

**Independent Investigation**  
**into the**  
**Care and Treatment Provided to Mr. Y**

**by the**  
**Mersey Care NHS Trust**  
**and**  
**Imagine Independence**

**Executive Summary**

**Commissioned by**  
**NHS North West**  
**Strategic Health Authority**

**Report Prepared by the Health and Social Care Advisory Service**  
**Report Authored by Dr. Androulla Johnstone**

**Contents**

<b>1.1. Background to the Case, Incident Description and Consequences</b>	<b>Page</b>
<b>1.2. Background to the Independent Investigation</b>	<b>Page</b>
<b>1.3. Terms of Reference</b>	<b>Page</b>
<b>1.4. The Independent Investigation Team</b>	<b>Page</b>
<b>1.5. Findings and Conclusions</b>	<b>Page</b>
<b>1.6. Notable Practice and Lessons Learned</b>	<b>Page</b>
<b>1.7. Recommendations</b>	<b>Page</b>

## 1. Executive Summary

### 1.1. Background to the Case, Incident Description and Consequences

#### Background Information for Mr. Y

Mr. Y was born in Liverpool on the 22 February 1972. Prior to her death in March 2010 Mrs. Y Senior gave a detailed history of her son to the Scott Clinic staff who were caring for him. Mr. Y apparently had a loving relationship with both of his parents. As a child Mr. Y was solitary and did not mix well with other children preferring his own company; his mother said that he was bullied at school and relied upon his elder brother to protect him. As an adult Mr. Y remained a solitary figure who enjoyed history and had a keen interest in keeping fit; he was described as not having a great deal of time for girls as he was shy and felt awkward around them. Mrs. Y Senior described her son as a person who had never been involved in fights, was not aggressive, and who disliked confrontation. Mr. Y spent significant periods of time after leaving school unemployed. Shortly before he became mentally ill for the first time he worked as a taxi driver. Mr. Y remained living at home with his parents.<sup>1</sup>

On the 7 March 2003 Mr. Y visited his GP because he was feeling shaky and had not been able to work following a road traffic accident the previous year. It was evident at this stage that Mr. Y was having hallucinatory experiences.<sup>2</sup> Over the following weeks it became evident that Mr. Y had some kind of psychotic illness for which Risperidone was prescribed and he was referred by his GP to secondary care mental health services. Mr. Y was seen by secondary care services in the Outpatient Clinic on the 28 March 2003 and the provisional diagnosis was "*a psychotic illness, paranoid schizophrenia*".<sup>3</sup>

Mr. Y was placed on Standard CPA and was allocated a Care Coordinator; he continued to have psychotic symptoms. By November 2003 it was becoming increasingly difficult to keep Mr. Y engaged with secondary care mental health services. Mr. Y's mental health began to deteriorate rapidly and by January 2004 a Mental Health Act (1983) assessment was being considered.<sup>4</sup> Mr. Y's mental health continued to deteriorate and discussions ensued

---

1. Clinical Records Set 2 PP. 82-83

2. GP Records PP. 14-17

3. GP Record PP. 54-55

4. GP Record P. 24

throughout the first two weeks of February 2004 as to whether or not a Mental Health Act (1983) assessment should take place in order to expedite a hospital admission.<sup>5</sup> On the 17 February Mr. Y was visited at his home by a Social Worker. On this occasion he agreed to an informal admission and the plans for an assessment under the Mental Health Act were abandoned. It was agreed that he would be admitted to hospital with immediate effect, however no bed was available until the 18 February and the admission was ultimately delayed until the 19 February. It was agreed that Mr. Y would be collected from his home at 10.00 hours and admitted to Calder Ward Broadoak Mental Health Resource Unit.<sup>6</sup>

### **Incident Description of the Death of Mr. Y Senior and the Resulting Consequences**

Early on the morning of the 19 February 2004 a Social Worker telephoned Mr. Y to arrange a time to come and collect him and take him into hospital. The telephone was answered by a Police Officer who said that Mr. Y had killed his father and seriously wounded his mother.<sup>7</sup>

Earlier that morning Mr. Y and his father had had a disagreement over money. Although they appeared to have resolved their differences Mr. Y went into the garage and retrieved a “hammer/spanner”. When he returned to the house his mother was upstairs packing bags for his forthcoming hospital visit and his father was downstairs. Mr. Y hit his father around the head until he fell to the ground. Mrs. Y Senior came downstairs at this point, she had been unaware of the attack on her husband, and Mr. Y assaulted her. She sustained injuries to her head, fingers and wrists. Mrs. Y Senior was able to reason with her son who stopped the attack and went upstairs. His mother called for the Police and Mr. Y made no further attempts of either resistance or violence.<sup>8</sup> Later on the same day Mr. Y was admitted to the Scott Clinic (a forensic medium secure unit) under Section 2 of the Mental Health Act (1983). The Police were of the view that he was mentally ill and required hospitalisation. Mr. Y was remanded on bail.<sup>9</sup>

On the 9 August 2004 at the Indictment at Liverpool Crown Court Mr. Y was charged as follows:

---

5. Mr. Y GP Record PP. 36-37

6. Trust Internal Investigation Report. P. 20

7. Clinical Records Set 2. P. 2

8. Trust Record PP. 56-57

9. Trust Record PP. 76 and 97 and 303

***“Count 1: murder, contrary to common law.***

*Particulars of the offence: Mr. Y on the 19 day of February 2004 murdered his father.*

***Count 2: attempted murder.***

*Particulars of the offence: Mr. Y on the 19 day of February 2004 attempted to murder his mother.*

***Count 3: causing grievous bodily harm.***

*Particulars of the offence: Mr. Y on the 19 day of February 2004 caused grievous bodily harm to his mother with intent to do her grievous bodily harm.”<sup>10</sup>*

On the 18 October 2004 Mr. Y was convicted of manslaughter and causing grievous bodily harm with intent. On this day Mr. Y was formally discharged from his detention under Section 3 of the Mental Health Act (1983). A Hospital Order was made at Liverpool Crown Court. He was to be detained at the Scott Clinic under Sections 37/41 of the Act. Mr. Y was returned to the Scott Clinic with immediate effect; his given diagnosis was Paranoid Schizophrenia.

### **Incident Description of the Death of Mrs. Y Senior and the Resulting Consequences**

For the next two years and two months Mr. Y remained at the Scott Clinic. On the 15 December 2006 a Mental Health Review Tribunal was convened and it was decided that Mr. Y would be discharged from the Scott Clinic subject to specific conditions. These conditions are set out below. Mr. Y was:

- to reside at 123, Moscow Drive Liverpool (24-hour supported accommodation);
- to provide access to any members of staff caring for him and to have face-to-face contact with staff on a daily basis;
- to comply precisely with all aspects of treatment as directed by the clinical team whether in the form of medication or other therapeutic interventions;
- to attend appointments with his Responsible Medical Officer, (Consultant Psychiatrist 3) his successor, or nominated deputy as required;
- to attend appointments with his Social Supervisor, her successor or nominated deputy as required;
- to attend appointments with his Community Psychiatric Nurse, (Care Coordinator 2), her successor, or nominated deputy as required;

---

10. Legal Documents PP.2-4

## Mr. Y Executive Summary Investigation Report

- to notify a member of staff (Imagine) at Moscow Drive of any face-to-face meeting with his mother;
- not to go within 200 metres of his mother's home;
- to be aware that powers of recall by the Ministry of Justice could be triggered at any time if the conditions were not fulfilled.<sup>11</sup>

On the 20 December 2006 Mr. Y was discharged from the Scott Clinic to live at 123 Moscow Drive, a supported living accommodation, which was managed by an organisation called Imagine Independence (Imagine). It is recorded that during this period Mr. Y settled quickly into the community and was reported to be doing well. Mr. Y had re-established a relationship with his mother prior to his leaving the Scott Clinic and he met with her on a regular basis.

On the 29 September 2009 Mr. Y moved to a self-contained flat at 133 Moscow Drive which was also part of the supported living scheme managed by Imagine.<sup>12</sup> Mr. Y was apparently very happy to be settled into a more independent living environment. He was reported as being both physically and mentally well at this time.

Four months after this move had taken place plans were put into action to try and move Mr. Y into a flat which would give him even more independence. Mr. Y expressed some concerns about this, however during February and March 2010 planning continued and Mr. Y was taken to view a flat five minutes away from where he lived and offered the opportunity of a long-term lease.<sup>13</sup> Mr. Y continued to be reported as mentally well during this period.

On the 30 March 2010 Mr. Y was reported to have given his television away to another service user. This was a point for concern as giving possessions away had been identified previously as being part of his relapse signature. Mr. Y however appeared to be mentally well. In the morning Imagine staff notified Mr. Y's Social Supervisor who made a visit to his flat. Mr. Y was not there as he was out, the plan having been to have lunch with his mother, which was usual. The Social Supervisor suggested that the Imagine staff contact her again if they identified anything unusual.

---

11. Tribunal Documentation. PP.1-7

12. Imagine Notes. PP. 311-312

13. Imagine Notes. PP.382-383

At 19.45 hours Mr. Y returned to 133 Moscow Drive. He spent some time with the Imagine staff talking about Scrabble and then went to his flat stating he was going to listen to music. At 22.30 hours a neighbour of Mr. Y's mother called Moscow Drive to say that she had not returned home, he subsequently called back to say that her house was on fire. Mr. Y was arrested at the scene of the fire and his mother's body was found subsequently in his flat at Moscow Drive; she had been stabbed to death with a kitchen knife.<sup>14</sup> Immediately after the incident Mr. Y was placed on a Section 3 of the Mental Health Act (1983 & 2007) and placed at the Scott Clinic. On the 7 June 2010 Mr. Y was discharged from his Section 3 and recalled under Sections 37/41 to Ashworth Hospital.<sup>15</sup>

On the 28 March 2011 Mr. Y was found guilty of manslaughter and attempted arson. He was sentenced to life imprisonment with a 20 year determination. He was detained at Ashworth High Secure Hospital on a Section 45 of the Mental Health Act (1983 & 2007).<sup>16</sup>

On the 19 April 2011, following an appeal by his defence team, Mr. Y's sentence was reduced to a minimum of a fifteen-year determination.<sup>17</sup>

## **1.2. Background to the Independent Investigation**

The Health and Social Care Advisory Service was commissioned by NHS North West (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:

---

14. Trust Record PP. 78-79 and 92-94

15. Trust Record P. 113

16. Trust Record PP. 172-173

17. Liverpool Echo.co.uk 19 April 2011

## Mr. Y Executive Summary Investigation Report

- 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 review thoroughly 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 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 interest of the wider public. This case has been investigated fully by an impartial and independent investigation team.



