

An Independent Investigation into the Care and Treatment of Mr A

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EXECUTIVE SUMMARY

Mr A was a forty six year old man who had been in brief contact with the services of West Hertfordshire Hospitals NHS Trust and Hertfordshire Partnership NHS Foundation Trust in the 24hrs prior to stabbing his female neighbour, Mrs Z, on the 30th April 2010. She subsequently died of her injuries in hospital on the 8th May 2010. Mr A also died at the scene of the incident from injuries inflicted by the victim's son defending his mother.

A joint inquest was held into the deaths of Mr A (the perpetrator), and Mrs Z (the victim) on the 14th December 2010. A verdict of lawful killing was returned into the death of Mr A and a narrative verdict returned into the death of Mrs Z as follows: "She died from stab wounds inflicted by someone suffering from a severe mental illness".

Whilst Mr A had had only brief contact with mental health services immediately prior to the incident on 30 April 2010, he had a long history of epilepsy, which was diagnosed as a teenager. He had many contacts with a Consultant Neurologist over the years, and his epilepsy was managed in both primary care and secondary care.

Mr A was originally referred for a psychiatric assessment in 1996 by his Consultant Neurologist, as he was suffering from behavioural problems. The Consultant Psychiatrist who assessed him found no evidence of a psychiatric condition, reporting that:

"I had been concerned to exclude the possibility of schizophrenia, given that this condition may be associated with temporal lobe epilepsy. Nonetheless, there was no evidence of it..... in the absence of any psychiatric conditions, I do not feel able to offer any useful input".

Mr A's care continued to be managed by the Consultant Neurologist. He was reviewed every six months.

On 29th April 2010, for the first time in approximately two years, Mr A presented at his GP surgery. He was in a confused state and was accompanied by his mother. It was thought that he had been confused for approximately one week, and that he may have been suffering from drug toxicity from the medication he had been prescribed to control his epilepsy. He was referred the same day to the Medical Registrar at Watford General Hospital, for investigation and exclusion of organic confusion prior to a potential psychiatric assessment.

Mr A was taken by family members for assessment to the Acute Admissions Unit (AAU) at Watford General Hospital the same day. He was seen by the medical officer, and blood samples were taken to assess toxicity screening from his medication. The

blood test results were received the same day and were found to be within the normal range. He was then referred to the on-call mental health team and assessed first by the mental health Liaison Nurse, and then by the mental health junior doctor who was on call that evening.

On assessment Mr A was noted to be thought disordered and deluded but was considered not to present a risk to self or others. On that basis a plan was made to discharge home in the care of his mother and refer him to the Crisis Assessment and Treatment Team (CATT) who were to see him the following morning, 30 April 2010. He was allowed to go home. Early the following morning Mr A left the home without his parent's knowledge and went to the neighbour's house where the tragic events unfolded.

It is the opinion of the investigation team that the epilepsy treatment was adequate throughout Mr A's life, and that at no stage was the incident preventable through a different regimen of epilepsy treatment.

Mr A possibly developed a psychotic illness, many years into the diagnosis of his epilepsy, in 2010. There is no evidence to suggest that an alternative epilepsy treatment regimen would have had any bearing on the development of his psychosis.

It is also clear from Mr A's neurology consultant that at no time during the regular consultations at the neurology clinic did Mr A express any suggestion of experiencing psychiatric symptoms. Mr A attended such appointments alone, as was completely appropriate.

The first area of concern relates to the shared decision to discharge Mr A to his home after psychiatric assessment on 29th April 2010, without medication. It is the view of the independent investigation team that this decision was wrong as it underestimated the volatility of Mr A's psychiatric state and overestimated the potential for his carers to cope with his psychotic state. It also did not respond to the needs of Mr A, who was suffering from delusions and hallucinations.

No attempt was made to treat him with anti-psychotic or anxiolytic medication potentially leaving him to experience more distress than he was on balance already likely to be experiencing.

It does appear from the testimony of the on-call psychiatrist delivered to the Coroner that a possible reason for not treating with medication was a concern of seizure worsening due to the use of antipsychotic medication. This is a possibility, but the risk and stress of Mr A's psychotic symptoms would have been greater than that posed by seizure worsening and psychiatric medication should, in the independent investigation team's view, be used in such circumstances.

In this context an alternative such as an anxiolytic medication should have been considered. In fact the presence of Mr A's epilepsy and the risks of seizure worsening would have further heightened the need for inpatient treatment.

The independent investigation team note that at no time was escalation of the decision to an on-call senior colleague considered. The independent investigation team are of the view that such an escalation should have occurred considering the risk posed by discharge to home. However, it is acknowledged that unless the senior colleague had seen and assessed Mr A themselves, and in the face of assurance from the Liaison Nurse and the junior doctors that it was safe to discharge Mr A home overnight, the decision to discharge home may have been endorsed by the on-call senior colleague.

The second area of concern relates to Mr A's return to the reception of AAU with his brother immediately following his discharge, asking for support, when his mother had left in her car. The decision by AAU staff to call the Shrodells mental health unit was appropriate. However, Hertfordshire Partnership NHS Foundation Trust has no record of this call being received. The independent investigation team are of the view that if this call was indeed received in the correct department, the decision by the recipient not to re-refer Mr A to the on-call CATT team was wrong.

However, notwithstanding the response from the Shrodells mental health unit, further action by the AAU staff was needed. Mr A was a man with an acute psychotic illness who had recently been discharged from their care, who was in distress on their premises. The decision for him to have home treatment appears to have been made on the grounds that he had his family with him, yet the carers were concerned, stressed and asking for support. The independent investigation team consider that this attendance should have been escalated to the medical staff within AAU, which then should have triggered a further assessment of Mr A or enabled them to have made a further attempt to engage the CATT team in an urgent reassessment of Mr A.

In fact, Mr A and his brother returned to the AAU for a further time in the early hours of the morning looking for their mother. This attendance should again have been responded to and escalated.

It is impossible for the independent investigation team to know what happened just prior to the homicide or Mr A's state of mind in the moments before he stabbed Mrs Z. As far as is known, Mr A did not have a history of violence and an incident of this magnitude could not have been predicted by anyone involved in his care. However, Mr A's psychosis was causing him considerable confusion and distress and it is the view of the independent investigation team that if this had been attended to more assertively on the evening of 29th April 2010. If Mr A had been adequately medicated this would have significantly reduced his risk of committing the offence, and if admitted to hospital, the homicide of Mrs Z would have been prevented.

The independent investigation team have concerns about the internal investigation process following the incident. Hertfordshire PCT clearly advised at a meeting attended by all parties that a joint internal investigation takes place between both West Hertfordshire Hospitals NHS Trust and Hertfordshire Partnership NHS Foundation Trust. This was to be led by Hertfordshire Partnership NHS Foundation Trust. Despite members of West Hertfordshire Hospitals NHS Trust being present at the meeting held by the PCT, it seems that a joint investigation did not take place. This resulted in West Hertfordshire Hospitals NHS Trust not benefiting from the learning opportunity that involvement in this process would have facilitated for them.

Furthermore, the independent investigation team also found that an attempt by the Coroner to alert West Hertfordshire Hospitals NHS Trust to the learning opportunities associated with this case, in the form of a letter to the Trust sent under Rule 43 of the Coroners' Rules 1984, was not used by that Trust to inform and embed changes in practice in a sustainable way.

Notwithstanding the lack of involvement from West Hertfordshire Hospitals NHS Trust, Hertfordshire Partnership NHS Foundation Trust conducted an internal investigation into the clinical care that Mr A received from the mental health services and has implemented some of the recommendations within it, and are in the process of implementing the remainder.

The independent investigation team makes the following 18 recommendations:

Recommendation 1

West Hertfordshire Hospitals NHS Trust and the future commissioning body responsible should ensure that any patient with epilepsy who has a psychotic episode, irrespective of apparent cause, should be referred to a psychiatrist with neuro-psychiatry experience, for psychiatric assessment.

Recommendation 2

West Hertfordshire Hospitals NHS Trust should consider involving epilepsy charities (Epilepsy Action, Epilepsy Bereaved and the National Society for Epilepsy) in the neurology services provided by them, and providing signposting advice to service users.

Recommendation 3

West Hertfordshire Hospitals NHS Trust and Hertfordshire Partnership NHS Foundation Trust should develop joint protocols that clearly detail action that should be taken, and what the response from both services should be, when there are concerns about the mental health or behaviour of an individual on the premises at AAU or in the A&E department. This should include clear processes for reporting such incidents into both organisations and an escalation process to be used when the response from one or both of the organisations is ineffective.

Recommendation 4

Hertfordshire Partnership NHS Foundation Trust should ensure that the ongoing implementation of the operational policies detailing roles, responsibilities, work

methods, processes, assessment methodologies and tools and interface arrangements in place for both the CATT and psychiatric liaison service are monitored, and there is demonstrable evidence in place to ensure that the Trust board can assure themselves that these are being appropriately implemented.

Recommendation 5

The Hertfordshire Partnership NHS Foundation Trust should ensure that all staff are aware of their responsibilities with regard to CPA screening and ensure demonstrable ongoing monitoring of this.

Recommendation 6

Hertfordshire Partnership NHS Foundation Trust should ensure there is a process in place to monitor the quality of risk assessments in the liaison psychiatry service on an ongoing basis.

Recommendation 7

Hertfordshire Partnership NHS Foundation Trust should review its risk management processes to ensure that these are based on comprehensive assessment, rather than purely on risk factor checklists, and backed up by appropriate skills training and access to experienced colleagues.

Recommendation 8

Hertfordshire Partnership NHS Foundation Trust should ensure adequate training of all liaison staff in the assessment of the care environment in acute situations. In the situation of new referrals to mental health services it is particularly important that the ability of carers to cope is not assumed, but that a more detailed assessment is undertaken as to the ability of carers to cope with an acutely psychotic Individual. In these situations consideration should be given to immediate assessment at home by the CATT rather than an overnight delay.

Recommendation 9

Hertfordshire Partnership NHS Foundation Trust ensure that all members of liaison teams have the appropriate training to ensure competency in assessing and treating psychiatric illness in association with medical ill health, including epilepsy

Recommendation 10

Hertfordshire Partnership NHS Trust should ensure that its staff are aware of the responsibilities outlined in National Institute for Health and Clinical Excellence (2011) guidelines "Service User Experience in Adult Mental Health: Improving the experience of care for people using adult NHS mental health services" and develop mechanisms to monitor this.

Recommendation 11

Hertfordshire Partnership NHS Foundation Trust should ensure that clear pathways for the use of medication in the AAU and Accident and Emergency department settings are developed. These should include risk assessment of medication use in all patients including those with medical co-morbidity.

Recommendation 12

GP surgeries should ensure that even when such specialist care is received by patients with long term conditions, regular, yearly visits to the primary care team should be maintained.

Recommendation 13

West Hertfordshire Hospitals NHS Trust should ensure that the services it provides to those with a diagnosis of epilepsy follow NICE guidance. In particular:

“Review and referral: At the review children, young people and adults should have access to: written and visual information, counseling service, information about voluntary organisations, epilepsy specialist nurses, timely and appropriate investigations, referral to tertiary service, surgery if appropriate”¹.

Recommendation 14

West Hertfordshire Hospitals NHS trust should ensure that responses to reports from the Coroner are accurate and that procedures are in place to make sure that Rule 43 reports are identified and that information is collected and action considered within a governance process which is monitored by the trust board.

Recommendation 15

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 communication with applicable and appropriate service users and their families are co-ordinated and timely.

Recommendation 16

Commissioners should ensure that all senior managers in NHS organisations within their sphere of responsibility are aware of their responsibility to work jointly with other NHS organisations when investigating a serious incident. Compliance with, and the efficacy of, this process should be monitored.

Recommendation 17

Commissioners should ensure that internal serious incident investigation panels, where more than one NHS organisation is involved, are led by panels with representation from all the organisations involved.

Recommendation 18

Hertfordshire Partnership NHS Foundation Trust should conduct an audit of compliance with the checklist outlined in the Learning Note issued to CATT and Liaison Team staff in February 2012.

¹ National Institute for Health and Clinical Excellence (2012) *The Epilepsies: The diagnosis and management of the epilepsies in adults and children in primary and secondary care* [CG137] pp. 56-57

1.0 INTRODUCTION

Niche Health & Social Care Consulting was commissioned by the NHS East of England Strategic Health Authority to conduct an Independent Investigation to examine the care and treatment of a service user under HSG (94) 27² (amended in 2005³). Under Department of Health guidance, Strategic Health Authorities (SHA) are 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 AND SCOPE 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 A, but also to put into context the care and treatment that he received in relation to the murder of Mrs Z and whether or not that could have been prevented; to establish whether any lessons can be learned for the future.

3.0 SUMMARY OF INCIDENT

Mr A was a forty six year old man who had brief contact as a mental health service user in the 24hrs prior to stabbing his female neighbour, Mrs Z on the 30th April 2010. She subsequently died of her injuries on the 8th May 2010 in hospital. Mr A also died at the scene of the incident from injuries inflicted by the victim’s son, whilst defending his mother.

² Department of Health (1994) HSG (94) 27: *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community*

³ Department of Health (2005) *Independent Investigation of Adverse Events in Mental Health Services*

A joint inquest was held into the deaths of Mr A (the perpetrator), and Mrs Z (the victim) on the 14th December 2010. A verdict of lawful killing was returned into the death of Mr A and a narrative verdict returned into the death of Mrs Z as follows: "She died from stab wounds inflicted by someone suffering from a severe mental illness"

Whilst Mr A had had only brief contact with mental health services immediately prior to the incident on 30 April 2010, he had a long history of epilepsy, which was diagnosed as a teenager. He had many contacts with a Consultant Neurologist over the years, and his epilepsy as managed in both primary care and secondary care.

Mr A was referred for a psychiatric assessment in 1996 by his Consultant Neurologist, as he was suffering from behavioural problems. The Consultant Psychiatrist who assessed him found no evidence of a psychiatric condition, reporting that:

"I had been concerned to exclude the possibility of schizophrenia, given that this condition may be associated with temporal lobe epilepsy. Nonetheless, there was no evidence of it..... In the absence of any psychiatric conditions, I do not feel able to offer any useful input".

Mr A's care continued to be managed by the Consultant Neurologist. He was reviewed every six months.

On 29th April 2010, for the first time in approximately two years, Mr A presented at his GP surgery. He was in a confused state and was accompanied by his mother. It was thought that he had been confused for approximately one week, and that he may be suffering from drug toxicity from his prescribed medication for epilepsy control. He was referred the same day to the Medical Registrar at Watford General Hospital, for investigation and exclusion of organic confusion prior to a potential psychiatric assessment.

Mr A was taken, by family members, for assessment to the acute admissions ward at Watford General Hospital the same day. He was seen by the medical officer, and blood samples were taken for toxicity screening. The blood test results were received the same day and were found to be within the normal range. He was then referred to the on-call mental health team and assessed first by the mental health Liaison Nurse and then by the mental health junior doctor who was on call that evening.

On assessment Mr A was considered to be thought disordered and deluded but was deemed not to present a risk to self or others. On that basis a plan was made to discharge home in the care of his mother and brother (with whom he was staying temporarily) and refer him to the Crisis Assessment and Treatment Team (CATT) who

were to see him the following morning, 30th April 2010. He was allowed to go home. Early the following morning Mr A left the home without his parent's knowledge and went to the neighbour's house where the tragic events unfolded.

4.0 CONDOLENCES TO THE FAMILIES

The Investigation Team would like to offer its condolences to both Mr A's and Mrs Z's family and friends. It is the investigation team's sincerest wish that this report provides no further pain and distress but addresses the outstanding issues that they may have whilst providing a chronology of events leading up to the tragic deaths of Mrs Z and Mr A and the subsequent events that took place.

5.0 ACKNOWLEDGEMENT OF PARTICIPANTS

The investigation team would like to acknowledge and thank all the employers and the health and social care staff that provided statements and agreed to participate in the interview process.

This investigation involved the interviewing of 15 clinical staff and managers and the investigation team would like to acknowledge the helpful contributions of staff members from Hertfordshire Partnership NHS Foundation Trust, Hertfordshire Primary Care Trust and West Hertfordshire Hospitals NHS Trust.

The investigation team would like to especially to 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

To provide an independent report into the care and treatment provided to Mr A from his first contact with the NHS up to the time of the offence.

This investigation is commissioned in accordance with the Department of Health guidance and follows the National Patient Safety Agency Good Practice Guidance for Independent Investigations.

Following the review of clinical notes and other documentary evidence:

The Terms of Reference were as follows:

Review the Hertfordshire Partnership NHS Foundation Trust's (the trust) 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 service user's first contact with services to the time of his offence and suitability of that care in view of Mr A's epilepsy and the impact this may or may not have had on his mental health.
- To explore the interface between services, primary care, secondary care including mental health, neurology, and specialist neuropsychiatry services.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs including any interface with the voluntary sector, 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 users harming themselves or others.
- Examine the effectiveness of the service users care plan including the involvement of the service user and the family.
- Examine the extent and adequacy of collaboration and communication between all services that Mr A was known too.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the SHA that includes measurable and sustainable Recommendations.

Method of working

- The panel will examine all appropriate documentation pertaining to the care of Mr A and seek evidence from those involved in his care, in order to properly carry out its investigation.
- The panel will agree appropriate communication arrangements with family members and give an opportunity to the families to contribute to the investigation, as the panel feels necessary.
- The panel will conduct its work in private.

Output and reporting arrangements

- The panel will provide a written report including recommendations specific to the care and treatment of Mr A to NHS East of England, the Trust and the commissioning Primary Care Trust
- The SHA will make the findings and the recommendations of the investigation public.

7.0 THE INDEPENDENT INVESTIGATION TEAM

This investigation was undertaken by the following healthcare professionals who are independent of the healthcare services provided in Hertfordshire:

Sian Wicks	Chair, Investigation Manager and Project Lead, Deputy Director Patient Safety of Niche Health & Social Care Consulting Ltd until leaving post in July 2012.
Nicola Cooper	Report Author, Registered Mental Health Nurse and Senior Patient Safety Lead of Niche Health & Social Care Consulting Ltd
Professor Mike Kerr	Professor of Learning Disability Psychiatry and Honorary Consultant Neuro-psychiatrist, Cardiff University

8.0 INVESTIGATION METHODOLOGY

This investigation follows national guidance⁴. The investigation commenced in April 2012.

Communication with Mrs Z's Family

A meeting was held with one of Mrs Z's relatives in order to explain the process and methodology of the investigation and discuss their concerns and support needs.

Communication with the Perpetrator and the Perpetrator's Family

The family of Mr A have been communicated with throughout the investigation process and are aware of the findings of the investigation.

Witnesses called by the Independent Investigation Team

The Investigation Team interviewed the clinical and managerial staff involved in Mr A's care making reference to the National Patient Safety Agency *Investigation interview guidance*⁵. Niche Health & Social Care Consulting adheres to the Salmon Principles⁶ in all investigations.

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

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.

Fifteen people who had been directly or indirectly involved with the care and treatment of Mr A or the management and commissioning of services were invited for interview in this investigation.

Five were from West Hertfordshire Hospitals NHS Trust. Eight were from Hertfordshire Partnership NHS Foundation Trust and two were GPs working in the surgery where Mr A received care.

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.

Root Cause Analysis

This report was written with reference to the National Patient Safety Agency (NPSA) guidance⁷. 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. 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.

9.0 SOURCES OF INFORMATION

The Independent Investigation Team considered a diverse range of information during the course of the investigation including Mr A's clinical and occupational health records.

Other information provided and reviewed was: Hertfordshire Partnership NHS Foundation Trust's Internal Investigation Report; policies and procedures from all of the Trusts involved; and internal performance management information.

A complete bibliography is provided in the appendices at Appendix C.

⁷ National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

10. CHRONOLOGY

10.1 Early Life

Mr A was born on 23 November 1963 in Watford. According to his brother, his childhood was normal.

It is reported that he did not like going to nursery school, preferred solitary play and never really had friends. He completed his GCSEs and later attempted a degree in engineering but did not complete it.

He had numerous jobs doing manual work and working at Hatfield University setting up experiments in the laboratories.

10.2 Background-statement by Mr A's brother at the Coroner's Inquest⁸

"(Mr A) seemed to lose confidence when his epilepsy started. He has never really had many friends. He describes a friend he had, but apart from that person it was me he used to socialise with. He played in a cricket team, had a small group of friends through the sport. That was many years ago when he was in his late teens.

As far as I am aware (Mr A) has never had a serious relationship but has been out for a few dates – some of which he has met and some of which have let him down. His parents have lived a fairly insular life with very few friends and hardly any social life at all.

Educationally I think (Mr A) achieved formal qualifications at school. He was very good technically and enjoyed engineering. When he left school he worked for a considerable time at the University of Hertfordshire in the South Laboratories, preparing and clearing away experiments and equipment. He was settled in this job and thoroughly enjoyed it.

While he worked at the university (Mr A) was living full time at my flat and was using the single bedroom. Unfortunately he had a seizure whilst at work. I was at home that night when there was a knock on the door. When I opened it (Mr A) was there with one of the lecturers from the university. I knew from this that (Mr A) must have had some sort of epileptic experience whilst at work and the staff had noticed. He did not return to work at the university following this incident. I think it knocked his confidence. He applied for several jobs and he felt that his epilepsy prevented him from getting work.

The most recent jobs I recall him doing were a spell at TK Maxx in Hatfield and Stevenage and Ocado in Hatfield. As far as I know this position was in the warehouse. He had a fit at Ocado and they moved him to a different department to accommodate his disability.

⁸ *Coroner's Inquest, 14/12/2010*

As I recall the last time he was employed was the end of 2009/beginning of 2010. He spent his time living at my parents' house well into his adult years, and the arrangement suited all. Unfortunately my father's health was failing for some years, which meant (Mr A) came to live with me in my flat. It is a two bedroom ground floor flat, and I sleep in the double room.

When (Mr A) stayed with me he slept in the single room. We got on well and used to go out occasionally to local pubs. (Mr A) was not a smoker. He used to drink only one or two pints of London Pride or Foster's lager socially. For some years (Mr A) was able to drive, but due to his epilepsy there were periods when he was not able to, which I think frustrated him, but three to four years ago he bought himself a sports car. He had it for about a year-and-a-half but sold it around a year-and-a-half ago in order to raise some money to buy his flat.

Since he was diagnosed with the illness (Mr A) has been prescribed drugs, and regularly took these. He was self-sufficient with medication, and did not require assistance with his routine. He could collect the prescriptions and would sometimes go to see the GP if he had a particularly bad episode. Over the years he continued to suffer from fits, sometimes weekly or monthly, during the day and the night. He never discussed with me what doctors had told him in relation to the cause or potential trigger factors associated with his condition. Sometimes he would speak to me in the mornings and ask 'did anything happen last night?' and I would simply tell him that he had a fit. (Mr A) just seemed to accept it. I don't recall him needing any first aid during a fit. He seemed to come out of the episode on his own, and he did not really discuss it afterwards. I would describe his fits as upsetting for me, and I don't think that (Mr A) would realise that he had actually had an episode. When he did have an episode he would flex his arms and legs and screw his face up and would shake. He would grunt and would go rigid, and this would sometimes last for up to 10 minutes. After the attacks I would just make him comfortable and safe, and (Mr A) would lie down and relax.

About a year ago (Mr A) sought to achieve a level of independence and purchased a property within the same block as mine. I believe he gave a lump sum as a deposit and had a mortgage. However he didn't settle well in his own property and began to tell me that he was hearing high-pitched noises inside his head, and believed radio waves were trying to control him. I never heard any of these noises, but (Mr A) sometimes mentioned he thought the man upstairs had some machinery and electrical signals were being transmitted into his head.

He left his flat and started to rent it out, and moved back in with me. From that period he would flip between my address and my parents' house at xxxxxxxx xxxxxx, but quite regularly he stayed with me. When he stayed with me he would sometimes complain of the same issue in respect of the high-pitched noises. This continued up to recent times and a couple of months ago he returned to my parents' address and lived with them. Since then he has occasionally stayed with me.

I have been asked if there have been any incidents with our neighbours that may have caused (Mr A) to attend (the victim's home address). The only thing I can recall is about two years ago there were discussions around a fence that had fallen down at the back, and in between (the victim's house) and my parents' house which is No. XX. This as far as I know was a one-off discussion but was not resolved as the fence remains damaged.

(Mr A's) health began to deteriorate about a year ago. His mental health and behaviour seemed to deteriorate dramatically over the last two weeks, roughly from mid-April 2010. My mother was struggling to cope with him so he returned to my flat. By this time his behaviour and mental health were concerning all the family. He told me things like he could hear high-pitched noises and frequencies inside his head, he had been possessed by robots and been digitalised, and then talking and rambling incoherently to himself"

10.3 Clinical Chronology

20th October 1969⁹

A Physician wrote to Mr A's GP reporting that Mr A's tonsils and adenoids needed to be removed.

