Niche PATIENT SAFETY

NHS Midlands and East

An independent investigation into the care and treatment of a mental health service user in Hertfordshire

August 2013

CONTENTS

EXECUTIVE SUMMARY

Mr. X was a 59 year old man who had been referred urgently by a Locum General Practitioner (GP) to the Community Mental Health Team (CMHT) in Hertfordshire Partnership NHS Foundation Trust on 15th December 2009, nine days before he murdered his estranged wife, Y, at their home.

The referral from the GP to the CMHT stated that Mr. X suffered from intermittent depression but that this had worsened in the previous six weeks due to the breakdown of his marriage and splitting up with his wife.

Mr. X was seen and assessed by a Community Psychiatric Nurse (CPN) and a Social Worker (SW) on 17th December 2009 and by a Consultant Psychiatrist on 22nd December 2009.

The following day, on 23rd December 2009, Mr. X was visited at home by his estranged wife, Y, and their step-daughter. Mr. X confronted his wife with evidence he had gained from a private investigator that she was having an affair and an argument ensued. Mr. X stabbed his wife repeatedly with a kitchen knife. She later died from her injuries.

Mr. X was arrested and after assessment by a Forensic Consultant Psychiatrist he was transferred to a medium secure unit on Section 48/49[1] of the Mental Health Act.

It has been difficult for the independent investigation team to gain a full picture of the service users' mental health history as the private psychiatrist who saw Mr. X on an ongoing basis in 2001 and 2002 did not wish to talk to the independent investigation team and was not able to supply copies of the clinical records pertaining to these consultations as they have since been destroyed. Additionally the GP who treated Mr. X between 2001 and 2009 also did not wish to take part in the independent investigation and was therefore not interviewed as part of the process. He did supply copies of Mr. X's GP notes but unfortunately, these did not provide full information.

Copies of correspondence between the private psychiatrist and Mr. X's GP in 2001 and 2002 suggested that Mr. X left his job as a doctor at that time due to mental ill health. The independent investigation team attempted to obtain copies of occupational health records from that time in an attempt to gain a better understanding of Mr. X's long term mental health history but unfortunately these were unavailable.

Mr. X had a complex history. He was born and brought up in Baghdad. He reports that his father was a merchant and businessman, and was killed by the Saddam Hussein regime, although his body was never found. Mr. X's mother died in 2009 in Dubai. Mr. X reports she had a history of depression. He had two brothers who he states were also murdered by the Saddam Hussein regime. Additionally he had mental health problems that led to him having

[1] Section of the Mental Health Act for those awaiting trial who's mental disorder is such that requires hospitalisation, section 48 is used to transfer subject to hospital and section 49 is a restriction order

to leave his job as a doctor, serious physical health problems and some marital difficulties that led to the depressive episode at the end of 2009.

The evidence suggests Mr. X may have experienced severe psychotic symptoms and thoughts on occasions, but was able to withhold these from professionals during assessments. Also, his preference for consulting private Psychiatrists meant that the communications between them and his GP were not as detailed as one would have expected if the Care Programme Approach (CPA) were being used as a framework for his care.

The independent investigation team, having reviewed the GP records provided, are of the view that the GP who treated Mr. X for depression did not do so in line with NICE guidance and that Mr. X might have benefited from earlier referral to secondary mental health care services, in 2001/2002.

However the independent investigation team commends the actions of the Locum GP who assessed Mr. X in December 2009 and made an urgent referral, on 15th December 2009, to secondary mental health services.

Following the referral Mr. X was seen by clinicians from the CMHT on 17th and 22nd December 2009. He refused further support from the Crisis, Assessment & Treatment team (CAT Team) as suggested by the Consultant Psychiatrist from the CMHT but did agree to continue to see staff from the CMHT.

As acknowledged by the Consultant Psychiatrist's own admission, due to the urgency of the referral and the time of year, Mr. X did not receive as full an assessment and clinical risk assessment as he usually would as he had to be fitted in before Christmas. For this reason he was seen between clinics.

It is unfortunate that Mr. X did not receive as full an assessment and risk assessment as he would have done under other circumstances but the independent investigation team notes that the CMHT attempted to ensure that Mr. X was assessed before the Christmas holidays.

Following the incident, Hertfordshire Partnership NHS Foundation Trust commissioned an internal senior team to conduct an investigation under the Trust's Serious Untoward Incident (SUI) procedure, which was completed in June 2010. This investigation resulted in a comprehensive report, which concluded that this incident was not predictable or preventable. However, the internal investigation did identify areas for care and service improvement, and the report contained recommendations to this effect.

It is the conclusion of the Independent Investigation Team that the tragic murder of Y was not predictable or preventable by services although there are areas of care that could have been improved and these provide opportunities for future learning. These have been identified in some detail within this report.

The independent investigation team make 9 recommendations as follows:

Recommendation 1
Commissioners of GP services should ensure, and ensure that they can demonstrate, that GPs are treating all patients, who present with depressive symptoms, in line with the current national NICE guidance 'Depression: The treatment and management of depression in adults (update) [CG90] 2009'

Recommendation 2
Commissioners of GP services should undertake a review of the provision of psychological therapies within the relevant GP surgery to ensure that practice, referral and uptake rates are consistent with national standards.

Recommendation 3
Commissioners of GP services should work with GPs to establish methods of assuring themselves that GP record keeping is of a consistently high standard

Recommendation 4
Hertfordshire Partnership NHS Foundation Trust should continually monitor community team performance in relation to adherence to prescribed timescales for response to urgent referrals, and the reasons for any variance.

Recommendation 5
Hertfordshire Partnership NHS Foundation Trust should provide clinical risk assessment documentation, for use by workers that enables them to clearly mark when a potential aspect of clinical risk has not been assessed, the reasons for this, and plans in place to ensure that the assessment is completed in a timely manner.

Recommendation 6
The Hertfordshire Partnership NHS Foundation Trust board should assure themselves that senior clinical staff are appropriately trained in the assessment and management of potential morbid jealousy.

Recommendation 7
Hertfordshire Partnership NHS Foundation Trust should ensure that one of the functions of the Incident Co-ordination Group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.

Recommendation 8
Hertfordshire Partnership NHS Foundation Trust should develop formal mechanisms to monitor compliance with clinical risk assessment training on an ongoing basis.

Recommendation 9
Hertfordshire Partnership NHS Foundation Trust should conduct annual audit to ensure ongoing compliance with the standards outlined in their clinical risk assessment policy.

1.0 INTRODUCTION

Niche Health & Social Care Consulting was commissioned by NHS Midlands and East Strategic Health Authority (SHA), to conduct an independent investigation to examine the care and treatment of a mental health service user who will be referred to for the purposes of this report as Mr. X. Under Department of Health guidance[2] Strategic Health Authorities (SHA) were required to undertake an independent investigation:

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

When it is necessary to comply with the State's obligation under Article 2 of the European Convention on Human Rights. Whenever a state agent is or may be responsible for a death, there is an obligation for the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

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

2.0 PURPOSE OF INVESTIGATION

Independent investigations should increase public confidence in statutory mental health service providers. The purpose of this investigation is not only to investigate the care and treatment of Mr. X, but to assess the quality of the internal investigation that took place following the incident and the implementation of subsequent learning and to establish whether any lessons can be learned for the future.

3.0 SUMMARY OF INCIDENT

Mr. X, at the time of the homicide, was a 59 year old man who was referred urgently by a Locum General Practitioner (GP) to the Community Mental Health Team (CMHT) in Hertfordshire Partnership NHS Foundation Trust on 15th December 2009, nine days before he murdered his estranged wife at their home.

The referral from the GP to the CMHT stated that Mr. X suffered from intermittent depression but that this had worsened in the previous six weeks due to the breakdown of his marriage and splitting up with his wife.

[2] Department of Health (1994) *HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care*, amended in 2005 by Department of Health (2005) *Independent Investigation of Adverse Events in Mental Health Services*

Mr. X was seen and assessed by a Community Psychiatric Nurse (CPN) and a Social Worker (SW) on 17th December 2009 and by a Consultant Psychiatrist on 22nd December 2009.

The following day, on 23rd December 2009, Mr. X was visited at home by his estranged wife, Y, and their step-daughter. Mr. X confronted his wife with evidence he had gained from a private investigator that she was having an affair and an argument ensued. Mr. X stabbed his wife repeatedly with a kitchen knife. She later died from her injuries.

Mr. X was arrested and after assessment by a Forensic Consultant Psychiatrist he was transferred to a medium secure unit on Section 48/49 of the Mental Health Act[3].

Following the incident, Hertfordshire Partnership NHS Foundation Trust commissioned an internal senior team to conduct an investigation under the Trust's Serious Untoward Incident (SUI) procedure, which was completed in June 2010. This investigation resulted in a comprehensive report, which concluded that this incident was not predictable or preventable but Hertfordshire Partnership NHS Foundation Trust did identify areas for care and service improvement, and the report contained recommendations to this effect.

4.0 CONDOLENCES TO THE FAMILY OF Y

The Independent Investigation Team would like to offer their deepest sympathies to the family and friends of Y. It is our sincere wish that this report provides no further pain and distress and addresses any outstanding issues and questions raised by his relatives regarding the care and treatment of Mr. X up to the point of the offence.

5.0 ACKNOWLEDGEMENT OF PARTICIPANTS

This investigation involved interviews with clinical staff and managers and we would like to acknowledge the helpful contributions of staff members from Hertfordshire Partnership NHS Foundation Trust and Hertfordshire Primary Care Trust. In particular we would like to especially thank the Patient Safety Manager and administration staff from Hertfordshire Partnership NHS Foundation Trust for their valuable and helpful assistance throughout this investigation.

6.0 TERMS OF REFERENCE

The following Terms of Reference were agreed between NHS Midlands and East and Niche Health & Social Care Consulting:

[3] This section of the Mental Health Act is for those awaiting trial who's mental disorder is such that requires hospitalisation, section 48 is used to transfer subject to hospital and section 49 is a restriction order

To provide an independent report into the care and treatment provided to Mr. X in primary care and from his first contact with mental health services up to the time of the offence.

Following the review of clinical notes and other documentary evidence:

- *Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- *Review the progress that the Trust has made in implementing the action plan.*
- *Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the time of his offence.*
- *Compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself.*
- *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, identifying both areas of good practice and areas of concern.*
- *Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.*
- *Examine the effectiveness of the service users care plan including the involvement of the service user and the family.*
- *Review and assess compliance with local policies, national guidance and relevant statutory obligations.*
- *Consider if this incident was either predictable or preventable.*
- *Consider any other matters arising during the course of the investigation, which are relevant to the occurrence of the incident or might prevent a recurrence.*
- *Provide a written report to the SHA that includes measureable and sustainable recommendations.*

6.1 Approach

The Independent Investigation Team will provide the necessary services to ensure the effective co-ordination and delivery of the independent investigation.

The Independent Investigation Team will conduct its work in private and will take as its starting point the Trust internal investigation supplemented as necessary by access to source documents and interviews with key staff as determined by the team.