### 1.3. Terms of Reference

The Terms of Reference for this Investigation were set by NHS North West Strategic Health Authority. The Mersey Care NHS Trust and Imagine Independence did not wish to make any additions. The Terms of Reference were as follows:

#### 1. To Examine:

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

#### 2. To Identify:

- learning points for improving systems and services;

- developments in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

**3. To Make:**

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

**4. To Report:**

- findings and recommendations to the NHS North West Strategic Health Authority Board as required by the SHA.

## **1.4. The Independent Investigation Team**

### **Selection of the Investigation Team**

The Investigation Team was comprised of individuals who worked independently of Liverpool-based services. 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.

### **Independent Investigation Team Leader**

Dr. Androulla Johnstone

Chief Executive, Health and Social Care Advisory Service. Chair, and Report Author

### **Investigation Team Members**

Dr. David Somekh

Consultant Psychiatrist Member of the Team

Mr. Alan Watson

Social Worker Member of the Team

Mr. Jon Allen

Nurse Member of the Team

Dr. Len Rowland

Psychologist Member of the Team

### **Support to the Investigation Team**

Mr. Christopher Welton

Investigation Manager, Health and Social  
Care Advisory Service

Mrs. Fiona Shipley

Stenography services

### **Additional Independent Advice to the Investigation Team**

Mr. Ashley Irons

Solicitor, Capsticks

## **1.5. Findings and Conclusions**

### **Findings**

The findings have been identified following a full review of the care and treatment that Mr. Y received from the Mersey Care NHS Trust and Imagine. These have been set out below together with their accompanying relevant causal, contributory and service issues.

The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Mr. Y received from the Mersey Care NHS Trust and Imagine. These thematic issues are set out below.

#### **1.5.1. Thematic Issues**

The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Y received from the Mersey Care NHS Trust and Imagine. These thematic issues are set out below.

#### **Number One**

**Diagnosis.** Mr. Y had Paranoid Schizophrenia. This was identified at an early stage following his first contact with secondary care mental health services in March 2003. Following his admission to the Scott Clinic ‘Theory of Mind’ deficit was introduced into Mr. Y’s diagnostic formulation. ‘Theory of Mind’ deficits have been observed in people with autistic spectrum disorders, with Schizophrenia, and some other conditions. There are clear links in the

academic literature with 'Theory of Mind' to Schizophrenia, but these are far from being straight forward.

In the case of Mr. Y the 'Theory of Mind' deficits identified were descriptive only. They were not used to provide an explanation for his condition and presentation. The emphasis placed on 'Theory Mind' by the Scott Clinic Treating Team displaced the thinking around Mr. Y's Schizophrenia and this amounted to a serious clinical misjudgement. The emphasis on the concept of 'Theory of Mind' seems to have distorted the perception that clinicians had of Mr. Y, especially in relation to risk. A rather simplistic view was taken that focused upon a behavioural approach with Mr. Y, one which was at odds with the research literature on this subject available at the time.

There was no acknowledgement of the implication of the diagnosis of Schizophrenia for Mr. Y's mental functioning. All psychological test results employed norms for the general population with no reference as to whether results might be different in persons with a diagnosis of Schizophrenia. Although a clear diagnosis had been made, and the condition stabilised in the inpatient setting *via* some antipsychotic medication, the subsequent approach to the patient by the whole clinical team seems to have been unduly influenced by the apparent blind spot shown in the psychology reports in regard to the possibility of ongoing influence of the current mental illness, even if he appeared superficially to be asymptomatic.

In short there was a failure to understand Mr. Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.

- *Contributory Factor One. There was a failure to understand Mr. Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.*

## **Number Two**

**Medication and Treatment. Medication.** Prior to the death of Mr. Y Senior, Mr. Y was not taking his antipsychotic medication on a regular basis. This served to ensure that his psychosis was, at best, only being partially treated. Following the death of Mr. Y Senior and Mr. Y's admission to the Scott Clinic in February 2004, a baseline assessment was not

conducted prior to the introduction of his new medication regimen. It was concluded by the Independent Investigation Team that Mr. Y was in denial about the death of his father, had a flattened affect and masked his symptoms. This led to Mr. Y's condition being assessed poorly and to his being under medicated whilst in the Scott Clinic.

Mr. Y was reported to have had consistent concerns about the side effects relating to his medication, prior to the death of his father, whilst he was still living in the community. This meant that he took his medication in a sporadic manner. Following his discharge from the Scott Clinic in 2006 Mr. Y self-medicated from an early stage. There was never any overt evidence that he failed to comply with his medication, however he remained demonstrably ambivalent about it. In such circumstances it could reasonably be predicted that Mr. Y may not have been compliant with his medication. Whether he was, or whether he was not, it would have been good practice to have had a medication management plan in place. This was absent.

**Treatment.** The lack of a clear formulation of Mr. Y's problems impacted upon the development of a clear treatment plan throughout his time with mental health services. From early in his contact with mental health services issues around family dynamics were identified but:

- this was never clearly formulated to inform an intervention;
- terms such as 'High Expressed Emotion' were used loosely. During the interviews with witnesses there appeared to be confusion between 'expressed emotion' (EE) and 'over involvement' (OI). Though both terms are used to describe families in the research of Wing, Leff, Beddinton *et al* this research does not make them interchangeable. Depending on which, EE or OI, characterised the family different approaches would have been appropriate;
- even at an early stage, prior to the first homicide, one would have expected some structured input to address the perceived family difficulties which did not happen;
- when Mr. Y was being prepared for discharge from the Scott Clinic some form of family intervention should have been put in place. In the absence of this how was his mother supposed to understand Mr. Y's problems and respond to him?

When examining the care and treatment Mr. Y received a theme was detected of identifying problems but not identifying the interventions to address them. Mr. Y clearly displayed the

symptoms of a psychotic illness. The National Institute for Health and Clinical Excellence guidelines state that Cognitive Behaviour Therapy (CBT) should be available to such individuals. There is a substantial literature on CBT approaches to auditory hallucinations, delusions etc. Mr. Y was not offered this kind of therapy and neither was he supported in being able to develop coping strategies to manage his condition.

At the point of his discharge from the Scott Clinic there was talk of employing the recovery model but neither the structured steps to independence nor a Wellness Recovery Action Plan (WRAP) were evident.

In short: if the treating team believed the things that they did about Mr. Y then they should have proceeded within a best-evidence treatment base. The prevailing belief was that Mr. Y had somehow been 'cured' when in actual fact he was probably masking his symptoms and was understood in a rudimentary manner only.

- *Service Issue One. The Scott Clinic practiced an unacceptable level of medicines management in the case of Mr. Y. Whilst this cannot be cited as either a contributory or causal factor it demonstrates a lack of medicines management systems and understanding on the part of Scott Clinic clinicians.*
- *Contributory Factor Two. Mr. Y did not receive treatment in line with national best practice guidelines. This represents a missed opportunity that left Mr. Y vulnerable to relapse.*

### **Number Three**

**Use of the Mental Health Act (1983 and 2007), Ministry of Justice and Criminal Justice Systems.** There are three main issues in relation to the use of the Mental Health Act (1983) before the first homicide:

1. the awareness of the Community Mental Health Team of the appropriate use of the Act;
2. active use of the provisions of the Act; and
3. timeliness of intervention.

## Mr. Y Executive Summary Investigation Report

The Independent Investigation Team concluded that Mr. Y could have been considered to have met the criteria for assessment under the Act at any time following his first presentation to his GP in March 2003. However, because Mr. Y had not manifested a threat of violence to either himself or to others, the degree of urgency to intervene was perceived to be low. This caused a delay in getting Mr. Y the treatment that he needed and consequently his mental health continued to deteriorate.

Following the death of Mr. Y Senior Mr. Y was detained at the Scott Clinic subject to a Court Order under Section 37/41. On the 15 December 2006 he was conditionally discharged from this Order by a Mental Health Review Tribunal (the issues relating to this discharge are detailed in bullet 6 below). At the point of his discharge Section 117 arrangements were not made explicit and this was to cause significant disruptions to his supported living housing arrangements in the years that followed.

After discharge from the Scott Clinic Mr. Y had nominated Social Supervisors and Care Coordinators allocated to him. The pattern of contact with the Social Supervisor, Care Coordinator and Responsible Clinician was maintained through a series of formal reviews in the out-patient clinic at Rodney Street, Liverpool and contacts with staff at a number of venues in the Liverpool City centre. Day to day contact and support was in the hands of the staff at Imagine who also took part in reviews.

From evidence it appears there were several critical issues in relation to the use of the Mental Health Act post discharge from the Scott Clinic and the practical interpretation of the conditions. These are set out below (please note the conditions of discharge are set out in full in Section 13):

- Handovers between members of the treating team were poor and failures occurred when transferring critical information e.g. the Theory of Mind construct.
- There was a lack of knowledge about the role of the Social Supervisor.
- The conditions of discharge were not protective in that they relied on Mr. Y to notify staff of contact with his mother (condition 7).
- Condition 8 did not take account of the potential risk in meetings between Mr. Y and his mother at other venues; it assumed that requiring Mr. Y to keep away from the family home would be effective.

- The discussion about moving Mr. Y to another residence (from 123 Moscow Drive to 133 Moscow Drive and then on to an independent flat) was not discussed with the Ministry of Justice and there is no record of their approval.
  - The review by *Supporting People* staff of the financial support provided to enable Mr. Y to remain successfully in the community did not acknowledge that Mr. Y was subject to Section 117 after-care, and that his funding was assured. There appeared to be pressure to move him on to less supported and less supervised accommodation. This should not have applied to Mr. Y. There were clinical reasons to be cautious when introducing changes to his living arrangements which were disregarded.
  - Staff at Imagine were not aware of the full range of conditional discharge arrangements and procedural requirements for changes in circumstances. They saw this as the role of the Social Supervisor and regarded the staff from the Scott Clinic as a ‘crack team.’
  - It is not clear whether, or how, the family of Mr. Y were involved in the construction of the conditional terms.
- ***Contributory Factor Three. There were serious failures in the implementation of the terms of Mr. Y's conditional discharge. This meant that the conditions put into place by the Ministry of Justice to protect the public were rendered ineffective.***

#### **Number Four**

**Care Programme Approach (CPA).** Mersey Care NHS Trust had a Care Programme Approach policy in place and operational during 2003 and 2004. Given that the documentation completed as part of the CPA process refers to Effective Care Coordination, it appears reasonable to conclude that this had taken into consideration the national guidance on effective care coordination issued in 1999.

It is not clear whether the Care Programme Approach was used at the point Mr. Y was first treated by the day hospital. There is no recorded Care Coordinator or evidence of hand over from the day hospital Keyworker to the community team Care Coordinator or of a Care Coordinator initiating a CPA review meeting to identify Mr. Y's needs and how these might be best/most effectively met.



