

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Miss E

A report for
NHS England, North Region

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1. Introduction

1.1 NHS North of England (now NHS England, North Region) commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Miss E, a mental health service-user who killed her mother.

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

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

1.4 Immediately after the incident the chief executive of Lancashire Care NHS Foundation Trust commissioned a post-incident review (PIR) into the care and management of Miss E. A professional nurse lead for adult services carried out the investigation with a consultant psychiatrist providing advice.

1.5 The PIR team made three recommendations. An action plan was developed to take forward the recommendations.

Background to the independent investigation

1.6 Miss E stabbed and killed her mother on 23 March 2011. She was convicted of manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order (Section 37/41 MHA).

1.7 Miss E had three episodes of contact with services between September 2009 and March 2011.

1.8 In the first episode, an appointment was made but she did not attend so was discharged.

1.9 In the second, Miss E was assessed but did not attend a further appointment so was discharged.

1.10 In the third, Miss E was assessed and referred to the early intervention services. Miss E killed her mother two days before her referral appointment.

Overview of the trust

1.11 Lancashire Care NHS Foundation Trust specialises in inpatient and community mental health services. The trust covers the whole of the county. Community services include primary care mental health teams that offer assessment and short-term psychological treatment and support for adults. The trust also provides an early intervention service that promotes early detection of mental illness and provides education about psychosis.

2. Terms of reference

2.1 The terms of reference for the independent investigation, set by NHS North of England Strategic Health Authority (the SHA), in consultation with Lancashire Care NHS Foundation Trust are as set out below.

2.2 To examine:

- the care and treatment provided to the service user at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate)
- the suitability of that care and treatment in view of the service user's history and assessed health and social care needs
- the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies
- the adequacy of risk assessments to support care planning and use of the care programme approach in practice
- the exercise of professional judgment and clinical decision making
- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs
- the extent of services engagement with carers; use of carer's assessments and the impact of this upon the incident in question
- the quality of the post-incident review conducted by the trust.

2.3 To identify:

- learning points for improving systems and services
- any development in services since the user's engagement with mental health service and any action taken by services since the incident occurred.

2.4 To make:

- realistic recommendations for action to address the learning points to improve systems and services.

2.5 To report:

- findings and recommendations to NHS North of England.

Approach to the investigation

2.6 The independent investigation team consisted of Chris Brougham and Amber Sargent, both investigators from Verita. Dr Douglas Gee, a general adult psychiatrist and medical director at Humber NHS Foundation Trust provided expert clinical advice. We refer to the investigation team as 'we' from now on.

2.7 We examined a range of trust documents including policies and procedures, the PIR report and supplementary information such as the action plan and records of meetings with staff. Miss E also gave her written consent for us to access her medical and other records for the purposes of the investigation. We interviewed staff only where we found a gap in information or an area that required clarification.

2.8 We interviewed the following staff:

- a community mental health nurse (nurse 3)
- an occupational therapist
- the post-incident lead reviewer
- a senior manager.

2.9 We met Miss E at the outset of the investigation to explain the nature of our work and to inform her that the commissioners of the investigation would probably publish the report in some form. Miss E was given the opportunity to comment on a draft of this report before it was finalised.

2.10 We contacted Miss E's father at the start of our work to offer to meet with him to explain about the investigation and to see whether he had any views about Miss E's treatment and care. He wrote to us to explain that he had not had any recent contact with Miss E and that he didn't want to meet with us. We contacted him again at the end of the investigation to see whether he wanted to hear about what we have found in our investigation. He contacted us and said he did not want to meet with us. We understand and respect his decision.

2.11 We did however meet with a relative of Miss E in the course of our work. She provided useful information about Miss E's mental health.

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

2.13 This report includes a chronology outlining the care and treatment of Miss E. The analysis appears in section 5 where relevant issues and themes arising from the terms of reference are examined.

2.14 Derek Mechen, partner from Verita, peer-reviewed this report.

3. Executive summary and recommendations

3.1 NHS North of England (now NHS England, North Region) commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service-user (Miss E).

3.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-36 issued in June 2005.

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

The incident

3.4 Miss E, a service-user from Lancashire Care NHS Foundation Trust, stabbed and killed her mother on 23 March 2011. She pleaded guilty to manslaughter. She was sentenced to a hospital order.

Overview of care and treatment

3.5 Miss E had three distinct episodes of contact with mental health services. The first episode was when Miss E was referred by her GP to mental health services in February 2009 although she did not agree to a referral appointment until September 2009. An appointment was made but Miss E failed to attend so she was discharged.

