Independent Investigation

into the

Care and Treatment Provided to Mr. Z

by the

Sussex Partnership NHS Foundation Trust

Commissioned by
NHS South of England (South East Coast)
Strategic Health Authority

Investigation Conducted by: HASCAS Health and Social Care Advisory Service
Report Authored by: Dr. Androulla Johnstone

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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. Z was commissioned by NHS South of England Strategic Health Authority (South East Coast) pursuant to *HSG (94)27*.[1] This Investigation was asked to examine a set of circumstances associated with the death of Mr. X who was found killed on the 4 September 2010.

Mr. Z received care and treatment for his mental health condition from the Sussex Partnership NHS Foundation Trust. It is the care and treatment that Mr. Z received from this organisation that is the subject of this Investigation.

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. The Trust's Senior Management Teams have acted at all times in an exceptionally professional manner during the course of this Investigation and have engaged fully with the root cause analysis ethos.

1. Health service Guidance (94) 27

2. Condolences to the Family and Friends of Mr. X

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. X. At the time of writing this report the commissioners of this Investigation had not been able to make contact with them.

3. Incident Description and Consequences

Background

Mr. Z was born on the 7 June 1989. He had suffered a degree of physical abuse as a young child and had subsequently accessed Child and Adolescent Mental Health Services as a teenager for related trauma.

On the 21 April 2010 Mr. Z visited his GP surgery accompanied by his father. It was reported that Mr. Z had been released from prison two to three weeks earlier and that he was feeling angry, irritable and paranoid.[2] The GP sent a referral to the Sussex Partnership NHS Foundation Trust West Access Team in Brighton for an urgent assessment. On the 28 April 2010 Mr. Z was seen by the West Access Team where an initial screening was undertaken. He was not thought to require further secondary care intervention at this stage and Mr. Z was referred back to his GP.[3]

On the 16 June 2010 Mr. Z returned to his GP who made a second referral to the West Access Team for an urgent assessment. Mr. Z was anxious and depressed. Mr. Z had described some reckless behaviour and the GP decided that he would benefit from secondary care intervention.[4] On the 17 June 2010 the West Access Team telephoned Mr. Z. However it was not possible for the Team to arrange an early appointment and Mr. Z became upset and hung up. On the 24 June 2010 Mr. Z was discharged from the service as he had not got back in contact to arrange an appointment.[5]

On the 15 July 2010 Mr. Z telephoned the West Access Team. He was having difficulty with crowds and found it difficult to visit his GP. He was still feeling anxious and depressed. He said that he wanted to see a psychiatrist. Mr. Z was told that he would have to be re-referred to the service by his GP and could not be seen otherwise. Mr. Z had no further contact with secondary care services.

Incident

Shortly before noon on 4 September 2010 a badly burnt body was found on a golf course north of Brighton. DNA tests found the body to be that of Mr. X who was known to local substance misuse services. He had suffered severe trauma to the brain prior to being set alight. It became apparent that Mr. X had been killed at an address in Brighton and later moved to the golf course where his body was burnt in an attempt to conceal its identity.

2. Clinical Record P.4
3. Clinical Record PP. 7-11
4. Clinical Record PP. 17-18
5. Clinical Record P. 24

Mr. Z was subsequently arrested for the murder of Mr. X on the 8 September 2010 and was remanded in custody. The two men had apparently been friends having met whilst they had both previously been on remand.

Mr. X was described in Court as being *"vulnerable, defenceless and completely without malice".*[6] On the 31 March 2011 Mr. Z was convicted of the murder of Mr. X and was jailed for life with a further seven-year sentence for attempting to pervert the course of justice. Mr. Z's father and brother were also jailed for attempting to pervert the course of justice for seven and six years respectively. These sentences were handed down because Mr. Z's father and brother were found guilty of helping him to conceal the murder of Mr. X.

When being tried for the murder of Mr. X the Court was told that Mr. Z had formerly been remanded for robbery and the actual bodily harm of a 15-year old boy. The Court was also told that Mr. Z was on the Sex Offenders' Register for the sexual assault of a 15-year old girl. The only mitigating factor cited during the Judge's sentencing remarks was Mr. Z's young age. No mention was made of any existing, or pre-existing, mental health condition that could have influenced his actions in the killing of Mr. X.[7]

6. BBC News Sussex 31 March 2011
7. Court Transcriptions

4. Background and Context to the Investigation (Purpose of Report)

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South of England, South East Coast (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94) 4*, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:
"…in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved".

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) 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.

ii) When it is necessary to comply with the State's obligations 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 on 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.

iii) 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.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of health services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Independent Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interests of the wider public. This case has been investigated fully by an impartial and Independent Investigation Team.

5. Terms of Reference

The Independent Investigation was commissioned by NHS South of England, South East Coast. The Investigation was commissioned in accordance with guidance published by the Department of Health in *HSG (94) 27 The Discharge of Mentally Disordered People and their Continuing Care in the Community* and the updated paragraphs 33 – 36 issued in June 2005. This Investigation was commissioned as a 'B' grade review. A 'B' grade review comprises a specialist team who are requested to build upon the work of internally commissioned investigation reports in order to ensure proportionality. This is an investigation with two investigators generally with access to expert advice as needed. It is appropriate in cases that appear to be less complex and where the investigation will focus on one agency and where the issues appear to be clear. As well as staff there will be a need to offer interviews to perpetrators, their families and families of victims. The outcome of this type of investigation is a report which provides a detailed chronology and analysis of the care and treatment of an individual and may include recommendations which relate to the organisation's managerial/clinical policy and practice.

Terms of Reference

1. *"To examine the care and treatment of Mr. Z, in particular:*

- *The history and extent of Mr. Z's involvement with the health and social care services.*
- *The suitability of Mr. Z's treatment, care and supervision in respect of:*
  - *his clinical diagnosis;*
  - *his assessed health and social care needs;*
  - *his assessed risk of potential harm to himself and others;*
  - *any previous psychiatric history;*
  - *any previous forensic history;*
  - *the assessment of the needs of carers and Mr. Z's family.*
- *The extent to which Mr. Z complied with his prescribed care plans.*
- *The extent to which Mr. Z's care and treatment corresponded to statutory obligations, the Mental Health Act (1983 & 2007), and other relevant guidance from the Department of Health.*
- *The quality of Mr. Z's treatment, care and supervision, in particular the extent to which his prescribed care plans were:*
  - *appropriate;*
  - *effectively delivered;*
  - *monitored by the relevant agency.*
- *The adequacy of the framework of operational policies and procedures applicable to the care and treatment of Mr. Z and whether staff complied with them.*
- *The competencies of staff involved in the care and treatment of Mr. Z and the adequacy of the supervision provided for them.*

- *The internal investigation completed by Sussex Partnership NHS Foundation Trust and the actions that arose from this.*
- *The Trust clinical governance and assurance systems as they relate to care and treatment provided to Mr. Z, this in particular regard to:*
  - *audit;*
  - *clinical supervision;*
  - *clinical leadership.*
- *Any other matters that the investigation team considers arise out of, or are connected with, the matters above.*

2 *To examine the adequacy of the collaboration and communication between all the agencies involved in the care and treatment of Mr. Z, or in the provision of services to Mr. Z, including Sussex Partnership NHS Foundation Trust and relevant housing agencies and GP services.*

3 *To prepare a written report that includes recommendations to the Strategic Health Authority, or successor organisations, so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.*

Approach

The Investigation Team will conduct its work in private and be expected to take as its starting point the Trust's internal investigation supplemented, as necessary, by access to source documents and interviews, as determined by the team. The Team is encouraged to engage relatives of the victim, Mr. Z and his family and any relevant staff in the investigation process.

The Team will follow good practice in the conduct of interviews by, for example, offering the opportunity for interviewees to be accompanied and giving them the opportunity to comment on the factual accuracy of their interview transcript.

Timetable

The precise timetable will be dependent on a number of factors including the availability of Mr. Z's clinical records, the Investigation Team's own assessment of the need for information and the number of interviews necessary. The team is asked to have completed the investigation, or a substantial part of it, within six months of starting its work. Monthly reports on progress should be provided to NHS South East Coast, or to successor organisations.

Publication

The outcome of the Investigation will be made public. The nature and form of publication will be determined by the NHS South East Coast, or its successor organisations. The decision on publication will take account of the views of the relatives and other interested parties".

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of The Trust subject to this Investigation. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Investigation Team Leader

Dr. Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service and Investigation Nurse Member and Team Leader

Investigation Team Members

Dr. David Somekh	HASCAS Health and Social Care Advisory Service Associate and Consultant Psychiatrist Member of the Team
Dr. Len Rowland	Director of Research and Development, HASCAS Health and Social Care Advisory Service and Clinical Psychologist Member of the Team

Support to the Investigation Team

Mr. Greg Britton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Ms. Fiona Shipley	Transcription Services

Independent Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

7. Investigation Methodology

In February 2012 NHS South of England, South East Coast (the Strategic Health Authority) commissioned HASCAS Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section four of this report. The Investigation methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. Z and all witnesses to this Investigation.

Consent and Communications with Mr. Z

Mr. Z was written to by the Strategic Health Authority (SHA) requesting his consent to access his clinical records. There was a significant delay between the commissioning of this Investigation and communication with Mr. Z due to his whereabouts being uncertain. In November 2013 the prison where he was detained was located and a letter sent to him. On the 17 October 2012 Mr. Z signed a consent form to allow the Independent Investigation Team access to his clinical records.

Communications with the Victim's Family

The commissioner of this Investigation was not able to make contact with the victim's family.

Communications with the Family of Mr. Z

The commissioner of this Investigation was not able to make contact with the family of Mr. Z.

Communications with the Sussex Partnership NHS Foundation Trust

The SHA made contact with the Sussex Partnership NHS Foundation Trust in August 2012. This communication served to notify the Trust that an Independent Investigation under the auspices of *HSG (94) 27* had been commissioned to examine the care and treatment of Mr. Z. A formal meeting was held between the Investigation Team Leader and the Trust in December 2012 once the clinical records had been released and the Investigation process commenced.

The Independent Investigation Team worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished;
- that a workshop for witnesses to the Independent Investigation was held on 22 January 2013. The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible;

- that interviews on 4, 5 and 6 February 2013 were held at the Trust Headquarters in Worthing, West Sussex. The Investigation Team were afforded the opportunity to interview witnesses and meet with the Senior Managers of the Trust.

Factual accuracy and headline findings communications were held between the Independent Investigation Team and the Sussex Partnership NHS Foundation Trust in accordance with Scott and Salmon compliant best practice.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon processes.

The total number of witnesses interviewed by the Independent Investigation Team was 11. The witnesses who attended for interviews are set out below in table one.

Table One
Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
4 February 2013	Trust Director of Nursing and Quality Trust Director of Governance *** Service Director Brighton and Hove	Investigation Team Nurse/Leader Investigation Team Psychiatrist Investigation Team Psychologist In attendance: Stenographer
5 February 2013	West Access Team Duty Coordinator West Access Team Referral Secretary West Access Team Worker 1 *** Community Psychiatric Nurse (CPN 1) Community Psychiatric Nurse (CPN 2) West Access Team Worker 2 *** Internal Investigation Lead	Investigation Team Nurse/Leader Investigation Team Psychiatrist Investigation Team Psychologist In attendance: Stenographer
6 February 2013	Clinical Director, Primary Mental Health Care and Wellbeing	Investigation Team Nurse/Leader Investigation Team Psychiatrist Investigation Team Psychologist In attendance: Stenographer

Salmon and Scott Compliant Procedures

The Independent Investigation Team adopted Salmon compliant procedures during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be given the opportunity to review clinical records prior to and during the interview.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual' manner and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was made aware in advance of their interview the general questions that they could expect to be asked.

The Team Met on the Following Occasions

First Team Meeting 15 January 2013

The Investigation Team examined and discussed the chronological timeline which had been produced following the receipt of the full clinical records. The Investigation Team decided which staff they wished to interview and agreed questions they would ask. The list of documents required was made; this consisted of various Trust Policies and Operational Policies together with information about the Trust.

Second Team Meeting 5 February 2013

There was opportunity during the interview schedule which allowed the Investigation Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the organisation and systems of the team that had contact with Mr. Z and also management and governance issues.

Following the witness interviews the Team received the transcriptions and were able to add to the chronological timeline to reflect upon the additional information. There were also additional policies and procedures sent from the Trust which were examined. The

Investigation Team was able to work in a virtual manner in order to complete the Root Cause Analysis methodology and develop the report findings and conclusions.

Other Meetings and Communications

The Independent Investigation Team Leader maintained communications on a regular basis with NHS South of England, South East Coast, throughout the process. Communications were maintained inbetween meetings by email, letter and telephone.

Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed throughout this process.
2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the Decision Tree and the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

8. Information and Evidence Gathered (Documents)

The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. Z's Trust-based clinical records.
2. Clinical Witness/ Witness transcriptions.
3. Healthcare Commission/Care Quality Commission Reports for the Sussex Partnership NHS Foundation Trust.
4. Sussex Partnership NHS Foundation Trust policies and procedures.
5. Sussex Partnership NHS Foundation Trust internal investigation archive and report.
6. Crown Court transcriptions and documents.
7. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006.
8. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005.
9. NICE and ICD 10 guidelines.

9. Profile of the Sussex Partnership NHS Foundation Trust Services

The Sussex Partnership NHS Trust was formed in 2006 and became a Foundation Trust in August 2008; it has a turnover of £240 million. The Trust currently serves a population of 1.5 million people, employs 5,000 staff and provides services from 120 sites in Hampshire, Kent, London, Surrey, East Sussex and West Sussex. During 2012/2013 the Trust made 100,000 clinical contacts with service users.

The Trust Vision

1. *"Our vision is to ensure that the people who use our services, their carers and staff have the best possible experience of receiving help or working within our services*

2. *We are one of the largest mental health, learning disability and substance misuse trusts in the country*

3. *Our 5,000 staff provide treatment at home, in clinics, centres and hospitals across Sussex and beyond"*

The Five Strategic Aims

1. *"High quality clinical care for all people using Sussex Partnership services*

2. *Employer of enabled, engaged, well trained and motivated staff*

3. *A leading teaching and research mental health trust*

4. *A well-governed sustainable organisation*

5. *A growing organisation that invests in improving services"*

Services Provided

1. *"Primary mental health and wellbeing services including partnerships with GPs*

2. *Adult community mental health services for all adults over 18 (no upper age limit)*

3. *Specialist mental health services including eating disorders, personality disorders, and recovery services*

4. *Adult crisis and inpatient services*

5. *Dementia and later life services*

6. *Children and young people's services*

7. *Secure and forensic services*

8. *Substance misuse services*

9. *Prison healthcare services to HMP Lewes and HMP Ford".*

10. Chronology of Events

Root Cause Analysis First Stage
The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. Z and on his care and treatment from mental health services.

Background Information

Mr. Z was born on the 7 June 1989. At some stage in Mr. Z's childhood he was physically abused by a person known to the family and this caused a significant level of trauma for which he treated by a Child and Adolescent Mental Health Service. At the time of the killing of Mr. X in September 2010 Mr. Z lived with his father in the Brighton area.

At the time Mr. Z was assessed by mental health services in April 2010 he had a previous conviction for robbery and the actual bodily harm of a 15-year old boy. Mr. Z was also on the sex offenders' register for the sexual assault of a 15-year old girl.

Clinical History with the Sussex Partnership NHS Foundation Trust

21 April 2010. A letter was written by a GP Registrar at Mr. Z's Surgery with a request for the Sussex Partnership NHS Foundation Trust West Access Team to assess Mr. Z urgently. He had problems with anger, irritability and mood. Mr. Z had been reluctant to attend the GP appointment which he attended with his father. He had been released from prison two to three weeks earlier and was staying at his father's home. Mr. Z was feeling paranoid believing that people were out to get him when he was in public places. Mr. Z said he did not feel suicidal, but his father told the GP that he was cutting his arms. Mr. Z presented as being very impulsive and *"stormed out"* of the consultation. He was reported as not taking drugs or alcohol.