24th October 1974¹⁰

A Consultant Paediatrician wrote to Mr A's GP updating him on his review on Mr A. He said the most likely diagnosis was epilepsy and confirmed that they would do a skull x-ray, fasting blood sugar and an EEG.

15th December 1975¹¹

A Paediatric Registrar wrote to Mr A's GP with an update on Mr A. He confirmed that an appointment was made to review him in 6 months.

16th August 1977¹²

A Casualty Officer wrote to Mr A's GP informing him that Mr A had presented in casualty having a grand mal fit. He confirmed that they had prescribed him Phenobarbitone and returned him to the GPs care.

5th March 1986¹³

A Clinical Assistant to a Consultant Neurologist wrote to the Medical Officer at Kingston Polytechnic where Mr A went to college. He confirmed receipt of the Medical officer's referral of to the Consultant Neurologist. He said he would arrange a CAT scan and an EEG and planned to see him in three weeks or less should the need arise.

⁹ Letter 20/10/1969

¹⁰ Letter 24/10/1974

¹¹ Letter 15/12/1975

¹² Letter from 16/08/1977

¹³ Letter from 05/03/1986

12th June 1986 ¹⁴

The Consultant Neurologist wrote to the Medical Officer at Kingston Polytechnic to inform him that the CT scan carried out on Mr A was normal, but the EEG was not and showed some episodic forms in the temporal areas.

10th September 1986 ¹⁵

The Registrar to the Consultant Neurologist wrote to the Medical Officer at Kingston Polytechnic informing him that his patient, Mr A, had failed to attend the Neurology clinic and had been sent a further routine appointment.

7th November 1988 ¹⁶

Mr A started work at the University of Hertfordshire as a Technical Officer. He did not declare his diagnosis of Epilepsy on his application form.

29th May 1990 ¹⁷

Mr A's GP wrote to Mr A confirming receipt of Mr A's recent note (Mr A had written asking the GP to supply him with a letter of consent for his employers so that he would be allowed to use machinery). He said he would not be able to provide Mr A with a certificate in the terms he requested and told Mr A to make an appointment to see him.

June 1990 ¹⁸

Mr A had an epileptic fit in the thermodynamics laboratory at work. This was investigated by the College Medical Officer and is reported that it appeared that it was probably related to a combination of missing out his medication and drinking alcohol.

11th June 1990 ¹⁹

The College Medical Officer wrote to the GP informing him of Mr A's epileptic fits at work and asking him for some guidance.

25th June 1990 ²⁰

The GP responded to the College Medical Officer's letter stating that he had not supplied the correct consent form and therefore the GP would not be able to supply him with a report. He asked the College Medical Officer to supply him with the correct form.

7th November 1990 ²¹

The College Medical Officer at Hatfield Polytechnic sent GP a copy of his letter to the Technical Manager under whose guidance Mr A was working.

¹⁴ Letter 12/06/1986

¹⁵ Letter 10/09/1986

¹⁶ Occupational Health Notes University of Hertfordshire

¹⁷ Letter 29/05/1990

¹⁸ Occupational Health Notes University of Hertfordshire

¹⁹ Letter 11/06/1990

²⁰ Letter from 25/06/1990

²¹ Letter from 07/11/1990

12th November 1992^{22, 23}

Mr A was referred to the Occupational Health (OH) nurse. He blacked out at work for 5-10 minutes. He was advised not to work machinery and to await the GP report.

24th November 1992

A GP wrote to the OH Nurse at the university. He said that Mr A's epilepsy was not adequately controlled.

30th November 1992²⁴

Mr A's GP report was received. The report stated that Mr A's epilepsy was not adequately controlled in all circumstances, for reasons which he felt to be unclear. The report stated that Mr A was statutorily barred from holding a driving licence and, other appropriate precautions should be taken.

Therefore the OH Nurse was advised that Mr A's work should not allow him to be in control of moving machinery and welding until such time as his condition has been adequately controlled. This meant he should be free of fits for a minimum of two years and under regular medical supervision from his GP.

The university contacted the British Epilepsy Association for some basic literature regarding epilepsy and work.

8th December 1992²⁵

Mr A was strongly advised at work, by a member of OH staff, to stop driving.

11th January 1993²⁶

Mr A was redeployed to work in an area not involving welding and operating machines.

3rd January 1993²⁷

OH staff had a meeting with Mr A's manager, as Mr A was apparently not felt to be performing to a sufficient standard. His colleagues had noticed he was very vague, eyes were rolling and he was uncommunicative. They discussed his recent episodes and alcohol intake. He was advised regarding his alcohol (advice not specified in the notes) and he was given a GP referral letter. A consultation with Consultant Occupational Physician was arranged.

25th October 1993²⁸

Mr A suffered a petit-mal seizure. He returned to work the next day.

²² Occupational Health Notes University of Hertfordshire, no signature

²³ Notes from early investigation and discussions between Personnel Officer, Technical Manager and Occupational Health Nurse regarding Mr A

²⁴ Occupational Health Notes University of Hertfordshire, no signature

²⁵ Occupational Health Notes University of Hertfordshire, no signature

²⁶ Occupational Health Notes University of Hertfordshire, no signature

²⁷ Occupational Health Notes University of Hertfordshire, no signature

²⁸ Occupational Health Notes University of Hertfordshire Sickness Report

16th December 1993 ²⁹

Mr A suffered what was thought to be another petit-mal seizure.

11th January 1994 ³⁰

Mr A suffered what was thought to be another petit-mal seizure.

21st January 1994 ³¹

The OH Nurse wrote to the GP to arrange for him to see Mr A to discuss Mr A's epilepsy.

26th January 1994 ³²

Mr A saw GP at surgery.

27th January 1994 ³³

Mr A saw GP at the surgery. The GP wrote to the Consultant Neurologist asking for his evaluation as to whether it was actually petit-mal seizures Mr A was suffering from and whether any change in medication was warranted.

12th May 1994 ³⁴

Mr A suffered another petit-mal seizure.

2nd September 1994 ³⁵

Mr A saw the GP at surgery.

4th October 1994 ³⁶

Mr A had a seizure. He stared into space and it was reported that his body swayed from side to side.

11th October 1994 ³⁷

A member of staff at work noticed Mr A standing against a wall clutching both temples tightly with his hands. He also had a very bright red face and did not respond when spoken to. A first aider was called.

31st October 1994 ³⁸

The Consultant Neurologist wrote to the GP acknowledging receipt of her letter regarding Mr A. He advised that Mr A be kept on the same dose of Carbamazepine, 400mgs twice each day, for the time being. No follow up was arranged. ³⁹

²⁹ Occupational Health Notes University of Hertfordshire Sickness Report

³⁰ Occupational Health Notes University of Hertfordshire Sickness Report

³¹ Occupational Health Notes University of Hertfordshire, Letter from OH Nurse to GP, 21/01/1994

³² GP notes (2nd batch)

³³ Occupational Health Notes University of Hertfordshire, Letter from GP to Consultant Neurologist, 27/01/1994

³⁴ Occupational Health Notes University of Hertfordshire Sickness Report

³⁵ GP notes (2nd batch)

³⁶ Occupational Health Notes University of Hertfordshire Sickness Report

³⁷ Occupational Health Notes University of Hertfordshire Sickness Report

³⁸ Letter from The Consultant Neurologist to GP, 10/04/1995

³⁹ GP notes (2nd batch)

24th January 1995 ⁴⁰

Mr A was seen by a Neurologist. There was no change in his treatment as a result of this appointment. He stated he felt unable to communicate with staff or anyone else, that he is not assertive and is always defensive. He stated that he had very few blackouts and feels he is coping with work. He states that he feels his personality brings on the fits. He was still unable to drive.

OH notes state OH staff had a meeting with Mr A's managers - they said he was unable to cope with menial tasks, was unable to concentrate and had spells of memory loss. He was taken home by a colleague and forgot his address. Managers stated they felt unsure how best to proceed with regard to Mr A in the working environment.

27th January 1995 ⁴¹

The Consultant Occupational Physician saw Mr A. He was still on the same medication as the previous year despite having been referred in the meantime to a consultant neurologist. He also said he hadn't been to see his GP since seeing his neurologist and the Consultant Occupational Physician urged him to see his doctor in the very near future. Mr A said he was still taking his tablets and received a repeat prescription every three months. He also said he was still drinking alcohol but it tended to be weekends only, about 3 or 4 pints or so. He said that when he got home from the pub he would have something to eat and then take all his pills which the Consultant Occupational Physician noted as a strange method of taking the correct medication. Consultant Occupational Physician stated he could find no sense of volition, that he belonged to no social groups, went nowhere, and did nothing. He was not attempting to find anywhere to live other than with his brother. He could not name his favourite authors. He did not buy any books as whenever he went into a bookshop, the multitude of choice flusters him and he ends up buying nothing. He has no favourite TV programmes, no favourite music but vaguely thinks he likes old pop songs. The Consultant Occupational Physician stated he found that Mr A had little awareness of his surroundings in his university life as well as his social life. The notes state the only positive statement Mr A made during his interview was that he was unhappy and maybe he should think of leaving his job and find another one elsewhere.

1st February 1995 ⁴²

GP wrote to Consultant Occupational Physician. She informed him that the Consultant Neurologist felt that it would be sensible to keep Mr A on the same dose of Carbamazepine.

3rd February 1995

Mr A saw GP at the GP surgery.

⁴⁰ Occupational Health Notes University of Hertfordshire, no signature

⁴¹ Occupational Health Notes University of Hertfordshire, letter from Consultant Occupational Physician to Occupational Health Department

⁴² Letter from GP to Consultant Occupational Physician, 01/02/1995

20th February 1995

The Consultant Neurologist wrote to the Consultant Occupational Physician acknowledging receipt of his letter regarding Mr A and informing the Consultant Occupational Physician that he would arrange to review Mr A in due course.

27th February 1995

The Consultant Neurologist wrote to Mr A informing him that he had an appointment at the Neurology Clinic on 10 April 1995. He advised him to attend with someone who had witnessed his attacks and seizures.

10th April 1995

The Consultant Neurologist wrote to the GP informing her that he had reviewed Mr A. Mr A was accompanied to the appointment. The person accompanying him stated that Mr A sometimes goes blank, stares vacantly and shakes and sways on his feet and that these seizures last for approximately 30 seconds. They said that this occurs weekly but Mr A disputed this.

The Consultant Neurologist arranged for Mr A to have a further EEG and a brain MRI and, as there may have been some more generalised intellectual deterioration, he arranged a formal psychometric assessment. Mr A's prescription of Carbamazepine was increased to 400mgs in the morning and 600mgs in the evening in the first instance, to be increased to 600mgs twice a day if the frequency of the attacks didn't reduce.

The Consultant Neurologist wrote to a Consultant Neurophysiologist at Luton and Dunstable Hospital NHS Trust requesting that he book Mr A in for a routine EEG.⁴³

The Consultant Neurologist wrote to the Clinical Psychologist at Royal Free Hospital requesting that she see Mr A.⁴⁴

The Consultant Neurologist wrote to the Neurophysiology Department at Royal Free Hospital requesting that Mr A be booked in for a routine brain MRI.⁴⁵

The Occupational Health Physician wrote to the GP. He gave her an update on his review of Mr A on 10 April and informed her that he was arranging a further EEG and a brain MRI.⁴⁶

6th June 1995⁴⁷

The Consultant Neurologist wrote to the GP informing her that Mr A's psychometric assessment showed some mild bi-temporal abnormalities but no frank epileptic discharge. The brain MRI was normal.

⁴³ Letter from the Consultant Neurologist, 10/04/1995

⁴⁴ Letter from the Consultant Neurologist 10/04/1995

⁴⁵ Letter from the Consultant Neurologist 10/04/1995

⁴⁶ Letter from Consultant Occupational Physician to GP, 10/04/1995

⁴⁷ Letter from The Consultant Neurologist to GP, 06/06/1995

26th June 1995 ⁴⁸

The Consultant Neurologist sent Mr A's psychometric test results to the GP. He said the test indicated that there had been some cognitive decline.

20th July 1995 ⁴⁹

Occupational health notes show Mr A had a brain scan at St Albans. Results showed that no abnormality was detected. Mr A was taking his medication, 400mgs twice daily. This was a reduction of 200mgs in the evening. The larger dose caused headaches. The records state he had some counselling about his poor social skills but didn't persevere with this. It was noted that he did not seem very happy. OH staff made a note to discuss this with the Consultant Occupational Physician.

25th July 1995 ⁵⁰

Mr A was seen by the Consultant Neurologist in an out-patient clinic.

25th July 1995 ⁵¹

The Consultant Neurologist wrote to the GP. He informed her that as far as he was aware Mr A was on Carbamazepine 400mgs each day but that he may have suggested to him to increase this in the past. He said that Mr A had developed side effects to Carbamazepine and that he should revert to the previous level. He added that it might be worth considering adding in Gabapentin at some stage.

9th August 1995 ^{52 53}

Managers at Mr A's work place wrote an email to the Personnel Officer saying that there had been a marked improvement in Mr A after his visit to the Consultant Neurologist. They reported an improvement in his ability and attitude towards his work. They state, however, that since then changes had occurred which included Mr A's mannerisms reverting to being slow and deliberate, a verbally aggressive attitude towards people and forgetfulness. The email details that, following these concerns, a colleague had spoken to Mr A who admitted not taking his tablets for 6-8 weeks. Mr A refused to admit there was a problem and was reported to demonstrate a lack of understanding of the importance of regular and continuous administration of his medication.

20th September 1995 ⁵⁴

The OH Department received an emergency call from Mr A's colleague. Mr A was reported to be recovering from a 'petit-mal' type episode following a stressful experience at work.

⁴⁸ Letter from The Consultant Neurologist to GP, 26/06/1995

⁴⁹ Occupational Health Notes University of Hertfordshire, no signature

⁵⁰ GP notes (2nd batch)

⁵¹ Letter from The Consultant Neurologist to GP, 25/07/1995

⁵² Email from Mr A's managers to the Personnel Officer, 09/08/1995

⁵³ Occupational Health Notes University of Hertfordshire, Internal Memorandum

⁵⁴ Occupational Health Notes University of Hertfordshire, no signature

2nd October 1995 ⁵⁵

The Consultant Neurologist at St Albans City Hospital, wrote to the GP and Consultant Occupational Physician informing them that Mr A had failed to keep his appointment and would be given another date.

16th November 1995 ⁵⁶

The Personnel Officer wrote to the Consultant Occupational Physician asking him to see Mr A again as his epilepsy was continuing to give his colleagues considerable concern.

20th November 1995 ⁵⁷

Mr A was referred back to the Neurologist.

24th November 1995 ⁵⁸

Mr A saw GP in surgery.

1st December 1995 ⁵⁹

The Consultant Occupational Physician wrote to the Consultant Neurologist. He said that Mr A's mood and manner had deteriorated further. He recommended that Mr A go on sick leave and the GP signed him off work while his future was being considered. The Consultant Occupational Physician asked the Consultant Neurologist to inform him if he anticipated any significant improvement in Mr A's condition such that he could give the University hope for a more productive future.

4th December 1995 ⁶⁰

The Consultant Neurologist wrote to the Consultant Occupational Physician informing him that Mr A had failed to keep his appointment on 1 December 1995. He said that it sounded like Mr A had not been taking his medication and was 'refusing to accept there is a problem with his behaviour and epilepsy' and that perhaps the GP would consider formal psychiatric assessment.

11th December 1995 ⁶¹

The Consultant Neurologist wrote to the GP updating her on his review of Mr A. His medication remained at Carbamazepine 400mgs twice each day. He said that he would review him in a year's time.

29th January 1996 ⁶²

The GP wrote to the Consultant Neurologist at the Community Mental Health Centre asking for his assessment of Mr A.

⁵⁵ Letter from The Consultant Neurologist to Consultant Occupational Physician cc'ing GP, 2/10/1995

⁵⁶ Occupational Health Notes University of Hertfordshire, letter, 16/11/1995

⁵⁷ Occupational Health Notes University of Hertfordshire, no signature

⁵⁸ GP notes (2nd batch)

⁵⁹ Occupational Health Notes University of Hertfordshire, letter to the Consultant Neurologist, 01/12/1995

⁶⁰ Letter to Consultant Occupational Physician, 04/12/1995

⁶¹ Letter from The Consultant Neurologist to GP, 11/12/1995

⁶² Letter from GP 29/02/1996

14th February 1996 ⁶³

The Consultant Occupational Physician wrote to the Consultant Neurologist requesting a further report on Mr A and news of his progress. He referred to him as a 'sad young man'. The Consultant Occupational Physician said that he hadn't seen Mr A since 20 November 1995 but that he and Mr A's manager at work were convinced that Mr A was no longer fit to continue his job. He expressed a preference for dismissing Mr A on health grounds rather than him resigning so that he could claim unemployment benefit straight away after finishing work.

20th February 1996 ⁶⁴

The Consultant Neurologist wrote to the Consultant Occupational Physician to inform him that Mr A had attended his appointment though did not bring someone who had witnessed his epileptic fits as advised. He said Mr A denied that the fits were epileptic.

29th February 1996 ⁶⁵

The GP wrote to the Consultant Neurologist at the Community Mental Health Team asking for a review of Mr A. She stated that the Consultant Occupational Physician had said that Mr A's duties at work had gradually been taken away from him over the years due to him seeming incapable of performing them. Mr A had recently been made redundant and the Consultant Occupational Physician was concerned about Mr A and would be keen to know if there was anything that could be offered to help him. She informed him that Mr A had been reviewed by a Neuropsychologist. The results showed that Mr A was functioning in the low to average range on verbal tests and in the average range on performance tests. She said the results probably represented a mild to moderate degree of general intellectual under-functioning; his language and visual-perceptual skills were satisfactory. Mr A's verbal memory was also satisfactory but his visual memory was impaired. His performance was reported to be a little weak on tests of executive functioning. However, all those results were in the context of difficulty with attention and concentration with general slowness. Given that he was able to obtain qualifications to HND levels in the past, the results suggested deterioration in his cognitive functioning since that time.

The GP also said that the Consultant Neurologist felt that a psychiatric assessment was required because Mr A continued to have difficulty with behavioural problems. The GP stated she did not feel that Mr A accepted that he had any particular problems but he had agreed to cooperate with psychiatric assessment.

She said that over the two years she had known him there had been several reported occasions of him arguing with people at work and then becoming blank for a few seconds.

Mr A was unemployed at this time and his GP issued him with a sick note for 6 months.

⁶³ Letter from Consultant Occupational Physician to the Consultant Neurologist, 14/03/1996

⁶⁴ Occupational Health Notes University of Hertfordshire, letter to the Consultant Neurologist, 01/12/1995

⁶⁵ GP notes (2nd batch), letter from GP, 29/02/1996

4th March 1996 ⁶⁶

The Consultant Neurologist wrote to the Occupational Health Physician saying that he thought there was enough evidence to allow Mr A to be dismissed from his job on ill health grounds.

15th March 1996 ⁶⁷

A Certificate of Permanent Incapacity was issued for Mr A and signed for by the Consultant Occupational Physician. This was supported by the Consultant Neurologist.

The Consultant Occupational Physician recommended that Mr A be dismissed from his job on ill health grounds⁶⁸.

20th March 1996 ⁶⁹

The Consultant Psychiatrist from the Community Mental Health Team wrote to the GP saying that he had assessed Mr A in the out-patient clinic. He reported Mr A appeared to be very vague and his speech was circumlocutory and repetitive. He stated that Mr A repeatedly spoke of a lack of confidence and that this was because of his nature rather than a condition. Mr A reported slow development and that his epilepsy started when he was fourteen but he now only suffered blackouts rather than convulsions. Mr A said that he worked as a Technical Officer and that he got moved around from department to department. The Consultant Psychiatrist said that there was no evidence of a psychiatric disorder. He said that he found no evidence of schizophrenia and had been concerned to exclude this given its association with temporal lobe epilepsy. In summary he described Mr A as a 'young man with epilepsy with low level of intellectual function'. He suggested that Mr A be retested in six months for the purposes of comparison.

22nd March 1996 ⁷⁰

The Consultant Psychiatrist from the Community Mental Health Team wrote to the GP. He said that he had assessed Mr A but, in the absence of any psychiatric condition, he did not feel able to offer any useful input. He suggested that Mr A be retested in six months for the purposes of comparison.

10th December 1996 ⁷¹

The Consultant Neurologist wrote to the GP to say that she had reviewed Mr A and he felt that he had no blank spells over the year. She had received a letter from the Consultant Psychiatrist who felt that there was no evidence for a psychiatric disorder.

17th October 1997 ⁷²

⁶⁶ Letter from The Consultant Neurologist to Consultant Occupational Physician, 04/03/1996

⁶⁷ Occupational Health Notes University of Hertfordshire

⁶⁸ Letter from Consultant Occupational Physician to OH Nurse, 15/03/1996

⁶⁹ Letter to GP, 20/03/1996

⁷⁰ Letter to GP, 22/03/1996

⁷¹ Letter from Consultant Neurologist to GP

Mr A saw the GP in surgery.

5th December 1997⁷³

The Registrar Assistant in Neurology, St Albans City Hospital, wrote to the GP with an update on Mr A. He said that the Driver and Vehicle Licensing Agency (DVLA) had withdrawn his driving licence. He informed her that he had arranged a further follow up appointment for Mr A in 12 months.

25th March 1998⁷⁴

Mr A was seen by a GP at the GP surgery.

1st December 1998⁷⁵

The Medical Registrar, Department of Neurology at St Albans City Hospital wrote to the GP. He reported he had reviewed Mr A in the Consultant Neurologist's clinic. The letter states that Mr A reported no further blank spells, and that he had had his driving licence back for two weeks. He said that he discussed Mr A with the Consultant Neurologist and they agreed that they would review him again in six months.

17th March 1999⁷⁶

Mr A saw the GP at surgery.

1st June 1999⁷⁷

The Consultant Neurologist, wrote to the GP stating that she had reviewed Mr A and that he had not had any further blackouts, had got a driving licence, had a job and continued on Carbamazepine 400 mgs twice daily. She advised that in view of potential problems with bioavailability that Mr A always got Carbamazepine branded medication when issued with a new prescription.

No follow up consultation was arranged due to Mr A's stability.⁷⁸

17th April 2001⁷⁹

Mr A saw the GP at surgery.

19th November 2002⁸⁰

Mr A was seen by the GP at the GP surgery.

4th December 2002⁸¹

⁷² GP notes (2nd batch)

⁷³ Letter from Registrar Assistant in Neurology to GP, 05/12/1997

⁷⁴ GP notes (2nd batch)

⁷⁵ Letter to GP, 01/12/1998

⁷⁶ GP notes (2nd batch)

⁷⁷ Letter from Consultant Neurologist to GP

⁷⁸ GP notes (2nd batch)

⁷⁹ GP notes (2nd batch)

⁸⁰ GP notes (2nd batch)

⁸¹ GP notes (2nd batch)

Mr A was seen by the GP at the GP surgery. The GP completed a DVLA Medical Examination Report for Mr A.

5th January 2004⁸²

Mr A experienced epileptic absences. He was seen by the GP and given Carbamazepine Retard tablets 400 mgs.

Prescription for Carbamazepine Retard 400mgs issued.

26th April 2005⁸³

Mr A reported to the GP that he had a seizure on 16 May 2004. He stated he was reapplying for his driving licence and would be eligible on 16 May 2005.

13th June 2005⁸⁴

Mr A was seen by a GP at the GP surgery. He had an absence at work the previous week. He was to continue on the same medication at present. The GP told Mr A to inform the DVLA immediately as he had just got a new licence. Mr A said that he would.

7th July 2005⁸⁵

The GP wrote to the Consultant Neurologist to refer Mr A to her.

She then wrote to Mr A to inform him that she had referred him back to the Consultant Neurologist's clinic because of his recent seizure.

5th August 2005⁸⁶

The Consultant Neurologist wrote to the GP. She said she had arranged a review with Mr A in six weeks.

12th September 2005⁸⁷

The Specialist Registrar (SpR) in Neurology at St Albans City Hospital wrote to the GP with an update of his examination of Mr A. He stated that Mr A felt that his epilepsy had been stable since his discharge in 1999 but that he experienced blackouts every six months or so. Mr A was taking Carbamazepine standard 800mgs each day. Mr A stated he could not tolerate higher doses as it caused headaches. He requested an MRI and EEG and that Mr A be prescribed 250 mgs daily of Levetiracetam, increasing gradually to 1000mgs each day. He stated that Mr A would be reviewed in three months to assess the drug change with a view to making a reduction in his Carbamazepine.