3.6 The second episode of contact was when Miss E's GP made a referral to the single point of access¹ at the trust in March 2010. A community mental health nurse assessed her and referred her to a consultant psychiatrist. The consultant never saw Miss E because she contacted the trust to say she did not want to see him. A referral to counselling services was made but Miss E did not attend so she was discharged.

3.7 The third episode of contact with the trust started on 2 March 2011 when Miss E was re-referred by her GP for an urgent assessment to the primary care team. Her GP was concerned that Miss E was suffering from a psychotic illness and that she appeared to be a vulnerable adult.

3.8 Miss E presented as being psychotic and was seen by a nurse. The nurse also recorded evidence of self-neglect and referred Miss E for an appointment with the early intervention service.

3.9 Four days before her planned appointment at the early intervention service, Miss E went without an appointment to the outpatient department in a taxi. She spoke to an occupational therapist through the open taxi window. Miss E said that she was experiencing problems with her neighbours and had told the police. The occupational therapist suggested that Miss E call the police to find out what they were doing.

3.10 A relative of Miss E contacted the police and mental health services at about 18.30 on 22 March. She was worried about Miss E and thought something bad was going to happen.

3.11 The relative told us the mental health services helpline said nothing could be done because she was not a close family member.

3.12 Next day a police constable (PC) contacted the early intervention service and spoke to a duty worker. He said Miss E had called the police to say that she could hear voices through the grommets in her ears. The PC was advised by a member of the early intervention team that Miss E had an appointment arranged for Friday morning - two days later. Miss E stabbed and killed her mother later the same day.

¹ Means that service-users need go through only one route to access services

Overall conclusions of the independent investigation

3.13 On the evidence that we have received, we do not think that this incident was predictable. We found no evidence to demonstrate that Miss E presented in an aggressive or intimidating manner and she did not have a forensic history. Nevertheless, there were clear signs that Miss E was psychotic in the third episode of contact with services. Her presentation should have prompted a more assertive approach by the clinical team. She should have been better assessed and seen by a senior member of the medical team. A thorough risk assessment should have been carried out with a clear risk management plan. These were missed opportunities although we cannot say whether these would have changed the course of events.

3.14 Since this incident the trust has undergone a major reorganisation of services for people who present as being psychotic for the first time. New trust guidance has also been developed. This advises that all presentations constitute a crisis and that an emergency assessment should take place on the day of presentation involving a senior member of medical staff. The guidance also states that a comprehensive assessment and care plan should be developed. This should include a risk management plan.

3.15 In view of the significant improvements that the trust has made since this incident, we make no recommendations about the management of people with first-time psychosis.

3.16 We comment on the helpline service and make recommendations to ensure that any calls are recorded and that any significant information or concerns about service-users are fed back into the service.

3.17 We also comment on the implementation of adult safeguarding procedures. Miss E presented as vulnerable and neglected. Despite this, no discussion took place with the GP or within the mental health team to see whether her presentation warranted further action such as a safeguarding referral.

Recommendations

R1 The trust should ensure that all calls to any out-of-hours phone services and helplines are risk assessed to see whether any immediate action needs to take place.

R2 The outcome of the call should be recorded and shared with appropriate services in a timely manner.

R3 The trust and the GP practice must ensure that all clinical staff carry out their responsibilities in line with local adult safeguarding policy and good practice guidance.

4. Treatment and care

Background

4.1 Miss E was born in Preston, Lancashire on 12 October 1984. She was a premature baby and was described in the clinical records as “*grossly growth retarded*”¹. This affected her development and she attended a special school to meet her educational needs.

4.2 Miss E was brought up by her mother. She met her father for the first time when she was seven. She has one older brother who lived with her father.

Chronology of care and treatment

First episode

4.3 The GP records show that Miss E attended the surgery for minor physical symptoms that appeared to cause her anxiety. GP1 suggested to Miss E in February 2009 that a referral to mental health services might be helpful because the concerns she was presenting with were causing her high levels of distress and anxiety. Miss E finally agreed on 30 September 2009 to a referral.

4.4 Miss E received a letter from the trust on 6 October 2009 asking her to contact the primary care mental health team to arrange an appointment. The trust closed her case when she did not make contact.

Second episode

4.5 GP1 made a routine referral on 22 March 2010 to the single point of access at the trust for Miss E to be assessed in relation to her continued presentation with “*strange*

¹ When the baby's weight is below the 10th percentile for his or her age

symptoms, non specified". In the referral GP1 described Miss E as vulnerable in terms of her physical presentation. She was described as a small lady and fairly unkempt.

4.6 The primary care mental health team received the referral on 29 March 2010 and Miss E was seen and assessed by a community mental health nurse (nurse 1) on 11 May 2010.