Mr. Z's father explained that his son had been physically abused as a child by a person known to the family and that he had received counselling for this which had not helped. Mr. Z's father expressed his concern about Mr. Z's behaviour, in particular the mood swings and irritability. Mr. Z refused to fill in a PHQ9 (a depression rating scale) but his father took a form for his son to complete at home.[8]

27 April 2010. A West Access Team single point of access recording sheet stated that a referral had been made. This form contained very little information but stated the referral was received by the Duty Coordinator, the form was filled in by a Team Worker, and the case was

8. Clinical Record P.4

allocated to a Community Psychiatric Nurse prior to assessment. No risks were specified. At this stage it was recorded that the decision about a Care Programme Approach level had yet to be made. There was no other information written on this form.[9]

At 14.30 hours it was noted that the referral had been marked as urgent and was dated the 21 April 2010 but that it had been sent through the post causing a delay. The West Access Team telephoned the number for Mr. Z given to them by the GP but found that the number was not recognised. The GP also gave Mr. Z's mobile telephone number which was called and a message left on voicemail.[10]

At 14.50 hours Mr. Z telephoned the West Access Team. He said he would like an appointment but was worried that he would walk out. He said that he was on probation and had been released from prison six weeks ago. Mr. Z said he had been depressed for several years and that he felt paranoid when out and about. He explained that he had found it hard to visit the GP the previous week but had gone because his father was worried about him. He did not feel suicidal but his father was concerned that he was. Mr. Z said he was more likely to come to harm in a fight as he had lots of enemies in Brighton. Mr. Z agreed to an appointment for the 28 April at 11.00 hours. He was warned in advance that he would be asked a lot of questions.[11]

28 April 2010 11.00 hours. Mr. Z was seen by the West Access Team and the entry was made by CPN 1 (Mental health Nurse). An initial screening form was completed and sent to the GP. The PQH9 score was: 17/27 6AD7: 14/21 indicating a moderate to severe depression.

It was noted that Mr. Z had suffered from depression for several years. He denied having problems with anger; it was just that people irritated him with their questions. It was difficult to specify what kind of help he needed or was willing to have. Mr. Z said he would be fine if he could continue to self-medicate with Valium. Medication was discussed and a Selective Serotonin Re-uptake Inhibitor (SSRI – antidepressant) was recommended. Mr. Z had been in prison for robbery and actual bodily harm. He was living with his father and spent his time with his friend and girlfriend. He had no plans for the future. It was noted that Mr. Z had undergone some work on anger management whilst in prison.

It was noted that he was not prescribed medication but was self medicating with Valium and *"weed"* and that he had been prescribed Zopiclone in the past for sleep problems. He was deemed to be at no risk of suicide, but to be at risk of self harm. He was not thought to be a risk to others and the section on previous harm to others was left blank (although he had told the assessor he had been in prison for Actual Bodily Harm). Mr. Z was not thought to be at risk of self neglect.

9. Clinical Record PP. 1-3
10. Clinical Record P.5
11.Clinical Record P. 6

It was recorded that the outcome of the meeting was that Mr. Z was given information leaflets and discharged. Counselling was discussed with him as an option but he was not interested, he was advised to contact his GP if he changed his mind. Mr. Z was also advised to see his GP about starting antidepressant medication. Mr. Z was written to and a copy of the 'care plan' sent to him (no record of which was present). The assessment documentation was sent to the GP.[12]

17 June 2010. A referral was received by the West Access Team at 10.20 hours. Once again the referral had been made by the GP. The referral was received and allocated prior to assessment to the Service Manager.

At 13.00 hours an entry was made. It was noted that Mr. Z had reckless behaviours and did not care if he lived or died, although he did not appear to be suicidal. A telephone call was made to Mr. Z, although he knew the GP had made the referral he was angry and aggressive about receiving the call. He was at home at this time doing a job for his mother. However Mr. Z was able to say that he had no immediate plans to harm himself but that he felt awful most of the time. At 08.30 hours that morning he had visited Hove Polyclinic, but it was not clear to them what help he was trying to get. He was asked if there were any drug or alcohol issues and he was *"affronted"* by this. Mr. Z felt that no one and nothing was helping him. He also said that he had commenced Citalopram 20mg that morning. It was explained that an assessment meeting could be offered to him the following week, but that no instant assessments could be made available. Mr. Z became angry that he could not be seen earlier and ended the telephone call. A letter was sent asking Mr. Z to book an assessment appointment. A copy of this letter was sent to the GP.[13]

24 June 2010. Mr. Z was discharged from the service. The reason given was that he had not made contact to book an appointment within the required two-week timeframe.[14]

15 July 2010 11.45 hours. Mr. Z telephoned the West Access Team, he wanted to know who it was that he had seen previously. Mr. Z said he had trouble with crowds and that he found it difficult to visit the GP due to anxiety and depression. Mr. Z wanted to be signed off work and to see a psychiatrist. He was told that he would need the GP to re-refer him. In the clinical record Mr. Z was described as being *"ok"* with this.[15]

4 September 2010. A man's body was found on a local golf course north of Brighton.

8 September 2010. Mr. Z was arrested and charged with murder and remanded in custody.

13 September 2010. The West Access Team was notified about Mr. Z's arrest by the Court Liaison Nurse. An assessment report was prepared for the Brighton and Hove Magistrates'

12. Clinical Record PP. 7-11
13. Clinical Record PP. 15-23
14. Clinical Record P. 24
15. Clinical Record P. 25

Court. The report was requested due to the gravity of the offence and Mr. Z's previous contact with mental health services. Mr. Z was agitated but understood he had been charged with murder and that members of his family had also been charged with perverting the course of justice.

Mr. Z appeared to be well orientated however his mood appeared to be incongruous as he did not appear to be aware of the seriousness of his situation.[16]

14 September 2010. Mr. Z was remanded to HMP Winchester due to death threats to both him and other family members being made. He was discussed at the Forensic Services referrals meeting and it was agreed that he required a psychiatric assessment.

31 March 2011. Mr. Z was convicted of the murder of Mr. X and was jailed for life with a further seven-year sentence for attempting to pervert the course of justice. Mr. Z's father and brother were also jailed for attempting to pervert the course of justice for seven and six years respectively. These sentences were handed down as Mr. Z's father and brother were found guilty of helping him to conceal the murder of Mr. X.

16. Clinical Record PP.27-34

11. Timeline and Identification of the Thematic Issues

Root Cause Analysis (RCA) Second Stage

11.1. Timeline

The Independent Investigation Team formulated a timeline and a chronology in a narrative format in order to plot significant data and identify the thematic issues and their relationships with each other. This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Team.

11.2. Thematic Issues Arising from the Timeline

On examining the timeline, care pathway and chronology, the Independent Investigation Team identified twelve thematic issues that arose directly from fulfilling the Terms of reference and analysing the care and treatment that Mr. Z received from the Sussex Partnership NHS Foundation Trust. These thematic issues are set out below.

1. Diagnosis. Despite two urgent referrals being made by primary care Mr. Z was not seen by a psychiatrist in secondary care and consequently no medically-derived diagnosis was made. Mr. Z's presentation was such to merit a medical examination. He had been recently released from prison, was known to have had a substance misuse problem and was also experiencing paranoid symptomology, intense anger and self-harming behaviour.

It was evident to this Investigation that the GP made the two referrals to primary care in order for an urgent assessment to be undertaken. It was known that:

- Mr. Z had been recently released from prison;
- Mr. Z was having some kind of adjustment difficulties;
- Mr. Z was self medicating with Diazepam (which not being prescribed for him) and *"weed"*;
- Mr. Z's father was extremely worried about him;
- Mr. Z was paranoid, experiencing feelings of extreme anger, was anxious and agoraphobic and was self harming.

Clinical witnesses to this Investigation stated that it was not acceptable for a service user such as Mr. Z not to be seen by a Psychiatrist but that this was how the service was managed at the time. The Independent Investigation Team would concur with the reflections of the clinical witnesses in that a medically-led assessment was indicated for Mr. Z.

2. Medication and Treatment. Despite no diagnosis being given the nurse who assessed Mr. Z at the West Access Team suggested that Mr. Z ask his GP for a SSRI (Selective serotonin re-uptake inhibitors – antidepressant). The fact Mr. Z reported he was self medicating with Diazepam was ignored. The medication and treatment advised by secondary care services was not as the result of a well thought through assessment and diagnostic formulation.

3. Mental Health Act (1983 and 2007). The Assessment of the use of the Mental Health Act was not relevant to this Investigation as at no time was application of the Mental Health Act indicated.

4. Care Programme Approach (CPA). Due to the brevity of contact with secondary care services it was not possible to assess the CPA process Mr. Z was subject to. However it is the finding of the Independent Investigation Team that Mr. Z's history and presentation met the criteria for being considered for full CPA.

5. Risk Assessment. Risk assessment was a tick box process which did not address what was known about Mr. Z and did not lead to a formulation of risk being made. The risk assessment process was not in keeping with either national or local policy guidance and fell short of the standard to be expected from a secondary care provider. The standard of recording was poor. The risk assessment process consisted of an initial risk screen only.

Two urgent referrals were made by primary care to secondary care services. It was known that Mr. Z:

(28 April 2010)

- was self harming;
- was self medicating with Diazepam and cannabis;
- was angry and impulsive with a history of violence;
- had recently been released from prison;
- was paranoid and at risk of getting into fights;
- was depressed;
- found it difficult to go outside without his father.

Despite this profile Mr. Z received a rudimentary assessment and was discharged back to the care of his GP.

(June 2010)

- Mr. Z was becoming increasingly reckless;
- Mr. Z was described as not caring whether he lived or died;
- Mr. Z was also agitated and aggressive.

Despite this, when he did not book in for an appointment, he was discharged from the service within seven days. Mr. Z presented with a substantial risk both to himself and to others. Without a robust assessment of his mental state, based on what was known about him at the time, it was poor practice to provide Mr. Z with such a rudimentary service.

6. Referral, Discharge and Handover Processes. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"There seems to be gaps in understanding between the expectations of the referrer as to what would happen as a result of the referral and the understanding of the Access Team as to their role. The term*

'comprehensive assessment' requires some clarification within an Access context so that referrers can be clear about this".[17]

7. Carer Assessment and Experience. Whilst this appears to have been of a reasonable standard in the primary care context it would appear that secondary care mental health services did not take carer concerns and issues into consideration.

8. Service User Involvement in Care Planning and Treatment. Whilst it is difficult to assess this due to the short length of time Mr. Z was in contact with secondary care services, it would appear that Mr. Z did not access a service that could respond to his presentation and needs.

9. Documentation and Professional Communication. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"The written documentation falls significantly below expected governance standards".*[18]

10. Adherence to Local and National Policy and Procedure. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"There is a clear policy governing the management of referral which has been ratified by the Access Integrated Governance Team. Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type".*[19]

11. Management of the Clinical Care and Treatment of Mr. Z. Overall the care and treatment provided by the West Access Team was of a poor standard. The Independent Investigation did not however find any contributory (save those already found by the Trust Internal Investigation Team) or causal factors linked to the killing of Mr. X as no links could be made linking any abnormality of mind Mr. Z may have been suffering from at the time and the killing of his victim.

12. Clinical Governance and Performance.

The thematic issues were also checked against the requirements of the Terms of Reference and are explored in depth in section 12 below. The internal investigation was of a high standard and this Investigation has been able to build upon it. The quality of the internal investigation is notable.

17. Trust Internal Investigation Report P. 6
18. Trust Internal Investigation Report P. 6
19. Trust Internal Investigation Report P. 6

12. Further Exploration and Identification of Contributory Factors and Service Issues

In its simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'five whys' could look like this:

- serious incident reported = serious injury to limb;
- immediate cause = wrong limb operated upon (ask why?);
- wrong limb marked (ask why?);
- notes had an error in them (ask why?);
- clinical notes were temporary and incomplete (ask why?);
- original notes had been mislaid (ask why?);
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. If it was applied to Mr. Z it would look like this:

- Mr. Z killed Mr. X (ask why?)
- Because he had an argument with Mr. X and killed him as a result.

A root cause is an initiating cause of a causal chain which leads to an outcome, in this case the death of Mr. X. In order for causality to be attributed to a service it has to be shown that the service had complete control over the outcome of the events in question.

The purpose of using root cause analysis is to seek out lessons that can be learned from the examination of a single case to try to establish how incidents of this kind can be prevented from occurring in the future. No Investigation Team should endeavour beyond a sensible limit to make connections where they cannot reasonably be made.

This Investigation has developed a detailed narrative which chronicles the events that occurred during Mr. Z's time with Brighton-based services. It has assessed whether services worked in accordance with extant national and local best practice guidance and detailed where interventions could have been improved.

RCA Third Stage

This section of the report examines all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key contributory and service issue factors.

In the interests of clarity each thematic issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'causal

factor', 'influencing factor' and 'service issue' are used in this section of the report. They are explained below.

Contributory factors can be identified as either being 'influencing' or 'causal'.

Contributory Factors (Causal). In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide perpetrated by them. The term 'causal factor' is used to describe an act or omission that is concluded to have had a direct causal bearing upon the failure to manage a service user effectively and that this as a consequence impacted directly upon an incident occurring. No causal factors were found by this Investigation.

Contributory Factors (Influencing). The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown of Mr. Z's mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors of an influencing kind are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide perpetrated by a third party.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Mr. X need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

Findings

The findings set out in this section analyse the care and treatment given to Mr. Z by the Sussex Partnership NHS Foundation Trust between 21 April 2010 and the 15 July 2010. Sections 12.1.1. and 12.1.2. address diagnostic, medication and treatment issues. These are key headings from the Terms of Reference and are addressed first in order to provide a context for the rest of the findings.

The care and treatment Mr. Z received was provided by the West Access Team. The Trust internal investigation report provided the following very useful information.
"Access Teams are primary care focused mental health teams that provide a range of time-limited interventions for people with mild to moderate mental health difficulties. They also provide improved access to Psychological Therapy (IAPT) services and offer a single point of

access into Sussex Partnership mental health services for people suffering from a wide range of mental health difficulties. In addition, Access Teams provide advice and support to General Practitioners and professionals working in other services, e.g. Police, Children's Services, Non-Statutory Agencies.

Access Services were established in Brighton and Hove in November 2007 and were in response to needs identified in a range of national policy documents including:

- *Layard R (2004) Mental Health: Britain's Biggest Social Problem*
- *National Institute for Clinical Excellence (2004a) Depression: Management of Depression in Primary and Secondary care. London. NICE (Clinical Guideline 23)*
- *National Institute for Clinical Excellence (2004b) Anxiety: Management of Anxiety (Panic Disorder, with or without Agoraphobia and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care. London. NICE (Clinical Guideline 22)*
- *National Institute for Mental Health England (NIMHE) (2005) Improving Access to Psychological Therapies. London: NIMHE*

Composition of Team

Access Teams are comprised of the following professionals:

- *Access Practitioners (Nurses, Occupational Therapists and Social Worker), CBT [Cognitive Behaviour Therapist] Therapists*
- *Primary Care Counsellors, Psychological Well-being Practitioners, Psychologists, Psychiatrists and Group Leaders*
- *Each team is supported by admin staff and is managed by an Integrated Team Manger supported by a Clinical Lead*

Assessments

Access Teams provide different types of assessments for referrals with different levels of priority. They provide an emergency/4-hour response to crisis referrals. There is a clear protocol in place within Access services detailing how these emergency referrals should be managed within the duty system. Referral should be conducted face-to-face and be detailed and comprehensive. Access Services also provide comprehensive assessments for people referred as priority and these people are assessed within five days of referral. Routine referrals are managed according to the stepped care principles that underpin primary care mental health services in general. These initial assessments tend to be brief screening assessments that aim to direct people efficiently and accurately to the interventions that they require.

Interventions

Access Teams provide short interventions for people who are experiencing common mental health problems (e.g. mild to moderate depression and/or anxiety) and onward referral for people who have more complex presentations. In order to do this access services are informed by a stepped model of care. Access Teams offer a range of interventions drawn from the following areas:

- *Cognitive Behavioural Therapy (CBT)*
- *Brief Solution Focused Therapy*
- *Workshops for anxiety*
- *Low intensity psychological interventions including guided self-help, CCBT, signposting and psychoeducation*
- *Psychiatric consultation (including medication review)*
- *Assessment of mental health need and risk screening*
- *Other psychological therapies including IPT, DIT and counselling".*

12.1.1. Diagnosis

12.1.1.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, mental state examination and observation.

The process of reaching a diagnosis can be assisted by a manual known as ICD 10.The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (tenth revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

12.1.1.2. Findings

Findings of the Trust Internal Investigation

This aspect was not assessed by the Trust internal investigation team.

Findings of the Independent Investigation Team

Management of the Diagnostic Issues within the Trust

This is a case where no firm diagnosis was ever made because the patient was only actually seen face-to-face on one occasion for screening, even though he had been seen twice by his GP regarding significant mental health difficulties both visits leading to urgent referrals to mental health services. There is plenty of data available to suggest that Mr. Z's mental condition amply justified a more comprehensive assessment, as the GP would appear to have felt, but there was both a system failure (as will be discussed in the section which follows) and a lack of sophistication in thinking associated with the assessment on the part of the West Access Team Worker (CPN 1) who did see him on that one occasion.