Once Mr. Y had been transferred to the Community Mental Health Team he was designated as requiring Standard CPA. The Investigation Team concluded that on balance given Mr. Y's presentation of serious mental illness, with accompanying positive risk factors such as non compliance with treatment, there was sufficient evidence to suggest he should have been on Enhanced CPA. This may have led to an increased sense of concern from the team when the Care Coordinator raised issues regarding risk with them. These identified risk issues appear to have been minimised by the team.

Following Mr. Y's admission to the Scott Clinic seven Effective Care Coordination reviews were recorded between the 23 March 2003 and the 27 November 2006. During this period the Care Coordinator role appeared to be nominal as the Responsible Medical Officer took on this role. It was evident that this role was understood poorly. Mr. Y did not engage with the CPA process and often refused to take part in any of the review and planning processes. The content of CPA documentation did not vary from one review meeting to the next and the information recorded was often incorrect (for example: it often recorded the presence of individuals that had left the employ of the Trust several years previously).

The clinical documentation that records CPA activity following Mr. Y's conditional discharge into the community is sparse. The documentation that is extant provides evidence for risk assessment and care planning having been considered, but there is little evidence to demonstrate that care planning was developed or implemented in a systematic manner. It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y worked in silos to the detriment of Mr. Y's overall case management.

- *Contributory Factor Four. It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y worked in silos to the detriment of Mr. Y's overall case management, care and treatment.*

## **Number Five**

**Risk Assessment.** Mr. Y was not understood in the context of his full risk profile. The issues around the management of risk are many fold.

- Risk assessments were not consistently undertaken at critical times/junctures.
- The conclusions of risk assessments were not always consistent with the evidence cited.
- There was a failure to involve Mr. Y's family, his mother in particular, with risk assessment processes and management plans. This meant that ultimately there was no risk management around the mother's safety at the time of Mr. Y's discharge from the Scott Clinic.
- There was a lack of formulation around risk. For example the treating team did not explore why Mr. Y killed his father.
- Risk assessment was not dynamic and did not lead to risk management plans. Risk plans were little more than a list of actions which did not of themselves address the risks identified.
- Multi-Agency Public Protection Arrangements (MAPPA) and Police National Computer (PNC) processes were neither considered nor put into place appropriately.

The identified problems as set out above combined together to ensure that Mr. Y's risk was not formulated, assessed in a dynamic manner, communicated appropriately with either his family or all relevant agencies, or mitigated against.

- *Contributory Factor Five. Mr. Y was not understood in the context of his full risk profile. Assessments of risk were undertaken in the absence of a robust formulation of the case. Consequently risk management plans and strategies were superficial and non-explicit. This, when taken alongside the failure to abide by the terms of the conditional discharge and decision not to consider MAPPA arrangements, ensured a critical lack of supervision and management. This was to the ultimate detriment of Mr. Y's health, safety and wellbeing and to the continued safety of his mother.*

## **Number Six**

**Referral, Admission and Discharge Planning.** Prior to the death of Mr. Y Senior there were delays in admitting Mr. Y to an inpatient setting. It was evident that Mr. Y needed a bed urgently in February 2004. There were delays to his admission due to the fact that no bed was available. Once a bed was available there was a tardy response to ensuring the admission took

place in a timely manner. This delay was significant as it was during this period Mr. Y killed his father and it had been identified that Mr. Y would need to be admitted under the Act if he refused an informal admission.

On the 30 September and 11 October 2006 Special Circumstances Reports were written for the Home Office in support of Mr. Y's forthcoming Tribunal by his Social Supervisor and his Responsible Medical Officer. On the 24 October the statement for the Home Secretary for the consideration of the Tribunal stated that whilst he was pleased to note Mr. Y's progress he would not be prepared to support his discharge at this time and that he needed to stay in hospital in order to receive treatment for both his own health and safety and for the protection of others. Despite this communication plans for Mr. Y's discharge went ahead. Whilst it was good practice to arrange overnight leave (with the permission of the Ministry of Justice) to prepare Mr. Y for an eventual discharge, it is not clear how well-considered the move to supported accommodation in Moscow Drive was.

Mr. Y's discharge in December 2006 appeared to have taken place in a hurried manner. It is unclear why this should have been the case. Mr. Y was discharged *de facto* on the 18 December and officially on the 20 December 2006 without his medication and without a discharge CPA and plan. Also, whilst it was recorded that some kind of Section 117 meeting had been arranged there was no documentation produced that details what occurred in this meeting.

- *Contributory Factor Six. The discharge process did not address in sufficient detail either the needs of Mr. Y or the continued safety of the public, with particular reference to Mrs. Y Senior. The process appeared to have been rushed and coordinated poorly. As a consequence the essential safety nets of care were not put into place to the ultimate detriment of the care, treatment and supervision that Mr. Y received up until the time of the killing of his mother.*

## **Number Seven**

**Service User Involvement in Care Planning and Treatment.** Between March 2003 and March 2010 it was evident that Mr. Y's treating teams attempted to provide a service that was acceptable to him. However this meant that, at times, there was no assertive management of

his medication regimen or liaison with his family. Whilst Mr. Y's wishes were taken into account, these were not always in the best interests of either himself or those around him.

It is a fact that health and social care staff found it difficult to access Mr. Y's inner world. This meant that he was understood poorly and that engagement was maintained at a fairly superficial level. It is recorded in the clinical record that Mr. Y rarely attended his CPA meetings whilst at the Scott Clinic and at times would refuse to sign off his care plans. Mr. Y was generally perceived as being a quiet and private person by members of his treating team and this appears to have become a barrier to a genuine therapeutic relationship being built up with him over time. His lack of involvement in his care planning and treatment, which was ostensibly regarded as Mr. Y 'being the way he was,' should have been challenged *via* the building and maintenance of a therapeutic relationship so that he could genuinely engage more fully in his own recovery.

- ***Contributory Factor Seven. Mr. Y's involvement in his care and treatment programme was superficial at best. The treating team placed too much confidence in his ability to work with his recovery programme and consequently failed to put routine protective plans in place to the ultimate detriment of the health and wellbeing of Mr. Y.***

## **Number Eight**

**Carer Assessment and Involvement.** Between March 2003 and March 2010 there was no active or documented plan in place to ensure that Mr. Y's family were involved in his care and treatment.

Prior to the death of Mr. Y Senior, members of the treating team mistakenly thought that they could not gain collateral information from the family because Mr. Y refused to give his consent. Once it was evident that Mr. Y was suffering from a severe and enduring mental illness no effort was made to either educate his family or to support them. At no time was a carer assessment considered.

During the period that Mr. Y was an inpatient at the Scott Clinic no family focused interventions took place and it is unclear from either reading the clinical documentation or from talking to members of the treating team what exact involvement the family had with Mr. Y's care and treatment programme and discharge planning arrangements.

Following Mr. Y's discharge from the Scott Clinic in 2006 it would appear that the family of Mr. Y made its own arrangements to protect Mrs. Y Senior in the absence of any management plan developed by the treating team. Communication with Mr. Y's mother appeared to take place in an unstructured manner and in isolation from any CPA processes. It is the conclusion of the Independent Investigation Team that this placed Mrs. Y Senior in a position of unmitigated risk.

- ***Contributory Factor Eight. The Scott Clinic failed in its duty of care to Mrs. Y Senior. This left her unsupported and without the protection of risk management plan.***

### **Number Nine**

**Housing.** Whilst at the Scott Clinic Mr. Y was identified as needing a small group nursing home. This was based on the belief that he suffered from Asperger's Syndrome and the observations about 'Theory of Mind'. There is no evidence that this 'need' was taken into consideration as part of his discharge planning. There is no record as to an evaluation regarding the appropriateness of fit between Mr. Y's needs and the environment/support offered by Moscow Drive and Imagine. Mr. Y appears to have been placed at Moscow Drive because that was the place that was available. This is common practice for services, but still poor practice. This lack of assessment for appropriate placement led to the care team taking a purely pragmatic approach to disposal after Mr Y left the Scott Clinic. A wider implication was that it obscured the need for the Local Authority and the Primary Care Trust to offer appropriate after-care under the terms of Section 117 of the Mental Health Act. A further implication was that the type of supported accommodation offered to Mr Y, carried with it an expectation that people would 'move on' to more independent living. Although this might be a reasonable aim for many people with mental health problems, it put pressure on Mr Y to move through the system at an inappropriate place.

Mr. Y was moved from one property at Moscow Drive to another because the first property was considered no longer suitable. In a material sense the move might have been a beneficial one, however given Mr. Y's known aversion to change; it was not necessarily psychologically so beneficial. There is no evidence of appropriate psychological preparation for this move. It appears, however, that the move went well and Mr. Y reported that he enjoyed his new accommodation and made (possibly for the first time in his life) a friend. The cost of increased independence was decreased supervision. This does not appear to have

been reflected upon or included in a risk assessment. Most importantly of all the Ministry of Justice was not consulted prior to this decision being made. This was a serious omission.

In the January of 2010 the Local Authority Supporting People team conducted an assessment of Mr. Y without the input of either the Imagine staff or mental health services. This was also conducted without understanding the statutory basis of Mr. Y's status in the community (Section 117 aftercare and his Conditional Discharge) and of the impact that this assessment could have made on Mr. Y's mental state. This action was inappropriate.

- *Contributory Factor Nine. Significant failures to manage Mr. Y's Section 117 aftercare arrangements and terms of his conditional discharge meant that his Supported Living provision was inadequately planned from the outset. This had the effect of creating a degree of instability in the life of a person who required structure and certainty and also prevented realistic protective measures being put into place.*

## **Number Ten**

**Documentation and Professional Communication.** Three main issues were identified by the Independent Investigation Team. First: The Trust has not archived Mr. Y's clinical records appropriately and a significant proportion of his clinical record appears to be lost and could not be made available to this Investigation. This is a serious omission, especially in light of the fact that Mr. Y's case is still open to the Trust and all of his clinical records should be available to his current treating team.

Second: the practice of clinical record keeping was poor. Significant CPA and Ministry of Justice documentation has not been held within the main body of the clinical record. It was evident to this Investigation that the general maintenance of the clinical record took the form of a continuous 'cut and paste' process. Assessment and care planning was not dynamic and did not change over time and incorrect information was carried forward from one assessment to the next.

Third: levels of professional communication fell below the level to be expected from a tertiary service team. Communication between Care Coordinators and Social Supervisors was poor in relation to Mr. Y's mother. Communication between Care Coordinators and other agencies, such as the Local Authority and Supporting People, was non-existent. It is expected

that a tertiary forensic service would communicate with the Ministry of Justice in a systematic and professional manner. This did not take place in accordance with statutory requirements and consequently the conditions of Mr. Y's discharge were breached.