4.7 Nurse 1 recorded that Miss E was hard to assess and it was difficult to hold her attention as she was occupied by concerns about her neighbours. Nurse 1 asked another nurse to sit in on the assessment to offer a further view of Miss E's presentation. Nurse 1 noted that Miss E showed evidence of neglect. After the assessment she referred Miss E to consultant psychiatrist 1 and discussed the case.

4.8 Miss E phoned the team later that day and said that she did not want to see a psychiatrist. Nurse 1 talked this through with her and Miss E agreed to see someone for a psychological assessment/counselling. Nurse 1 discussed this decision with GP1.

4.9 A few days later nurse 2 had a brief discussion with Miss E and her mother about Miss E's mental health. No new concerns were raised during this conversation and referral for counselling was in progress.

4.10 Miss E did not attend the psychological assessment appointment and so she was discharged from mental health services on 19 January 2011.

Third episode

4.11 On 2 March 2011 GP2 re-referred Miss E for an urgent assessment to the primary mental health care team. GP 2 was concerned that Miss E was suffering from a psychotic illness and that she appeared to be a vulnerable adult.

4.12 A community mental health nurse (nurse 3) who was acting as the single point of access nurse contacted Miss E to offer a same-day appointment (2 March). Miss E said that she was unable to attend that day but agreed to attend on 4 March 2011. Nurse 3 informed Miss E's GP about the appointment.

4.13 Nurse 3 saw Miss E in the outpatients department at the trust on 4 March 2011. She told nurse 3 that the neighbours at her new address were pestering her. She believed they were connected to her previous neighbours and they were staying next door illegally to harass her. She said that they were playing “*mind games*” and trying to trick her to catch her out. Miss E said that her neighbours were calling her a paedophile, making sexual references and trying to get her in trouble with the police. Miss E said that she could hear her neighbours through the walls talking about her and had tried to record them. Miss E’s mother told her that she could not hear voices and Miss E was frustrated that she could not convince her mother of their existence. This resulted in arguments between Miss E and her mother.

4.14 Miss E told nurse 3 that she could hear the voices because she had had grommets put in her ears as a child. She said neighbours at her last address spied on her and that her new neighbours were also doing so but less obviously. Miss E kept her curtains closed because of this.

4.15 Miss E said that the voices had been ongoing since July 2010. She added that she had recently been feeling more distressed and was frequently contacting the housing association *Gateway*. They put a stop on her calls. Miss E told nurse 3 that she spoke to other neighbours in the area to tell them about her worries and tried several times to report her concerns to the police. Miss E told nurse 3 that she was having difficulty sleeping because of the voices.

4.16 Nurse 3 recorded evidence of self-neglect. Miss E’s hair was unkempt and matted. Miss E said that she visited her father at the weekends, which she enjoyed. Nurse 3 recorded that Miss E showed no insight into her experiences and said several times during the assessment “*I am not schizophrenic*”. Miss E asked a social worker to help build her evidence against the people she believed were persecuting her.

4.17 Nurse 3 described Miss E as having persecutory delusions and auditory hallucinations which she had probably been experiencing for some time. Miss E had no insight and although she would not consider treatment, she did agree to be seen again for further assessment. Nurse 3 concluded that Miss E was vulnerable in her physical presentation and her mental illness symptoms but that she had the support of her mother, which nurse 3 thought helped protect against any vulnerability.

4.18 Nurse 3 referred Miss E to the early intervention service.

4.19 A copy of the assessment was sent to GP1. Nurse 3 planned no further follow-up because she was waiting for an appointment with the early intervention service. She gave Miss E a care plan with contact numbers for the crisis resolution home treatment team and the primary care mental health team. She also told Miss E that she could contact her if she had any concerns in the meantime.

4.20 Miss E was offered an appointment with the early intervention service for 25 March 2011.

4.21 Miss E phoned a duty worker for the early intervention service on 12 March 2011 in response to the letter she received about her appointment on 25 March 2011. Miss E was concerned because she thought that the appointment was to take place at her flat and she was unhappy about this because she was a "*private person*". The duty worker explained that the appointment with the early intervention service would take place at West Strand House, a community mental health team base. A brief conversation took place about the support the service offered. Miss E seemed to recollect what the primary care mental health team had been explained to her. She said medication and hospital had been mentioned but she did not know by whom. She was clear that neither of these suggestions was welcome. Miss E agreed to attend for the assessment on 25 March 2011.

4.22 Miss E phoned the police about her neighbours on 19 March 2011. A police constable (PC 1) went to see her at home. She told the PC that she had no problems. PC 1 spoke to Miss E's mother on her own. She told him she had no concerns about Miss E and did not think she would cause any harm. Miss E's mother added that she had no fears about her personal safety. Despite this, PC 1 had his own concerns and so he asked a colleague to make contact with mental health services.

