VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr Z

A report for
NHS England, Midlands and East Region

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Contents

1. Introduction

On 26 August 2011, Mr Z, a 49-year-old man, stabbed and killed his estranged wife, by whom he had a daughter then aged eight. He was found guilty of murder and sentenced to life imprisonment with a recommended 24-year minimum term.

Mr Z had received inpatient and community care and treatment from five trusts:

- South Essex Partnership University NHS Foundation Trust (SEPT);
- Hertfordshire Partnership NHS Foundation Trust (HPFT);
- Oxford Health NHS Foundation Trust (OHFT);
- Milton Keynes Community Health Services (MKCHS); and
- Luton and Dunstable Hospital NHS Foundation Trust (L&DFT).

Background to the independent investigation

NHS England, Midlands and East Region, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr Z.

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

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

The five trusts each carried out internal investigations into the care and treatment of Mr Z. East of England Strategic Health Authority and NHS Bedfordshire combined the individual investigation teams into one investigation team to produce a single multi-health agency integrated report.

This multi-health agency investigation made 13 recommendations across three trusts: HPFT, SEPT and OHFT. An integrated action plan was developed to take these recommendations forward.

Overview of the trusts

SEPT

SEPT provides community health for a population of approximately 2.5 million people throughout Bedfordshire, Essex, Luton and Suffolk. This includes services provided by the Luton and South Bedfordshire crisis resolution and home treatment (CRHT) team and the South Bedfordshire community mental health team (CMHT).

HPFT

HPFT provides mental health and social care services for adults of working age, older adults, children and adolescents and specialist learning disabilities services. Beyond Hertfordshire, it also provides specialist learning disability services in Norfolk and North Essex. This includes inpatient services at Albany Lodge, a psychiatric unit in St Albans.

OHFT

OHFT provides a range of specialist mental health services in five different locations as well as physical healthcare to patients in Oxfordshire. This includes the Oxford crisis resolution and home treatment (CRHT) team and the community mental health team (CMHT).

MKCHS

MKCHS provides a full range of acute services to Milton Keynes and the surrounding area. This includes inpatient services at the Campbell Centre, a 38-bed acute inpatient mental health unit in Milton Keynes.

L&DFT

L&DFT is an acute hospital providing medical and surgical services for more than 350,000 people in Bedfordshire, north Hertfordshire and parts of Buckinghamshire. This includes services at the medical intensive treatment unit (ITU) at the Luton and Dunstable Hospital.

2. Terms of reference

The terms of reference for the independent investigation, set by NHS England, Midlands and East region, in consultation with the five trusts are as set out below:

- Review the multiple trusts' internal investigation recommendations and action plans.
- Compile a chronology of events leading up to the homicide, if not already available, or review the existing chronology.
- Review the progress that the trusts have made in implementing the recommendations and the learning from their internal investigations.
- Review the care, treatment and services provided by the NHS from the service user's first contact with services to the time of the offence.
- Review the appropriateness of the treatment of the service user in light of any identified health needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself or others.
- Examine the effectiveness of the service user care plan, including the involvement of the service user and the family.
- Observing the principles of *Being Open*[1], involve the families of the victim and the perpetrator as fully as is considered appropriate and according to the families' wishes.
- Examine the appropriateness of the cross-boundary communication between all the healthcare organisations.
- Examine the discharge arrangements between the organisations.
- Review the effectiveness of maintaining continuity of care across providers.
- Consider if this incident was either predictable or preventable.
- Provide a written report to NHS England that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post-investigation evaluation.

[1] Being open refers to the NHS framework for open and honest communication with patients when something goes wrong and a patient suffers harm.

3. Approach of the independent investigation

The investigation team (referred to in this report as 'we') comprised of Tariq Hussain, a senior investigator, and Liz Howes, a Verita associate. Professional psychiatry advice was provided by Dr Peter Jefferys, honorary consultant psychiatrist, Norfolk & Suffolk NHS Foundation Trust. Biographies for the team are given in appendix A.

We examined a range of trust documents, including policies and procedures, the trust internal investigation reports , the multi-health agency investigation undertaken by East of England Strategic Health Authority and NHS Bedfordshire and supplementary information such as the integrated action plan and records of meetings with staff.

Mr Z gave his written consent for us to access his medical and other records for the purposes of the investigation.

We interviewed staff only where we found a gap in information or an area that required clarification.

We interviewed the following staff at SEPT:

- A&E liaison nurse CRHT;
- social worker CRHT;
- associate director for adult mental health services, Bedfordshire;
- interim service manager for acute inpatients and crisis team; and
- clinical group manager.

We held telephone interviews with:

- service line lead (acute & rehab services) HPFT; and
- head of service – business and performance adult directorate, OHFT

We met Mr Z at the outset of the investigation to explain the nature of our work and to inform him that the commissioners of the investigation would publish the report in some form. He was also given the opportunity to comment on a draft of this report before it was finalised.

We met Mr Z's relatives at the start of our work to explain the investigation and to see whether they had any views about Mr Z's treatment and care. We met with them again at the end of the investigation to share our findings.

We also offered to meet the victim's family at the start of our investigation, but they declined the invitation. We understand and respect their decision. We contacted them again at the end of our investigation and met with them to share our findings.

We based our findings on the evidence we received. Our recommendations are intended to improve services.

This report includes a chronology outlining the care and treatment of Mr Z. The analysis is in sections 7 to 14, where relevant issues and themes arising from the terms of reference are examined.

Derek Mechen, a partner at Verita, provided peer review for this report.

4. Executive summary and recommendations

NHS England, Midlands and East Region, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr Z, a mental health service-user.

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

The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it might find things that could have been done better.

The incident

On 26 August 2011, Mr Z, a 49-year-old man, stabbed and killed his estranged wife. He was found guilty of murder and sentenced to life imprisonment with a recommended 24-year minimum term.

Overview of care and treatment

Mr Z presented at the A&E at Luton and Dunstable Hospital on 17 June 2011 after telling his wife that he intended to commit suicide. He was assessed by a SEPT mental health liaison nurse from the CRHT team as requiring admission to a mental health unit. Mr Z's wife and the clinicians caring for Mr Z decided that he should not be admitted to a bed within SEPT because his wife worked in the trust. He was therefore admitted to a bed at the Campbell Centre in Milton Keynes. Mr Z was discharged on 20 June to the SEPT CRHT team, who cared for him until 10 July 2011.

On 27 June Mr Z took an overdose of prescribed medication. He was assessed by the CRHT team but he refused to go into hospital. He was therefore discharged to his home address having been considered suitable for home treatment.

On 7 July Mr Z took another overdose after he had attended a local authority child and family services safeguarding meeting relating to his daughter. Following this overdose he was admitted to Luton and Dunstable Hospital where he was treated in the Medical Intensive Treatment Unit (ITU).

Following assessment by a SEPT psychiatrist on 9 July, Mr Z agreed to be admitted to a mental health unit. On 10 July a bed was identified at Albany Lodge, an inpatient unit in St Albans managed by HPFT.

Mr Z was discharged from Albany Lodge on 18 August. He went to stay temporarily with his parents in Oxfordshire. Arrangements were made for the OHFT CRHT team to make contact with him; a care coordinator was allocated from the SEPT South Bedfordshire CMHT.

Overall conclusions of the independent investigation

We found no evidence from Mr Z's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently. Mr Z did express hatred of his wife on one occasion on 22 June 2011 however he had never expressed any thoughts of harming his wife and had no history of violence or aggression and had never presented in a violent, aggressive or intimidating manner to staff during his care and treatment. Mr Z's GP saw him 2 days prior to the incident and wrote a referral requesting an urgent assessment due to Mr Z having thoughts of self harm but he did not have a suicide plan. Therefore we conclude that this incident was not predictable.

The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so. Mr Z was carefully observed and assessed during admission to Albany Lodge. There is no evidence that he showed any signs of psychotic depression in the three weeks prior to his discharge on 18 August, just over a week before the incident. He was well enough to be treated in the community and could not have been sectioned under the Mental Health Act. His depressive illness was appropriately treated in the weeks prior to the incident and there is nothing to suggest that those involved in his care could have foreseen the incident or changed his treatment to prevent it happening. We found that the incident was therefore not preventable.

We did, however, find areas for improvement in the care and treatment that Mr Z received.

The formulation of diagnosis

Although we found the absence of diagnostic formulations[1] to be a significant and repeated omission, an appropriate mental health diagnosis of depressive illness was made. We find that Mr Z's clinical pathway of care and the management of his depressive disorder were appropriate. At different stages he was treated with antidepressant medication, was admitted to hospital at times of high suicidal risk and was offered and took part in psychological treatments during his final hospital admission. These were all appropriate. However, the failure to record an adequate formulation almost certainly limited the ablity of successive clinicians treating Mr Z to understand the importance of his anger towards his wife, and any risk associated with it.

[1] A clinical formulation is developed from the information obtained through clinical assessment. Formulations are used to provide the most suitable treatment approach.

Pathway of care

Mr Z's admissions to both the Campbell Centre on 17 June and Albany Lodge on 10 July were appropriate given his presentation and the circumstances of his wife's employment within SEPT. Although Mr Z was admitted to Albany Lodge instead of the Campbell Centre on 10 July we do not consider that this change of location had any detrimental effect on his care and treatment.

Mr Z's discharge[1] from the care of the Oxford CRHT team on the basis of phone contact alone fell below good practice given the known risks he presented.

Out-of-area placements

There was no reciprocal[2] out-of-area protocol in place at the time of the incident, but staff were aware of the process for identifying an out-of-area bed when one was required.

We agree with the multi-health agency investigation that the policies which the trusts had in place at the time presented difficulties for staff when dealing with out-of-area placements.

Risk assessment and risk management

There were a number of occasions when the risk assessment and risk management of Mr Z fell below good practice.

There was no reference in the risk assessment, the risk management plan or the discharge summary to Mr Z's military history, of his feeling angry and hateful towards his wife which was explictly documented in his notes on 22 June 2011.

Safeguarding

We consider that the lack of contact between the relevant social worker and Mr Z when the latter was discharged from Albany Lodge represents a significant and serious omission in safeguarding practice. It is possible that the failure of SEPT to allocate a care coordinator for Mr Z either while he was under the care of the CRHT team between 21 June and 7 July or following his admission to Albany Lodge contributed to this breakdown in communication.

[1] The term discharge was used in the multi agency report but we recognise that Mr Z had never been formally referred.

[2] There was no reciprocal agreement in place with a specific trust but staff were able to contact a number of trusts to identify an available bed if one was required.

Care programme approach (CPA)

The agreed trust discharge and CPA policies were not followed. This led to a delay in passing on information. This was compounded by the lack of a care coordinator whilst Mr Z was under the care of the CRHT and the delay in allocating a care coordinator prior to his discharge from Albany Lodge which meant that he never met his care coordinator. Mr Z contacted the care coordinator on 20 August and arranged an appointment for 26 August in Dunstable, the same day as the incident. Mr Z did not attend the appointment.