The referral from the GP dated 21 April 2010 mentioned that Mr. Z was living at his father's home, after being released from prison a few weeks earlier, and describes *"significant problems with anger, irritability and mood swings. He also feels paranoid that people are after him, especially when out in public places…. He has no suicidal thoughts but his father describes self-harm in the form of cutting. He is however very impulsive and stormed out of the consultation today"*. The GP also mentioned in the referral letter *"he suffered abuse as a child when his mother's ex-partner tried to drown him age 5. He had a lot of counselling after this which did not help. His father is extremely worried about his behaviour, and in particular the mood swings and irritability".*

Following the GP referral being made Mr. Z telephoned the West Access Team on 27 April 2010 and it was recorded that *"he wants an appointment but is worried that he won't be able to handle being here and said that he is likely to walk out. Is currently on probation having been released from prison approx. 6 weeks ago… feels he has been depressed for years now, feels agitated and 'paranoid' when out and about, can't bear anyone walking behind him, has to slow down to let them pass…states in the last couple of weeks he has been involved in fights and has enemies in Brighton. …walked out of GP Surgery during consultation because 'it was getting too heavy' and father said he was suicidal".*

Mr. Z was seen for initial screening by the West Access Team on 28 April 2010. Under 'presenting problem' it was recorded *"denies any problem with anger 'it's just that people irritate me with their questions'"* (Mr. Z had marked the item 'becoming easily annoyed or irritable' on the GAD-7 'nearly every day' (max. score)). It was recorded *"can't specify what kind of help he needs or is willing to have now".* No mention was made of Mr. Z's paranoid feelings in public places, mentioned both in the GP referral and the record of the more recent telephone call. Mr. Z admitted self medicating with Valium (presumably bought on the street) and it was recorded that he was just out of prison (robbery and Actual Bodily Harm (ABH)) and that he had undergone anger management whilst detained.

The initial screening form compiled by the Community Psychiatric Nurse (CPN 1) did not have space for a provisional diagnosis. It is to be noted that in the section 'risk indicator tools' what might have proved to be the crucial element 'harm to others' is the only element left blank, even though it had already been recorded by the assessor that he had just served a

sentence for robbery and ABH and Mr. Z had disclosed to both his GP and during his telephone call that recently he had been getting into fights. If that item had been marked with a 'yes' it would have (according to the extant West Access Team protocol) automatically triggered a full CPA Level 1 risk assessment and possible referral to acute secondary care services. Instead Mr. Z was offered counselling and serotonin-specific reuptake inhibitor (SSRI) antidepressants were suggested. He declined the former but, it transpired, did go to his GP and accept medication.

Another partner in the GP practice re-referred Mr. Z to mental health services on 16 June 2010. This urgent referral mentioned that he had stopped Sertraline after two months of good compliance because it wasn't helping. Mr. Z described symptoms of social anxiety and agoraphobia. The letter also stated *"he does describe reckless behaviour and acknowledges that he doesn't care whether he is alive or dead. He used to attend his appointments wearing a bullet proof vest because of concerns related to people he had met in prison that he felt were after him".*

Mr. Z was contacted by telephone on 17 June 2010 by a member of the West Access Team. Mr. Z was irritable and annoyed that he would have to wait to be seen by a West Access duty worker the following week, at which point he hung up. A letter, copied to the GP was sent that day to Mr. Z stating *"before offering you an appointment we would like to know if you still wish to be seen. If you do, please ring (clinic number) within the next week. If we do not hear from you by 24 June we will presume you are no longer in need of an appointment…".*

A week later a note was entered in Mr. Z's file dated 24 June 2010 *"...no contact made by patient within two weeks after opt-in letter was sent. Now discharged".* On 15 July 2010 Mr. Z telephoned the West Access Team wanting to know who he had seen before and asking if he could come and see a psychiatrist because of continuing anxieties. He said he was feeling too anxious to go and see his GP. He was told that he should go to his GP to get a new referral. He committed the index offence on 4 September 2010 and was arrested and charged with murder on 8 September 2010.

The statement provided by CPN 1 dated 23 September 2010 contained in the papers for the Trust internal investigation report adds little. She stated *"the purpose of the meeting was to discuss his situation and find out what could be helpful for him in the future".* In other words there is no mention of making a diagnosis. Reference is made to Mr. Z's distractibility and the unusual fact that he remained standing by a window throughout the assessment.

At interview with the Independent Investigation Team CPN 1 was asked *"his GP was pretty worried and was talking about his anger, and you have picked up that he can get quite angry. You witnessed that he was quite agitated; he is (also) self-medicating. Did you think about a serious mental illness and maybe involving an early intervention team or something?"* Answer: *"No, he didn't come across like psychotic or anything like that; he wasn't addressing those kinds of risk issues that would make me refer him on to the crisis team for example".*

The CPN was also asked *"had you in your mind formed any kind of formulation about what might be this guy's problem?"* The reply was *"in my mind I thought 'He has just been out of prison for a few weeks' and he was getting back into society, really, and getting things settled accommodation-wise and his activities and all that. That is the impression he gave me".*

Mr. Z was judged to be suffering from a situational reaction, suitable for 'opt-in' rather than in need of a more in depth assessment. As a consequence no referral for a psychiatric opinion was made and no diagnosis formulated.

12.1.1.3. Conclusion

It is not a task of an Independent Investigation Team to provide a working diagnosis for the service user under review during the course of its work. However it is an appropriate task to consider whether the absence of a diagnostic formulation was of significance or not, or whether it constitutes a departure from good practice. In the case of Mr. Z the conclusion of the Independent Investigation Team was that Mr. Z's referral data and presentation required a psychiatric referral and psychiatric medical assessment.

In terms of diagnosis, the following facts were known by the West Access Team. Mr. Z had:

- a history of severe emotional abuse as a child followed by treatment from child and adolescent services with limited apparent benefit;
- a history of antisocial behaviour (known convictions for robbery and ABH) and was self-reporting acts of violence as he was getting into fights;
- some evidence of self-medication with Valium and cannabis;
- a long-standing low grade mood disorder, not responsive to antidepressants, with recent increased irritability;
- presented with evidence of previous and current self-harm;
- frank paranoid beliefs, more than transitory, which were affecting his behaviour (socially phobic and wearing bullet-proof vest on occasions);
- raised a significant level of concern at his GP Surgery leading to two urgent referrals being made.

On this basis alone a presumptive diagnosis of borderline personality disorder could have be considered, although it would have been important to have a medical assessment, with a view to a trial of low dose antipsychotic medication to reduce his anxiety levels. This condition is notoriously difficult to treat effectively, however there was some evidence that Mr. Z actively wanted help, even if his motivation was variable (this would be entirely consistent with this diagnosis in a young person).

At the time Mr. Z received his care and treatment from the West Access Service a full-time Psychiatrist was embedded within the team. Psychiatric assessments could be accessed if it was deemed to be required.

We heard from a senior clinical witness during interview that at the time Mr. Z received his care and treatment the Duty urgent referral process into mental health services was held by

the Access Service. This Investigation heard that at this time there was confusion within the system as to how 'urgent', 'priority' and 'emergency' referrals should be managed, by which service and within what timescales. We were told by a Senior Manager that *"One of the challenges in the old access service was we'd constructed a service to manage both clinical need but also waiting time targets, …we used to do twenty-minute screening assessment slots; because of the numbers we were doing these screening assessments".* This same Senior Manager also told us about a conversation that he had held with CPN 1 following the killing of Mr. X *"Even though she felt that she should have completed the full risk assessment – and she learnt from this – the time slot didn't allow for that".* This particular incident (the killing of Mr. X) was seen as confirmation that changes needed to be made to the current system in as far that the *"tick box"* quick screening process adopted for people deemed suitable for primary care interventions did not always ensure a more in-depth clinical assessment for more complex cases and the timely referral for secondary care intervention. The service was closed on the 31 May 2012 and replaced with a primary care-based Wellbeing Service.

At the present time all referrals come through to the Secondary Care Assessment and Treatment Service, often with clinician-to-clinician discussion, but always with a multi-disciplinary triage meeting at which all professionals are represented. The referral is discussed and the decision reached as to whether or not it will be directed straight to psychology, for example, or to a consultant psychiatrist, for a comprehensive assessment.

Whilst this Investigation could not establish any causal links between the lack of formal diagnostic processes deployed in the care and treatment of Mr. Z and the killing of Mr. X, it could be established, with the agreement of many of the clinical witnesses interviewed, that Mr. Z's presentation required a more in-depth assessment period that could have benefitted from a medical opinion and diagnostic formulation. Whilst the omission to provide a diagnosis may have compromised the quality of the care and treatment offered to Mr. Z it could not be found to have made a significant contribution, or to have been a causal factor in the killing of Mr. X. The Independent Investigation Team concluded that the omission to provide a diagnosis in the light of Mr. Z's presentation was a service issue however the evidence provided to the Investigation Team was strongly suggestive of the current service having been modernised and that such an omission would be less likely to happen again in similar circumstances.

- ***Service Issue One. The service in operation at the time Mr. Z was receiving his care and treatment was not always conducive to the development of robust clinical assessments due to both time pressures and inherent difficulties with the model. This was to have implications when providing a diagnostic formulation and any subsequent care, medication and treatment package.***

12.1.2. Medication and Treatment

12.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (for example cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers. Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

In prescribing medication there are a number of factors that the prescriber must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

Consent is defined as '*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent'* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act under a Treatment Order (Section 3 or 37), medication may be administered without the patient's consent for a period of up to three months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time? Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly/monthly. Depot medication can be particularly useful for those patients who

refuse to take the medication that is necessary for the treatment of their mental disorder, and/ or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and therefore a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia (restlessness) and dystonia (involuntary muscle movements). Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

Sertraline

Sertraline is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. Sertraline is primarily prescribed for major depressive disorders in adults as well as obsessive-compulsive behaviour, panic, and social anxiety disorders in both adults and children. In the early stages of treatment Sertraline can intensify feelings of anxiety and depression.[20]

Diazepam/Valium

Diazepam is a benzodiazepine drug. It is prescribed principally to treat anxiety, panic attacks, insomnia, seizures (including *status epilepticus*) and muscle spasms. Adverse effects of diazepam include anterograde amnesia (especially at higher doses) and sedation, as well as paradoxical effects such as excitement, rage or worsening of seizures in epileptics. Benzodiazepines also can cause or worsen depression. Long-term effects of benzodiazepines such as diazepam include tolerance, benzodiazepine dependence and benzodiazepine withdrawal syndrome upon dose reduction. Diazepam is a drug of potential abuse and can cause serious problems of addiction and as a result is scheduled. Sometimes, it is used by stimulant users to 'come down' and sleep and to help control the urge to overeat.

Cannabis

Cannabis is a popular recreational drug around the world, illegal in this country. Primary psychoactive effects include a state of relaxation, and to a lesser degree, euphoria from its main psychoactive compound.

The effects (taken from NHS Choices Website)

"The effects of cannabis vary:

- *Some people may feel chilled out, relaxed and happy, while others have one puff and feel sick.*
- *Others get the giggles and may become talkative.*
- *Hunger pangs are common and are known as 'getting the munchies'.*

20. http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Anxiety&medicine=sertraline&preparation=Sertraline%2050mg%20tablets

- *Users may become more aware of their senses or feel that time is slowing down. These feelings are due to its hallucinogenic effects.*
- *A stronger joint (typically when skunk or sinsemilla is used) may have more powerful effects. Some users may moderate these effects by using less cannabis. Others may find it becomes tempting to binge smoke.*

Risks (taken from NHS Choices Website)

The following risks are associated with cannabis use:

- *Even hard-core smokers can become anxious, panicky, suspicious or paranoid.*
- *Cannabis affects your co-ordination, which is one of the reasons why drug driving, like drink driving, is illegal.*
- *Some people think cannabis is harmless because it's a plant, but it isn't harmless. Cannabis, like tobacco, has lots of chemical 'nasties', which, with long-term or heavy use, can cause lung disease and possibly cancer. The risk is greater because cannabis is often mixed with tobacco and smoked without a filter. It can also make asthma worse, and cause wheezing in people without asthma.*
- *Cannabis itself can affect many different systems in the body, including the heart. It increases the heart rate and can affect blood pressure.*
- *If you have a history of mental health problems, taking cannabis is not a good idea. It can cause paranoia in the short term, but in those with a pre-existing psychotic illness, such as schizophrenia, it can contribute to relapse.*
- *If you use cannabis and have a family background of mental illness, such as schizophrenia, you may be at increased risk of developing a psychotic illness.*
- *It is reported that frequent use of cannabis can cut a man's sperm count and reduce sperm motility. It can suppress ovulation in women and so may affect fertility.*
- *If you're pregnant, smoking cannabis frequently may increase the risk of the baby being born smaller than expected.*
- *Regular, heavy use of cannabis makes it difficult to learn and concentrate. Some people begin to feel tired all the time and can't seem to get motivated.*
- *Some users buy strong herbal cannabis (also known as skunk) to get 'a bigger high'. Unpleasant reactions can be more powerful when you use strong cannabis, and it is possible that using strong cannabis repeatedly could increase the risk of harmful effects such as dependence or developing mental health problems".*[21]

Zopiclone

As Zopiclone is sedating it is marketed as a sleeping pill. It works by causing a depression or tranquilization of the central nervous system. After prolonged use the body can become accustomed to the effects of Zopiclone. When the dose is then reduced or the drug is stopped, withdrawal symptoms may result. These can include a range of symptoms similar to those of benzodiazepine withdrawal.

21.http://www.nhs.uk/Livewell/drugs/Pages/Cannabisdangers.aspx

12.1.2.2. Findings

Findings of the Trust Internal Investigation

This aspect was not assessed by the Trust internal investigation team.

Findings of the Independent Investigation Team

Medication

When Mr. Z was seen by CPN 1 at the West Access Team base on the 28 April 2010 it was suggested by her that a SSRI antidepressant might be helpful to him. This was duly prescribed by the GP. On face value this appears to have been a sensible approach however it is not clear to what degree Mr. Z's self-harm in the form of cutting and his suicidal ideas (as described by his father) had been taken into account. At this stage it would have been good practice for a more detailed risk assessment to have been conducted prior to CPN 1 making this recommendation to the GP. This is because Sertraline is also paradoxically known to increase the effects of anxiety and depression in some people and is not advised for those with suicidal ideation. Mr. Z had also been prescribed Zopiclone to assist with his sleeping.

Of concern to this Investigation was the fact that Mr. Z mentioned the use of non-prescribed Diazepam and cannabis to CPN 1. It is generally well known that people with mental health problems often self-medicate to alleviate their symptoms. Unfortunately this self-medication regimen can often exacerbate the very symptoms the service user is attempting to improve. Mr. Z's self-medication regimen was not explored by the CPN and neither was it thought by her to add an additional layer of complexity to his presentation which would require a more in-depth level of assessment.

Treatment

When Mr. Z was seen by the West Access Team on the 28 April 2010 he was unable to articulate the kind of help that he was hoping to receive. Mr. Z told CPN 1 he would be able to manage as long as he continued with his self-medication regimen. Mr. Z was offered counselling which he refused. Consequently Mr. Z was referred back to his GP and given some information leaflets about medication.

On the 17 June 2010 a second urgent GP referral was received at the West Access Team. Mr. Z continued to present with the same problems. When he was telephoned by the Team so that an appointment could be made he was upset that he could not be seen immediately and did not want to wait several days. This led to Mr. Z ending the telephone call. In the event Mr. Z's case was closed on the 24 June as he did not contact the Team to arrange an appointment.

On the 15 July 2010 Mr. Z telephoned the West Access Team. Mr. Z wanted to know who it was that he had seen previously. Mr. Z said he had trouble with crowds and that he found it difficult to visit the GP due to anxiety and depression. Mr. Z wanted to be signed off work and to see a psychiatrist. He was told that he would need the GP to re-refer him. In the clinical record Mr. Z was described as being *"ok"* with this.[22]

22. Clinical Record P. 25

On two occasions the results of PHQ9 assessments were recorded within Mr. Z's clinical notes. The first following the assessment conducted by CPN 1 at the West Access Team on the 28 April 2010 and the second following a consultation with Mr. Z by the GP on the 17 June 2010. On the 28 April 2010 Mr. Z was assessed as having a score of 17 which indicated moderately severe depression. On the 17 June 2010 Mr. Z was assessed as having a score of 21 which indicated severe depression. Practice guidance for either score would indicate that psychotherapy should be considered and that referral to a psychiatrist for consultation and management (especially when a score exceeds 20) should be expedited. Based upon the outcome of these assessments alone there was an indication that Mr. Z required clinical intervention over and beyond that which his GP alone could provide.