4.23 Miss E attended the outpatient department in a taxi On 21 March 2011 and went to reception for an appointment. Occupational therapist 1 went to reception and found Miss E sitting in the back of the taxi. She spoke to her through the open window. Miss E said she was experiencing problems with her neighbours and had told the police. Occupational therapist 1 suggested that Miss E call the police to find out what they were doing. The occupational therapist did not know why Miss E had attended when her appointment was

scheduled for 25 March 2011. She said she was staying with her mother but agreed to return on Friday for her appointment.

4.24 A relative of Miss E told us that she contacted the police at about 18.30 on 21 March to say she was worried about Miss E and thought “*something bad was going to happen*”. The relative told us she rang the mental health services helpline but was told nothing could be done because she was not a close family member.

4.25 On 23 March 2011 PC 2 followed up the visit to Miss E and the call from the family member and contacted early intervention services. She spoke to a duty worker and said Miss E had called the police to say she could hear voices through the grommets in her ears. PC 2 was told that Miss E had an appointment for Friday morning - two days later.

4.26 Miss E did not attend her appointment. She went to a local shop and asked staff to help her remove her mother’s dead body. The police were contacted and they confirmed that Miss E’s mother had died of multiple stab wounds, which Miss E admitted to inflicting.

5. Arising issues, comment and analysis

5.1 In this section we provide our comment and analysis on the issues that we have identified as part of our investigation. Our comments appear in bold italics.

5.2 We consider the following issues:

- referral to mental health services
- engagement with mental health services
- the management of people with psychosis and the use of the Mental Health Act
- risk assessment and management
- safeguarding adults
- carers assessment.

Referral to mental health services

5.3 The National Institute for Health and Care Excellence (NICE) guidance on psychosis and schizophrenia in children and young people advises that GPs should urgently refer all young people (14 years or over) with a first presentation of sustained psychotic symptoms (lasting four weeks or more) to an early intervention in psychosis service.

5.4 GP1 referred Miss E to the single point of access for assessment on 22 March 2010 because she had presented with strange symptoms. The GP believed Miss E was a vulnerable adult.

5.5 GP2 referred Miss E for an urgent assessment on 2 March 2011 because he was concerned she was suffering from a psychotic illness and was possibly a vulnerable adult.

Comment

Miss E was appropriately referred to mental health services by the GP as outlined in NICE guidance. We discuss later the issue of vulnerability.

Engagement with mental health services

5.6 Miss E has shown a reluctance to engage with mental health services. GP1 suggested to her in February 2009 that a referral to mental health services might be helpful because her concerns were causing her high levels of distress and anxiety. She finally agreed to a referral in September 2009. Miss E received a letter from the trust on 6 October 2009 asking her to contact the primary care mental health team to arrange an appointment. It said if she did not make contact within 14 days, the trust would tell her GP and close the case. Miss E did not make contact, so her GP was informed and her case was closed.

Comment

Rather than the trust just closing the case, it would have been more helpful if a discussion had taken place with Miss E's GP to see if she had a history of risk and to provide advice to the GP about the management of her case.

5.7 The trust now has clear guidance in place about non-attendance and loss of contact with mental health services. The guidance makes clear that discussions must be held to discuss any trigger factors and that a risk management strategy should be put in place if necessary to manage any known risks. In view of these developments we make no recommendation in relation to non-attendance.

The management of people presenting with psychoses

5.8 GP1 made a routine referral to the single point of access at Lancashire Care NHS Foundation Trust on 22 March 2010 for Miss E to be assessed in relation to a continued presentation with strange symptoms. The GP's referral letter noted "*very concerned about her wellbeing*" and described her as "*a vulnerable adult*".

5.9 A community mental health nurse (nurse1) assessed Miss E on 11 May 2010. Nurse 1 recorded that Miss E was hard to assess and it was difficult to hold her attention because she was occupied by concerns about her neighbours. Nurse 1 noted that Miss E appeared

to be neglected. Nurse1 discussed the case with consultant psychiatrist 1. They agreed that the consultant should assess Miss E.

5.10 Miss E phoned the team later that day and said she did not want to see a psychiatrist. Nurse 1 discussed this with her and Miss E agreed to see someone for a psychological assessment/counselling. Nurse 1 discussed this decision with GP 1.

5.11 Nurse 2 met Miss E and her mother a few days later. Miss E's mother said there had been no change in Miss E's presentation for several years. Nurse 2 knew a referral was in progress and that no new concerns had been raised.