As well as key staff, the Independent Investigation Team is encouraged to engage actively with the relatives of the victim and Mr. X so as to help ensure that as far as possible, the investigation is informed by a thorough understanding of the incident from the perspective of those directly affected, and will provide appropriate support to relatives throughout the investigation process.

The Independent Investigation Team will follow established good practice in the conduct of interviews, for example offering the opportunity for interviewees to be accompanied and be able to comment of the factual accuracy of their transcript of evidence.

If the Independent Investigation Team identify a serious cause for concern, this will immediately be notified to NHS Midlands and East.

6.2 Publication

The outcome of the investigation will be made public. NHS Midlands and East will determine the nature and form of publication. The decision on publication will take into account the views of the Independent Investigation Team, those directly involved in the incident and other interested parties.

If the Independent Investigation Team identify a serious cause for concern, this will immediately be notified to NHS Midlands and East.

6.3 Timescales

The independent investigation team will complete its investigation within six months of starting work. The six months will start once the team is in receipt of Mr. X's records and sufficient documents are available to the team for interviews to start. The investigation manager will discuss any delay to the timetable with NHS Midlands and East and will also identify and report any difficulties with meeting any of the Terms of Reference to NHS Midlands and East. A bi-monthly progress report will be provided to the SHA along with a bi-monthly detailed update report suitable for all stakeholders.

7.0 THE INDEPENDENT INVESTIGATION TEAM

This investigation was undertaken by the following healthcare professionals who are independent of the healthcare services provided by Hertfordshire Partnership NHS Foundation Trust:

Nicola Cooper	Investigation Manager and Report Author, Registered Mental Health Nurse and Senior Patient Safety Lead of Niche Health & Social Care Consulting Ltd
Dr Paul Alford	General Practitioner

8.0 INVESTIGATION METHODOLOGY

This investigation followed national guidance[4]. The investigation commenced in May 2012.

8.1 Communication with victims family

Mr. X's daughter and the victim's (Y's) mother were contacted at the commencement of the investigation. The victim's mother did not respond to the communication and Mr. X's

[4] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

daughter did not wish to meet with the investigation team at that time but did ask to be contacted for feedback on the findings of the investigation on completion of the report. The findings of the investigation were shared with the family.

8.2 Consent

Written consent permitting access to his medical records was provided by Mr. X to the Strategic Health Authority in advance of the commissioning of the investigation.

8.3 Communication with the Perpetrator

The Independent investigation team met with Mr. X in prison to discuss the process for the investigation and his views on the clinical care he received prior to his offence. The findings of the investigation were shared with Mr. X.

8.4 Witnesses called by the Independent Investigation Team

The Independent Investigation Team interviewed the staff involved making reference to the National Patient Safety Agency Investigation interview guidance[5]. Niche Health & Social Care Consulting adheres to the Salmon Principles[6] in all investigations.

Six people from Hertfordshire Partnership NHS Foundation Trust who had been involved with the care and treatment of Mr. X or the management and commissioning of services, and the Locum GP who referred Mr. X to the CMHT in December 2009, were invited for interview in this investigation.

The independent investigation team were able to interview the Locum GP who referred Mr. X to the CMHT for assessment in December 2009. However she only met Mr. X on the one occasion. The team would have liked to have interviewed Mr X's personal GP who had provided care to Mr. X since 2001 but he declined to be interviewed for the purposes of this investigation.

Additionally, the private psychiatrist who was treating Mr. X for a period of time up until 2002 also declined to be interviewed.

The Independent Investigation team are disappointed that the two doctors did not attend for interview. As they both knew Mr. X over a lengthy period of time, they could have provided potentially valuable information regarding Mr. X's historical mental state to help this investigation.

Every interview was recorded and transcribed and all the interviewees had the opportunity to check the factual accuracy of the transcripts and to add to or clarify what they had said.

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[5] National Patient Safety Agency (2008) *Root Cause Analysis Investigation Tools: Investigation interview guidance*

[6] The '*Salmon Process'* is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere.

8.5 Root Cause Analysis

This report was written with reference to the National Patient Safety Agency (NPSA) guidance[7]. The information gathered was analysed using Root Cause Analysis (RCA). Root Cause Analysis is a retrospective multi-disciplinary approach designed to identify the sequence of events that led to an incident. It is a systematic way of conducting an investigation that looks beyond individuals and seeks to understand the underlying system features and the environmental context in which the incident happened[8]. The Fish Bone analysis was used to assist in identifying the influencing factors which led to the incident. This is represented diagrammatically in Section 15.4.

The Trust's Serious Untoward Incident Report was benchmarked against the National Patient Safety Agency's "investigation credibility & thoroughness criteria"[9] and the results analysed.

9.0 SOURCES OF INFORMATION

The independent investigation team considered a diverse range of information during the course of the investigation. Unfortunately Mr. X's clinical records pertaining to the care provided to him by the private psychiatrist who treated Mr. X until 2002 were not available, as these have been destroyed as part of routine practice.

Other sources of information reviewed were the Trust's Internal Investigation Report[10], Mr. X's GP records, CMHT records, Trust policies and procedures and internal performance management information.

The independent investigation team consulted policies, strategy documents and circulars on the care of people with depression and personality disorder, and the management of risk from the Department of Health. A complete bibliography is provided in the appendices.

10.0 PROFILE OF HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST

At the time of the incident, Hertfordshire Partnership NHS Foundation Trust provided mental health and learning disability services to the people of Hertfordshire, and learning disability services in north Essex and Norfolk. It employed around 3,300 staff over approximately 80 sites.

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[7] National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*
[8] id p38
[9] National Patient Safety Agency (2008) *RCA Investigation: Evaluation, checklist, tracking and learning log*
http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60183&type=full&servicetype=Attachment

The Trust obtained foundation trust status on 1st August 2007 under the National Health Service Act 2006 and is regulated by Monitor, the independent regulator of foundation trusts.

In 2006, reconfiguration of services took place that meant that all residents of Hertfordshire would now receive services from Hertfordshire Partnership NHS Foundation Trust. Under the previous arrangements some services were provided to the residents of Hertsmere and Potters Bar by Barnet, Enfield and Haringey Mental Health Services.

Currently Hertfordshire Partnership Foundation Trust provides specialist mental health and learning disability services for the people of Hertfordshire. It also has services in Norfolk and North Essex, comprising of in-patient care and community services, with specialist community teams for Assertive Outreach, Early Intervention in Psychosis, Crisis Intervention and Child and Adolescent Mental Health Services. The Trust now employs approximately 2700 members of staff on over 60 sites.

Hertfordshire Partnership NHS Foundation Trust now organises its services into three geographical business streams:

1. Learning Disability and Forensic Services in Hertfordshire, Norfolk and Essex
2. West Hertfordshire
3. East and North Hertfordshire

11.0 CHRONOLOGY

11.1 Background and early life[11]

Mr. X was born and brought up in Baghdad. He reports that his father, a merchant and businessman, was killed by the Saddam Hussein regime, although his body was never found. Mr. X's mother died in 2009 in Dubai. Mr. X reports she had a history of depression. He had two brothers who he states were also murdered by the Saddam Hussein regime. He has two sisters; one died in 2009 from breast cancer and the other lives in Dubai. He has no contact with her.

Mr. X states he had a poor relationship with his father who he alleges was a violent man. Additionally Mr. X claims to have been sexually abused for around a year when he was 8 years old. Mr. X reported a sense of anger and rage directed towards the perpetrator but he has not resorted to any violence over the years nor has he attempted to seek him out or to retaliate against him.

Mr. X performed well at school and later started training as a doctor in Iraq, completing his qualifications in Manchester and Edinburgh. He worked as a GP but also specialised in treatment for substance misuse. After retiring from medical practice, on the grounds of

[11] Letter from Consultant Psychiatrist at Partnerships in Care, 13/1/2010

mental ill health, he worked on a voluntary basis as a drug counsellor. He reports that his qualifications are MBCHB, MR.CP, Diploma in Surgery, Diploma in Alcohol and Drug addiction and a Masters degree in Drug Addiction. He also worked towards an MBA in Architectural Building at Bedfordshire University in Luton.

There is a family history of mental illness. Mr. X's mother suffered from depression, his uncle committed suicide and he has a cousin who suffers from schizophrenia.

Mr. X has previously been diagnosed with carcinoma of the kidney and an endocrine carcinoma of the stomach.

Mr. X left Iraq in the 1980s but returned for a brief period in the 1990s where he claims to have been further traumatised by witnessing decapitation and the after effects of people who had been tortured.

He spent two years in the United States where he states he was diagnosed with Psychotic Depression by a psychiatrist. He also describes having possibly hypo-manic symptoms in the past and a time when he used to have recurrent thoughts about becoming President or someone famous. He states that at the time he had plenty of energy and undertook many degrees and diplomas including undertaking a Masters Degree in Drug and Alcohol Dependency. Despite the reported mental health problems apparently Mr. X successfully completed these courses and achieved qualifications.

He was married twice. He believes his divorce occurred around 1998 and reports there was no violence in the relationship.

His second marriage, to Y, lasted 19 years. He has two daughters; one from each marriage.

In 2009, following problems with Y, his wife, they separated and he stayed in the family home while she moved out. Despite their separating, he and his wife would see each other. He alleges that she began an affair with a neighbour and he hired private detectives who, he states, photographed her embracing and kissing a man in a restaurant.

On the day of the homicide, Mr. X states he challenged her with the photographs provided by the private detective. He states she admitted to the affair, which led to an argument. One of his daughters was upstairs at the time. He recalls there was a kitchen knife on the table, which he picked up. He claims he heard voices, which were loud and wild, and 'making him crazy' saying "harm, harm". He then stabbed her in the chest and upper body.

Mr. X reports he had not been drinking heavily but had had one glass of wine that afternoon and was apparently breathalysed by the police that afternoon after the incident.

11.2 Criminal History

The independent investigation team were presented with no evidence that indicated Mr. X had any forensic history until the offence occurred in December 2010.

11.3 Medical and Psychiatric History

16th March 2001

Mr. X was seeing a private psychiatrist who wrote to Mr. X's GP at the time to inform him that he had been seeing Mr. X since mid 2000 in his capacity as a private psychiatrist and reported very little improvement. He reported Mr. X was still depressed, had suicidal thoughts and was unable to make decisions. He said he had told Mr. X to increase his Amitriptyline (an antidepressant) to 150 mg a night. He reported he did not feel that Mr. X was ready for work and that he had recommended that he leave work stating it was not fair on him or his patients. He reported that Mr. X was disappointed at the loss of his profession.

The private psychiatrist stated, in a letter to his GP, that at the time Mr. X was unable to see his children and that this had made him feel worse. It was reported he had not been looking after himself and had lost weight.

The private psychiatrist referred in the letter to 'similar incidents' that had occurred three years ago. He stated Mr. X's mother and sister suffered from depression and that although Mr. X kept it a secret, his first divorce was related to his depression.

The private psychiatrist stated that long term Mr. X would need medication, support, group work and psychotherapy and that he would review him again in May 2001.

