dr S' questions are listed in Mr Allinson's report which we set out below.

Introduction

I was asked to undertake an independent review of the medication management/optimisation of Andy in relation to the time frame of 27th October 2012 till the 4th October 2013. It is unfortunate under the circumstances that we find ourselves in that Andy is sadly no longer with us. My remit included a review of prescriptions and prescribing decisions that pertained to the case for evidence of practice that would be expected as opposed to those that would not be expected.

I have focussed mainly on the period 18/08/2013 till 04/10/2013 where the majority of the changes in therapy occurred whilst noting medication issues outside of this time frame. I have also responded to the questions raised by Dr S from the information available to me as well as my knowledge.

Best practice

Admission to Cygnet - 18/8/13 to 20/9/13

- Lithium dose gradually reduced over a month period from 600mg to 400mg then to 200mg and discontinued 19/9/13.

Note: One of the questions here is the decrease on admission from Lithium Carbonate 1200mg each night to 600mg – consideration for doing this would be an inability to ascertain adherence with therapy. This needs to be clarified. There were reports of erratic adherence with Lithium prior to admission therefore the plan was to reduce and discontinue. Benefits of Lithium are in keeping the plasma level in the therapeutic range therefore if adherence is not consistent then benefits would be negatively impacted.

Stopping Lithium

If stopping Lithium, reduce the dose gradually over at least 4 weeks, and preferably up to 3 months, even if the person has started taking another antimanic drug. During dose reduction and for 3 months after Lithium treatment is stopped, monitor the person closely for early signs of mania and depression.

Diazepam

Plan for gradual withdrawal of Diazepam – this followed a stepwise fashion till discontinued on 19/09/2013.

Clozapine

Clozapine initiated and dose increased as per Maudsley guidelines – records of monitoring are in place. BP, pulse recorded as per standard.

Combination of antipsychotics and Citalopram/Escitalopram

QT interval[100] prolongation

Escitalopram/Citalopram is contraindicated together with medicinal products that are known to prolong the QT interval.

Escitalopram/Citalopram has been found to cause a dose-dependent prolongation of the QT interval. Cases of QT interval prolongation and ventricular arrhythmia including torsade de pointes[101] have been reported during the post-marketing period, predominantly in patients of female gender, with hypokalaemia, or with pre-existing QT interval prolongation or other cardiac diseases

Pharmacokinetic and pharmacodynamic studies of Escitalopram/Citalopram combined with other medicinal products that prolong the QT interval have not been performed. An additive effect of Escitalopram and these medicinal products cannot be excluded. Therefore, co-administration of Escitalopram with medicinal products that prolong the QT interval, such as antipsychotics (e.g. Phenothiazine derivatives, Pimozide, Haloperidol), is contraindicated.

If the combination of Escitalopram/Citalopram is considered the most appropriate pharmaceutical approach, then there should be a discussion with the patient and a record in the patients notes of the unlicensed nature of the combination. The advice then is for ECG

[100] QT interval is a measure of the heart's electrical activity.
[101] A type of abnormal heart rhythm

monitoring at baseline and appropriate intervals such after doses increases or yearly if dose is maintained.

Escitalopram

Dose of Citalopram prescribed by the GP of 10mg daily was not equipotent with Escitalopram 10mg daily. The dose of Citalopram prescribed should have been 20mg daily.

Citalopram dosing

The increase in dose of Citalopram does not follow a standard pattern. Upon admission to Derbyshire Healthcare – regular medication confirmed by the pharmacist on 01/10/2017 included Escitalopram 10mg daily as per discharge from Cygnet Kewstoke. The pharmacist identified the dose change required to Citalopram 20mg and noted this had been prescribed.

Patient review on the same day by the consultant psychiatrist incorrectly identified that Andy had been taking Escitalopram 20mg daily for 4 weeks and the dose of Citalopram was increased to 40mg daily after one dose of 20mg. This escalation in dose could have increased alertness and agitation.

Benzodiazepine treatment

Benzodiazepines have been prescribed regularly and when required from October 2012 till this was discontinued at Cygnet Kewstoke in September 2013.

Varying doses of Benzodiazepine medication – best practice is to review Benzodiazepines and restrict treatment to no more than 4 weeks duration. Doses prescribed varied up to 8 mg of Clonazepam daily.

As a standard conversion from the BNF(British National formulary) – 250micrograms of Clonazepam is approximately equivalent to 5mg of Diazepam therefore an 8mg daily dose is regarded as equivalent to 160mg of Diazepam daily.

500micrograms of Lorazepam is approximately equivalent to 5mg of Diazepam therefore a 4mg daily dose is regarded as equivalent to 50mg of Diazepam.

Note: It would not be standard practice to prescribe such potent medication namely Clonazepam at the reported doses in the community setting.

From 01/08/2013– information was to stop Clonazepam 2mg FOUR times daily plus Lorazepam 1mg FOUR times daily and replace with Diazepam 5mg THREE times daily.

The total equivalent dose of Diazepam being taken from medication prescribed and not from other sources; if all was administered was 200mg daily of Diazepam

As per Cygnet Kewstoke prescription chart

18/8 to 20/8 Clonazepam 2mg FOUR times daily (Stopped)

20/8 to 21/8 Diazepam 10mg THREE times daily (Started)

21/8 to 24/8 Diazepam 10mg MORNING and NIGHT plus 5mg in the AFTERNOON (reduced)

24/8 to 27/8 Diazepam 5mg MORNING and LUNCHTIME plus 10mg each NIGHT (reduced)

27/8 to 29/8 Diazepam 5mg THREE times daily (reduced)

29/8 to 5/9 Diazepam 5mg TWICE daily (reduced)

5/9 to 9/9 Diazepam 2mg MORNING and 5mg each NIGHT

9/9 to 12/9 Diazepam 2mg TWICE daily (reduced)

12/9 to 16/9 Diazepam 2mg each NIGHT (stopped)

The decrease from Clonazepam 2mg FOUR times daily to Diazepam 10mg THREE times daily is a big drop. It should have been considered to reduce the Clonazepam dose gradually before consideration for a conversion to Diazepam

Procyclidine

Procyclidine is a synthetic anticholinergic agent which blocks the excitatory effects of acetylcholine at the muscarinic receptor**.** It is indicated for the control of extrapyramidal symptoms induced by psychotropic drugs (e.g. antipsychotic medication) including pseudo-parkinsonism, acute dystonic reactions and akathisia.
Idiopathic Parkinson's disease is thought to result from degeneration of neurones in the *substantia nigra* whose axons project and inhibit cells in the corpus striatum. Blockade by neuroleptic drugs of the dopamine released by these terminals produces a similar clinical

picture. The cell bodies in the corpus striatum also receive cholinergic innervation which is excitatory.

Relief of the Parkinsonian syndrome can be achieved, either by potentiation of the dopaminergic system or blockade of the cholinergic input by anticholinergics. It is by a central action of this latter type by which procyclidine exerts its effect.

Procyclidine is particularly effective in the alleviation of rigidity. Tremor, akinesia, gait, sialorrhoea and drooling, sweating, oculogyric crises for example are also beneficially influenced

Neuroleptic-induced extrapyramidal symptoms

The effective maintenance dose is usually 10 to 30mg Procyclidine per day. After a period of 3 to 4 months of therapy, Procyclidine should be withdrawn and the patient observed to see whether the neuroleptic-induced extra-pyramidal symptoms recur. The recommendations are that cessation of treatment periodically is advised even in patients who appear to require the drug for longer periods. Procyclidine in practice should be used on an as and when required basis to manage symptoms.

In my opinion, as this medication is used to treat the side effects of antipsychotics such as rigidity which I could not see reported, I do not feel the omission of prescribing it on 01/10/2013 on admission to Ward 36, Radbourne unit has contributed to the negative outcome.

Questions from Dr S

Andy was at Cygnet hospital 18/8/13 – 20/09/13

- ***Was he discharged too soon?***

I am not able to comment on this – All I can infer is that the information in the notes indicates there were plans in place and the Andy was reportedly doing well enough to be discharged.

- ***Was the switch from one lot of medication to another too quick?***

There was in place a pharmaceutical care plan for the reduction and discontinuation of certain medications and a rationale for medicines optimisation to reduce the medication burden.

The risks of a rapid change in medication could include

a. Precipitating a relapse or recurrence of the underlying illness

b. An inability to attribute the benefits or otherwise in a patients presentation to a particular change in therapy. This could impact negatively on rational future prescribing decisions.
c. The risk of adding medications or increasing doses before ascertaining the benefits of earlier changes - resulting in poor medicines optimisation.

In my opinion, the changes in medication could have been better managed by undertaking it over a longer period of time and evaluating the benefits or otherwise of individual changes before giving due consideration to making further amendments to the medication therapy.

- ***He had only stopped Lithium and Diazepam a couple of days before discharge. Was there a rebound effect from stopping Diazepam?***

A Benzodiazepine withdrawal syndrome may develop at any time up to 3 weeks after stopping a long-acting Benzodiazepine. Long-term users should be withdrawn over a much longer period of several months or more. Short-term users of Benzodiazepines (2 to 4 weeks only) can usually taper off within 2 to 4 weeks.

The reduction of the Diazepam in this case was over a 4 week period. Andy had been on Benzodiazepines for up to 1 year. Andy was previously prescribed Clonazepam and Lorazepam at varying doses. So there is a risk that he could have had a Benzodiazepine withdrawal syndrome. This can be typically characterised by anxiety, panic, palpitations, sweating, tremor, general malaise, loss of appetite.

From the ward review notes, Andy was keen to come off Diazepam as he indicated it was causing him nightmares.

In my opinion, the time frame for discontinuation of the Diazepam should have been longer.

- ***Was Andy suffering with side effects at Cygnet Hospital Kewstoke? He was when he returned home.***

Side effect reported in ward notes from 05/09/2013 was sedation.

Coarse tremors related to Lithium - 29/08/2013

I am not able to ascertain any other reports of side effects in that admission from 18/8/2013 to 20/9/2013.

Vital signs chart

- ***Why* [was Andy] *so tachycardic on discharge day?***

02/10/2013 Pulse 130; BP 125/87 – There are various reasons this could be so. Anxiety, Clozapine (fast pulse rate is a common side effect).

- ***Was the doctor informed?***

I cannot ascertain this from the information provided.

- ***Why not repeated?***

I cannot ascertain this from the information provided.

- ***No comment given, no ECG, no previous ECG review, no medical exam***

Baseline ECG undertaken on admission to Cygnet Kewstoke. No records I can glean relating to an ECG undertaken at Derbyshire on admission.