12.1.2.3. Conclusion

The Independent Investigation Team concluded that Mr. Z was probably highly ambivalent about receiving assessment, care and treatment from the West Access Team. It would appear that this initial ambivalence led the team to take its cue as to how to proceed from what Mr. Z said to them alone rather than by observing his presentation, reading through the issues raised by his two GPs and assessing his mental state. This lack of assessment meant that no meaningful decision could be made in relation to Mr. Z's mental state, needs, risk or level of required intervention. It is important to note that Mr. Z was not only presenting with the symptoms of depression, but also symptoms of paranoia, anxiety, phobia, agoraphobia, and a self report of substance misuse.

It is always problematic trying to recommend medication in the absence of a diagnosis and/or a sufficiently robust clinical assessment and mental state examination. However the Independent Investigation Team understands that the GP would have been able to ensure the safety of Mr. Z prior to the Sertraline being prescribed and that the GP Practice continued to monitor and work with him.

It is obviously difficult trying to come to any significant level of conclusion considering Mr. Z was seen only once by the West Access Team. However it can be said that Mr. Z's mental state should have received a more in-depth assessment and that the complexity of his presentation should have been given greater consideration prior to medication being recommended and any discharge considered, either on the 28 April or on the 24 June 2010. By the 15 July Mr. Z realised that he needed help from mental health services as his situation appeared to be deteriorating. However he was not able to get support and treatment as his case appeared to fall outside of the referral system as operated by the West Access Team preventing him at this stage from accessing services.

The Independent Investigation Team, whilst acknowledging that Mr. Z's case was not managed in an optimum manner, did not find that the issues were either contributory or causal in the killing of Mr. X. The reader is asked to refer to Service issue One.

12.1.3. Use of the Mental Health Act (1983 & 2007)

12.1.3.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

At any one time there are up to 15,000 people detained by the Mental Health Act. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[23]

12.1.3.2. Findings and Conclusions

Any Independent Investigation that is trying to understand the appropriateness and effectiveness of services offered to a mental health service in relation to a homicide perpetrated by them must consider the powers made available by the Mental Health Act (1983 & 2007) and the proper application of them.

It was evident to the Independent Investigation Team that during the two times Mr. Z was referred to the West Access Team he did not meet the criteria to be detained under any Section of the Act. No service issues, contributory or casual factors were found.

12.1.4. The Care Programme Approach (CPA)

12.1.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.[24] Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach.*[25]

23. Mental Health Act Commission 12th Biennial Report. 2005-2007
24.The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990
25.Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

"*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services"* (Building Bridges: DoH 1995).[26]

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and to maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long-term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient;
  - to monitor that the agreed programme of care remains relevant; and
  - to take immediate action if it is not;
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

Sussex Partnership NHS Foundation Trust CPA Policy (in place at the time)

Trust CPA Policy

The Sussex Partnership NHS Foundation Trust CPA policy references and echoes the Department of Health guidance. The policy identifies that *"The CPA will be applicable to all adults and older people with mental health problems who have complex needs and are in contact with the secondary mental health system. Its principles may equally apply to those adults with less complex needs".*

26.Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

In identifying who should be cared for under the CPA protocol the Trust policy quotes *Refocusing the Care Programme Approach.*

"Characteristics to consider when deciding if support of CPA is needed:

- *Severe mental disorder (including Personality Disorder) with a high degree of clinical complexity;*
- *Current or potential risk(s), including:*
  - *Suicide, self-harm, harm to others (including history of offending);*
  - *Relapse history requiring urgent response;*
  - *Self-neglect/non-concordance with treatment plan;*
  - *Vulnerable adult; adult/child protection e.g. exploitation e.g. financial/sexual;*
  - *Financial difficulties related to mental illness;*
  - *Disinhibition;*
  - *Physical/emotional abuse;*
  - *Cognitive impairment;*
  - *Child protection issues.*
- *Current or significant history of severe distress/instability or disengagement;*
- *Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability;*
- *Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies;*
- *Currently/recently detained under Mental Health Act or referred to Crisis/Home Treatment team;*
- *Significant reliance on carer(s) or has own significant caring responsibilities;*
- *Experiencing disadvantage or difficulty as a result of:*
  - *Parenting responsibilities;*
  - *Physical health problems/disability;*
  - *Unsettled accommodation/housing issues;*
  - *Employment issues when mentally ill;*
  - *Significant impairment of function due to mental illness;*
  - *Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues."*

The policy then goes on to identify the similarities and differences between service responses for those needing care under CPA and those receiving standard care. The policy states that service users requiring CPA are characterised by having complex needs, multi-agency input, and presenting higher levels of risk; while those not requiring care under this protocol have more straightforward needs, receive care from one agency or experience no problems with accessing other agencies and/or support services, and present a lower level of risk.

For those service users on standard care the policy comments:
"What the service users should expect:

- *Support from professional(s) as part of clinical/ practitioner role. Lead practitioner identified;*

- *Service user self-directed care, with support;*
- *A full assessment of need for clinical care and treatment, including risk assessment;*
- *An assessment of social care needs against FACS eligibility criteria (plus Direct Payments);*
- *Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter);*
- *On-going review as required but at least annually;*
- *On-going consideration of need for move to CPA if risk or circumstances change;*
- *Self-directed care, with some support if necessary;*
- *Carers identified and informed of rights to own assessment".*

The policy indicated that those not receiving care and treatment under the CPA protocol will have a 'Lead Practitioner' rather than a Care Co-Ordinator. *"The Lead Practitioner has responsibility for facilitating the delivery of care to the service user who has been identified as having straightforward needs so does not require the more formal approach of CPA. They are likely to only have contact with one agency and this will be the person identified as being most appropriate from that agency".*

12.1.4.2. Findings

Findings of the Trust Internal Investigation

This aspect was not assessed by the Trust internal investigation team.

Findings of the Independent Investigation Team

Due to the brevity of contact with secondary care services it was not possible to assess the CPA process Mr. Z was subject to. However it is the finding of the Independent Investigation Team that Mr. Z's history and presentation met the criteria for being considered for full CPA. There were a significant number of matches between Mr. Z's presentation and history and the Sussex Partnership NHS Foundation Trust CPA Policy criteria in place at the time. The salient factors are set out below.

1. The CPA policy stated that people with severe mental disorders (including Personality Disorders) should be considered for full CPA. Mr. Z was referred principally for depression and anxiety. However he was also describing thoughts and behaviours that could have been the result of paranoia. This merited further assessment and investigation considering his age.
2. The CPA policy stated that people with current or potential risks should be considered for full CPA. These risks included suicide, self-harm and harm to others (including a history of offending). Mr. Z was self-harming (cutting himself) at the time of his first referral and his father had voiced fears that his son was suicidal. Mr. Z was also known to have a history of perpetrating Actual Bodily Harm for which he had received a conviction and a period of imprisonment, during this time he had received

anger management interventions. Mr. Z was also noted to be angry and irritable and getting into fights.[27]

3. The CPA policy stated that people with current and significant levels of distress/instability should be considered. Mr. Z was described by his GPs at the time of both referrals as being anxious, paranoid when in public places, impulsive and suffering from mood swings.[28]
4. The CPA policy stated that the presence of a non-physical co-morbidity such as substance misuse and prescription drug misuse should be considered. It was known that Mr. Z was abusing cannabis and self-medicating with Diazepam.[29]
5. The CPA policy also stated that multiple service provision from different agencies including the Criminal Justice System was an indicator that full CPA should be considered. At the time Mr. Z received his screening from the West Access Team it was known that he had been recently released from prison. There appeared to have been no curiosity shown as to whether Mr. Z was currently under the aegis of the Probation Service. This should have been a key component of the Initial screening process.

It would appear that when asked at interview the West Access Team and CPN 1 were not aware of the content of the Trust CPA policy and did not choose to consider it when assessing and triaging service users.

12.1.4.3. Conclusions

The Independent Investigation Team concluded that not considering Mr. Z for full CPA was a significant omission on the part of the West Access Team generally and CPN 1 in particular. Mr. Z presented in a complex manner and met the criteria for full CPA. Had the initial screening been conducted in accordance with extant Trust policy, and based on what was known about Mr. Z at the time, then it could reasonably have been expected for him to have been referred directly to the West Access Team Psychiatrist and/or secondary care services with immediate effect.

It is unclear why this omission occurred. In mitigation this Investigation heard from clinical witnesses that the West Access Team was under significant pressures and had to process in excess of 800 referrals a year. This workload contributed to superficial assessments being made within very tight time constraints. However based upon what was known about Mr. Z at the time of the referral, and the subsequent screening assessment, it would appear that he met the criteria for full CPA and this should have been progressed in a timely manner in keeping with Trust policy expectation.

The Independent Investigation Team concluded that whilst the omission to consider Mr. Z for CPA did not constitute a causal or contributory factor in the killing of Mr. X, it did constitute a service issue in that the poor management of Mr. Z's care and treatment probably ensured

27. Clinical Records PP. 7-11
28. Clinical Record P. 4
29. Clinical records PP. 7-11

that he continued in a state of distress without the level of assessment, care and treatment that he required. Whether Mr. Z would have ultimately been accepted onto the secondary care caseload is something we cannot assume as no further attempt to assess this individual was made, however it is the conclusion of the Independent Investigation Team that it was clinically indicated that Mr. Z should have been graduated through the system for a full clinical assessment and mental state examination whereupon a decision regarding a future care and treatment approach could have been agreed in a systematic manner.

- ***Service Issue Two. Mr. Z's presentation was such that at the time of his referral to, and assessment by, the West Access Team he should have been considered eligible for full CPA. The failure to ensure that this was considered meant that Mr. Z continued in a state of distress necessitating a second urgent GP referral.***

12.1.5. Risk Assessment

12.1.5.1. Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and / or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service users' past and current clinical presentation to allow an informed professional opinion about assisting the service users' recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that *"positive risk management as part of a carefully constructed plan is a desirable competence for all mental health*

practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed"*[30].

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Sussex Partnership NHS Foundation Trust Clinical Risk Policy (in place at the time)
The Sussex Partnership NHS Foundation Trust Clinical Risk Assessment and Management Policy and Procedure (2012) echoes and references much of the Best Practice Guidance.
The policy notes that:
"Risk assessment and management are an integral part of a service user's care and should be undertaken in the wider context of a holistic and recovery approach to care planning.

Risk assessments and risk management plans should involve:

- *Engagement and the building of a trusting relationship with the service user and carer*
- *Collaboration with the service user and carer*
- *Discussion and consultation with all members of the multidisciplinary team, private services, and other agencies involved in the service user's care*
- *Structured clinical (or professional) judgement supported by the best evidence and information available in order that the best decision is made at the time*
- *A stepped approach and use of agreed risk tools for each care group and service area reflecting the level of detail or speciality required".*(P.5)

The policy requires at least a risk screening to be undertaken for all service users at the point of first contact with the service. It continues:
"Service users who present risks that require more detailed investigation for effective management will have a more comprehensive risk assessment to include a formulation and a risk management plan [Level 1 or equivalent]. Service users who pose high risk/s and/or

30.Best Practice in Managing Risk; DoH; 2007

require complex management will have a multidisciplinary/multi-agency formulation and risk management plan (Level 2 or equivalent).

Level 1 comprehensive risk assessment and management plans can be completed by a single practitioner but where there is multidisciplinary (MDT) or multiagency input into the assessment or plan, this must be documented. When a level 2 risk assessment and management plan is indicated, this must reflect input from all involved and relevant parties…

…The risk assessment must be undertaken in collaboration with the service user and carer, and when this has not been possible, the rationale for not doing so must be clearly documented". (P. 6)

"Service users with identified high risk behaviours requiring further assessment to ensure effective management, will have a level 2 Multi-disciplinary (MDT)/Multi-agency (or equivalent inpatient MDT review) review of their risks (building on the comprehensive screening assessment) and MDT/Multiagency input regarding the risk management plan. This will include all service users admitted into acute/rehabilitation or secure and forensic inpatient care, and Assertive Outreach Teams". (P.10)

The policy provides the following descriptions of high medium and low risk service users:
"High Risk: This service user presents a risk of committing an act that is either planned or spontaneous, which is very likely to cause serious harm. There are few, if any, protective factors to mitigate or reduce that risk.

Medium risk: This service user is capable of causing serious harm, but in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The service user evidences the capacity to engage and occasionally, to contribute helpfully, to planned risk management strategies and may respond to treatment. This patient may become a high risk in the absence of the protective factors identified in this assessment.

Low risk: This service user may have caused, attempted or threatened serious harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. He is likely to cooperate well and contribute helpfully to risk management planning and he may respond to treatment. In all probable future scenarios in which risk might become an issue, a sufficient number of protective factors (e.g., rule adherence, good response to treatment, trusting relationships with staff) to support ongoing desistance from harmful behaviour can be identified".(P. 18)

12.1.5.2. Findings

Findings of the Internal Investigation

The 'care and service delivery problems' section of the SUI report identifies *"at the initial assessment interview conducted on 28/04/2010, the risk screening tool was not properly completed. This resulted in a failure to complete a Level 1 Risk Assessment".*[31]

The internal investigation report also stated that *"Although the member of staff who carried out the first assessment appointment described a comprehensive assessment process during heir witness statement, including a description of the treatment options discussed with the service user, this was not reflected in the written documentation about the appointment".*[32]

The report also made mention of a potential service issue in that the West Access Team conducted both comprehensive assessments for emergency and priority referrals and briefer screening assessments for routine referrals. The implication being that Mr. Z's referral may have been categorised as 'routine' rather than 'emergency' or 'priority' even though his GP had referred him as 'urgent'.[33] This confusion regarding referral categorisation will be examined in detail in section 12.1.6. below.

Findings of the Independent Investigation Team

Risk Events History

At the time of Mr. Z's first GP referral on the 21 April 2010 and of his assessment with the West Access Team on the 18 April 2010 it was known that he had been recently released from prison where he had served a sentence for Actual Bodily Harm.

Self Harm and Vulnerability

At the time of Mr. Z's first GP referral on the 21 April 2010, and of his assessment with the West Access Team on the 18 April 2010, it was known that he was cutting himself and was acting in an impulsive manner. His father was worried about him particularly in relation to his mood swings.

When Mr. Z was contacted by the West Access Team to arrange an assessment appointment it was recorded that he found it difficult going outside of his home as he was *"paranoid"* when out and about fearing the people around him. He said that whilst he was not actively suicidal he did not care whether he lived or died. It was also recorded that Mr. Z was at risk of harm due to the fights he had been involved in with his *"enemies in Brighton".*[34]

During the assessment with CPN 1 on the 28 April 2010 an 'Initial screening Form' was completed. It was recorded that Mr. Z had been recently released from prison and that he had suffered from a low mood for several years. It was also recorded that Mr. Z was self medicating with Valium/ Diazepam) and cannabis.

31. Trust Internal Investigation Report P. 5
32. Trust Internal Investigation Report P.6
33. Trust Internal Investigation Report P.6
34.Clinical Records P. 6

On the Risk Screen the following was recorded;

"Self-Harm

- *Has the person ever made any self-harm attempts?: yes*
- *Are you concerned about the person being exposed to circumstances or emotions that could trigger self-harm?: No*
- *Is the person having self-harming thoughts or fantasies?: No".*[35]

The narrative section of the Risk Screen noted that Mr. Z had a history of cutting himself in prison to get his own way and that he said he was not feeling suicidal. The assessor recorded that she did not think Mr. Z was a suicide risk. Mr. Z was not thought to be vulnerable of self neglect.

Mr. Z's PHQ9 score for depression was assessed by CPN 1 as being 17 which placed him in the moderately severe depressed range. The national guidance would indicate that a person with a score such as this should be considered for psychotherapy and should be monitored for deterioration. A referral to a Psychiatrist is also recommended for consideration.