Comment

The independent investigation team found no indication in the GP clinical notes that any dialogue between the private psychiatrist and the GP, or Mr. X and the GP, took place to ascertain how Mr. X would access support, group work and psychotherapy and there is no indication that this was arranged for Mr. X, or that he received it. It is the view of the independent investigation team that given the assessment of Mr. X's needs at the time, Mr. X might have benefited from a referral from his GP for psychological counselling or additional mental health service input. It is not evident from the GP records whether this was considered, or indeed discussed with Mr. X.

5th May 2001[12]

The private psychiatrist wrote to Mr X's GP to inform him that he had been reviewing Mr. X since mid-2000 in his capacity as a private psychiatrist. He said that Amitriptyline 150mgs at night had brought about some improvement but that Mr. X still complained of insomnia and difficulty expressing his feelings. The private psychiatrist said that staying away from work as a GP, in his opinion, had helped him to maintain improvement. The private psychiatrist said he had been coaching Mr. X in the use of cognitive therapy techniques.

15th September 2001[13]

The private psychiatrist wrote to the GP to inform him that he reviewed Mr. X in early September. Mr. X described a settled period but still had difficulty with sleeping and poor motivation. The private psychiatrist told him to continue taking Amitriptyline 150 mg at

[12] Letter from private psychiatrist to GP, 5/5/2001
[13] Letter from private psychiatrist to GP, 15/9/2001

night. The private psychiatrist said he did not feel Mr. X was ready to return to work and planned to review him again in December 2001.

18th January 2002[14]

The private psychiatrist wrote to the GP to inform him that he reviewed Mr. X in early January. He said he felt better but that he still had difficulty with sleeping, concentration and motivation. He asked him to continue to take Amitriptyline 150 mg at night. Mr. X said he was dreading returning to work. The private psychiatrist planned to review Mr. X again in April 2002.

18th May 2002[15]

The private psychiatrist wrote to the GP to inform him that he had reviewed Mr. X and he had indicated that he was maintaining his improvement. Mr. X had complained of poor appetite and sleep disturbances. He said he would like Mr. X to continue to take his Amitriptyline 150 mg at night. The private psychiatrist reports that his impression was that Mr. X was not looking forward to returning to work.

The private psychiatrist reported he would be seeing Mr. X again In September 2002 and that he would keep the GP updated with progress.

Comment

No further communications from the private psychiatrist were found in the GP records. The independent investigation team are unclear if Mr. X continued his treatment with the private psychiatrist following their consultation on 18th May 2002, or if not, why this ceased. It is also unknown to the independent investigation team when Mr. X ceased to take Amitriptyline 150 mg or what affect this had on his mood and day-to-day functioning. There is no evidence in the GP records that this issue was raised by the GP with Mr. X.

14th June 2004[16]

Mr. X was to undergo an endoscopy but it was terminated due to his distress and inability to relax. It is reported that he pulled the endoscope out of himself. He had severe oesophagitis, grade 3 redness pre-pyloric erosions and that there was difficulty intubating the duodenum.

Comment

The independent investigation team found no indication in the GP notes of how or why Mr. X came to be having an endoscopy or who referred him.

4th August 2004[17]

Mr. X underwent a gastroscopy.

[14] Letter from private psychiatrist to GP, 18/1/2002
[15] Letter from private psychiatrist to GP, 18/5/2002
[16] Endoscopy unit report, Lister Hospital, 14/6/2004
[17] Endoscopy unit report, Lister Hospital, 4/8/2004

13th September 2004[18]

A Clinical Fellow at Lister Hospital wrote to the GP to inform him that he had reviewed Mr. X in Mr. X surgical out-patient clinic for follow up. He had been admitted 6 weeks previously for lower right abdominal pain which he reported was treated conservatively. Given the history of cancer in Mr. X's family, a colonoscopy was ordered.

24th September 2004[19]

Mr. X went to see the GP after feeling unwell for a week with a kidney infection. Presence of E Coli was found.

7th October 2004[20]

Mr. X had a colonoscopy at Lister Hospital. He had complained of abdominal pain, weight loss and diarrhoea.

23rd August 2006[21]

Mr. X went to his GP surgery and during the consultation a diagnosis of reactive depression was noted. Mr. X reported that he had been hand-cuffed and interrogated at John F Kennedy Airport in New York and at Heathrow for approximately 7-8 hours. He states he was in New York for a family holiday and was sent back to the UK as he had the same name as a wanted person from Saddam Hussein's regime and that his had caused him reactive anxiety. The GP documented that Mr. X appeared OK but that he had lost weight. He reported that he was going to see a close friend in Liverpool who was a psychiatrist. Apparently Escitalopram was prescribed.

Comment

The independent investigation team found no reference in the GP notes that this consultation was followed up by the GP, whether Mr. X took Escitalopram (an anti depressant) 10mgs as prescribed, or the efficacy of this.

17th July 2007[22]

Mr. X was admitted to hospital with non specific abdominal pain and discharged on the 19th of July 2007.

6th March 2009[20]

Mr. X went to see his GP and he was diagnosed with Reactive Depression. It was noted he had been diagnosed with renal cancer and was awaiting an operation. It was also noted that Mr. X had separated from his wife two weeks previously and that he was living in bed and breakfast accommodation. He is recorded to have been very tearful, having problems sleeping and reporting poor concentration. He told the GP that he was seeing a friend who

[18] Letter 13/9/2004
[19] Patient Calls Report, 24/9/2004
[20] Report from Endoscopy Unit, Lister Hospital, 7/10/2004
[21] GP records
[22] Discharge notification, Lister Hospital, 19/7/2007

was a psychiatrist. No psychotic features were present. Citalopram Hydrobromide (an anti depressant) was prescribed.

Comment
Mr. X indicated that he was seeing a friend who was a psychiatrist during this consultation. There is no evidence in the GP records whether this was explored further with Mr. X by the GP, or if the GP attempted to ascertain the identity of the psychiatrist, or the basis of this relationship, in order to consider whether formal communication regarding Mr. X's care and treatment at that time, would be appropriate.

17th March 2009[20]
Seen by GP in the GP surgery. Mr. X is reported in the notes to be very agitated, low in mood and to be taking Citalopram Hydrobromide 20mgs per day. The GP noted that he contacted the Consultant Psychiatrist from the CMHT for advice and he reportedly advised that Mr. X continue with the Citalopram for 2 weeks and then if Mr. X's mood did not improve, he would be happy to see him.

Comment
On 6th March 2009, Mr. X was prescribed Citalopram Hydrobromide 10mgs. However on 17th March 2009 the GP has noted he said he was taking 20mgs. This has not been commented on by the GP in the GP clinical records.

The independent investigation team found no reference in the GP clinical records that this consultation was followed up, whether Mr. X took continued to take Citalopram Hydrobromide, or the efficacy of this.

7th May 2009[23]
A Clinical Fellow in Gastroenterology, UCLH, wrote to the Consultant Urological Surgeon at Lister Hospital, Department of Urology, to inform him that Mr. X required some physical investigations. He said they would be happy if the investigations were done locally or they could be organised at UCLH.

26 May 2009[24]
The Consultant Urological Surgeon wrote to MR X's GP to inform him that on review Mr. X was doing very well and gradually returning to normal activities but that a small renal cancer had been found but was in the low risk prognosis category. A scan was arranged for October 2009 and results would be reviewed afterwards.

27 May 2009[25]
Clinical Fellow Gastroenterology UCLH wrote to the Consultant Urological Surgeon to say that Mr. X was discussed at the multidisciplinary meeting and a surgical review was planned.

[20] GP records
[23] Letter 7/5/2009
[24] Letter
[25] Letter 27/5/2009

5 June 2009[26]

A Clinical Fellow in Gastroenterology at UCLH wrote to the GP to inform him that after discussion with the team, the plan was for Mr. X to see the Pancreato-Biliary team or surgical team at UCLH for consideration of resection.

16 June 2009[27]

The Consultant Surgeon at Hepatobiliary and Pancreatic Surgical Unit wrote to the GP to inform him that he had reviewed Mr. X and arranged for him to have a catecholamine and metaneprine screens.

26 June 2009[28]

The Consultant Urological Surgeon wrote to the GP, to update him on Mr. X. He said that he was doing really well and gradually returning to full normal activities. He was placed in the low risk prognostic category.

24 July 2009[29]

The Consultant Surgeon at Hepatobiliary and Pancreatic Surgical Unit wrote to the GP to inform him that he had reviewed Mr. X and that a neuroendecrine tumour had been found. He informed him that they were going to resect the mass he was diagnosed with.

14th September 2009

Mr. X was admitted to hospital for removal of the mass in his stomach.

23rd November 2009[30]

Seen by GP in surgery. It is noted that Mr. X had split up with his wife and that an Ear, Nose and Throat Department (ENT) referral was to be made. Citalopram Hydrobromide 20mgs per day prescribed.

Comment

The independent investigation team found no indication in the GP clinical notes as to why Mr. X was referred to the ENT department or what his depressive symptoms were, that led to him being prescribed an anti depressant.

9th December 2009[31]

Mr. X was admitted to University College London Hospitals (UCLH) for operations on his pancreas and other specified block dissection of lymph nodes.

4th December 2009[32]

The Consultant Surgeon at the Hepatobiliary and Pancreatic Surgical Unit wrote to the Consultant Gastroenterologist at UCLH with an update on Mr. X . He said that he had

[26] Letter 5/6/2009
[27] Letter 16/6/2009
[28] Letter 26/6/2009
[29] Letter 24/7/2009
[30] GP records
[31] Discharge summary, 14/9/2009
[32] Letter 4/12/2009

recovered from surgery well and that he had arranged for him to have his gastrin measured again and was asking for an upper GI endoscopy. There was a history of a non healing duodenal ulcer which he had for many years. At the time of examination, he was asymptomatic and off all drugs.

Comment
The independent investigation team are unclear whether the statement that Mr. X was 'off all drugs' included the anti-depressant that he was prescribed by the GP in November 2009, or whether he was taking it as prescribed.

14th December 2009[33]
Mr. X was discharged home following his operations.

15th December 2009[34]
A Locum GP at the surgery wrote to Letchworth Community Mental Health Team (CMHT) to refer Mr. X to them. She reported that he had suicidal thoughts but had made no active plans. She reported that he had suffered from intermittent depression, which had become much worse due to his wife recently leaving him. She stated in the referral that he was still feeling very low. The referral was marked as urgent.

Comment
It was policy at the time that Mr. X was referred to the CMHT, that urgent referrals would be seen within 24 hours. This did not occur in this case.

17th December 2009[35]
Mr. X was seen by a Community Psychiatric Nurse (CPN) and a Social Worker (SW) from the CMHT in response to the GP referral. The CPN recorded that Mr. X presented as distraught, tearful and depressed following the break-up of his marriage. He stated that he was in telephone contact with his wife although he did not know where she was living and expressed fears that he suspected his wife had been having a relationship with another man. Mr. X had suspicions that the man was someone that he and his wife had known as a friend.

He admitted to experiencing thoughts of suicide and stated that he felt he *'could not tell us the truth about these feelings'*. Mr. X stated that he had no active plans to kill himself but also admitted that he knew how to get hold of heroin, which would be his chosen method of suicide if he was going to do it. He said that if he did it there would be *'no messing around'* and that '*it would be the end'*.