Questions about prescribing at Nash ward

- ***What is the effect of stopping [Lamotrigine] suddenly?***

Bipolar affective disorder - In clinical trials, there was no increase in the incidence, severity or type of adverse reactions following abrupt termination of Lamotrigine versus placebo. Therefore, patients may terminate Lamictal (Lamotrigine) without a step-wise reduction of dose.

- ***Are there withdrawal symptoms?***

Bipolar affective disorder - In clinical trials, there was no increase in the incidence, severity or type of adverse reactions following abrupt termination of Lamotrigine versus placebo. Therefore, patients may terminate Lamictal (Lamotrigine) without a step-wise reduction of dose.

- ***What is the impact on rapid cycling of illness?***

There should no discernible impact on rapid cycling illness as recorded above.

NICE (National Institute for Health and Care Excellence) indicate that patients with rapid cycling bipolar disorder should have the same interventions as people with other types of bipolar disorder because there is currently no strong evidence to suggest that people with rapid cycling bipolar disorder should be treated differently.

- ***Is this good practice?***

In practice, a reduction in dose over a short timeframe would be considered an appropriate strategy.

- ***Prescription Sertraline in 2 stat doses because forgot to put on takeout meds*** [Coombe Havens Ward 25/12/12-27/12/12]

Implication/impact – There should be no impact of 2 stat dose as they are being administered on the appropriate days. The total daily dose was the same i.e. 100mg. The only issue could be administration late in the evening as Sertraline could be alerting in some patients.

Overall view of care

I will only focus on a medication perspective.

1) Of concern was the escalation of the dose of Citalopram prior to discharge. This fell below accepted care levels.

   As with all antidepressant medicinal products, Citalopram dosage should be reviewed and adjusted, if necessary, within 3 to 4 weeks of initiation of therapy and thereafter as judged clinically appropriate. There may be an increased potential for undesirable effects at higher doses. If after some weeks on the recommended dose, an insufficient response is seen, some patients may benefit from having their dose increased up to a maximum of 40 mg a day.

   Dosage adjustments should be made carefully, on an individual patient basis, to maintain the patient at the lowest effective dose.

   Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers

of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour.

From a pharmaceutical care perspective an increase in dose from 10mg daily of Citalopram (prescribed by the GP though not equipotent with Escitalopram 10mg prescribed on discharge from Cygnet Hospital Kewstoke) to Citalopram 20mg daily prescribed in Derby and administered for one dose followed by a further increase to 40mg daily of Citalopram fell below accepted pharmaceutical care standards.

2) There are further questions that need answering in relation to the monitoring of Blood pressure and pulse prior to discharge from Ward 36 on 02/10/2013. Was an ECG requested and undertaken?
3) Doses of Benzodiazepines prescribed between March 2012 and July 2013 were higher than would be expected in an outpatient setting; what was the rationale for these doses?

The plan for a medication review at Cygnet Hospital Kewstoke was appropriate, due consideration should have been given to a longer time frame for the changes to occur in a more gradual and stepwise fashion.

Review of the Trust(s) internal investigations

Summary

Each of the three Trusts involved in Andy's care during the period of this review produced an investigation into significant events. Two of these were Serious Incident (SI) reports:

- In March 2013, Somerset Partnership NHS Foundation Trust produced a level 2 investigation report (jointly with Devon Partnership NHS Trust) looking at the breakdown of Andy's leave home (the review was commissioned in December 2012). The action plan was not finalised until over 2 years later April 2015.
- In March 2014, Derbyshire Healthcare NHS Foundation Trust produced a Serious Incident Investigation 6 months after the death of Andy.
- In March 2015, Devon Partnership NHS Trust produced two Independent Investigating Officer's reports following a formal complaint about Andy's care submitted by his mother in February 2014. She listed a range of concerns. The first report was of poor quality, poorly evidenced and judgemental of Andy. A second report was completed in August 2015. The second report is the version we consider below.

We note the significant period in which reviews and investigations were undertaken in relation to Andy's care and treatment. This work did involve three healthcare providers, but taken cumulatively, the first review was commissioned in December 2012 and the last report was completed in August 2015. Leading from this, we note that each Trust is still undertaking work in relation to its action plan and that there is a need for further monitoring and evaluation of changes made.

This report considers each of the Trusts investigations separately to identify whether they met the terms of reference and if learning ensued. This also includes an update of action taken as a result of the investigations and any impact this has had on current care. We conducted a series of interviews with senior managers from each of the Trusts to identify what had changed and what, if any, impact this has made.

A wide range of issues were covered across the three investigations by the Trusts. The following common issues/concerns were identified and investigated in at least two of the three reports.

Issue/concern identified	Theme investigated?		
	Somerset Partnership NHS Foundation Trust	Derbyshire Healthcare NHS Foundation Trust	Devon Partnership NHS Trust
CPA/Care planning	Yes	Yes	Yes
Risk assessment/management	Yes	Yes	Yes
Role of police	Identified but not investigated	Yes	Yes
Staff capacity	No	Yes	Yes
Communication between departments or services	Yes	Yes	Yes
Communication with patient and family	Yes	Yes	Yes
Record keeping	Yes	Yes	Yes
Delays in decision making	No	Yes	Yes
Safeguarding of others	Yes	No	Yes
Service issues (e.g. access to information, delays)	Yes	Yes	Yes
Mental Health Act	Yes	Yes	Yes
Crisis care	Yes	Yes	Yes
Inpatient care	Yes	Yes	Yes
Medication	No	Yes	Yes

Individual reports

Somerset Partnership NHS Foundation Trust SI

The investigation was jointly undertaken with Devon Partnership NHS Trust but led by Somerset. This investigation report was written by a team of two managers and a Consultant Psychiatrist, all of whom were employed by the Trust. The report does not identify a Trust lead. Although the report was written in March 2013, it was revised in August 2013 and the

action plan was finalised in April 2015. The reason for the delay to finalisation of the report is not known.

The report contains clear terms of reference. However, Andy and his family were not involved in developing the terms of reference for the investigation, although they were interviewed as part of the process. There is no direct link between the terms of reference and the findings. This means that aspects that should have been investigated were not. For example, the report does not answer the question about staff training for those delivering Andy's care. If it had, this may have led to an explicit recommendation about how to involve other agencies when people with mental illness become acutely unwell in the community.

The report lists those staff interviewed. However, Devon Community Mental Health Team staff, who were responsible for Andy's care while he was on leave, were not interviewed as part of the investigation. Neither did the investigators interview Devon and Cornwall Police, who had been heavily involved in the incident.

Similarly, although it is clear from the report that Somerset Partnership NHS Foundation Trust's and Devon Partnership NHS Trust's operational procedures and medical records were considered as part of the investigation, there is no reference to the consideration of operational procedures and/or records made by Devon and Cornwall police. This means there was a missed opportunity to consider a joint Taser policy between the mental health services and the police, nor was there any reference as to how to involve other agencies in joint management when people with mental illness become acutely unwell in the community.

The report does refer to benchmarking information (e.g. trust policy) but this is limited to whether Andy should have been allowed to drive while on leave. Although it concludes that this was not against the Mental Health Act guidance, much of the report questions whether this should have been allowed to happen. The driving issue detracts from the root causes of the incident.

The investigators conclude that the root cause of this incident was that Andy should not have gone on Section 17 leave while he was so ill; there was poor decision making and that his family possibly put pressure on the Trust to allow this. The report also cites a lack of contemporaneous notes as being one of the root causes for the incident.

This explanation does not address what went wrong when Andy was on leave and therefore limits learning about crisis management in the community, joint working between acute and community trusts and joint police/Section 17 recall procedures and Taser policies.

The perspective that the family put pressure for a Section 17 leave fails to adequately consider the carer and family needs and the pressure that they were under from Andy. It does not

adequately explore whether their views were considered in context of those of the staff on the ward. Full risk assessment is the responsibility of professionals and the investigators should have assessed whether the decision was reasonable or not in terms of the consideration of family views.

The report does contain a lessons learned section. However this is worded like a set of recommendations, only some of which can be seen to be carried into the action plan. Despite not interviewing the police or reviewing policies or procedures this section of the report contains a recommendation about agreeing with the police how to handle situations like this one. However, this went no further than the report and was not carried over into the action plan. As a consequence no change will have resulted on this issue. The failure to ensure recommendations were drawn from evidence and followed into action plans meant the learning was likely to be limited.

Finally, this report led to a separate action plan with recommendations. There are a number of issues to note about the plan:

- Although the family and Andy himself had an opportunity to comment on the draft action plan in May 2013, it was not finalised until April 2015, which was after he had died. The reasons for the delay are not mentioned.
- Not all of the recommendations in the action plan are Specific, Measurable, Achievable, Relevant and Time-Bound (SMART). This means that it may not be possible for them to be evaluated.
- The wording of some of the recommendations detract from the recommendation itself, which will also make them difficult to action.

In summary, this was a Somerset-centric investigation (as opposed to joint review looking at the role of both Trusts). An over focus on Andy's driving and whether he should have been on leave in the first place detracted from what else caused this incident while he was on leave. This means that learning was missed from the SI report.

The report was shared with Andy's family who had a number of concerns in relation to the findings. Andy's family engaged in extensive correspondence with the Trust in relation to the report and they submitted a formal complaint in December 2012.

Since the report – what has changed as a result and what impact has this had?

The report action plan was finalised in April 2015. At that time, all of the actions were marked as achieved, with the exception of one[102], because it was noted that this was outside the realms of the Trust (though the Trust lead was identified as the Head of Clinical Effectiveness and Research).

We spoke to the Trust Mental Health Act Coordinator and the Trust Deputy Service Director (adult mental health) about changes implemented since the investigation.

In terms of an overview of progress, we were told the Trust has reviewed all their policies, where this was a recommendation. Some were reviewed straight after the event and others have been changed and changed again as they became more specific. The managers also reflected that the action plan was not SMART and that, following feedback from their CCG, they have recently changed the way they write SI action plans.

As previously mentioned, this report focused on Andy's leave and missed an opportunity to provide learning and make recommendations about how to deal with patients on leave who become unwell and need to return to the ward. It did not consider whether the response in this case was proportionate or how the escalation of events could have been avoided. When asked about this in the follow up call, the senior managers from the Trust described other change[103]s they had made, prompted by this event, even though these were not part of the action plan.

[102] "There must be a joint RCPA community care plan in place, including full recall information, before home leave is taken but particularly if this involves more than one NHS Trust.