5.12 Miss E failed to attend the appointment for a psychological assessment/counselling. No follow-up was offered.

5.13 Miss E was discharged from mental health services on 19 January 2011 because she did not attend the appointment the psychological therapy part of the service had offered.

5.14 The clinical records do not make clear on what basis nurse 1 made a referral to counselling services on 11 May.

5.15 At this point there was a combination of a likely psychotic disorder with a presentation of self-neglect. This was associated with significant concern about her vulnerability expressed by her GP.

Comment

When Miss E decided she did not want to see a psychiatrist it would have been beneficial for nurse 1 to discuss the case with the consultant psychiatrist to see whether Miss E's presentation warranted a referral to counselling or whether a Mental Health Act assessment or any other more assertive follow-up was needed to manage any risks.

5.16 On 2 March 2011 GP 2 referred Miss E again for an urgent assessment to the primary care team. He was concerned that she was suffering from a psychotic illness and was therefore vulnerable.

5.17 The referral noted significant concern about Miss E's mental health presentation, which seemed to have developed into a psychosis. The referral said despite Miss E having moved house the previous year, she continued to describe the same problems with neighbours, saying that they talked about her but that only she could hear them.

5.18 Nurse 3, the single-point-of-access nurse, contacted Miss E to offer a same-day appointment (2 March). Miss E said she could not attend that day but agreed to do so on 4 March 2011. Nurse 3 told Miss E's GP about the appointment.

Comment

The decision to offer a same-day appointment was appropriate and in line with trust policy, as was telling the GP that Miss E could not attend it.

5.19 Nurse 3 saw Miss E in the outpatient department on 4 March 2011. Miss E told her the neighbours at her new address were bothering her. She believed they were connected to her previous neighbours and they were staying next door illegally to harass her and play mind games. Miss E said she could hear her neighbours through the walls talking about her.

5.20 Miss E said the voices had occurred regularly since July 2010. She said she had been contacting the housing association *Gateway* but they barred her calls.

Comment

Miss E described the voices as present since July 2010. This presentation demonstrated to the GP that her mental health had deteriorated hence an urgent referral.

The fact that the housing association barred her calls also demonstrated that Miss E had started to act on her beliefs.

5.21 Nurse 3 recorded evidence of self-neglect, including that Miss E's hair was unkempt and matted. Nurse 2 recorded that Miss E showed no insight into her experiences and said several times during the assessment "*I am not schizophrenic*".

5.22 Nurse 3 described Miss E as having persecutory delusions and auditory hallucinations which she had probably been experiencing for some time. Miss E had no insight and although she would not consider treatment, she did agree to be seen again for further assessment. Miss E was vulnerable in her physical presentation and mental illness symptoms but nurse 3 considered the fact that Miss E was living at home with her mother would help protect her.

5.23 Nurse 3 referred Miss E to the early intervention service on 7 March 2011.

Access to a psychiatrist and assessment

5.24 The *Mental Health Act Code of Practice* makes clear that several factors should be considered in deciding whether patients should be detained for their own health and safety. These include:

- *"Evidence suggesting that patients are at risk of suicide - self harm - self neglect or being unable to look after their own health and safety or - jeopardising their own health and safety accidentally or unintentionally; or that their mental disorder is otherwise putting their health and safety at risk;*
- *Any evidence suggesting that the patients mental health will deteriorate if they do not receive treatment*
- *The reliability of such evidence, including what is known of the history of the patients mental disorder;*
- *The views of the patient and of any carers, relatives or close friends, especially those living with the patient, about the likely course of the disorder and the possibility of improving;*
- *The patient's own skills and experience in managing their condition;*

- *The potential benefits of treatment, which should be weighed against any adverse effects that are being detained might have on the patient’s well-being; and*
- *Whether other methods of managing the risk are available.”*

5.25 Miss E’s history provides evidence of self-neglect. Furthermore, the fact that she had on a number of occasions acted on her delusional beliefs suggests the possibility that she was jeopardising her “*own health or safety accidentally, recklessly or unintentionally*”. Piecing the details of Miss E’s history together, a pattern emerges of deterioration. It is clear that due to lack of insight Miss E had limited ability in her, “*own skills and experience in managing*” her condition.

Comment

These issues should have raised an alarm for nurse 3 particularly as self-neglect was evident, despite Miss E living with her mother.

Miss E was unlikely to engage with any meaningful therapeutic intervention. A discussion with the consultant psychiatrist would therefore have helped to inform clinical decisions about her presentation and whether a Mental Health Act assessment should have taken place. Her history makes clear that she was suffering significantly as a result of her psychosis. Given her presentation and with reference to the code of practice, we think she might have met the criteria of having a mental disorder of a nature and degree to warrant detention under Section 2.