He said that he'd had two bouts of reactive depression in the past, in 2000 and 2006, and that these had been effectively treated with Amitriptyline.

[33] Discharge summary, 14/9/2009
[34] Letter to Letchworth Community Mental Health Team
[35] CPN's notes, 17/12/2009

Mr. X said that he was happy to receive help from the CMHT. He said that he felt hopeless about the future and was finding it hard to talk to his friends as he couldn't admit what had happened.

Mr. X stated that he'd grown up in Iraq and that both his parents and some of his siblings were killed in the Saddam Hussein regime. He stated he has one sister who, like himself, managed to flee the regime. He reported poor sleep and appetite and limited motivation. Mr. X also described his recent physical health problems and that he had been treated for kidney cancer earlier in the year.

At the end of the assessment it was agreed that an urgent outpatient appointment be arranged with the Consultant Psychiatrist from the CMHT and for the team duty worker to call Mr. X the following week. Following the assessment a clinical risk assessment was completed as follows:

Risk to staff	No	
Threatening self harm	Yes	Denied active plans but did state that he had considered how he could do this. Stated he'd indicated that he'd made arrangements with his daughters to take care of his affairs if anything happened and had asked both daughters to forgive him if he did *'something silly'*
Actual or threatened violence	No	
Previous danger and impulsive acts	No	
Previous use or current threat to use weapons	No	
Threatened or actual aggression to carers	No	
Arson or fire risk	No	
Misuse of drugs (prescribed or illegal)	No	
Excessive use of alcohol	No	
Evidence of self neglect	Yes	Currently eating very little. Trying to keep up his strength with milk.
Abuse/exploitation by others	No	
Sexually inappropriate behaviour	No	
Other	No	
Expressing suicidal ideas/plans	Yes	
Feels hopeless about the future	Yes	Reports that he finds it hard to visualise a future without his wife.
Mental disorder and sustained anger and fear	No	
Paranoid delusions about others	No	
Mental disorder and plans/fantasies of attack	No	
Morbid jealousy	No	
Loss of	No	

memory/disorientation		
Physical health problems	Yes	Liver cancer this year
Other reports/evidence that cause concern		Distressed as wife left him 6 weeks ago
Risk to children	No	
Immediate plan to manage the risk; Outpatients appointment 24/12/09 Emergency contact numbers given to patient Duty worker to follow up 22/12/09		

Comment
The independent investigation team note that some aspects of potential risk, such as the risk of violence and morbid jealousy have been deemed not to be a risk. However, it is apparent from the clinical records, and interviews with assessing staff, that these issues, as they were not immediately apparent, were not assessed or explored.

22 December 2009[36]
Mr. X was assessed by the Consultant Psychiatrist from the Letchworth CMHT who noted the following:

Mr. X stated he had returned from a trip to Iraq to find out his wife was leaving him. He believed she was having an affair with the neighbour and was devastated by her departure. He became extremely distressed and developed a recurrence of severe depressive symptoms such as profound low mood, anxiety, agitation, tearfulness, disturbed sleep, reduced appetite and weight loss. He felt worthless and would ruminate about why his wife left him. He usually did not drink alcohol but in recent weeks had been drinking around three glasses of wine per day and his caffeine intake had increased greatly to around six or seven double espressos per day.

He had been married for just under 20 years and felt that the relationship was solid for the most of it. They experienced problems about a year ago when she left him temporarily for another man. They reunited and went for marriage counselling and he worked hard on their relationship. He felt particularly embarrassed by the fact that she was having an affair.

Over the past year he had other major stresses to contend with - renal cancer and neuro-endocrine tumour of the stomach which were both successfully excised by surgery in June and September 2009. There was no metastatic spread of either tumour.

He was started on Citalopram 20 mgs daily for four weeks and has been on 40 mg daily for the last 2 of those four weeks.

He grew up in Iraq and did most of his medical degree there but moved to Manchester for the final year of his degree. After completing his Membership of the Royal College of Physicians (MRCP), he worked as a physician for several years before moving in to the substance misuse field. He was medically retired in 2000 because of depression. He did not

[36] Letter Consultant Psychiatrist, Letchworth Mental Health Team, to GP, 23/12/2009

receive any formal treatment for depression until the late 1990s when he was treated in primary care with Amitriptyline. He could not recall what dose of Amitriptyline he was taking and was unsure whether it really helped.

He presented as thin, tense and agitated and was tearful throughout most of the interview but calmed somewhat as the interview progressed. He described clear depressive symptoms but did not have any psychotic symptoms.

He said he felt worthless and alluded to having contemplated suicide but declined to go into detail about any suicide plans. He was looking forward to seeing his adult daughters on Christmas day. He was keen to engage with the staff and willing to accept help.

Mr. X described considerable trauma in his young adult life when several members of his family were assassinated which left him vulnerable to experiencing depressive episodes for much of his adulthood. He had to retire from working as a substance abuse doctor in 2000 because of depression.

For most of the last few years he stated he was reasonably well mentally. His depressive symptoms recurred markedly after his wife left him approximately six weeks ago. So far treatment with Citalopram had not helped but he had only been on it for four weeks. He experienced considerable adversity in recent months with two cancers and his wife leaving him. He contemplated suicide but resisted these thoughts so far mainly out of concern for his daughters.

His care plan following the assessment was as follows:

1. Allocated to a CPN for Care Coordination and support
2. Increase Citalopram to 60 mgs once a day and complete a six week trial of Citalopram before contemplating a switch of antidepressant.
3. Because of agitation start Diazepam 5 mg twice a day.
4. The Consultant Psychiatrist discussed with him a referral to the Crisis Assessment and Treatment Team (CATT) team but Mr. X was not keen on that option and had agreed to see the CMHT regularly instead.
5. Review with Consultant Psychiatrist in his clinic in a week's time
6. Telephone numbers for the Trust helpline given to Mr. X and explanation that he could contact them or their duty worker if necessary explained to him.

<u>23rd December 2009</u>

Mr. X was visited at home by his estranged wife and their daughter. Mr. X apparently confronted his wife with evidence he had gained from a private investigator that she was having an affair and an argument ensued. Mr. X stabbed his wife repeatedly with a kitchen knife. She later died from her injuries.

3rd January 2010 (Post incident)[37]

Mr. X was assessed in prison following the homicide, whilst he was on remand. This assessment was completed for the purposes of establishing whether Mr. X should be detained in a secure hospital facility where he could receive treatment for his mental health problems. It was agreed by the assessing Forensic Consultant Psychiatrist (FCP) that this would be appropriate.

At the time of the assessment, Mr. X was under constant observation on the health wing within the prison due to low mood, thoughts of harming himself, and fleeting paranoid ideas.

During the assessment, Mr. X told the FCP that his father and brother were allegedly murdered by Saddam Hussain's regime. He said he left Iraq in the 1980's and returned for a brief period in the 1990's when he witnessed traumatic sights and events including people who had been tortured and decapitated. He sad at that time he was apparently taking Haloperidol and Risperidone (anti psychotic medications).

Mr. X stated that he had worked as a GP but was retired on medical grounds in 1999.

He stated that he had previously lived in the United States for two years where he had been diagnosed as suffering from psychotic depression and was under the care of a psychiatrist there.

The FCP recorded Mr. X told him that he had a very strong history of mental illness within the family. He stated that his mother suffered from depression, a cousin committed suicide and his cousin suffered from schizophrenia.

Comment

It is apparent to the independent investigation team that the account of his history given to FCP by Mr. X demonstrates that he suffered from mental health problems on occasions throughout the 1990's and possibly beyond. It is difficult to be definitive about what Mr. X's long-standing GP practice and the private psychiatrist knew of this as the independent investigation team have been unable to ask them. The clinical notes made by both, however do not indicate that this information was known to them.

The Consultant Psychiatrist, the Social Worker and the Community Psychiatric Nurse (CPN) from the CMHT, who conducted assessments of Mr. X's mental health on 17th and 22nd December 2009, were certainly not made aware of this element of Mr. X's psychiatric assessment by him, or indeed the extensive prevalence of serious mental illness in his family.

[37] Letter detailing Forensic Consultant Psychiatrist assessment, 13/01/2010

12.0 REVIEW THE ASSESSMENT, TREATMENT AND CARE THAT MR. X RECEIVED

12.1 Primary Care

12.11 *Quality of Clinical Care*

As previously stated, the independent investigation team have not been able to talk to the GP, who provided care to Mr. X on an ongoing basis. The GP practice did, however, supply the clinical records made by GPs in the practice following consultations with Mr. X.

Mr. X was being treated for depression by the private psychiatrist in 2001, when he first became a patient at the GP surgery in Hertfordshire. The GP there subsequently treated him for depression in 2006 and again in 2009.

National guidance[38] outlines in detail the treatment that should be offered to people with a diagnosis of depression. It divides the treatment and management of depression into four descriptions as defined within the ICD 10[39]. These are: mild depression, moderate depression, severe depression and severe depression with psychotic symptoms. These are defined by the number of symptoms presented by the individual concerned and preferred treatment protocols for each category are defined within the document.

Comment
Mr. X's GP notes provided to the independent investigation team are scant and do not define the level of depression being treated, as defined in the guidance. This leaves the independent investigation team unclear as to the GPs assessment of the level and severity of Mr. X's depression both in 2006 and 2009. However the guidance states that anti-depressant medication is not recommended for mild depression so the independent investigation team presume that the GP was of the view that Mr. X's depression was at least moderate in nature, as anti-depressants were prescribed on both occasions for Mr. X.

The guidance states that patients who are prescribed anti depressants should be seen after two to three weeks and then at regular intervals after that. It also states that a review of the continuing need for anti depressants should take place after a 6-month period of taking the medication has elapsed.

Mr. X was prescribed anti-depressants by his GP on 23rd August 2006. He was not seen again by his GP until the following summer. Mr. X's depression and previous anti- depressant prescription was not mentioned in the GP records made following this consultation.

On 6th March 2009 Mr. X was seen again by his GP and was prescribed anti-depressants for depression. He was reviewed by his GP 11 days later. Following this Mr. X was seen by his

[38] NICE (2004) *Depression: Management of depression in primary and secondary care* [CG23] this has been replaced by NICE (2009) *Depression: The treatment and management of depression in adults (update)* [CG90]

[39] World Health Organization (1993) *ICD-10: The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines*

GP many times throughout 2009 for physical health issues but the clinical records show no further mention of Mr. X's depression or prescription of anti-depressants until he was seen by the Locum GP, and referred to the CMHT, on 15th December 2009.

Comment

It is not possible to ascertain from the clinical notes how long Mr. X continued to take his anti depressant medication both in 2006 and 2009, and the efficacy of this. The independent investigation team found no evidence in the clinical records that this was monitored by the GP, as stipulated as good practice in the national guidance.

The national guidance[40] states:

'The effective assessment of a patient (including where appropriate, a comprehensive review of physical, psychological and social needs and a risk assessment) and Mr. X bsequent co-ordination oh his care may contribute significantly to improved outcomes. This is particularly important if the patient receives primary and secondary care.