- [103] Developing clear guidance about getting a warrant on a Section 135, for people who are absent without leave. This covers how staff encourage people to go back to hospital and their being recalled from their sections or on CTOs. However, this does not cover out-of-area patients.
- Working with the police in relation to Section 135s or 136s
- Making sure that staff have support out of hours e.g. if they need to request a warrant
- Making a crisis team available during the night
- The establishment of a control room triage (CPN and MH operated) based at Avon and Somerset Police headquarters with access to the Trust RiO system. When the police attend an incident they can contact the control room and ask that a nurse review the patient's notes.
- Development, by the Trust of a new Approved Clinician/Responsible Clinician policy (2015) that states the importance of everybody, including the patient and their family, being clear about who the responsible clinician is, including at times of transition.

Updates on the specific actions in response to the recommendations of the investigation are as follows (we have highlighted in bold the points that pertain to Andy's case, distinguishing it from broader changes each Trust has made):

Action	Final actions, outcomes and impact (updated July 2017)
Staff should be given clear guidance on the recall of a detained patient to hospital as set out by the Mental Health Act; this includes the Responsible Clinician writing to the patient being recalled.	**<u>Partially achieved</u>** **The Section 17 policy was updated in 2017 (though we note the version on the Trust website is dated 2014).** **The policy now has a narrative and guidance, which we were told, gives staff more confidence. We were told there is a crib sheet on what to do in certain situations, which staff may find helpful.** **In terms of clarifying the process for recall, the policy now includes a template letter for responsible clinicians, in accordance with the MHA. The Managers acknowledged that, in this situation, the clinician would not have had time to write a letter. The policy says:** ***"9.4 In emergency circumstances, when the patient's Responsible Clinician has stated the patient needs to be returned to hospital but there has not been time to furnish written notification to that effect, the patient should be asked to return. If he / she refuse to return, they should be treated as Absent without leave and the Trust's Detained Patients and Absent Without Leave policy should be followed."*** **The Trust revised AWOL policy (2017) includes similar wording in relation to an emergency recall.** **<u>Aspects still to be addressed</u>** **The Trust's Section 17 leave policy wording in relation to emergency recall is not consistent with the Mental Health Act[104] or the supporting information in the Code of**

[104] (4) In any case where a patient is absent from a hospital in pursuance of leave of absence granted under this section, and it appears to the [responsible clinician] that it is necessary to do in the interests of the patient's health

	Practice[105] or the Reference Guide[106]. Specifically that a patient must be furnished with written notification in the event of an emergency recall. The Trust policy says this does not have to happen. **The Trust needs to review its policy to ensure that it is in line with Mental Health Act law.** **We asked the Trust how it is monitoring compliance with the policy. We were told that recall from leave is quite rare and the Trust has not audited this in the last couple of years. This follow up has prompted them to do so. We were told that it will form part of the monitoring of the new policy. However, we have not seen evidence of when this will occur.**
Documented clinical and risk information must be shared between organisations as part of the inpatient transfer and care planning process	**<u>Partially Achieved</u>** **A computerised transfer check list is now in place on the wards. Prior to this incident, the Trust used an inter-wards transfer checklist. Following this and other incidents, it developed an updated transfer checklist (we are unclear if this includes care planning information), even though all wards use the same computer system. The transfer checklist makes sure information is updated on the computer system and that people have access to the right information. For example, the Trust will use the transfer checklist when an out of area patient is being discharged to his/her original Trust**

or safety or for the protection of other persons, [that clinician] may, subject to subsection (5) below, **by notice in writing given to the patient or to the person for the time being in charge of the patient, revoke the leave of absence and recall the patient to the hospital** [our emphasis]

[105] 27.33 The responsible clinician must arrange for a notice in writing revoking the leave to be served on the patient or on the person who is for the time being in charge of the patient. Hospitals should always know the address of patients who are on leave of absence and of anyone with responsibility for them whilst on leave.

[106] 25.18 To recall a patient, the responsible clinician must issue a notice in writing of the recall to be given to the patient or to the person, if there is one, in charge of the patient during their leave. The reasons for recall should be fully explained to the patient and a record of the explanation included in the patient's notes. (https://www.gov.uk/government/publications/mental-health-act-1983-reference-guide)

	Following this incident, the Trust wanted to use the same checklist across other counties. Devon Partnership Trust uses the same computer system but not the same version so some amendments have been made to the checklist to make sure they can use it too. **As referrals out of area are quite rare, the use of the checklist out of area is also rare, but it has been used.** **In the case of the few patients who go out of area, the Trust uses the checklist to make sure they have the right information.** **We were told by the Trust that the checklist has improved practice because:** • **It ensures that people check that everything is up-to-date before people leave the care of the ward or Trust.** • **The receiving ward has up-to-date information provided at the point of admission.** **<u>Aspects still to be addressed</u>** **We have not seen any formal evaluation to confirm the checklist is effective or information on how many times it has been used. We note that in order for the checklist to be effective, staff need to have access to the initial notes (i.e. in Andy's case, his notes were not always readily available and had to be requested).**
There must be a joint RCPA[107] community care plan in place, including full recall information, before home leave is taken but particularly if this involves more than one NHS Trust.	**<u>Not achieved</u>** **The Trust has made these changes to its RCPA policy but it has not been agreed by the Local Authority, which has recently separated from the Trust. Therefore, there is ongoing work to align all policies, where possible.** **Trust managers have explained that when someone moves from a different Trust, they work with them according the**

[107] Recovery Care Programme Approach

	Trust CPA policies and protocols. If a patient moves to another Trust, they send a copy of their CPA care plans. **<u>Aspects still to be addressed</u>** **RCPA Policy to be agreed and signed off by Local Authority. We note that the Trust investigation was finalised in August 2013 and the resultant action plan was finalised in April 2015.**
Staff should be given clear guidance on their responsibilities and actions if they are concerned about a patient's ability to drive a road vehicle (refers specifically to patients on section 17 leave)	**<u>Not achieved</u>** **The Trust managers told us that in instances where patients are detained under the MHA and a consultant psychiatrist agrees they can go on leave, there are many things that have to be considered. They did not understand why the report was so specific about driving. This is one of the things that would be considered as part of the risk assessment.** **<u>Aspects still to be addressed</u>** **The Section 17 leave policy was not changed as a result of this recommendation. However the Trust told us, that with hindsight, it was a helpful recommendation as it generated some discussion about driving in general. Some of the discussions were around the GMC and NMC guidance (we do not have further detail of these discussions or any resultant action).** **We reviewed the Trust's Section 17 leave policy in relation to emergency recall. The policy is not consistent with the Mental Health Act or the supporting information in the Code of Practice or the Reference Guide.** **The Trust needs to reviews its policy to ensure that it is in line with Mental Health Act law.**
Safeguarding issues must be considered and documented as part of risk	**<u>Achieved</u>** **The Trust amended "Safeguarding" to "Risk" in its Section 17 leave policy. The rationale for this is that patients subject**

assessment when considering Section 17 leave.	**to the MHA are treated and managed under the MHA. Decisions about leave are made by the Responsible clinician, who would consider risk to self or others or neglect, and not by a safeguarding meeting/process.** **As an update, the Trust managers feel that the amended policy will not necessarily be the thing that makes the difference, or a service change. However about 18 months ago, the Trust enabled a 24-hour Home Treatment Team, which provides more cover and support to patients that may be at risk. The ward team does joint risk assessments with the Home Treatment Team before the patient is discharged. The team has access to care plans and computerised notes so they can be much more responsive.** **The Trust 'clinical assessment and management of risk of harm to self and others policy' (2015) signposts the reader to the Safeguarding Vulnerable Adults and Safeguarding Children policies and highlights the need to consider risks around safeguarding.**
To review involvement of family and/or carers to disclose risk management when the family/carers need seems to act against the interests of the patient.	**<u>Achieved</u>** **The Clinical Risk Assessment, Working with Families and Management of Risk to Self and Others Policies were reviewed.** **The Trust is now part of the Triangle of Care[108] and now finds that anyone working with the Home Treatment Teams will have access to a family liaison worker, who carry out a family liaison assessment.**

[108] The Triangle of Care approach was developed by carers and staff to improve carer engagement in acute inpatient and home treatment services. The guide outlines key elements to achieving this as well as examples of good practice. It recommends better partnership working between service users and their carers, and organisationshttps://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

	We were told that the Trust received its 'second star' in 2016, following an external assessment, which reflected an achievement of the standards in inpatient and community mental health services. The Trust is now working to extend this into community hospitals and community health services. The Trust has a standing Triangle of Care Steering group that involves patients, carers, voluntary sector organisation governors and staff. The group recently produced a Carers' Charter and guidance on confidentiality and information sharing for carers. **All wards now have family liaison workers[109], who will offer to meet with the family within 24 hours of admission. Families are encouraged to talk about their worries, their concerns and how the Trust can support them.** **We were told that by having that discussion with the family early on in admission it meant staff could develop some terms of reference – so that they understand when a relative wants something different to what the patient wants – and agree how to manage this. It also means that when a case is transferred to Crisis Services or Home Treatment Services, staff can refer to this and continue to build relationships with the families. We have not seen evidence of how the Trust quantifies and evaluates this. It is our understanding that the liaison role is separate to that of the Responsible Clinician whom would still be required to engage with families.** **The views of carers and families are taken into account at CPA review or planning meetings. They do not always want to be included, but where possible, the families' views are taken into account on discharge planning.** **We were told that involving relatives in discussions about every Section 17 leave would not be possible (we were not told why). Whilst we accept that in some cases it is not**

[109] Dr S told us that Mrs S had been offered a Family Liaison Officer but they were told he would not be on the ward long and therefore assumed they would not need the additional support.