14th September 2005⁸⁸

⁸² Patient Summary

⁸³ GP notes (2nd batch)

⁸⁴ GP notes (2nd batch)

⁸⁵ GP notes (2nd batch), letter 07/07/2005

⁸⁶ Letter from Consultant Neurologist to GP, 05/08/2005

⁸⁷ Letter 12/09/05

⁸⁸ Letter from Consultant Neurologist to GP, 14/09/2008

The SpR in Neurology wrote to the GP surgery with an update on his appointment with Mr A.

15th September 2005

Prescription for Levetiracetam 250mgs each day for one week and then increasing to twice a day, issued by the GP surgery.

28th September 2005⁸⁹

The GP spoke to Mr A, who was in an acute confusional state following his change in medication. Mr A stated he thought that the army had done something to his drugs and his brain. He had taken his Carbamazepine that evening. The GP's view was that Mr A may need a psychiatric assessment if the situation deteriorated.

Mr A had stopped Carbamazepine when starting Levetiracetam reported feeling terrible and low following this.

The GP advised him to restart Carbamazepine immediately and to return for a review in two weeks before increasing his dose of Levetiracetam.

10th October 2005⁹⁰

The GP recorded that Mr A had an adverse reaction to Levetiracetam and had experienced hallucinations and nervousness.

17th October 2005⁹¹

The GP wrote to the Consultant Neurologist, stating that Mr A had been seen by the Consultant Neurologist's team. He stated he was started on Levetiracetam, which was supposed to be in addition to the Carbamazepine. However, it was not clear what he should do so he stopped the Carbamazepine for a week before starting Levetiracetam and developed adverse reactions to it after six tablets. She said he had been off work since the beginning of October and she was not planning to send him back to work until his memory and thought improved. She confirmed he was back on Carbamazepine 400 mgs.

25th October 2005⁹²

The Consultant Neurologist wrote to the GP confirming that she had received her letter explaining Mr A's unfortunate experience with Levetiracetam. She confirmed that she felt it was the best thing to switch him back to his previous prescription.

17th December 2005⁹³

Mr A had an MRI scan. The findings were within normal limits.

23rd January 2006⁹⁴

⁸⁹ GP notes (2nd batch)

⁹⁰ Patient Summary

⁹¹ GP notes (2nd batch), Letter from GP to Consultant Neurologist

⁹² Letter from Consultant Neurologist to GP, 25/10/2005

⁹³ MRI report, 17/12/2005

⁹⁴ Letter from Consultant Neurologist to GP, 23/01/2006

The Consultant Neurologist wrote to the GP to update her on her review on Mr A. She said that his EEG showed changes and that his MRI scan results were normal. She recorded that it appeared that he had had some headaches and paranoid thoughts. Mr A was taking Carbamazepine 400mgs twice each day but the Consultant Neurologist recorded that she wasn't clear if this was the normal or retard preparation. She recorded that he did not appear to have had a major seizure for a while but that he had experienced some blank spells.

21st July 2006 ⁹⁵

Mr A was seen in the out-patients department for an epilepsy medication review. He had been seizure free for twelve months.

24th July 2006 ⁹⁶

The Consultant Neurologist wrote to the GP informing her that she had reviewed Mr A. He had reported it had been a year since his last seizure and that he continued to take Carbamazepine 800mgs each day which he should continue with as it seemed to suit him so much better than Levetiracetam. She said she had not made any follow up arrangements and had discharged him to GP's care.

27th September 2006 ⁹⁷

Mr A had a review at the GP surgery. Mr A reported he had had two further absences in the past six weeks, with no further follow up from the Consultant Neurologist. He stated that he had complied with the medication, had no concurrent illness and that the seizures hadn't changed in character. He was not keen to increase his dose of medication. Mr A stated he was not driving at that time. The GP sent a letter to the Consultant Neurologist asking for Mr A's Carbamazepine levels to be checked.

4th October 2006 ⁹⁸

The GP wrote to the Consultant Neurologist to inform her that Mr A had had two episodes of absences but that he was not keen to increase his Carbamazepine. His Carbamazepine levels were found to within the therapeutic range. The GP asked whether it was possible for him to be offered a routine review appointment in view of his continued seizures.

7th November 2006 ⁹⁹

The Consultant Neurologist wrote to the GP to let her know that Mr A had cancelled his appointment that was made at the GP's request as he indicated that it was no longer needed.

⁹⁵ *Patient Summary*

⁹⁶ *Letter from Consultant Neurologist to GP, 24/07/2006*

⁹⁷ *GP notes (2nd batch)*

⁹⁸ *Letter 04/10/06*

⁹⁹ *Letter from Consultant Neurologist to GP, 07/11/2006*

26th February 2007 ¹⁰⁰

Mr A was seen at the GP surgery. He had had one further absence at work and stated they had let him go from his job as he had been having difficulty with work. He said he found that if he let a company know about his condition, he would not get or keep the job. He was reluctant to increase his dose of Carbamazepine as he didn't know if it would help. He was advised that he could stay on the current dose but should seek another appointment if he had more absences. He was advised not to drive.

5th June 2007 ¹⁰¹

Mr A was seen at the GP surgery. He had been having more absences over the last few months. He was advised to continue Carbamazepine and advised not to drive or work with machinery. Referral to the Consultant Neurologist was arranged.

7th August 2007 ¹⁰²

The Neurology Specialist Registrar to the Consultant Neurologist wrote to the GP with an update on Mr A following a review appointment. Mr A reported having had 3-4 seizures since Christmas and all of these had occurred whilst doing agency work, which had led to his dismissal.

Mr A had had a seizure three weeks previously while digging up a tree for his mother and had experienced episodes when he'd fallen out of bed and woken up with a severe headache. He denied any tongue biting, myalgia or incontinence. She advised him to stop driving and alert the DVLA to his condition.

Mr A was taking Carbamazepine 400mgs twice daily prior to the consultation. The Neurology SpR advised switching to Carbamazepine Retard 1000mgs per day, then 1200mgs after a fortnight and then increased every fortnight until Mr A was taking 1600mgs each day. She advised that if he was unable to tolerate dose escalation that his Carbamazepine could be switched to Oxcarbazepine. She said that if these manoeuvres were unhelpful then he could try an alternative agent to be used in addition to his Carbamazepine in the first instance such as Sodium Valproate Chrono. This should start at 300mgs each day increasing gradually to 1000mgs each day at which point his Carbamazepine could be withdrawn if seizures under control.

She said she had given him an appointment in four months to evaluate the effectiveness of the new medication regime.

28th December 2007

Prescription for Carbamazepine 400mgs each day issued by the GP surgery.

¹⁰⁰ GP notes (2nd batch)

¹⁰¹ GP notes (2nd batch)

¹⁰² Letter to GP, 07/08/2007

27th February 2008 ¹⁰³

Mr A was reviewed by the GP. He stated he had just lost another job because he had a seizure the day before. He had not increased Carbamazepine as recommended by the Consultant Neurologist yet. He was due to see her the next month.

This was the last time Mr A was seen at the GP surgery until 29 April 2010.

10th March 2008 ¹⁰⁴

The Consultant Neurologist wrote to the GP with an update on Mr A. She said he had been doing reasonably well apart from losing his job at the blood products laboratory because he had what sounded like a partial seizure, within the last month. In addition, he probably had one event arising from sleep. He had not changed his medication although it was suggested by the Neurology SpR in August. He had been maintained on Carbamazepine 400 mgs twice daily. She said that he had not yet started on the Carbamazepine Retard 400 mgs twice daily that had been prescribed by GP and said that she would encourage him to do so. She said she would review him again in four months.

9th June 2008

Prescription for Carbamazepine Retard issued by the GP surgery.

28th July 2008 ¹⁰⁵

The Consultant Neurologist wrote to the GP informing her that she had reviewed Mr A and found that his Carbamazepine Retard 800mgs per day was not working and therefore she introduced Sodium Valproate at a dose of 200 mgs daily. She asked the GP to increase the dosage in two weeks and informed her that she would schedule a review at the end of August.

27th August 2008 ¹⁰⁶

Mr A was seen as an outpatient for an epilepsy medication review.

2nd September 2008 ¹⁰⁷

The Consultant Neurologist updated the GP on Mr A. He had had 2-3 seizures since the last consultation. She said she had advised him to increase his medication and had given him a seizure diary to keep. Mr A told her that he was taking Carbamazepine retard 600mgs in the morning and 400mgs at night. He said he was taking 200mgs of Sodium Valproate each day. The Consultant Neurologist asked Mr A to increase his Sodium Valproate, incrementally, to 600mgs each day.

29th September 2008 ¹⁰⁸

The Consultant Neurologist updated the GP on Mr A. She said she arranged a review in two months. She recorded that Mr A had had no further seizures. He told her that

¹⁰³ GP notes (2nd batch)

¹⁰⁴ Letter from Consultant Neurologist to GP, 10/03/2008

¹⁰⁵ Letter from Consultant Neurologist to GP, 28/07/2008

¹⁰⁶ Patient Summary

¹⁰⁷ Letter from Consultant Neurologist to GP, 02/09/2008

¹⁰⁸ Letter from Consultant Neurologist to GP, 29/09/2008

he was taking Sodium Valproate 400mgs twice a day and Carbamazepine retard 600mgs twice a day. She commented that this was slightly different from what she had advised him but that as he had had no fits she had left him on these dosages. His Carbamazepine level was taken and was low at 10.7 but she had re-checked it as Mr A said he had increased his Carbamazepine dosage himself.

22nd December 2008 ¹⁰⁹

The Consultant Neurologist wrote to the GP with an update on Mr A. She said that he had had four seizures since the last consultation and that she felt that the Sodium Valproate wasn't contributing effectively to his seizure control. She stated that she felt it should be phased out. She requested he be started on Topiramate 25mgs daily for one week and then twice daily for a further week. She advised on the third week he be prescribed 75mgs per day and ultimately increased to 100mgs per day. She arranged a further review in 4-6 weeks when she said she would start to withdraw Mr A's Sodium Valproate if Mr A had suffered no adverse effects.

3rd February 2009

Prescription for Sodium Valproate 400mgs twice a day issued by surgery.

8th April 2009 ¹¹⁰

The Consultant Neurologist wrote to the GP with an update on Mr A. She said that she had arranged a review in six weeks. She said she was under the impression, from what Mr A had told her, that he was prescribed Sodium Valproate 400mgs, Carbamazepine Retard 600mgs and Topiramate 25mgs. She advised that if this was the case, for the Sodium Valproate to be reduced to 200mgs at night with a view to withdrawing it and the Topiramate to be increased to 50mgs daily. She asked the GP to confirm what Mr A was being prescribed.

24th April 2009 ¹¹¹

GP by telephone confirmed that Mr A was prescribed 800mgs of Sodium Valproate and 1200mgs of Carbamazepine.

30th April 2009 ¹¹²

The Consultant Neurologist wrote to the GP asking if she had prescribed Topiramate for Mr A as she had previously requested.

12th May 2009 ¹¹³

The Consultant Neurologist wrote to the GP to let her know that she had reviewed Mr A and would review him again in two months. She had asked Mr A to stop taking the small dose of Sodium Valproate that he had been taking.

¹⁰⁹ Letter from Consultant Neurologist to GP, 22/12/2008

¹¹⁰ Letter from Consultant Neurologist to GP, 08/04/2008

¹¹¹ File note, phone message from GP to Consultant Neurologist 24/04/09

¹¹² Letter from Consultant Neurologist to GP, 30/04/2009

¹¹³ Letter from Consultant Neurologist to GP, 12/05/2009

5th August 2009 ¹¹⁴

The Consultant Neurologist wrote to the GP. She said that she reviewed Mr A but it was very difficult to know how frequent his seizures were, but she thought he had none apart from the one event in July when he seemed to come to finding himself cycling back to his work from where he had just come. She said this might suggest that he had some form of confusional episode, which may have been a seizure. She found it very difficult to know whether he had any other events as he implied that he did not know when he was going to have one or when he had had one.

She said Mr A would continue on Carbamazepine Retard 600 mgs twice daily and she had now asked him to increase the Topiramate to 50 mgs in the morning, leaving the evening dose at 25 mgs for two weeks and then to 50 mgs twice daily. He was very sceptical as to whether that would work.

She said he had been in touch with the DVLA regarding driving. She told him that it was unlikely that he would be granted a licence, as he had not been seizure free for a year. She arranged to see him in six weeks.

16th September 2009 ¹¹⁵

The Consultant Neurologist wrote to the GP with an update on Mr A. She said he had reported no fits and that he was not working at the time. She noted that his fits seemed to occur more often when he was under pressure at work. He was taking Topiramate 50 mgs daily and Carbamazepine Retard 600 mgs twice daily. She told him to continue with the medication and said she would review him in three months.

22nd September 2009

Prescription for Topiramate Capsules issued by the GP surgery.

27th October 2009

Prescription for Topamax Sprinkle Capsules issued by the GP surgery.

21st December 2009 ¹¹⁶

The Consultant Neurologist wrote to the GP with an update on Mr A. She said she had reviewed him and, based on his reports of his experiences of the last month, she felt he had suffered a complex partial seizure. He reported talking to someone at work and then finding himself in the canteen. He was told that a colleague walked him there. The Consultant Neurologist requested that GP give him some Topiramate 25 mgs tablets. She arranged for another review in two months.

31st March 2010 ¹¹⁷

The Consultant Neurologist wrote to the GP informing her that she had reviewed Mr A and that he reported no further seizures. She recorded that he continues on Topiramate 125mgs each day and Carbamazepine Retard 600mgs twice daily. She

¹¹⁴ GP notes (2nd batch)

¹¹⁵ Letter from Consultant Neurologist to GP, 16/09/2009

¹¹⁶ Letter from Consultant Neurologist to GP, 21/12/2009

¹¹⁷ Letter from Consultant Neurologist to GP, 31/03/2010

arranged for a follow up review in six months. The Neurologist reported that Mr A expressed no psychiatric symptomatology at this time.

6th April 2010

- Prescriptions - Carbamazepine Prolonged Release M/R Tablets 400 mg BD 2*56 tablet
- Prescriptions - Carbamazepine Prolonged Release M/R Tablets 200 mg BD 2*56 tablet
- Topamax Sprinkle Capsules 50 mg 2*60 capsule
- Topamax Sprinkle Capsules 25 mg 2*60 capsule

Week commencing 26th April 2010 – taken from statement made by Mr A’s brother in Coroner’s Inquest.¹¹⁸

During the week commencing 26 April 2010 Mr A was staying with his brother, and on the first night had a seizure. His brother checked on him and stayed with him until he settled down. In the morning he continued to ramble to himself. The following evening Mr A became increasingly agitated and anxious, rambling about high-pitched noises inside his brain. He informed his brother that he was going to book into a bed and breakfast in order to get away from the noises. At that point, his brother was not too concerned about his welfare. He had made a choice to avoid the noises he kept going on about.

Mr A left the flat with two holdalls. The next day during the morning his brother went to visit their parents at their home. He told them that Mr A had chosen to leave the flat the night before and intended to stay in a bed and breakfast. Their mother told him Mr A had said, or given them a message to say, that he was going to London and would be back after the elections.

Later that day Mr A turned up at his brother’s. He informed him that he had slept rough in the cemetery at the top of St Peter’s Street, St Albans. He didn’t appear rough in appearance and he seemed alright, so they didn’t discuss this any further.

On 29 April 2010 their mother managed to arrange an appointment via the local GP. She said Mr A attended the appointment, following which he was referred to Watford General Hospital for assessment, and to have a blood test to check the level of toxins from the epilepsy drugs were not affecting his mental health.

29th April 2010¹¹⁹

Mr A saw a GP at the GP Surgery. The GP reported that Mr A was with his mother who told him that Mr A had been confused for a week. Mr A was living with his mother and his brother. Mr A was very confused but there was no evidence of hallucinations although he had previously been hallucinating. The GP made a note to contact Mr A’s brother, and to tell him to take Mr A to Watford General Hospital so that they could investigate the possibility of Mr A experiencing drug toxicity.

¹¹⁸ *Coroner’s Inquest transcript 14/12/ 2010*

¹¹⁹ *West Hertfordshire notes, Patient Summary*

29th April 2010– taken from statement made by Mr A’s brother in Coroner’s Inquest¹²⁰.

Mr A’s brother attended Watford General Hospital with Mr A and his mother. He was initially seen and had blood taken. During this process Mr A believed that the staff injected him with viruses and wanted to kill him. His eyes were examined with a small torch and he stated he believed the staff were sending messages to his brain to control him. Mr A was agitated, talking to himself and the walls. Later staff from the mental health team joined them. They asked him questions. At one stage the two staff members also spoke to Mr A’s brother and their mother privately, and said that Mr A was displaying potential symptoms of schizophrenia and that he might have been in his own hallucinatory world.

About 9.30pm they were allowed to leave hospital. They were told that somebody would call them on the telephone the following morning to give them an appointment for somebody to see Mr A’s brother felt uncomfortable about this, as Mr A continued to “ramble”.

As they stood near to the exit and began to leave, an unidentified member of staff reportedly said ‘We can’t just let him leave’, but after a while nobody came to them and they just stood there waiting. A male member of staff came out and looked around Mr A. He touched him and then went back into the ward without saying anything. They waited but nobody came and told them anything, and nobody seemed interested, and therefore they started to leave.

Mr A’s brother reported that Mr A was ‘still rambling’. Mr A’s brother drove up the access road and pulled up near to Mr A. He asked him to get into the car but Mr A refused. He continued to rant on and refused to get in, so Mr A’s brother got out and tried to coax him into the car. He again refused, so Mr A’s brother went back into the hospital to try and get help. He could not communicate with Mr A.

Mr A’s brother spoke to the nurse at the desk. She said one of the male nurses could help. However the male nurse was not able to assist and just stood there and let Mr A ‘ramble on’. They still couldn’t get an ambulance to take Mr A home. After a short while they went back to the car and found it had gone. Mr A’s brother presumed that their mother had been so upset about what happened that she had gone home. By this time the only other option was to walk back to St Albans. They walked along Vicarage Road, through the town, joined Saunders Road travelling towards St Albans when they reached a large grass-fronted hotel, past the big roundabout on the right-hand side. Mr A walked to the reception through the front door and then walked straight through the foyer into the bar area. He began rambling on at several customers inside. Mr A’s brother followed Mr A and encouraged him to leave, which he did after only a few minutes. At around midnight they found and took a cab to St Albans.

¹²⁰ *Coroner’s Inquest transcript 14/12/2010*

29th April 2010 – report from hospital records¹²¹

Earlier that day Mr A's mother and brother accompanied Mr A to Watford General Hospital on advice from the GP that morning. They arrived at 1.35pm. He was taken into the triage area and assessed. His baseline observations were recorded and all were within normal parameters. The notes state that Mr A appeared confused.

At 1.52pm Mr A was placed in the bay on the ward at the Admission and Assessment Unit (AAU).¹²²

At 3pm¹²³ Mr A was assessed by a physician. He recorded that Mr A had suffered from delusions for 2-3 months, which had worsened over the previous week and that he'd been talking to himself. Mr A's brother told the physician that he thought that Mr A might have always had delusions to some extent.

The physician noted that the family were unclear about Mr A's compliance with medication as he self-administered this. Mr A had had a small seizure the previous week but generally his seizures were well controlled.

The physician notes that Mr A believed that androids were trying to control his mind and that he thought that the physician was trying to kill him. He wrote that Mr A had pressure of speech, disordered thinking and was paranoid but that he did not seem distressed by these thoughts.

Blood samples were taken from Mr A to ascertain his Carbamazepine levels and some physical tests were performed to ascertain if his mental state was attributable to drug toxicity. The results of these were normal so the physician referred Mr A for psychiatric review at 6pm.

29th April 2010¹²⁴

Mr A was referred to the psychiatric liaison service by the physician at Watford General Hospital following him being assessed there due to changes in his behaviour.

Mr A was seen by a Liaison Nurse and a Junior Doctor in psychiatry for psychiatric assessment in the AAU Department. They also saw his mother and brother who accompanied him. Mr A's family expressed concern about his behaviour. He had had a seizure four days earlier. They told the Junior Doctor that he was rambling and they were unsure about his compliance with his anticonvulsant medication. They described that he had appeared to experience bizarre thoughts for about a year. He had spoken about people controlling him with high frequency and interfering with his thoughts and brain. He had attempted to move into a flat in the same building as his brother but believed that his neighbours were controlling him. At the time of the assessment he was living with his parents, his 82 year old mother and his father who had had a stroke a few years previously. Mr A's mother and brother said he isolated

¹²¹ Notes by Physician, 29/04/2010

¹²² Incident report template, 29/04/2010

¹²³ Incident report template, 29/04/2010

¹²⁴ Notes by Junior doctor, 29/04/2010

himself, appeared withdrawn and that his conversations were dominated by his beliefs.

Mr A told the assessors he was trying to make sense of racism, that he was being controlled by an external force, and that they had implanted a chip in his ear. He also told the Liaison Nurse that when he had had some blood samples taken that he thought a 'chip' had been put in his arm to control him, and the sandwich that he had eaten had exploded in his stomach. Mr A spoke about his mother and the conception of his brother being involved. Mr A denied auditory hallucinations, suicidal thoughts, intentions or plans.

The Junior Doctor in psychiatry recorded that Mr A appeared unkempt and suspicious but co-operative. He had pressure of speech and flat affect and evidence of formal thought disorder.

Mr A is recorded as not presenting a risk to others.

The Junior Doctor in psychiatry's recorded impression was that Mr A was presenting with delusional thoughts and formal thought disorder. She records that these symptoms may be attributed to a postictal episode (i.e. after an epileptic fit) but are more likely to be indicative of schizophrenia.

The discharge plan was as follows¹²⁵:

- Discharge home with mother and brother
- Mental health helpline given to his mother which she stated she would use if need be
- Referral to CATT St Albans
- For possible initiation of an antipsychotic

In her notes¹²⁶, the Liaison Nurse noted that Mr A's mother was 82 years old and was caring for her husband who suffered a stroke three years earlier. She noted that the family have a carer to assist them once a week, and that Mr A's mother had significant other health problems that could have impacted upon her ability to care for Mr A. The Liaison Nurse reported that the family were offered help at home with Mr A's father, but this was declined.

The Liaison Nurse describes Mr A as floridly psychotic and comments that he was 'one of the worse cases' she had seen. She records that he was paranoid in presentation but in a subtle rather than an aggressive way but that she felt that he may become agitated if not listened to or understood. She stated that he was one of the most thought disordered cases she had seen, but that he was very passive, holding her hand. Mr. A acknowledged feeling lonely and stated that he'd wished he'd had sex with a neighbour when she'd asked him to years earlier (this is a different neighbour to Mrs Z). Mr. A commented that this was when it all 'started going wrong in his head'.

¹²⁵ Notes by Junior doctor, 29/04/2010

¹²⁶ Notes by the Liaison nurse, 29/04/10

The notes state that the Liaison Nurse concluded that Mr A might have been unwell for some time, as apparently he told her he had started hearing voices in his twenties.

It is recorded that she spoke to the CATT team on the telephone at 8.30pm that evening to confirm that she would be sending a referral and that they had agreed to visit Mr A at his mother's home the following day, to monitor his mental state and any risk to himself or others, prescribe medication and offer support to Mr A's family.

29th April 2010 following Mr A's discharge from the AAU department ¹²⁷

At approximately 10pm, following Mr A's discharge from the AAU department, the Nursing Sister from the AAU saw Mr A and his brother in the car park following a request from a colleague for assistance. She took a nursing colleague who had been involved in Mr A's care in the AAU with her. Mr A's brother told her that Mr A had refused to walk with him to the car where their mother was waiting. The nurse reported that Mr A's brother asked her to talk to Mr A but that Mr A did not engage with her and her colleague and that Mr A's brother seemed frustrated with the situation. The Nursing Sister states that she left her colleague and went back into the hospital to call the Shrodells Unit which is the psychiatric inpatient unit on the hospital site. The Nursing Sister stated that the Psychiatric Liaison Team is also based at the unit. The Nursing Sister cannot recall who she spoke to in the unit but states that she explained to them that Mr A had been assessed by the psychiatric team and they said that he could go home, but that the problem was that he would not go with his brother to the car park. She asked if someone could come down and talk to him, but they said they could not. She said the person stated that Mr A would be assessed in the morning and that she should call the police.

The Nursing Sister states that she then called the police and asked for assistance but they replied that they could not assist if Mr A was not being aggressive. The Nursing Sister states that when she returned to the scene Mr A and his brother had gone.

Later that night, at approximately midnight, the Nursing Sister reports that Mr A and his brother returned to the AAU stating they were looking for their mother. She said they asked her how they were going to find their mother. She informed them to contact relatives or the police.