It is not evident from the GP clinical records whether a comprehensive assessment of Mr. X took place by the GP prior to that undertaken by the Locum GP in 2009.

The lack of information in the GP clinical records has made it impossible for the independent investigation team to ascertain how much Mr. X's long term GP knew about his psychiatric symptoms and history, which in turn, leaves the independent investigation team unable to make a judgement regarding whether the GP should have made an earlier referral to specialist psychiatric services at the CMHT.

It is the view of the independent investigation team that, indeed, if Mr. X's GP was aware of any of this information, it would have been appropriate for him to have referred Mr. X to the CMHT, and monitored him more closely, during and following his earlier bouts of depression.

Recommendation 1

Commissioners of GP services should ensure, and ensure that they can demonstrate, that GP's are treating all patients, who present with depressive symptoms, in line with the current national NICE guidance 'Depression: The treatment and management of depression in adults (update) [CG90] 2009'

The guidance[41] states that for both mild and moderate depression, patients should be offered psychological therapy.

[40] NICE (2004) *Depression: Management of depression in primary and secondary care* [CG23] this has been replaced by NICE (2009) *Depression: The treatment and management of depression in adults (update)* [CG90]

[41] NICE (2004) *Depression: Management of depression in primary and secondary care* [CG23] this has been replaced by NICE (2009) *Depression: The treatment and management of depression in adults (update)* [CG90]

The Improving Access to Psychological Therapies (IAPT) programme was set up nationally in May 2006. It aims to improve public access to a range of National Institute for Health and Clinical Excellence (NICE) approved psychological therapies for depression and anxiety disorders through:

- Provision of an appropriately trained workforce,
- Delivering therapies to specific quality standards,
- Routine monitoring of patient reported outcome measures,
- Defined care pathways (characterised by a stepped care model) and
- Flexible referrals routes (including self-referral by potential patients).

At the time of this report, NHS Hertfordshire had an Enhanced Primary Mental Health Service (EPMHS) which delivers psychological therapies to service users referred by Hertfordshire GPs.

Comment
The independent investigation team found no evidence that Mr. X was offered psychological therapies in primary care, by his permanent GP, in either 2006 or 2009. It is the view of the independent investigation team that this was particularly pertinent in Mr. X's case due to the trauma he experienced and witnessed in his earlier life.

Recommendation 2

Commissioners of GP services should undertake a review of the provison of psychological therapies within the relevant GP surgery to ensure that practice, referral and uptake rates are consistent with national standards.

On 15th December 2009 the Locum GP at Mr. X's surgery wrote to Letchworth CMHT to refer Mr. X to them after seeing him in surgery. She reported that he had suicidal thoughts but had made no active plans and that he had suffered from intermittent depression, which had become much worse due to his wife recently leaving him. She stated in the referral that he was still feeling very low. The referral was marked as urgent.

Comment
The independent investigation team found that the Locum GP acted quickly and effectively given Mr. X's presenting condition, social circumstances, and history of recurrent depression and serious physical illness. The decision to refer Mr. X to the CMHT urgently at that point was appropriate.

12.12 *Record Keeping*

It has been difficult to gain clarity on a lot of issues pertaining to Mr. X's ongoing mental health care from the GP due to the paucity of the GP records.

The General Medical Council (GMC) state in their guidance to doctors,[42] that they should;

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 investigation or treatment

Comment
As outlined in the chronology the lack of detail contained within the GP records has left the independent investigation team unclear whether gaps in the information are due to poor recording or deficits in clinical care. As Mr. X's GP did not wish to be involved in this investigation the independent investigation team have been unable to explore this issue further.

Recommendation 3

Commissioners of GP services should work with GPs to establish methods of assuring themselves that GP record keeping is of a consistently high standard

12.13 *Private Psychiatrist*

As previously stated, the independent investigation team have not been able to talk to the private psychiatrist who provided care to Mr. X on an independent basis, or examine the clinical records made by him following these consultations. This is unfortunate as he might have been able to enlighten the independent investigation team as to the details of Mr. X's psychiatric history.

The independent investigation team did have some correspondence with the private psychiatrist as part of the investigation process. He stated within this correspondence that he was now retired and no longer was in possession of Mr. X's records and was unable to assist with the investigation. He also said that he had remained friends with Mr. X following his clinical involvement with him and also stated[43]:

'They were many facts I did NOT know that were highlighted in the Court & that he (Mr. X) did NOT confide in me as he did with other friends'

Due to the lack of information available about the care provided to Mr. X by the private psychiatrist, all judgments made about this by the independent investigation team are

[42] GMC Good medical practice: Providing good clinical care, www.gmc-uk.org, 2013
[43] Email from the private psychiatrist to Lead Investigator, 11/7/2012

based on the letters from the private psychiatrist to Mr. X's GP, found in the GP clinical records. These are dated 16th March 2001, 5th May 2001, 15th September 2001, 18th January 2002 and 18th May 2002.

It appears from the letters that Mr. X was being treated by the private psychiatrist for depression. The private psychiatrist's letter demonstrated that this included suicidal thoughts, insomnia, and difficulty expressing his feelings, poor appetite, concentration and motivation.

It is also stated within the correspondence from the private psychiatrist to the GP that he had recommended to Mr. X that he leave his job as a GP stating as '*it was not fair on him or his patients'.*

Comment
The independent investigation team contacted the organisation that had employed Mr. X in 2001 as a doctor (when the private psychiatrist stated in his letters to the GP that he advised Mr. X to leave his job) in an attempt to obtain the occupational health records relevant to Mr. X. These were no longer held within the organisation so were not available to be accessed.

In the letter dated 16th March 2001 to the GP, the private psychiatrist stated his view that in the long term Mr. X would need medication, support, group work and psychotherapy and that he would review him again in May 2001.

Comment
The independent investigation team found no indication in the GP clinical notes that any dialogue between the private psychiatrist and the GP, or Mr. X and the GP, took place to ascertain how Mr. X would access support, group work and psychotherapy and there is no indication that this was arranged for Mr. X or that he received it. It is the view of the independent investigation team that Mr. X would have benefited from communication between the private psychiatrist and the GP about how the private psychiatrist's recommendations could have been achieved.

12.2 Secondary Mental Health Care Services

12.21 *Timescales with regard to assessment by the CMHT*

Mr. X was referred to the Letchworth CMHT by the Locum GP on 15th December 2009. He was first seen by the CPN and the Social Worker from the CMHT on 17th December 2009, 48 hours later. Following this, he was reviewed by the Consultant Psychiatrist on 22nd December 2009, 1 week after referral.

The independent investigation team were told at interview that it is now standard practice that service users referred urgently by GPs are seen within 24 hours but that this was not the case in 2009.

The trust's internal investigation report[44] states that the initial assessment was carried out jointly by two disciplines, which was compliant with the CMHT's Operational Policy.

It goes on to point out that the CMHT Operational Policy at the time, however, required urgent referrals to be seen within 24 hours of referral, which didn't occur in this case.

Staff interviewed by the independent investigation team were not able to articulate the reason for this discrepancy other than it was the festive period and therefore very busy, but also one of them seemed to recall that the appointment was possibly booked in response to Mr. X's preference of date and time and was arranged at his convenience, although there is no objective evidence of this.

Recommendation 4

Hertfordshire Partnership NHS Foundation Trust should continually monitor community team performance in relation to adherence to prescribed timescales for response to urgent referrals, and the reasons for any variance.

Following the assessment by the CPN and Social Worker on 17th December 2009, it was deemed that Mr. X needed to be seen by the Consultant Psychiatrist. Due to the need to expedite this appointment, the busyness of clinicians and a full outpatient clinic prior to the pending Christmas period, arrangements were made for him to be seen by the Consultant Psychiatrist during a lunchtime period.

The independent investigation team were told at interview that the team were eager that Mr. X should have been seen quickly so urgent arrangements were made, but this did mean the appointment with the Consultant Psychiatrist was shorter than the average first appointment and therefore he was unable to undertake as full an assessment as he normally would.

The trust's internal investigation report[45] states:

> *"The (internal investigation) team believed the heavily booked out patient clinic the Consultant worked through was significant and found that the reasons for this pressure were due to delays in recruitment. The team was concerned that this situation resulted in a clinician having to work under such pressure and no apparent contingencies in place to support him. The team was impressed with the Consultant's tenacity and commitment under these difficult circumstances."*

Comment

The independent investigation team concur with the internal investigation team's view that the Consultant Psychiatrist tried hard to accommodate the needs of Mr. X as best he could

[44] Hertfordshire Partnership NHS Foundation Trust (2010) *Internal Review into the Care and Treatment of XX Provided by Hertfordshire Partnership NHS Foundation Trust*

[45] Hertfordshire Partnership NHS Foundation Trust (2010) *Internal Review into the Care and Treatment of XX Provided by Hertfordshire Partnership NHS Foundation Trust*

given the circumstances and are of the view that additional medical capacity in the CMHT at that time would have prevented him having to see Mr. X for a shorter time period than usual, resulting in a less thorough assessment.

The Trust's internal investigation report makes recommendations as follows:

> *Direct services should explore the specific circumstances surrounding the shortage of doctors in the Letchworth team at the time of this incident and understand why the doctor was under such pressure and what management action should have been taken to alleviate that pressure-to prevent a similar situation occurring again, or elsewhere.*

And

> *The Joint Heads of Service should examine the management of consultant clinics and associated case load pressures and ensure contingencies are developed to provide for the management of emergencies. The Trust has a responsibility to ensure all staff can work effectively despite the prevailing demand. There may be a need to consider more routine cases being delegated to more junior doctors to enable emergencies are properly assessed.*

However, the independent investigation team were also told at interview that it is not the perception of clinician's in the team that there was a shortage of doctors in the team at that time or that there were vacant posts. It was conveyed that the service was "*busy and stretched*' at that time but that this was not unusual, and that professionals expected that to happen on occasions.

The independent investigation team were told that the numbers of medical staff in the team had not increased since this incident.

13.0 CARE PROGRAMME APPROACH (CPA), QUALITY OF ASSESSMENT, RISK ASSESSMENT AND CLINICAL CARE

13.1 Clinical risk assessment

The Trust's internal investigation report[46] commented that an enhanced level risk assessment should have been carried out by the CMHT, as Mr. X met the criteria for CPA due to the concerns about his thoughts of suicide.

At interview, the independent investigation team were told that assessors from the CMHT were aware that Mr. X potentially required more detailed risk assessment but that the risk

[46] Hertfordshire Partnership NHS Foundation Trust (2010) *Internal Review into the Care and Treatment of XX Provided by Hertfordshire Partnership NHS Foundation Trust*

assessment completed by the SW, CPN and later, the Consultant Psychiatrist, would have been developed in more detail over time. As it was, the homicide occurred before this could be completed.

Comment
Although the independent investigation team concur with the internal investigation team that Mr X required a more detailed clinical risk assessment, at what was recognised in the Trust as enhanced level, it is accepted that the assessments carried out on Mr X were limited by time factors and that the assessing clinicians, particularly the Consultant Psychiatrist, had to stick to the *'salient issues'* for practical reasons given the time constraints. The independent investigation team notes the comments heard at interview indicating that more detailed risk assessment would occur over time and are of the view that this was realistic in the circumstances.