- *Contributory Factor Ten. The standards of clinical record keeping and interagency communication were poor. This made a significant contribution over time to Mr. Y being neither understood nor managed in the full context of his mental illness in a multiagency arena.*

## **Number Eleven**

### **Adherence to Local and National Policy, Procedure and Clinical Guidelines.**

- CPA: While the Trust had in place a CPA Policy that reflected national guidelines this did not appear to have been adhered to in Mr. Y's case:
  - there was a lack of clarity and of appropriate training regarding the role and responsibilities of the Care Coordinator;
  - comprehensive needs assessments and plans were not drawn up and reviewed in a timely manner;
  - Mr. Y and his mother were not involved when identifying his needs and developing his care plans. This involvement should have involved more than inviting people to CPA review meetings. There should have been an ongoing and proactive effort at engagement;
- Risk assessment and management planning:
  - the Trust had an appropriate policy in place and at least whilst Mr. Y was in the Scott Clinic some appropriate standardised devices were employed. However the Best Practice guidance goes beyond the collection of data and requires an understanding of the risk that an individual poses. This was not evident in Mr. Y's case. The guidance recommends that the individual and his family should be involved in identifying and understanding risk and in developing the management plan. This did not happen in Mr. Y's case.
- There are guidelines available for the treatment of/intervention for individuals suffering with schizophrenia/psychosis and for personality disorders, these do not appear to have considered when planning Mr. Y's care and treatment

- The Independent Investigation Team was informed that the practice of the Scott Clinic in referring people to MAPPa was at odds with that of the rest of the Trust. The primary aim of MAPPa is to share information relating to the risk an individual poses and to put in place arrangements for managing and, where possible, reducing that risk. This function of MAPPa does not seem to have been reflected upon; rather the emphasis was on whether Mr. Y met the criteria for referral.
- Mental Health Act: Some clinical witness appeared to be unclear as to the provisions of the Mental Health Act and its accompanying Code of Practice. Neither the Trust nor the Local Authority and those representing it appeared to be familiar with responsibilities under Section 117 of the Act and the requirement to monitor and adhere to the terms of the Conditional Discharge;
- Social Supervisors were unclear as to their role and did not appear to have received appropriate training or supervision.
- *Contributory Factor Eleven. Policy non adherence made a significant contribution to the poor overall management of Mr. Y's case which was to the overall detriment of his health, safety and wellbeing.*

## Number Twelve

### Overall Management of the Care and Treatment of Mr. Y.

- **There was a consistent lack of clarity in understanding and formulating Mr. Y's problems and needs.**
  - There is no clear evidence in Mr. Y's clinical notes of the process of: assessment, formulation, identification of needs, interdisciplinary/agency planning, intervention and evaluation of the intervention.
  - Prior to Mr. Y killing his father he was displaying the symptoms of a serious mental illness. He was non-compliant with the interventions identified (medication and attendance at the day hospital) and he was deemed to need admission as an inpatient. Mr. Y had been identified as needing a Mental Health Act assessment but his situation was allowed to drift for several months. This resulted in a number of missed opportunities and consequently his acute psychosis went untreated and continued to deteriorate.



- Whilst in the Scott Clinic there was no evident sustained planning for his discharge other than that provided by the Occupational Therapist. There was no evident effort, recorded in Mr. Y's notes, to discover why he killed his father, to consider the relationship(s) of his 'Theory of Mind' (ToM) difficulties to his other symptomatology, to consider the implication of his ToM difficulties on his ability to function successfully outside the highly structured environment of the Scott Clinic and on the risks he might pose to others. There was no meaningful involvement of Mr. Y's mother in planning for Mr. Y's discharge, identifying the risks he might pose to her or identifying her needs e.g. for understanding her son's problems. Cognitive Behaviour Therapy and other strategies for coping with psychological distress/difficulties recommended by Best Practice guidance were not made available to Mr. Y.
- Following Mr. Y's discharge from the Scott Clinic there was no clear formulation of his problems other than that his ToM difficulties might present difficulties in social situations. The result of this was that there were no focused interventions put in place, monitoring lacked focus and there was a lack of clarity as to how Mr. Y's progress or changing risk profile might be monitored and evaluated.
- **Mr. Y was known to be reluctant to comply with interventions and was described on an number of occasions as 'a private person' however there were a number of levers that could have been used more effectively to promote Mr. Y's engagement and involvement:**
  - prior to Mr. Y killing his father the provisions of the Mental Health Act (1983) could have been used in a more timely and assertive manner;
  - the terms of Mr. Y's conditional discharge should have formed the basis for a clear and more constructive risk management plan; this did not happen;
  - Section 117 of the Mental Health Act (1983) should have been used more forcefully and creatively to ensure that Mr. Y had fully funded ongoing support. This should have been informed by a robust and comprehensive care plan which Mr. Y and his mother should have been involved in drawing up.

- **Interagency collaboration and communication.**

- Given Mr. Y's history it was of considerable importance that information regarding the risks he posed, or changes in his risk profile, should have been shared between relevant agencies. MAPPAs were the obvious forum for this sharing of information and for establishing protocols for information sharing between agencies. Mr. Y was not referred to MAPPAs this was a significant omission in the management of his care.
- Imagine staff provided a significant amount of support and supervision for Mr. Y following his discharge from the Scott Clinic. They were invited to his CPA reviews and Mr. Y's Care Coordinators and Social Supervisors communicated with the Imagine staff on a regular basis. However, on at least one occasion Imagine had to ask for the minutes of the CPA review and the related care and risk management plan. It was noted by this Investigation that CPA documentation was far from complete in Mr. Y's Imagine-held record. The meetings with the Care Coordinators were unstructured and not focused upon the responsibilities of the two agencies for delivering an agreed care plan. There appeared to be a lack of clarity as to the roles and responsibilities of the two organisations. A robust management plan with a clear review structure would have addressed this and increased the efficacy of both organisations.

- **Clarity of roles and responsibilities.**

- Following Mr. Y's discharge from the Scott Clinic his two Care Coordinators were Community Psychiatric Nurses (CPNs). They appear to have fulfilled the role of the CPN rather than assuming the role of the Care Coordinator and ensuring that Mr. Y's needs were identified, that there were plans in place to meet these needs, that these plans were reviewed in a timely manner and that these plans were delivered.
- One of Mr. Y's Social Supervisors informed the Independent Investigation Team that she had no training as a Social Supervisor and received very limited supervision. Both Social Supervisors appeared not to focus upon their primary role of monitoring Mr. Y's terms of Conditional Discharge.
- Whilst in the Scott Clinic Mr. Y's Responsible Medical Officer/Clinician was also his nominal Care Coordinator. There appears to have been some

confusion about the roles of the Responsible Medical Officer/Clinician and Care Coordinator once Mr. Y had been discharged from the Scott Clinic.

- The Local Authority, as represented by Supporting People, does not appear to have understood its responsibilities under Section 117 of the Mental Health Act (1983). The Local Authority does not have to make funding available to support an individual in the community *via* the Supporting People funding stream on an ongoing basis if it is no longer deemed to be appropriate. However if funding is removed from this stream, and the individual concerned is eligible for Section 117 aftercare, the Local Authority and Primary Care Trust must make it available *via* an alternative route. The Local Authority has a duty to ensure that such changes are not detrimental to the well-being of the individual. In the case of Mr. Y the change in funding had two immediate and probably detrimental consequences to his accommodation arrangements: (i) uncertainty was introduced into Mr. Y's life without the necessary time being available to prepare him for the proposed change; (ii) he would have been moved to a living situation which entailed less supervision and possibly less support.
  
- *Causal Factor One. There was a failure by the Scott Clinic treating team to ensure that best practice clinical policy guidance was applied to the care and treatment of Mr. Y. Consequently Mr. Y's case was managed in an unstructured fashion which placed an over reliance upon 'gut instinct' over and beyond clinical formulation. This was compounded by the weak discharge planning processes that ensued when Mr. Y went to live at Moscow Drive. Protective measures were not put into place in accordance with statutory expectation that could have provided more support for Mr. Y's recovery and a higher level of protection to his mother.*

### **Number Thirteen**

**Clinical Governance and Performance.** The quality and effectiveness of Trust governance systems cannot be assessed when viewed through the single lens of this particular case. It would appear that the Trust has robust policies and procedures which are both evidence-based and robust. It is also evident that the Trust has in place a comprehensive governance system which is compatible with national best practice expectations.

Whilst the Trust had in place a number of appropriate policies and procedures informed by national best practice policy guidance there were some instances in the care received by Mr. Y where these policies were not adhered to. This lack of adherence was not identified in a timely manner by the Trust governance procedures and protocols and as a result weak (remedial) action was put into place to ultimate detriment of Mr. Y's care, treatment on ongoing case management.

### **1.5.2. Conclusions**

#### **Issues Relating to the Killing of Mr. Y Senior**

##### **Quality of Care and Treatment and Trust and Independent Investigation Processes**

The Independent Investigation Team concurs broadly with the findings of the Trust Internal Review 2004. The care and treatment that Mr. Y received did not adhere to the expectations of extant Trust policy and procedure in place at the time of the killing of Mr. Y Senior. The treating team did not act in a timely manner which would have ensured Mr. Y's acute psychosis was appropriately treated. This impaired his recovery and led to his mental health continuing to deteriorate up until the time he killed his father. Court processes and the Criminal Justice system found a link between Mr. Y's mental state and the killing of his father.

In 2004 the National Patient Safety Agency had commenced a training programme that required NHS Trusts to adopt a Root Cause Analysis (RCA) methodology when conducting internal investigations. The Trust Internal Review (2004) into the care and treatment that Mr. Y received was conducted prior to the national requirement for implementation and consequently did not use a RCA methodology. Even so, the report produced a useful and insightful set of findings.

#### **Impact of Lessons to be Learned from the Killing of Mr. Y Senior and any Consequences Regarding the Killing Mrs. Y Senior**

NHS North West (the Strategic Health Authority who commissioned this Investigation) requested that the Independent Investigation Team assess whether its decision not to subject the homicide of Mr. Y Senior (2004) to an HSG 94 (27) full Independent Investigation impacted upon the killing of Mrs. Y Senior (2010) in any way.