5.26 Nurse 3 told us:

“We didn’t have very much access to consultant psychiatry. The consultant psychiatrists were divided into sectors. If we made a referral to the Consultant Psychiatrist, the waiting list was quite lengthy, longer than the referral to the Intervention Team. So that was not very practical. I worked within trust policy and chose the pathway that was there at that time. This was that this lady was presenting with first episode psychosis, she was under the age of 35 years, and the pathway was a referral into the Early Intervention Team.”

5.27 Nurse 3 went on to explain that the system had changed since this incident:

“If that lady came to see me today, she would have a referral to our Crisis Home Treatment Team and she would be seen on the same day by a psychiatrist.”

5.28 We have reviewed the new policies in place about service users being referred to the crisis home treatment team and the need for a service user to be assessed by a psychiatrist on the same day. We make no recommendations in this area given the safety improvements the trust has made since this incident.

Risk assessment and management

5.29 National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. Trust policy says that all service-users should have a risk assessment as part of their overall assessment. Any risks or issues around safety should be incorporated into the service-user’s care plan and reviewed as appropriate for up to a maximum of 12 months.

Comment

Nurse 3 described the risk assessment she carried out with Miss E but the records do not accurately reflect that a comprehensive risk assessment was undertaken as part of her overall mental health assessment. The early intervention referral form was not completed in full. It contains blank sections, including the details of risk. This is significant given Miss E’s presentation.

5.30 The trust is reviewing the risk assessment documentation to make it easier for clinical staff to complete the forms. See also reference within this report about the improvements the trust has introduced for the assessment of people presenting with the first episode of psychosis.

5.31 A relative of Miss E told us she contacted the police on 21 March 2011 to say she was worried about Miss E and thought something bad was going to happen. The police confirmed to us that this phone call took place. They gave her a phone number for the mental health service. Miss E's relative told us that she rang the helpline number but was told that nothing could be done because she not a close family member. A trust manager has advised us that there is no record of this call and so we cannot corroborate whether the call took place and if so what Miss E's relative was told by the helpline staff. Despite this we have no reason to disbelieve Miss E's relative.

Comment

We believe that Miss E's relative held important information about Miss E's mental state. She was so worried about Miss E that she contacted the police and mental health services out-of-hours helpline to try to get help. The trust's free phone helpline service is available for people in Blackpool, North Lancashire, Central Lancashire and West Lancashire.

It would have been helpful if the information from the telephone call had been conveyed to Miss E's treating team and connected with the available history. This would have demonstrated a pattern suggesting deterioration. This information alongside the call from the relative to the police might have triggered the consideration of use of the Mental Health Act.

5.32 On 23 March 2011 PC2 followed up the call Miss E's relative had made by contacting the early intervention service. He spoke to a duty worker and told him that Miss E had called the police to say she could hear voices through the grommets in her ears. PC2 was told Miss E already had an appointment for Friday morning.

Comment

The police took appropriate action by visiting Miss E and following up this visit by getting in touch with the early intervention service.

Recommendations

R1 The trust should ensure that all calls to any out-of-hours phone services and helplines are risk assessed to see whether any immediate action is needed.

R2 The outcome of the call should be recorded and shared with appropriate services in a timely manner.

Safeguarding adults

5.33 Lancashire safeguarding guidance defines a vulnerable adult as a person aged 18 years or over who may be unable to take care of themselves, or protect themselves from harm or from being exploited. This could be because they have a mental health problem, a disability, a sensory impairment, are old and frail, or have some illness. The guidance goes on to say that vulnerable adults are at greater risk of being abused.

5.34 Miss E had attended a special school in order to meet her educational needs. As we say above, she also had a history of self-neglect and presented with a mental disorder.

5.35 GP 2 referred Miss E to mental health services in March 2011 because he was concerned that she was suffering from a psychotic illness and was possibly a vulnerable adult.

Comment

Miss E was described as a vulnerable adult and observed as presenting with self-neglect. On the evidence we have seen, Miss E would probably have met the definition of a vulnerable adult. We found no evidence that a discussion took place between the GP and the mental health team or within the mental health team to consider making a safeguarding referral.

Recommendation

R3 The trust and the GP practice must ensure that all clinical staff carry out their responsibilities in line with local adult safeguarding policy and good practice guidance.

Carer's assessment

5.36 Our terms of reference specify the need to examine the extent of services engagement with carers; use of carer's assessments and their impact on the incident in question.

5.37 The trust carer's strategy sets out key principles about the involvement of carers in assessment and care planning. It outlines the need to make sure that a carer's assessment takes place every year.