Within the clinical risk assessment that was completed during the two staged assessment conducted by the CMHT it was deemed that Mr. X did not present any clinical risks in terms of harm to others, use of weapons, or morbid jealousy. However it is apparent from the clinical records, and the information conveyed to the independent investigation team during interviews that these aspects were not assessed, as the issues did not present themselves during the assessment.

Comment
The independent investigation team accepts that given the time constraints of the two staged assessment of Mr. X that certain aspects were not explored. It is the view of the independent investigation team however, that in such cases the issues should be recorded as unassessed rather than not to present a risk.

Recommendation 5

Hertfordshire Partnership NHS Foundation Trust should provide clinical risk assessment documentation, for use by workers, which enables them to clearly mark when a potential aspect of clinical risk has not been assessed, the reasons for this, and plans in place to ensure that the assessment is completed in a timely manner.

Mr. X told the Consultant Psychiatrist during the assessment that he was devastated by his wife's departure and that he was ruminating about why she left him. However the possibility of the effects of this, and potential morbid jealousy were not explored in detail with Mr. X.

Comment
The independent investigation team accepts that during the short period of assessment there was no reason apparent during the meetings with Mr. X to indicate a history of harm to others or use of weapons. However Mr. X did indicate the main reason for his deterioration in mood was his estrangement from his wife and his belief that she was having an affair with another man.

Research regarding morbid jealousy [47] shows:

Once suspicions regarding the partner's fidelity are established, they quickly become preoccupying. Overt behaviours to investigate suspicions and preoccupations are common and evident to all involved. They include interrogation of the partner, repeated telephone calls to work and surprise visits, stalking behaviour, or hiring a private detective to follow the partner. Jealous individuals may search the partner's clothes and possessions, scrutinize diaries and correspondence, and examine bed linen, underclothes and even genitalia for evidence of sexual activity. They may hide recording equipment to detect clandestine liaisons, and some go to extreme lengths, including violence, to extract a confession from their partner.

The accused partner is assumed to be guilty until evidence of innocence is found, but this cannot materialise. Heroic efforts to prove innocence or disprove guilt must fail, as irrational preoccupations cannot be refuted rationally.

Kingham and Gordon go on to point out the relevance to jealousy in romantic relationships to homicide rates in the UK:

Dell (1984) concluded that 'amorous jealousy/possessiveness' accounted for 17% of all cases of homicide in the UK. Mowat (1966) reported on 110 morbidly jealous subjects who had killed or committed serious assaults and been admitted to a British forensic psychiatric facility. In 94 cases, the victim had been the partner. In Mooney's (1965) series, 14% of morbidly jealous individuals were considered to have made 'homicidal attempts', the majority against the accused partner. Repeated denials of infidelity may provoke extreme anger and violence. Alternatively, the longsuffering partner, plagued by repeated cross-examination and accusations of infidelity, may yield and give a false confession, provoking a violent rage in the jealous individual. Domestic violence is a common result of jealousy, normal or morbid. According to the British Crime Survey, 23% of women and 15% of men have been physically assaulted by their partners (Mirrlees- Black, 1999). Domestic violence is associated with increased risk of death at the hands of the perpetrator.

Kingham and Gordon state that assessment of morbid jealousy requires a wide ranging approach and careful history taking, and state:

The issue of jealousy should be approached tactfully, as the jealous individual may believe that the partner's alleged infidelity is creating the difficulties, not their own jealousy. It is important to complete a full psychiatric history and mental state examination, looking carefully at the phenomenology of the jealousy. It may be possible to distinguish between jealousy that is delusional, obsessional or an overvalued idea, and this may be significant in terms of risk. Evidence of associated mental illness and substance misuse should be carefully elicited. It is recommended that more than one interview be conducted to assess the marital relationship, and that a sexual and domestic violence history be taken from both partners, who should be seen separately as well as together.

[47] Kingham, M. & Gordon, H. (2004) Aspects of morbid jealousy. *Advances in Psychiatric Treatment.* 10: 207-215

They outline the essential components of assessment as follows:

Take a full psychiatric history, including:
• affective and psychotic disorders
• threatened and perpetrated violence
• the quality of the relationship
• family constitution
• substance misuse
• collateral and separate history from spouse

Carry out a mental state examination, including:
• the form of morbid jealousy
• associated psychopathology
• consideration of organic disorder

Conduct a risk assessment for both partners, considering:
• suicide
• history of domestic violence
• history of interpersonal violence, including any third party (e.g. suspected rival)
• risk to children

They conclude that management should include, where relevant, the following:

Principles of management:
• Treat the mental disorder
• Manage the risk

Biological options:
• Antipsychotic medication
• Selective serotonin reuptake inhibitors

Psychosocial options:
• Treatment of any substance misuse
• Cognitive–behavioural therapy
• Couple therapy
• Dynamic psychotherapy
• Child protection proceedings
• Admission to hospital (compulsory detention if necessary)
• Geographical separation of the partners

They conclude:

The modern clinician has a variety of drug treatments and psychosocial approaches with which to tackle the disorder, and the prognosis may not be as bleak as was once thought. Given the potential for tragic consequences, morbid jealousy is a symptom to be treated vigorously.

Recent data on homicides committed by people with mental illness shows that in most case, the victim is known to the perpetrator[48].

Comment
The independent investigation team are aware that at the time of the CMHT two-staged assessment, Mr. X did not make any of the assessors aware that he had engaged a private detective to conduct surveillance on his wife, or the outcome of this.

However, given Mr. X's expressed statement that his low mood was due to his wife leaving him and his ruminations about this, it would have been beneficial if the assessors had been able to explore in more detail the effect that concerns about his wife having an affair with another man were having on him, and how he intended to deal with this when he next saw her.

As previously stated, the independent investigation team are aware of the time constraints faced by the assessing clinicians from the CMHT, and the shorter than usual assessment slot afforded to this SU due to pressures of work and a full clinic but are of the view that this particular aspect of risk, given the known risks of morbid jealousy in romantic relationships, should have been prioritised.

Recommendation 6

Hertfordshire Partnership NHS Foundation Trust board should assure themselves that clinical staff are appropriately trained in the assessment and management of potential morbid jealousy.

13.2 Involvement of the Community Assessment and Treatment Team (CATT)

The internal investigation report states:

The Team concluded that in line with NICE guidance, the Consultant's preferred intervention of referring Mr. X to the CATT may have been a better course of action and this could have been explored in context of his need for more intensive support.

Comment
Mr. X refused to engage with the CATT team but agreed to maintain regular contact with the CMHT. The independent investigation team concur with the Trust's internal investigation team that ideally he would have been best served, at that moment at time, by the intensity and regularity of visits and interventions that the CATT team could have offered. However, given that Mr. X refused this, but did agree to engage with the CMHT, the independent investigation team are of the view that the CMHT staff involved with Mr. X had little option than to offer Mr. X the service that he was prepared to accept. The only circumstances in which this could have been over ridden was if Mr. X appeared unwell to the extent that he could have been assessed for possible compulsory detention in hospital

[48] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2012) *Annual Report July 2012*

under the Mental Health Act. However, all the clinicians from the CMHT believe that Mr. X's presentation did not warrant this at the time that they saw him an the independent investigation team found no evidence in the clinical records that contradicted this view.

14.0 INTERNAL INVESTIGATION PROCESS

14.1 Quality of the investigation report

Following the homicide, Hertfordshire Partnership NHS Foundation Trust put a team together to investigate the incident, and conduct a root cause analysis. The team's investigation was concluded in June 2010. The internal investigation team comprised senior clinical and managerial staff from within the Trust and was chaired by the Chair of the Trust board.

The Trust's Internal Investigation Report was benchmarked using the National Patient Safety Agency's "Investigation credibility and thoroughness criteria"[49]. The Trust Internal Report scored well. The investigation and report are generally of a high standard and the findings and recommendations appropriate.

Areas where the investigation and report could have been improved were that there was no executive summary and the report did not contain information relating to the care and support of the victim's family or the perpetrator's family. It did not refer to support and engagement of staff in the internal review.

Comment
Despite the aforementioned, the independent investigation team were impressed with the standard of the investigation and report produced by Hertfordshire Partnership NHS Trust and found most of the findings to be well thought out and consistent with their own findings.

14.2 Liaison with the police and the family

In 2006 a Memorandum of Understanding[50] was agreed by the Association of Chief Police Officers, Health and Safety Executive and Department of Health laying out multi-agency procedures to be followed in the event of patient safety incidents that cause death or serious harm.

The protocol specifies that, in the event of a serious incident that will require police, health service and potentially Health and Safety Executive investigation, an Incident Co-ordination Group should be set up that incorporates the appropriate bodies to provide strategic oversight and investigation co-ordination. The protocol specifies that the group should be attended by senior representatives from each organisation and each meeting be formally minuted.

[49] National Patient Safety Agency (2008) *RCA Investigation: Evaluation, checklist, tracking and learning log*
[50] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*

A multi-agency policy is in place in Hertfordshire[51] that mirrors the content of the national Memorandum of Understanding[52]. This document states that the responsibility for initiation of the Incident Co-ordination Group rests with the health services.

The need for the establishment of an Incident Co-ordination Group was not made clear in the Trust's Incident Investigation Policy[53] in 2007 but is specified in the current policy. The responsibility for health service managers to initiate this within five days of the incident is not, however, made clear.

Despite the requirement for appropriate liaison to take place with families and victims and perpetrators of homicides being well documented in Trust policy and national guidance such as the Being Open framework[54] the families involved in this case were not contacted by the Trust.

It is acknowledged that this was due in part to the instruction given by the police for the Trust not to interview any staff or members of the public. The appropriateness of this instruction is unclear in this case but when such an agreement is in place this should not prevent identified persons within the Trust contacting families to offer support and inform them of the processes in place and the agreements that have been made by the Trust or multi-agency Incident Co-ordination Group.

Comment

The internal investigation report states that Mr. X's family were not contacted at the point of the internal investigation due to the fact that a police investigation was ongoing. The independent investigation team accept that questioning relatives who are involved in an ongoing police investigation when such an incident has taken place can be problematic and is, in some instances, inadvisable. However it is the view of the independent investigation team that, in circumstances such as these, Trusts should find ways to ensure that service users' relatives are offered appropriate support and information about internal investigation processes.

Recommendation 7

The Trust should ensure that one of the functions of the Incident Co-ordination Group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.

[51] Memorandum of Understanding for Investigating Patient Safety Incidents involving Unexpected Death or Serious Untoward Harm: A protocol for liaison and effective communications between East & North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust, Hertfordshire Constabulary, HM Coroner for the County of Hertfordshire and the Health & Safety Executive

[52] Department of Health, Association of Chief Police Officers, Health and Safety Executive (2006) *Memorandum of Understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm*

[53] Hertfordshire Partnership NHS Foundation Trust. *Learning from Adverse Events: Policy document and reporting & managing adverse events procedures and investigations of incidents, complaints & claims procedure* – Version 4, May 2007

[54] National Patient Safety Agency (2004) *Being Open Guidance* (Updated November 2009)

14.3 Findings of the Trust's internal investigation report (quotations from the Trust's internal investigation report in italics)

The (Trust's internal) team concluded that, overall, the care and treatment provided to Mr. X during the brief episode of care he experienced from the (CMHT) service, was generally of a good standard, provided by committed and sympathetic staff.