Mr A's brother told the inquest that he was refused an ambulance home by the AAU department (but this could not be corroborated) and when he could not find his mother and the car, assumed that she had driven home without them so he and Mr A started walking home. He described Mr A as rambling and talking about his hallucinations on the journey and at one stage wandered into a hotel bar and started to 'ramble at the customers'. Eventually they managed to get a taxi to take them home.

¹²⁷ Interview notes Nursing Sister, 20/07/12

About 1.30am on 30 April 2010 they arrived at their parents' house and found there was no car in the drive or in the garage, and the house was in darkness. Mr A's brother had a key for the door but there was a security latch on the inside, which was locked and prevented them from getting in. Mr A's brother was concerned to know the whereabouts of his mother so he got in to his car with Mr A and drove straight back to Watford and to the hospital. He drove round the car park looking for his mother and the car but could not find it. He states he parked outside the front of the ward and went back inside to tell them what had happened. He states that Mr A followed him inside and began to 'rant' again. He says that he then took Mr A to his own home but that Mr A did not want to go to bed and sat upright on the sofa where he had what Mr A's brother described as a small seizure. Later, when he was in bed, he reports that he could hear Mr A making lip smacking and chewing noises. At one point during the night, he got up to check on Mr A and found him to be still sitting upright on the sofa in a 'trance'.

At about 8.00am on the morning of 30 April 2010 Mr A's brother states he was awakened by Mr A walking past his room, putting his duvet and pillows back into his room. A short while later he states he could hear the sounds of Mr A making himself some breakfast in the kitchen. As he was eager to ensure his mother had arrived home safely he drove himself and Mr A to their parents' home at approximately 8.30am.

On their arrival at their parents' home, Mr A's brother states that his parents' car was still not on the driveway. They went inside and Mr A's brother found his mother lying on the bed. In the meantime, not knowing where his mother was, it's reported that Mr A was upset and went and told his father that his mother was dead. Mr A's brother reassured him that this was not the case. Mr A's brother then went home, leaving Mr A at his parents address.

30th April 2010 ¹²⁸

Early in the morning the CATT Social Worker tried to contact Mr A to arrange a time for CATT to visit with a Psychiatrist but was advised by his mother that he was not at home and had stayed at his brother's. She rang Mr A's brother who informed her that Mr A had left the house. As his whereabouts were unknown a provisional appointment was made for 11.30am that day.

Mr A's brother explained that they had had problems with Mr A after leaving the hospital the previous night. He said that they had had difficulty leaving the hospital and that Mr A had been preoccupied and ranting about 'androids'. This led to Mr A's mother becoming upset and leaving the area and then Mr A's brother being unable to find her. He said he requested an ambulance take them home as he thought his mother had gone off in the car but was told this could not be facilitated. He described being distressed and embarrassed as Mr A was shouting and would not move. Mr A's brother said he'd eventually had to entice Mr A out of the area and

¹²⁸ Notes by The CATT Social Worker, 30/04/2010

they had to walk home. Mr A kept stopping people en route and ranting to them. He said they arrived home and Mr A did not settle until the early hours of the morning.

11:10 am, 30th April 2010

The CATT Social Worker requested a Mental Health Act assessment following CATT not being able to locate Mr A. This was agreed and it was agreed to discuss this with Mr A's brother. She also agreed to contact Mr A's GP and tell them they were concerned about Mr A and that they wanted to undertake an assessment.

She noted that at 2.40pm when the team contacted Mr A's brother to discuss the assessment they were advised by him that a neighbour was critically injured and that Mr A had been killed by the neighbour's son.

Details of Mr A's prescriptions issued by GP practice ¹²⁹

Repeat prescriptions last issued 6th April 2010:

Carbamazepine Retard 400mgs twice daily
Carbamazepine retard 200mgs twice daily
Topamax Sprinkle Capsules 50mgs twice daily
Topamax Sprinkle Capsules 25mgs twice daily

Past medication:

Carbamazepine Retard 400mgs issued 5/1/04
Levetiracetam 250mgs once a day for 1 week and then increasing to 2 twice daily issued 15/9/05
Carbamazepine 200mgs 2, twice daily issued 28/12/07
Carbamazepine Retard 200mgs BD and 400mgs twice daily issued 9/06/08
Sodium Valproate 200mgs 2 twice daily issued 3/2/09
Topiramate Capsules 25mgs twice daily issued 22/09/09
Topamax Sprinkle Capsules 25mg 2 twice daily issued 27/10/09

11. AN EXAMINATION OF SERVICES PROVIDED TO MR A IN RESPECT OF HIS DIAGNOSIS OF EPILEPSY AND SUITABILITY OF THAT CARE

11.1 Background to the health and social care needs related to Mr A's epilepsy

The primary health and social care needs of Mr A revolved around the diagnosis and treatment of his epilepsy. In this section the nature of this and his contacts with health and social care is reviewed before the specific terms of reference are commented on.

Mr A had a diagnosis of epilepsy from the age of 12.

¹²⁹ GP records

An initial letter from paediatric services at St Albans City Hospital¹³⁰ seems to have been his first contact and this is where the initial diagnosis and investigations were made.

He was started on treatment with Phenobarbital, an antiepileptic drug, in January 1975.

The seizures were described as involving an aura of a feeling of warmth, followed by him passing out and jerking¹³¹.

A diagnosis of left temporal lobe epilepsy was made at this time, in 1986, and he was started on treatment with Carbamazepine with an aim to wean him off his existing treatment with Phenobarbitone. Temporal lobe epilepsy is a term that suggests a specific anatomical location for the start of the seizures. Such individuals will often, but not invariably, have abnormalities on their MRI brain scans.

A CT scan of his head and an electroencephalogram (EEG) was arranged. The CT scan was normal and the EEG abnormal with some abnormal activity in the left temporal lobe.

By 1990 Mr A was described as having very well controlled seizures, though he did have occasional seizures sometimes as much as one year apart.

Further neurological review of Mr A's epilepsy occurred in 1995 at St Albans City Hospital. At this time there was concern that the seizures were more frequent and his anticonvulsant medication was reviewed and increased. In addition, further investigations were requested in terms of an EEG and an MRI scan of his head.

At this time a concern was raised that Mr A was undergoing some sort of deterioration in cognitive function and referral for neuropsychological assessment was made.

A psychometric assessment was made on the 5 June 1995 that showed Mr A had an IQ of 84.

A further referral was made to psychiatric services in 1996. This again was due to concerns over deterioration in his cognitive function¹³².

The result of the psychiatric assessment in March 1996 was that Mr A had no evidence of psychiatric illness.

Mr A continued with regular review from consultant neurology services at the St Albans City Hospital. He was seen at either yearly or six monthly intervals from 1995 through to 1999.

¹³⁰ *Herts Partnership notes undated*

¹³¹ *Letter 05/03/1986 Herts Partnership notes*

¹³² *Referral letter from GP 29/02/1996*

Mr A was re-referred to neurology services in 2005. At this time he is described as considering his condition to be stable. His epilepsy was re-evaluated at this time with a further MRI scan and EEG¹³³.

Sometime after this referral he had a drug change whereby his Carbamazepine was reduced and he was commenced on a new antiepileptic drug, Levetiracetam. Mr A attended his GP with his mother on the 28th September 2005. The records show "Pt with mother now & he is having delusions. Thinks that the Army has done something to his brain. Not aggressive or dangerous in any way & has taken his Carbamazepine".

He returned to the GP on 10 October 2005 and was described as "All settling now, although still feels slightly confused. Can probably go back to work next week"¹³⁴.

This event was put down as a toxic effect of the anticonvulsant, Levetiracetam. He settled afterwards and returned to his usual state. Details on the exact timeline of this episode are not clear. The situation was complicated by the fact that Mr A appears to have been confused about the change and stopped his Carbamazepine prior to starting his Levetiracetam.

Mr A continued under neurology review. In 2007 he was described as having had 3-4 complex partial seizures in an eight month period. It was also noted that he could be having seizures at night.

In the period from 2007 through to the index event, Mr A was seeing his neurologist at approximately six month intervals. He had a further antiepileptic drug introduced at a low dose, Topiramate, to which he does not appear to have had any adverse reactions. He appears to have been having few seizures; those that did occur involved fairly brief periods of loss of consciousness and associated confusion.

Mr A's last contact with his GP at this time had been 27 February 2008.

Mr A was last seen in the neurology clinic, St Albans City Hospital, on 31 March 2010. At this occasion he was on Topiramate 50mg in the morning, 75mg at night and Carbamazepine Retard 600mg twice a day. Following this it is reported in his clerking pro-forma from the admission team in the AAU, dated 29th April 2010, that he had suffered a small fit one week previously. Drug levels for his Carbamazepine taken at this time did not show drug toxicity.

In Mr A's brother's report to the coroner¹³⁵, he states that on the week commencing Monday 26 April 2010 Mr A was staying with him and had a seizure. This was noticed as he was awakened by the noise of the seizure. This is likely to have been a secondarily generalised tonic clonic seizure.

¹³³ West Herts Trust notes, letter dated 15/09/2005

¹³⁴ GP electronic records page 1 of 4

¹³⁵ Notes from the Coroner's Inquest 14/12/2010

It is also possible he had a seizure in the night of his discharge from AAU. This is not clear but, as noted in his brother's witness history, he was heard making 'lip-smacking' noises in his bedroom. Such noises are quite typical of complex partial seizures.

11.2 Referral and treatment

Epilepsy: The independent investigation team are of the view that the care received by Mr A from his neurology and primary care team was excellent. Of particular note was the regular review by the neurology team. The care fulfilled NICE guidance¹³⁶ in respect of diagnosis made by a specialist, investigation, MRI scan and EEG, treatment, use of monotherapy and add-on therapy.

Mental illness: The investigation team note that there was no referral to specialist psychiatric assessment following Mr A's psychotic episode in 2005. It is clear from the clinical records that this was because it was believed to be a side effect of his new antiepileptic drug. This was in concordance with usual practice.

NICE guidance does not offer any guidance on psychosis associated with epilepsy.

Recommendation 1

West Hertfordshire Hospitals NHS Trust and Hertfordshire PCT should ensure that any patient with epilepsy who has a psychotic episode, irrespective of apparent cause, should be referred to a psychiatrist with neuro-psychiatry experience, for psychiatric assessment.

11.3 Social Care

It appears that at no time did Mr A receive support from social care or from epilepsy charities. The independent investigation team could not find evidence that Mr A was referred to any epilepsy charities.

The voluntary sector can make a significant contribution to the support of individuals with epilepsy. This can be in terms of educational support, telephone help lines and direct contact. In the case of Mr A we have no evidence that he made any contact with the voluntary sector, or that any such support was available in the St Albans area. The absence of an epilepsy specialist nurse in the area may have compounded this lack of support, as often specialist nurses form links to community voluntary services. It certainly cannot be said that this absence had any bearing on the outcome of this case. But such services may have offered an alternative route for support for Mr A through which his psychiatric illness might have become more obvious.

¹³⁶ National Institute for Health and Clinical Excellence (2012) *The Epilepsies: The diagnosis and management of the epilepsies in adults and children in primary and secondary care* [CG137]

Recommendation 2

West Hertfordshire Hospitals NHS Trust should consider involving epilepsy charities (Epilepsy Action, Epilepsy Bereaved and the National Society for Epilepsy) in the neurology services provided by them, and providing signposting advice to service users.

11.4 Medication

Mr A received appropriate medication, as indicated in NICE guidance, for his epilepsy.

The investigation team do not believe that Mr A was offered appropriate psychotropic medication when discharged, or when an inpatient in AAU.

Clinical statements for the treatment of neuropsychiatric disorder in epilepsy recommend the use of symptomatic treatment for psychosis of epilepsy¹³⁷. The investigation team believe this should have been offered to Mr A in the AAU and for his discharge.

11.5 Diagnosis

Mr A received an appropriate diagnostic process by an epilepsy specialist in line with NICE guidance.

The independent investigation team believe the referral by Mr A's GP to AAU was based on an appropriate diagnostic pathway to rule out drug toxicity before receiving expected psychiatric assessment and treatment.

The assessment for toxicity and onward referral to psychiatric assessment by the medical staff in AAU was appropriate.

The diagnostic assessment by the liaison psychiatric nurse and on-call psychiatrist in AAU accurately recognised Mr A to be suffering from a psychotic illness. The Liaison Nurse believed that Mr A had been in a psychotic state for many years, as he had told her that he had started hearing voices in his twenties, and that was "when it started going wrong in his head". However, the acute, severely deteriorating nature of his condition was not identified.

11.6 Assessment of decisions taken and their validity

Epilepsy: The key decisions made regarding Mr A's epilepsy care related to the initial diagnostic and assessment process and to his on-going treatment.

The independent investigation team feel that the diagnostic, assessment and treatment process were all appropriate and within NICE guidance.

¹³⁷ Kerr, MP. et al. (2011) *International consensus clinical practice statements for the treatment of neuropsychiatric conditions associated with epilepsy*. *Epilepsia* 52(11): pp. 2133-8

The independent investigation team are of the view, however, that referral for psychiatric assessment would have been appropriate following assessment of his apparent drug induced psychotic episode in 2005.

11.7 Adequacy of epilepsy care

It appears that Mr A's epilepsy care plan was, in the main, developed through the clinic letters from his neurology appointments. This was an adequate and appropriate means of planning his main epilepsy needs, that is, medication change in relation to information on his seizure control. The primary care team and neurologist appeared to have developed a strong understanding that any concerns would be dealt with.

The only potential weakness in this was that with regular neurology review, and with the primary care team having no concerns, the more holistic primary care review was supplanted by neurology review.

12. AN EXAMINATION OF THE MENTAL HEALTH SERVICES PROVIDED TO MR A AND SUITABILITY OF THAT CARE IN VIEW OF MR A'S EPILEPSY AND THE IMPACT THIS MAY OR MAY NOT HAVE HAD ON HIS MENTAL HEALTH

During the week commencing 26 April 2010, Mr A was staying with his brother and had a seizure. His brother states he checked on him and stayed with him until he settled down. In the morning he was reported to be 'rambling' to himself. The following evening, according to Mr A's brother, Mr A became increasingly agitated and anxious, rambling about high-pitched noises inside his brain. Mr A informed his brother that he was going to book into a bed and breakfast hotel in order to get away from the noises. At that point, Mr A's brother says he was not too concerned about Mr A's welfare as he had made a choice to avoid the noises he was concerned about.

Mr A's brother states that Mr A left the flat with two holdalls. The next morning Mr A's brother went to visit their parents at their home. He told them that Mr A had chosen to leave the flat the night before and intended to stay in a bed and breakfast hotel. Their mother told him Mr A had told them to say that he was going to London and would be back after the elections.

Later that day Mr A turned up at his brother's flat. He informed him that he had slept rough in the local cemetery. Mr A's brother said that Mr A did not appear rough in appearance and he seemed alright, so they did not discuss this any further.

On 29 April 2010 Mr A's mother managed to arrange an appointment via the local GP for Mr A due to concerns about his mental state. She attended this appointment with him.

Comment

Mr A's family report that he had appeared odd on occasions for up to a year but were clearly concerned that there had been a marked deterioration in his mental state in the days leading up to them facilitating his appointment with the GP on 29 April 2010. It is apparent from the clinical records and accounts from the clinicians who were involved in Mr A's care on a regular basis that it was not usual for him to attend clinical appointments accompanied by members of his family. It is the view of the investigation team, therefore, that the family's concerns about Mr A's presentation were higher than usual on this occasion.

12.1 29 April 2010: GP appointment¹³⁸

Mr A saw a GP at the surgery. The GP reported that Mr A was with his mother who told him that Mr A had been confused for a week. The GP observed that Mr A was very confused but he found no evidence of hallucinations although it was reported by Mr A's mother that he had previously been hallucinating. The GP advised that the family should take Mr A to Watford General Hospital so that they could investigate the possibility of Mr A experiencing drug toxicity in relation to his anticonvulsant medication. He made a referral to this effect, outlining details of Mr A's presentation and the potential need for psychiatric assessment if drug toxicity was excluded as an explanation for Mr A's confusion.

The GP who saw Mr A told the investigation team¹³⁹ that in cases where there were concerns about a patients' mental state he would usually refer directly to mental health services but given that Mr A was prescribed Carbamazepine for seizures, and that toxicity could potentially be the cause of Mr A's confusional state, this needed to be investigated and treated or eliminated in the first instance.

Comment

It is the view of the independent investigation team that the GP acted swiftly and appropriately in response to the concerns about Mr A's mental state. He accurately identified a differential diagnosis of drug toxicity or mental illness and his referral through the AAU was an appropriate pathway to manage this differential diagnosis.

12.2 29 April 2010: AAU assessment¹⁴⁰

Mr A's mother and brother accompanied Mr A to Watford General Hospital on advice from the GP that morning. They arrived at 1.35pm. He was taken into the triage area of the AAU and assessed. Mr A's baseline observations were recorded and all were within normal parameters but his confusion was noted.

At 3pm¹⁴¹ Mr A was seen by a doctor who recorded that Mr A had suffered from delusions for 2-3 months, which had worsened over the previous week and that he'd

¹³⁸ West Hertfordshire notes, Patient Summary

¹³⁹ GP interview notes, June 2012

¹⁴⁰ Notes by AAU doctor, 29/04/2010

¹⁴¹ Incident report template, 29/04/2010

been talking to himself. Mr A's brother told the doctor that he thought that Mr A might have always had delusions to some extent.

The doctor noted that the family were unclear about Mr A's compliance with medication as he self-administered this.

The family reported Mr A had had a small seizure the previous week but generally his seizures were well controlled.

The doctor noted that Mr A believed that androids were trying to control his mind and that he thought that the doctor was trying to kill him. He wrote that Mr A had pressure of speech, disordered thinking and was paranoid, but it is noted in the clinical record that Mr A didn't seem distressed by these thoughts.

The doctor took blood samples from Mr A to ascertain his Carbamazepine levels and did some physical tests to ascertain if his mental state was attributable to drug toxicity. The results of these were within normal limits so Mr A was declared medically fit and referred for to the Liaison Team for psychiatric review at 6pm.

Comment

The independent investigation team are of the view that the decision by the AAU medical team to refer to the liaison psychiatric nurse was appropriate.

12.3 29th April 2010: Liaison Nurse assessment¹⁴²

Mr A, his mother and brother, were seen by a Liaison Nurse. Mr A's family expressed concern about his behaviour and said he had had a seizure four days earlier.

The Liaison Nurse recorded that Mr A was pleasant in demeanour but floridly psychotic, thought disordered and deluded and referred to Mr A as 'one of the most thought disordered cases I've seen'.

The assessment document contains a description of Mr A being inappropriate in speech content, totally preoccupied with delusions and unable to concentrate. He is described as having no insight into his condition.

The Liaison Nurse recorded that he was paranoid in presentation but in a 'subtle rather than an aggressive way' but that she felt that 'he may become agitated if not listened to or understood'.

The Liaison Nurse observed that Mr A was experiencing low motivation and that his psychosis was affecting his ability to function on a day-to-day level. Mr A was reported to be having trouble eating due to delusional ideas about food and the nurse noted that he was thin, dark under the eyes and unshaven.

¹⁴² Notes by the Liaison nurse, 29/04/2010

Mr A acknowledged feeling lonely and stated that he wished he had had sex with a neighbour when she had asked him to years earlier. Mr A commented that this was when it all 'started going wrong in his head', and the voices started.

Comment

This is not the neighbour killed by Mr A and is thought to be indicative of his delusional thinking at that time.

The notes state that the Liaison Nurse concluded that Mr A might have been unwell for some time.

The Liaison Nurse noted that Mr A's mother was 82 years old and was caring for her husband who suffered a stroke three years earlier. She noted that the family 'have a carer assist them once a week' and that Mr A's mother had other significant health problems that would have impacted upon her ability to care for Mr A.

The Liaison Nurse recorded that she deemed Mr A to be appropriate for enhanced level Care Programme Approach (CPA).

It is recorded in the clinical notes that she spoke to the Crisis and Treatment Team (CATT) on the telephone at 8.30pm that evening to confirm the pending referral and that they had agreed to visit Mr A at his mother's home the following day to monitor his mental state and any risk to himself or others, prescribe medication and offer support to Mr A's family.

Following her assessment the Liaison Nurse was of the view that Mr A may need treatment from the CATT in the community so she contacted the junior doctor who was the psychiatrist on duty that evening.

12.4 29 April 2010¹⁴³ Duty junior doctor's assessment¹⁴⁴

Mr A's family told the junior doctor that he had appeared to experience bizarre thoughts for about a year. He had spoken about people controlling him with high frequency and interfering with his thoughts and brain. Mr A had attempted to move into a flat in the same building as his brother but believed that his neighbours were controlling him. At the time of the assessment he was living with his parents, namely his 82 year old mother and his father who had had a stroke a few years previously. Mr A's mother and brother said he isolated himself, appeared withdrawn and that his conversations were dominated by his beliefs.

The junior doctor recorded that Mr A appeared unkempt and suspicious but co-operative. He had pressure of speech and flat affect and evidence of formal thought disorder.

Mr A told the junior doctor he was trying to make sense of racism, that he was being controlled by an external force, and that they had implanted a chip in his ear. He also

¹⁴³ Notes by junior doctor, 29/04/2010

¹⁴⁴ Duty junior doctor's assessment, 29/04/2010

stated that the bloods that had been taken from him earlier that day were taken in an attempt to control him and the sandwich that he had eaten had exploded in his stomach. Mr A spoke about his mother and the conception of his brothers being involved. Mr A denied auditory hallucinations, suicidal thoughts, intentions or plans.

Mr A is recorded as not presenting a risk to others.

The junior doctor recorded her impression that Mr A was presenting with delusional thoughts and formal thought disorder. The doctor recorded that these symptoms may be attributed to a postictal episode, but were more likely to be indicative of schizophrenia.

Following her assessment, the junior doctor and the Liaison Nurse discussed their findings and agreed a discharge plan as follows¹⁴⁵:

1. Discharge home with mother and brother.
2. Mental health helpline number given to his mother.
3. Referral to CATT St Albans.
4. For possible initiation of an antipsychotic.

Clinical records show the plan was discussed with Mr A and his family and the Liaison Nurse had recorded in the clinical records that they agreed with the proposals.

Evidence given to the coroner during the inquest by Mr A's brother¹⁴⁶ indicates that he wasn't happy with Mr A being sent home as he was still unwell and that he would have preferred Mr A to have been admitted to hospital.

Mr A's family are recorded in the clinical records to have agreed with the plan to send Mr A home that evening. However, Mr A's brother clearly told the coroner at the inquest¹⁴⁷ that admission to hospital was never offered to them. The investigation team were told at interview that Mr A and his family were told that he was being offered intervention from the CATT as an alternative to admission and assumed that, as the family did not dispute this, they were in agreement.

12.5 29 April 2010: Phone call to CATT team leader

The CATT team leader stated in a statement that at 8.30pm he received a telephone call from the Liaison Nurse saying she would be seeing a man not known to the mental health services. She stated Mr A was reported to have been at AAU following an epileptic fit and requested the CATT fax number because she was planning to refer him to CATT and that he was to be seen the following day. She told the CATT team leader that Mr A was not depressed and not suicidal, but very psychotic and thought disordered. She stated that she would fax her assessment later that day when she had finished her writing up. The Liaison Nurse said that she could not discuss the detail of Mr A as he and his mother were near her.

¹⁴⁵ Notes by Junior doctor, 29/04/2010

¹⁴⁶ Notes from the coroner's inquest, 14/12/2010

¹⁴⁷ Notes from the coroner's inquest, 14/12/2010

12.6 29 April 2010: following Mr A's discharge from the AAU department¹⁴⁸

At approximately 10pm, following Mr A's discharge from the AAU department, the Nursing Sister from the AAU saw Mr A and his brother in the car park following a request from a colleague for assistance. Mr A and his brother had entered the unit and requested assistance in getting home as Mr A would not get in the car. He requested an ambulance, which had been refused. The Nursing Sister took a nursing colleague who had been involved in Mr A's care in the AAU with her to talk to Mr A and his brother. Mr A's brother told her that Mr A had refused to walk with him to the car where their mother was waiting. The Nursing Sister reports that Mr A's brother asked her to talk to Mr A but that Mr A did not engage with her and her colleague and that Mr A's brother seemed frustrated with the situation. The Nursing Sister states that she left her colleague with Mr A and his brother and went back into the hospital to call the Shrodells Unit, which is the psychiatric inpatient unit on the hospital site, to ask for advice. The Nursing Sister cannot recall who she spoke to in the unit but stated that she explained to them that Mr A had been assessed by the psychiatric team and they said that he could go home to await CATT assessment the following day but that he would not now go with his brother to the car. She asked if someone could come down and talk to him, but they said they could not. She said the call recipient stated that Mr A would be assessed in the morning and that she should call the police.