5.38 In the first episode of contact, an appointment was made for Miss E but she did not attend so she was discharged. Because of this, there was no opportunity to ask Miss E if she would like any member of her family to act as a carer.

5.39 In the second episode, Miss E was assessed but did not attend a further appointment so was discharged. There is no record to demonstrate whether or not clinical staff asked her if she would like any member of her family to act as a carer during her first assessment.

5.40 In the third episode of care Miss E was assessed and referred to the early intervention services. There is no record to demonstrate whether or not clinical staff asked her if she would like any member of her family to act as a carer in this final episode of care. However, given Miss E's presentation it is unlikely that she would have identified any member of her family to act as a carer at this stage because she did not consider herself to be ill and was reluctant to engage with services. If Miss E had continued to receive care and treatment within the trust, an assessment under the care programme approach would have triggered a discussion with Miss E about whether she would have liked a friend or relative to act as a carer.

Comment

A carer had not been identified but we found no evidence that this had an impact on the incident.

Conclusion

5.41 The evidence we reviewed gives us no reason to believe this incident was predictable. We found nothing to suggest that Miss E presented in an aggressive or intimidating manner and she did not have a forensic history. Nevertheless, there were clear signs that Miss E was psychotic in the third episode of care. Her presentation should have prompted a more assertive approach by the clinical team. She should have been better assessed and seen by a senior member of the medical team. A thorough risk assessment should have been carried out with a clear risk management plan. We agree with the trust post incident review team that this was a missed opportunity. We cannot say it whether this omission would have changed the course of events. We are aware that the trust has undertaken significant service redevelopment since this incident to improve services for people presenting with first-time psychosis.

5.42 The acting assistant director, step 4 services, told us:

“Since this incident there has been a transformation of services within Lancashire Care Trust. Referrals come through the single point of access for triaging. Servicer users are now allocated to a care co-ordinator within 48 hours.”

5.43 The acting director went on to explain that the trust had also developed new guidance for treating people who present with a first episode of psychosis. We have reviewed the guidance. This states that where an individual is actively psychotic and untreated, and therefore at risk to themselves or others, they require an emergency assessment on the day of presentation and this should involve a senior member of medical staff.

5.44 All presentations are now referred to the crisis resolution and home treatment team to ensure this happens. This approach recognises that all presentations constitute a crisis, and the possibility always exists that inpatient treatment might also be needed. The

trust acknowledges that any delay in assessment and intervention could increase the possibility of the individual disengaging from services. The service-user now receives a comprehensive assessment and a care plan is developed which includes a risk management plan. A care coordinator is also allocated to lead and coordinate care.

5.45 We note that the trust undertook a post-review learning event in September 2011 with the key players involved in Miss E's care and treatment. The focus of the session was to consider the case and the issues raised around the care and treatment of people presenting with first episode of psychosis.

5.46 We make no recommendation in relation to the management of people presenting with first-time psychosis given the significant improvements that the trust has made in this area since the incident.

6. The trust's internal investigation and progress made against the recommendations

6.1 The terms of reference for this investigation include assessing the quality of the internal investigation and reviewing the trust's progress in implementing the action plan.

6.2 In this section we examine the national guidance and trust's incident policy to find out whether the investigation into the care and treatment of Miss E met the requirements set out in these policies.

The trust's internal review

6.3 The good practice guidance *Independent investigation of serious patient safety incidents in mental health services* (NPSA February 2008) advises that following a homicide an internal NHS mental health trust investigation should take place to establish a chronology and identify underlying causes and any further action needed. The trust policy also says an internal investigation should take place after a serious incident to see if any lessons can be learnt. The trust commissioned a post-incident review into the care and treatment of Miss E. The review was led by the professional nurse lead from adult services with advice from a retired psychiatrist.

6.4 The trust introduced the procedure for the investigation of incidents, complaints and claims policy in February 2009. This policy was still in place at the time of the incident.

6.5 The trust's policy says that unexpected deaths e.g. suicides and/or incidents where care or delivery issues may have contributed to the SUI should be managed as a multi-disciplinary post-incident review.

6.6 The terms of reference for the review were:

- *"To review the care and treatment of the Service User*
- *To develop a clear chronology of events*
- *To provide a detailed narrative of events of the incident*
- *To identify any care delivery problems that may have arisen in relation to the*

direct provision and process of care

- *To identify any service delivery problems associated with the process of service delivery, focusing particularly on the processes and systems in place.*
- *To identify any factors contributing to the identified care or service delivery problems*
- *To explore the barriers that could be adopted to minimise the likelihood such an incident would occur again under similar circumstances*
- *To explore barriers and initiatives that could be adopted to improve the quality and safety of services for all in light of the review's more general findings*
- *To make recommendations informed by the review in relation to improving the quality and safety of future care/service delivery”*

Comment

The trust commissioned a post incident review (PIR) into the care and treatment of Miss E in line with national and local good practice.