Record-keeping

Record-keeping fell below good practice in this case and did not meet the Nursing and Midwifery Council (NMC) record-keeping guidelines or the standards in the Royal College of Psychiatrists' *Good Psychiatric Practice* (third edition, 2009).

For the period 20–26 August 2011 we found that little useful contemporaneous evidence was available to us. We relied on evidence gleaned from the internal investigations by OHFT and SEPT, which included a number of interviews with relevant staff.

Multi-health agency investigation

We reviewed the multi-health agency investigation report. The detailed chronology provided is highly informative and the analysis and conclusions are persuasive. We have no difficulty in endorsing all the comments it contains about serious weaknesses in communication, recording-keeping and other operational arrangements in place in 2011. However the involvement of Mr Z's family in the investigation process would have provided an opportunity to clarify some of the information in the report.

Since this incident, SEPT and HPFT have further developed their processes for CPA and Safeguarding, and OHFT has remodelled its community services to provide a number of improvements. The changes that OHFT has made to its services have dealt with the recommendations in the multi-health agency investigation report.

In addition, since this incident SEPT and HPFT have developed an out-of-area protocol, "Treatment of staff and their relatives/partners". However, while this protocol includes information on the principles for the treatment of staff and relatives, it does not specifically cover several of the points detailed in the recommendation of the multi-health agency investigation.

We have suggested a different emphasis on some issues in this report and we have made eight recommendations based on our findings.

Recommendation

We have made the following recommendations across the trusts involved in this incident.

SEPT, MKCHS and HPFT should ensure all medical practitioners meet the requirements of *Good Medical Practice* (GMC) and *Good Psychiatric Practice* (Royal College of Psychiatrists) with respect to recording their reasons for reaching diagnostic conclusions and for treatment decisions.

OHFT should provide assurance that the remodelling of services and the systematic changes being made deliver the required outcomes to deal with the recommendations made in the multi-health agency investigation report.

SEPT should ensure that all clinicians put into practice the trust risk assessment and risk management policies and provide assurance that these are in routine use.

MKCHS should ensure that all clinicians document relevant clinical information in the clinical notes.

HPFT should ensure that all clinicians put into practice the trust risk assessment and risk management policy, and that every discharge communication contains all known information relating to risk. The trust should also provide assurance that this is embedded in practice.

HPFT and SEPT should provide assurance that all staff adhere to children's and adults' safeguarding policies and procedures and monitor that these are in routine use.

SEPT should have a clear process in place to ensure that those affected by serious incidents are supported and involved in the trust internal investigation to meet the requirements of the statutory duty of candour.

SEPT and HPFT should review the joint protocol *Treatment of staff and their relatives* to ensure that it includes all the points included in the recommendation in the multi-health agency investigation.

5. Chronology of care and treatment

Mr Z was born in Oxfordshire in 1961. He first married when he was 22 years old and has two children from his first marriage. He subsequently remarried and has a daughter from his second marriage born in 2003.

Mr Z left school when he was 18 years old. He initially worked for the civil service, after which he joined the RAF and remained in the RAF for nine years. When he left he worked as an aircraft instructor in Saudi Arabia. In 1993 he returned to the civil service.

In May 1994 Mr Z took an overdose of tablets after the break-up of his first marriage. He was referred by his GP to secondary mental health services. Mr Z was seen on one occasion by a counsellor and discharged back to his GP for "further counselling".

The multi-health agency investigation report shows that Mr Z had received treatment for post-traumatic stress disorder (PTSD) in primary care but these sessions had finished before he was saw his GP in June 2011. When we met with Mr Z, he told us that his PTSD related to factors regarding his child's health. No further information is available about this treatment.

Mr Z was assessed by his GP in early June 2011 and was signed off sick with anxiety and depression. Mr Z told his GP that he had been driving around in his car with a large quantity of tablets with the intention of taking them. He had intended to write a note but was unable to do so. He decided to drive back home.

On 13 June his wife called the police after an incident at home. After the incident she said that she wanted to end the marriage. Mr Z was presenting with suicidal thoughts and told staff that he had been depressed and experienced suicidal thoughts since March 2011.

On 17 June Mr Z wrote a note and then called his wife who at the time was out with their daughter. She returned home and found the note; she sought advice from colleagues at SEPT where she worked.

On the basis of this advice Mr Z attended A&E. He was referred to the CRHT team and was seen by a mental health liaison nurse in the hospital. His wife was present during the assessment. The notes record that Mr Z reported previously having been referred by his GP for counselling for PTSD, due to his child's health problems and some incidents during the Gulf War. He told staff that he was shocked and distressed about an issue relating to his marital difficulties. He had shared this information with his daughter. When her schoolteachers became aware of this situation, they reported it to children's services.

Due to his wife's employment in SEPT, Mr Z was admitted to an out-of-area bed at the Campbell Centre, an inpatient mental health unit in Milton Keynes. He was assessed as "at moderate to high risk of suicide and deliberate self-harm". He remained in hospital for three days. The psychiatrist diagnosed Mr Z with an acute stress reaction.

Mr Z was discharged on 20 June to the care of the Luton and South Bedfordshire CRHT team, a part of SEPT. The team undertook daily visits. Records show that Mr Z had fleeting thoughts of suicide but make no mention of any threats to harm others.

On 22 June Mr Z attended a psychiatric medical review. The contemporaneous notes record that Mr Z felt anger and hatred towards his wife. The plan for future action was as follows:

- to reduce medication;
- for Mr Z to visit Relate tomorrow; and
- CRHT to continue daily visits.

On 27 June Mr Z took an overdose of prescribed medication. He was admitted to L&DFT for acute care and at the team handover on 29 June it was agreed that the CRHT liaison nurse was to review Mr Z while he was in the hospital.

On 29 June Social Services wrote to the CRHT asking to be kept informed of Mr Z's progress so that they could be involved in his discharge from hospital.

Mr Z was assessed on 30 June by the liaison nurse while he was in L&DFT acute hospital, but he refused admission to a mental health hospital. The clinical team concluded that he was not a high risk or detainable under the Mental Health Act, so he was discharged to his home address.

On Friday 1 July Mr Z attended an appointment with a CRHT worker to whom he made an allegation about his wife which related to his marital difficulties. He denied suicidal or homicidal thoughts. The plan was recorded in the notes as:

- "Day appointment at Limetrees[1]
- Medication given for tonight 37.5mg zopliclone[2], 1mg sertraline[3]
- Medication given for tomorrow 1 x 37.5mg zopliclone, 1 x 50mg sertraline
- Day appointment for Limetrees on Sunday
- MR on Monday
- Do not inform Mr Z of information from children's services worker
- Offered admission but declined. Mr Z will let CRHT know if he is unable to cope
- Mr Z has emergency contact number if unable to cope
- To discuss further in handover."

Between 2 July and 6 July Mr Z attended further appointments with the CRHT team.

On 7 July Mr Z attended a child protection meeting. He was accompanied by a CRHT social worker. He stated that he did not feel listened to and felt that the outcome of the meeting had already been decided. He was very distressed and

[1] Limestrees is the SEPT CRHT team base

[2] Zopiclone is a nonbenzodiazepine hypnotic agent used in the treatment of insomnia.

[3] Sertraline is prescribed for depression, anxiety disorders, and obsessive-compulsive disorder.

walked out before the meeting had finished. He spent some time with the CRHT social worker and appeared to calm down. Mr Z went home and sent his wife a worrying text message. His wife was concerned by the content, so she contacted the CRHT team. The police were called by the CRHT social worker. The police attended and broke into the bedroom where Mr Z was found to have taken a significant multiple overdose of prescribed medication. He was taken to the ITU at the L&DFT and received treatment.

On 9 July Mr Z was assessed by a SEPT psychiatrist while at L&DFT. He agreed to be admitted on an informal basis to a mental health unit. He was assessed as moderate to high risk of harm to himself at this time.

Mr Z was admitted to a Hertfordshire inpatient bed at Albany Lodge on 10 July 2011.

A care plan was developed on 10 July that included:

- "To nurse Mr Z on 10-minute observations
- Nurse to have 1:1 sessions with Mr Z to enable him to vent his feelings and discuss coping mechanisms
- Nurse to administer medication".

The care plan also included Mr Z being discharged from hospital. The clinical team carried out a risk assessment and found that Mr Z continued to be a moderate/high suicide risk.

On 11 August the SEPT CRHT social worker attended a ward review at Albany Lodge. He said that "Mr Z should not be discharged without a care plan" and reported that Mr Z would be staying at his parents' home in Oxford. The CRHT social worker further stated that there had been no warning signs that Mr Z would react the way that he did at the child and family meeting on 7 July. The social worker offered to make contact with the Oxford CRHT team to assist the transfer. Mr Z said that he was keen to be discharged.

On 12 August the records show that the SEPT CRHT team was unable to refer Mr Z to the Oxford CRHT as he did not have a GP in the Oxford area. A member of the clinical team contacted Mr Z's mother to discuss the issue. She said that she would be registering Mr Z with the local GP. She was made aware that Mr Z would not be discharged until this had been arranged.

On 16 August the modern matron at Albany Lodge contacted the Luton CMHT to request a care coordinator for Mr Z. The modern matron was told that they would telephone the following day with details of the care coordinator.

On 17 August Mr Z spent time off the ward but returned feeling anxious. He was given 0.5mg clonazapam[1] to take according to his needs.

[1] Clonazepam is a benzodiazepine drug having anxiolytic, anticonvulsant, muscle relaxant, amnestic, sedative, and hypnotic properties.

On 17 August the records show that a care coordinator from the SEPT South Bedfordshire CMHT had been allocated to Mr Z. The SEPT clinical lead advised the modern matron at Albany Lodge of the name of the care coordinator and the modern matron agreed to advise Mr Z. The management plan was as follows:

- "Mr Z to be discharged from Albany Lodge
- Mr Z to attend scan at L&D at 13.00
- Mr Z's brother to take Mr Z to his home address in Dunstable to collect some things
- Mr Z and brother to travel to Oxford".

As part of our investigation we met with Mr Z's family. They have told us that Mr Z's brother was never going to take Mr Z to his home address or Oxfordshire and that Mr Z was never going to stay with his brother.

On 18 August the care coordinator from the SEPT South Bedfordshire CMHT called the OHFT CRHT team to advise them of a man who had recently been discharged from inpatient care coming to Oxford to stay with his parents.

The multi-health investigation report states that the SEPT care coordinator did not have all the information available since they had not met Mr Z. The care coordinator was unable to provide the OHFT CRHT team with contact details for Mr Z's brother or his psychiatrist or the name of the GP in Oxford. The care coordinator was under the impression that the information had been sent to the OHFT CRHT by the SEPT CRHT but staff from OHFT CRHT said during the investigation process that this had not been received.