Comment

Hertfordshire Partnership NHS Foundation Trust has no record of this call being received and the independent investigation team have been unable to investigate this issue further as the Nursing Sister who states she made the call, cannot recall who she spoke to.

She then called the police and asked for assistance but they replied that they could not assist if Mr A was not being aggressive. The Nursing Sister states that when she returned to the scene Mr A and his brother had gone.

Later that night, at approximately midnight, the Nursing Sister reports that Mr A and his brother returned to the AAU stating they were looking for their mother. She said they asked her how they were going to find their mother. She informed them to contact relatives or the police.

Comment

It is the view of the investigation team that both the AAU and the CATT had a duty of care to Mr A and his family as he was awaiting assessment from CATT, had been very recently discharged from AAU, and was still on their premises. It is acknowledged that the Nursing Sister from AAU made some efforts to assist Mr A's brother by telephoning the Shrodells Unit and the police, but the lack of response from the Shrodells Unit should have been followed up and more assertive efforts made to expedite the CATT assessment when it became apparent that Mr A was becoming more agitated and that his family were not coping with this. Additionally, the

¹⁴⁸ Interview notes Nursing Sister, 20/07/2012

psychiatric services should have responded to the call from the AAU and made sure the CATT team were aware of the situation and their need to respond to it.

Recommendation 3

West Hertfordshire Hospitals NHS Trust and Hertfordshire Partnership Trust NHS Foundation Trust should develop joint protocols that clearly detail action that should be taken, and what the response from both services should be, when there are concerns about the mental health or behaviour of an individual on the premises at AAU or in the A&E department. This should include clear processes for reporting such incidents into both organisations and an escalation process to be used when the response from one or both of the organisations is ineffective.

12.7 29 April 2010: following Mr A's discharge from the AAU department¹⁴⁹

Mr A's brother told the coroner's inquest that he was refused an ambulance home by the AAU department and he could not find his mother and the car, assumed that she had driven home without them and so he and Mr A started walking home. He describes that Mr A was rambling and talking about his hallucinations on the journey and at one stage wandered into a hotel bar and started to 'ramble at the customers'. Eventually they managed to get a taxi to take them home.

About 1.30am on 30 April 2010 they arrived at their parents' house and found there was no car in the drive or in the garage, and the house was in darkness. Mr A's brother had a key for the door but there was a security latch on the inside, which was locked and prevented them from getting in. Mr A's brother was concerned to know the whereabouts of his mother so he got back in his own car with Mr A and drove straight back to Watford and to the hospital. He drove round the car park looking for his mother and the car but couldn't find it. He states he parked outside the front of the ward and went back inside to tell them what had happened. He states that Mr A followed him inside and began to 'rant' again. He says that he then took Mr A to his own home but that Mr A didn't want to go to bed and sat upright on the sofa where he had what Mr A's brother described as a small seizure. Later, when he was in bed he reports that he could hear Mr A making lip smacking and chewing noises. At one point during the night, he got up to check on Mr A and found him to be still sitting upright on the sofa in a 'trance'.

At about 8.00am on the morning of 30 April 2010 Mr A's brother states he was awakened by Mr A walking past his room, putting his duvet and pillows back into his room. A short while later he states he could hear the sounds of him making some breakfast in the kitchen. As he was eager to ensure his mother had arrived home safely he drove himself and Mr A to their parents' home at approximately 8.30am.

On their arrival at their parents' home, Mr A's brother states that his parents' car was still not on the driveway. They went inside and Mr A's brother found Mr A's

¹⁴⁹ *Notes from the Coroner's Inquest, 14/12/2010*

mother lying on the bed. In the meantime, not knowing where his mother was, it is reported that Mr A was upset and went and told his father that his mother was dead. Mr A's brother reassured him that this was not the case. Mr A's brother then went home, leaving Mr A at his parents' address.

12.8 30 April 2010 ¹⁵⁰

The following morning, on receipt of the referral from the Liaison Nurse a Social Worker from the CATT tried to contact Mr A to arrange a time for the CATT to visit Mr A with a doctor but was advised by his mother that he was not at home and had stayed at his brother's. She telephoned his brother who informed her that Mr A had left the house and relayed the events of the previous evening to her. He described his distress and embarrassment the previous evening when he was trying to get Mr A home and informed her that Mr A was 'ranting at' members of the public.

As Mr A's whereabouts were unknown a provisional appointment was made for 11.30am that day. The Social Worker informed the independent investigation team at interview that the content of the referral indicated that Mr A needed to be seen by a psychiatrist urgently as he had not been prescribed medication the previous night and was reported to be agitated, thought disordered and to be experiencing paranoid delusions.

12.9 30 April 2010 ¹⁵¹

Following the inability to locate Mr A the CATT social worker arranged an assessment for Mr A to be conducted under the Mental Health Act as soon as he was located. She discussed this with Mr A's brother and GP.

The clinical records state that at 2.40pm, when the team contacted Mr A's brother to discuss the proposed assessment, they were advised by him that a neighbour was critically injured and that Mr A had been killed by the neighbour's son.

Comment

The independent investigation team commend the social worker in the CATT for her thorough assessment of the content of the referral for Mr A, and her subsequent efficient action and liaison with the family. Unfortunately this did not affect the outcome in this case but nonetheless her actions constitute notable practice.

12.10 Role and function of the Liaison Team

One of the responsibilities of the independent investigation team is to establish actual practice, compare this to agreed local or national good practice standards and ascertain the cause of any variance. It has not been possible for the independent investigation team to review the quality of the service delivered by the Liaison Nurse against agreed operational standards that were in place at the time as the Liaison Service Operational Policy V1 was not issued in the Trust until January 2012. It does

¹⁵⁰ Notes by The CATT Social Worker, 30/04/2010

¹⁵¹ Notes by CATT Manager 30/04/2010 3.05pm

not appear that the Liaison Service was working to a written Trust operational policy at the time of the incident.

Additionally, the appropriateness of the referral of Mr A to CATT, or the adequacy of the referral process cannot be measured against agreed local standards that were current at the time as the CATT Operational Policy was issued in 2006 and was due for review in 2008.

Comment

Hertfordshire Partnership NHS Foundation Trust has since developed operational policies for both the CATT and Liaison services. The most recent are dated January 2012.

National policy and implementation guidance¹⁵² for liaison psychiatry describes the aims of liaison psychiatry and psychological medicine services (LPT) aim to increase the detection, recognition and early treatment of impaired mental well-being and mental disorder to:

- i. Reduce excess morbidity and mortality associated with co-morbid mental and physical disorder.
- ii. Reduce excess length of stay associated with co-morbid mental and physical disorder.
- iii. Reduce risk of harm to the person or others in the general hospital by adequate risk assessment and management.
- iv. Reduce overall costs of care by reducing time spent in the emergency department and general hospital beds and minimising medical investigation and use of medical and surgical outpatient facilities.

Four distinct functions are required of a liaison psychiatry and psychological medicine service:

- i. Giving advice, training and coaching on the management of mental health problems by other professionals in the general hospital.
- ii. Providing bio-psycho-social assessment, formulation and diagnosis for people identified by general hospital staff as experiencing impaired mental well-being or whose physical symptoms are unexplained.
- iii. Providing brief interventions or advice, signposting and hand holding to care provision from a range of other agencies.
- iv. Conducting Mental Health Act and Mental Capacity Act assessments and risk assessments for harm to self and others. Providing expert advice regarding capacity to consent for medical treatment in complex cases involving both physical and mental health problems.

The liaison psychiatry and psychological medicine team should be able to:

¹⁵² Aitken, P. (2007) *Mental Health Policy Implementation Guide. Liaison Psychiatry and Psychological Medicine in the General Hospital*. Royal College of Psychiatrists

- i. Maximise access for general hospital patients to services for improving mental well-being and treating mental disorder.
- ii. Provide mental health advice and support to general hospital staff, patients their families and carers.
- iii. Provide prompt and expert assessment of mental health problems.
- iv. Provide effective, evidence based brief interventions and treatments to reduce and shorten distress and suffering.
- v. Ensure that inappropriate or unnecessary medical investigations and treatments are avoided.
- vi. Provide support and advice in relation to mental health to general hospital services corporately.
- vii. Contribute to educational programs for general hospital staff.
- viii. Ensure that there is shared clinical governance between the LPT and the general hospital.
- ix. Ensure that regular clinical meetings occur between the LPT and the general hospital teams to discuss and share the management of patients.
- x. Establish effective liaison with local primary care team members and other agencies to provide onward care pathways.
- xi. Establish a detailed understanding of all local resources relevant to support of individuals with mental health problems and promote effective interagency working.
- xii. Gain a detailed understanding of the local population, its mental health needs and priorities, and provide a service that is sensitive to this, and its religious and gender needs.
- xiii. Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign Language.

The Trust's current Liaison Team Operational Policy¹⁵³ describes a much narrower function of their service than national guidance outlines:

"The mental health liaison team will carry out a full bio-psycho-social assessment of people's needs; will provide appropriate interventions to meet presenting needs. They will offer an early, on site, assessment service and together with Crisis Assessment and Treatment Teams and acute inpatient services, form the current basis of Hertfordshire Partnership Trust's acute/crisis service provision."

Comment

It appears to the independent investigation team that the function of the liaison team in the Trust was focused on crisis assessments. The Liaison Team Operational Policy in place at the time does not indicate that the team had a treatment function and did not outline standards and process of assessment or any tools or methodologies to be used.

¹⁵³ Hertfordshire Partnership NHS Foundation Trust (2011) *A&E Liaison Team Operational Policy, Version 1*

Recommendation 4

Hertfordshire Partnership NHS Foundation Trust should ensure that the ongoing implementation of the operational policies detailing roles, responsibilities, work methods, processes, assessment methodologies and tools and interface arrangements in place for both the CATT and psychiatric liaison service are monitored, and there is demonstrable evidence in place to ensure that the Trust board can assure themselves that these are being appropriately implemented.

12.11 Care Programme Approach (CPA)

The assessment completed by the Liaison Nurse and junior doctor states that Mr A met the criteria for enhanced CPA but the Liaison Nurse did not complete the paperwork putting Mr A on to CPA. She told the investigation team at interview that this was not her role and her expectation was that this would be completed when Mr A was assessed by the CATT team the following day.

Trust policy¹⁵⁴ states:

“The A&E Liaison Team assessor is responsible for completing CPA information when the service user is not a current user of services. For any individual offered a short period of follow-up, a member of the team will be nominated Care Co-ordinator at Standard level CPA. If the case is transferred to the local CMHT the Care Co-ordinator role will be transferred, via the CPA process, to a member of the CMHT.”

Comment

Trust policy states that it was the responsibility of the Liaison Nurse to take responsibility for ensuring that Mr A, given that he met the criteria for CPA, was put on CPA, even if this meant that this responsibility was transferred to the CATT the following day. The fact that she did not do this was a deviation from Trust policy. The investigation team have been told that it had never been practice for managers to enforce this policy.

Recommendation 5

The Hertfordshire Partnership NHS Foundation Trust should ensure that all staff are aware of their responsibilities with regard to CPA screening and ensure demonstrable ongoing monitoring of this.

12.12 Risk assessment

Trust policy regarding clinical risk assessment¹⁵⁵ states:

¹⁵⁴ Hertfordshire Partnership NHS Foundation Trust (2011) *A&E Liaison Team Operational Policy, Version 1*

¹⁵⁵ Hertfordshire Partnership NHS Foundation Trust (2008) *Clinical Risk Assessment and Management for Individual Service Users, Policy and Procedures, V5.1*

“All service users must have a recorded risk assessment. The nature of the risk assessment will be dependent upon how well known the service user is known to the professionals completing the assessment. A risk assessment that takes place within an initial interview in Accident and Emergency or when someone is admitted as an emergency in the middle of the night will be different from a risk assessment that is part of the ongoing management of a long term case.”

Mr A was not known to the mental health services so it is acknowledged that the opportunity for comprehensive clinical risk assessment, at the point of assessment by the Liaison Nurse and the junior doctor, was limited. In circumstances such as this, Trust policy requires the completion of a Standard Risk Assessment Form as follows:

“This form is to be used for:

- New mental health service users at first clinical interview/meeting.
- Standard CPA.
- Those under the care of services for people with learning disabilities – who are not on Enhanced CPA.

Who records and signs: The person or persons conducting the clinical interview.

When: At the first clinical interview, or at times of crisis/emergencies when no other, or up to date, risk assessment is available.

Who receives a copy: All Hertfordshire Partnership NHS Foundation Trust staff and seconded ACS staff who are involved with the service user should be informed of the risk assessment and a copy should be placed on the care record. Where separate records are held by other disciplines a copy should be placed on each file.

With whom should the information be shared: This is a professional decision however in situations of high risk it is important to consider the need to share information with other agencies, carers, and providers of other services. See Section 14 “Communication and Confidentiality.

When completing the form for new users of the service consideration should be given to the appropriate level of CPA or whether no further input is required by the specialist services. The management plan should detail these issues.”

Comment

The independent investigation team found no evidence that the Trust’s standard risk assessment form was completed as part of the assessment conducted by the Liaison Nurse and junior doctor. This is a deviation from Trust policy.

The main documentation separately completed by the Liaison Nurse and the junior doctor both state that Mr A denied risk to others or suicidal plans or intent, but there is no other specific reference to risk within these entries.

The assessment documentation repeats the statement that Mr A denied risk to others or suicidal plans or intent, but the other sections in the document pertaining to clinical risk are not completed. A box indicating that the service user could be at risk due to their vulnerability is ticked on the assessment, but the text box inviting assessors to provide more information on this is not completed.

Comment

The independent investigation team is of the view that the clinical risks to, or from, Mr A were not adequately assessed in this case and that Trust policy on clinical risk assessment was not followed.

The risk of harm to self or others was screened out, but there was no reference to how the identified risks that were alluded to should be managed in the short term, until Mr A could be seen by the CATT team, the following day.

The assessors from the liaison service appear to have assessed Mr A's risk of harming himself or others by only asking him if that was his intent. As previously stated, the investigation team acknowledge the limitations of conducting an initial crisis assessment with very little information other than service user and family report, but is of the view that the fact that Mr A was acutely psychotic, was experiencing persecutory delusions and hallucinations, had no insight, was confused and disorientated and had not experienced psychosis to this extent previously, should have alerted them to, at the very least, the potential of him being a risk to himself or others.

Additionally, there were risks with regards to Mr A's physical health. He was suffering from regular seizures for which he was taking medication and the Liaison Nurse had recorded concerns with regards to Mr A's dietary intake stating that he was neglecting his dietary and hygiene needs and looked thin, unshaven and dark under the eyes. Other than the observation that these factors were present, there was no reference in the assessment documentation, to a risk management plan with regard to these factors.

The independent investigation team are of the view that Mr A may have been responding to his beliefs when he was restless at night and was sleeping out and moving rooms. This could have been explicitly covered in the risk assessment, and further risk reduction advice such as advising the family to call for support, or warning the police about his vulnerability, could have been considered.

National research into suicides and homicides committed by people with mental ill health ¹⁵⁶ states:

“In the majority of both patient suicides (90%) and patient homicides (81%), immediate risk at final contact with services had been seen as low. This is a finding

¹⁵⁶ *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2011) Annual Report: England, Wales and Scotland. Centre for Suicide Prevention, University of Manchester*

that we have also reported in other parts of the UK. It is likely to be explained by one or more of the following:

- Risk factors are common and this can make it difficult to identify people at the highest
- Immediate risk.
- Risk in patients can fluctuate rapidly.
- Staff may become desensitised to evidence of risk.

It is clear that a risk management strategy cannot have much effect in reducing suicides and homicides if it is based mainly on improved care for patients known to be at the highest levels of risk – there are too few of these, according to our sample. Risk management has to be improved for the majority of patients if the few who will otherwise die by suicide or commit a homicide are to be reached.”

Recommendation 6

Hertfordshire Partnership NHS Foundation Trust should ensure there is a process in place to monitor the quality of risk assessments in the liaison psychiatry service on an ongoing basis.

Recommendation 7

Hertfordshire Partnership NHS Foundation Trust should review their risk management processes to ensure that they are based on comprehensive assessment, rather than purely on risk factor checklists, and backed up by appropriate skills training and access to experienced colleagues.

12.13 Psychiatric assessment of Mr A on 29 April 2010

The Liaison Nurse involved the junior doctor in her assessment of Mr A when she realised that he may need further treatment, possibly from CATT at home. This involvement of medical staff is good practice and is in line with Trust policy¹⁵⁷. Both the junior doctor and the Liaison Nurse spent a good amount of time assessing Mr A, talking with him and his family, and liaising with each other. They recorded their assessments separately using an assessment pro-forma provided on the Trust’s electronic record keeping system.

Both the Liaison Nurse and the junior doctor came to common conclusions about the presence of psychosis and the need for Mr A to receive further assessment and treatment. They both agreed to the plan to send Mr A home without treatment and to be seen by the CATT the following day.

Comment

It appears that the Liaison Nurse made some assumptions in her assessment that Mr A had been psychotic for many years, and thus the importance of his rapid and severe deterioration in mental state was not recognised. The independent

¹⁵⁷ Hertfordshire Partnership NHS Foundation Trust (2011) *A&E Liaison Team Operational Policy*. V1

investigation team found no evidence that the service user had experienced long term psychosis, despite the Liaison Nurse reporting that Mr A had told her that he had started hearing voices in his youth. This is likely in its view to have influenced her view on the risk associated with Mr A returning home.

Both the Liaison Nurse and the junior doctor were of the view that Mr A needed antipsychotic medication but that it was not urgent. It is the view of the independent investigation team that this was confounded by the perception that Mr A had been unwell for a long time.

Both the Liaison Nurse and the junior doctor told the independent investigation team during the interviews that Mr A having a supportive family with whom he lived contributed to their decision to discharge him and that if he had been assessed alone and had not had a supportive family, they might have been more inclined to admit him to hospital.

The Institute of Medicine's definition of the dimensions of patient-centred care¹⁵⁸ are as follows:

1. Compassion, empathy and responsiveness to needs, values and expressed preferences.
2. Co-ordination and integration.
3. Information, communication and education.
4. Physical comfort.
5. Emotional support, relieving fear and anxiety.
6. Involvement of family and friends.

NICE guidance¹⁵⁹ states in relation to crisis assessments:

“When undertaking a crisis assessment:

- address and engage service users in a supportive and respectful way
- provide clear information about the process and its possible outcomes,
- addressing the individual needs of the service user
- take extra care to understand and emotionally support the service user in crisis, considering their level of distress and associated fear, especially if they have never been in contact with services before, or if their prior experience of services has been difficult and/or they have had compulsory treatment under the Mental Health Act (1983; amended 1995 and 2007).

Assessment in crisis should be undertaken by experienced health and social care professionals competent in crisis working, and should include an assessment of the

¹⁵⁸ Goodrich, J. and Cormwell, J. (2008) *Seeing the Person in the Patient: The Point of Care review paper. The King's Fund*

¹⁵⁹ National Institute for Health and Clinical Excellence (2011) *Service User Experience in Adult Mental Health: Improving the experience of care for people using adult NHS mental health services [CG136]*

service user's relationships, social and living circumstances and level of functioning, as well as their symptoms, behaviour, diagnosis and current treatment.

If assessment in the service user's home environment is not possible, or if they do not want an assessment at home, take full consideration of their preferences when selecting a place for assessment.

When a person is referred in crisis they should be seen by specialist mental health secondary care services within 4 hours of referral.

Health and social care providers should provide local 24-hour help lines, staffed by mental health and social care professionals, and ensure that all GPs in the area know the telephone number.

Health and social care providers should ensure that crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, and available to service users in crisis regardless of their diagnosis.

To avoid admission, aim to:

- explore with the service user what support systems they have, including family, carers and friends
- support a service user in crisis in their home environment
- make early plans to help the service user maintain their day-to-day activities, including work, education, voluntary work, and other occupations such as caring for dependants and leisure activities, wherever possible.

At the end of a crisis assessment, ensure that the decision to start home treatment depends not on the diagnosis, but on:

- the level of distress
- the severity of the problems
- the vulnerability of the service user
- issues of safety and support at home
- the person's cooperation with treatment.

Consider support and care needs of families or carers of service users in crisis. Where needs are identified, ensure they are met when it is safe and practicable to do so.

Health and social care providers should support direct self-referral to mental health services as an alternative to accessing urgent assessment via the emergency department."

Comment

The independent investigation team are of the view that the assessment carried out by the Liaison Nurse and the junior doctor covered the appropriate topics and identified the issues presented by Mr A and his family in terms of his psychiatric

diagnosis. However, there is no evidence that the impact of his symptoms and coping mechanisms were explored with Mr A. Such exploration might have given the assessors an opportunity to explore the impact of Mr A's persecutory delusions on him and how he would cope with them if he felt in danger or under threat. There should have been a more patient and family centred approach that gave a higher degree of priority to the alleviation of Mr A and his family's distress. It is noted by the independent investigation team that, since this incident, clinical risk assessment training within the Trust has been reviewed and strengthened.

Recommendation 8

The Hertfordshire Partnership NHS Foundation Trust should ensure adequate training of all liaison staff in the assessment of the care environment in acute situations. In the situation of new referrals to mental health service it is particularly important that the ability of carers to cope is not assumed but a more detailed assessment is formed as to the ability of carers to cope with an acutely psychotic individual. In these situations consideration should be given to immediate assessment at home by the CATT rather than an overnight delay.

12.14 Treatment of psychosis associated with epilepsy

There is no reference to the treatment of psychosis and epilepsy in NICE guidance¹⁶⁰. Guidance does now exist in the form of international treatment statements¹⁶¹, but these were published subsequent to the index event. They offer the following guidance:

Assessment and management of psychoses associated with epilepsy

1. Awareness of the psychoses associated with epilepsy is essential to ensure identification of this rare but severe group of conditions.
2. Ictal and postictal psychotic episodes are of particular importance since they lead to substantial risk to people with epilepsy and their carers due to the unpredictability and potential severity of the affective psychotic symptoms.
3. Symptomatic antipsychotic treatment is generally warranted in postictal psychosis and should be carefully tapered off. For very short episodes of psychosis, where symptom remission is rapid, this can occur after 5 days. For longer episodes, where symptom remission takes more than few days, a period of 1-2 months following complete remission of psychosis is recommended

¹⁶⁰ National Institute for Health and Clinical Excellence (2012) *The Epilepsies: The diagnosis and management of the epilepsies in adults and children in primary and secondary care* [CG137]

¹⁶¹ Kerr et al "International consensus clinical practice statements for the treatment of neuropsychiatric conditions associated with epilepsy" *Epilepsia*; Volume 52, Issue 11, pages 2133–2138, November 2011

before an attempt is made to tail of the antipsychotic medication.

4. Symptomatic treatment of interictal psychosis is the same as treatment for primary Schizophrenia and should be administered long-term following remission.
5. In those cases where alternative psychosis and forced normalization occurs, carers and doctors should together decide, through a process of shared decision-making, how to proceed with Anti-Epileptic Drugs and antipsychotic drugs.

Comment

It is the view of the independent investigation team that Mr A was likely to have had an interictal psychosis on 29th April 2010, possibly worsened by a response to his recent seizure. We now know that current guidance would recommend the need for ‘*treatment as usual*’. This means that the service user’s treatment should be the same as any individual presenting with a psychotic illness.

Whilst we recognise that this guidance was not published until after the death of Mr A and Mrs Z, the independent investigation team note that the use of ‘*treatment as usual*’ was not performed in the case of Mr A, and that he should have received antipsychotic medication. For future practice therefore, we make the following recommendation.

Recommendation 9
Hertfordshire Partnership NHS Foundation Trust should ensure that all members of liaison teams have the appropriate training to ensure competency in assessing and treating psychiatric illness in association with medical ill health, including epilepsy.

13. EXAMINE THE EFFECTIVENESS OF THE SERVICE USER’S PSYCHIATRIC CARE PLAN ON 29th APRIL 2010, INCLUDING THE INVOLVEMENT OF THE SERVICE USER AND THE FAMILY

13.1 Adequacy of Care Plan

The plan of care agreed by the Liaison Nurse and the junior doctor for Mr A was as follows;

1. Discharge home with mother and brother.
2. Mental health helpline number given to his mother.
3. Referral to CATT St Albans.
4. For possible initiation of an antipsychotic.

13.2 Discharge home

Clinical records show the plan was discussed with Mr A and his family and the Liaison Nurse has recorded in her the clinical records that they agreed with the proposals.

Evidence given to the coroner during the inquest by Mr A's brother¹⁶² indicates that he was not happy with Mr A being sent home as Mr A was still unwell and that he would have preferred Mr A to have been admitted to hospital.