By the 17 June when Mr. Z's GP re-referred Mr. Z to the West Access Team it was noted that Mr. Z continued with his symptoms of agoraphobia, anxiety and depression. It was noted that Mr. Z had been switched from Sertraline to Citalopram earlier in the day. Mr. Z's PHQ 9 score was 21 which placed him in the severely depressed category. The national guidance would suggest that referral to a psychiatrist would be indicated at this stage for consultation and management.[36]

Potential Risk to Others

Consistent features between 21 April 2010 (Mr. Z's first contact with his GP) and 17 June 2010 (Mr. Z's second referral to the West Access Team) were Mr. Z's impulsive behaviour and irritability. Mr. Z by his own admission was getting into fights and was self-medicating for his anger and irritability by taking Diazepam (Valium). It was also known that he had recently been released from prison for actual bodily harm. When Mr. Z was seen by CPN 1 on the 28 April the following was recorded on the Risk Screen:

"Harm to Others

- *Has the person ever engaged in episode of harm to others?: (left blank)*
- *Is there an identified intention to cause harm to others?: No".*[37]

On the 17 June 2010 Mr. Z's reckless behaviours were cited as being one of the main reasons prompting the GP referral. When he was telephoned by the West Access Team to arrange an appointment Mr. Z was noted to be angry, abusive and verbally aggressive.

35. Clinical Records P. 10
36. Clinical Records PP. 17-18
37. Clinical Records P. 10

Risk Assessments and Management Plans - Process and Procedure

The Independent Investigation Team found the Risk Screen to be incomplete. It was also a finding of this Investigation that the risk screening and assessment processes did not synthesise all of the information sufficiently in order to produce a competent and effective assessment and plan of care for Mr. Z. Had the Risk Screen tool been used in accordance with Trust policy, based upon the information held about Mr. Z, then a Level 1 Risk Assessment should have been completed. This was not done.

12.1.5.3. Conclusions

The Independent Investigation Team concurs in part with the findings of the Trust internal investigation in that the risk assessment documentation was of a poor standard and that a Level 1 assessment was indicated. However the Independent Investigation Team concluded that this was not simply a matter of poor recording techniques, and when taking all of the evidence made available during the course of its work, decided that Mr. Z was subject to an inadequate level of clinical assessment by the West Access Team which did not synthesise everything that was known about Mr. Z in a systematic and evidence-based manner. This was a serious omission which whilst does not comprise a causal or contributory factor in relation to the killing of Mr. X does constitute a service issue in relation to the poor management of Mr. Z's care and treatment.

The risk assessment process appears to have been a 'tick box' method which did not address what was known about Mr. Z and did not lead to a formulation of risk being made. The risk assessment process was not in keeping with national or local policy and guidance and fell short of the standard to be expected from either a primary or secondary care provider.

Two urgent referrals were made by primary care to secondary care services. It was known that Mr. Z:

(28 April 2010)

- was self-harming;
- was self-medicating with Diazepam and cannabis;
- was angry and impulsive and had a history of violence;
- had recently been released from prison;
- was paranoid and at risk of getting into fights;
- was depressed;
- found it difficult to go outside without his father.

Despite this profile Mr. Z received a rudimentary assessment and was discharged back to the care of the GP.

(June 2010)

- Mr. Z was becoming increasingly reckless;
- Mr. Z was described as not caring whether he lived or died;
- Mr. Z was also agitated and aggressive.

Despite this on the 24 June 2010 when he did not book in for an appointment he was discharged from the service within seven days (and not the two-week interval as recommended within the policy). Mr. Z presented with a substantial risk both to himself and to others. Without a robust assessment of his mental state, based on what was known about him at the time, it was poor practice to provide Mr. Z with such a rudimentary service. It is difficult to see how the interventions offered by the West Access Team added to the value of Mr. Z's care as the basic processes deployed by the Mental Health Service Provider could have been undertaken at the same, or better, level within the GP Practice.

- ***Service Issue Three. The failure to conduct a professional level of clinical and risk assessment was a significant omission. Based upon what was known about Mr. Z in conjunction with his presentation, and concerns raised by the GP practice and his father, a robust clinical and risk assessment process should have been deployed in order to inform the management of Mr. Z in a systematic and evidence-based manner.***

12.1.6. Referral, Transfer and Discharge

12.1.6.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

12.1.6.2. Findings

Findings of the Trust Internal Investigation

The Trust internal investigation found this aspect of Mr. Z's care and treatment to be the pivotal part of the lessons for learning. The most pertinent findings are given below.

"The policy governing processes for managing urgent referrals was not implemented satisfactorily, particularly the process that calls for 'liaising with the GP where appropriate'. Given the concerns expressed by the GP in the second referral, and given the negative response to the offer of an assessment appointment from the patient, a discussion with the GP who had made an urgent referral would have been appropriate. It is acknowledged that it is not the purpose or function of Access teams to proactively try to engage with service users who do not want to engage. However, by contacting his GP, the GP could have made a decision about whether they wanted to refer the person to a service that does have that mandate to actively engage service users…

…The current Trust policy is not consistent in its terminology in relation to different types of assessment. Trust documents refer to Urgent (requiring the referred person to be seen within

four hours) Priority (requiring an assessment within 5 days) and Routine (requiring a 20-day response). The terminology has been clarified in recent communications with the Brighton Integrated service. These are: 4 hours/Emergency (4-hour response), Priority/Urgent (5 working days) and Routine (20 working days)… It is not clear whether all GPs are aware of this agreement and the lack of clarity presents risks to people in need of a 4 hour emergency response…

…There seems to be gaps in understanding between the expectations of the referrer as to what would happen as a result of the referral and the understanding of the Access team as to their role. The term 'comprehensive assessment' requires some clarification within an access context so that referrers can be clear about this…".[38]

The Trust internal investigation found notable the response of the West Access Team to the first referral on 27 April 2010 in that it was prompt and that the telephone contact with patient on the 17 June 2010 represented a genuine attempt to provide him with a timely response despite the fact the Mr. Z ended the call before a second assessment appointment could be arranged.

Findings of the Independent Investigation Team

The Independent Investigation Team concurs with the findings of the Trust internal investigation report. The findings of the internal review were made particularly relevant and useful by virtue of the process deployed during the investigation in that a GP in local practice was part of the investigation and could ensure that system issues relating to referral and discharge could be examined in full.

12.1.6.3. Conclusions

Conclusions of the Trust Internal Investigation

The following lessons for learning were identified:

1. There are various inconsistencies in the terminology used around emergency, priority and routine referrals that need to be addressed.
2. All staff within the West Access Team need to be made aware of the Trust guidance around managing Priority and Emergency referrals.
3. Roles within the team in relation to the management of the duty system require clarification.

Conclusions of the Independent Investigation Team

The Independent Investigation Team has nothing to add in relation to this issue and has adopted the contributory factors as set out by the Trust internal investigation report. The contributory factors are set out below and relate to the poor management of Mr. Z's care and treatment rather than to a specific contribution relating to the death of Mr. X.

- ***Contributory Factor One. There is a clear policy governing the management of referrals which has been ratified by the Access Integrated Governance Team.***

38. Trust Internal investigation report PP. 5-6

Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type. The West Access Team management needs to address this issue as a matter of urgency and ensure that appropriate governance around the management of emergency referrals is in place.

- ***Contributory Factor Two. When the 'back up duty worker' contacted the service user by telephone to try to arrange a second face-to-face appointment with a duty worker, there may have been a blurring of the assessment function. It is certainly clear that the service user turned down the offer of a second face-to-face assessment and ended the telephone call before an appointment was set up. Given this, the decision to write to the service user to offer a further appointment seems reasonable in most circumstances given that Access do not have a remit to actively engage service users who have turned down the offer of treatment. However, the urgent nature of the referral means that the duty worker should also have contacted the GP directly to let the GP know that the service user had turned down the appointment. This would have enabled the GP to make a decision about whether any further action was required, including whether they needed to refer the service user to a service which does have the resources to actively engage people at risk.***

12.1.7. Carer Assessment and Carer Experience

12.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that *"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes"*. In particular the National Service Framework for Mental Health (Department of Health 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. Also that it will *"deliver continuity of care for a long as this is needed'*, '*offer choices which promote independence'* and '*be accessible so that help can be obtained when and where it is needed"*.

Carer involvement

The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer Recognition and Services Act (1995) gave carers a clear legal status. It also provided for carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared for person's type and level of service provision required.

Further to this, The Carers and Disabled Children Act (2000) gave local councils mandatory duties to support carers by providing services directly to them. It also gave carers the right to an assessment independent of the person they care for.

The Carers Equal Opportunities Act (2004) placed a duty on local authorities to inform carers, in certain circumstances, of their right to an assessment of their needs. Also that it facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis.
- have their own written care plan which is given to them and implemented in discussion with them.

12.1.7.2. Findings

Findings of the Trust Internal Investigation

This aspect was not assessed by the Trust internal investigation team.

Findings of the Independent Investigation Team

Mr. Z was not accepted into secondary care services and so the issue of conducting a carer assessment for his father and/or family would not have been relevant. However it would have been good practice to have considered in more detail the fact that Mr. Z's father was worried about him. It is of concern that Mr. Z's accounts of his self-harming and suicidal thinking and those of his father may not have been in accord and that Mr. Z's father's concerns could not be voiced further as an Access Team would not normally seek collateral information from family members as part of an assessment or triage process.

12.1.7.3. Conclusions

Whilst it may have been neither appropriate nor possible for the West Access Team to have sought information from Mr. Z's father, due the primary care nature of its service, it would have been good practice to have taken the father's known concerns into consideration during the assessment process. Voiced family concerns are well established indicators that service users may require additional levels of assessment and that there may be additional factors to take into account beyond any observable presentation.

12.1.8. Service User Involvement in Care Planning

12.1.8.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act (1990) stated that:

"The individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

In particular the National Service Framework for Mental Health (Department of Health 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in planning and delivery of care"*. It also stated that it will *"deliver continuity of care for as long as this is needed", "offer choices which promote independence"* and *"be accessible so that help can be obtained when and where it is needed".*

12.1.8.2. Findings

Findings of the Trust Internal Investigation

It was found as a point of notable practice that Mr. Z valued the assessment process offered to him on the 28 April 2010 and that he appears to have considered the treatment options available to him as well as the advice given.

Findings of the Independent Investigation Team

The Independent Investigation could find no evidence to support the findings of the internal investigation as nothing was brought forward to suggest this. In fact the interpretation of the findings presented to the Independent Investigation Team tended to point the Investigation away from this stance being taken.

It is important that when assessing and providing a care and treatment plan/plan of care that the service user not only appears to value a service, or intervention, but benefits positively from it where at all possible and also has an assessment conducted that is specific to individual needs and presentation.

It was evident to the Independent Investigation Team that the assessor, CPN 1, did not appreciate the relevance of the information that Mr. Z brought to the meeting. It is unclear why she ignored his recent confinement in prison, his illegal drug taking or his violence and self-harming behaviour. A sign of a successful assessment cannot be measured in feeling that the service user somehow 'valued' the approach when none of the issues that he raised and were concerned about during the meeting were explored adequately. It is a fact that Mr. Z left his assessment meeting no further along a care and treatment pathway than when he went in. This of course may have been due to his ambivalence, but then again may have been due to the relatively superficial assessment he received.

12.1.8.3. Conclusions

The Independent Investigation Team cannot state that Mr. Z did not value his assessment meeting on the 28 April 2010. However it can state that the approach taken did not appear to be person-centered and nor did it focus upon the very specific concerns and needs of Mr. Z. The intervention offered, counselling, may not have been the most way appropriate way forward for a young person with moderately severe depression, phobias and social anxiety,

paranoia, anger and self-harming issues, and illegal drug misuse. The suggestion for counselling appeared to have been 'menu selected' rather than 'person-centered'. It is apparent that leaflets were given to Mr. Z regarding SSRI medication. It is important for mental health care services to ensure that services provided are not simply 'valued' but also relevant and person-centered. In the case of Mr. Z the Independent Investigation Team was left with the impression that the assessor did not know how to approach his difficulties as they appear to have fallen outside of the range of interventions she could think to offer him.

12.1.9. Documentation and Professional Communication

12.1.9.1. Context

"Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion".[39]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone[40]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively[41]. The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

12.1.9.2. Findings

Findings of the Trust Internal Investigation

Documentation

The internal investigation report found the following:

"Although the member of staff who carried out the first assessment appointment described a comprehensive assessment process during their witness statement, including a description of the treatment options discussed with the service user, this was not reflected in the written documentation about the appointment. The written documentation falls significantly below expected governance standards. There may be a service issue here as Access Services conduct both comprehensive assessment processes for emergency and priority referrals as well as briefer screening assessments for routine referrals. Staff must ensure that their written documentation of assessments reflect the comprehensiveness of the assessment undertaken".[42]

39. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy,* (2002) P.121
40. Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999). P.144
41. Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)
42. Trust Internal Investigation Report P. 6

Professional Communication

The internal investigation report found the following:

"Poor communication with the referring GP concerning

1. *The outcome of the referral made on 17/06/10.*

2. *The patient's subsequent discharge.*

3. *The original triage process".*[43]

Findings of the Independent Investigation Team

The Independent Investigation Team concurs in full with the findings of the Trust internal investigation.

12.1.9.3. Conclusions

It is important that all health and social care professionals ensure that they record in full everything that takes place within a clinical/social care consultation. It is apparent that CPN 1, when interviewed, recalled more that took place within the consultation than was actually recorded, however the rationale for the approach taken by her, and the decisions made by her are absent, and also largely beyond her recall. This compromises the quality of clinical care for the service user and also leaves the health or social care worker vulnerable if called upon to defend actions and decisions made.

The Trust internal investigation report sets out well the issues regarding poor professional communication. It is essential that all health and social care workers liaise with referring colleagues so that they are clear what actions have been undertaken and what future actions may require to be taken. This is essential in order to maintain good working relationships, and more importantly the safety of the service user. Whilst poor documentation and communication did not constitute a causal or contributory factor in the killing of Mr. X, poor professional communication was seen as being a service issue regarding the manner in which Mr. Z's case was managed, which was not optimal. It was the conclusion of the Independent Investigation Team that the poor quality of the documentation also constituted a service issue.

- ***Service Issue Four. Poor levels of professional communication led to Mr. Z's case not receiving a timely consideration of whether or not he required a different approach being taken. This meant that his distress and mental health problems remained largely unassessed and untreated requiring a second urgent referral.***

- ***Service Issue Five. The standard of clinical documentation was of a poor standard in the case of Mr. Z and fell short of Trust policy expectations.***

43. Trust Internal Investigation Report P. 5

12.1.10. Adherence to Local and National Policy and Procedure

12.1.10.1. Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[44] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 12.1.12. below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

12.1.10.2. Findings

Findings of the Trust Internal Investigation

The internal investigation report mentioned that the following policies and processes were either implemented and/or understood poorly by the West Access Team:

1. eCPA documentation policy.
2. Access Operational Policy (with reference to referral procedures).

The findings have been explored above in detail in sections 12.1.6. and 12.1.9. of this report. It must be noted here that the Trust internal investigation cited notable practice as being the rapid initial responses made directly following each of the GPs referrals. This was good practice.

44.Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p. 328

Findings of the Independent Investigation Team
The Independent Investigation Team concurs with the findings of the Trust internal investigation. In addition we found that the Trust CPA and risk policies were not adhered to and appear to have been considered or implemented appropriately. The findings have been explored above in detail in Sections 12.1.4. and 12.1.5. of this report.

12.1.10.3. Conclusions
The Independent Investigation Team could not find any reason why policy and procedure did not appear to have considered or implemented when seen through the lens of this single case. During interviews with clinical witnesses no explanation could be given why these basic building blocks of clinical procedure were not used. Had all four of the policies and procedures identified above been utilised appropriately Mr. Z would have received a more systematic and effective assessment and it could reasonably be expected that he would have been signposted to services which could have been of assistance to him. Whilst it is possible that Mr. Z would have refused the help offered to him, this is not the point. Policy and procedure exits to ensure that an evidence-based approach is taken with all service users regardless of the care pathway they are on and the levels of engagement that they display. Failure to do this compromises the quality of the assessment, care and treatment provided and can potentially also compromise the service user's safety.

The Independent Investigation Team did not find the poor application of policy and procedure to be a causal or contributory factor in the killing of Mr. X. However it was concluded that a service issue existed regarding the application of Trust policy and procedure brought about principally by poor levels of awareness.

- ***Service Issue Six. Staff within the West Access Team appeared to have had poor levels of awareness regarding Trust policy and procedure and their obligations regarding them.***

12.1.11. Management of the Clinical Care and Treatment of Mr. Z

12.1.11.1. Context
This report subsection serves as a summary section which considers all of the Investigation findings in a way which considers their interrelationships.