The review was led by an appropriate senior person in the trust with advice from a retired psychiatrist working to clear terms of reference. These were proportionate and appropriate given the seriousness of the incident.

The investigative process

6.7 The trust investigation guidance sets out a clear process for undertaking a post incident review. The PIR lead explained to us that she developed a chronology of events and gathered witness statements from those involved. She also set up a post-incident group review meeting so that a discussion could take place about the incident and whether any lessons could be learned.

Recommendations and action plans

6.8 This section looks at the trust's progress in implementing the action plan resulting from the internal investigation report.

6.9 The report identified several areas that needed improvement and made three recommendations:

“1. Staff need to be clear that service users presenting with psychosis should have their care managed to ensure more assertive and timely access to care and treatment.

2. A reflective learning opportunity should take place to consider the area of vulnerability in terms of psychosis.

3. To ensure GP’s are clear about how to access the appropriate services to ensure timely input to service users presenting with first episode psychosis.”

6.10 An action plan was developed by the trust to take forward the recommendations. Each recommendation was allocated to a lead person and a timescale was identified. The trust has given us evidence that they have put the recommendations in place. For example, we have seen a copy of the new Bluelight guidance sent to all trust staff to highlight the pathway for persons presenting with first-episode psychosis. People we interviewed were familiar with the new guidance.

Comment

The post-incident review was carried out in line with trust procedure. A post-incident group review meeting took place and individual statements from staff were obtained. The trust made recommendations and an action plan was developed to take them forward. This has now been completed. A copy of the action is appears in appendix A.

Trust action plan

Recommendation	Action Required	Responsible Lead	Timescale	Evidence on completion
Staff need to be clear that service users presenting with psychosis should have their care managed to ensure more assertive and timely access to care and treatment	<p>RR to be discussed at step 2/3 governance and opportunity to fast track service users with active psychosis for early input.</p> <p>A Bluelight to go out to all Trust staff to highlight the pathway for persons presenting with first episode psychosis</p>	<p>Asst Network Director</p> <p>Medical Director</p>	September 2011	Evidence of communication of this area to the team
Reflective learning opportunity to take place to consider the area of vulnerability in terms of psychosis	Oxford model event to take place for the team to explore the issues raised around care and treatment and service to this lady.	Team manager/clinical governance	Sept 2011	Date of event and attendance
To ensure GP's are clear about how to access the appropriate services to ensure timely input to service users presenting with first episode of psychosis.	Senior managers from both EIS and Step 2/3 to meet and feedback on the issues raised within this review	Senior Managers Step 2/3 & EIS	September 2011	Minutes of meeting

Biographies

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. As head of training Chris has developed and delivered courses on different aspects of systematic incident investigation. She has held senior nursing and managerial positions at regional and local level within the NHS, including director of mental health services for older people. Chris heads Verita's office in Leeds.

Amber Sargeant

Amber joined Verita as a senior investigator in 2009. Previously she worked at the Care Quality Commission (CQC) where she led on several major investigations into patient safety, governance and concerns around performance.

In addition to carrying out reviews and investigations Amber leads Verita's work on reducing sickness absence within NHS trusts and improving medical device safety. She has recently worked with a foundation trust to help it develop its care pathway for cardiology services and benchmark services against national and international standards.

Douglas Gee

Douglas graduated from medical school in 1990 and after gaining membership of the Royal College of Psychiatrists (MRCPsych) in 1995, he obtained an MSc in advanced studies in clinical psychiatry. He took on clinical responsibility for adult mental health services for Humber NHS Foundation Trust in 2001 and became medical director in 2005. As well as being responsible for the professional leadership of medical staff, he leads the pharmacy team and on risk management and clinical governance within the trust. This includes responsibility for complaints, serious untoward incidents and adverse incident management. Externally from the trust, Douglas is part of SHA wide mental health patient

safety group, SHA Mental Health Darzi group and Clinical Policy Forum. He has also provided expert psychiatric advice to a number of mental health homicide investigations for Verita over the past four years.

Documents reviewed

- Miss E's clinical records
- The trust post incident review report
- The trust's clinical risk assessment and risk management guidance
- The trust's carers strategy
- The trust's blue light guidance
- National guidance on clinical risk assessment
- The National Institute for Health and Care Excellence (NICE) guidance on psychosis and schizophrenia in children and young people
- Lancashire guidance on safeguarding adults
- *No secrets* (DH) 2000
- *Mental Health Act*