The care coordinator was given the OHFT CRHT fax number and a trial fax was sent to confirm the number. The care coordinator was advised that a referral form would be started but no further action would take place until more information was available.

The multi-health investigation report states that the following took place on 19 August:

The South Bedfordshire CMHT care coordinator rang Mr Z's brother, who said that Mr Z was going to stay with him not his parents. The care coordinator then rang Mr Z who said he was going to stay with his parents.

As part of our investigation Mr Z's family told us that the only time Mr Z's brother was contacted was on the day of the incident.

The SEPT CRHT social worker informed the OHFT CRHT team that Mr Z had been discharged, and advised that Mr Z would be staying with his brother. The SEPT CRHT social worker obtained the relevant paperwork from Albany Lodge and faxed a summary to the number he believed to be that of the OHFT CRHT team after working hours. The SEPT CRHT team sent a fax to the SEPT Luton and South Bedfordshire CMHT care coordinator to ask him to make contact with Mr Z or his brother to formulate plans.

The care coordinator sent a fax to the SEPT CRHT team indicating that he had spoken to Mr Z, who had advised that he would be staying with his parents. The parents' phone number was included in the fax.

The content of the telephone conversation with the care coordinator was verbally relayed at the OHFT CRHT team meeting but OHFT subsequently reported to the multi-health investigation that no further information was received.

On 20 August, the following occurred:

- Mr Z called the SEPT care coordinator to say that he had received no contact from the OHFT CRHT team;
- The SEPT care coordinator rang the OHFT CRHT team, who confirmed that they had received the referral and would contact Mr Z;
- An OHFT CRHT support worker spoke with Mr Z, who confirmed that he had moved and was looking forward to staying with his brother for a while. He said he did not feel the need for contact with the CRHT team and agreed to contact his GP if he had further worries or concerns;
- The OHFT CRHT worker then telephoned the care coordinator in South Bedfordshire and agreed that the OHFT CRHT team would take no further action at this stage; and
- The OHFT CRHT worker fed back the outcome of the telephone conversation between Mr Z and the care coordinator to the CRHT shift coordinator.

Mr Z told us that on 24 August he contacted the emergency number that he had been given by the OHFT CRHT because he was feeling unwell. He was told that, since he had previously been discharged, he should contact his GP.

The South Bedfordshire CMHT care coordinator contacted Mr Z to see if he had settled in Oxfordshire. Mr Z told the care coordinator that he had been discharged by the OHFT CRHT team on 10 July, the day he was discharged from Albany Lodge. The care coordinator made an appointment to meet Mr Z on 26 August at 3.00 pm. Mr Z had said that he was coming to Dunstable that day and could see the care coordinator as well.

On 24 August Mr Z went to see his temporary GP in Oxford. As a result of this consultation the GP contacted the OHFT CRHT team by phone on the same day. He wanted to know why Mr Z had been discharged. The person he spoke to was unable to give him any further information because Mr Z had never been formally referred and accepted onto the caseload, and advised him to contact the CMHT, because during working hours urgent assessments go through the team's duty worker.

The GP contacted the CMHT as directed and left a message on the answer phone requesting a call back by the end of the day.

The GP received no response, so on 25 August, after 5.00 pm, he faxed a referral to the City Central CMHT in Oxford. The referral requested an urgent assessment as Mr Z was having thoughts of self-harm, although he did not have a suicide plan. He

had complained to the GP about poor sleep and anxiety. The GP wrote the following in his referral:

- "Mr Z had insight and was not suicidal;
- his mother was dispensing medication, which was citalopram[1] 20mg once a day and zopiclone 3.75mg once or twice a night, and he had a prescription until the 24 August; and
- Mr Z has an appointment with his care coordinator Friday 26 August".

The referral was read by the duty worker on 26 August. He made three attempts to call Mr Z and left a message on his answer phone for him to call back.

On the same day, , Mr Z failed to keep his appointment with his care coordinator in Dunstable.

When we met with Mr Z he told us that he received the message on his phone but by this time he had decided to kill himself so did not ring back.

Also on 26 August, the psychiatrist from the OHFT CMHT called the GP to discuss the case in greater detail. The GP provided further information about Mr Z's circumstances, including that he had taken an overdose due to the breakdown of his marriage and he had no previous psychiatric history before the marital problems. The GP said that in his clinical judgement Mr Z was a low risk to himself. The GP also reported that Mr Z had told him he had an appointment with his care coordinator in Dunstable for "today" (Friday 26 August) but the GP did not know the name of the coordinator or which CMHT.

The psychiatrist asked the GP to attempt to find out the details of the CMHT and care coordinator and to fax any relevant information over to him. The psychiatrist also suggested a referral to TalkingSpace[2]. The psychiatrist and the GP agreed that since Mr Z was due to see his care coordinator that day, the Oxford team would not see him as well. The GP agreed to call the psychiatrist on Tuesday 30 August (the Monday was a Bank Holiday) with any information he had been able to find out. Arrangements for an assessment in the week beginning 29 August would be made.

On 30 August the GP called the psychiatrist in the CMHT and said that he had rung Mr Z to find out more information on 26 August but that he had already left to go and see his care coordinator in the South Bedfordshire CMHT.

[1] Citalopram is an antidepressant drug of the selective serotonin reuptake inhibitor (SSRI) class.
[2] TalkingSpace supports people in Oxfordshire who are suffering from mild to moderate symptoms of anxiety or depression. The service is provided by Oxford Health NHS Foundation Trust in partnership with Oxfordshire Mind.

6. Issues arising, comment and analysis

In the following sections we provide our comments on and analysis of the issues regarding the care and treatment of Mr Z that we have identified as part of our investigation.

We consider the following issues:

- diagnosis and treatment;
- pathway of care/out-of-area and discharge arrangements;
- CPA and communication;
- risk assessment and risk management;
- safeguarding;
- record-keeping;
- predictability and preventability; and
- the internal investigations and progress made against the recommendations.

7. Diagnosis and treatment

In this section we examine whether due consideration was given to Mr Z's diagnosis and whether he was on the right pathway of care.

The General Medical Council's (GMC's) *Good Medical Practice* (2006–current during Mr Z's care) states:

> "Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
> "You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.
>
> "Clinical records should include:
>
> - relevant clinical findings
> - the decisions made and actions agreed
> - who is making the decisions and agreeing the actions
> - who is making the record and when."

The Royal College of Psychiatrists' *Good Psychiatric Practice* (second edition, 2009) sets out standards of practice for psychiatrists. It is aligned to the GMC's *Good Medical Practice* and sets out the standards for all medical practitioners. It states:

> "Good clinical care must include:
>
> - adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views and where necessary examining the patient;
>
> - keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigations or treatment;
>
> - make records at the same time as the events you are recording or as soon as possible afterwards;
>
> - a psychiatrist must undertake competent assessments of patients with mental health problems and must be competent in obtaining a full and relevant history that incorporates developmental, psychological, social, cultural and physical factors."

Analysis

The approaches to considering and formulating a diagnosis for Mr Z are evident from clinical record entries made at different stages:

SEPT (Luton & Dunstable Hospital A&E Department)

On 17 June 2011 the SEPT psychiatric liaison nurse recorded a detailed history and examination concluding with a summary Impression:

> "49-year-old going through marital difficulties and not coping. Feeling totally out of his depth and having suicidal thoughts… For out-of-county admission".

Milton Keynes Community Health Services (MKCHS) Campbell Centre admission

During Mr Z's brief admission between 18 and 20 June 2011, a clinical record was made describing the circumstances of his admission, but without mention of any diagnostic discussion. When interviewed as part of the subsequent investigation, the consultant and ward doctor said their working diagnosis was "acute stress reaction". The ward doctor's discharge notification reads:

> "Patient was admitted to Campbell Centre with suicidal ideation. He now feels alright. We have not prescribed any medications. Follow up by home treatment team at Luton".

SEPT CRHT management, 21–26 June 2011

The circumstances of Mr Z's referral to the community service, which included recent suicidal intention, were documented. On 22 June a psychiatrist recorded "first episode of depression". An antidepressant was prescribed, but no record of a diagnostic discussion or formulation was made during this period.

SEPT (Luton & Dunstable Hospital post-overdose), 27–30 June 2011

Mr Z was recovering from an antidepressant overdose. A detailed psychiatric assessment was undertaken by a SEPT psychiatrist on 30 June but without written reference to any diagnostic summary or formulation.

SEPT CRHT, 1–7 July 2011

A comprehensive risk assessment was undertaken on 1 July, following re-referral, much of which was repeated at subsequent contacts made between 1 and 7 July 2011. However, there was no record of any discussion of Mr Z's diagnosis during this period. A GP discharge summary completed on 18 July gave a diagnosis of recurrent depressive disorder.

SEPT (Luton & Dunstable Hospital post-overdose) 7–10 July 2011

Towards the end of a further admission between 7 and 10 July, following an overdose, Mr Z was assessed again on 9 July by a SEPT psychiatrist. A diagnosis of 'depressive episode' was recorded but was not accompanied by any record of a fuller diagnostic formulation.

HPFT Albany Lodge, 10 July–19 August 2011

Mr Z was an inpatient at Albany Lodge during this period. His clinical records indicate that considerable discussion about his treatment needs took place, but did not include a detailed diagnostic formulation. His discharge diagnosis was recorded as severe depressive episode without psychotic symptoms.

Findings

The working diagnosis of "acute stress reaction" made during Mr Z's first admission, as stated by the MKCHS doctor to the investigators, was consistent with the clinical information available at that time.

Mr Z's subsequent clinical records indicate that his primary mental health diagnosis was considered to be depressive illness. This diagnosis was made for the first time by the SEPT CRHT team who managed his care between 21 June and 7 July and subsequently confirmed by HPFT at Albany Lodge during Mr Z's last inpatient admission. It was an appropriate diagnosis, consistent both with Mr Z's clinical presentation and with information obtained about him by those treating him.

However, there is no recorded evidence throughout the entire period of a detailed discussion or formulation of Mr Z's diagnosis by those assessing and treating him. A comprehensive treatment plan relies on a fuller formulation than a simple diagnostic label. A diagnostic formulation is not only of central importance in shaping an individual's care and treatment plan, but also plays a vital role in ensuring effective means of communication between professionals about that person's further care.

In Mr Z's case, care was repeatedly transferred between service providers. Each new provider was unable to obtain effective access to his clinical records. In these circumstances, a clear diagnostic formulation providing information about the specific factors relevant to his presentation and diagnosis, such as the breakdown of his marriage and child custody issues, would have been of particular value in ensuring effective monitoring of risk as well as continuity of care.

A robust diagnostic formulation for Mr Z would have weighed the significance of his marital difficulties, and made mention of the one occasion on which he stated that he hated his wife. A good formulation would have discussed the significance of ongoing safeguarding proceedings involving his daughter and his fear that he would lose her. It is possible that when Mr Z's care transferred from one clinical team and service to another, reliance was placed on an apparently straightforward diagnostic conclusion of "depressive illness", in the absence of a recorded diagnostic formulation. A

serious consequence could have been that the key dynamic of Mr Z's relationship with his wife and daughter was largely overlooked.