Comment
The independent investigation team concur with this finding.

There is no evidence to indicate that the attack on his wife could have been predicted as it appears to have been an impulsive act, inconsistent with his previous history.

Comment
The independent investigation team concur with this finding.

The (Trust's internal) team would like to have interviewed Mr. X's registered General Practitioner to have asked why there had been no other or previous referrals to the NHS mental health services.

Comment
The independent investigation team concur with this finding.

SIGNIFICANT FACTORS IN CARE AND TREATMENT
The (Trust's internal) team identified five key areas or issues that they believe emerge as significant factors in the care and treatment of Mr. X. These are as follows:

1. ***An incomplete picture relating to his mental health history**, including psychotic symptoms/episodes he had previously experienced and the wide range of medication he had previously taken.*

Comment
The independent investigation team concur with this finding. The evidence suggests that the clinicians from the CMHT were not given a full picture of the extent of Mr. X's mental health history, family history or the fact that Mr. X, on occasions, suffered from hypo-mania and psychosis by Mr. X. The evidence also suggests that this information was not known to the referring GP either.

2. ***A two staged approach to assessment with the absence of a clear care management plan** arising from the first assessment which should have been triggered and initiated as part of the CPA and the role of the care co-ordinator.*

Comment
The independent investigation team do not fully agree with this finding. Although not documented on a document entitled 'care plan' it appears to the independent investigation team that the plan of the care in the short term was known and understood by the CMHT clinicians involved in the initial assessment of Mr. X .

3. ***The absence of a comprehensive psychiatric assessment*** *due to time and operational pressures on the Consultant Psychiatrist.*

Comment
The independent investigation team concur with this finding.

4. ***A missed opportunity to relieve the distress and agitation felt by the patient and his functional impairment,*** *which had been escalating for several weeks.*

Comment
The independent investigation team do not fully concur with this finding.

The Trust's internal investigation report states:

The (Trust internal) team concluded that if the Consultant Psychiatrist had known more about Mr. X's medication history and the range of drugs that he had taken in the past, his approach to the medication he prescribed for Mr. X may have been very different. However, even without the benefit of this knowledge, the Team concluded that he might have considered alternative medication for Mr. X to treat his escalating distress and agitation which had shown no signs of abating with the existing drug regime.

It is the view of the independent investigation team that if the Consultant Psychiatrist had known more about Mr. X's medication history and the range of drugs that he had taken in the past, his approach to the medication he prescribed for Mr. X might have been very different. However, given Mr. X's presentation, and the information known to him at the time, it is the view of the independent investigation team that the Consultant Psychiatrist's prescription for Mr. X was reasonable.

5. ***Deferring referral to CATT*** *in deference to the patient's preference.*

Comment
The independent investigation team do not fully concur with this finding.

The Trust's internal investigation report states:

The (Trust internal) team concluded that in line with NICE guidance, the Consultant's preferred intervention of referring Mr. X to the CATT may have been a better course of action and this could have been explored in context of his need for more intensive support.

Mr. X refused to engage with the CATT team but agreed to maintain regular contact with the CMHT. The independent investigation team concur with the Trust's internal investigation team that, ideally, he would have been best served, at that moment at time, by the intensity and regularity of visits and interventions that the CATT team could have offered. However, given that Mr. X refused this, but did agree to engage with the CMHT, the independent investigation team are of the view that the CMHT staff involved with Mr. X had little option than to offer Mr. X the service that he was prepared to accept. The only

circumstances in which this could have been over ridden was if Mr. X appeared unwell to the extent that he could have been assessed for possible compulsory detention in hospital under the Mental Health Act. However, all the clinicians from the CMHT believe that Mr. X's presentation did not warrant this at the time that they saw him and the independent investigation team found no evidence in the clinical records that contradicted this view.

14.4 Recommendations outlined within the trust's internal investigation report (quotations from the Trust's internal investigation report in italics)

The Trust should consider how the CMHTs respond to requests for urgent referrals to prevent those patients requiring urgent, comprehensive MTD assessment, including by the Consultant Psychiatrist experiencing unnecessary delay in completing this process. Whilst the custom and practice is for an initial joint assessment by two disciplines within the CMHT, for patient's in an obviously distressed and agitated state, this only serves to exacerbate their symptoms and delay treatment. This may be an opportunity to review the service response to emergency situations and referrals.

Comment
The independent investigation team concur with this recommendation.

The Trust should review the relevant policy and its approach to the purpose of assessment and expected outcomes from this process.

Comment
The independent investigation team concur with this recommendation.

The Trust should consider how it manages the pressures associated with predictable periods of high demand and low staffing levels (e.g. Christmas/New Year season and August holiday times) and develop contingencies for business management/continuity. Direct Services should look at the practices across the Trust and determine what might be best practice to ensure patients have timely access to appropriate assessment and care when the service is likely to be under increased pressure. Any systems should ensure adequate provision for giving emergencies the essential priority needed.

Comment
The independent investigation team concur with this recommendation.

Direct Services should explore the specific circumstances surrounding the shortage of doctors in the Letchworth team at the time of this incident and understand why the doctor was under such pressure and what management action should have been taken to alleviate that pressure – to prevent a similar situation occurring again or elsewhere.

Comment
The independent investigation team concur with this recommendation.

The Joint Heads of Service should examine the management of consultant clinics and associated case load pressures and ensure contingencies are developed to provide for the management of emergencies. The Trust has a responsibility to ensure all staff can work effectively despite the prevailing demand. There may be a need to consider more routine cases being delegated to more junior doctors to enable emergencies to be properly assessed.

Comment
The independent investigation team concur with this recommendation.

14.5 Implementation of Trust's internal action plan

Action outlined in Trust's action plan

1. *Staff to ensure mandatory training in Clinical Risk is in date, which includes refresher on gathering comprehensive information to inform risk assessment*

Evidence of implementation
The Trust have submitted evidence to demonstrate that compliance with clinical risk assessment training is currently at 71% across the Trust and the trajectory for April 2013 is 98% across the Trust, for new and existing staff. This includes refresher training. In addition to the mandatory training the Trust are commissioning bespoke training for teams in clinical risk assessment and an advanced practitioner high level course.

Comment
The independent investigation team note that the Trust are working towards ensuring that all the relevant staff are appropriately trained in clinical risk assessment training and that the trajectory suggests that 100% compliance will be achieved by April 2013. It is the view of the independent investigation team that the trust board needs to monitor ongoing achievement with their standards for compliance with clinical risk assessment training on an ongoing basis.

Recommendation 8

Hertfordshire Partnership NHS Trust should develop formal mechanisms to monitor compliance with clinical risk assessment training on an ongoing basis.

2. *Staff to be reminded of the requirements for Enhanced CPA, and the need for Enhanced Risk Assessment when Enhanced CPA is identified.*

Evidence of implementation
The Trust told the independent investigation team that its enhanced level risk assessment document is currently being phased out in line with the changes to the CPA process outlined in the national document 'Refocusing the CPA". The Trust now uses one clinical risk assessment tool. The Trust has developed its clinical risk tool in an electronic format which is compatible with the Electronic Patient Record System used within the Trust. This has been piloted successfully and is a single, generic tool, which is to be used in the majority of care

settings within the Trust. The changes to the clinical risk assessment process are outlined in the trust's updated Care Coordination Policy, which was developed in December 2012

In July 2011 the Trust conducted an audit into the quality of clinical risk assessment pertaining to service users that had committed suicide.

The audit report[55] states:

The Trust achieved a high standard 29/30 (97%) for risk assessments being located, however for such a small sample (30) it should have been 100%. It is Trust policy that all service users have a risk assessment.

The risk management plan and crisis plan was a lot lower 25/29 (86%) and 20/26 (77%) however in an audit undertaken in 2009 and again in 2010 this figures in this audit show a year on year improvement.

Categories of risk again achieved a high standard 90% for both risk of violence and risk of self harm but again as in 2009 and 2010 audits the risk of self neglect was lower 76% however the audit did show an overall improvement in recording this section of the risk assessment for 2011.

Patient and Family/carers involvement in risk assessments/management process was quite low at 45% and 31% this was a decrease from the 2010 audit for patient involvement and an increase for family/carers involvement.

The Trust achieve 83% on the quality of risk management plan adequately reflecting the overall risk assessment, this is a vast improvement on the previous audit where 49% was achieved.

Recommendation 9

Hertfordshire Partnership NHS Foundation Trust should conduct annual audit to ensure ongoing compliance with the standards outlined in their clinical risk assessment policy.

3. *Ensure assessment processes are in line with Trust Policy*
4. *Staff to be reminded that assessment of urgent referrals should be completed within 24 hours, and that a full needs assessment should be completed within 48 hours of referral.*
5. *The new electronic needs agreement format prompts the completion of an initial care plan.*

Evidence of implementation

The Trust have updated the CMHT Operational Policy in January 2011. They state that the revised policy makes it clear how referrals should be responded to. Additionally, the Trust

55

now operate a single point of access referral process from a central point. The Trust state there is clear guidance around the urgency and escalation of referrals associated with this process.

Comment

The independent investigation team are pleased to see that policies have been updated and guidance to staff regarding the urgency of referrals, and the strengthening of a single point of access system has been implemented. However, the Trust does not yet appear to have tested compliance with this. The independent investigation team are of the view that these actions have been partly implemented until compliance has been tested by implementation of recommendation 4.