	possible to involve a family, in cases where the family is visible in care planning, every effort should be made to ensure that risk assessments capture their views. **We were told that when there's a discharge planning meeting and the person has a leave plan, this discussion will include the family. We do not have Trust monitoring data in relation to this e.g. how often families are not involved.** The Trust has added a requirement that, if anyone is going home where there is someone else (e.g. not family) living in that accommodation, that person needs to be involved in that plan, subject to confidentiality (e.g. the contingency plan). **<u>Aspects still to be addressed</u>** **Whilst this recommendation has been met there is a lack of evaluation and objective evidence that there has been an improvement in family engagement in leave arrangements and discharge planning.** The Trust should be clear as to the circumstances where engagement with family/carer is not possible when agreeing S17 leave.
The purpose of Section 117 meetings need to be clearly explained to patients and family members prior to the meeting taking place. As part of the planning process there should be a detailed aftercare plan.	**<u>Not achieved</u>** **We were told that the Trust has not yet revised its Section 117 policy, and is using one that was in existence at the time of the incident in 2013.** **We were told the delay was because the Mental Health Act Code of Practice states that the policy should be agreed by the Local Authority and the CCG.** **The Trust, Local Authority and CCG has met on numerous occasions to develop a draft policy. The policy remains in draft form and needs to be ratified by the Local Authority. The Trust Managers told us that the Trust is no longer**

	integrated with the Local Authority and that this has created some challenge in terms of forming agreement in terms of use and access to social services. **<u>Aspects still to be addressed</u>** Section 117 Policy needs to be agreed by the Local Authority and CCG
It is not appropriate for out of area patients to be on Section 17 leave from a Somerset ward to a community venue in their county of origin. Consideration should be given to transfer back to the referring ward before section 17 leave is taken outside of Somerset	**<u>Partially achieved</u>** The wording of this recommendation is ambiguous – it is not SMART. **If the recommendation means that Andy should have gone back to a ward in Devon and then got Section 17 leave from there, this would not necessarily have been appropriate or be appropriate for other patients. In response, the Trust has reworded the Section 17 policy to say that it will give consideration to transferring people back to their home county as an inpatient, and then they can consider Section 17 leave in local area if necessary. We have not received any detail in relation to how the Trust monitors this.** **The managers fed back that they have used this recommendation to consider the important issue underneath this: that everyone should be clear about who the responsible clinician is at all times.** **In Somerset now, when someone is discharged into the community, their responsible clinician is transferred to a community doctor. We were told that this sometimes caused confusion during periods of Section 17 leave, where somebody assumes someone else has become the responsible clinician, and that person didn't know they were. Therefore, the Trust has developed an Approved Clinician/Responsible Clinician policy that states the importance of everybody, including the patient and their**

	family, being clear about who the responsible clinician is, including at times of transition. **<u>Aspects still to be addressed</u>** **The Trust need to provide detail in relation to its monitoring of the implementation of the new Section 17 policy, particularly in relation to out of area patients.**

Derbyshire Healthcare NHS Foundation Trust Internal Serious Incident Investigation

This report was written by a team of two people – one manager, who was an RNMH (Registered Nurse in Mental Health), and a Consultant psychiatrist and Clinical Director.

The report was written following Andy's death. His family were involved in developing the terms of reference for the report.

This report adheres to best practice in terms of the way it is structured and written:

- It clearly identifies the Trust lead;
- It answers all of the questions asked in the terms of reference;
- It contains a detailed chronology of events, contributory factors and root cause analysis;
- It references and applies relevant local and national best practice and benchmarks; and
- It contains a "lessons learned" section and an action plan, which effectively addresses outstanding issues and concerns.

All but one of the report's recommendations are SMART (specific, measurable, achievable, relevant and time-bound).

The findings of the investigation clearly link to the evidence and identify issues re:

- Ineffective and fragmented care coordination
- Andy's discharge from in-patient care (Ward 36, Radbourne Unit)
- His Mental Health Act 1983 s136 Assessment
- Medical review & outpatient care
- Crisis medical contacts
- Engagement with the service user's family and use of collateral information
- The Support Worker role in complex CRHTT Care
- Availability of information
- Delays in processing the referral

The report also highlights a complicated picture of polypharmacy and lack of clarity around Andy's medication.

Since the investigation – what has changed as a result and what impact has this had?

We undertook a group interview with the Trust Legal Services Manager, the Director of Nursing and Patient Experience, the Deputy Director of Operations, and the Acting Assistant Director for Clinical Professional Practice to discuss the Trust's progress with its action plan. We set out below details of evidence the Trust submitted to us and what we were told during the interview. We asked the Trust to provide us with evidence to underpin the interview, in some instances this had not been provided at the time of writing.

The last review of the action plan attached to the final SI report was in March 2014. At that time, all of the actions were to be met by May 2014 at the latest (we discuss this below). A number of changes have been made that have impacted on a number of issues relating to this case:

1. **Information sharing**. During the investigation period (in 2013-14) the records were a combination of paper and electronic. Now, the records of all inpatient and community patients are held on a new electronic patient record system (PARIS) system. Senior managers from the Trust, reported that the PARIS system had enabled them to meet a number of the recommendations from the report.

   One change due to PARIS is that letters from a different service provider about a patient, are scanned and a summary or the whole letter placed into the electronic record. All services would then have an ability to access that information

   The managers interviewed about the action plan commented that:

   > *"*[PARIS has] *transformed our information*. *Our campus areas, our inpatient beds being able to talk to all services, some discrete services, someone presenting in A&E, services talking to services... We have a multi-agency safeguarding hub, a MASH service… so police station services, healthcare services all mix to* [communicate with] *each other. If they were concerned about someone and it was a family and it was felt it wasn't being looked into in the Health Service, it could be triggered to that MASH service and they would have full access to the record live."*

   The electronic system has a tracker and audit function which holds a record of which notes are accessed, when they are read, and all entries have a timeline of completion. This function enables the Trust to audit the reviewing of care plans and documents by professionals involved in a patient's care to ensure information is shared throughout the services. We were told that the tracker is routinely used and enables staff to see if a case is known to the Trust. We have not seen details of the Trust auditing use of the tracker.

On PARIS, there is a designated place for assessment of patient capacity, and each patient has a capacity assessment on admission. These assessments are audited for quality assurance. The Trust gave examples of these audits (e.g. Radbourne unit capacity audit November 2017) detailed in its 'MCA Training and Compliance report' (May-November 2017). It also provided details of an audit undertaken by the Lead for Mental Capacity and a Locum Consultant Psychiatrist that looked at capacity being recorded on PARIS. The audit reviewed 240 patients in Derby inpatient units on 8 September 2017. It recorded 95.42% of patients had either a 'Capacity to Consent to Assessment' or a 'Capacity to Consent to Treatment' recorded on PARIS. It was found that 67% of patients had both assessments recorded on PARIS.

The Trust has produced guidance for doctors and nurses about how to use PARIS to record these

2. **Family involvement.** Since the report, the Trust has been rolling out an external accreditation programme for family and carers' engagement called the Triangle of Care. The standards include having a family and carers strategy (which families and carers were involved in writing). The Trust has achieved a second Triangle of Care star for Family Involvement. As part of this, every clinical and operational service had a quality visit by a Board member and non-executive director, to review its family-inclusive practice. Part of this years' initiative is focused on 'family collateral history' which is essentially the involvement of families in contributing to details about their relative's history e.g. their concerns, the signs or symptoms of relapse, constructive means of challenge if you're worried your relative is becoming unwell.

   The Trust also now has a Family Liaison Service, which can talk to people where they disagree with the clinical teams and they want somebody else to talk to about complex family situations.

3. **Communication with out-of-area providers.** The Trust has not been able to arrange a meeting with Cygnet to discuss what safeguards to put in place to avoid this happening again. We have seen evidence that the Trust did contact Cygnet in relation to arranging a meeting.

   Derbyshire now has a PICU Case Manager – a role fulfilled by a Band 7 nurse working in the inpatient areas. The role is specifically to relate to PICU providers in terms of managing care. There is an added focus around managing out-of-area patients and repatriation. In reality, this means that the nurse will travel all around the country to go

and assess people and monitor transfer back to the Trust. The Trust told us the role is similar to an advanced practitioner and is in a position to agree to discharge or leave (or not) and will make transition agreements. Her role looks to ensure there is family involvement in arrangements for transfer and has meant that the Trust has a better idea of the out-of-area patients. We were told there has been some reduction in bed occupancy, improved performance from PICU providers and smooth clinical transitions. We have not had evidence of this being formally evaluated.

The Trust has also recruited some administrative support, called 'flow' coordinators, who help to manage the out-of-areas directory. These facilitate such cases and make sure that other hospitals are in contact with the right people within the Trust.

4. **Trust developments.**

The managers reported that the Trust had received about £1 million for additional investment in the community in 2016/17 year. They told us this will mainly be used on therapeutic activity and personalised planning. In 2015/16, there had been changes in ways of working, moving mental health to a social recovery and wellbeing model of service. Initiatives include locality neighbourhood-based recovery courses, social recovery, psycho-education, a family liaison service, suicide prevention work with football clubs and rugby clubs and walking groups.

Updates on the specific actions in response to the recommendation of the investigation are as follows:

Action	**Final actions, outcomes and impact (updated July 2017)**
Care coordination Review of Care coordination - to include a review of operational practice between Planned Care and Urgent Care, with focus on the Crisis and recovery teams in order to: • Ensure effective overview of all care	**<u>Achieved</u>** **The specific recommendation around care co-ordination concerned a review of operational practice between Urgent and Planned Care, with a focus on crisis teams. It is reported that the policy was reviewed and updated but that, since Andy's death, the community services have been transformed into neighbourhoods. This meant that all operational policies were reviewed.** **Since Andy's death, there have been, meetings between the crisis team and the neighbourhoods to share learning and specific work to address the issues arising.**

being delivered and any necessary internal transfers of care are planned and safe. • Ensure that care coordinator has continuous overview of all care delivered to the patient for whom they are responsible and that all teams/clinicians providing input, facilitate this overview.	**The crisis team review means that now a patient would not be discharged from the team unless they had been seen by somebody who had been involved with their previous care episode. Because PARIS has inpatient, Crisis in the community, Crisis review inpatient and community notes, there is a live log of what has happened to that patient.** **The Trust told us it has reviewed its crisis and home treatment service in light of the National Confidential Inquiry into Suicide, particularly as regards the involvement of multiple Mental Health Professionals in an individual's care. This led to a team-nursing approach, which reduced the number of people's potential contacts and improved continuity, personal knowledge and relationships as well as the formal information and notes. The Trust reported that this has led to reducing the number of individuals involved in patient reviews, for example using consultant psychiatrists rather than having locum psychiatrists.** This initial review also highlighted the volume of activity within the service and the wider challenges it faces. Therefore, a second larger review, looking at the Crisis service is now in progress (we do not know when this is scheduled to finish). This will look at the functioning of the service as a whole, and the level of resource pathway management. This will include the interface between the inpatient unit and at the service functioning and the level of resource pathway management – this will including interfaces with the inpatient unit. Currently the Crisis service is via GP referrals. This review aims to open that up into self-referrals and a wider resource team. This is about having the ability to have a 24/7 service without building a model that could potentially mean that patients see more professionals. Before the publication of the investigation, the Trust had taken other steps to assist consistency of care, such as a patient only

	being discharged from the crisis team by an individual who has assessed them previously in that care episode. The Trust implemented a PICU Case Manager role (discussed above) in July 2016 designed to work with patients and their families/carers in instances when out of area placements are required. The PICU Case Manager undertakes gatekeeping and case management for PICU patients. The PICU Case Manager told us[110] that this entailed ensuring patients were appropriately placed as per NAPICU[111] Guidelines, and that they have a clear/appropriate treatment plan, implemented in a timely manner. The PICU Case Manager is also responsible for overseeing their return to local services – subject to documentation and communication between providers and the Trust. As part of this process the PICU Case Manager will attend multidisciplinary team meetings and CPA case conferences, share information about the patient with providers and develop a good knowledge of the individual and their biopsychosocial needs. At present the Trust has 5 contracted male beds at Cygnet Bradford, 1 contracted female bed at Cygnet Coventry, and from 1 November 2017 an additional female contracted bed at NHS Leicestershire PICU. Hardwick CCG has recently asked for expressions of interest from private providers who wish to provide PICU facilities within Derbyshire for the Trust. The PICU Case Manager told us that having contracted beds with PICU providers gives the Trust easier access to beds and helps to build positive working relationships with the external provider and the staff. The PICU Case Manager is able to visit more regularly and monitor the quality of service. The Trust receives regular written and verbal progress reports from providers which