Good clinical care depends on an adequate assessment taking account of symptoms as well as psychological, social and cultural factors. Weighing these factors forms part of the diagnostic process and is standard psychiatric practice. Most patients or their families expect an explanation of how a particular diagnosis has been reached, bringing these elements of assessment and diagnosis together amounts to a diagnostic formulation without a record of such a formulation, devising an appropriate care plan may be compromised. Moreover, absence of a recorded diagnostic formulation has even greater potential significance for the safety of patients or the public in the cases of patients whose care is transferred between professional teams or services, as happened here.

Conclusion

Although we found the absence of any diagnostic formulation to be a significant and repeated omission, an appropriate mental health diagnosis of depressive illness was made. We find that Mr Z's clinical pathway of care and the management of his depressive disorder were appropriate. At different stages he was treated with antidepressant medication, was admitted to hospital at times of high suicidal risk and was offered and took part in psychological treatments during his final hospital admission. However, the failure to record an adequate formulation may have limited the ability of successive clinicians treating Mr Z to appreciate the potential signifance of his anger towards his wife and custody fears and its impact on risk.

We have therefore made a recommendation about diagnostic formulation.

Recommendation

SEPT, MKCHS and HPFT should ensure all medical practitioners meet the requirements of *Good Medical Practice* (GMC) and *Good Psychiatric Practice* (Royal College of Psychiatrists) with respect to recording their reasons for reaching diagnostic conclusions and for treatment decisions.

8. Pathway of care/out-of-area and discharge arrangements

The multi-health agency investigation states:

> "Reciprocal arrangements between providers do not exist although many believed they existed. Out-of-area placements are not supported by guidance to indicate criteria for initiating such placements, particularly in relation to relatives of employees of the 'host' provider".

In addition, the OHFT CRHT service operational document dated May 2007 states:

> "The CRHT team will provide comprehensive and accessible home-based treatment to individuals in an acute phase of mental illness, who in the absence of the team's crisis intervention, would be at acute risk of inpatient care."

The different roles of unqualified and qualified staff are not included in the document.

Analysis

The initial decision to admit Mr Z on 17 June 2011 was made by the SEPT liaison nurse in A&E who learned that Mr Z's wife was employed by SEPT. After a clinical decision to arrange admission had been made, Mr Z's wife requested admission to a non-SEPT bed. Clearance from an on-call SEPT manager was sought and provided. It is clear from the internal reviews undertaken by SEPT and the multi-health agency report that there was a widespread belief within SEPT that such arrangements could be made in these circumstances.

Mr Z clearly needed an urgent admission and it was appropriate for the assessing clinician to take note of the request by Mr Z's wife for an out-of-area admission, given that she was employed by SEPT. The decision on where the admission should be was made late at night by senior management. It is clear that in 2011 SEPT staff believed that reciprocal arrangements for out-of-area admissions were in place to accommodate circumstances such as these. It would not have been appropriate, given the need to arrange immediate admission, for the manager on call to insist on fresh information from Mr Z or his wife about her employment once an available bed had been identified.

This was Mr Z's first contact with mental health services since 1994; therefore there were no issues about the need for continuity of mental health at this stage. Mr Z needed a brief assessment admission to reduce immediate suicide risk. The admission to a bed less than 20 miles from his home met with the trust protocol for out-of-area placement and had no adverse consequences at this stage.

The second admission decision on 9 July was made by a duty psychiatrist who assessed Mr Z in the ITU. Mr Z told the doctor that he did not wish to be admitted to a SEPT unit in Bedfordshire because his wife was an employee of the trust. The doctor sought advice, first from a more senior doctor on call, and then from the SEPT

on-call manager, who liaised with NHS Bedfordshire, which authorised the Albany Lodge admission.

Evidence shows that on 9 July Mr Z needed urgent admission and a bed was found. In light of Mr Z's request to be treated outside of Bedfordshire, it was appropriate for the assessing psychiatrist to explore the possibility and speak first with a senior psychiatrist. Following approval by the latter, responsibility was then passed to the senior manager on call, who in turn contacted NHS Bedfordshire, which authorised the Albany Lodge placement.

There is no indication that any approach was made to the Campbell Centre, which had discharged Mr Z less than three weeks previously. However, it is not obvious that Mr Z would have benefited from readmission to this acute care unit. He had spent only three days there. He had limited contact with medical staff. A comprehensive formulation or treatment plan was never recorded, and his treatment had been primarily supportive. Mr Z had no disability that might have made it difficult for him to adjust to an unfamiliar ward.

In these particular circumstances, and given that there is no evidence that SEPT and the Campbell Centre enjoyed a close working relationship, greater efforts to readmit Mr Z to the Campbell Centre were unnecessary. However, we support the principle of continuity of care, and this should be considered as part of care planning.

Mr Z's initial management at Albany Lodge was appropriately focused on careful observation and monitoring of his mental state and suicide risk. It was followed by engagement with clinical staff from which two strands of focused work were pursued, both of which were appropriate. One strand was liaison with his wife including arrangements for contact with his daughter, which was appropriate. The second was more intensive psychological work led by a clinical psychologist examining his life situation more widely and adjustment to his changed circumstances. There is useful evidence in his clinical records that he engaged well with both these elements of his care pathway with apparent benefit during the admission. The need for antidepressant medication was carefully considered and Mr Z was appropriately given Citalopram, to continue after discharge.

Following successful periods of day leave and some overnight leave, which was managed appropriately, Mr Z's discharge was delayed. This was primarily because of difficulty re-engaging SEPT who needed to allocate a care coordinator. It was complicated by Mr Z's decision to live temporarily with his parents in Oxford on discharge. Determined efforts were made by the ward clinical team to keep SEPT informed and avoid an ill-prepared discharge. There is no evidence that the delay in discharge from the ward, had a significant adverse impact on Mr Z's mental state or prognosis. A SEPT CMHT care coordinator was eventually allocated, who had never met Mr Z, and was given the lead in arranging initial follow-up on discharge with the Oxford CRHT team.

A discharge letter,despatched on the day Mr Z left hospital was sent to Mr Z's former GP, registration with a new GP in Oxford was planned, and to the designated SEPT care coordinator. The letter lists discharge medication and includes a diagnosis of severe depressive episode without psychotic symptoms. There is no reference to Mr

Z's recent life events or of any risk to himself or others. The care plan and follow up arrangements simply refer to initial follow up by the Oxford CRHT whilst staying with his parents in Oxford and states that his named care coordinator would arrange further follow up as required. This represents the only formal written communication from HPFT relating to Mr Z's hospital admission made available to the professionals who were to take responsibility for his subsequent community care.

We have relied on the information provided in the multi-health agency investigation in relation to Mr Z's referral to the Oxford CRHT team. We concour with the investigation conclusions about the serious operational gaps and flaws relating to discharge and follow-up arrangements.

There was a period of six days between Mr Z's discharge from Albany Lodge and his visit to his GP on 24 August. Neither SEPT nor OHFT undertook a detailed assessment between his discharge from Albany Lodge and 26 August, the date of the incident.

When Mr Z was discharged, Albany Lodge, SEPT CRHT and the SEPT CMHT made no arrangements for a seven-day follow-up, although he did present at his GP six days later. Mr Z was a vulnerable individual with a recent serious mental health history who was in the middle of a series of major upheavals in his life. His recovery had only just started and he needed continued professional support and intervention. In light of his move to Oxford. Specifically, he needed prompt access to services when required, and their availability to him should have been confirmed prior to his departure from Albany Lodge.

When we met with Mr Z he told us that he received a phone call on 19 August from the Oxford CRHT team and he confirmed that he told the worker he was feeling well. He told us that he was given an emergency number to call should his situation change. Mr Z said he was not told that he had been discharged from CRHT.

OHFT managers who were interviewed as part of the multi-health agency investigation said that it was their expectation that making contact with Mr Z by the OHFT CRHT should have been undertaken by a qualified member of staff. However, details of who should undertake the initial contact with service users is not included in the CRHT operational document dated May 2007.

We also agree with the findings of the multi-health agency investigation that professionals were over-reliant on Mr Z's self-reporting of how he was feeling.

Findings

The lack of clear guidelines for out-of-area placements for relatives of employees working in a trust contributed to the lack of coordination of care and the poor communication about Mr Z's care and treatment between the trusts. Despite this, Mr Z's admissions to both the Campbell Centre and Albany Lodge were appropriate in the circumstances and no benefit would have been derived from Mr Z being readmitted to the Campbell Centre on 9 July. Albany Lodge is sited less than 20

miles from Mr Z's home, which was not an undue distance and should not have impeded reasonable contact with SEPT services.

We agree with the multi-health agency investigation that it is unclear why the decision was made to refer Mr Z to the OHFT crisis team. The preferred route would have been to refer and transfer CPA responsibility for Mr Z to a local community mental health team in Oxfordshire. This plan would have included undertaking the seven-day follow-up after discharge.

We also find that Mr Z's discharge from the Oxford CRHT based on phone contact alone by a support worker was inadequate given the known risks presented by Mr Z.

We also agree with the findings of the multi-health agency investigation that professionals placed excessive reliance on Mr Z's self-reporting of how he was feeling.

Progress in OHFT

Since this incident, OHFT has remodelled its community services which includes the CRHT team, the CMHT and the assertive outreach teams (AOTs) being integrated into five locality teams. The locality teams have an assessment and treatment function with two shifts of staff working between 7.00 am and 9.00 pm; there has also been an increase in the numbers of staff available on each shift. The response times are four hours for an emergency, five hours for an urgent case and 20 days for a routine referral. The duty worker has a dedicated mobile phone and is usually based in the team headquarters.

The teams no longer have healthcare support workers in the assessment function which is now carried out by highly skilled clinicians. At the triage stage the workers will contact the referrer for further information. After assessment the service users then move on to the treatment phase.

The trust has performance indicators that include the time from referral to assessment and the number of service users who are in the assessment and treatment clusters at any time.

Conclusion

Since this incident, OHFT has made significant improvements in remodelling the community services in line with the recommendations in the multi-health agency report. We have, however, made one further recommendation.

Recommendation

OHFT should provide assurance that the remodelling of services and the systematic changes being made, deliver the required outcomes to deliver the recommendations made in the multi-health agency investigation report.

9. CPA

In this section we examine how the CPA was used to plan and coordinate the care and treatment of Mr Z.

CPA is the process used to coordinate the care of people with mental health problems. The concept was introduced in 1991, and in 1999 the Royal College of Nursing policy booklet *Effective care coordination in mental health services – modernising the care programme approach* set out the arrangements for all adults of working age under the care of secondary mental health services. The key elements of CPA are:

- systematic arrangements for assessing the health and social care needs of people accepted by specialist mental health services;
- a care plan which identifies the health and social care to be provided from a range of sources;
- a named care coordinator to keep in touch with the service user and to monitor and coordinate care; and
- regular reviews and agreed necessary changes to the care plan.