12.1.11.2. Findings
It was the finding of the Independent Investigation that Team Mr. Z presented to the West Access Team in a complex manner. This level of complexity did not appear to have been understood by either the Team generally or CPN 1 specifically. The Independent Investigation Team does not wish to unduly censure the clinical activities of CPN 1. This would be neither fair nor helpful. It was evident to this Investigation that there were flaws within the system which did not support the effective assessment and management of Mr. Z.

The Service Director we interviewed told us that the Access Service was developed alongside the Trust being awarded wave-one pilot status for the IAPT (Improving Access to Psychological Therapies) programme in 2007. The service was set up as a single point of access into secondary care services for the city area of Brighton and Hove but also comprised the IAPT service. The Access Service was structured on three teams and the three teams were structured on the geography of Brighton, namely the East Access Team, the Central Access Team and the West Access Team. The staff in each team was supported by one Psychiatrist with access to junior doctor and Registrar time. The Access Teams also comprised administrators and managers, talking therapy staff, and two psychologists who were focused on providing therapies to those with severe and enduring mental ill health, and Cognitive Behaviour Therapy therapists under the IAPT programme. It also comprised several psychodynamic counsellors.

The main referrers were GPs and the Trust Access Service received on average about 800 referrals a month of a very diverse kind (in relation to severity). This ensured that the West Access Team Service had to process on average 65 referrals each week as well as ensuring the ongoing treatment and management of service users on the caseload. At the time Mr. Z was referred the team comprised some 30-40 individuals.

Nurse assessors and practitioners were also part of the Access Teams. Prior to the inception of the service in 2007 the nurses had been aligned closely to GP practices. When the Access Service was created this staff group was drawn back into the teams. What that created was an immediate dissonance between the referrer making the referral for large numbers of people with a variety of needs and a disconnection between managing capacity within GP practices. There were significant levels of pressure to meet referral targets and also a great deal of dissatisfaction in that they were not always being met. The high level of dissatisfaction in the service led to its closure on 31 May 2012. The Serious Untoward Incident relating to Mr. Z served to focus concerns that were already present regarding the service.

At the time Mr. Z was referred to the Access Service, initial screening assessments only allowed for a 20 minute consultation due to the pressures generated by so many referrals. This meant that level 1 risk assessments were not conducted even though they might have been indicated.

The Independent Investigation Team also heard that the West Access Team found it very difficult to refer service users onto a secondary care service pathway, particularly if alcohol or substance misuse formed part of the presentation.

Set against the intense pressures that the West Access Team was experiencing it was the finding of the Independent Investigation Team that practitioners were working within a system under intense pressure which ran counter to the application of good clinical practice. This was to compromise the quality of clinical assessment, professional communication and policy adherence.

12.1.11.3. Conclusions

Overall the care and treatment provided by the West Access Team was of a poor standard. The Investigation did not however find any contributory (save those already found by the Trust internal investigation team) or causal factors linked to the killing of Mr. X as no links could be made between any abnormality of mind Mr. Z may have been suffering from at the time, and the killing of his victim. However there are significant lessons for learning in the analysis of the case of Mr. Z. As such the Killing of Mr X was not preventable.

If an urgent referral is made by a GP for assessment then it is reasonable to expect the receiving service to add value to the clinical picture and to exceed any process normally to be found within a GP Practice. The Independent Investigation Team concluded that Mr. Z presented in a complex and problematic manner which met the criteria for full CPA consideration. He also met the criteria for a level 1 risk assessment to have been undertaken. Based upon what was known, and thought to be known, about Mr. Z at the stage he was referred, and following his assessment consultation on the 28 April 2010, it was poor practice to discharge him from the service back to the care of GP. This poor practice was exacerbated by poor levels of communication with the GP which served to potentially delay any further help and support being offered to Mr. Z in a timely manner.

The Trust internal investigation report mentioned *"Information concerning the patient's care and treatment whilst serving a custodial sentence was not made available to primary care when he was released".* When the Independent Investigation Team interviewed witnesses and the lead for the Trust internal investigation no clarity could be ascertained as to what this actually referred to. It was reported in the media at the time of Mr. Z's trial that he self-reported that he suffered from Paranoid Schizophrenia. The implication might have been that the prison service may have had previous knowledge of this which was not passed onto either primary or secondary care services at the time of Mr. Z's release. The Independent Investigation Team made every effort to understand whether this was true or not. We made contact with the Youth Offending Institution where Mr. Z had been detained up until March 2010 and learned that no records of his having any mental illness were either held by them or known to them.

In order to pursue the matter further the Independent Investigation Team accessed the Court sentencing transcriptions pertaining to Mr. Z's trial for the murder of Mr. X. The evidence heard at the trail demonstrated that Mr. Z was a violent young man who had several arrests for assault, robbery, and altercations of a violent nature with drug dealers. It was evident Mr. Z had a propensity for violence. These were facts known to the GP Practice and the West Access Team in April 2010 as they had been self-reported by Mr. Z himself. It is unclear why no contact was made with Probation Services in order to build up robust liaison and communication process. This would have been good practice. Whilst it is probable that time constraints would have prevented this from happening, it would also appear that mental health services did not think this to be a relevant intervention to make, or a reason for CPA to be potentially considered. At this stage neither the GP Practice nor mental health services were aware of Mr. Z's previous sex offending and Heroin addiction, both of which were

mentioned in Court and something which his Probation Officer was aware of. It would appear that Mr. Z did in fact wear a bullet-proof vest due to legitimate fears for his safety. However the Independent Investigation Team would point out that mental health services should have explored this aspect further in relation to a possible paranoia.

To summarise: Mr. Z was a violent young man who presented to the West Access Team with a complex presentation. It was evident that Mr. Z was ambivalent about receiving services, but it is a fact that he presented himself on four occasions seeking help (twice to his GP in person, and twice to the West Access Team, once in person and once over the telephone). It was evident that the way in which Mr. Z's case was managed was suboptimal and did not follow prescribed Trust policy and procedure.

12.1.12. Clinical Governance and Performance

12.1.12.1. Context

'*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.*'[45]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. Z was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

During the time that Mr. Z was receiving his care and treatment the Trust should also have been subject to robust performance monitoring and review from local statutory authorities charged with the commissioning of local-based Mental Health Services.

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr. X. The issues that have been set out below are those which have relevance to the care and treatment that Mr. Z received.

45. Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

12.1.12.2. Findings

The following information has been taken from the Trust's 2012/1013 Annual Quality Report.

The Trust sets itself 'stretch' targets on all aspects of quality, via annual objectives, each with markers and measures. Progress is reviewed at the Trust Board on a monthly basis to ensure corrective action is taken where needed.

Priorities for Improvement 2012/2013

These include:

- treating service users with dignity and respect;
- a compassionate and caring approach;
- safe environments;
- providing care and treatment that staff and patients would recommend to their family and friends.

These quality markers are measured and examined at every Board meeting by the use of a summary dashboard.

Priorities for Improvement for 2013/2014

These include:

- improving the patient experience (The Trust is working with the friends and family test introduced by David Cameron in 2012 to ensure that all services are improved);
- safety (the safety thermometer developed as a result of the Staffordshire Inquiry is used and the Trust will work closely with the Clinical Commissioning Groups to ensure incidents are managed properly);
- effectiveness (services are in the process of being aligned to outcome focused care pathways which incorporate National Institute of Clinical Excellence guidance, this will be linked to Payment by Results and Commissioning for Quality Improvement requirements);

Care Quality Commission (CQC)

Sussex Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'without condition'. The Care Quality Commission has not taken enforcement action against Sussex Partnership during 2012-13.

The Trust has participated in special reviews and investigations by the Care Quality Commission during 2012-13 in relation to the management of ligature anchor points at the Department of Psychiatry, Eastbourne and Mill View Hospital, Hove.

Follow up special reviews and investigation visits took place in March 2013. Inspection reports have been shared for Mill View Hospital and the Department of Psychiatry, which demonstrate the essential standards of Care and welfare of people who use services and safety and suitability of premises have now been met. The CQC's judgement was that patients

received safe, appropriate and personalised treatment and support through the coordinated assessment, planning and delivery of care at both locations. Since the last inspections the locations have improved the care planning documentation and the inspection reports note that care plans documented the plan of treatment and reflected the care and support people received.

The inspection reports reflect that the CQC are satisfied that there are systems in place to manage both individual and environmental risks at the locations. The CQC were satisfied that the hospitals had undertaken a major programme of environmental upgrades, refurbishment and redecoration to provide a safe and therapeutic care.

Sussex Partnership has made the following progress by 31 March 2013 in taking such action as prioritising removing high risk ligature points from areas where vulnerable patients had unaccompanied access. This has been achieved by replacing windows, providing anti-ligature fixings in bathrooms and high risk areas. The CQC are satisfied that the Trust was taking appropriate steps to manage the environmental risks in order to keep people safe at Mill View Hospital and Department of Psychiatry. The Downs Nursing Home also received a compliance visit from the CQC in March 2013. It was judged as fully compliant with all outcomes assessed against.

Organisational Learning from Internal and External Reviews

One of the Trust's 2012-13 quality priorities was to deliver safe services by demonstrating learning from internal and external reviews. In Quarter 1 the Trust's Report and Learn bulletin was revised to show a clearer link between incidents and the learning. The serious incident section also focused on a small number of themes or learning in order that managers and professional leaders are able to focus on priorities.

In Quarter 2 the Trust committed to ensuring that serious incident reviews were only signed off when confirmation was received about when, and by whom, the review would be fed back. A recent audit of this demonstrated 100% compliance. Throughout 2012-13 all internal reviews were undertaken by an objective peer with the recognised training to undertake the work. Furthermore, from 2012-13 action plans were written and owned by the manager responsible for the service. This ensured that from the construction of the action plan, actions were locally owned and delivered. The Trust holds currently a central risk register of all open actions and maintains a log of progress made.

In 2013-14 one of the Trust's priorities for improvement was to review and revise the Serious Incident review process. The Nurse Consultant for Patient Safety works closely with the Executive Director of Nursing and Quality to ensure national best practice is reflected in the local incident review process.

The Trust implemented the Medical Early Warning Signs (MEWS) model for full roll out in January 2014. Training in MEWS commenced in January 2013.

Clinical Leadership and Governance Structures
The Trust has recently re-developed its clinical leadership and governance structures. Full details can be found at:
http://staff.sussexpartnership.nhs.uk/staff/corporate/comms/wmb/?assetdetesctl6829718=391773.

The Trust states:
"This new structure aims to reduce bureaucracy and improve clinical engagement through a flatter structure with distributed leadership, and greater involvement in decision-making. The interactive network model is a framework for effective working, there is, of course, no substitute for good leadership or getting the right people on the right tasks. The management restructure, intends to do just that, and the changes outlined in this paper will be underpinned by a robust programme designed to provide leaders for the future and develop managerial maturity. To this end, we will be reviewing in-house programmes designed for managers and providing a more integrated and focused approach to development and talent management.

This structure provides an opportunity for senior clinicians to step up and become much more involved in leading the organisation. This is a big ask as the future will be challenging, to meet the challenge of improving quality, productivity and efficiency we need to work differently, be less centrally driven and more customer-focused. However, this is a new way of working, getting it right involves full commitment to our strategic aims, a robust grip on the detail, and a willingness to work vertically and horizontally to deliver…

… The divisional structures are based on matching local and clinical need, achieving best fit in terms of service clusters. This is in keeping with the overarching guiding principle that 'form should follow function'. In core divisions we need to embrace consistency and promote best practice, while we develop effective relationships with clinical commissioning groups (CCGs).

Specialist divisions have various commissioning arrangements in and beyond Sussex as services grow and funding is less reliant on block contracts. The inclusion of Kent and Medway within the Children and Young Peoples' Division (CYPD) requires a purpose-built governance structure to support the scale and geographical spread of this new service. In the Adult Specialist Division (ASD) services are diverse and there is a need to use the synergies between care pathways and focus on our aim to lead the way in this field.

While recognising the inherent differences, clinical leadership structures are based on the same principles and designed by division...

… The Senior Clinical Director post
To ensure consistency and maximise learning in core services a new role is being introduced; the senior clinical director (SCD). There are three of these posts and their role is to bring a mixed clinical perspective to strategic planning for care groups trust- wide. Each represents

a different component of service, and together they represent the journey from primary to secondary care, care clusters and care pathways. Their experience of clinical leadership within the organisation provides the stability going forward with this more ambitious organisational structure. They are accountable to the chief operating officer and will work in partnership with a service director to:

- *develop divisional clinical leadership*
- *identify the context for change*
- *facilitate transformation through innovation and improvement*
- *ensure patient safety*
- *critically evaluate services*

It is envisaged the SCDs will spend less time on operational management than they did in their clinical director role, this is because the structure seeks to embed decision-making closer to the frontline, supported by an approach to workforce planning processes which will aim to coordinate skills and special interests in a way that is more beneficial. Post holders will be supported through training and personal development and will have clarity of role to prevent upward delegation. This principle applies across all operational services.

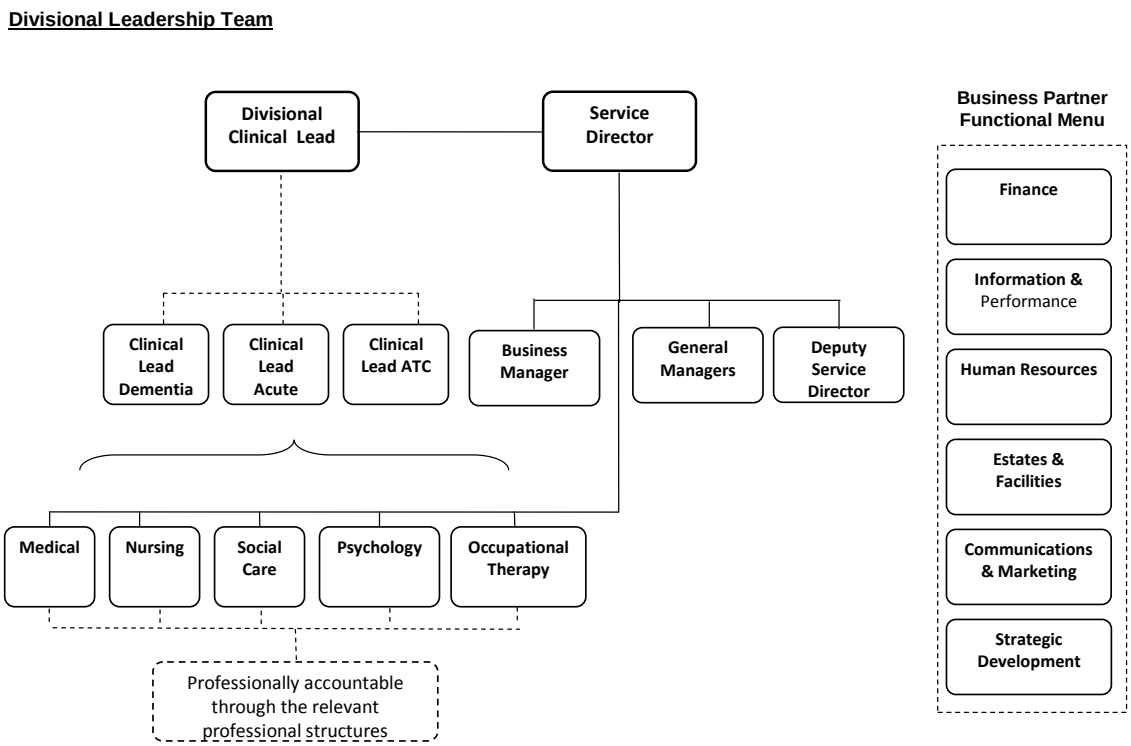
The Divisional Clinical Lead post

The DLT will be chaired by the divisional clinical lead (DCL), a new post. This role, unlike the SCDs, is not care group specific, and the post holder is accountable to and jointly responsible with the service director for the integrated services within the division. The DCL will be professionally accountable to an appropriate SCD or senior professional within the relevant professional structure.

Reporting to the divisional clinical lead, will be clinical leads, each of whom will take on the responsibility for a functional service area, (i.e. Acute Care, ATCs, etc) in partnership with a general manager. These clinical leads will report to the divisional clinical lead and be jointly accountable with the general manager for the delivery of their objectives.

The post will be open to applicants from any profession, provided they have experience of professional leadership at a senior level.

The chart below indicates responsibilities and accountability within a DLT in core services.



12.1.12.3. Conclusions

The Independent Investigation Team found the governance structures and processes in place at the Sussex Partnership NHS Foundation Trust to be robust. The new structures are in the process of being embedded and will be subject to monitoring and review by the Trust Board and local scrutiny and commissioning agencies.