[110] The Trust submitted a written statement from the PICU Case Manager in response to a number of queries we had raised.
[111] National Association of Psychiatric Intensive Care Units (NAPICU) NAPICU provide guidance for secure service in the UK.

	are subsequently scanned into PARIS. The PICU Case Manager told us that liaison with families and carers had improved because her role served as a single point of contact for the PICU and patients. We have not seen evidence of any assessment and/or evaluation of the impact of this role in terms of engaging with families. The Trust has drafted a policy and procedure for PICU transfer which is currently awaiting Commissioner sign off (we were not told when this is anticipated). We were told that the intention of this policy is to provide guidance for staff about the process and rationale for transferring a patient to a PICU. We note that the PICU Case Manager is in place and presumably working to Trust policy in relation to PICU transfers. **The Trust reports out of area placements nationally and benchmarks against other Trusts. The Trust gave us monitoring data for out of area placements per week between April 2013 and December 2017. There are periods in which out of area placements were down to zero - most recently in December 2017.** The Trust is working with NHS Improvement (NHSI) on a quality improvement programme ('Red2Green[112]') to reduce the number of out of area placements/length of stay by improving the quality and effectiveness of the service. The Trust told us the programme is still in its infancy but there is evidence from other Trusts that the programme does produce positive outcomes. The Trust anticipates that it will see improvements in early 2018. The CCG monitors the performance of the PICU providers – the Trust also monitors performance. The Trust told us that it does not have a substantial number of SIRIs in relation to transition

[112] https://improvement.nhs.uk/improvement-offers/red2green-campaign/

	and as such, we were told, it is not considered to be an area of concern. We have not seen any benchmarking evidence. **<u>Aspects still to be addressed</u>** **Continuing to consistently reduce the number of out of area placements** Evaluation of the implementation of Red2Green
Mental Health Act 1983 The outcome of the investigation should be fed back to [A&E Doctor 1[113]] through his educational supervisor with a view to him accessing training to develop his skills in talking with carers and ensuring that their concerns are listened to within the framework of proper information governance	**<u>Achieved</u>** **The expected date for completion was January 2014. It was reported that this was carried out by the Clinical Director within the specified timescale.**
Medical review and Outpatient care Junior doctors to have closer consultant support and supervision both before the appointment to ensure a clear understanding of the role of the sector consultant in providing a clear formulation and clinical leadership in managing	**<u>Achieved</u>** The specific actions identified to meet this recommendation were: • Case review with reflection on applying lessons learned from this incident; and • Review of junior doctor supervision practice No information is available about this recommendation about how this case was reviewed and lessons learned. However, managers commented that this may have been superseded by

[113] We have used our own anonymisation

someone with a complex history. And, to make sure the old notes are reviewed and understood; to ensure that the assessment had been adequately comprehensive and that there had been adequate liaison between the doctor and the CPC (and other agencies) and any follow up arranged is adequate**.** Request for more information from external agencies and trusts should be followed up with the support of the medical secretary to ensure that the information sent through is available in the medical notes.	the community services moving into neighbourhoods (i.e. community services have moved to a neighbourhood model). Since 2017, the Trust has been talking to its junior doctors about their supervision and support, including what support they get from their consultants. We were told that the junior doctors had fed back and attended boards to say that they felt they are now getting more regular supervision, that things are improving and they feel more supported than they have been. The Trust gave us reports from the East Midlands office of Health Education England (HEE EM) for 2014 and 2015. The feedback said that all trainees receive supervision and that no one was made to work beyond their competence. There were concerns about trainees not being supported by Locum Consultants in busy clinical areas. We were told that trainees are generally not placed where there is a predicted Consultant vacancy. If a Consultant leaves midway through a trainee's placement, Locum Consultants are supported by the Associate Directors of Medical Education (ADMEs) or the trainee's placement is moved. We were told further feedback can be obtained via DATIX reporting to identify any patterns of clinical practice shortfall. These are linked with patient case scenarios and any learning and systematic changes are facilitated through weekly inpatient business meeting which Clinical Supervisors attend (junior doctors are timetabled to contribute to these). There are also weekly junior doctor meetings, weekly experiential sessions, a weekly teaching programme and monthly meetings with Tutors. The Trust has Tutors (ADMEs) for Foundation, GP and Psychiatry Trainees in Derby and Chesterfield. There are also tutors for undergraduate students. Feedback is provided by external reviews and trainee's anonymised end of placement feedback (the Trust gave us examples of completed feedback form). The Trust Director of Medical Education told us (in writing) that all junior doctors receive an induction when they join the Trust and

	they have individual trainee led and clinical area led workplace training. Trainees have access to education staff and their Tutors. Leading from this, staff participate in regular clinical operational meetings which are supported by the educational admin staff to ensure resources are available. Junior doctors are entitled to reflective learning, Work Place based assessments and weekly one hour protected supervision. There is more medical supervision of their juniors and a medical training survey has substantially improved in the outcomes for trainees. We do not have any further detail about this survey in terms of when it was carried out and by whom. We were told that the Trust conducts a supervision audit and that the medical education (supervision numbers) are captured as part of the audit. We have not seen details of these audits and results. **In terms of accessing clinical information from other Trusts and agencies, we were told that electronic patient record ensures records can be accessed more quickly. Medical secretaries and administrative staff are now based in the same building as the doctors and the team for the neighbourhood. We were told that though the information system is key to patient information, the support staff have a fundamental role in bringing together information.**
Crisis medical contacts Discussion with the Trust Medical Director re the performance concerns Feedback to [Consultant 11] from the Clinical Director For formal supervision from a more senior consultant for a period of at least 12 months	**<u>Achieved</u>** **Managers reported that there was a separate individual investigation into one doctor which concluded with no action required. Nevertheless a period of 12 months' formal supervision was undertaken by the Clinical Director.**

Discharge The discharge of Andy is subject of a clinical review by the team on ward 36, with a view to learning the lessons. A new procedure 'Discharge Against Medical Advice' (DAMA) is developed this should include • A recommended 'cooling off' period prior to a person leaving the ward. This time to be used to debrief the patient, to review reasons prompting the early discharge together with exploration of steps that can be taken to make the patient agree to continue the ward programme. • Steps to be taken to provide adequate after care and rapid follow up, including consideration of Home Treatment. • Family/carer support	**<u>Achieved</u>** **The specific action to enable the Trust to meet this recommendation was that it would develop a new discharge against medical advice (DAMA) procedure containing the recommendation elements. The latest version of the policy (issue 3) is dated March 2015 and called 'Discharge, Transfer/Transitions and Leave Policy & Procedure for people with mental health difficulties'.** **The Trust told us that the policy and the form were updated by the Medical Director. The wording was updated, in relation to the Mental Health Act and Mental Capacity Act, both of which have helped direct some of the points raised in the SI report e.g. family involvement in decisions and a cooling off period prior to discharge.** **Alongside this, a new Medical Capacity Lead was appointed. Part of the role is to conduct audits of patient consent to treatment, and, to work with medics to improve practice performance. A Mental Capacity and Mental Health Act lead also delivers training to Trust staff. The Trust has appointed a Clinical Lead who reviews care plans and capacity assessments and talks through any issues with the medics. We do not know how the Trust monitors this role and whether this had led to any change in practice.** **We were told that if the relatives of the patient and/or the patient do not want to be discharged on a particular day, there will be a 24-hour cooling off period[114] so that they can make alternative arrangements for discharge, and to assess the concerns the patient has. The Trust Legal Services Manager told us he was aware of patient discharges being delayed in response to last minute changes to accommodation or if alternative arrangements needed to be**

[114] "Wherever possible a family or care view on the risks and issues should be sort. And a pause or inbuilt agreed delay of 24 hour or 48hours to ensure family carer collateral information has been sought and a planning meeting to occur, to ensure safe and effective discharge should be offered wherever possible."

	sourced by the patient or their family, but we have not seen further detail of this. **We were told that the involvement of relatives in the discharge against medical advice policy has now improved, as part of a general improvement in communication with relatives. However, this is quite a difficult issue in practice, due to the time pressures involved in managing a DAMA. It is acknowledged that although it is important, it is quite difficult to implement.** **We were told that the Trust undertakes community follow-up within two days of discharge where there has been a *history* of serious harm/suicide attempt – this goes beyond *current* risk. We are unclear if this is directed by Trust policy and/or guidance. A history of harm is a statistical point of risk in the National Confidential Enquiry into Suicides; current risk is a standard recommended by NICE guidance.** **The Trust told us there is now more knowledge around the Mental Capacity Act backed up with all the information which is freely available on PARIS. We do not have any evidence of how the Trust has quantified this.** **Managers' report that impact is difficult to quantify because at the point of discharge, there is a cooling off period in which to decide if someone wants to leave. However, it is reported that knowledge about capacity has improved (we do not have evidence of how this is quantified) so the managers would be confident that capacity to make a decision to leave would be assessed at the point of leaving. We were told – but have not seen evidence – that staff (nurses rather than medical staff) have sought a second opinion and advocates or Healthwatch have intervened and discussed what is in the best interest of the patient, and whether there is a need for a**

	strategy meeting. In the last year, there have been no incidents relating to post-discharge against medical advice. The Trust provides an e-learning package as part of the MCA module which is to be a 3 yearly competency requirement on mental health professionals' passports. This time frame would be brought forward it there was a change in MH law that staff should be aware of. The e-learning module is supplemented by face-to-face training provided by the MCA/MHA lead, the Medical Appraisal and MCA lead or Legal Services manager. For certain specialist areas (e.g. learning disabilities), face-to-face training is delivered in conjunction with a clinical lead from the relevant area. In addition, 'on the ward' training for staff is provided by the Practice Development and Compliance lead. This training is designed to help staff improve the quality of their care plans and patient documentation in relation to MCA. The Practice Development and Compliance Lead, and, Medical Appraisal and MCA Lead, undertake compliance audits and provide feedback to staff. We do not have details of how many staff have undertaken the above training and how the Trust monitors and audits this. The MCA assessments are recorded centrally on PARIS. Guidance is available for staff completing MCA and Best Interests assessments. We have not seen detail about how many staff have undergone this training and how the Trust is monitoring and evaluating its use/impact. **The Trust told us that family involvement in capacity assessments is twofold – to provide collateral information prior to assessment (and then on an ongoing basis); and**