The Department of Health published *Refocusing the care programme approach* in March 2008. This document updates the guidance and emphasises the need to focus on delivering person-centred mental health care. It also confirms that crisis, contingency and risk management are integral parts of assessment and care planning.

Analysis

We found no evidence in the notes that any of the trusts providing care to Mr Z in 2011 had any knowledge of his suicide attempt in 1994.

At Mr Z's first assessment on 17 June 2011, SEPT recorded Mr Z as subject to CPA. He was not, however, allocated a care coordinator.

The HPFT CPA policy in place at the time stated that anyone under a crisis team or receiving inpatient care will be subject to CPA and as such a care coordinator should be allocated.

Although Mr Z received regular visits from the SEPT CRHT team after his discharge from the Campbell Centre, he was still not allocated a care coordinator.

The notes evidence difficulties and delay by SEPT in allocating a care coordinator to Mr Z on his discharge from Albany Lodge.

When we met with SEPT staff, we were told that the CRHT team does not have care coordinators. Care coordinators are allocated by the CMHT. We found no evidence that the CRHT team requested a care coordinator.

A discharge meeting was held on 11 August, a week before Mr Z's actual discharge from Albany Lodge. The social worker from the SEPT CRHT team attended this meeting but no care coordinator had been allocated by the CMHT and no one from the South Bedfordshire CMHT was present. We were told at interview with staff that the CMHT had received no invitation but it is noted in the multi-health agency investigation report that the SEPT CRHT had received three invitations to attend CPA Meetings.

On 16 August, five days after the discharge planning meeting, the modern matron at Albany Lodge advised the SEPT on-call manager that a care coordinator was required for Mr Z prior to discharge. On 17 August the SEPT locality director, two SEPT clinical group managers and the HPFT bed manager all became involved in organising a care coordinator for Mr Z.

On 18 August it was confirmed that SEPT CMHT would hold the care coordinator role for Mr Z and the name of a care coordinator was passed on to Mr Z prior to his discharge. Mr Z telephoned the care coordinator on 29 August and arranged an appointment for 26 August in Dunstable but Mr Z did not attend this appointment.

As detailed in the pathway of care section of this report (section 8), Albany Lodge, the SEPT CRHT team and the SEPT CMHT made no arrangements for a seven-day follow-up.

Findings

We agree with the multi-health agency investigation that the trusts' discharge and CPA policies were not followed and led to a delay in passing on information. This was compounded by the lack of a care coordinator.

SEPT did not allocate a care coordinator for Mr Z either while he was under the care of the CRHT team between 21 June and 7 July or following his admission to Albany Lodge. This was a serious failing; however, there is no evidence that this contributed towards the incident.

There is no evidence that the services involved in delivering care and treatment to Mr Z on his discharge from Albany Lodge were brought together to plan for his discharge. When this did not happen the South Bedfordshire CMHT care coordinator took insufficient action to ensure that they had all the relevant discharge paperwork from Albany Lodge.

It was unclear who would be undertaking the seven-day follow-up after Mr Z's discharge from Albany Lodge.

It was a serious failing that the relevant information was not received by the OHFT CRHT team on Mr Z's discharge from Albany Lodge, however there is no evidence that this contributed towards the incident.

The newly allocated care coordinator from the South Bedfordshire CMHT did not have the requisite information and was reliant on the Luton and South Bedfordshire CRHT team to fax the information to the OHFT CRHT team.

In turn, the OHFT CRHT team did not have the Luton and South Bedfordshire CRHT team's contact number to explain that the information had not arrived, but they did not alert the care coordinator in the SEPT CMHT to this fact.

We have found conflicting evidence as to whether Mr Z was staying with his parents or his brother in Oxfordshire. We recognise that the address he was to stay at was correct but there are references in the notes and in interviews with staff to him staying with both his brother and his parents. He did in fact stay with his parents while in Oxfordshire.

As detailed in the pathway of care section (section 8) of this report, we agree with the multi-health agency investigation that it is unclear why the decision was made to refer Mr Z to the OHFT crisis team. The preferred route would have been to refer and transfer CPA responsibility for Mr Z to a local community mental health team in Oxfordshire. This plan would have included undertaking the seven-day follow-up after discharge.

Progress in SEPT

When we met with staff from SEPT, they told us that arrangements for seven-day follow-ups are now robust and performance-managed within the trust.

Services are advised immediately whenever there is an exception and the case is examined to find out why the seven-day follow-up did not take place. Responsibility for undertaking the seven-day follow-up is now allocated as part of the discharge planning. Joint handovers also take place and involve the service user to ensure engagement with the new worker.

The multi-disciplinary team (MDT) of managers of the various community teams, inpatient units and the crisis team now hold weekly meetings at which the planned dates for follow-up (within seven days of discharge) are recorded and their completion is monitored.

Staff told us that there is also a process for note-taking at handover meetings. In relation to the out-of-area placements, a daily return is completed that identifies where patients are placed. This enables staff to review where the patients are, how long they have been there, and confirm that a named care coordinator is allocated. It also enables contact to be maintained with any individual who has been placed out of area, thus enabling any social care, immigration or accommodation needs to be dealt with prior to discharge.

We also heard that SEPT has implemented a system of individual CPA audits. This system involves each team manager identifying a care coordinator on a rota basis and auditing three sets of case notes, chosen at random, from their caseload.

CPA audits also take place. These cover risk assessment and risk management and involve the team manager spending time with the workers and auditing their case records.

Records are also included in the clinical supervision process to emphasise individual responsibility and accountability, rather than solely looking at team results as previous audit processes had done.

Progress in HPFT

We have received evidence that, since the incident, a list of service users admitted to inpatient areas within the previous seven days has been sent to the weekly community teams meeting, at which care coordinators are identified and new ones allocated if necessary.

In addition, a discharge list is sent to the same weekly community meeting which identifies when the seven-day follow-up is due. Senior managers in acute (inpatient) and community services are alerted four to five days into the seven-day period if contact has not been made. Senior managers then investigate the situation and ensure that contact is made with the service user. We were told that this process has been thoroughly effective.

The person responsible for undertaking the seven-day discharge is routinely agreed at CPA discharge meetings. This is usually the care coordinator but sometimes, depending on circumstances, the CRHT team or the team most closely involved with the service user.

Conclusion

The trusts' agreed discharge and CPA policies were not followed. This led to a delay in passing on information about Mr Z's care and treatment. This was compounded by the lack of a care coordinator. However, in view of the work that SEPT and HPFT have undertaken on CPA since the incident, we have made no further recommendation.

10. Risk assessment and risk management

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. Risk management should be an integral component of CPA. The outcome of risk assessment should feed back into the overall clinical management.

National best practice guidance in managing risk in mental health services (Department of Health, 2007) sets out three risk factor categories. These are:

1. Static factors. These are unchangeable, e.g., a history of child abuse or suicide attempts.
2. Dynamic factors – those that change over time, e.g., misuse of drugs or alcohol.
3. Acute factors or triggers. These change rapidly and their influence on the level of risk may be short-lived.

Risk assessments were undertaken for Mr Z on a number of different occasions. We set these out below.

SEPT input Luton & Dunstable Hospital A&E Department

On 17 June 2011 a detailed summary of risk factors was recorded for Mr Z. The facts that he had a history of previous counselling, arranged by his GP for post-traumatic stress syndrome relating to his experiences during the Gulf War, together with his daughter's childhood health issues were noted. Three risks – of suicide, deliberate self-harm and self-neglect – were categorised as "moderate to high".

MKCHS Campbell Centre, 18–20 June 2011

A structured risk assessment was electronically recorded by the admitting nurse. The historical factors highlighted that might increase the risk were recorded as: harm to self; harm from others; unsafe use of medication; incidents involving the police; major life event and current mental state.

A forensic assessment also completed on 18 June by the receiving nurse does not include any detail about the marital issues or past PTSD, although the summary correctly concludes Mr Z is undergoing marital problems and is finding it difficult to cope. It records that Mr Z was presenting as feeling suicidal, low in mood, with poor concentration and motivation, poor sleep pattern and dietary intake.

The only identifiable medical entry was on 20 June, the day of discharge, which simply notes Mr Z's denial of suicidal intent and makes no reference to risk.

SEPT CRHT management, 21–26 June 2011

A structured summary risk assessment (SEPT CPA4.1), initially completed on 21 June, was repeated on 23, 24 and 26 June by nurses examining Mr Z. A psychiatric review undertaken on 22 June noted: “a fear of losing his daughter; his former military service in the Gulf; and ‘anger and hatred towards his wife’”.

This information was not referenced in any other risk assessments documented by the CRHT team in this period.

SEPT Luton & Dunstable Hospital

On 30 June 2011 a psychiatric assessment notes “no thoughts of suicide/deliberate self-harm at present”. Reference was made to protective factors[1]. Mr Z declined psychiatric admission but agreed to attend the CRHT base the following day, which he did.

SEPT CRHT, 1–7 July 2011

A review of the risk assessment was undertaken on 1 July. Mr Z disclosed a visit on 23 June to the home of an individual against whom he made an allegation related to his marital difficulties. It is recorded that Mr Z used “threatening words” towards him. Mr Z denied “having any weapon with him at the time or intending harm”, “any plans, thoughts or ideas of harming the male or his wife or daughter” and “any thought of self-harm – he has never self-harmed before”. It is further recorded that “he stated that due to some military experience he is well capable of violence but has never gotten into any altercation with anyone since his school days. However, based on his past military career he is able to access firearms”.

The CRHT worker asked Mr Z to explore this further, but Mr Z was unwilling to give any additional information. He denied having any firearms in his home or in his possession at present.

Between 1 and 7 July summary risk assessments were repeated, on six out of the seven days, by the CRHT team. The risk of suicide was rated 0 (no/very low risk/no concerns) on 1, 2 and 3 July with an increase to a rating of 1 (low risk/minor concerns) on 5 July which was escalated to a rating of 2 (medium risk/definite indicators) on 6 and 7 July. Risk to others was consistently rated 0 throughout this period.

[1] Protective factors are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people to deal more effectively with stressful events and mitigate or eliminate risk.

SEPT Luton & Dunstable Hospital ITU

On 9 July 2011 Mr Z was assessed as having "significant risk to self: remains moderately high".

HPFT Albany Lodge, 10 July–19 August 2011

The enhanced risk assessment form created on 10 July and updated on 11 August contains limited information as follows:

- History of risk to self: "Overdoses x 2" (10 July and 11 August)
- Current (and possible future) risks: "Low mood, marital strife, stress at work" (10 July); "Patient denies any thoughts to harm himself" (11 August)
- Specific risks to staff or carers: "Nil identified" (10 July and 11 August)
- Clinical factors: "Suicidal thoughts but no plans" (10 July); "Settled MS[1], euthymic[2] with reactive affect, anxious about how he will cope following discharge; no evidence of any psychotic phenomena or thoughts to harm self or others. Has benefited a lot from psychological input" (11 August).
- Warning signs (past indicators of relapse): "Relationship breakdown" (10 July); "Recurrence of suicide thoughts, feeling of inability to cope" (11 August).