13. Findings and Conclusions Regarding the Care and Treatment Mr. Z Received

13.1. Findings

1. Diagnosis. Despite two urgent referrals being made by primary care Mr. Z was not seen by a psychiatrist in secondary care and consequently no medically-derived diagnosis was made. Mr. Z's presentation was such to merit a medical examination. He had been recently released from prison, was known to have had a substance misuse problem and was also experiencing paranoid symptomology, intense anger and self-harming behaviour.

It was evident to this Investigation that the GP made the two referrals to primary care in order for an urgent assessment to be undertaken. It was known that:

- Mr. Z had been recently released from prison;
- Mr. Z was having some kind of adjustment difficulties;
- Mr. Z was self medicating with Diazepam (which was not being prescribed for him) and *"weed"*;
- Mr. Z's father was extremely worried about him;
- Mr. Z was paranoid, experiencing feelings of extreme anger, was anxious and agoraphobic and was self harming.

Clinical witnesses to this Investigation stated that it was not acceptable for a service user such as Mr. Z not to be seen by a Psychiatrist but that this was how the service was managed at the time. The Independent Investigation Team concurs with the reflections of the clinical witnesses in that a medically-led assessment was indicated for Mr. Z.

- ***Service Issue One. The service in operation at the time Mr. Z was receiving his care and treatment was not always conducive to the development of robust clinical assessments due to both time pressures and inherent difficulties with the service model. This was to have implications when providing a diagnostic formulation and any subsequent care, medication and treatment package.***

2. Medication and Treatment. Despite no diagnosis being given the nurse who assessed Mr. Z at the West Access Team suggested that Mr. Z ask his GP for an SSRI. The fact Mr. Z reported he was self medicating with Diazepam was ignored. The medication and treatment advised by secondary care services was not as the result of a well thought through assessment and diagnostic formulation.

3. Mental Health Act (1983 and 2007). The Assessment of the use of the Mental Health Act was not relevant to this Investigation as at no time was the Mental Health Act indicated.

4. Care Programme Approach (CPA). Due to the brevity of contact with secondary care services it was not possible to assess the CPA process Mr. Z was subject to. However it is the

finding of the Independent Investigation Team that Mr. Z's history and presentation met the criteria for being placed on CPA.

- ***Service Issue Two. Mr. Z's presentation was such that at the time of his referral to, and assessment by, the West Access Team he should have been considered eligible for full CPA. The failure to ensure that this was considered meant that Mr. Z continued in a state of distress necessitating a second urgent GP referral.***

5. Risk Assessment. Risk assessment was a tick box process which did not address what was known about Mr. Z and did not lead to a formulation of risk being made. The risk assessment process was not in keeping with national or local policy and guidance and fell short of the standard to be expected from a secondary care provider. The standard of recording was poor. The risk assessment process consisted of an initial risk screen only.

Two urgent referrals were made by primary care to secondary care services. During this time it was known that Mr. Z had recently been released from prison following a conviction for actual bodily harm. It was also known that Mr. Z:

(28 April 2010)

- was self harming;
- was self medicating with Diazepam and cannabis;
- was angry and impulsive and had a history of violence;
- had recently been released from prison;
- was paranoid and at risk of getting into fights;
- was depressed;
- found it difficult to go outside without his father.

Despite this profile Mr. Z received a rudimentary assessment and was discharged back to the care of his GP.

(June 2010)

- Mr. Z was becoming increasingly reckless;
- Mr. Z was described as not caring whether he lived or died;
- Mr. Z was also agitated and aggressive.

Despite this when he did not book in for an appointment he was discharged from the service within seven days. Mr. Z presented with a substantial risk both to himself and to others. Without a robust assessment of his mental state, based on what was known about him at the time, it was poor practice to provide Mr. Z with such a rudimentary service.

- ***Service Issue Three. The failure to conduct a professional level of clinical and risk assessment was a significant omission. Based upon what was known about Mr. Z, in conjunction with his presentation and concerns raised by both his GP practice and father, a robust clinical and risk assessment process should have been deployed***

in order to inform the management of Mr. Z in a systematic and evidence-based manner.

6. Referral, Discharge and Handover Processes. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"There seem to be gaps in understanding between the expectations of the referrer as to what would happen as a result of the referral and the understanding of the Access Team as to their role. The term 'comprehensive assessment' requires some clarification within an Access context so that referrers can be clear about this".*[46] The contributory factors set out below relate to the poor management of Mr. Z's care and treatment rather than to a specific contribution relating to the death of Mr. X and were developed by the Trust's internal investigation.

- ***Contributory Factor One. There is a clear policy governing the management of referrals which has been ratified by the Access Integrated Governance Team. Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type. The West Access Team management needs to address this issue as a matter of urgency and ensure that appropriate governance around the management of emergency referrals is in place.***

- ***Contributory Factor Two. When the 'back up duty worker' contacted the service user by telephone to try to arrange a second face to face appointment with a duty worker, there may have been a blurring of the assessment function. It is certainly clear that the service user turned down the offer of a second face to face assessment and ended the telephone call before an appointment was set up. Given this, the decision to write to the service user to offer a further appointment seems reasonable in most circumstances given that Access do not have a remit to actively engage service users who have turned down the offer of treatment. However, the urgent nature of the referral means that the duty worker should also have contacted the GP directly to let the GP know that the service user had turned down the appointment. This would have enabled the GP to make a decision about whether any further action was required, including whether they needed to refer the service user to a service which does have the resources to actively engage people at risk.***

7. Carer Assessment and Experience. Whilst this appears to have been of a reasonable standard in the primary care context it would appear that Trust mental health care services did not take carer concerns and issues into consideration.

8. Service User Involvement in Care Planning and Treatment. Whilst it is difficult to assess this due to the short length of time Mr. Z was in contact with secondary care services, it would appear that Mr. Z did not access a service that could respond to his presentation and needs.

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9. Documentation and Professional Communication. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"The written documentation falls significantly below expected governance standards".*[47]

- ***Service Issue Four. Poor levels of professional communication led to Mr. Z's case not receiving a timely consideration of whether or not he required a different approach being taken. This meant that his distress and mental health problems remained largely unassessed and untreated requiring a second urgent referral.***

- ***Service Issue Five. The standard of clinical documentation was of a poor standard in the case of Mr. Z and fell short of Trust policy expectations.***

10. Adherence to Local and National Policy and Procedure. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"There is a clear policy governing the management of referrals which has been ratified by the Access Integrated Governance Team. Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type".*[48]

- ***Service Issue Six. Staff within the West Access Team appeared to have had poor levels of awareness regarding Trust policy and procedure and their obligations regarding them.***

11. Management of the Clinical Care and Treatment of Mr. Z. Overall the care and treatment provided by the West Access Team was of a poor standard. The Independent Investigation did not however find any contributory (save those already found by the Trust Internal Investigation Team) or causal factors linked to the killing of Mr. X as no links could be made linking any abnormality of mind Mr. Z may have been suffering from at the time and the killing of his victim.

12. Clinical Governance and Performance.
The thematic issues were also checked against the requirements of the Terms of Reference and are explored in depth in Section 12 below. The internal investigation was of a high standard and this Investigation has been able to build upon it. The quality of the internal investigation is notable.

13.2. Conclusions

Mr. Z was a violent young man who presented to the West Access Team with a complex presentation. It was evident that Mr. Z was ambivalent about receiving services, but it is a fact that he presented himself on four occasions seeking help (twice to his GP in person, and

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twice to the West Access Team, once in person and once over the telephone). It was evident that the way in which Mr. Z's case was managed was suboptimal and did not follow prescribed Trust policy and procedure.

However despite the poor levels of care and treatment Mr. Z received from secondary care services the Independent Investigation Team could find no causal link between any act or omission on the part of the Sussex Partnership NHS Foundation Trust and the killing of Mr. X.

When being tried for the murder of Mr. X the Court was told that Mr. Z had formerly been remanded for robbery and the actual bodily harm of a 15-year old boy. The Court was also told that Mr. Z was on the Sex Offenders' Register for the sexual assault of a 15-year old girl. The only mitigating factor cited during the Judge's sentencing remarks was Mr. Z's young age. No mention was made of any existing, or pre-existing, mental health condition that could have influenced his actions in the killing of Mr. X.[49]

49. Court Transcriptions

14. Sussex Partnership NHS Foundation Trust Response to the Incident and Internal Investigation

14.1. The Trust Serious Untoward Incident Process

The Sussex Partnership NHS Foundation Trust has a clear policy and procedure in place for reporting, investigating and managing serious untoward incidents. The policy required an initial notification of a serious incident to the Governance Support Team with 24 hours, a serious incident reviewer to be appointed within three days, and a first draft of the investigation report to be prepared within 25 days.

14.2. The Trust Internal Investigation Processes

Terms of Reference for Internal Investigation

"To establish the facts
To establish any root causes to the incident
To provide a report recording the investigation process
To establish and record notable practice and any identifiable service/care delivery problems
To establish how risk of a recurrence may be reduced
To formulate recommendations
To provide a means of sharing learning from the incident"[50]

Team Members for the Internal Investigation

1. *"Service Manager Early Intervention in Psychosis - Investigating Manager*
2. *GP Mental Health Lead Brighton and Hove - Review Panel*
3. *Consultant Psychiatrist - Review Panel*
4. *Deputy Director of Nursing - Governance - Review Panel*
5. *General Manager Children and Adolescent Mental Health Services Brighton and Hove"*[51]

Methodology

Scope and Level of Investigation

Level 2 – Comprehensive.

To Span

27 April 2010 (the date of the first referral by the GP Surgery to West Access).
15 July 2010 (last contact with West Access Team).

Services Involved

West Access Team (SPT).

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Sackville Road Surgery (PCT).

Methods Used

- information gathering via: Interviews with Staff at West Access and at Sackville Road Surgery;
- utilisation of Multidisciplinary notes;
- identifying Service Delivery Problems;
- involvement and support of patient and relatives;
- in view of the current criminal charges against the patient and members of the immediate family, the Trust position was to liaise with the GP Surgery with an offer to provide support to other family members should they come forward for assistance;
- involvement and support provided for staff involved;
- staff at the West Access Team have been debriefed by a General Manager from another part of the Access Care Group;
- a number of West Access staff contributed to this review.

Information and Evidence Gathered

- interviews with Staff at West Access undertaken on 23 September 2010;
- interview with the referring GP (by telephone) on 27 September 2010;
- interview with the General Manager, Brighton and Hove Access Services, on 29 September 2010;
- Operational Policy for Access Services Brighton and Hove and Appendices;
- joint document BICS and Sussex Partnership Document Mental Health Working Age Referrals;
- the eCPA case notes for Mr. Z;
- confidential witness statements.

A chronology of events was developed as a tabular timeline.

Key Findings and Conclusions

Notable Practice

"The response of the team to the first referral on 27/04/10 was prompt and there is evidence that the assessment process was valued by the patient who appears to have considered the treatment options available to him, as well as the advice given, and subsequently attempted to act on it.

The phone contact with the patient on 17/06/10 represents a genuine attempt to provide the patient with a prompt response despite the fact that the patient ended the phone call before a second assessment appointment had been arranged".[52]

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Care and Service Delivery Problems

- *"Information concerning the patient's care and treatment whilst serving a custodial sentence was not made available to primary care when he was released.*
- *At the initial assessment interview conducted on 28/04/2010, the risk screening tool was not properly completed. This resulted in a failure to complete a Level 1 Risk Assessment.*
- *A correct application of the policy relating to urgent (5 Day Response) referrals would have resulted in a Level 1 Risk Assessment being undertaken resulting in a more comprehensive assessment of risk.*
- *Poor communication with the referring GP concerning:*
  1. The outcome of the referral made on 17/06/10.
  2. The patient's subsequent discharge.
  3. The original triage process.
- *Decision making around triage was not recorded on eCPA.*
- *The policy governing processes for managing urgent referrals was not implemented satisfactorily, particularly the process that calls for 'liaising with the GP where appropriate'. Given the concerns expressed by the GP in the second referral, and given the negative response to the offer of an assessment appointment from the patient, a discussion with the GP who had made an urgent referral would have been appropriate. It is acknowledged that it is not the purpose or function of Access teams to proactively try to engage with service users who do not want to engage. However, by contacting the GP, the GP could have made a decision about whether they wanted to refer the person to a service that does have a mandate to actively engage service users.*
- *There appears to be a blurring of boundaries as Psychological Wellbeing Practitioners (PWP) were being asked to support the duty function as a 'Back Up Duty Worker' through contacting people by phone to arrange a face to face assessment with the duty worker who was currently engaged elsewhere.*

  > *'there are 2 workers in the team, one is a graduate worker, the other is a group leader, who also work as duty second. They are there for back up only and do not cover the same work that a qualified worker would cover, and do not provide cover for sickness, their role is solely to answer the phone when the duty worker is in an assessment, refer any difficult calls to the duty worker and be the second person in an assessment with a qualified worker when required." (Excerpt from email from West Access Service Manager).'*

- *The eCPA entry from the group worker on 17/06/10 suggests that this role might sometimes get blurred as the entry suggests that the back up duty worker in this case was also obtaining information that would usually be part of an assessment. The use of a 'back up duty worker' is also not a part of the format policy for managing the duty system, and the appropriateness of using a PWP in this role should be questioned.*

- *The current trust policy is not consistent in its terminology in relation to different types of assessment. Trust documents refer to Urgent (requiring the referred person to be seen within four hours) Priority (requiring an assessment within 5 days) and Routine (requiring a 20 day response). The terminology has been clarified in recent communications with the Brighton Integrated Care Service. These are: 4 Hours/ Emergency (4 Hour response), Priority/ Urgent (5 working Days) and Routine (20 Working Days) BICS Working Age Referrals Document-Appendices Document App 5a to 5c. It is not clear whether all GPs are aware of this agreement and the lack of clarity presents risks to people in need of a 4 hour emergency response.*
- *There seem to be gaps in understanding between the expectations of the referrer as to what would happen as a result of the referral and the understanding of the Access Team as to their role. The term 'comprehensive assessment' requires some clarification within an Access context so that referrers can be clear about this.*
- *Although the member of staff who carried out the first assessment appointment described a comprehensive assessment process during their witness statement, including a description of the treatment options discussed with the service user, this was not reflected in the written documentation about the appointment. The written documentation falls significantly below expected governance standards. There may be a service issue here as Access Services conduct both comprehensive assessment processes for emergency and priority referrals as well as briefer screening assessments for routine referrals. Staff must ensure that their written documentation of assessments reflect the comprehensiveness of the assessment undertaken".*[53]

Contributory Factors

- *"There is a clear policy governing the management of referrals which has been ratified by the Access Integrated Governance Team. Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type. The West Access Team management needs to address this issue as a matter of urgency and ensure that appropriate governance around the management of emergency referrals is in place.*
- *When the 'back up duty worker' contacted the service user by telephone to try to arrange a second face to face appointment with a duty worker, there may have been a blurring of the assessment function. It is certainly clear that the service user turned down the offer of a second face to face assessment and ended the telephone call before an appointment was set up. Given this, the decision to write to the service user to offer a further appointment seems reasonable in most circumstances given that Access do not have a remit to actively engage service users who have turned down the offer of treatment. However, the urgent nature of the referral means that the duty worker should also have contacted the GP directly to let the GP know that the service user had turned down the appointment. This would have enabled the GP to make a decision about whether any further action was required, including whether they*

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needed to refer the service user to a service which does have the resources to actively engage people at risk".[54]

Root Causes

"In relation to the subsequent homicide, no root causes were identified".

Lessons Learned

- *"There are gaps in the provision of information from the Criminal Justice System to Primary Care relating to released prisoners who have received treatment for their mental health whilst incarcerated.*
- *There are various inconsistencies in the terminology used around emergency, priority and routine referrals that need to be addressed.*
- *All staff within the West Access Team need to be made aware of the Trust guidance around managing Priority and Emergency referrals.*
- *Roles within the team in relation to the management of the duty system require clarification.*
- *Communication with the referrer was not prioritised.*
- *Clear guidance needs to be put in place to guide staff in decision making where a service user is referred for a 4 hour assessment but does not engage in the appointment or refuses to take up what is offered to them. The need to work in close collaboration with the GP must be emphasised".*[55]

Independent Investigation Team Feedback on the Internal Investigation Process

The internal investigation was of a high standard and this Investigation has been able to build upon it. The quality of the internal investigation is notable. The Independent Investigation Team has found some additional points for consideration and learning. This is not an unusual situation with an Investigation of this kind as our terms of reference are wider than that of an internal investigation and should not be seen in any way as a criticism of the work of the Trust internal investigation.