	attend the assessment, subject to patient consent (or in their best interests if the patient cannot consent), if it is felt it will empower the patient to make decisions or express their views better. The role of families and carers in capacity assessments varies considerably according to the patient. The Trust MCA policy (2016) has a prep sheet for MCA assessments that includes the involvement of families[115]. The Nearest Relative will also be consulted if the patient is detained under the MHA. The point of capacity is revisited in ward round where families are often present.
Family Engagement and Use of Collateral Information Engaging with family or carer should be embedded into training both for clinical risk management and the role of care co-ordinator. Family or carers should routinely be asked to participate as facilitators for this training.	**<u>Achieved</u>** The specific action against this recommendation was that the Trust should develop training material to specifically identify contribution of carers/family. **Managers explained that the Triangle of Care involves training – including video podcasts with families and carers talking about how they are involved. The Trust has achieved 2 stars for Triangle of Care[116] for family involvement.** Families and carers were involved in developing and presenting the Trust submission. They were also involved in writing the Family and Carers strategy and subsequent training development for the Triangle of Care. Family and carer involvement has been evaluated externally as part of the Triangle of Care accreditation process. **The Trust is also including the Think Family approach in its Safeguarding Adults and Safeguarding Children training. By the end of 2017, 85% of the clinical workforce will have been trained in Think Family.**

[115] Under MCA guidance a family should also be involved in any decision made in the best interest of the patient
[116] https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health/triangle-care-membership-scheme

Support Worker role in CRHTT The role of support workers in the CRHTT should be reviewed to ensure the support for this role is robust. Information collected by support workers on home visits should be subject to immediate review for 'Red' and 'Amber' cases	**<u>Partially achieved</u>** The specific action identified to meet this recommendation was that there should be a review of the role of support workers in CRHTT and an update of the policy. The managers reported that this was led by the consultant nurse within the crisis team. The team had reviewed the issues around the role, and gathered the learning around it and that was embedded in the policy update. **It is reported that the impact of this has been that support workers in the team have a better level of *clinical support.* Much of this relates to liaison and support work. It is reported that it is difficult to quantify this – we do not have any detail as to how the Trust feels this is being achieved. We are unclear as to whether the Trust has undertaken audit work or any analysis of the support worker home visits.** We were told that the Trust undertakes reviews of all its CMHTs via quality visits (conducted by Non-Executive Directors and Executives). The Trust's most recent CQC inspection (2016) rated adult CMHT as requiring improvement but highlighted that substantial levels of innovations, including initiatives such as 'Spireities[117]' and recovery projects. **<u>Aspects still to be addressed</u>** The Trust to provide detail of any audit/monitoring work in relation to clinical support given to support workers.
Clinical information Requests for more information from external trust's and agencies should	**<u>Achieved</u>** This recommendation focussed on three issues:

[117] This is a programme undertaken with Chesterfield FC Community Trust designed to motivate people and improvement their mental and physical health through adopting a more active lifestyle. Football is used as the motivator to support change.

be followed up with the support of the medical secretary to ensure that the information is available in a timely manner in the medical notes. [We note this recommendation has been previously listed under Medical Review and Outpatient care] In complex, or high risk cases, or longer term admissions in any setting a case summary (CareNotes[118] case Summary Document) should be completed by the care coordinator or community or in-patient Consultant. Information provision for MDM[119]s should be reviewed to ensure that a bio-psycho-social review is informed by objective observations based on the assessed and presenting needs of the patient	1. The first was how to access clinical information from external Trusts and agencies. The managers reported that the use of their new electronic patient record system would have improved this. **We were told letter or discharge summaries from other Trusts are now scanned in to the records, which means it will now get into the clinical record more quickly, and will stay in the clinical record because it will remain there as collateral information. This contributes to historical safety planning instead of a safe risk assessment, it helps clinicians to consider the longitudinal risks.** Administrative and medical secretaries are now in the same building as the doctors and the team for the neighbourhood. We have not seen any monitoring/audit data. 2. The second aspect of this recommendation focussed on clinical information in the case of complex or high risk cases, or longer term admissions. **The managers reported that the Trust has changed the way it assesses risk and has also changed the documentation and the assessment behind the FACE risk. It has moved to a safety planning process which, if someone was new to the area, would be completed on their initial assessment or ongoing assessment. If they have been previously known, it would be in their history, but a much fuller record of risk and referred to in a wider range of risk management. It plans to take this to the next level to involve family members' which will mean the assessment will include even more level of detail.**

[118] Carenotes was the Trust patient record system used before PARIS.
[119] Multi-Disciplinary Meeting. These are more commonly known as Multi-Disciplinary Team (MDT) meetings.

	The new document is in two parts: **1. A summary of what the person feels keeps them safe and what we the clinicians have identified with them going forward might help them feel safe in the future.** **2. Identification of specific risk areas, so if somebody is feeling particularly suicidal or if they are at risk of self-neglect, there are particular criteria against which the clinician can assess whether there was historical risk or a current risk. In a rapid assessment situation, the document supports more rapid clinical decision-making.** 3. The third part of this recommendation concerned information provision for multidisciplinary (MDT) meetings to be reviewed, to ensure that a bio-psycho-social review is informed by objective observations. We were told that staff adopt a bio-psycho-social approach in MDTs as a matter of course. However we have not seen evidence of how this is reviewed. **The Trust told us it is assured that the PARIS system has improved sharing information with other Trusts and external agencies because it enables staff to have 24hour access to patient notes. For example, if a patient attends A&E, the Mental Health Liaison team can access their CMHT/Crisis notes in advance of any assessment. This information will inform the clinical plan. PARIS has a designated section entitled 'external documents' where documents from other providers can be uploaded/scanned. Once uploaded these documents can also be found in the 'chronology' section of the patient record.** We note that the above demonstrates that there is an information sharing pathway in place but we have not seen evidence of assurance that staff do share information with other Trusts.

	Though staff can access information they remain reliant on others ensuring its transfer. **The Trust has adopted a Safety plan (moving away from FACE risk) that is less numerically based and focuses more on a qualitative risk which encompasses the patient's history. There is a specific section within the plan that has questions for families and carers and their comments.**
Administrative procedures The administrative process should be reviewed with regard: • The handling of misdirected clinical letters • Procedure for managing mail during a leave of absence	**<u>Achieved</u>** The managers reported that this recommendation has been achieved; the Administrative Lead reviewed the process and met with medical secretaries. Since then, because of the changes to the electronic record, much of this has changed anyway. However we have not seen evidence of these changes and/or any subsequent audit/monitoring. Managing mail during leaves of absence would not be impacted by the electronic patient record. However, this has been followed up in the form of briefings about people covering for each other and opening each other's mail. We have seen the minutes of Medical Secretary meetings[120] that discuss administrative support in relation to incoming post and data access requests; and cover for annual leave and sickness. Cover includes opening post and any urgent work for Consultants. The minutes we have seen are high level summaries e.g. "*Discussed that cover should also include opening the mail and any urgent work for consultants. Secretaries stated that this was done and consultants were emailed if there was anything urgent."* The minutes do not detail any staff concerns or ongoing issues/challenge.

[120] November 2016, January 2017, May 2017, June 2017, August 2017, September 2017,

Concerns over medication management: Escitalopram/ Citalopram The drug and therapeutics committee will be asked to review the situation and provide trust guidance. The committee will also be asked to raise this at the district forums.	**<u>Achieved</u>** The specific action identified to meet this recommendation was that the drug and therapeutics committee would be asked to review the situation and provide trust guidance. The committee would also be asked to raise this at the district forums. **The managers reported that the prescribing of these drugs has now changed and is described in the drug formulary.** **Access to Escitalopram for patients who had already been prescribed this medicine, or had responded to Escitalopram in a previous episode, was put in place in 2015 because it was reclassified (previously it had been classified as not routinely recommended).** **Derbyshire Medicines Management and Prescribing Guidelines[121] classify Escitalopram as 'Brown[122]'. It outlines two circumstances in which it can be prescribed:** ***"1. For patients who have already been prescribed Escitalopram and who are responding to the treatment.*** ***2. For patients who have had a good response to Escitalopram for a previous episode after formulary choices or now require an antidepressant, following recommendation from a tertiary centre".*** We have not seen evidence of this being raised at district forums.

Regulation 28 Report to Prevent Future Deaths

The Coroner wrote to Derbyshire Healthcare NHS Foundation Trust after Andy's Inquest, on 7 November 2016, requesting a formal response to a number of questions (Regulation 28 Report to Prevent Future Deaths). We set out details of the Trust response to the questions

121 http://www.derbyshiremedicinesmanagement.nhs.uk/home/full_traffic_light_classification/show_drug/Escitalopram/

122 *"Lack of data on effectiveness compared with standard therapy"*

(sent to the Coroner in December 2016) but note that much of its response is superseded by what is set out above in relation to its action plan:

1. *Mr* [Andy] *was treated by in excess of 30 Mental Health Professionals in the absence of an effective and overarching care plan which resulted in essential key personnel in Derby, i.e. three consultants being* [un]*aware of essential information that would have impacted and modified his management and treatment.*

The Trust advised that PARIS had been implemented for all community patients and that steps were being taken to implement the service across all inpatient wards by March 2017. Any paper correspondence received was scanned and entered on to the electronic patient record, and therefore available to inpatient and community consultants.

In the case of Andy, this would mean that the letter sent by Consultant 2 would have been scanned into the electronic system and available to the community and inpatient teams.

Correspondence and care plans are now available across community, crisis and home treatment and inpatient services. There is also a tracker and audit function which records when notes are accessed and all entries have a timeline of completion. We have not seen detail of this audit/monitoring.

In relation to the number of Mental Health professionals involved in Andy's care, the Trust advised that it was reviewing its crisis and home treatment service, in view of the National Confidential Inquiry into Suicide. Specific attention was in relation to the involvement of numerous healthcare professionals in a patient's care. It added that the development of the electronic patient record would make it easier to identify the clinicians involved.