In 2007 Strategic Health Authorities (SHAs) across the country had difficulty in responding to HSG 94 (27) requirements in a timely manner due to extensive NHS reorganisation. Consequently many SHAs made the decision to conduct large-scale 'Legacy Reviews' in order to ensure that lessons were learned. NHS North West commissioned a Legacy Review analysis of 22 cases in 2007. The case of Mr. Y was one of the cases commissioned for investigation as part of this review. An Independent Investigation Team was appointed to conduct this work. It was decided that:

*“As requested by NHS North West, the panel considered the option of recommending a further independent investigation for each case where this had not taken place. On balance, the panel decided against this approach on the grounds that:*

- the time lapse since the incidents was such that many families would find further investigation distressing;*
- staff would have moved on and would need to be traced or may be unavailable;*
- service users had not given consent for their personal information or health records to be accessed or made public;*
- as a result of this review, all cases had been subjected to further scrutiny by an expert panel and the root cause and contributory factors had been identified”.*<sup>18</sup>

It was not recommended that the case of Mr. Y needed to be put forward for a separate Independent Review.

It is unlikely that a separate Independent Investigation would have yielded information of a kind to have prevented the death of Mrs. Y senior six years into the future. The reasons this Independent Investigation Team hold this view are set out below.

- The Trust Internal Review (2004) was of a good standard and yielded robust findings and valuable insights. Examination of the Trust action plan demonstrates service improvements took place.
- The Independent Legacy Review process was conducted by a panel of experts who were able to identify key areas of learning on both a thematic and individual case basis.
- The services that Mr. Y received his care and treatment from prior to the killing of his father in 2004 and prior to the killing of his mother in 2010 where entirely different

---

18. NHS North West *Patient Safety: a review of case requiring mental health Independent Investigation in the North West (2007)*

services, albeit within the same Trust. This meant that the service improvements that subsequently occurred in one service (CMHT secondary care) did not necessarily impact directly upon the other service (Scott Clinic forensic tertiary care). This is because the findings and recommendations were not generalisable.

- There was a time interval of six years between the killing of Mr. Y's mother and father. It is unlikely, in the light of constant NICE and Department of Health policy guidance change, that the issues regarding the learning in 2004 automatically carried forward to 2010.
- Following the death of Mrs. Y Senior the Scott Clinic treating team were supported by the secondary care CMHT for a period of several months in order to ensure that Mr. Y's past psychiatric history was understood and incorporated into forensic service assessment processes. Therefore an independent investigation process would not have contributed information about Mr. Y which was not already understood by the Scott Clinic utilising a more reliable and professional process; that of clinical team cooperation.

It was the conclusion of the Independent Investigation Team that the decision not to commission a traditional HSG 94 (97) process following the killing of Mr. Y Senior in 2004 had no far-reaching consequences in relation to the death of Mrs. Y Senior in 2010.

### **Issues Relating Specifically to the Killing of Mrs. Y Senior**

It was evident that there was a causal link between the omissions of the treating team providing care and treatment to Mr. Y and the killing of his mother. This is because the treating team did not:

- accept the significance of the patient's condition in relation to his potential for high risk behaviours (this was despite having identified significant risk factors in relation to Mr. Y's potential for future offending and the ensuing risk to his mother);
- put into place an appropriate system to detect any relapse in Mr. Y's mental state;
- put into place an appropriate supervision and risk management plan;
- adhere to either local or national best policy guidance in order to ensure that essential safety nets of care were put into place which would have been considered the norm for any patient with the history and diagnosis that Mr. Y presented with (e.g. CPA, MAPPA, and Ministry of Justice conditions of discharge).

When examining the effectiveness and quality of care and treatment it is reasonable to assume the following:

- sound assessment leads to a) a plan to manage risk, care and treatment b) informed care and treatment;
- risk management and treatment plans can reasonably be expected to reduce risk and to improve and maintain mental health.

On the 28 March 2011 the Crown Prosecution Service stated *“The experts preparing these reports, having access to all the evidence and to the defendant's medical records, ultimately concluded that ... [Mr. Y] was suffering from an abnormality of the mind that substantially impaired his mental responsibility for his acts at the time he killed his mother. Taking account of the weight of medical opinion as to the defendant's mental condition the Crown accepted the defendant's plea to manslaughter on the grounds of diminished responsibility”*.<sup>19</sup> Mr. Justice Calvert-Smith also made orders under the Mental Health Act, sending Mr. Y to Ashworth hospital without a time limit. He said: *“This was a dreadful offence committed by a man who had already unlawfully killed his father some six years before and made a serious attack on his mother at the same time. This was about a serious a breach of trust as can be imagined, to kill your mother who was of advanced years and therefore vulnerable”*. The Court was also told how three psychiatrists agreed Mr. Y was suffering from an abnormality of mind and his responsibility was *“substantially, although not necessarily entirely, impaired”*.<sup>20</sup> This Investigation found a direct causal link between the lack of appropriate supervision and risk management strategy implementation that Mr. Y was subject to and the killing of his mother and as such concurs with the findings and conclusions of the Trust Internal Review Report (2010) which also made the same causal link.

However, despite the above finding, it was also the conclusion of the Independent Investigation Team that the Mersey Care NHS Trust in 2012 has sound governance processes and that this particular tragic incident does not indicate that the Trust is operating poorly in general. The Independent Investigation Team recognises that it is not possible to assess the functioning of an entire organisation when examined through the lens of a single case. However the evidence collected throughout the course of this inquiry process has given the

---

19. [http://www.cps.gov.uk/mersey-cheshire/cps\\_merseyside\\_cheshire\\_news/sentencing\\_of\\_Mr\\_Y](http://www.cps.gov.uk/mersey-cheshire/cps_merseyside_cheshire_news/sentencing_of_Mr_Y)

20. <http://www.thefreelibrary.com/FREED+TO+KILL+HIS+MUM,+70%3B+Man,+39+had+battered+dad+to+death.-a0252645494>

Independent Investigation Team a high degree of confidence in the Trust, both as a learning organisation, and as a responsible provider of clinical services in general.

When examining the quality of the care and treatment a person receives from a mental health Trust the following four findings categories can be utilised when causality is being considered.

**Category 1.** The Trust implemented high standards of service delivery that were appropriate, effective and in keeping with best practice and the Independent Investigation Team was unable to identify any causal or contributory factors to the homicide in question.

**Category 2.** The Trust implemented high standards of service delivery that were appropriate, effective and in keeping with best practice. However a single act or omission, or the unexplained practice of a single team, led directly to the circumstance in which a serious untoward incident occurred. Causality was found between the untreated mental state of the service user/the quality of the care and treatment provided, and the subsequent actions of the service user.

**Category 3.** The Trust delivered less than effective services where systems were chaotic and best practice standards were not implemented. However no direct causal relationship between what the services actually did or did not do was connected to the incident.

**Category 4.** The Trust delivered less than effective services where systems were chaotic and best practice standards were not implemented. Causality was found between the untreated mental state of the service user/the quality of the care and treatment provided, and the subsequent actions of the service user.

It was the conclusion of the Independent Investigation Team that the Mersey Care NHS Trust findings belonged to Category 2. However it was evident that there was a direct causal link between the omissions of the clinical team providing care and treatment to Mr. Y, the lack of appropriate supervision and risk management strategy implementation, and the death of Mrs. Y Senior. The Independent Investigation Team concludes that there were significant omissions on the part of the Scott Clinic treating team and the overall standard and of care and treatment offered to Mr. Y over a period of several years fell below that to be expected



form either a secondary or tertiary care service. This Investigation concludes that the omissions and poor levels of care and treatment occurred due to three principle reasons.

1. Scott Clinic culture, custom and practice had not been successfully incorporated into those of the Mersey Care NHS Trust prior to the killing of Mrs. Y Senior. Consequently the Scott Clinic adhered to processes which could not be described as best practice.
2. Scott Clinic staff did not appear to have accessed suitable levels of training and supervision which exacerbated the non adherence to both local and national best practice policy guidance.
3. Trust clinical governance systems were not sensitive enough to detect policy and procedure non adherence. This was because the Scott Clinic staff applied the principles of policy and procedure to the point where a loose and poorly constructed compliance took place. This is demonstrated by the fact that forms were filled in and reports and care plans written. However there is a substantial difference between *basic* compliance and *quality* care and treatment delivery. It has to be noted here that many NHS mental health Trust's may not have governance systems that are sensitive enough to assess the quality of clinical work. Nationally, audit processes tend to focus mainly on compliance.

It is to the credit of the Mersey Care NHS Trust that these issues were identified within its own Internal Review Report (2010) and that a substantial amount of work has been put into train and significant improvements have been accomplished since the killing of Mrs. Y Senior. These are detailed in Sections 17 and 19 below.

### **Summary**

Had Mr. Y been subject to a robust supervision and management strategy the risk that he would have killed his mother would have been substantially reduced. This is a complex case. There were numerous factors to take into consideration all of which interacted with each other as well as having significant relevance in their own right. Over time it was evident that Mr. Y was understood poorly and factoids developed within the treating team in regard to his mental state and likelihood of relapse, none of which were based on the evidence that had been collected.

It is essential that all NHS clinicians adhere to both national guidance and local policy and procedure. 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 policies or procedures or to raise any implementation issues as they arise with immediate effect. The failure to abide by policy and procedure ensures that the safety nets of care are not effectively in place. This puts the service user at risk and places the clinician in a vulnerable and often indefensible position. The Trust had, and continues to have, sound policies and procedures. However it remains a corporate, local management and individual worker responsibility to ensure that they are used at all times and that audit assures the Trust Board that this is in fact occurring.

The Independent Investigation Team concludes that the treating team had the knowledge, opportunity and means to intervene in order to ensure Mr. Y was supervised and managed appropriately. However the treating team did not fulfil its obligations and failed in its duty of care. The treating team both *could* and *should* have put into place a coherent care and management strategy around the conditions of discharge imposed by the Ministry of Justice. This was not achieved. This in effect left Mr. Y to regulate his own activities and set his own boundaries, consequently he fell through the safety net of care that was not robust enough to try and ensure the safety of either Mr. Y or his mother.

## **1.6. Notable Practice and Lessons Learned**

**The following notable practice was identified.**

- 1. Clinical Policies and Procedures.** Mersey Care NHS Trust policies and procedures were of a high standard. Each policy set out national best practice expectation and how this should be implemented by services locally in a clear and concise manner. Of particular note were the Trust Clinical Risk and Multi Agency Public Protection Arrangements policies and procedures. The Independent Investigation Team concluded that these policies represented notable practice and that they would be a useful reference point for any other mental health service to be signposted to.

- 2. Internal Investigation Processes. Mersey Care NHS Trust** The standard of the Trust internal review reports for both 2004 and 2010 were of a high standard. The Independent Investigation Team noted that the Trust 2004 report represented an exceptional example of its kind considering that nationally most Mental Health NHS Trusts at this time struggled to compile such comprehensive and useful investigation reports. The 2010 Trust internal report was insightful and far-reaching ensuring that sound recommendations were set based upon solid findings and conclusions. The Review Team was comprised of senior and experienced personal and the friends and family of Mrs. Y Senior were offered the appropriate levels of support by senior members of the Trust Board.