6. *Direct Services should explore the specific circumstances surrounding the shortage of doctors in the Letchworth team at the time of this incident and understand why the doctor was under such pressure and what management action should have been taken to alleviate that pressure – to prevent a similar situation occurring again or elsewhere.*
7. *Ensure Consultant Psychiatrists are available for emergency consultations*
8. *The Joint Heads of Service should examine the management of consultant clinics and associated case load pressures and ensure contingencies are developed to provide for the management of emergencies. The Trust has a responsibility to ensure all staff can work effectively despite the prevailing demand. There may be a need to consider more routine cases being delegated to more junior doctors to enable emergencies to be properly assessed.*
9. *The Trust should consider how it manages the pressures associated with predictable periods of high demand and low staffing levels (e.g. Christmas/New Year season and August holiday times) and develop contingencies for business management/continuity. Direct Services should look at best practice across the Trust and determine what might be best practice to ensure patients have timely access to appropriate assessment and care when the service is likely to be under increased pressure. Any systems should ensure adequate provision for giving emergencies the essential priority needed.*

Evidence of implementation

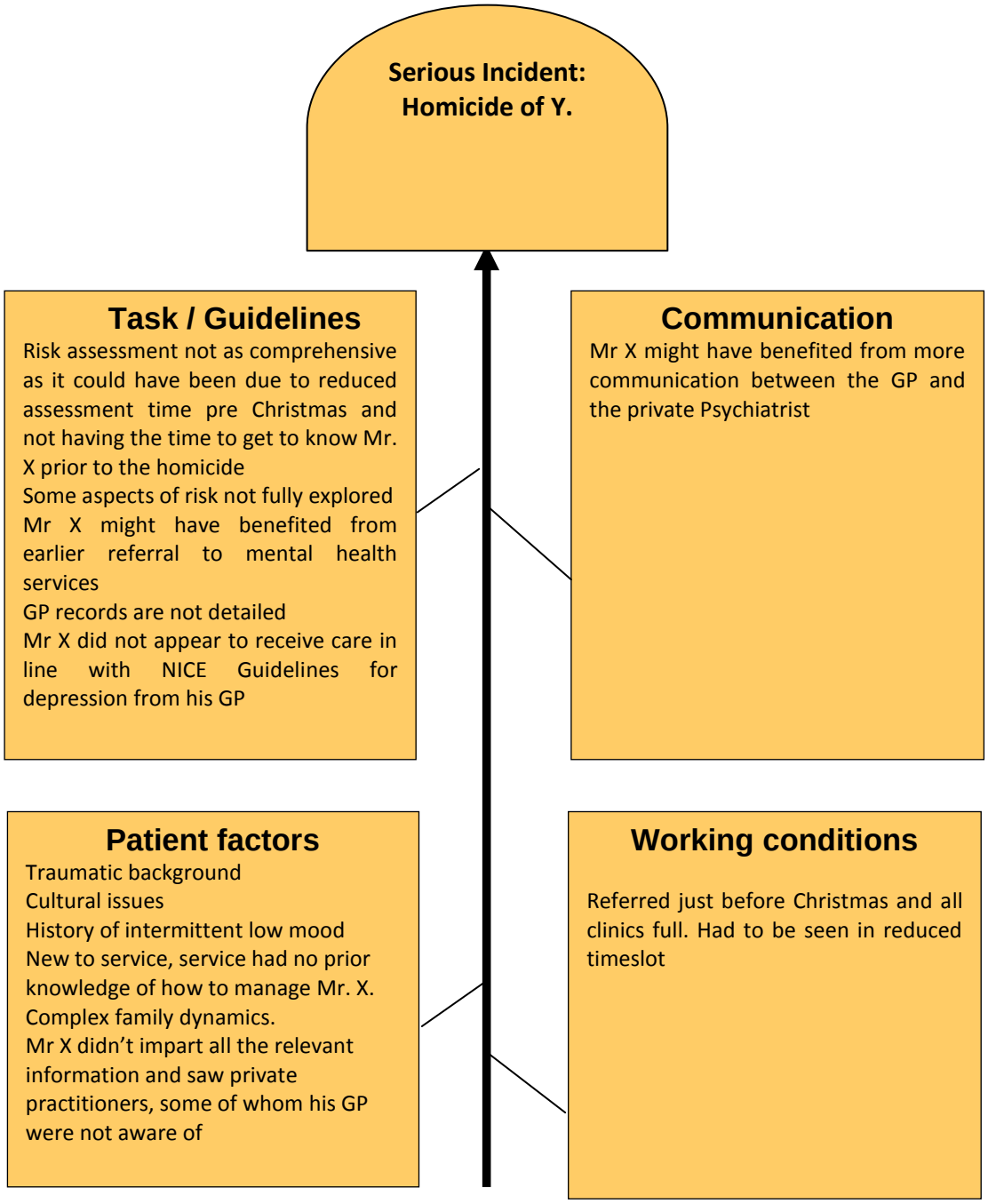
The Trust told the independent investigation team that since May 2010 the team has had a full time speciality doctor. This has considerably relieved the pressure and made more medical resource available for complex cases. The middle grade doctor at the time of the incident was on the first on call rota at the Lister Hospital so was frequently absent due to being on call there or having been on call the previous night. Since then, in 2012, the Trust began a review of its community mental health services aimed at providing more efficient and less fragmented services, with a fresh skill mix putting the most senior staff in areas where their expertise is most needed. An implementation plan of deployment of medical staff will soon be available.

The revised CMHT Operational Policy emphasises that Consultant Psychiatrists should utilise their skills for the most complex cases and that they should be available for consultation in the management of referrals, particularly in relation to referrals and assessments for people with complex needs and/or significant risk.

Comment

The independent investigation team are pleased to see that a review of expert medical cover has taken place and that Consultant Psychiatrist capacity and expertise is to be more focused on service users with complex needs and risk. However, the Trust do not appear to have had the opportunity yet to test the efficacy of this. The independent investigation team are of the view that these actions have been partly implemented and that effectiveness of these changes will be demonstrated on completion of recommendation 11.

14.6 Root Cause Analysis – 'Fishbone' Diagram



15.0 CONCLUSION

Mr. X, at the time of the homicide, was a 59 year old man who was referred urgently by a Locum GP to the CMHT in Hertfordshire Partnership NHS Foundation Trust on 15th December 2009, nine days before he murdered his estranged wife at their home.

Prior to this he had been treated intermittently for depression by his GP and had seen a private psychiatrist. Since the homicide Mr. X has informed doctors caring for him whilst in custody that he has a strong family history of mental illness and suicide and that he had experienced psychotic and bi-polar symptoms in the preceding years. This information was not imparted to the clinicians from the CMHT who assessed Mr. X in December 2009 and as far as the independent investigation team are aware, this information was also not known to the GP who had treated Mr. X for some years.

It has been difficult for the independent investigation team to gain a full picture of the service user's mental health history as the private psychiatrist who saw Mr. X on an ongoing basis in 2001 and 2002 did not wish to talk to the independent investigation team and was not able to supply copies of the clinical records pertaining to these consultations as they have since been destroyed. Additionally the GP who treated Mr. X between 2001 and 2009 also did not wish to take part in the independent investigation and was therefore not interviewed as part of the process. He did supply copies of Mr. X 's primary care records but unfortunately, these did not, in parts, provide thorough information.

Copies of correspondence between the private psychiatrist and the GP in 2001 and 2002 suggested that Mr. X left his job as a doctor at that time due to mental ill health. The independent investigation team attempted to obtain copies of occupational health records at the time in an attempt to gain a better understanding of Mr. X's long term mental health history but unfortunately these were unavailable.

Mr. X had a complex history which included being born and brought up in Baghdad. He reports that his father was a merchant and businessman, who was killed by the Saddam Hussein regime, although his body was never found. Mr. X's mother died in 2009 in Dubai. Mr. X reports she had a history of depression. He had two brothers who he states were also murdered. Additionally he had mental health problems that led to him having to leave his job as a doctor, serious physical health problems and some marital difficulties that led to the depressive episode at the end of 2009.

The evidence suggests Mr. X potentially experienced severe psychotic symptoms, and thoughts, on occasions but was able to withhold these from professionals during assessments. Also, his preference for consulting private Psychiatrists meant that the communications between them and his GP were not as detailed as one would have expected if the CPA was being used as a framework for his care.

The independent investigation team are of the view having reviewed the GP clinical records that Mr. X's GP who treated him for depression did not do so in line with NICE

guidance and that Mr. X might have benefited from earlier referral to secondary mental health care services, in 2001/2002.

The independent investigation team commend, however, the actions of the Locum GP who assessed Mr. X in December 2009 and made an urgent referral, on 15th December 2009, to secondary mental health services.

Following the referral Mr. X was seen by clinicians from the CMHT on 17th and 22nd December 2009. He refused further support from the CATT team as suggested by the Consultant Psychiatrist from the CMHT but did agree to continue to see staff from the CMHT.

Due to the urgency of the referral and the time of year Mr. X, did not receive as full an assessment and clinical risk assessment as he usually would as he had to be fitted in before Christmas and for this reason the Consultant Psychiatrist saw him between clinics.

It is unfortunate that Mr. X did not receive as full an assessment as he would have done under other circumstances but the independent investigation team recognises that the CMHT did the best that they could under the circumstances to ensure that Mr. X was assessed before the Christmas holidays.

Following the incident, Hertfordshire Partnership NHS Foundation Trust commissioned an internal senior team to conduct an investigation under the Trust's Serious Untoward Incident (SUI) procedure, which was completed in June 2010. This investigation resulted in a comprehensive report, which concluded that this incident was not predictable or preventable but Hertfordshire Partnership NHS Foundation Trust did however, identify areas for care and service improvement and the report contained recommendations to this effect.

It is the conclusion of the Independent Investigation Team that the tragic murder of Y was not predictable or preventable by services although there are areas of care that could have been improved. These have been identified in some detail within this report. It has to be acknowledged that Mr. X's presumed reluctance to disclose his psychotic symptoms, albeit understandable, did make it difficult for the CMHT, and possibly also the GP to fully understand the extent of his difficulties.

APPENDIX A:
LIST OF RECOMMENDATIONS

APPENDIX A: LIST OF RECOMMENDATIONS

Recommendation 1
Commissioners of GP services should ensure, and ensure that they can demonstrate, that GPs are treating all patients, who present with depressive symptoms, in line with the current national NICE guidance 'Depression: The treatment and management of depression in adults (update) [CG90] 2009'

Recommendation 2
Commissioners of GP services should undertake a review of the provison of psychological therapies within the relevant GP surgery to ensure that practice, referral and uptake rates are consistent with national standards.

Recommendation 3
Commissioners of GP services should work with GPs to establish methods of ensuring themselves that GP record keeping is of a consistently high standard

Recommendation 4
Hertfordshire Partnership NHS Foundation Trust should continually monitor community team performance in relation to adherence to prescribed timescales for response to urgent referrals, and the reasons for any variance.

Recommendation 5
Hertfordshire Partnership NHS Foundation Trust should provide clinical risk assessment documentation, for use by workers that enables them to clearly mark when a potential aspect of clinical risk has not been assessed, the reasons for this, and plans in place to ensure that the assessment is completed in a timely manner.

Recommendation 6
The Hertfordshire Partnership NHS Foundation Trust board should assure themselves that clinical staff are appropriately trained in the assessment and management of potential morbid jealousy.

Recommendation 7
Hertfordshire Partnership NHS Trust should ensure that one of the functions of the Incident Co-ordination Group is to devise and agree a communications plan to ensure that appropriate service users and their families are communicated with in a co-ordinated way.

Recommendation 8
Hertfordshire Partnership NHS Trust should develop formal mechanisms to monitor compliance with clinical risk assessment training on an ongoing basis.

Recommendation 9
Hertfordshire Partnership NHS Foundation Trust should conduct annual audit to ensure ongoing compliance with the standards outlined in their clinical risk assessment policy.

APPENDIX B: GLOSSARY

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A&E	Accident and Emergency	
HSG	Health Service Guidelines	
NPSA	National Patient Safety Agency	
RCA	Root Cause Analysis	The Root Cause is the prime reason(s) why an incident occurred. A root cause is a fundamental contributory factor. Removal of these will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future
SHA	Strategic Health Authority	
CMHT	Community Mental Health Team	
GP	General Practitioner	
CAB	Citizens Advice Bureau	
CPA	Care Programme Approach	

APPENDIX C: BIBLIOGRAPHY

APPENDIX C: BIBLIOGRAPHY

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