Mr A's family are recorded in the clinical records to have agreed with the plan to send Mr A home that evening. However, Mr A's brother clearly told the coroner at the inquest¹⁶³ that admission to hospital was never offered to them. The independent investigation team were told at interview that Mr A and his family were told by the assessors that he was being offered intervention from the CATT as an alternative to admission and assumed that, as the family did not dispute this, they were in agreement. However, the independent investigation team were told at interview that both the assessing clinicians did not consider admission to hospital, as they did not feel it was warranted as Mr A appeared calm, and that they did not consider him to present clinical risks.

Both the Liaison Nurse and the junior doctor told the investigation team at interview, however, that if Mr A had not had a supportive family at home with him they would have considered admitting him to psychiatric inpatient care, and that the supportive network around Mr A was a deciding factor in determining that he could be treated at home.

Comment

The independent investigation team can find no evidence that the care options for Mr A were discussed with the family in a way that gave them the opportunity to explore the risks and benefits of each. Additionally no evidence was found to indicate that Mr A's mother's home situation and ability to care for Mr A was explored with her or taken into consideration.

Again, recommended best practice has changed since the death of Mr A and Mrs Z. National guidance¹⁶⁴ now states:

"At the end of a crisis assessment, ensure that the decision to start home treatment depends not on the diagnosis, but on:

- the level of distress
- the severity of the problems
- the vulnerability of the service user
- issues of safety and support at home
- the person's cooperation with treatment."

Therefore to inform and improve future practice we make the following recommendation.

¹⁶² Notes from the coroner's inquest, 14/12/2010

¹⁶³ Notes from the coroner's inquest, 14/12/2010

¹⁶⁴ National Institute for Health and Clinical Excellence (2011) *Service User Experience in Adult Mental Health: Improving the experience of care for people using adult NHS mental health services* [CG136]

Recommendation 10

Hertfordshire Partnership NHS Foundation Trust should ensure that their staff are aware of the responsibilities outlined in National Institute for Health and Clinical Excellence (2011) Service User Experience in Adult Mental Health: Improving the experience of care for people using adult NHS mental health services and develop mechanisms to monitor this.

Comment

It appears clear to the independent investigation team, from the assessment, that Mr A was potentially lacking capacity to look after himself as he was disorientated and confused with no insight into his delusions. He was also presenting a first episode of a severe psychosis and was therefore unpredictable, given that he had not experienced such a presentation previously. His mother is recorded as being an elderly woman with caring responsibilities for her disabled husband and the Liaison Nurse noted her as having a significant health problem which could have impacted upon her ability to care, and having hearing problems.

It is the view of the independent investigation team that, given the extent of Mr A's confusion and psychosis, and his mother's capacity to provide care for him, it was not appropriate to send Mr A home without treatment or a more robust support package. In the event of Mr A refusing treatment, or to remain in the hospital for further assessment or a period of admission, the symptoms and presentation exhibited by Mr A would have warranted assessment for detention under the Mental Health Act.

13.3 Mental health helpline

Mr A and his family were given the Trust's mental health helpline number to access overnight if they needed advice, help or support.

The independent investigation team were told at interview that the helpline is manned overnight by the CATT worker covering the night shift. This worker was expected to take calls on the helpline between assessments and other duties. The independent investigation team were also told that the helpline primarily is able to help people who are already in touch with the service and who need someone to talk to during the night, and that if a service user phoned in crisis the CATT worker receiving the call would have to advise them to go to the Accident and Emergency department at the local hospital.

Comment

The independent investigation team recognise the value of people under the care of the CATT being able to speak to a professional on the telephone if they are in distress and need reassurance, advice and/ or support to help them to get through the night until they can see a worker the following day. Mr A and his family did not call the helpline during the night before Mr A's offence.

The independent investigation team are of the view that supply of a helpline number was an inadequate intervention to support the family of Mr A. The family clearly did not call and this is likely to be due to the fact that they did not know when to call or what help to expect. It is the view of the independent investigation team that in this acute situation the family would have needed very clear instructions about what level of deterioration merited a call.

13.4 Medication

Both the Liaison Nurse and the junior doctor were clear that Mr A needed to commence antipsychotic medication but felt that this was not urgent given that he was being seen by the CATT the following morning and that they thought he'd been unwell for some time and that therefore waiting until the next day would not be detrimental to Mr A.

Additionally, no other treatment was prescribed to assist Mr A to relax for the night and alleviate some of his anxiety in the short term. The independent investigation team were told that this was not felt to be needed as Mr A had told the Liaison Nurse that he slept well at night.

Comment

During the assessment Mr A was clearly extremely psychotic and at times, distressed. It is the view of the independent investigation team that the alleviation of this distress should have been the priority of the Liaison Nurse and junior doctor and that Mr A should have been prescribed some anti-psychotic and or anxyolitic medication either in AAU, or to take home from AAU. Whilst not explicitly stated, it is possible that the presence of his epilepsy may have deterred the use of antipsychotic medication for fear of seizure worsening. At interview the Liaison Nurse and junior doctor stated that it was not their perception that Mr A needed medication urgently as it was perceived by them that he had already been unwell for some time and therefore could wait until assessed by the CATT team. It is also possible that due to Mr A's passivity, the acuity and severity of his apparent psychosis was downplayed due to his passivity.

Recommendation 11

Hertfordshire Partnership NHS Foundation Trust should ensure that clear pathways for the use of medication in the AAU and Accident and Emergency department settings are developed. These should include risk assessment of medication use in all patients including those with medical co-morbidity.

13.5 Referral to CATT

The CATT Operational Policy¹⁶⁵ at the time stated:

“Within 1 hour of receipt of a referral CATT will contact the referrer to agree the level of urgency and a time for the assessment to occur. The assessment planned will usually occur in the referred service user’s home (if this is feasible and clinically appropriate taking into due account any safety issues) or within the A & E Department. Whenever possible the referrer or Care Co-ordinator should be present during the CATT assessment.”

And

“When a new referral indicates a crisis of such severity that in-patient admission is being considered the CMHT Duty Officer, the A&E Liaison Team or a medical member of the teams should rapidly screen the referral. If the referral is generated within A&E or the General Hospital a check should be made with the CMHT to ensure the user is not known. The CMHT/A&E/medical screening procedure should include a conversation with the referrer and whenever possible contact with the carer or the person referred. All possible information, including any accessible records should be scrutinised. The level of urgency should be determined. Following screening immediate contact with CATT should be made if in-patient admission may be necessary.”

And

Out of hours referrals will be accepted for assessment from local GPs, GP On-call Service, the Emergency Duty Team, NHS Direct, on-call consultants, Community Support Teams, A & E Liaison and the Police Surgeon. Details of the service user’s situation will be required and it is anticipated a short Mrs Screening assessment and information regarding any previous contact with mental health services will have been gathered prior to any contact with CATT

And

“Out of normal office hours. Referrals should be made direct to the local team until 9.0pm each evening 7 days a week including bank holidays. After 9.0pm and before 9.0am referrals should be made to the CATT overnight service. See appendix A for contact details.”

And

“Within 1 hour of receipt of a referral CATT will contact the referrer to agree the level of urgency and a time for the assessment to occur. The assessment planned will usually occur in the referred service user’s home (if this is feasible and clinically

¹⁶⁵ Hertfordshire Partnership NHS Trust (2006) *Operational Policy for Crisis Assessment and Treatment Teams*

appropriate taking into due account any safety issues) or within the A & E Department. Whenever possible the referrer or Care Co-ordinator should be present during the CATT assessment.”

The Liaison Nurse did not fax the referral regarding Mr A through to the CATT until later in the evening but had already informed them that Mr A did not need to be seen until the following morning when she had spoken on the telephone to the CATT Team Leader at 8.30pm.

The independent investigation team were told at interview that there existed a strong culture in the organisation of home treatment being preferable to inpatient treatment.

Comment

The independent investigation team recognise that such a view is consistent with a wish to reduce the impact on carers and individuals, and the associated stigma that can occur with inpatient psychiatric admissions. However there is a danger that such a culture may negatively influence clinical decision making. The Junior Doctor and Liaison Nurse in this case, however, stated that was not a factor in this case and that they did not consider admission because they did not feel it was clinically appropriate, rather than for any other reason.

Trust policy indicates that home treatment with the CATT is offered to those who are deemed appropriate for admission, as an alternative. The Liaison Nurse and the junior doctor made the decision that Mr A could wait until the next day to be assessed by the CATT despite the severity of his symptoms and the fact that the CATT do offer a service throughout the night and that a more immediate assessment from CATT could have been available to them.

It is the view of the independent investigation team that the severity and complexity of Mr A's presentation should have warranted a request for CATT to undertake their assessment at the earliest possible opportunity and that he should have remained in the hospital until this could be carried out. It is not known how quickly the CATT team could have come to assess Mr A that night as they were not asked to do so by the Liaison Nurse, as she stated in her phone call to them, he did not need to be seen until the next day.

13.6 Communication with the family on 29th April 2010

National guidance¹⁶⁶ states in relation to those treated by liaison psychiatric services:

“All patients and their families and carers should be provided with information on the services both in printed form and also as part of individualised engagement. This should include:

¹⁶⁶ Aitken, P. (2007) *Mental Health Policy Implementation Guide. Liaison Psychiatry and Psychological Medicine in the General Hospital*. Royal College of Psychiatrists

- Description of the service, the range of interventions provided and what to expect.
- Name and contact number and details of the care co-ordinator and other relevant members of the team.
- Contact details for out of hours advice and help.
- A written plan of care.
- Specific information about their disorder and any drug being used, including side-effects.
- Relapse plan and crisis plan.
- Contingency plans.
- Information on how to express their views on the service and make complaints.
- Information about patient/user forums and PALS.”

With regard to involving carers in decisions about the assessment and management of risk, national guidance¹⁶⁷ states:

“Where there is a carer involved, they are a vital source of support for the service user and may also be a key person in helping to manage the risks identified. Practitioners should be sensitive to the relationship between the service user and the carer, as there may be risks within this relationship and different points of view about the best actions to be taken. If the carer is at risk, they should be seen individually so that the risks can be explored and actions can be agreed.

The carer should receive enough information in a comprehensible format to enable them to provide the necessary care.

The carer’s worries about the service user should always be taken seriously, even if the care team is less concerned. The carer should be offered an assessment and should be helped to develop a plan for meeting their own specific needs.”

The independent investigation team found no evidence that any written information, a care plan or contingency plan, was provided to Mr A’s family when they were sent home from hospital on 29 April 2010.

The Liaison Nurse and the junior doctor state that they implied that admission to hospital was a possibility for Mr A when they offered him, and the family, assessment and home treatment by the CATT stating it was an ‘alternative to admission’. They were of the view that Mr A and his family were happy with this as they did not voice disagreement. Mr A’s brother stated at the coroner’s inquest that he would have wanted admission to hospital for Mr A if it had been offered.

The Liaison Nurse and the junior doctor were aware that Mr A’s carer was his mother who was elderly and also had caring responsibilities for her husband who

¹⁶⁷ Department of Health (2007) *Best Practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*

had had a stroke. The Liaison Nurse noted in her assessment that, in her opinion, Mr A's mother was suffering from dementia and had hearing problems.

Comment

It is the view of the independent investigation team that the quality of communication that took place between the assessors and the family was insufficient. The plan to send Mr A home that evening was relayed to the family, and the fact that the family did not challenge the decision was taken by the assessors as their implicit agreement. The independent investigation team are of the view that the decision to send Mr A home for home treatment was not made collaboratively with Mr A and his family, and the expectation that the family would challenge the plan of care if they were unhappy with it was not reasonable. Mr A's family were anxious, had been in the hospital for many hours and had no experience of mental health services, what to expect or what their potential options were, and were completely reliant on the professionals concerned making the most appropriate decision in light of the clinical symptoms that Mr A was presenting.

The independent investigation team recognise that at interview it was reported that since the event greater efforts have been made to ensure collaboration between psychiatric and medical service in AAU.

Additionally, the independent investigation team are of the view that it was not reasonable to expect Mr A's mother to care for Mr A overnight given her age, existing caring responsibilities and the health problems that the assessors suspected she was experiencing. In light of this it is the view of the independent investigation team that her ability to care for Mr A, in the circumstances, was not adequately assessed or explored with her, or either of her sons, before the decision was made to send Mr A home.

14. THE SUITABILITY OF MR A'S CARE IN VIEW OF HIS DIAGNOSIS OF EPILEPSY AND THE IMPACT THAT THIS MAY, OR MAY NOT, HAVE HAD ON HIS MENTAL HEALTH

During his life Mr A had two contacts with mental health services. The first was in 1996. This contact was to exclude the presence of mental illness; it was an appropriate referral at the time and informs us that at this time he was not expressing any evidence of mental illness.

The second contact was with the Liaison Nurse and on-call psychiatrist in the AAU. The investigation team have already highlighted the issues around this contact in terms of a lack of use of medication and the decision to discharge home.

An important question that arises in this review is the impact of epilepsy, and the quality of the epilepsy care on the index event. The investigation team have chosen to review this by asking the following questions:

- 1) What is the link between epilepsy and violent events?

- 2) What is the link between epilepsy and psychotic illness?
- 3) In the context of the knowledge of these links was the epilepsy treatment adequate and at any stage was the index event preventable through the treatment of his epilepsy?

14.1 What is the link between epilepsy and violent events?

Recent evidence¹⁶⁸ has shown that individuals with epilepsy are not associated with a higher risk of committing violent crime than their peers. In particular it is important to note that violence is a very rare manifestation of a seizure, and when it occurs is in the main associated with events where an individual enters the personal space of a person having a seizure¹⁶⁹.

Alternatively violence can be seen in the postictal state though it is rarely goal directed and is usually in association with confusion¹⁷⁰.

It is therefore uncommon for epilepsy to be associated with violent events.

14.2 What is the link between epilepsy and psychotic illness?

Psychosis is an uncommon but severe complication of epilepsy. There are a few population based epidemiological surveys looking for the prevalence of mixed psychosis in epilepsy producing figures between 0.5% and 9%¹⁷¹

The International League against Epilepsy classifies psychosis into the following groupings:

Ictal psychosis is typically an expression of non-convulsive status epilepticus, including simple partial status, complex partial status, and absence status epilepticus¹⁷².

Postictal psychosis (PIP) accounts for approximately 25% of psychosis of epilepsy¹⁷³. It often follows clusters of complex partial or secondarily generalized seizures¹⁷⁴. Classically there is a lucid interval between seizure and psychosis lasting from 1 to 6 days¹⁷⁵. Most patients with PIP present with abnormal mood and delusions, which

¹⁶⁸ Fazel, S. et al. (2011) Risk of violent crime in individuals with epilepsy and traumatic brain injury: a 35-year Swedish population study. *PLoS Med.* Dec; 8(12):e1001150. Epub 2011 Dec 27 <http://www.ncbi.nlm.nih.gov/pubmed/22215988>

¹⁶⁹ Brower, M.C. & Price, B.H. (2000) Epilepsy and violence: when is the brain to blame? *Epilepsy & Behavior.* 1:145-149; Marsh, L. and Kraus, G.L. (2000) Aggression and violence in patients with epilepsy. *Epilepsy & Behavior.* 1:160-168

¹⁷⁰ Ito, M. et al. (2007) Subacute postictal aggression in patients with epilepsy. *Epilepsy & Behavior.* 10: 611-614

¹⁷¹ Gudmundsson G. (1966) Epilepsy in Iceland. A clinical and epidemiological investigation. *Acta Neurologica Scandinavica.* 43: Suppl-124; Schmitz, B. & Wolf, P. (1996) Psychosis in epilepsy: Frequency and risk factors. *Journal of Epilepsy.* 8: 17-25;

Bredkjaer, S.R. (1998) Epilepsy and non-organic non-affective psychosis. National epidemiologic study. *British Journal of Psychiatry.* 172: 235-238

¹⁷² Wolf, P. (1985) Biological antagonism and epileptic psychosis. *British Journal of Psychiatry.* 146: 272-276

¹⁷³ Dongier, S. (1960) Statistical study of clinical and electroencephalographic manifestations of 536 psychotic episodes occurring in 516 epileptics between clinical seizures. *Epilepsia.* 1: 117-142

¹⁷⁴ Kanner, A.M. (1996) Postictal psychiatric events during prolonged video electroencephalographic monitoring studies. *Archives of Neurology.* 53: 258-263

¹⁷⁵ Trimble, M.R. (1991) *The Psychoses of Epilepsy.* New York: Raven Press

are often grandiose, religious and mystic in nature¹⁷⁶. Due to the severity of postictal syndromes they may pose a safety risk for the affected patients and carers alike. Psychotic symptoms often remit spontaneously within days or weeks but sometimes chronic psychosis develops from recurrent or even one single postictal psychosis¹⁷⁷.

Interictal Schizophrenia like psychosis of epilepsy (SLPE) occurs between the seizures and cannot be linked directly to the ictus. While they are less frequent than PIP, clinically they are more significant in terms of severity and duration¹⁷⁸. SLPE generally present as a paranoid hallucinatory syndrome similar to Schizophrenia, however, there is controversy as to whether the absence of negative symptoms and formal thought disorder, and better preserved personality function, might distinguish SLPE clinically from Schizophrenia. SLPE typically begins 10-15 years after the onset of the epilepsy and sometimes develops out of PIP.

Alternative Psychosis and Forced normalization: The term *alternative psychosis* describes a clinical constellation where patients with chronic epilepsy either suffer from frequent seizures or following treatment and seizure freedom from psychotic symptoms¹⁷⁹. The term *forced normalization* refers to an electrophysiological correlate of this clinical constellation where the phase with high seizure frequency goes along with pathological EEG findings whereas the normalization of the EEG generally following AED treatment goes along with the development of psychotic symptoms.

14.3 In the context of the knowledge of these links was the epilepsy treatment adequate and at any stage was the index event preventable through the treatment of his epilepsy?

Comment

It is the opinion of the independent investigation team that the epilepsy treatment was adequate throughout Mr A's life. At no stage was the event preventable through a different regimen of epilepsy treatment. Mr A developed a psychotic illness, possibly an interictal psychosis, in 2010, many years into the diagnosis of his epilepsy. There is no evidence to suggest that an alternative epilepsy treatment regimen would have had any bearing on the development of his psychosis.

It is also clear from his neurology consultant that at no time during the regular consultations at neurology clinic did Mr A express any suggestion of experiencing psychiatric symptoms. Mr A attended such appointments alone as was completely appropriate.

¹⁷⁶ Kanemoto, K. (1996) Postictal psychosis: a comparison with acute interictal and chronic psychoses. *Epilepsia*. 37: 551-556

¹⁷⁷ Logsdail, S.J. & Toone, B.K. (1988) Postictal psychoses. A clinical and phenomenological description. *British Journal of Psychiatry*. 152: 246-252

¹⁷⁸ Slater, E. & Beard, A.W. (1963) The schizophrenia-like psychoses of epilepsy. v. Discussion and conclusion. *British Journal of Psychiatry*. 109:143-150

¹⁷⁹ Trimble, M.R. & Schmitz, B. (2008) *Forced Normalization and Alternative Psychoses of Epilepsy*. Peterfield: Wrightson Biomedical Publishing

14. THE INTERFACE, COLLABORATION AND COMMUNICATION BETWEEN SERVICES, PRIMARY CARE, SECONDARY CARE, INCLUDING MENTAL HEALTH, NEUROLOGY AND SPECIALIST NEUROPSYCHIATRY SERVICES

14.1 AAU and psychiatric services

Prior to his admission to AAU, Mr A was known to two medical services: the primary care team (GP) and the local specialist neurology service. Evidence from both the medical notes and our interviews made it clear that there was excellent collaboration between these services with both feeling supported by the other.

When in AAU the key collaboration was between AAU staff and the on-call psychiatric team consisting of, in this case, the Liaison Nurse and the on-call psychiatrist; in general this seems to have gone well. However, as we have already discussed, there were significant deficits in the collaboration between AAU staff and the psychiatric services following discharge. This related in the main to post discharge where key decisions needed to be made on the two occasions Mr A returned to the AAU. There appeared no clear effective way of escalating concerns through to the psychiatric service.

14.2 Primary care and neurology

The independent investigation team found evidence of an excellent relationship between the primary care team and neurology. The primary care team stated they were well served by the neurology service. The investigation team did note, however, that Mr A had not been reviewed in person by the primary care team as he was in such regular contact with the neurology service.

Recommendation 12

GP surgeries should ensure that even when specialist care is received by patients with long term conditions, regular yearly visits to the primary care team should be maintained.

14.3 Primary care and psychiatry

In this case the primary care team did not make a direct referral to psychiatric services re Mr A, except for the referral in the 1990s. However the primary care team were very clear that they viewed their local psychiatric services as very helpful and responsive and would have envisaged no difficulties in doing so if they had felt it appropriate.

14.4 Neurology and Psychiatry including specialist neuropsychiatry services

The neurology services made direct referral to psychiatric services relating to Mr A, though recommended the referral from the GP in the 1990s. Neuropsychiatric services were only available outside of the locality, but were not called upon in this case.

Comment

The independent investigation team is of the view that there is a paucity of direct psychosocial support in the neurology clinic with no specialist epilepsy nurse, charity involvement or counseling services available for patient in the Hertfordshire area.

Recommendation 13

West Hertfordshire Hospitals NHS Trust should ensure that the services they provide to those with a diagnosis of epilepsy are in line with NICE guidance. In particular:

“Review and referral: At the review children, young people and adults should have access to: written and visual information, counseling service, information about voluntary organisations, epilepsy specialist nurses, timely and appropriate investigations, referral to tertiary service, surgery if appropriate”

15. WEST HERTFORDSHIRE TRUST’S RESPONSE TO THE OUTCOME OF THE CORONER’S INQUEST

At the inquest on 14th December 2010 the Coroner concluded;

“Where I think things would have been helped is if that team that looked at him had been informed of the difficulties that had occurred after he left. Whether it would have made a difference I don’t know, but it would I think have been appropriate for that to have happened. As I understand it what happened is that (Mr A) came into the West Herts Hospital explaining the difficulties, and that clearly his brother was agitated. His mother had left, and I will not go into that. He had a telephone number but he went into the hospital, and it would be appropriate for me under Rule 43 to report these facts to the Chief Executive of the West Herts Hospital to see whether there can be alerts of communication, that if somebody who on the records had been seen by the mental health team, if they come back would in these situations just tell the mental health team. The mental health team might think ‘Actually, we will keep him here, or just come out and have a chat and see what happens’. It may not have made any difference, but that would have been helpful, so I will write under Rule 43 to that.

That means that I write and send a copy off to more interested persons, and also to the Ministry of Justice and to the Coroners’ Society, and then I communicate the results of the response usually within 56 days. I do this quite a lot for general things, so this is what I propose to do under Rule 43”.

Rule 43 under the Coroner’s Rules¹⁸⁰ gives the coroner the power to make reports to an organisation where the Coroner believes action needs to be taken to prevent future deaths and where that organisation may have the power to act. Historically there was no obligation on an organisation to act upon the report but a recent review of the Coroners Rules saw an amendment, which became law in July 2008.

¹⁸⁰ Coroners Rules 1984

This places a duty on organisations receiving Rule 43 reports from a Coroner to respond within 56 days. There is still no obligation for an organisation to act upon the Coroner's recommendations but the response must indicate what action has been taken or is proposed and if no action is taken, an explanation must be given.

The Coroner's letter to West Hertfordshire Hospitals Trust outlined his concerns and was dated 16th December 2010. It stated;

'I would be grateful therefore if you could reinforce to your staff at reception that when a person who has had a psychiatric assessment returns to the unit shortly thereafter and still appears to be behaving in a bizarre manner that at least some communication is made with the psychiatric team to see whether they need to see the patient again for re assessment. The notes would have recorded that there had been a full assessment'.

The Chief Executive of West Hertfordshire Hospitals NHS Trust responded to the Rule 43 letter from the Coroner stating;

Following receipt of your letter I asked Mr XXXX, Clinical Director for Emergency Care, to review the recommendation you made. XXXXX has assured me that Mr A was not in fact seen by the Accident and Emergency Department but had been referred by his General Practitioner to the Acute Assessment Unit (AAU). Notwithstanding this it is evident from your findings that an error was made by AAU staff in not seeking further help for (Mr A's) family when this was requested. Mr XXXX has assured me, that in light of your recommendation, that he has asked the Lead Nurse and the Reception Manager to ensure that, should future requests be made for further assistance, for patients who have undergone psychiatric review, but who return shortly after discharge clearly in need of additional support, contact is made with the psychiatric service in order to determine whether they need to review the patient again.'

Mills and Reeve Solicitors¹⁸¹ state in their advice publication to NHS Trusts who receive Rule 43 reports from their local Coroner;

Each NHS trust will need to ensure that responses to reports from the Coroner are prompt and accurate and should be mindful that any response may become public. Procedures must be put in place to make sure that Rule 43 letters are identified and that information is collected and action considered. It is suggested that this should be a board level responsibility and delegated appropriately within the governance department."