**Imagine.** It must be drawn to the reader's attention that Imagine Independence has never had to deal with a serious untoward incident of this nature before. It is therefore remarkable that this organisation was able to produce an internal review of such a high standard. The findings, conclusions and recommendations were both insightful and robust.

Both the Trust and Imagine worked together to ensure that the findings of their individual investigation reports were brought together in order for the recommendations to be worked through together.

- 3. Governance and Learning Organisation Systems.** Mersey Care NHS Trust has modernised its governance systems in recent years. The Trust is also utilising the Oxford Model (the Oxford Model is a Serious Untoward Incident/Complaint rolling review process which is a way of taking forward the lessons learnt from Serious Untoward Incidents/Complaints, and sharing that learning with a broader audience. Each incident/complaint will already have been reviewed, this process provides the possibility of identifying further issues or concerns and also involves staff in the improvement process) in order to disseminate learning following serious untoward incidents. This approach is now embedded into the way that the Trust learns and was found by this Investigation to be notable practice.
- 4. Medical Appraisal.** This Independent Investigation Report has raised issues in relation to the quality of clinical decision making. The Mersey Care NHS Trust has

worked to develop a significant model for medical appraisal and revalidation. In 2010 the Trust was selected to become one of ten national pathfinder pilots for medical appraisal and revalidation. Six of the original nine Merseyside Trusts were together successful in a bid to test a revised electronic appraisal system. By the end of the pilot in April 2011, 474 new appraisals had taken place within the Mersey pilot (more than any of the other pilots). This allowed strengthening of the working relationships across the different Trusts in the region and also provided an opportunity for feedback to the independent evaluators. 85 doctors within Mersey Care (out of a possible 100) were able to take part in this pilot. Despite difficulties with the system, participants valued the experience because it increased their awareness of how to successfully undergo appraisal. The approach within Mersey Care NHS Trust has therefore been of moving from the default position of a paper based appraisal process to taking advantage of new approaches, encouraging feedback, and thus ensuring that psychiatrists are able to help influence the development of appraisal. This overall approach also leads to better clinical governance processes by sharing the expectations of revalidation within the Trust.

### **Lessons for Learning**

#### **1. Adherence to national and local policy and procedure best practice guidance.**

National and local best practice policy and procedure guidance is an evidence-based method of ensuring both the quality and safety of the clinical care and treatment provided to service users. If treating teams do not adhere to this guidance then the effectiveness of any treatment programme can be compromised. In the case of Mr. Y it was found by this Investigation that significant departures were made from extant Trust policy and procedure. This had the effect of providing a care and treatment package to Mr. Y that was sub-optimal placing both him and those around him at risk.

Trust policies and procedures were found by this Investigation to be of an excellent standard and the Trust benefitted from having clinical policy authors with national standing. It was unfortunate that members of Mr. Y's treating team chose to ignore this guidance, choosing instead to follow an *ad hoc* and localised way of doing things. A lack of policy and procedure adherence is a common finding in HSG (94) 27 reports of this kind. It is also a common finding that the failure to follow best practice policy guidance leads to the provision of sub-optimal care and treatment delivery.

The lesson to be learned here is that NHS Trusts and the individuals who work within them have a duty of care placed upon them which requires total adherence to policy and procedure guidance unless there are clear clinical indications for a departure in the best interests of the patient. Whilst it is far from unusual to find a lack of policy adherence this is not good practice. NHS Trusts must be mindful of corporate responsibilities and individual practitioners must be mindful of the duty of care placed upon them by their registration bodies. NHS Trusts should develop a culture where there is a zero tolerance of clinical policy and procedure non adherence.

- 2. Sub-audit ‘blind spots’.** All NHS Trusts will have clinical governance processes and systems in place in order to ensure patient safety and efficient and effective practice. It is often difficult to understand how a Trust with a sophisticated clinical governance system can still fail to detect poor or unsafe clinical practice.

It is a fact that many audit processes focus upon compliance rather than quality. In effect this means that increasingly Trust electronic record systems are used to collect basic data. For example, a clinical CPA audit may check whether or not services users have a care plan. It is possible to find Trust audits which show a 100% compliance rate. However when the quality of the care plans are examined it can be seen that the general standard is extremely poor and the implementation, monitoring and review of the care plans is non-existent. This appears to have been situation with Mr. Y’s case. It was evident that risk assessment documentation and care plans were developed, however the quality of this work was weak and did not fulfil Trust policy expectations. However to a causal observer it appeared that everything was in order.

Once again when this Investigation considered the documentation available in Mr. Y’s clinical record it appears that everything was in order. Documentation included:

- CPA;
- risk assessments;
- Tribunal reports;

However it is a fact that key clinical policies and procedures were paid ‘lip service’ only. This Investigation concluded that this was a cultural issue which was neither

identified nor tackled in a robust manner. Sub-audit blind spots can only be detected and ameliorated by the existence of robust examination and reflection. Clinical audit alone cannot ensure this occurs. Clinical supervision, appraisal and revalidation are essential tools in ensuring that practitioners adhere to best practice guidance and that care and treatment is delivered in an optimal manner. It is only when clinical practice is examined in detail that departures from procedure can be detected.

- 3. Statutory responsibilities.** Ministry of Justice (MoJ) requirements and also those of the Mental Health Act (1983 & 2007) fall under statute. It is never acceptable for practitioners working in specialist services to either ignore or ‘bypass’ the statutory duty of care placed upon them.

Individuals working in specialist fields cannot use ignorance of policy, procedure or statutory role as any kind of defence for the failure to act appropriately. Each individual has a duty of care to ensure that they meet both the requirements of their role and the requirements of the MoJ and the Mental Health Act. NHS Trusts retain a corporate duty of care to ensure that statutory compliance is monitored and upheld. The point of learning here is that individuals should not superimpose their own interpretations, methods or preferred ways of working onto any statutory process. If members of a treating team disagree with a mandated approach then any challenge or concern should be taken up in a formal manner, it is not acceptable for an alternative approach to be taken under any circumstance.

- 4. Professional and inter agency communication.** HSG (94) 27 independent homicide investigations of this kind have consistently found causal factors in relation to homicides perpetrated by mental health service users and failures in levels of professional and inter agency communication. It is common for members of a treating team to know a service user well. It is also common for documentation to not always record all of the pertinent details known about any one individual. When service users are handed over from one treating team to another it is often the case that only partial information is imparted. In the case of Mr. Y a sequence of poor communication occurred:

- at the juncture between Mr. Y being transferred from the Scott Clinic to the Forensic Integrated Resource Team;

- at the juncture of Mr. Y's conditional discharge from the Scott Clinic to Imagine;
- at the juncture of his move from 123 to 133 Moscow Drive.

At each of the three above listed junctures incomplete information was passed on to services.

Inter agency communication was also poor. The failure to communicate with the Police and other statutory agencies served to place both Mr. Y and those around him at risk. Had information about Mr. Y been communicated appropriately a more robust approach to his care and treatment would have been taken. The lesson for learning here is that treating teams have a duty of care to ensure that this essential aspect of care and treatment delivery is always achieved in full.

## 1.7. 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 Mersey Care NHS Trust and Imagine Independence to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice have 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 inquiry process.

**The Independent Investigation acknowledges the fact that the Trust and Imagine internal reviews produced robust recommendations which have been implemented. The recommendations below are provided in addition to those already identified and do not seek to replicate them. The reader is advised to refer to report Sections 15 and 16 which set out previous recommendations. Appendix Two sets out the action plan and progress made to date.**

The Executive Directors of the Mersey Care NHS Trust and Imagine Independence had the opportunity to review the recommendations required for this case at both the preliminary feedback stage and during the factual accuracy checking stage. The Trust and Imagine should be given recognition for the work that it has put into this process and the progress that has already made.

### **1.7.1. Diagnosis**

- *Contributory Factor One. There was a failure to understand Mr. Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.*

### **Trust/Imagine Progress and Commentary**

The Multidisciplinary Teams have introduced formulation as a core process to inform treatment and risk management. Diagnostic assessments, which apply accepted diagnostic criteria (ICD-10/or DSM-IV), remain a central part of the evaluation process. However, a more in-depth and specific formulation is developed that takes account of the wide range of psychopathology that may cross diagnostic boundaries. The need to develop sophisticated formulations of understanding has been the focus of a series of presentations and teaching events within the Clinical Business Unit (CBU). The implementation of this approach has been evaluated by the Clinical Director in specific case discussions and more general clinical discussions. In undertaking such assessments there is recognition that symptoms, that may not be considered core to the diagnostic construct or that are present a less obvious degree, may still be important in understanding the case and the related risks. As a result of increased awareness, training and greater access to Psychology resource, more attention is also paid to enduring features such as personality traits. The diagnostic assessment is led by the medical member of the MDT, with active contribution from all team members. The increased availability of Psychology resource has meant that greater attention is paid to the wider formulation based assessment. Again all members of the MDT are involved in this process. Particular attention is paid to aspects of the clinical profile that are associated with risk.



### **Recommendation 1**

A systematic audit of diagnostic practice within the Scott Clinic should take place to provide assurance to the Trust Board and commissioning bodies six months following the publication of this report. The audit should include:

- an audit and assessment of formulation practice to include aspects of clinical profile and potential risk;
- an in-depth case study sample should be audited to check for compliance against accepted diagnostic criteria.

#### **1.7.2. Medication and Treatment**

- *Service Issue One. The Scott Clinic practiced an unacceptable level of medicines management in the case of Mr. Y. Whilst this cannot be cited as either a contributory or causal factor it demonstrates a lack of medicines management systems and understanding on the part of Scott Clinic clinicians.*
- *Contributory Factor Two. Mr. Y did not receive treatment in line with national best practice guidelines. This represents a missed opportunity that left Mr. Y vulnerable to relapse.*

#### **Trust/Imagine Progress and Commentary**

With regard to treatment protocols, there has been an updated review of the National Institute of Health and Clinical Excellence (NICE) guidelines relating to the conditions that fall within the remit of Trust services. *Via* Governance Forums, Audit Forums and Clinical Meetings the need to adhere to the relevant NICE guidelines has been emphasised. A rolling programme of audits is underway to assess compliance with NICE guidelines. An Audit has been undertaken and presented on medication adherence. The standards from the relevant NICE guideline were audited.