14.3. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

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- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

In view of the then current criminal charges against the patient and members of the immediate family, the Trust position was to liaise with the GP Surgery with an offer to provide support to other family members (not being called to trial or as witnesses to the trial) should they come forward for assistance. No family members from either the perpetrator or victim came forward.

The Independent Investigation Team suggests that in future that the Trust should liaise with the Police in order to ensure that all family members (both perpetrator and victim) are contacted and offered support as appropriate.

14.4. Staff Support

Prior to and During the Internal Investigation
Staff were supported and communications maintained throughout the internal investigation process. This appears to have happened to a satisfactory standard.

During and Following the Internal Investigation
During the Independent Investigation the Trust maintained communications with all witnesses called and ensured that communications were maintained and support offered when needed.

14.5. Trust Internal Investigation Recommendations

1. *"Protocols need to be agreed with the Criminal Justice System regarding the transfer of information when a prisoner is released locally.*
2. *There is an urgent need for assurance in relation to the implementation of the Trust policy around the management of duty referrals within Brighton and Hove Access Teams to ensure that all staff are aware of, and following, the Trust guidance. Structures to provide assurance on this need to be put in place.*

3. *The role of the Duty worker requires clarification via written procedures. The way in which back up staff are employed to support this role should be reviewed.*
4. *Record keeping must provide a clear indication of the rationale for decisions taken and must match the comprehensiveness of the assessment undertaken.*
5. *Referrals requiring either a four hour or five day follow up indicate the presence of risk. Under these circumstances, communication with the referring GP should be considered a priority. The method of communication (fax, letter or telephone) will be a matter of clinical judgement.*
6. *Current Trust policy needs to be made consistent with the terminology around Emergency, Priority and Routine referrals as agreed between the Trust and BICS.*
7. *To strengthen the Emergency and Priority referral processes, GPs should be given the option to request a direct assessment by a Psychiatrist. This would be supported via provision of clear criteria and training for GPs".*[56]

14.6. Progress against the Trust Internal Investigation Action Plan

Trust Serious Untoward Incident Plan (dated 20 December 2010)

Findings	Action Required	Lead	Audit	Current Status
		Level	**Actions**	
Inconsistencies re: terminology used for referrals	The PCT and BICS have agreed the terminology, but it does continue to cause confusion. Laminated chart is available in each area and for GPs. Further action is required to ensure Trust and staff are clear as to the process.	Service Manager	Visual check by Team Leader	In place and a chart with the colour coded description is available for staff and the duty desks.
Staff to be aware of the Access pathways for 4 hour, 5 day and routine referrals.	To be aware of information sent in the early part of the year. Information to be shared in business meetings and re-distributed.	Service Manager	Team Leader to send pathway out, and discuss in supervision.	Sent earlier this year to re-send by the end of January 2011.
Management of the duty system.	It is to be made clear as to who is on duty and that they are expected to liaise with the referring GP.	Service Manager	Duty rota for duty should be completed in advance, and that person should speak to the GP. The Team Leader should check and ensure that a form is in place that needs to be signed off before a case is closed.	Duty rota in place, staff are aware that the qualified person should be the one liaising with the GP. Completed.
Guidance is required regarding what to do	Duty Worker to discuss and agree way forward with the	Service Manager	Team Leader to check forms have been	Policy guidance in place

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when the patient is not engaging when a 4 hour assessment has been requested.	GP. A should be in place as a checklist to ensure this is done.		completed before signing off.	
BURS service needs to be put into place.	The Trust is currently looking at this with the GPs. To be in place depending on the financial position by February 2011.			SPFT and PCT have agreed funding. New service in place.

15. Notable Practice

The Independent Investigation Team found the Trust's internal investigation to be of an excellent standard which made it possible for this investigation process to build upon it.

The Independent Investigation Team also found that the 'Under One Roof' (U1R) modernisation process of Sussex Partnership NHS Foundation Trust to be a notable service modernisation initiative. The reader is invited to contact the Trust directly to discover more about this approach to managing and delivering secondary care mental health services. A summary of the service is set out below.

"Key elements of the new model
The U1R model for community mental health services provides an ageless, needs-led service for adult population suffering with complex mental health conditions that require specialist help/interventions (previously served separately by WAMHS & OPMHS). It is designed to be lean and efficient, providing quick response with comprehensive assessments by our most skilled professionals followed by evidence based treatments with emphasis on recovery and independent living. The model will ensure less need for re-assessments and transition between teams and care will follow clear treatment pathways with periodic monitoring of progress to enable/achieve desired clinical outcomes. The model is based on recovery and personalization principles and will facilitate through-put through the system; it is designed to better patient engagement and compliance as well as enhancing their experience and quality of life.

The U1R model sits on the foundations of a robust primary care service which has been/is being designed around local communities to provide advice and interventions for people with mild to moderate mental health issues. The primary care service (i.e. Health in Mind in East Sussex) is also tasked with managing demand by building capacity in primary care medical services and working across with other partner agencies.

The U1R model has assessment and treatment components which will be served by appropriately skilled professionals drawn from a large pool of skill-mix. The required workforce/skill-mix will be brought together by removing the bureaucratic boundaries that have existed between care groups in our mental health delivery system. As part of the U1R model the roles, responsibilities and expertise of all professionals working in the system will be clearly defined and their skills effectively and efficiently deployed to the needs of service users. Following a comprehensive initial assessment where the diagnosis, case formulation with prognosis and a management plan will be drawn out, treatment will broadly follow one of two lines, i.e. short-term treatment and discharge or longer term care management for the more complex and high risk cases which require a slower recovery approach. However irrespective of the course through the system all patients will be provided treatment as per designated evidence-based treatment pathways with regular periodic monitoring of agreed outcome goals.

U1R services will be provided from one (or occasionally two) centre(s) called the "Assessment and Treatment Centres" in each locality. These A&T Centres will act as the main point of entry and service provision for all our adult service users and as such lessen the confusion that has hitherto existed in negotiating appropriate care by their referrers. Besides the economies of scale of a large pool of professionals working together and the wealth of experience and expertise that they bring should provide confidence and stability in the workforce to take on the challenges of care provision with less reliance on hospital beds. The model is envisaged to increase productivity, reduce unnecessary waste and be user and referral friendly".

16. Lessons Learned

Even though Mr. Z had but a fleeting contact with secondary care mental health services there are several lessons for learning. Some speak to the overarching system which provided the context for the care and treatment being provided and others speak to the individual team culture and the adherence to Trust-wide policy and procedure.

First Lesson: managers of the Access Service were aware that it was struggling to process the number of referrals that were coming through for several years from the time of its inception. Ultimately this meant that service users could not be assessed appropriately as timeslots were reduced and only the most rudimentary approach could often be taken. The service had been reorganised and it was apparent that processes were not working well as a result. It is important that all new service modernisation initiatives are monitored and reviewed on a regular basis to ensure that the early warning signs of an overburdened provision are identified in a timely manner and are not allowed to continue providing service users with compromised care and treatment.

Second Lesson: the West Access Team culture became one of 'getting on and doing' in the face of extreme service pressures. This meant that individuals departed from Trust clinical policy and procedure guidance. The departure from policy and procedure guidance in the case of Mr. Z illustrates how easy it is to miss key significant diagnostic and risk assessment factors when a 'tick box' approach is taken to the basic building blocks of care. It is essential that individual clinicians, and the individuals who manage them, ensure that a strict adherence to evidence-based practice continues regardless of any pressures within a service. Each clinician and service manager has a duty of care to ensure that, if it is no longer possible to provide effective and evidence-based care and treatment, this has to be brought to attention of senior managers with immediate effect. Individuals should not continue to 'muddle' through as this potentially places service users, their families and members of the general public at risk.

17. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Sussex Partnership NHS Foundation Trust to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress, development and good practice has been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this investigation process. It should be noted that the Trust has completed the recommendations set by its own internal investigation process and so these are not repeated here.

Each recommendation is set out below in accordance with the relevant progress that the Trust has already made since the time of the incident.

17.1. Diagnosis

- ***Service Issue One. The service in operation at the time Mr. Z was receiving his care and treatment was not always conducive to the development of robust clinical assessments due to both time pressures and inherent difficulties with the model. This was to have implications when providing a diagnostic formulation and any subsequent care, medication and treatment package.***

Trust progress regarding current practice in relation to the Independent Investigation findings:
The Access Service has now been modernised and current provision falls within the 'Under One Roof' initiative. All service users being referred from primary care will now receive a psychiatric assessment.

Recommendation 1
The Trust will audit the effectiveness of the Under One Roof initiative within six months of the publication of this report with particular reference to:

- **appropriate response to specific referral information (such as PHQ9 scores);**
- **appropriate psychiatric assessment at the time of each initial service user referral;**
- **the presence and quality of diagnostic formulation;**
- **the consequent development of evidence-based care and treatment packages based upon the clinical assessment of the service user.**

17.2. Medication and Treatment (see service issue above)

Mr. Z's GP was advised by CPN 1 to prescribe SSRI medication which may not have been good practice in the light of his suicidal ideation and self-harming behaviors. This advice was also provided in the absence of a robust clinical assessment.

Please see Recommendation 1 above.

17.3. CPA

- ***Service Issue Two. Mr. Z's presentation was such that at the time of his referral to, and assessment by, the West Access Team he should have been considered eligible for full CPA. The failure to ensure that this was considered meant that Mr. Z continued in as state of distress necessitating a second urgent GP referral.***

Trust progress regarding current practice in relation to the Independent Investigation findings

All services in Brighton and Hove provide care and treatment under the umbrella of the Care Programme Approach. The Trust has taken steps recently to revitalise the CPA in Assessment and Treatment Services across Sussex supported by the Trust-wide leadership group.

The Trust has recently undertaken a significant organisational change programme and reorganised clinical services around a 'functional' model rather than the traditional adults / older people service configuration. The current adult services in Brighton and Hove are now organised into Assessment and Treatment Teams and Recovery and Well Being Teams. The Care Programme Approach is used within these services but there is a differentiation between the role of Lead Practitioner and Care Coordinator. The distinction is made on the grounds of complexity, risk, diagnosis, assessed need and the requirements for on-going involvement from secondary care.

The Trust CPA Policy is currently undergoing a consultation process led by the adult mental health Strategic Governance Group.

Recommendation 2

The Trust will audit its revised CPA processes within six months of the publication of this report. This audit will be devised in conjunction with the relevant Clinical Commissioning Group. Particular focus on the following is required:

- **adherence to CPA policy assessment criteria when allocating service users to CPA or non-CPA;**
- **CPA training update uptake within the Brighton and Hove area.**

17.4. Risk and Clinical Assessment

- ***Service Issue Three. The failure to conduct a professional level of clinical and risk assessment was a significant omission. Based upon what was known about Mr. Z in conjunction with his presentation and concerns raised by GP practice and father a robust clinical and risk assessment process should have been deployed in order to inform the management of Mr. Z in a systematic and evidence-based manner.***

Recommendation 3
The Trust will conduct an audit of its risk assessment processes within six months of the publication of this report to determine:

- **the compliance of all clinicians in the completion of risk assessments for every service user;**
- **the compliance of clinicians in incorporating all relevant clinical information within the risk assessment documentation;**
- **the compliance of all clinicians in the development of risk management plans;**
- **the compliance of all clinicians in completing all risk assessment documentation and not leaving sections bank unless there are good reasons for doing so.**

17.5. Referral, Discharge and Handover Processes

- ***Contributory Factor One. There is a clear policy governing the management of referrals which has been ratified by the Access Integrated Governance Team. Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type. The West Access Team management needs to address this issue as a matter of urgency and ensure that appropriate governance around the management of emergency referrals is in place.***

- ***Contributory Factor Two. When the 'back up duty worker' contacted the service user by telephone to try to arrange a second face to face appointment with a duty worker, there may have been a blurring of the assessment function. It is certainly clear that the service user turned down the offer of a second face to face assessment and ended the telephone call before an appointment was set up. Given this, the decision to write to the service user to offer a further appointment seems reasonable in most circumstances given that Access do not have a remit to actively engage service users who have turned down the offer of treatment. However, the urgent nature of the referral means that the duty worker should also have contacted the GP directly to let the GP know that the service user had turned down the appointment. This would have enabled the GP to make a decision about whether any further action was required, including whether they needed to refer the service user to a service which does have the resources to actively engage people at risk.***

Trust progress regarding current practice in relation to the Independent Investigation findings

The Trust has completed the recommendations set by the internal investigation process.

Recommendation 4

The Trust will conduct an audit in conjunction with Primary Care stakeholders to ascertain the timeliness of referral processes. This audit will be completed within six months of the publication of this report. The Trust will ensure that referral pathways are revised if necessary in the light of the audit findings. Particular attention will be given to the following:

- **GP satisfaction with current referral processes and the usefulness of terminology clarification processes;**
- **success in working the Access Pathway (for example four hours, five days and routine referrals);**
- **the quality of Duty Worker communication and liaison with GPs.**

17.6. Documentation and Professional Communication

- ***Service Issue Four. Poor levels of professional communication led to Mr. Z's case not receiving a timely consideration of whether or not he required a different approach being taken. This meant that his distress and mental health problems remained largely unassessed and untreated requiring a second urgent referral.***

- ***Service Issue Five. The standard of clinical documentation was of a poor standard in the case of Mr. Z and fell short of Trust policy expectations.***

Recommendation 5

The Trust will ensure that professional communication and liaison processes are built into all care pathways and all clinical policy and procedure documents. Professional communication and liaison processes will be made explicit regarding the interface between primary and secondary care. This review work will be completed within six months of the publication of this report.

Recommendation 6

The Trust will conduct an audit of Brighton and Hove community-based services to ensure that all clinical documentation is completed in accordance with Trust policy expectations. This will be completed within six months of the publication of this report.

17.7. Adherence to Local and National Policy and Procedure

- ***Service Issue Six. Staff within the West Access Team appeared to have had poor levels of awareness regarding Trust policy and procedure and their obligations regarding them.***

Recommendation 7

The Trust must revise all policy documentation in keeping with the findings of this Investigation report and as set out in the recommendations above. All policy documentation should be subject to review and audit for both compliance and effectiveness as part of the Trust audit cycle.

Glossary

Cannabis	Cannabis is a popular recreational drug around the world, illegal in this country. Primary psychoactive effects include a state of relaxation, and to a lesser degree, euphoria from its main psychoactive compound.
Care Programme Approach (CPA)	CPA is a national systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Diazepam/Valium	Diazepam is a benzodiazepine drug. It is prescribed principally to treat anxiety, panic attacks, insomnia, seizures (including *status epilepticus*) and muscle spasms. Adverse effects of diazepam include anterograde amnesia (especially at higher doses) and sedation, as well as paradoxical effects such as excitement, rage or worsening of seizures in epileptics. Benzodiazepines also can cause or worsen depression. Long-term effects of benzodiazepines such as diazepam include tolerance, benzodiazepine dependence and benzodiazepine withdrawal syndrome upon dose reduction. Diazepam is a drug of potential abuse and can cause serious problems of addiction and as a result is scheduled. Sometimes, it is used by stimulant users to ‘come down’ and sleep and to help control the urge to binge.
Mental Health Act (1983 &	The Mental Health Act (1983 & 2007) covers the

2007)	assessment, treatment and rights of people with a mental health condition.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Paranoid Schizophrenia	Paranoid schizophrenia is the most common type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances.
Primary Care	Primary care refers to services provided by GP practices, dental practices, community pharmacies and high street optometrists. About 90% of peoples' contact with the NHS is with these services.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk Assessment	An assessment that systematically details a persons risk to both themselves and to others.
Secondary Care	Secondary care is defined as a service provided by medical specialists who generally do not have first contact with patients. Secondary care is usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Selective Serotonin Re-uptake Inhibitor (SSRI)	SSRIs are a class of compounds typically used as antidepressants in the treatment of depression, anxiety disorders, and some personality disorders.
Sertraline	Sertraline is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. Sertraline is primarily prescribed for major depressive disorders in adults as well as obsessive-compulsive behaviour panic, and social anxiety disorders in both adults and children.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
Zopiclone	As Zopiclone is sedating it is marketed as a sleeping pill. It works by causing a depression or tranquilization of the central nervous system. After prolonged use the body can become accustomed to the effects of Zopiclone. When the dose is then reduced or the drug is stopped, withdrawal symptoms may result. These can include a range of symptoms similar to those of benzodiazepine withdrawal.