Comment

The independent investigation team spoke to senior clinicians and managers from the AAU. Most of them had no knowledge of the Rule 43 letter from the Coroner or the requirement for them to alter their practice as a result of a directive from the Coroner. West Hertfordshire Hospitals NHS Trust produced no evidence that the

¹⁸¹ Changes to Rule 43 of the Coroners Rules – Explanatory Notes Mills and Reeves 2009

Coroner's directive, and the Trust's response to it, had been considered and agreed within a governance process.

Recommendation 14

West Hertfordshire Hospitals NHS Trust should ensure that responses to reports from the Coroner are prompt and accurate and that procedures are in place to make sure that Rule 43 reports are identified and that information is collected and action considered within a governance process which is monitored by the trust board.

16. ENGAGEMENT AND INVOLVEMENT OF FAMILIES FOLLOWING THE HOMICIDE

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 framework¹⁸² the families involved in this case were not contacted by the Trust following the incident.

Later in the year, following the Coroner's inquest, in December 2010, the Trust contacted the relatives of Mr A, offering to share with them the findings of the internal investigation report. The family did not take them up on this offer.

There is no evidence that the family of Mrs Z were contacted following the incident.

In 2006 a Memorandum of Understanding¹⁸³ 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.

A multi-agency policy is in place in Hertfordshire¹⁸⁴ that mirrors the content of the national Memorandum of Understanding¹⁸⁵. This document states that the

¹⁸² National Patient Safety Agency (2004) *Being Open Guidance (Updated November 2009)*

¹⁸³ 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*

¹⁸⁴ *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*

¹⁸⁵ 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*

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 Trusts Incident Investigation Policy¹⁸⁶ 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.

The Trust provided evidence that the Trust has recently reviewed the local Memorandum of Understanding with the local police in meetings that took place in late 2011 and early 2012. This document is undated. It does not, however, refer to the requirement for an Incident Co-ordination Group.

Comment

The independent investigation team acknowledge that contacting the relatives of the victim and the perpetrator following such a traumatic and tragic occurrence is a difficult and harrowing experience for the staff concerned and that this is why there is poor compliance nationally with the Being Open Guidance issued by the Department of Health. However compliance with the Memorandum of Understanding and better liaison with the police would have enabled the Trust to have conducted liaison with the families in a collaborative way with the police who would have been communicating with them anyway.

Recommendation 15

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.

17. REVIEW OF THE INTERNAL INVESTIGATION

Quality of the investigation report

Hertfordshire Partnership NHS Foundation Trust's Internal Investigation Report was benchmarked using the National Patient Safety Agency's "*Investigation credibility and thoroughness criteria*"¹⁸⁷. The Trust internal report scored well. The investigation and report are generally of a high standard and the findings and recommendations appropriate.

The investigation and report could have been improved by securing the formal involvement of West Hertfordshire Hospitals NHS Trust on the investigation panel. Additionally, there was no executive summary and the report did not contain

¹⁸⁶ 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*

¹⁸⁷ National Patient Safety Agency (2008) *RCA Investigation: Evaluation, checklist, tracking and learning log*

information relating to the care and support of the victim's family or the perpetrator's family. The investigation report 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 Foundation Trust and found most of the findings to be well thought out and consistent with their own findings.

17.1 Liaison between West Hertfordshire Hospitals NHS Trust and Hertfordshire Partnership NHS Foundation Trust

At the time this incident occurred Hertfordshire Partnership NHS Foundation Trust commissioned a seven-day report¹⁸⁸. The seven-day report included a summary of the incident, a timeline and initial findings of events with recommendations.

The initial findings were as follows:

- “The client information sheet/CPA sheet had the majority of the areas completed with the exception of the NHS number
- The Risk Assessment was generally detailed in its approach and support given to the family by the assessment team was evident. The risk assessment may have benefitted from input from a more senior clinician to assist in interpretation of the findings.
- Current and possible future risks - documentation should have included - self neglect; vulnerability; risks to health and welfare.
- Clinical factors – The issue of non-compliance with the treatment plan was not addressed although a follow appointment by CATT was arranged.
- Current personal and contextual factors – A carer's assessment could have been offered to the family.
- Contingency /Crisis Plan – The help line number was given to the family as a point of support and contact in case there was a deterioration in Mr A's presentation. Night CATT could have been requested to support family.
- Significant information was obtained by Miss K (social worker/AMHP) in discussion with Mr A's brother; history, perceived potential for risk from others and the inability of the family to cope with Mr A's presentation.”¹⁸⁹

The immediate recommendations were as follows:

“Where complex cases present, for assessors to exploit support systems that exist by using those systems to further inform decisions.

A more comprehensive Root Cause Analysis to be completed.”

¹⁸⁸ Hertfordshire Partnership NHS Trust Seven day report template dated 30/04/2010

¹⁸⁹ Hertfordshire Partnership NHS Trust Seven day report template dated 30/04/2010 page3

“In order to provide assurance regarding the quality and calibre of all mental health assessments undertaken by the Watford A&E liaison service all assessment outcomes are being subject to an additional level of clinical scrutiny for one week initially”.

An internal panel was convened at the Trust to undertake a review of the care and treatment of Mr A. This incident was reported to the Primary Care Trust (PCT) on 30th April 2010. An initial meeting was instigated by NHS Hertfordshire (the PCT) to discuss a cohesive approach to the investigation of this Serious Untoward Incident. A multi-agency meeting was held by the PCT on 9th June 2010, who identified the Trust as the lead investigator with input and a lead panel member from West Hertfordshire Hospitals NHS Trust¹⁹⁰.

Senior clinicians from the AAU department, who attended the meeting, told the independent investigation team at interview that following the meeting, they were asked to provide a chronology of events with regard to Mr A’s care and treatment at AAU on the day of 29th April 2010, which they subsequently did. Senior clinical staff from AAU told the independent investigation team at interview that following the meeting, they informed the Associate Director of Clinical Governance within West Hertfordshire Hospitals NHS Trust that a joint investigation would be taking place, with Hertfordshire Partnership NHS Foundation Trust.

The development of a chronological timeline by AAU staff from West Hertfordshire Hospitals NHS Trust took some time as the police had taken the clinical notes following the homicide. The independent investigation team was informed that the chronological timeline, once completed, was then sent to the Associate Director of Clinical Governance within West Hertfordshire Hospitals NHS Trust.

One of them told us that a few months later they were invited to an interview by Hertfordshire Partnership NHS Foundation Trust as part of the internal investigation process and that during this interview; they were informed that Mr A and his brother had gone back to the AAU department seeking assistance. She states she had not been aware of this until this point.

The Risk Manager at Hertfordshire Partnership NHS Foundation Trust liaised with the police and coroner’s office in advance of the internal investigation process and had permission to proceed with this ahead of the inquest. The Terms of Reference were established.

Senior managerial staff at West Hertfordshire Hospitals NHS Trust told the independent investigation team that they do not feel that West Hertfordshire Hospitals NHS Trust were adequately involved in the internal investigation, or informed, in a timely manner of its findings.

¹⁹⁰ *Statement of Assistant Director of Risk and Governance West Hertfordshire NHS Trust and minutes of NHS Hertfordshire 09/06/2010*

Hertfordshire Partnership NHS Foundation Trust's¹⁹¹ policy at the time did not specify what action should be taken in terms of incident investigation where there is more than one NHS organisation involved in the care and treatment of the individual concerned. West Hertfordshire Hospitals NHS Trust's policy¹⁹², however, states:

“Some Serious Incidents involve other health organisations in the care pathway. In such circumstances it may not be immediately apparent which organisation will lead the investigation. This may require negotiation with the other agencies involved and with the PCT to agree a lead organisation. It is preferable that the agencies come to an agreement mutually. However the PCT will be called to intervene if no agreement is reached. The PCT has developed a Joint Investigation Protocol to support multi agency investigations, to ensure all investigations understand their responsibilities in co-operating fully with the investigation. All staff of the West Hertfordshire Hospitals NHS Trust are expected to co-operate fully in such circumstances, which will be co-ordinated through the Assistant Director for Clinical Governance and Risk.”

Comment

It appears to the independent investigation team that senior managers within West Hertfordshire Hospitals NHS Trust are of the impression that they were not adequately involved in the serious incident investigation co-ordinated by Hertfordshire Partnership NHS Foundation Trust. However, the independent investigation team have found evidence that they were invited to the initial meeting hosted by the PCT, and that this was attended by senior clinicians from AAU, where it was agreed that West Hertfordshire Hospitals NHS Trust would contribute to the investigation and supply information. It is the view of Hertfordshire Partnership NHS Foundation Trust that they only received minimal information as a contribution from West Hertfordshire Hospitals Trust.

It is the view of the independent investigation team that there were attempts by Hertfordshire Partnership NHS Foundation Trust to involve West Hertfordshire Hospitals NHS Trust in the internal investigation process. However, although West Hertfordshire Hospitals NHS Trust did engage, this was not as whole hearted as it should have been.

In hindsight, escalation to senior management may have remedied this, but given the evidence now known, this would have been unlikely. In this instance it would have been beneficial for West Hertfordshire Hospitals NHS Trust to have been represented on the internal serious investigation panel, as initially indicated as being required, by the PCT.

Recommendation 16

Commissioners should ensure that all senior managers in NHS organisations within their sphere of responsibility are aware of their responsibility to work jointly with other NHS organisations when investigating a serious incident, and that compliance with, and efficacy of, this process should be monitored.

¹⁹¹ Hertfordshire Partnership NHS Foundation Trust (2010) *Learning from Adverse Events*

¹⁹² West Hertfordshire Hospitals NHS Trust's *Serious incidents requiring Investigation Version 1,3 October 2010*

Recommendation 17

Commissioners should ensure that internal serious incident investigation panels, where more than one NHS organisation is involved, are led by panels with representation from all the organisations involved.

18. PATIENT SAFETY AND INTERNAL ASSURANCE SYSTEMS DEVELOPED IN THE HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST SINCE THIS INCIDENT

Hertfordshire Partnership NHS Foundation Trust state that trend analysis after this incident was undertaken by the Risk Department with the Head of Practice Governance. This showed that the Trust's CATT teams had been involved in a high proportion of serious incidents over the previous twelve months.

The Executive Director – Quality and Patient Safety therefore commissioned an analysis of these cases in addition to the standard investigation process that had taken place for each. This was carried out by the Head of Practice Governance, Associate Medical Director/Consultant Psychiatrist and the Head of Nursing.

This led to a set of actions to improve the effectiveness of the CATT service with a focus on best practice with regard to clinical risk assessment and risk management. This included specialist training to these teams provided by a Consultant Forensic Psychiatrist and strengthened support and induction for new members of CATT teams.

There has been an increasing focus in the Trust on quality and patient safety since this incident. In effect, this began in 2009 with the reconfiguration of the Executive Team. The post of Medical Director became Executive Director – Quality and Medical Leadership and the Director of Nursing post was developed into Executive Director – Quality and Patient Safety.

In 2010 a new post of Head of Nursing and Patient Safety was created. Reporting to this person, a new post of Patient Safety Manager was created. This was complemented by developments in the practice governance system for the Trust.

The Trust has developed a Quality Strategy that covers the period 2012 to 2015. This outlines the Trust's current approach to quality and safety. A key aspect of this is the Patient Safety framework. The implementation of this has been led by the Head of Nursing and Patient Safety.

The strategy outlines the lines of accountability for quality assurance from Trust board to teams or wards.

Trust Board meetings since 2010 have included standing agenda items on quality including quarterly reports on customer experience, patient safety and quality as a whole.

A programme of workshops was set up with a regular place for items on quality assurance. These have used the key Monitor and Department of Health publications to check that the Board was meeting the latest standards for quality assurance as laid out nationally.

Although the Trust became a Foundation Trust in 2007, the Trust states it continues to measure itself against the quality governance standards expected by Monitor of aspiring Foundation Trusts. The most recent workshop was in December 2012 and in the same way this used "Quality in the New NHS System" (2012) (National Quality Board) to identify areas where the Trust could continue to improve its systems of quality assurance.

The Trust board uses an Integrated Governance system to carry out its responsibilities for quality assurance. With regard to patient safety, the Integrated Governance Committee (IGC) receives all panel reports into Serious Incidents within the Trust.

The Quality and Risk Management Committee reports to the IGC and reporting to it are several sub-groups, including the Clinical Risk and Learning Lessons Group, which was established in 2010.

This group has led a full review of the Trust's clinical risk assessment and management practices. For each of adult mental health, child and adolescent and forensic services, Consultant Psychiatrists and managers have worked together to agree and implement new systems for assessing and managing risk incorporating the latest evidence on clinical effectiveness.

These developments are complemented by the mandatory clinical risk training programme in the Trust. Recently, in response to the latest National Confidential Inquiry into Suicides and Homicides (NCISH) annual report (2012), the Clinical Risk and Learning Lessons Group has confirmed that additional training will be provided to certain specialist staff, CATT staff being a particular priority.

The Trust states that, in modernising their approach to patient safety, the Trust was keen to learn from national and international examples of best practice. To that end, a leading Trust Consultant Psychiatrist became a fellow of the NHS Leading Improvement in Patient Safety (LIPS) programme and led a group of staff who visited the Henry Ford Centre in Detroit, USA. There, suicides had been drastically reduced through an approach that involved consistent application of tools to assess risk, intensive support to all those at highest risk and a culture of optimism around the preventability of all suicides. The Trust state that this is the culture on which their approach to all serious incidents is now based.

The Clinical Risk and Learning Lessons group also ensures that lessons from incidents are learned and implemented. This process is co-ordinated by the Patient Safety Team who hold a central database of recommendations from all investigations. They provide monthly reports to the three Strategic Business Units on any outstanding actions. Practice Governance leads are the staff who make sure each business unit responds as required. Their vehicle for this is the Quality and Risk Management Groups which are held in each business unit and are chaired by their Clinical Director. The Clinical Directors are all Consultant Psychiatrists.

In support of the communication which takes place through these meetings, the Trust states that around 20 learning notes are distributed each year within services, capturing in a plain and concise way the key learning points. These in turn are supplemented by quarterly Sharing Good Practice newsletters for each business unit, and an annual conference.

18.1 External Assurance

With regard to external assurances on quality and safety, it can be noted that all Trust services have remained fully registered with the Care Quality Commission (CQC) since the registration system began. The Trust states it makes use of the monthly quality and risk profile reports from CQC in order to maintain this level of compliance. Since Hertfordshire Partnership NHS Foundation Trust became a Foundation Trust the quality governance rating given by Monitor has been consistently “Green”. Additionally, the Trust has used the NHS Litigation Authority (NHSLA) standards as another way to ensure that approaches to managing risk, both clinical and corporate, are as robust as possible.

Hertfordshire Partnership NHS Foundation Trust achieved level 2 for NHSLA in 2009 and retained this status in September 2011. The Trust scores in 2011 included 100% on the Learning from Experience dimension which includes the investigation of serious incidents.

Comment

There is evidence that internal systems for providing assurances to Board on quality and safety have become more sophisticated over the past three years and that processes for the learning and implementation of lessons from serious incidents are being embedded into the governance and assurance processes and structures within the Trust.

19. FINDINGS OF THE INTERNAL SERIOUS INCIDENT INVESTIGATION CONDUCTED BY HERTFORDSHIRE PARTNERSHIP NHS TRUST

The conclusions drawn from the findings of the internal investigation report, which was completed in November 2010, were as follows;

1. The tragic deaths of Mr A and his neighbour could not have been predicted and there was no previous evidence in his history to suggest he was a risk to others,

Comment

The independent investigation panel concur with this finding.

2. A more in depth assessment of Mr A by the mental health professionals in the Mental Health Liaison Team could have elicited a fuller picture of the changes in his behaviour and the associated time frame, which may have led to the decision to admit

Comment

The independent investigation panel concur with this finding.

3. There was an over reliance on the personal belief of the Mental Health Liaison team Nurse that Mr A had been living in the community for some time with schizophrenia. This was subjective speculation and assumption rather than being supported by evidence.

Comment

The independent investigation panel concur with this finding.

4. The doctor was advised of the proposal to refer to CATT before she undertook her assessment-which may have unwittingly influenced her decision not to consider admission

Comment

The independent investigation panel are of the view that this finding is speculative and is not based in fact. When interviewed by the independent investigation panel the Junior Doctor concerned was very clear about her professional accountability and her ability to overrule the assessment of the Liaison Nurse if she had felt it to be necessary. Both the Junior Doctor and the Liaison Nurse stated on interview that the reason they did not admit Mr A to hospital that night was because they felt it not to be warranted.

5. A review of what appeared to be a fairly complex presentation with a more senior and experienced practitioner was warranted in this case.

Comment

The independent investigation panel concur with this statement. It would have been appropriate for the junior doctor to have called an on call senior member of staff in this situation; although it is not clear that it would necessarily have made a difference to the outcome of this case

6. The Risk Assessment was limited and did not take into account the risk associated with his potential for agitation if not listened to or misunderstood.

Comment

The independent investigation panel concur with this finding.

7. Some ambiguity exists relating to the role and interface of the Mental Health Liaison Team and the CATT in relation to powers to admit. This appears to vary across the county and there is a need for clarity and consistency.

Comment

The independent investigation panel concur with this finding. However the Junior Doctor and the Mental Health Liaison Nurse stated on interview that the reason they did not admit Mr A to hospital that night was because they felt it not to be warranted, not because they did not feel empowered to admit Mr A to hospital if they had felt that they needed to, even if this had required a Mental Health Act assessment.

8. Overall, the staff of the Mental Health Liaison Team appear to carry a significant burden in terms of risk assessment of patients presenting at A&E and the AAU, with little guidance on when additional advice might be required.

Comment

The independent investigation panel concur with this finding.

9. The Panel's review of care and treatment of Mr A whilst in the AAU was limited by them not being able to get a copy of the AAU notes and interview the doctor who assessed Mr A. Access to both of these would have been eased if there had been joint ownership of the process.

Comment

The independent investigation panel concur with this finding.

19.1 Recommendations following the internal serious incident investigation conducted by Hertfordshire Partnership NHS Foundation Trust

The recommendations outlined within the internal investigation report, which was completed in November 2010, were as follows;

1. The Trust should review the operational policies of the Mental Health Liaison Service and CATT to eliminate any ambiguity about powers to admit and the role of CATT as gatekeepers to inpatient beds. This should be followed up by discussion and training for the teams concerned.

Trust action in action plan corresponding to this recommendation

Operational policies for Mental Health Team and Crisis Assessment Treatment Team should be reviewed to eliminate ambiguity about powers to admit.

Trust update as of March 2011

Policy reviewed, felt to be clear and all staff aware of procedures.

2. The Trust should develop training for staff in risk assessment which helps staff to develop a more sophisticated interpretation of risk based upon a range of presenting factors, rather than relying so heavily on the patient's expressed intention to harm himself or others.

Trust action in action plan corresponding to this recommendation

The Trust should develop training for staff in risk assessment, which helps staff to develop a more sophisticated interpretation of risk based upon a range of presenting indicators.

Trust update as of March 2011

Risk Training reviewed and new training module being delivered.

3. The Trust should develop an aide memoire or check list to indicate when an opinion from the second on call/more experienced practitioner should be sought, particularly for patients presenting at A&E and AAU depts., where admission may be considered.

Trust action in action plan corresponding to this recommendation

The Trust should develop a check list for staff to indicate when an opinion from the second on call/more experienced practitioner should be sought – particularly for patients presenting at Accident and Emergency/ Acute Admissions Unit where admission might be considered

Trust update as of March 2011

Learning note including check list has been written and circulated to the Liaison team and CATT

4. There should be greater definition when recording a carer/families view on the assessment of a patient/service user and their care plan. It is not sufficient under: 'Carers view of the risk management plan' to write 'agrees' without some supporting evidence and information.

Trust action in action plan corresponding to this recommendation

A Lessons Learning memo to be sent to all acute service team members to enforce the requirement to define family/carers views (elicited during assessment) with supporting evidence/ information when recording

Trust update as of March 2011

A learning note regarding collecting collateral history has been written and circulated to all in Mental Health Liaison team (MHLT) and CATT.

5. The Trust should involve the Duty Psychiatrist and the Mental Health Liaison Nurse in a reflective practice seminar to provide an opportunity to learn from this serious incident.

Trust action in action plan corresponding to this recommendation

A reflective practice seminar will be held involving the Mental Health Liaison Team nurse, Duty doctors and prescribed panel members

Trust update as of October 2011

Feedback seminar arranged and attended by those involved.

6. This specific case should also be picked up in supervision for both the Duty Psychiatrist and the Mental Health Liaison Nurse in relation to clinical judgement in the assessment of service users with complex presentations and risk management.

Trust action in action plan corresponding to this recommendation

Supervision session will be arranged for both team members to individually discuss the case.

Trust update as of July 2011

Supervision sessions were provided for the team members by CATT South West Manager and undertaken as a one off session relating to this incident. Routine supervision is still ongoing.

7. The A & E and AAU departments, together with Hertfordshire Partnership Trust, should develop a clearer protocol for getting advice about the management of mental health patients in reception or associated areas in the department-before or after they have been assessed by the mental health team

Trust action in action plan corresponding to this recommendation

The Accident and Emergency and Acute Admissions Unit together with Hertfordshire Partnership NHS Foundation Trust should develop a clearer protocol for getting advice about the management of mental health patients in reception or associated areas in the department – before or after they have been assessed by the mental health team

Trust update as of March 2012

A new shared policy/protocol is currently being jointly reviewed by WHHT and HPFT staff, with plan to ratify and establish as a shared policy.

8. When a serious incident occurs involving a patient who has been cared for by both the acute trust and Hertfordshire Partnership Trust, consideration should be given to commissioning a joint review, with jointly agreed terms of reference and panel membership. This would involve joint ownership of the process, access to information and staff and joint ownership of any subsequent report. This should be included in Serious Incident policies for both Trusts

Trust action in action plan corresponding to this recommendation

Consideration should be given to commissioning a joint internal review, with jointly agreed terms of reference and panel membership when a Serious Untoward Incident occurs involving a patient who has been cared for by both the acute trust and HPFT. SI policies should be amended to reflect the change in practice.

Trust update as of March 2012

All Patient Safety Leads in the county met about this and agreed joint investigations (all providers) should be initiated where appropriate and this was documented. HPFT internal policy "Learning from Adverse Events" will be reviewed and re-ratified this September 2012 so that can be incorporated.

19.2. Evidence of implementation of actions outlined in the trust's internal serious incident action plan AT THE TIME OF SUBMISSION OF THIS REPORT-FEBRUARY 2013

1. The Trust should review the operational policies of the Mental Health Liaison Service and CATT to eliminate any ambiguity about powers to admit and the role of CATT as gatekeepers to inpatient beds. This should be followed up by discussion and training for the teams concerned.

Trust action in action plan corresponding to this recommendation

Operational policies for Mental Health Team and Crisis Assessment Treatment Team should be reviewed to eliminate ambiguity about powers to admit

Evidence of implementation

Hertfordshire Partnership NHS Trust produced an Interim Operational Policy for the CATT teams in November 2011¹⁹³. This was issued for use in January 2012 with a review date planned for March 2012.

The policy states:

"CATT will assess anyone where there is an indication that there is a need for hospital admission to determine whether or not an alternative can be provided.

The policy very clearly states that the CATT team will act as gatekeepers to inpatient admission and will routinely be involved in the assessment period where inpatient admission is being considered.

An Accident and Emergency Team Operational policy¹⁹⁴ was developed in November 2011 and was issued for use in January 2012. This policy states;

¹⁹³ Hertfordshire Partnership NHS Foundation Trust (2011) *Operational Policy for the Crisis Assessment and Treatment Teams Crisis Assessment and Treatment Teams V3*

¹⁹⁴ Hertfordshire Partnership NHS Foundation Trust (2011) *A&E Liaison Team Operational Policy V1*

If admission needs to be considered the A&E Liaison team will contact the CATT team or the Duty Psychiatrist to consider whether home treatment could be used as an alternative to inpatient admission, reassessment not advised unless there are obvious discrepancies.”

Practice Governance meetings took place on 18th November 2010 and 16th Feb 2011. These meetings were attended by staff from the Mental Health Liaison Team, and CATT. The minutes show that that the gate-keeping role of the liaison team, and quality of clinical risk assessment was discussed. The Trust also provided evidence that this was discussed in a learning seminar with staff following this incident.

Comment

It is the view of the independent investigation team that this recommendation has been fully implemented.

Hertfordshire Partnership NHS Trust produced an Interim Operational Policy for the CATT teams in November 2011¹⁹⁵. The independent investigation team are satisfied that both policies devised in November 2011 make the process of admission, and CATT’s gate-keeping responsibilities clear.