A discharge letter sent on the day Mr Z left hospital, lists discharge medication and provides a diagnosis of severe depressive episode without psychotic symptoms. There is no reference to Mr Z's recent life events or of risk to himself or others. The care plan and follow up arrangements simply refer to initial follow up by the Oxford CRHT whilst staying with his parents in Oxford and that his named care coordinator would arrange further follow up as required.

All providers agreed that Mr Z's most prominent risk was suicide, and management plans were devised to address this. Hospital admission was offered or arranged to reduce immediate suicide risk. Close monitoring of his suicidal thoughts was central to his inpatient management plans and to his management by the CRHT team. In addition, psychological therapy focusing on marital conflict issues formed an essential part of his management plan during his longer admission to Albany Lodge.

Findings

We recognise that it is easy to be critical after a serious adverse event because of "hindsight bias" when reviewing contemporaneous risk assessments and risk management plans. However, identifying weaknesses may point to lessons of potential benefit to future mental health patients. We therefore make the following comments:

[1] Mental State

[2] Euthymic-pertaining to a normal mood in which the range of emotions is neither depressed nor highly elevated.

SEPT Luton and Dunstable A&E

On 17 June 2011 an immediate and serious risk of suicide was correctly identified. Appropriate action was taken to manage the risk by arranging immediate hospital admission. In these circumstances it was not necessary to record a more systematic risk assessment in A&E. The clinical record of this assessment is comprehensive and to an exceptionally high standard. Details of personal and relationship history and mental state are recorded which more than match most later records. It is unclear whether copies of this assessment were made available to MKCHS or to CRHT team members subsequently responsible for Mr Z's care.

MKCHS Campbell Centre, 18–20 June 2011

A structured risk assessment was completed on admission to the Campbell Centre with risk and protective factors referred to as part of Mr Z's management plan. It was appropriately focused on suicidal ideation and the need to offer regular 1:1 interviews, in part to monitor evolving suicide risk more closely.

Mr Z showed significant clinical improvement. A detailed psychiatric examination was conducted prior to his discharge three days later. It did not incorporate a comprehensive risk assessment. Although the risk proforma completed on admission was updated, it is unclear whether a more robust assessment of risk apart from suicide was undertaken.

Although the psychiatrist told the investigation panel that he had assessed Mr Z prior to his discharge, there is no record of this in the clinical notes; this is unsatisfactory.

SEPT CRHT, 21–26 June 2011

During this period, the only risk that the trust identified in its assessments of Mr Z were of harm "to self/health through severe self-neglect". In the light of this, an appropriate management plan of daily contact with monitoring of suicide risk was devised. Everything else on the risk assessment form was scored as no/very low risk/no concerns. However, we note that when structured risk templates are used there is a danger that repeat assessment means simply "ticking boxes" rather than fresh investigation, particularly in areas not identified at the initial screening.

Mr Z's overall risk assessment takes no account of the information documented by a CRHT psychiatrist on 22 June about his former military service, fear of losing his daughter and feeling anger and hatred towards his wife. This represents a serious omission, as these factors had particular relevance to his future risk to others as well as to himself. They should have been given weight and formally recorded on the risk assessment form.

SEPT Luton and Dunstable

On 30 June 2011 the main focus of risk assessment was suicide. This was appropriate in light of Mr Z's recent overdose. The offer of admission was

appropriate. When Mr Z declined the admission, more senior psychiatric advice was sought. An alternative, intensive CRHT follow-up was agreed and implemented.

SEPT CRHT, 1–7 July 2011

Mr Z's suicide risk was systematically scored on each CRHT visit. A score of 0 was recorded between 1 and 3 July with a modest increase to 2 (medium risk/definite indicators) on 6 July. It is difficult, in retrospect, to understand the scoring rationale here, given Mr Z's very recent overdose of prescribed medication. It may be that the threshold used by the CRHT team for scores in excess of 0 or 1 was exceptionally high, given that five points were available altogether (0–4). This is potentially a serious practice issue, since it could mean that more intensive management plans to reduce suicide risk are not triggered when they should be in someone with increasing risk.

Two significant pieces of information, relevant to Mr Z's risk to himself or others, do not seem to have led to a revision of his risk management plan. The first was expression on 22 June of feeling hatred and anger towards his wife and his fear of losing custody of his child. The second was the news received on 29 June that the local authority was undertaking an imminent child protection meeting. The CRHT team's failure to take these factors into account in Mr Z's risk management plan represents a serious omission.

More positively, the CRHT team was proactive before a crucial safeguarding meeting on 7 July: Staff held a pre-briefing and accompanied Mr Z to the meeting. After Mr Z left the meeting abruptly, they took steps to ensure his immediate safety and to monitor his movements. Unfortunately he took a serious overdose of prescribed medication on his return home before further direct contact was made. The CRHT contacted the police who attended Mr Z's home.

SEPT Luton & Dunstable Hospital ITU

On 9 July 2011 Mr Z's suicide risk was correctly identified as significant and his immediate admission was arranged.

HPFT Albany Lodge 10 July–19 Aug 2011

Mr Z's suicide risk was identified as significant at an initial assessment on 10 July and then again, but less so, when re-rated on 11 August. Enhanced observations were appropriately initiated on admission and reduced realistically in light of Mr Z's subsequent clinical improvement and cooperation with his treatment plan. The risk assessment completed on 11 August appropriately included the need to look at his relationship with his wife. Mr Z engaged well with focused and appropriate psychological therapy.

However, there is no indication that Mr Z's risk assessment and management plan took account of key information: his military history; his previously expressed anger at and hatred of his wife; and his fear of losing his daughter. This is a significant omission because it limited the scope of his risk management plans. Neither the

discharge letter from Mr Z's GP nor the fuller discharge summary makes reference to this key information. The latter makes no reference to short/medium/long-term risks following discharge. These omissions meant that those responsible for Mr Z's subsequent management were not in possession of all relevant information.

Conclusion

There were a number of occasions when risk assessment and risk management of Mr Z fell below good practice.

SEPT

- It is unclear from the records whether the full assessment undertaken on 17 June was shared between the teams and services involved with Mr Z's care.

- Mr Z's overall risk assessment should have included the information documented by a SEPT CRHT psychiatrist on 22 June about his former military service, fear of losing his daughter and hatred towards his wife. This represents a serious omission, since these factors had particular relevance to Mr Z's future risk to others as well as to himself.

- It is possible that the rating score used by the SEPT CRHT team may not reflect increasing risks that should trigger more intensive management plans.

MKCHS

- There is no record of the alleged assessment made by the consultant immediately prior to Mr Z's discharge from the Campbell Centre on 20 June.

HPFT

- During Mr Z's admission to Albany Lodge there is no indication that his risk assessment and management plan took account of his military history, or his previously expressed feelings of hatred towards his wife, documented on the 22 June 2011, or of his fear of losing his daughter.

- Neither the GP discharge letter nor the fuller discharge summary makes reference to any of the above causes for concern. The latter document makes no reference to Mr Z's short/medium/long-term risks following his discharge.

Recommendations

SEPT should ensure that all clinicians put into practice the trust risk assessment and risk management policy and provide assurance that this is in routine use.

MKCHS should ensure that all relevant clinical information is documented in the clinical notes.

HPFT should ensure that all clinicians put into practice the trust risk assessment and risk management policy.

HPFT should ensure that all clinicians include in discharge communications all known information relating to risk.

11. Safeguarding

Safeguarding children

The government has defined the term ‘safeguarding children’ as:

> “The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully”.

In 2006 the government released *Working together to safeguard children*, which set out the ways in which organisations and individuals should cooperate to ensure the wellbeing of children. In 2010 this was superseded by *Working Together to Safeguard Children*. These documents were in place at the time Mr Z received care and treatment

Safeguarding adults

The government is committed to improving the quality of health and social care, to developing accountability to patients and to strengthening the choice and control they have over their care. Adult abuse can happen to anyone, anywhere, and the responsibility for dealing with it lies with everyone.

The government’s *No Secrets: guidance on protecting vulnerable adults in care* (2000) defines an adult at risk as “any person 18 or over who is or may be in need of community care services by reason of mental or other disability, age or illness and who is, or may be, unable to take care of him or herself, or unable to protect him or herself against significant harm or serious exploitation”.

Analysis

Child Safeguarding

The local authority child safeguarding referral was triggered by earlier police intervention and their investigation was already underway before Mr Z’s contact with mental health services on 17 June 2011. The local authority appropriately liaised with Mr Z’s daughter’s school and informed the CRHT team about the progress of their investigations and timing of the key safeguarding meeting. SEPT services responded appropriately to requests for information and cooperation.

However, we have not been provided with reliable evidence of further contact with the local authority by either SEPT or HPFT following Mr Z’s admission to Albany Lodge. There was some supervised contact between Mr Z and his child during this period but we are not aware of whether this was coordinated via social services.

More critically, there is no evidence that the relevant social worker was contacted when discharge plans for Mr Z from Albany Lodge were being considered. These discharge discussions took place over at least three weeks prior to his discharge. The internal reviews concluded that no safeguarding contacts were made either by HPFT or SEPT during this period.

Adult Safeguarding

On 22 June 2011 Mr Z said that he hated his wife, we found no evidence that further enquiries were made about their relationship either by talking to Mr Z's wife or his GP who may have had more information.

Findings

Child safeguarding

When Mr Z was discharged from Albany Lodge there was no contact with the relevant social worker. This is a significant omission. It is possible that the serious failure of SEPT to allocate a care coordinator for Mr Z either while he was under CRHT care between 21 June and 7 July or following his admission to Albany Lodge contributed to this failure of safeguarding communication.

Adult Safeguarding

We found no evidence that adult safeguarding had been considered as part of Mr Z's risk management plan.

Progress in HPFT

We were told that, at CPA discharge meetings, it is agreed who needs to be contacted and who is responsible for what. The trust does not have a performance indicator for safeguarding, but the need for a multi-agency approach is included in safeguarding training.

Progress in SEPT

When we met with staff, they told us that since the incident they now receive a list of cases that are referred to a multi-agency risk assessment conference (MARAC), which is part of a coordinated community response to domestic abuse.

In cases known to the trust, a care coordinator attends the relevant MARAC meeting. In addition there is a rota system to ensure that a care coordinator attends to provide advice and guidance on all the cases. This ensures that any mental health issues are identified and can be signposted to the appropriate service.

We were also told that SEPT was participating in The Kidstime Workshop, a pilot scheme led by Central Bedfordshire Children's Social Care in a joint initiative with the Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health. The Kidstime Workshop comprises ten sessions of activities for the whole family. It was developed by the Anna Freud Centre and is for families where one or more of the parents are experiencing a mental health issue.