2. *Mr* [Andy]*'s care and management at Derby was process driven which was confined to risk assessment and management without evidence of significant therapeutic intervention of his complex psychosocial needs. The Independent Expert described the management as no more than putting out fires.*

The Trust response acknowledged Dr A's comment about 'risk managing' Andy, but added that Dr A had not attached criticism to this, and that he had noted the Trust's approach to Andy to have been dictated by his clinical presentation i.e. that Andy was too unwell for therapeutic intervention.

The Trust advised that it was *"committed to providing safe, effective clinical support to its patients"* and was developing its neighbourhood service to improve therapeutic and social recovery care and treatment. The Trust referenced the forthcoming implementation of the Triangle of Care (which has since been achieved).

3. *Mr* [Andy]*'s discharge from Somerset back to Derby and into the community was inappropriate as he had been commenced on clozapine but not stabilised. The independent expert was of the opinion that Mr* [Andy] *should have been admitted back to a bed in Derby for further assessment. Again, this was reflective of ineffective care co-ordination as the Derby Care Co-ordinator failed to appreciate the significance of commencing him on clozapine and discharging him to home when had obviously complex psychosocial needs.*

The Trust advised that Cygnet hospital was responsible for Andy's discharge to the community and that it could not influence the discharge decisions of clinicians it does not employ or fund. It advised that it would share the Coroner's letter with Cygnet and ask that they provide assurance in relation to learning from Andy's case.

Devon Partnership NHS Trust Independent Investigating Officer's Report

Devon Partnership NHS Trust produced two independent complaint reports in response to Dr S' complaint submitted to the trust after Andy's death. The first is only briefly mentioned here as it was superseded by the second. However, Andy's family had sight of the first report, which they considered to be of poor quality, poorly evidenced and judgemental of Andy.

The second, revised independent complaint response is comprehensive. It overturns most of the judgements of the previous report by referring to evidence rather than quoting legislation.

As a response to a letter of complaint, this report does not have terms of reference as such. However, it deals with each of Dr S's complaints in turn and incorporates any lessons learned as it addresses each complaint.

There is a separate action plan, which addresses outstanding issues or concerns. However, not all of the issues raised led to a recommendation.

This is the only one of the four reports reviewed that considers the role of the police in terms of legislation and best practice. However, this did not lead to a recommendation.

The other specific issues that the report addresses, which are not addressed by other reports are:

- Crisis care
- Frequently moving inpatient settings
- Lack of agreed use of medication when Andy's condition deteriorated

Since the response to the complaints – what has changed as a result and what impact has this had?

The last action plan on file was sent as a draft for Andy's mother to review in November 2015. This was updated via a telephone call with the Trust's Deputy Director of Nursing and Practice and Andy's mother in January 2016.

We spoke to the Trust Deputy Director of Nursing about changes at the Trust since the response.

A number of changes have been made:

1. The Trust introduced a two-year programme called the **Four Steps programme**. This focused on reducing the frequency and severity of violence and aggression in all inpatient wards. The programme, implemented in 2015, was developed in collaboration through the Health Foundation with South London & Maudsley NHS Foundation Trust[123].

The programme focused on improving four areas on wards: patient engagement, proactive care, teamwork and the environment. A toolkit was developed as part of the programme, which included an observational predictive tool, a structured communication tool and a formalised structure to review and escalate risk. The aim of the programme was to increase patient and staff wellbeing whilst reducing violence and aggression.

Four Steps focused on how staff worked with patients admitted to the inpatient wards. One of the biggest issues is around the therapeutic engagement process, in terms of how staff develop a rapport and therapeutic relationship with somebody. If somebody is

[123] See https://www.slam.nhs.uk/patients-and-carers/4-steps-to-safety

becoming aggressive because their needs are not being met, and they are not wanting to engage, this is about the strategies staff can use to help them.

Another part of the Four Steps programme was to employ a range of strategies, which, not only looked at environmental factors, but also ensured staff actively engaged with patients on a regular schedule ('intentional rounding'). This was viewed as a more proactive approach because it meant patients knew that staff would be regularly available to support them. There is evidence and research about the work that has been done, particularly with South London & Maudsley NHS Foundation Trust (SLaM), to indicate the strategies can reduce violence and aggression by up to 55%.

The formal rollout of the programme across all inpatient wards in the Trust was completed in September 2017. As a result of the programme changes in practice have been incorporated into local induction, relevant clinical policies and training; it is also monitored via the Trust's performance dashboard. The Trust told us that there is a commitment to maintain a partnership with SLaM.

We were told that current analysis of the accident/incident data using Statistical Process Control Charts – by both Trusts over the period of the programme - indicates a significant reduction in violence and aggression across wards. The Trust submitted monitoring data from August 2014 to May 2017 that showed 85% of wards had a reduction in violence, 60% in physical violence and 25% in verbal aggression. The Trust reported 13 out of 19 wards had a reduction in physical violence; and that 9 of the 13 had a reduction in verbal aggression. One ward had a significant reduction in verbal aggression though the level of physical aggression had increased. Three wards had seen an increase in physical and verbal aggression. Five wards had reduced their use of seclusion and/or physical restraint. We do not have information in relation to monitoring police attendance to the ward or Taser use (by the police).

A formal evaluation of the programme by Kings College is due shortly, though we were not given a timeframe for this (originally advised as the end of 2017).

2. Although it did not lead to a recommendation, the Trust was asked for an update on the **role of the police in dealing with aggression on the wards.** The Deputy Director of Nursing reported that the Trust has a draft policy for police being called into the ward ('Calling the police to Assist with Incidents on Wards') and where there is the potential for Tasers to be used. This also includes the care and treatment of patients afterwards. The

policy is yet to be ratified. The Trust also has a new multi-agency group that meets quarterly, and has agreed joint agency protocols around such things as Tasers. The Trust has a 2015 procedure for 'Aftercare of those who have been exposed to PAVA (Captar) spray or Taser devices').

The Deputy Director of Nursing said that ultimately they should not need to call the police if the Trust has robust policies and procedures in place. It should be an exception. We were told that the Four Steps programme reduces that need but were not given figures/evidence to underpin this view. He acknowledged that there was a period when acute wards would immediately dial 999, and, that the police might intervene if they saw a violent situation.

The Trust has developed a joint protocol with Devon and Cornwall police which is currently being finalised.

We were told that the Trust now has safer staffing on its inpatient wards. The Trust has provided us with details of monitoring vacancy and agency use for a three month period (see below). The Trust produces a monthly Safer Staffing report which goes to the Senior Management Board. The report details vacancies, clinical and staffing incidents, bank and agency cost and usage, RAG ratings of inpatient wards, and a breakdown by service (e.g. older peoples and secure services). The Trust gave us copies of the reports for July, August and September 2017. The September report detailed a drop in inpatient ward vacancies from 56.22FTE (Full Time Equivalent) to 49.62FTE. A decline in RMN vacancies was reported from May 2017 to September 2017 (76.16FTE to 49.62FTE). The September report also said that agency placement for inpatient services were 15FTE, reducing the actual deficit of qualified nurses in post from 49.62FTE to 34.62FTE. Inpatient wards were, on average, working with -1.7FTE qualified nurses.

The evidence provided by the Trust provides a helpful snapshot of staffing at the Trust but we are not in a positon to comment as to whether it is consistently adhering to safer staffing.

We were told that recruitment and retention remains challenging, but the Trust has a better skill mix, better staffing establishments and fewer beds on the wards. In terms of quality improvement, this has reduced incidences of aggression and also improved the therapeutic aspect of the inpatient wards[124]. When Andy was an inpatient, wards had 25

[124] The Trust provided us with detail of incident recorded between August 2016 and July 2017.

beds. Now, there are 16 beds on each ward. The Trust is in the lowest quartiles for beds per 100,000 (detailed in its Urgent Care Pathway outline business case).

3. Since Andy died, The Trust has improved continuity by reducing its number of **PICU providers**. Cygnet Hospital Kewstoke in Weston-Super-Mare has the PICU beds for men. It works with Cygnet Group for female beds, which are between Bristol and London (these are dedicated beds to ensure continuity). The Trust has service level agreements with these providers to ensure that they meet the Trust's requirements, not only their threshold but also the timing and repatriation of people back into local services.

   At the moment, the Trust does not have a dedicated PICU ward. It will open a 10-bedded ward in Exeter in 2018.

   The Trust has also developed and recruited a PICU 'Unplanned Care Repatriation Coordinator' (PICU Repatriation Coordinator) post in the bed management team. The role is line managed by the Safe Staffing and Bed Capacity manager. This post links regularly with the PICU providers and reviews and works with local teams to agree the care pathway for those people once they are in the PICU.

   The post holder liaises with the multi-disciplinary teams responsible for PICU and Acute patients. The post holder attends Cygnet Hospital Kewstoke twice a week for ward rounds on Nash (male PICU) and Sandford (male acute). The post also attends Cygnet Coventry (female PICU) roughly twice a month to attend ward round or receive feedback from the Cygnet MDT. They assume a similar role with other providers in the event of a patient being placed in alternative locations. The post holder chairs the twice weekly PICU conference call that takes place on Mondays and Thursdays. Nursing representatives from Cygnet Kewstoke and any other PICU providers partake in this call to provide feedback about patients' recovery and timescales for stepping down to acute services. These calls in turn feedback into the tri-weekly Trust meetings.

   The Trust told us it has procured a single PICU provider (April 2017- March 2019), through competitive tendering, which it described as having enhanced quality and safe care, improved clinical outcomes, reduced length of stay, improved patient/carer experience, enhanced clinical relationships between the Trust and PICU provider and is closer to Devon. We note the positive aspects of these statements but have not seen details of

how the Trust monitors this (e.g. clinical outcomes) and how it quantifies improved patient and carer experience.

Access to the PICU is gate kept through the CRTs based on clinical need and risk assessment. There are twice weekly PICU conference calls with clinicians from Devon and the PICU provider to monitor patients' progress. The PICU Repatriation Coordinator visits the PICU on a weekly basis to review patients with the clinical team and to sense check the clinical environment.

We were told that these changes had led to a reduction in PICU activity. The number of patients in PICUs has reduced from 20 – 25 to 10 - 15 people in PICU.