It appears, however, that this was not an issue in this case. This process was not followed, as neither the Liaison Nurse nor the Junior Doctor that carried out the assessment of Mr A’s mental state, were of the view that Mr A required admission that evening, which was why a more urgent CATT assessment was not requested by them.

2. The Trust should develop training for staff in risk assessment which helps staff to develop a more sophisticated interpretation of risk based upon a range of presenting factors, rather than relying so heavily on the patient’s expressed intention to harm himself or others.

Trust action in action plan corresponding to this recommendation

The Trust should develop training for staff in risk assessment which helps staff to develop a more sophisticated interpretation of risk based upon a range of presenting indicators.

Trust update as of March 2011

Risk Training reviewed and new training module being delivered.

Evidence of implementation

The Trust state that CATT and Mental Health Liaison staff are now jointly managed which should ensure they function more effectively together.

The independent investigation team were told by the Trust that CATT staff were subject to extra clinical risk training and made changes to the way they functioned in

¹⁹⁵ Hertfordshire Partnership NHS Foundation Trust (2011) *Operational Policy for the Crisis Assessment and Treatment Teams Crisis Assessment and Treatment Teams V3*

2010. This included the provision of more support to the less experienced staff being built into their practice. CATT staff remain a priority for expert training in risk assessment and management within the Trust.

The independent investigation team have been provided with evidence that shows that compliance with clinical risk assessment training is 100% in Mental Health Liaison Teams and above 80% in all CAT Teams. The Trust are aiming for 98% compliance across the Trust by April 2011.

Comment

It is the view of the independent investigation team that this recommendation has been fully implemented.

3. The Trust should develop an aide memoire or check list to indicate when an opinion from the second on call/more experienced practitioner should be sought, particularly for patients presenting at A&E and AAU departments, where admission may be considered.

Trust action in action plan corresponding to this recommendation

The Trust should develop a check list for staff to indicate when an opinion from the second on call/more experienced practitioner should be sought – particularly for patients presenting at Accident and Emergency/ Acute Admissions Unit where admission might be considered

Trust update as of March 2011

Learning note including check list has been written and circulated to Liaison Teams and CATT

Evidence of implementation

The Trust issued a Learning Note¹⁹⁶ which was circulated within the Trust, following this incident, in February 2012.

It advised staff of the following:

“That a review of what appeared to be a fairly complex presentation with a more senior and experienced practitioner was warranted in this case.

A more objective assessment of the views and needs of his carers might have indicated their inability to cope with service user’s rapidly deteriorating condition and provided a more realistic perspective on condition

When staff in the CATT and MHLT carry out an assessment where the situation is **complex** such as:

- service user presenting with physical health problems as well as mental health issue,

¹⁹⁶ Hertfordshire Partnership NHS Trust Learning note, February 2012

- dual diagnosis,
- unusual presentation,
- multi-faceted presentation,
- limited information available,
- disagreement between professionals,
- service user demanding outcome that professional assessment does not indicate,
- complex social situation
- criminal behaviour,

the opinion of the second doctor on call or a consultant must be sought.

In the case of service users presenting at A&E/AAU, where admission might be considered, it should **always** be the case that the opinion of the second doctor on call or a consultant should be sought.

Please do always remember the first on call doctor has usually limited experience and in any doubt seek advice of the more experienced doctor.

Clinical notes should be consistent, and discussed between the members of the assessing team and signed by all/both workers. There needs to be clear and direct correlation between what has been recorded in the clinical notes/ risk assessment and the action plan.

When the service user is presenting with a first time psychiatric symptoms, it is safe practice for all referrals from AAU/Medical wards to be thoroughly assessed by senior clinicians for the medical condition before a transfer of care takes place.

This list is not definitive however serves to guide; practitioners should always ensure they practice within their area of competency and seek guidance when necessary.

With regards to family and carers; it is important when carrying out an assessment that attempts are made to seek and define the viewpoint of family members or carers. This information needs to be recorded with supportive evidence and information, and used to inform the outcome of the assessment.”

Comment

It is the view of the independent investigation team that this recommendation has been implemented but that further work needs to take place to ensure compliance.

The independent investigation team are supportive of the content of the checklist outlined in the learning note issued by Hertfordshire Partnership NHS Foundation Trust in February 2012.

Recommendation 18

Hertfordshire Partnership NHS Foundation Trust should conduct an audit of compliance with the checklist outlined in the Learning Note issued to CATT and Liaison Team staff, in February 2012.

4. There should be greater definition when recording a carer/family's view on the assessment of a patient/service user and their care plan. It is not sufficient under: 'Carer's view of the risk management plan' to write 'agrees' without some supporting evidence and information.

Trust action in action plan corresponding to this recommendation

A Lessons learning memo to be sent to all acute service team members to enforce the requirement to define family/carers views (elicited during assessment) with supporting evidence/ information when recording.

Trust update as of March 2011

A learning note regarding collecting collateral history has been written and circulated to all in MHLT and CATT.

Evidence of implementation

Hertfordshire Partnership NHS Foundation Trust have updated their Clinical Risk Assessment Policy¹⁹⁷ and strengthened the statement within it about the importance of involving carers in the clinical risk assessment process. In addition, the Trust has developed its clinical risk tool in an electronic format which is compatible with the electronic patient record system that is in use in 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.

Comment

It is the view of the independent investigation team that this recommendation has been implemented but that further work needs to take place to ensure compliance.

The independent investigation team are pleased to see that the Trust have strengthened the statement about the involvement of carers in the clinical risk assessment process. **Compliance with this should be audited as part of the audit that is recommended in Recommendation 18.**

5. The Trust should involve the Duty Psychiatrist and the Mental Health Liaison Nurse in a reflective practice seminar to provide an opportunity to learn from this serious incident.

Trust action in action plan corresponding to this recommendation

A reflective practice seminar will be held involving the Mental Health Liaison Team nurse, Duty doctors and prescribed panel members.

Trust update as of October 2011

Feedback seminar arranged and attended by those involved.

¹⁹⁷ Hertfordshire Partnership NHS Trust Clinical Risk Assessment Policy, August 2010

Evidence of implementation

Hertfordshire Partnership NHS Foundation Trust have provided documentary evidence to show that a reflective practice seminar was held on 29th June 2011 and the Mental Health Liaison Team, Duty Doctor, Senior Managers and internal investigation panel attended this event.

Comment

It is the view of the independent investigation team that this recommendation has been fully implemented.

6. This specific case should also be picked up in supervision for both the Duty Psychiatrist and the Mental Health Liaison Nurse in relation to clinical judgement in the assessment of service users with complex presentations and risk management.

Trust action in action plan corresponding to this recommendation

Supervision session will be arranged for both team members to individually discuss the case.

Trust update as of July 2011

Supervision sessions were provided for the team members by CATT South West Manager and undertaken as a one off session relating to this incident. Routine supervision is still ongoing.

Evidence of implementation

Supervision notes for both the Junior Doctor and Liaison Nurse have been reviewed.

The notes pertaining to the Liaison Nurse demonstrate that this incident was discussed in supervision with her in October 2010, when the internal investigation report was published. Supervision notes suggest that the discussions focused on the learning points for CATT within the report and a note was made that the Liaison Nurse needs to learn about postictal psychosis. At interview the Liaison Nurse stated that she recalls that there were some talks on postictal psychosis as a result of the incident.

The Junior Doctor described receiving support and supervision following the incident.

Comment

It is the view of the independent investigation team that this recommendation has been implemented.

7. The A & E and AAU departments, together with Hertfordshire Partnership Trust, should develop a clearer protocol for getting advice about the management of

mental health patients in reception or associated areas in the department-before or after they have been assessed by the mental health team.

Trust action in action plan corresponding to this recommendation

The Accident and Emergency and Acute Admissions Unit together with Hertfordshire Partnership Foundation Trust should develop a clearer protocol for getting advice about the management of mental health patients in reception or associated areas in the department – before or after they have been assessed by the mental health team.

Trust update as of March 2012

A new shared policy/protocol is currently being jointly reviewed by West Hertfordshire Hospitals NHS Trust and Hertfordshire Partnership NHS Foundation Trust staff, with plan to ratify and establish as a shared policy.

Evidence of implementation

Since this incident the Trust states it has strengthened its capacity to provide a full mental health assessment service at Watford Hospital and a shared protocol¹⁹⁸ was devised in October 2011. This work is continuing this year with the implementation this summer of a new Rapid Assessment Interface and Discharge (RAID) service at the hospital.

This has been in use since October 2011; the Trust evaluated it for 6 months. Following this Hertfordshire Partnership NHS Foundation Trust and West Hertfordshire Hospitals NHS Trust met in spring 2012 to look at the pilot data. This demonstrated significant improvements including a reduction in incidents and waiting times.

The triage process has been improved in the AAU department to ensure that it follows the same principles as other triage scales used in A&E departments. The aim of this is to ensure that patients can be assessed quickly and appropriately. This will be included in the procedures for the RAID service.

Comment

The independent investigation team are pleased to see that a joint protocol detailing a clear referral process has been developed between Hertfordshire Partnership NHS Trust and West Hertfordshire Hospitals Trust in October 2011. This details the use of the Australian Triage Scale in order to prioritise referrals and response times. This constitutes good practice.

However the issue in this case related to staff from the AAU department being able to access assistance from mental health services following an assessment by the mental health Liaison Team. It is unclear in the protocol whether such a situation would be covered by this protocol, or whether it pertains to new referrals only. **See recommendation 3.**

¹⁹⁸ Hertfordshire Partnership NHS Trust and West Hertfordshire Hospitals Trust Shared protocol for prioritisation, action and escalation process of Mental Health Liaison Team referrals, October 2011

8. When a serious incident occurs involving a patient who has been cared for by both the acute trust and Hertfordshire Partnership NHS Foundation Trust, consideration should be given to commissioning a joint review, with jointly agreed terms of reference and panel membership. This would involve joint ownership of the process, access to information and staff and joint ownership of any subsequent report. This should be included in Serious Incident policies for both Trusts

Trust action in action plan corresponding to this recommendation

Consideration should be given to commissioning a joint internal review, with jointly agreed terms of reference and panel membership when a Serious Untoward Incident occurs involving a patient who has been cared for by both the acute trust and Hertfordshire Partnership NHS Foundation Trust. Serious Incident policies should be amended to reflect the change in practice.

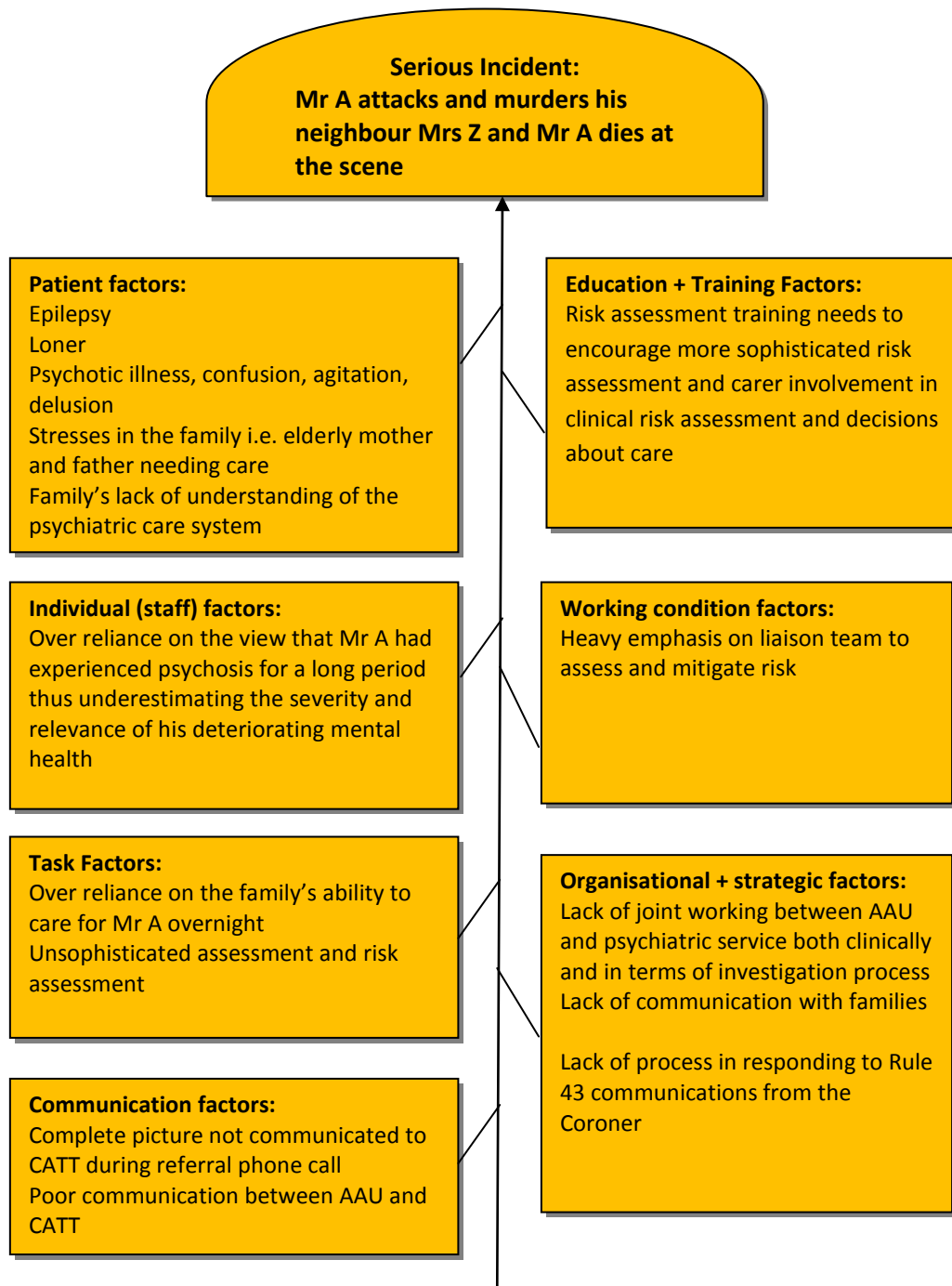
Trust update as of March 2012

All Patient Safety Leads in the county met about this and agreed joint investigations (all providers) should be initiated where appropriate and this was documented. Hertfordshire Partnership NHS Foundation Trust internal policy "Learning From Adverse Events" will be reviewed and re-ratified this September 2012 so that can be incorporated.

Comment

Hertfordshire Partnership NHS Foundation Trust have included this element in their most recent internal policy that covers SI investigation and learning from adverse events. However, it is the view of the independent investigation team that this process should be initiated, overseen and governed by service commissioners.

20. ROOT CAUSE ANALYSIS: FISHBONE HIGHLIGHT FOR ORGANISATIONAL LEARNING



21. CONCLUSION

It is the opinion of the independent investigation team that the epilepsy treatment was adequate throughout Mr A's life, and that at no stage was the incident preventable through a different regimen of epilepsy treatment.

Mr A possibly developed a psychotic illness, many years into the diagnosis of his epilepsy, in 2010. There is no evidence to suggest that an alternative epilepsy treatment regimen would have had any bearing on the development of his psychosis.

It is also clear from Mr A's neurology consultant that at no time during the regular consultations at neurology clinic did Mr A express any suggestion of experiencing psychiatric symptoms. Mr A attended such appointments alone, as was completely appropriate.

The first area of concern relates to the shared decision to discharge Mr A home after psychiatric assessment on 29th April 2010, without medication. It is the view of the independent investigation team that this decision was wrong as it underestimated the volatility of Mr A's psychiatric state and overestimated the potential for his carers to cope with his psychotic state. It also did not respond to the needs of Mr A who was suffering from delusions and hallucination and would likely have been in great psychological distress.

No attempt was made to treat him with antipsychotic or anxiolytic medication leaving him to inevitably experience more distress.

It does appear from testimony of the on-call psychiatrist delivered to the Coroner that a possible reason was a concern of seizure worsening due to the use of antipsychotic medication. This is a possibility, but the risk and stress of Mr A's psychotic symptoms would be greater than posed by seizure worsening and psychiatric medication should be used in such situations.

In this context an alternative such as an anxiolytic medication should have been considered. In fact the presence of Mr A's epilepsy and the risks of seizure worsening would have further heightened the need for inpatient treatment.

The independent investigation team note that at no time was escalation of the decision to an on-call senior colleague considered. The independent investigation team feel such an escalation should have occurred considering the risk incurred by discharge home. However, it is acknowledged that unless the senior colleague saw and assessed Mr A themselves, and if they had received reassurances that in the Liaison Nurse and the junior doctor's view, it was safe to discharge Mr A home overnight, this may have appeared acceptable to them.

The second area of concern relates to Mr A's return to the reception of AAU with his brother asking for support as his mother had left in her car. The decision by AAU staff to call the Shrodells mental health unit was appropriate. However, Hertfordshire Partnership NHS Foundation Trust have no record of this call being received. The independent investigation team are of the view that, if this call was indeed received in the correct department, the decision by recipient not to re-refer Mr A to the on-call CATT team was wrong.

However, notwithstanding the response from the Shrodells mental health unit, further action by the AAU staff was needed. Mr A was a man with an acute psychotic illness who had recently been discharged from their care, who was in distress on their premises. The plan for him having home treatment appears to have been made on the grounds that he had his family with him, yet the carers were concerned, stressed and asking for support. The independent investigation team feel that this event should have been escalated to the medical staff within AAU, which should have triggered a further assessment of Mr A or enabled them to have made a further attempt to engage the CATT team in an urgent reassessment of Mr A.

In fact, Mr A and his brother returned to the AAU a further time in the early hours of the morning looking for their mother. This event should again have been responded to and escalated.

It is impossible for the independent investigation team to know what happened just prior to the homicide, and Mr A's state of mind in the moments before he stabbed Mrs Z. As far as is known, Mr A did not have a history of violence and that an incident of this magnitude could not have been predicted by anyone involved in his care.

However, Mr A's psychosis was causing him considerable confusion and distress and it is the view of the independent investigation team that if this had been attended to more assertively on the evening of 29th April 2010. If Mr A had been adequately medicated this would have significantly reduced his risk of committing the offence, and if admitted to hospital, the homicide of Mrs Z would have been prevented.

Following the incident, the independent investigation had concerns about the internal investigation process. Hertfordshire PCT clearly advised at a meeting attended by all parties that a joint internal investigation take place between both West Hertfordshire Hospitals NHS Trust and Hertfordshire Partnership NHS Foundation Trust. This was to be led by Hertfordshire Partnership NHS Foundation Trust. Despite members of West Hertfordshire Hospitals NHS Trust being present at the meeting held by the PCT, it seems that a joint investigation did not take place. This resulted in West Hertfordshire Hospitals NHS Trust not benefiting from the learning opportunity that involvement in this process would have facilitated for them.

Furthermore the independent investigation team found that an attempt by the Coroner to alert West Hertfordshire Hospitals NHS Trust to the learning

opportunities associated with this case, in the form of a letter to the Trust sent under Rule 43 of the Coroner's rules was not used to inform and embed changes in practice in a sustainable way.

APPENDIX A: RECOMMENDATIONS

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Recommendation 1

West Hertfordshire Hospitals NHS Trust and the future commissioning body responsible should ensure that any patient with epilepsy who has a psychotic episode, irrespective of apparent cause, should be referred to a psychiatrist with neuro-psychiatry experience, for psychiatric assessment.

Recommendation 2

West Hertfordshire Hospitals NHS Trust should consider involving epilepsy charities (Epilepsy Action, Epilepsy Bereaved and the National Society for Epilepsy) in the neurology services provided by them, and providing signposting advice to service users.

Recommendation 3

West Hertfordshire Hospitals NHS Trust and Hertfordshire Partnership NHS Foundation Trust should develop joint protocols that clearly detail action that should be taken, and what the response from both services should be, when there are concerns about the mental health or behaviour of an individual on the premises at AAU or in the A&E department. This should include clear processes for reporting such incidents into both organisations and an escalation process to be used when the response from one or both of the organisations is ineffective.

Recommendation 4

Hertfordshire Partnership NHS Foundation Trust should ensure that the ongoing implementation of the operational policies detailing roles, responsibilities, work methods, processes, assessment methodologies and tools and interface arrangements in place for both the CATT and psychiatric liaison service are monitored, and there is demonstrable evidence in place to ensure that the Trust board can assure themselves that these are being appropriately implemented.

Recommendation 5

The Hertfordshire Partnership NHS Foundation Trust should ensure that all staff are aware of their responsibilities with regard to CPA screening and ensure demonstrable ongoing monitoring of this.

Recommendation 6

Hertfordshire Partnership NHS Foundation Trust should ensure there is a process in place to monitor the quality of risk assessments in the liaison psychiatry service on an ongoing basis.

Recommendation 7

Hertfordshire Partnership NHS Foundation Trust should review its risk management processes to ensure that these are based on comprehensive assessment, rather than

purely on risk factor checklists, and backed up by appropriate skills training and access to experienced colleagues.

Recommendation 8

Hertfordshire Partnership NHS Foundation Trust should ensure adequate training of all liaison staff in the assessment of the care environment in acute situations. In the situation of new referrals to mental health services it is particularly important that the ability of carers to cope is not assumed, but that a more detailed assessment is undertaken as to the ability of carers to cope with an acutely psychotic Individual. In these situations consideration should be given to immediate assessment at home by the CATT rather than an overnight delay.

Recommendation 9

Hertfordshire Partnership NHS Foundation Trust ensure that all members of liaison teams have the appropriate training to ensure competency in assessing and treating psychiatric illness in association with medical ill health, including epilepsy

Recommendation 10

Hertfordshire Partnership NHS Trust should ensure that its staff are aware of the responsibilities outlined in National Institute for Health and Clinical Excellence (2011) guidelines “Service User Experience in Adult Mental Health: Improving the experience of care for people using adult NHS mental health services” and develop mechanisms to monitor this.

Recommendation 11

Hertfordshire Partnership NHS Foundation Trust should ensure that clear pathways for the use of medication in the AAU and Accident and Emergency department settings are developed. These should include risk assessment of medication use in all patients including those with medical co-morbidity.

Recommendation 12

GP surgeries should ensure that even when such specialist care is received by patients with long term conditions, regular, yearly visits to the primary care team should be maintained.

Recommendation 13

West Hertfordshire Hospitals NHS Trust should ensure that the services it provides to those with a diagnosis of epilepsy follow NICE guidance. In particular: “Review and referral: At the review children, young people and adults should have access to: written and visual information, counseling service, information about voluntary organisations, epilepsy specialist nurses, timely and appropriate investigations, referral to tertiary service, surgery if appropriate”¹⁹⁹

¹⁹⁹ National Institute for Health and Clinical Excellence (2012) *The Epilepsies: The diagnosis and management of the epilepsies in adults and children in primary and secondary care* [CG137] pp. 56-57

Recommendation 14

West Hertfordshire Hospitals NHS trust should ensure that responses to reports from the Coroner are accurate and that procedures are in place to make sure that Rule 43 reports are identified and that information is collected and action considered within a governance process which is monitored by the trust board.

Recommendation 15

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 communication with applicable and appropriate service users and their families are co-ordinated and timely.

Recommendation 16

Commissioners should ensure that all senior managers in NHS organisations within their sphere of responsibility are aware of their responsibility to work jointly with other NHS organisations when investigating a serious incident, and compliance with, and the efficacy of, this process should be monitored.

Recommendation 17

Commissioners should ensure that internal serious incident investigation panels, where more than one NHS organisation is involved, are led by panels with representation from all the organisations involved.

Recommendation 18

Hertfordshire Partnership NHS Foundation Trust should conduct an audit of compliance with the checklist outlined in the Learning Note issued to CATT and Liaison Team staff, in February 2012.

**APPENDIX B:
SUMMARY OF FACE-TO-FACE CONSULTATIONS BETWEEN
MR A AND HEALTHCARE PROFESSIONALS IN THE TWO
YEARS PRE-CEDING THE HOMICIDE**

APPENDIX B: SUMMARY OF FACE-TO-FACE CONSULTATIONS BETWEEN MR A AND HEALTHCARE PROFESSIONALS IN THE TWO YEARS PRECEDING THE HOMICIDE

Date	Professional
27/2/08	GP
5/3/08	The Consultant Neurologist
23/7/08	The Consultant Neurologist
27/8/08	The Consultant Neurologist
24/9/08	The Consultant Neurologist
17/12/08	The Consultant Neurologist
8/4/09	The Consultant Neurologist
12/5/09	The Consultant Neurologist
5/8/09	The Consultant Neurologist
16/9/09	The Consultant Neurologist
16/12/09	The Consultant Neurologist
31/3/10	The Consultant Neurologist
29/4/10	GP, Physician, Junior Doctor, The Liaison Nurse

**APPENDIX C:
BIBLIOGRAPHY**

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