The role of psychological professionals has been reviewed within the Service: all psychologists have three days dedicated time working clinically in the in-patient setting. This enhanced role allows them to undertake individual work with service users and to share their formulation skills with their colleagues. The aim is to ensure that all staff has access to psychological expertise and guidance when assessing and planning care. It was recognised

that the client group has gradually changed over time with an increased number of service users having a multiple diagnosis, frequently including the presence of a Personality Disorder. The Trust has appointed an Enhanced Care Psychological Team led by the Clinical Director who work with and advise the staff on the management of this very complex group. The Enhanced Care Team works full time in in-patient services. This has proved very beneficial and gives the staff a resource to gain guidance with which to amend and enhance their practice.

The Trust also has systems in place to ensure that a statutory process in relation to the rights and needs of carers is met. The Trust is optimising the involvement of carers in all aspects of care, risk and care planning. Currently family interventions *via* Cognitive Behaviour Therapists (Barraclough and Tarrier) can be offered however family therapy as a standard intervention is not routinely offered. The Trust is looking to advice from its Lead Psychologist regarding the need for this level of intervention.

## **Recommendation 2**

The Trust medicines management policy should be reviewed/redeveloped to ensure that service users who have been conditionally discharged are managed effectively in the community. This review should include:

- the clarification of definitions between service user medication adherence and service user medication concordance;
- developing sections that set out the requirements for service user and carer education regarding medication purpose, usage and side effects;
- including the requirement for service users with a history of medication non adherence to have a medicines management care plan which is reviewed on a regular basis.
- sections that set out the requirements for the education and support to be provided to non statutory agencies involved in the care of service users in the community.

The reviewed/redeveloped policy should be audited 12 months after the date of its inception.

### **Recommendation 3**

Service users at the Scott Clinic should receive a broad spectrum of treatment in line with NICE guidance. This treatment should be:

- delivered by therapists experienced and trained in the therapeutic interventions prescribed;
- mindful of the need for family-focused therapy requirements; this to be of particular note if there is a history of either violence or sexual abuse involving family members;
- in keeping with the therapy-service approach to be found in all other parts of the Trust.

The provision and uptake of psychological therapy approaches in keeping with NICE guidance at the Scott Clinic should be audited within 12 months of the publication of this report.

#### **1.7.3. Mental Health Act (1983 and 2007)**

- *Contributory Factor Three. There were serious failures in the implementation of the terms of Mr. Y's conditional discharge. This meant that the conditions put into place by the Ministry of Justice to protect the public were rendered ineffective.*

#### **Trust/Imagine Progress and Commentary**

The Trust/Imagine did not wish to provide a commentary here.

### **Recommendation 4**

The Trust should develop a specific set of clinical guidelines regarding the requirements for treating teams when receiving conditions for discharge on behalf of the patients in their care.

These guidelines should include the need for:

- robust risk assessment;
- consultation and involvement of service users;
- consultation and involvement of carers and family members;
- clear and well communicated care plans;
- the clarification of roles and responsibilities for the implementation, monitoring and review of the conditions of discharge;

- a communication strategy that ensures all partners in care, multi agency personnel, and family members are kept informed and can provide feedback.

#### **1.7.4. Care Programme Approach (CPA)**

- *Contributory Factor Four. It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y worked in silos to the detriment of Mr. Y's overall case management, care and treatment.*

#### **Trust/Imagine Progress and Commentary**

In February 2010 Mersey Care NHS Trust CPA conference launched the CPA documentation to be introduced in April 2010. SaFE Partnerships CBU, although at the time was working within the Care Programme Approach, needed to address these changes in a fashion which not only reflected the different paperwork required, but to ensure that a change in approach was adopted from a quality perspective and was also considered a crucial factor in ensuring high quality care was, delivered, monitored and audited. SaFE Partnerships CBU Medium Secure Unit (MSU) had previously used documentation it devised itself. It was recognised that this option was not in line with Mersey Care NHS Trust CPA Policy.

To ensure effective adherence to the Trust policy it was agreed that the service needed to support the workforce and ensure that a training programme was developed and delivered to potential Care Coordinators to develop the skills and knowledge necessary. The subsequent schedule and delivery of training was based on a training needs analysis, 120 staff were initially identified to complete this training delivered by experienced staff within the CBU. This training has continued to be rolled out and the SaFE Partnerships is confident that appropriate staff has been engaged in this direct learning.

SAFE Partnerships CBU has now commenced the process of assessing the competency of Care Coordinators. The work completed by the National CPA Group for the Department of Health cross referenced Care Coordination Competencies with National Occupational Standards and KSF dimensions. This competency framework has been adopted by SaFE Partnerships CBU.

As SaFE Partnerships CBU provides some regional services it was necessary to develop local guidelines for the MSU to support an effective approach to CPA and to ensure links are made with Secondary Services across Merseyside and Cheshire. The Guidelines for interface between the Forensic Service and Secondary Services were ratified by the Clinical Governance Group initially in 2009 and again following amendments in 2012. This document clarifies expectations of local services in the CPA process during admission to the MSU and for those discharged to the Community Forensic Integrated Resource Team.

Since May 2010 SaFE Partnerships CBU has continued its involvement with Trust focused CPA work and continues to ensure adherence to the Trust Policy.

### **Recommendation 5**

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding CPA. The Trust should review the effectiveness of its CPA policy at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

#### **1.7.5. Risk Assessment**

- *Contributory Factor Five. Mr. Y was not understood in the context of his full risk profile. Assessments of risk were undertaken in the absence of a robust formulation of the case. Consequently risk management plans and strategies were superficial and non-explicit. This, when taken alongside the failure to abide by the terms of the conditional discharge and decision not to consider MAPPAs arrangements, ensured a critical lack of supervision and management. This was to the ultimate detriment of Mr. Y's health, safety and wellbeing and to the continued safety of his mother.*

### **Trust/Imagine Progress and Commentary**

#### **MAPPAs**

As a result of the Mr. Y incident an extensive specific work stream was undertaken with Mersey Regional Forensic Services (SaFE Clinical Business Unit), primarily in patient and community services to identify and implement systems for MAPPAs.

A 'series of scoping exercises' took place from June 2010 with SaFE Clinical Business Unit under the headings of 'MAPPAs panels days' when MAPPAs coordinators, probation staff, Scott Clinic staff and the criminal justice liaison team (including lead for MAPPAs for Mersey

Care) came together to discuss specific cases and systems for recording MAPPA arrangements.

Through this forum an extensive MAPPA work stream took place ensuring that the identification and notification of MAPPA eligible service users took place and any service users that needed immediate referral to MAPPA were identified.

This work was undertaken in partnership and in conjunction with multi-agency colleagues from Probation and the Police. There was a series of meetings with the MAPPA co-ordinators from both Merseyside and Cheshire and with the Partnership Interagency Manager (PIM) for the police in the St Helen's area as an immediate response to improve multi agency working.

A police liaison forum was established in August 2010 which meets monthly in conjunction with the Mental Health Police Liaison Officer, local Police, Scott Clinic staff and CJLT. These arrangements have been placed within the Mersey Care NHS Trust governance arrangements. A MAPPA mental health sub group was developed to support MAPPA arrangements across Merseyside and ultimately Mersey Care's MAPPA governance arrangements were developed.

The MAPPA Champions forum was developed in October 2010 which is chaired by Mersey Care SMB Lead and the forum developed the MAPPA governance arrangements and MAPPA framework that Mersey Care adheres to. Senior representatives from all Clinical Business Units attend the Champions group and SaFE Clinical Business Unit is represented by psychiatrists, senior nurses and senior social workers.

A database has been developed which is a fluid document and the mechanism to record all MAPPA eligible offenders, future MAPPA dates and a number of other features. Each CBU has a responsibility to maintain its own database which is available for the SMB lead, CJLT and the MAPPA champions group to consider.

The SMB lead also has regular dialogue with the MAPPA co-ordinator (Probation lead for responsible authorities) and attends an SMB MAPPA mental health sub group.

The Scott Clinic has been an active participant in the MAPPA champions group and led on establishing a SaFE partnership Clinical Business Unit MAPPA guidance document which supports the arrangements for MAPPA.

### *Conclusion*

Mersey Care NHS Trust are at the forefront of development in their current arrangements relating to MAPPA and it is evident from feedback from the SMB and benchmarking against local and North West mental health partners that Mersey Care has guidance which is forward thinking and been held as an example of good practice for other SMBs.

Throughout this period Scott clinic staff has actively engaged in the process to improve MAPP arrangements and knowledge of MAPPA systems.

**The Independent Investigation Team has reviewed evidence to support the progress that the Trust has made and is satisfied with the work that the Trust has undertaken and have no further recommendations to make in this area.**

### *Risk*

The Multi Disciplinary Team is taking a more directive approach to Service User involvement in all aspects of care including their engagement in interventions aimed at risk management to maintain therapeutic optimism. Failure for the service user to engage may mean a change of care pathway possibly resulting in long-term hospitalisation.

The use of information obtained by the current risk assessment profile, health and social care reports and other professional information are essential components to contribute to the development of an individual 'Risk Formulation' for each service user.

A risk formulation will be generated for all service users by the MDT based on their completed HCR20 Risk Assessment. This information together with relevant data from Health, Social Care reports and other professional information will be actively utilised, reviewed and updated by the MDT. Each risk formulation should be discussed by MDT members and amended on a regular basis. Risk formulation information should be entered this into the E-Pex system by the chair of the meeting. This would demonstrate that risk factors and new information had been actively discussed and considered by the MDT

assisting team decision making. This formulation would also guide the individual service users care pathway indicating areas to be addressed by both inpatient and community teams.

The format has been developed to guide staff in conducting MDT's and formulating care plans with the aim of providing staff with guidance on the minimum standards required and the breadth and scope of the work they are required to undertake.

The CPA has been augmented by the standardised use of the HCR20, the formulation template and critical information is directly linked to care plans. This critical information also includes the Ministry of Justice conditions are also put into place to ensure efficacy in relation to the public protection.

The service will ensure adherence to the National and Local Standards in relation to Care Programme Approach.

The formulation practices will guide decision making around care pathways and discharge.

## **Recommendation 6**

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding risk management processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

### **1.7.6. Referral, Admission and Discharge Planning Processes**

- *Contributory Factor Six. The discharge process did not address in sufficient detail either the needs of Mr. Y or the continued safety of the public, with particular reference to Mrs. Y Senior. The process appeared to have been rushed and coordinated poorly. As a consequence the essential safety nets of care were not put into place to the ultimate detriment of the care, treatment and supervision that Mr. Y received up until the time of the killing of his mother.*

### **Trust/Imagine Progress and Commentary**

The Trust/Imagine did not wish to provide a commentary here.