Updates on the specific actions in response to the recommendations of the complaint report are as follows:

Action	**Final actions, outcomes and impact (updated July 2017)**
Guidance to be reviewed in the context of two policies: 1. Promoting Safe and Therapeutic Management of violence and Aggression; and *2.* C11 Physical Intervention Policy	**Achieved** Both policies have been reviewed, updated and ratified. **The physical intervention policy is supported by the Four Steps programme and training, which has been significantly changed. The policy remains clear about maintaining restrictive policies and guidance, but now ensures that where physical interventions are required, staff use the most up-to-date approaches, and are less physical as possible.** It is reported that the Four Steps programme has helped the Trust with these two policies.
1. Invest in the procurement of an electronic health record. 2. Embed Practice Consistency Guidance	**Achieved** These recommendations arose from the complaint about the lack of continuity of care and appropriate care For Andy in the hospital. There were three recommendations. **1. Investing in the procurement of an electronic health record. The Trust has had electronic records for 5**

following the transition to care notes (August 2015); ensure this identifies an expectation of a completed Crisis/Relapse Management Plan and ensure individuals are aware of the option to develop an advanced directive. Manage via Performance Information. 3. Review quality measures for care records – ensuring that this includes a Crisis/Relapse Management Plan	**years but, in the last 18 months – 2 years, it has moved from RiO to Care Records[125]. The Deputy Director of Nursing told us that using electronic records has helped continuity of care. The impact of this on the wards is that, because progress notes are updated on every shift, here is a live document running all the time. We were told that all the clinical staff are trained to be able to enter progress notes electronically on a consistent basis but we have not seen evidence of how this is monitored. In terms of continuity, we were told that handovers are managed by projecting the live data feed onto screens.** **2. The Trust has developed a set of standards for urgent care (e.g. those in crisis or relapse), particularly as it had a number of issues with care planning and ensuring continuity between the inpatient ward, the crisis team and the generic community mental health teams. These are part of the Trust's clinical record monitoring, which means that they are audited by the adult directorate. The impact of this is that now it would be possible to see crisis contingency care planning for those people who are also in the community. For example, in the case of Andy, the triggers around his behaviours that changed according to what was happening from a mental health perspective, and also from an environmental perspective, would be more available to staff. Leading from this they would be able to see what sort of interventions would be helpful.** **3. Reviewing quality measures for care records and ensuring that a crisis or relapse management plan**

[125] Both RiO and Care Notes are Electronic Patient Record systems

	is included. The Deputy Director of Nursing told us the QRCRP (Quality Review of Clinical Records Programme) has been in place since May 2016, and that different services went 'live' at different times. The Trust aims for this to be completed by the end of the year. The Trust gave us copies of quality audits (individual and collective RAG feedback) of clinical records which evidenced ongoing monitoring. The Trust gave us a copy of the QRCRP monitoring standards and told us that the areas reviewed changed every 8 weeks as agreed by Directorate Governance Board.
Policy and continuous staff development to be addressed by the Trust. The Trust ensures that its policies and training are compliant with these new guidelines (linked to complaint 1)	**<u>Achieved</u>** This recommendation arose from the complaint that Andy's mental health symptoms were criminalised rather than being dealt with by the staff. The recommendations pertained to policy and health staff development and ensuring that these were implemented and staff were compliant. In November 2016, the Trust reported on the action plan that it had been involved in a quality improvement programme which should be completed in September 2017. As an update, the manager reported that the Trust is now much more focused on quality improvement initiatives. **In the last two/three years, the Trust has been focussing on getting the basics back in place and having an overall Policy Improvement Programme. The Four Steps programme has led to work around engagement in the care planning process and the assessment process. This is supported by a number of policies, for example giving people dedicated one-to-one, therapeutic and protected time on wards. Provisional findings from the programme have reported a reduction in aggression and violent**

	incidents on wards (the Kings College evaluation is due in early 2018). **It is reported that the impact of this focus on quality improvement has led to a reduction in aggression and violence, improved engagement and observation of people, a reduction in patients absent without leave (AWOLs) and a reduction in calls to the police.** The Trust gave us a copy of its quality dashboard that illustrated a reduction in AWOLs between August 2016 and July 2017. Management and monitoring of AWOLs has been within clinical directorates for the past 3 years. The last Quality Improvement initiative was led by the practice development staff in the adult directorate in 2016. Within the Adult directorate they have worked on re-launching the AWOL bundle via inpatient workshops and used learning from an RCA to support work. This is incorporated in the Trust Missing Person policy. **The Deputy Director of Nursing told us that Mental Health Act training in the Trust is more robust than it was five or six years ago. The Trust's Mental Health Act office provides a range of staff training, both online and face-to-face, which includes the Mental Capacity Act and Deprivation of Liberty Safeguards.**
Errors in patient record re: past personal history, psychiatric history, the recording of what happened during Andy's 2010 admission and forensic reports completed in 2012 and 2013. The complaint was that these errors influenced staff	**No recommendation was made in relation to this complaint and it links to the previous complaint. However, an update from the Trust is that the Trust uses supported engagement observations on admission. These are a key indicator and involve a 72-hour assessment, through which the ward agrees the level of observations required. This requires ward staff to undertake a number of interventions to help them gain a better holistic picture of somebody and their presentation, which makes them better able to handle any deterioration.**

perceptions and treatment options.	
Lessons not learned about Andy's sudden deterioration and the urgent need for consultant input.	**Achieved** The recommendation refers to the action recommended for complaint 2 to deal with this issue (relapse plans). **The Trust has recruited an 'unplanned Care Repatriation Coordinator' role to review the care of individuals placed on an urgent basis outside of Devon. Please see page 138 for more information.** The Four Steps programme has led to better identification of the need for escalation and involvement of consultants (see previous update).
Continuity of care and need to move Andy.	This has been covered earlier in the action plan update. It did not include a recommendation. The Trust has developed two new posts: **1. Out-of-Area Urgent Care Co-ordinator – to review the care of individuals placed on an urgent basis outside Devon.** **2. PICU Repatriation Co-ordinator – who overseas and manages the caseload of those in PICU beds and arranges their safe return to local services.** **In November 2016 a block contract for Devon based PICU (10 beds) was awarded to Cygnet Hospital Kewstoke.**
Managers and staff to consider whether they would respond to a similar incident differently in the light of subsequent guidance from the Department of Health	**Achieved** The Trust told us that this is covered as part of the Four Steps programme which focuses on positive and proactive care (see above for further information). It is also covered by the new PUMA (Positive Understanding of the Management of Anger) syllabus, the staff guide which has

(DH) "Positive and Proactive Care"	been drafted but not signed off. The PUMA syllabus extends to all inpatient staff.
As a Devon resident and patient, what responsibility did Devon have for assuring the quality of his care by another Trust (Somerset)?	This aspect of the complaint related to the fact that Andy went between Devon and Somerset and there was a lack of clarity as to who had overall responsibility. There was no recommendation raised. **As an update, the manager again referred to the PICU Repatriation Co-ordinator and the out-of-area Urgent Care Co-coordinator posts. This means that the Trust now has dedicated people to act as conduit between one organisation and another.** **The Trust has also established weekly conference calls with all the staff involved in the patients' care to make sure that whatever is planned for those individuals is happening and to consider whether anything needs to be escalated.**

Further action required

We note that each Trust has undertaken a significant amount of work in relation to their action plans, but the implementation of change in some cases, remains in its infancy (e.g. policies still have not been ratified). Leading from this, work in relation to monitoring and evaluation of such change is required. We recommend, that as a priority, each Trust set out a programme of evaluation and assessment, revisiting all aspects of their action plan to ensure that changes have been implemented and are being monitored.

As part of this process we recommend that particular attention be given to:

- **The role of families/carers in developing risk assessments, risk management plans and care plans**
- **Developing, clarifying and/or ratifying policies in relation to:**
    - **Section 17 leave**
    - **The use of Tasers on NHS premises and the aftercare of patients who have been subject to an event involving a Taser**

    - **The involvement of police on wards (e.g. liaison, individual roles and responsibilities, when to escalate and involve the police on the ward, and, how this should be managed, minimised and situations de-escalated)**
- **Pharmaceutical oversight of transferred patients with a history of severe mental illness**
- **The role of the responsible clinician in patient transfers between Trusts/provider services.**

Taking into account the time that has passed since each action plan was developed, we advise that this work be completed within six months. This should include a clear programme of monitoring and evaluation going forward.

Final reflection capturing family thoughts shared with us through the review

We engaged extensively throughout this review with Andy's family – and in particular his mother. We were asked to reflect his mother's feelings throughout his care in relation to their experience and we add this section here to reflect those thoughts.

Andy was a loving, committed family man who was central to his family. He was much loved and is very much missed.

Andy's family was a fundamental support to him throughout his illness, particularly in the last 12 months of his life (as set out in 'carer involvement'). His mother, wife and sister were involved in his care - contacting the wards, raising concerns and engaging with healthcare professionals.

During the last 12 months of Andy's life, his family raised a number of concerns in relation to his care which culminated in written complaints to all three NHS Trusts. Some of these complaints were submitted by Andy's mother (on his behalf) whilst he was still alive. We do not revisit the detail of these complaints or the Trust responses here, but note that the volume of correspondence between Andy's family and the Trusts was significant. We have seen examples of extensive, prolonged correspondence on both sides, in relation to specific points.

Andy's family have always maintained that a number of healthcare professionals (e.g. Care coordinator 1 and Consultant 2) were supportive of Andy and tried to help him when he was well and unwell. In particular they were complimentary about the care and respect shown to Andy when he was an inpatient at Cygnet Kewstoke hospital. However they also highlighted to us their sense of indifference from some healthcare professionals, a failure to listen to them and Andy, and above all, a lack of compassion. This was something they shared at Andy's Inquest, submitting a document entitled 'Family Reflections on Compassion, Care and Kindness'.

Andy's family wanted us to draw attention to the lack of compassion he and themselves sometimes experienced and the negative impact it had on all of them. Leading from this, they wanted to highlight the value and difference it made to Andy and themselves when they did experience kindness and compassion; and how even small actions could have a positive effect. They consider this a wider learning point for all healthcare professionals.

Appendix A

Documents reviewed

The following provides a summary of the documents reviewed:

- Andy's medical and nursing notes
- Andy's GP notes
- Risk assessments and care plans
- Forensic assessments
- Prescription sheets
- Admission and discharge paperwork
- Ward round notes
- Trust policies and procedures
- Investigation reports
- Action plans and associated evidence
- Meeting notes
- Correspondence (emails, letters and phone records)
- Staffing reports
- Dashboard reports
- Incident reports
- Documents pertaining to Andy's inquest (including Findings of Fact, Regulation 28 report and associated response)
- Independent expert witness report for the Coroner
- Complaint reports
- Ambulance report and details pertaining to the incident on 14 November 2014 (e.g. police statements)
- Reflections on compassion, care and kindness (submitted by Andy's family)
- Statement written by Andy about his care and treatment (submitted by his family)

Appendix B

Interviewees

Derby

- Director of Nursing and Patient Experience
- Deputy Director of Operations
- Legal Services Manager
- Acting Assistant Director for Clinical Professional Practice

Devon

- Deputy Director of Nursing

Somerset

- Mental Health Act Coordinator
- Deputy Service Director, Adult Mental Health