Conclusion

The lack of contact with the relevant social worker when Mr Z was discharged from Albany Lodge represents a significant and serious omission in relation to child safeguarding practice. Although both SEPT and HPFT have made some progress with safeguarding since this incident, we have made a further recommendation in relation to safeguarding policy.

Recommendation

HPFT and SEPT should provide assurance that all staff adhere to child and adult safeguarding policies and procedures and monitor that these are in routine use.

12. Record-keeping

According to the NMC's *Record Keeping Guidelines*:

> "Good record-keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. Good record-keeping, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:
>
> - helping to improve accountability
> - showing how decisions related to patient care were made
> - supporting the delivery of services
> - supporting effective clinical judgements and decisions
> - supporting patient care and communications
> - making continuity of care easier
> - providing documentary evidence of services delivered
> - promoting better communication and sharing of information between members of the multi-professional healthcare team".

Good Psychiatric Practice (Royal College of Psychiatrists, 2009) states:

> "A psychiatrist must maintain a high standard of record-keeping:
>
> - good psychiatric practice involves keeping complete and understandable records and adhering to the following:
> - handwritten notes must be legible, dated and signed with the doctor's name and title printed
> - electronic records must be detailed, accurate and verified
> - a record must be kept of all assessments and significant clinical decisions
> - the reasoning behind clinical decisions must be explained and understandable in the record and, if appropriate, an account of alternative plans considered but not implemented must be recorded
> - the record should include information shared with or received from carers, family members or other professionals
> - notes must not be tampered with, changed or added to once they have been signed or verified, without identifying the changes, and signing and dating them".

Findings

For the period 20–26 August 2011, we found little useful contemporaneous evidence was available to us so we relied on the internal investigations conducted by OHFT and SEPT, which included a number of interviews with relevant staff.

We have also found that after speaking with Mr Z's family there is conflicting information about Mr Z's brother's involvement in Mr Z's discharge from Albany Lodge and that the brother was never contacted until the day of the incident - and not on 18 August as reported in the multi-agency report.

There were a number of occasions when the standard of record-keeping fell below good practice as identified in the multi-health agency investigation. These were:

- record-keeping relating to the Luton and South Bedfordshire CRHT team meetings;
- record-keeping by some of the Luton and South Bedfordshire CRHT, the South Bedfordshire CMHT care coordinator and other SEPT staff involved in the out-of-county transfer; and
- record keeping in the Oxford crisis team: the OHFT notes relating to Mr Z 's referral and subsequent actions were entered onto the RiO[1] electronic system retrospectively.

We have also identified in the risk assessment section of this report that there is no record of the alleged assessment made by the consultant immediately prior to Mr Z's discharge from the Campbell Centre on 20 June. We consider this unsatisfactory and have made a recommendation.

Progress in SEPT

Staff told us at interview that there is now a process for note-taking at handover within the Luton and South Bedfordshire CRHT meetings

Progress in OHFT

All staff are now trained on the RiO electronic system. This is described in more detail in the section on implementing the multi-health agency action plan (14.5).

Conclusion

Record-keeping fell below good practice in this case. Recommendations were included in the multi-health agency action plan and the trusts concerned have made improvements to practice. However, we have made one further recommendation in the risk assessment section of this report (10.10.2) in relation to MKCHS that relevant clinical information should be documented in the clinical notes.

[1] RiO is the electronic patient record in use in OHFT for the recording and documenting the provision of healthcare services.

13. Predictability and preventability

Predictability

We would consider that the homicide was predictable if we found evidence from Mr Z's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

Mr Z expressed hatred of his wife on one occasion on 22 June 2011. This information should have been further explored and included in his risk and adult safeguarding assessments. However, Mr Z never expressed any thoughts of harming his wife. He never presented in a violent, aggressive or intimidating manner to staff during his care and treatment and as far as the trust staff were aware, he did not have a history of violence or aggression. Mr Z's GP saw him 2 days prior to the incident and wrote a referral requesting an urgent assessment due to Mr Z having thoughts of self-harm but he did not have a suicide plan.

Finding

We find that the incident was not predictable.

Preventability

The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so.

Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

We found no evidence to indicate that staff had the knowledge, opportunity or means to prevent the homicide. Mr Z was carefully observed and assessed during admission to Albany Lodge and there is no evidence that he showed any signs of psychotic depression in the three weeks prior to his discharge on 18 August 2011, just eight days before the incident.

Mr Z was carefully observed and assessed during admission to Albany Lodge. He received psychological treatment at Albany Lodge, from which he gained benefit and with which he was invited to continue after leaving the ward. This treatment was appropriate. There is no evidence that he showed any signs of psychotic depression in the three weeks prior to his discharge. He was well enough to be treated in the community and could not have been sectioned under the Mental Health Act. His depressive illness was being appropriately treated in the weeks prior to the incident and there is nothing to suggest that those involved in his care could have foreseen the incident or changed his treatment to prevent it happening.

Finding

We find that the incident was not preventable.

14. The internal investigations and progress made against the recommendations

The terms of reference for this investigation include assessing the quality of the multi-trusts' internal investigations and reviewing the trusts' progress in implementing the action plans.

We examined the national guidance and the trusts' incident policies to find out whether the investigations into the care and treatment of Mr Z met the requirements set out therein.

The trusts' internal reviews

The good practice guidance *Independent investigation of serious patient safety incidents in mental health services* (National Patient Safety Agency [NPSA], February 2008) advises that, following a homicide, an internal NHS mental health trust investigation should take place to establish a chronology and identify underlying causes and any further action that needs to be taken. In this case, all five trusts commissioned internal reviews into the care and treatment of Mr Z. A multi-health agency report was also written on behalf of the four mental health NHS organisations that provided care and treatment to Mr Z. The report is an integration of the five internal reviews carried out by the provider organisations involved in Mr Z's care. The reviews are listed below:

- SEPT 72-hour internal management report dated 26 August 2011 and internal management review dated 8 September 2011;
- Luton and South Bedfordshire CRHT team and CMHT internal management review dated 29 February 2012;
- MKCHS chronology of events (undated);
- HPFT seven-day report dated 6 September 2011 and internal investigation dated 10 January 2012;
- OHFT root cause analysis investigation report dated 9 February 2012 and associated initial investigation report;
- L&DFT domestic homicide review dated 16 March 2012; and
- multi-health agency investigation by NHS East of England NHS Bedfordshire dated 22 June 2012.

We have reviewed the multi-health agency investigation.

Multi-agency investigation NHS East of England, NHS Bedfordshire

Terms of reference

The multi-health agency report was written on behalf of all the mental health NHS organisations that provided care and treatment to Mr Z. The report is an integration

of the five internal reviews carried out by the provider organisations involved in Mr Z's care.

The terms of reference are for an overarching integrated investigation and review of the care and treatment of Mr Z across three counties from the first contact with mental health services to the time of the homicide. They were as follows:

1. Compile a chronology of events and interaction by all healthcare providers leading up to the time of the incident.

2. Review the appropriateness of the treatment, care and supervision of the mental health service user in light of any identified health and social care needs; this will include (but not be restricted to):

    1. medication;
    2. assessment of decisions taken and their validity;
    3. any cultural factors that affected the needs of the service user;
    4. staff responses to the service user's concerns;
    5. range of treatments/interventions considered;
    6. social care; and
    7. reliability of the case notes and other documentation.

3. Establish whether the assessment and management of risk in relation to self and others were adequate at each stage of care, including acute, mental health and primary care.

4. Establish whether there were acceptable standards of care and treatment offered by the service providers.

5. Examine the adequacy of information-sharing between health services during the transition of care between providers on referral, admission and discharge, and to determine whether timescales were appropriate.

6. Examine the effectiveness of the service user's care plan, including the involvement of the service user and his family and consideration of child protection issues.

7. Explore and comment on the reciprocal arrangements between HPFT and SEPT in this case, including appropriateness circumstances that led to the decision consent and risk assessment.

8. Examine the process undertaken when there is a transfer of care from one area to another.

9. Establish if there was any engagement with the wife, the parents or others on transfer of care and discharge.

10. To establish the role and responsibility of the care coordinator provided by SEPT and whether this was clear to the service user care coordinator and other provider services

11. Provide a written report that includes recommendations and an action plan to address issues identified in the investigation to improve practice and reduce risk.

12. Review and assess compliance with local policies, including those concerning the handling of complaints, national guidance and statutory obligations, including the appropriate use of the Mental Health Act regarding admission discharge and granting of leave.

13. Engage with the service user and family members in the process of the investigation, encourage their contribution, and offer support and guidance as appropriate.

14. Consider any other matters arising during the course of the investigation that are relevant to the occurrence of the incident or might prevent a recurrence.

15. Identify any areas of good practice to share with all organisations.

16. Provide a written report to the investigation panel and the primary care trust that includes measurable and sustainable recommendations.

Analysis

Given the complexity of the care and treatment that Mr Z received prior to the incident, NHS Bedfordshire commissioned a multi-health agency investigation into this incident. The terms of reference were agreed with NHS Bedfordshire, SEPT, MKCHS, HPFT, OHFT and L&DFT.

The terms of reference are clear and contain the names of those who formed the investigation panel (a senior member of each organisation involved). A clear remit for the investigation was agreed with all panel members.

Point 13 of the terms of reference for this investigation included the involvement of the service user and family. The NPSA good practice guidance *The investigation of serious patient safety incidents in mental health services* (2008) states that an opportunity should be provided for the victim and his or her family to meet senior, appropriately experienced staff from the trust. At this meeting their involvement in the investigation process can be discussed. The guidance also states that families should be consulted on the terms of reference for both internal and independent investigations, be provided with the terms of reference, and be advised of how they will be able to contribute to the process of investigation, for example by giving evidence. Subsequently, the findings of the internal investigation and the actions to be taken should be discussed with them.

The NPSA guidance document *Being open: communicating patient safety incidents with patients, their families and carers* (2009) states that being open about what happened and discussing incidents promptly, fully and compassionately can help families to cope better with the after-effects.

We note that, within the report, reference is made to the fact that the involvement of Mr Z and his family was not possible since Mr Z was in a forensic unit under constant observation and was felt not to be well enough to participate or to give consent for his family to be approached. Mr Z's parents' GP also advised that they were too distressed at the time but that he would be prepared to approach them once Mr Z had given his consent.

When we met with the family members and Mr Z, they told us that they had not been aware of an investigation by either the individual trusts or the multi-health agency and had not been involved.

When we met with Mr Z's parents and his brother and sister in law they told us that while they appreciated why the trust had decided not to involve Mr Z's parents in the investigation after the incident, had members of the family been contacted directly it is likely that Mr Z's brother would have participated.