### **Recommendation 7**

Both the Trust and Imagine internal reviews addressed the issues relating to referral, admission and discharge processes in a robust manner. The Trust and Imagine should review the effectiveness of their risk management processes with the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

#### **1.7.7. Service User Involvement in Care Planning and Treatment**

- *Contributory Factor Seven. Mr. Y's involvement in his care and treatment programme was superficial at best. The treating team placed too much confidence in his ability to work with his recovery programme and consequently failed to put routine protective plans in place to the ultimate detriment of the health and wellbeing of Mr. Y.*

#### **Trust/Imagine Progress and Commentary**

The Trust/Imagine did not wish to provide a commentary here.

### **Recommendation 8**

Guidance should be provided to clinical staff as a part of the Clinical Risk and CPA policy documentation which sets out requirements for service user engagement in therapeutic work and long-term care planning. Guidance should be provided in the following areas:

- when taking positive risks;
- when balancing aspects of a recovery programme with an individual service user's choices and wants which may run counter to that person's best interests.

#### **1.7.8. Carer Assessment and Involvement**

- *Contributory Factor Eight. The Scott Clinic failed in its duty of care to Mrs. Y Senior. This left her unsupported and without the protection of risk management plan.*

#### **Trust/Imagine Progress and Commentary**

Audit of the service against the standards laid out in the 'Triangle of Care' has enabled the service to identify key areas of action to improve upon the inclusion and involvement of carers in the care planning process. This has been in conjunction with improvements to the Trust wide CPA review and documentation to make the change to a more service user and

carer led focus. Specific actions resulting from the audit have included a baseline audit of carer's views and knowledge being sought throughout the assessment and treatment processes for the period between January 2011 – May 2012. This covers the period when the changes were implemented. This has shown an increase in the number of carers who have been invited to attend CPA reviews and their attendance at reviews. All Care Coordinators have been reminded of their responsibility to record the carer's concerns and views within the CPA documentation and this is being monitored. Written consent of the service user is routinely obtained with regard to carer involvement. There are always a number of service users who do not provide consent and this is reviewed at each CPA meeting with the service user.

A challenge within the service, and across the Trust, has been the development of Carer Awareness training. This is currently being explored and it is hoped that this will take place with the support of Positive Care Partnerships Clinical Business Unit and Knowsley College within the next six months (autumn/winter 2012).

Work is being undertaken to engage carers more widely across SaFE Partnerships Clinical Business Unit. This has been particularly successful at Rathbone Low Secure Unit with regular 'Friends and Family' meetings and events. A Carer Support event has been held for the Carer's of community service user's which, although poorly attended, was evaluated as helpful to those who attended. Plans are now in place for an event for the carers of inpatient service users. In addition carer's views are being sought in preparation for the annual Forensic Quality Network Peer Review due to take place in November 2012. This will also contribute to enabling the service to benchmark involvement of carers and provision of support to carers.

Monthly complex case reviews are held and chaired by the Lead Consultant where each consultant attends and bring cases for open discussion and analysis. Clinicians are encouraged and supported to accept and respond to change in relation to their practice in a safe and supportive environment.

### **Recommendation 9**

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding carer assessment and involvement processes. The Trust should

review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

### **Recommendation 10**

When carers or family members are either injured or traumatised by a Trust service user the Trust should make available to the carer or family member a support package that address ongoing needs and the offer of a therapeutic input/counselling etc. if deemed appropriate.

#### **1.7.9. Housing**

- *Contributory Factor Nine. Significant failures to manage Mr. Y's Section 117 aftercare arrangements and terms of his conditional discharge meant that his Supported Living provision was inadequately planned from the outset. This had the effect of creating a degree of instability in the life of a person who required structure and certainty and also prevented realistic protective measures being put into place.*

### **Imagine/Imagine Progress and Commentary**

Imagine staff at all levels, have been empowered to question other organisations and professionals involved in care provision of our service users. Imagine is working with the Mental Health Providers' Forum in developing templates on risk for use across the voluntary sector. This work will produce a set of safety planning principles, templates and tools to support safety, sustainability and quality practices. Best practice, sample policies and procedures will be made available on their website.

The Headline Findings meeting with HASCAS was instrumental in encouraging Imagine to reinforce the message that staff could, and would, question partner organisations appropriately, to ensure the primacy of the safety of clients, staff and the general public. It also encouraged the potential of recognition of specialist services by local funding bodies.

### **Recommendation 11**

The Local Authority, Supporting People, Commissioning Bodies, Imagine and Mersey Care NHS Trust should ensure the following actions take place.

- Contracts must be more robust and reviewed regularly in terms of performance and cost by all agencies involved in the contract and/or the care of the client, at least annually with all agencies present. The principal objective must be to establish the primacy of the safety of clients, staff and the general public.
- The relationship between funders, social care and residential care providers and mental health care providers must be discussed, agreed and recorded in service contracts.
- Decisions about long-term packages of care for individuals eligible for Section 117 aftercare MUST be based upon clinical assessment and need and MUST not be made by any single agency outside of the appropriate multi-agency arrangements.
- Ministry of Justice requirements must be complied with at all times, specifically in this case residential requirements. The environment at 133 Moscow drive did not contribute directly to this event, however, on reflection some changes to the physical environment may improve the safety and effectiveness of the property.
  - Move the staff flat to the ground floor; this will improve the staffs' awareness of whether residents are in or out of the premises and whether visitors are present.
  - Install an intercom system between the staff flat and the residents' flats to allow residents to call staff or *vice versa*.
  - Modify tenancies to allow staff to retain a copy of residents' keys for use in emergencies e.g. a resident being ill and unable to leave the flat.

#### **1.7.10. Documentation and Professional Communication**

- *Contributory Factor Ten. The standards of clinical record keeping and interagency communication were poor. This made a significant contribution over time to Mr. Y being neither understood nor managed in the full context of his mental illness in a multiagency arena.*

#### **Trust/Imagine Progress and Commentary**

The Trust/Imagine did not wish to provide a commentary here.

### **Recommendation 12**

The Trust should conduct a clinical records audit at the Scott Clinic in order to assure both compliance and quality. This audit should include:

- risk assessment and risk care planning documentation;
- CPA documentation;
- ward round discussions;
- diagnostic and risk formulation;
- rationales for decisions taken;
- evidence of a dynamic approach taken regarding evaluation and review.

### **Recommendation 13**

The minutes of meetings between agencies, e.g. Section 117 planning meetings etc. should be documented clearly within service users' clinical records. A clear audit trail should be created at each juncture on a service users' care pathway where one or more agencies are involved.

With particular regard to Imagine Services the Scott Clinic should:

- be required to make a recording in Imagine notes on every visit;
- ensure clinical risk assessment documentation be clearly separated from social care and support assessments to give clarity of responsibilities to staff from all agencies;
- risk and CPA documentation must be sent out to Imagine at the same time this documentation is forwarded on the GP.

#### **1.7.11. Adherence to Local and National Policy, Procedure and Clinical Guidelines**

- *Contributory Factor Eleven. Policy non adherence made a significant contribution to the poor overall management of Mr. Y's case which was to the overall detriment of his health, safety and wellbeing.*

#### **Trust/Imagine Progress and Commentary**

The Medium Secure Unit, is now part of SaFE Partnerships CBU, which also includes low secure and Prison In-Reach services. Each CBU is both clinically and managerially led by a Service Director and Clinical Director.

Clinical and Service Directors are accountable to the Executive Director for Service Development and Delivery for the adherence to care and service delivery standards. An

accountability framework is in place which clearly sets out the systems that will be used to identify any gaps in provision.

The Performance Assurance Framework which contains national, local and commissioning indicators is used to direct the work of the Clinical Business Units, monitoring is undertaken monthly and shared with the Accountable Executive Director. Quarterly Governance checks which include the key performance indicators and other key targets set by the Trust are facilitated by the Executive Director and her team. Remedial actions are agreed where gaps in provision are identified; the completion of actions and adherence to standards is reviewed by the Integrated Governance Committee a sub committee of the Trust Board.

Following concerns about the performance of SaFE Partnerships CBU the Clinical and Service Directors were replaced in February 2010.

A Consultant Clinical Psychologist was appointed to review the views of staff working in the CBU and this provided a baseline in which the newly appointed Directors could move forward and develop a plan that would specifically change practice and develop a more open culture.

Governance structures within the service have been reviewed with the aim of ensuring that accurate data is used to help clinicians and managers prioritise their work and to ensure that experiences of staff, carers and service users are represented. New arrangements have been put in place to supervise and support staff to ensure that they are provided with every opportunity to meet the standards set.

### **Recommendation 13**

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding governance and policy adherence processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

### **1.7.12. Overall Management of the Care and Treatment of Mr. Y**

- *Causal Factor One. There was a failure by the Scott Clinic treating team to ensure that best practice clinical policy guidance was applied to the care and treatment of Mr. Y. Consequently Mr. Y's case was managed in an unstructured fashion which placed an over reliance upon 'gut instinct' over and beyond clinical formulation. This was compounded by the weak discharge planning processes that ensued when Mr. Y went to live at Moscow Drive. Protective measures were not put into place in accordance with statutory expectation that could have provided more support for Mr. Y's recovery and a higher level of protection to his mother.*

### **Trust/Imagine Progress and Commentary**

Following the Internal Review of Mr. Y, the Clinical Business Unit commissioned a full review of MDT working across SaFE Partnership CBU. The purpose of the review was to provide an opportunity to help inform CBU Directors regarding current and future working practices across SaFE Partnerships CBU.

The review highlighted the different styles and practices used within all the Teams to manage and facilitate MDT meetings and thus provided clear direction for us to establish MDT processes that produce consistency across the whole service. The MDT is recognised as the vehicle for decision making regarding the delivery of high quality care for service users. The changes made in composition of the teams and further efficiency of MDT practices will benefit both service users and professionals.

The MDT review recommended that all meetings have an external professional to chair Multi Disciplinary Team meetings initially as an interim measure to help staff develop systems and enhance their skills in managing meetings and formulating plans of care. The MDT meetings have now been arranged so there is opportunity for a full in-depth discussion around each service users risk formulation, care planning and future planning. Documentation and processes have been enhanced to reflect the above.

This new way of working will effect a change of culture and behaviour and allow people to feel confident in participating fully and effectively in the MDT process. These systems have been piloted, adopted and implemented into MDT and CPA meetings.

#### **Recommendation 14**

The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding team working and operational processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

#### **1.7.13. Progress against Internal Investigation Processes**

##### **Trust and Imagine Progress**

Both the Trust and Imagine have worked on the recommendations that were developed during the course of their internal review work. This work was largely nearing completion at the time of writing this report. Progress against the work is set out in Appendix Two.

#### **Recommendation 15**

The Trust and Imagine action plans should be formally assured and signed off as part of the recommendation action following this HSG (94) 27 Investigation. Any outstanding action should be incorporated into the recommendation action plan developed as a consequence of this current Investigation process.