They expressed a wish to have sight of the report now. We contacted NHS England after our meeting with the family, and the multi-health agency report has now been shared with the family. Having now seen the report the family have provided conflicting information about Mr Z's brother's involvement in Mr Z's discharge from Albany Lodge in that the brother was never contacted until the day of the incident and not on 18 August as reported on the multi-agency report.

The multi-agency report has also been shared with Mr Z.

Conclusion

Given the circumstances of the care and treatment leading up to the incident, NHS Bedfordshire appropriately commissioned the multi-agency investigation. The terms of reference were clear and the seniority of the investigation team was appropriate given the seriousness of the case. While it is regrettable that Mr Z and his family were not able to be involved, efforts were made to engage with them at the time. However, we found no evidence that any attempt to make contact with either Mr Z or his family had been made when circumstances changed. This did not meet the NPSA *Being open* guidance.

The multi-health agency report has now been shared with Mr Z and his family.

Investigatory process

The multi-health agency investigation provides a detailed chronology of the health service contacts made with Mr Z between 17 June and 26 August 2011. It draws largely on his records together with some interview notes from internal investigations undertaken in late 2011 and early 2012 by the five NHS organisations involved in Mr Z's care. This review identified "a number of care/service delivery factors whereby service providers could improve on the management of the care and treatment

provided to Mr Z' but emphasised that none of these ultimately contributed to the index offence.

Conclusion

The chronology in the multi-agency review provides sufficient evidence to support its conclusions about care and service delivery weaknesses, particularly those relating to communication and cross-boundary referrals. Its findings are evidence-based and well argued. We have no difficulty in endorsing all its comments about serious weaknesses in communication, recording-keeping and other operational arrangements in place in 2011.

However the involvement of Mr Z's family in the investigation process would have provided an opportunity to clarify some of the information in the report.

We have made a recommendation that SEPT review their process to meet the requirements of the statutory duty of candour. This is outlined below.

Recommendation

SEPT should have a clear process in place to ensure that those affected by serious incidents are supported and involved in the trust internal investigation to meet the requirements of the statutory duty of candour.

Progress on implementing the action plan

In this section we look at the trusts' progress in implementing the integrated action plan resulting from the multi-health agency investigation report.

The review identified eight care and service delivery factors relating to SEPT's management of Mr Z. Most of these concerned record-keeping or communication within the trust or with other providers; some concerned referral for treatment by other providers. Three discharge-related factors were highlighted in relation to care provided by HPFT. Factors highlighted with respect to OHFT related to record-keeping, communication across organisational boundaries, the allocation of tasks to appropriately qualified staff and the timeliness of their response.

The multi-agency review identified issues from which lessons could be learned but concluded that none of these issues "ultimately contributed to, or were material to the index offence". These were:

- weaknesses in communication relating to discharge from Albany Lodge and follow-up arrangements, leading to delays in face-to-face contact with Mr Z.
- Lack of clarity relating to seven-day follow-up after HPFT discharge;

- compromised continuity of care owing to the involvement of four mental health providers;
- no risk assessment related to two inpatient episodes; and
- a number of factors affecting sharing of information between providers with deviation from usual discharge/CPA procedures, compounded by lack of care coordination and delay in allocating a care coordinator.

Recommendations made in the multi-agency review

Recommendations for HPFT and SEPT

HPFT and SEPT should document a mutually agreed policy or protocol relating to out-of-area placements (dispelling the "myth" of the existence of reciprocal arrangements) covering the care and treatment of staff members or their family members in circumstances when they are unable to be treated in their respective organisations. This should specifically cover responsibilities in the management of a robust care and treatment package (as opposed to contractual arrangements and financial remuneration) and in particular include:

- definitive statements relating to the provision of out-of-hours area placements for employees requiring mental health care;
- the conditions and criteria under which such arrangements should be deployed for direct employees of the organisations;
- the criteria under which such arrangements should be deployed for family members of employees and the definition of "family members";
- an assessment of risk associated with being placed out of the local area for care and treatment, particularly for relations of employees, and the need to balance the needs of the service user against the wishes/needs of his or her relatives who may be employees of the trust in question;
- the rights and wishes of the service user in such arrangements;
- responsibilities for care coordination and allocation of a care coordinator if appropriate;
- responsibilities of the host organisation;
- discharge and follow-up arrangements following an episode of inpatient care;
- arrangements for transfer of care across organisational boundaries;
- guidance on arrangements for more than one inpatient admission; and
- cross-reference to and reinforcement of the CPA policy in the management of out-of-area placements.

Consideration should be given to sharing such a protocol (as described in 14.6.1, above) to ensure a consistent approach to arrangements throughout the area.

Recommendations for SEPT

The locality director for Central Bedfordshire should obtain assurance that the practice of the South Bedfordshire CMHT care coordinator who was involved in this case has been addressed. Record-keeping practices should meet the required

standards and it should be ensured that all relevant information is obtained to inform decision-making in relation to assessment and management of risk.

Recommendations for HPFT

HPFT should ensure that it keeps clear records of who will carry out seven-day follow-up for out-of-county service users. This should be guided and reinforced by the related discharge and CPA policies.

HPFT should ensure that in the absence of an "active" care coordinator, the completion of the needs assessment is undertaken in a timely manner, with an interim care coordinator completing, at the earliest point, a needs assessment which should support the final discharge and follow-up process.

HPFT to alert all professionals involved to the discharge arrangements – particularly social services CSF[1] if involved, within the agreed process of needs assessment and discharge follow-up.

Recommendations for OHFT

Recruitment to Band 7 deputy managers and Band 6 care coordinators.

CMHT to undertake a review of duty and referrals systems.

Review of the Oxon crisis team in the context of the whole patient pathway.

Development and agreement of a clear protocol for the crisis service for managing information about potential new referrals. This protocol should include statements to the effect that:

- referrals must be received and triaged by qualified team members;
- the remit for the crisis team must be agreed with the referrer (what is the team being asked to do?); and
- all contact with a referrer must be recorded on RiO even when no further action is required.

Targeted training of staff to ensure that they are confident and competent to record information on RiO relating to new patients. This training can be delivered locally by administrative staff.

The introduction of team systems that include random audit of progress notes against patient contacts.

The CMHT should reorganise its duty function to ensure that there is a duty worker based in the team on a daily basis. The duty worker should be responsible for triaging all referrals, regardless of how they are received in the team on a day-to-day basis, and for coordinating with the crisis team as appropriate.

[1] CSF -Children, Schools and Families service

Progress in SEPT and HPFT

We have had sight of the document “Treatment of staff and their relatives”, a joint protocol between HPFT and SEPT dated 4 November 2013. When we met with staff from SEPT they told us that this has been embedded into the services and is now sometimes used for out-of-area admissions.

While the protocol includes information on the principles for the out-of-area treatment of staff and their relatives, it does not specifically cover the following points detailed in the recommendation of the multi-health agency investigation:

- an assessment of risk associated with being placed out of the local area for care and treatment, particularly for relations of employees, and the need to balance the needs of the service user against the wishes/needs of their relatives who may be employees of the trust in question;
- responsibilities for care coordination and allocation of a care coordinator if appropriate;
- responsibilities of the host organisation;
- discharge and follow-up arrangements after an episode of inpatient care;
- arrangements for transfer of care across organisational boundaries;
- guidance on arrangements for more than one inpatient admission; and
- cross-reference with and reinforcement of the CPA policy in the management of out-of-area placements.

In addition, the staff we interviewed were not able to confirm that this protocol has been shared across the region as suggested in the action plan. However, we have had confirmation from NHS England Midlands and East that this has happened.

Progress in SEPT

When we met with staff we received corroborated evidence that the recommendation relating to record-keeping had been adopted and that all individual practitioners’ notes are reviewed under supervision to ensure that they are up to date and of the required trust standard.

Progress in HPFT

As described in the CPA section of this report (section 9), since this incident, HPFT has made several service improvements in relation to seven-day follow-up and the allocation of care coordinators. We received corroborated evidence that, as part of the CPA discharge meeting, those who need to be contacted are identified and responsibilities for doing so are agreed. This includes contact with the social service children’s services.

Progress in OHFT

Since this incident OHFT has significantly remodelled its community services. The changes it has made have dealt with the recommendations in the multi-health agency investigation report. OHFT has integrated the CRHT, CMHT and AOT into five locality teams. The trust consulted with patients and carers and the wider community. Through the consultation, service users said that they wanted to see someone they knew. The locality teams' areas are co-existant with those of the clinical commissioning groups, an arrangement that facilitates working with primary care. The locality teams have an assessment and treatment function with two shifts of staff working between 7.00 am and 9.00 pm, there has also been an increase in the numbers of staff available on each shift. The response times are four hours for an emergency, five hours for an urgent case and 20 days for a routine referral. The duty worker has a dedicated mobile phone and usually works at the team base.

The teams no longer have healthcare support workers in the assessment function which is now carried out by highly skilled clinicians. At the triage stage the clinician will contact the referrer to discuss the referral and risks and they will agree how to proceed. After assessment, the service users then move on to the treatment phase.

All staff have been trained on RiO, but the trust is moving to a new electronic system and has a robust training programme in place which will ensure that all clinicians are trained to use the new system before they are authorised to input any information. This has been led by learning from this incident.

The trust undertakes random audits of the CPA process and progress notes; any issues arising are discussed by team managers in monthly supervision sessions with staff. The trust has performance indicators that include the time from referral to assessment and the number of service users who are in the assessment and treatment clusters at any time.

Conclusion

Since this incident, SEPT and HPFT have developed an out-of-area protocol and their processes for CPA and safeguarding. OHFT has remodelled its community services to provide a number of improvements.

However, we have made a recommendation that SEPT and HPFT review their out-of-area protocol. This is outlined below

Recommendation

SEPT and HPFT should review the joint protocol *Treatment of staff and their relatives* to ensure that it includes all the points raised in the multi-health agency investigation.

Appendix A

Team biographies

Liz Howes

Liz Howes has 20 years' experience of senior management in the NHS, specialising in mental health and learning disabilities. Liz led on a service improvement project in mental health services as part of a national pilot with the National Institute for Mental Health in England, and was responsible for leading a multi-agency project to provide new homes for people with learning disabilities that promoted social inclusion and personalised care. Her previous posts have included interim director of learning disabilities and specialist services and head of services redesign and information services at Leicestershire Partnership NHS Trust; and director of mental health services at Leicestershire and Rutland Healthcare NHS Trust.

Tariq Hussain

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations, grievance and abuse inquiries and reviews of team working in various acute care specialties.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Dr Peter Jefferys

Peter is an experienced consultant psychiatrist specialising in old age and former trust medical director. He is a non-executive director for Norfolk & Suffolk NHS Foundation Trust. He has investigated unexpected mental health deaths for health authorities, the Mental Health Act Commission and CQC as well as conducting extensive suicide audits. He is a former advisor to the Parliamentary and Health Services Ombudsman, chairs MPTS (GMC) Fitness to Practice Panels and serves on mental health review tribunals.