

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of

Mr N

A report for
NHS England, North Region

October 2014

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1 Introduction

On 18 June 2011 Mr N robbed and assaulted an 89-year-old woman who died from the injuries sustained in the attack. He was convicted of manslaughter and two counts of robbery. On the date of the assault Mr N was not in receipt of mental health services, having been discharged on 7 April 2011.

1.1 Background to the independent investigation

NHS England, North Regional Team, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr N.

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

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

The Chief Executive of South West Yorkshire Partnership NHS Foundation Trust commissioned an internal trust investigation into the care and treatment of Mr N.

The investigation team made four recommendations and an action plan was developed to implement them.

1.2 Overview of the Trust

South West Yorkshire Partnership NHS Foundation Trust provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. The Trust also provides some medium secure (forensic) services to the whole of Yorkshire and the Humber.

2 Terms of reference

1. Review the Trust's internal investigation, and assess the adequacy of its findings, recommendations and action plan.
2. Review the progress that the Trust has made in implementing the action plan.
3. Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of his offence.
4. Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
5. Examine whether safeguarding issues were identified and whether the appropriate safeguarding protocols were subsequently applied.
6. Review the adequacy of risk assessments and risk management, including specifically the risk of service users harming themselves or others.
7. Examine the patient's forensic history and establish whether it was appropriately taken in to account in the risk assessment and risk management process.
8. Examine the effectiveness of the service user's care plan, including the involvement of the service user and his family.
9. Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with victim support, police and other support organisations.
10. Review and assess compliance with local policies, national guidance and relevant statutory obligations.
11. Consider if this incident was either predictable or preventable.
12. Provide a written report for the investigation team that includes measurable and sustainable recommendations.
13. Assist NHS England in undertaking a brief post-investigation evaluation.

3 Approach of the independent investigation

The investigation team (referred to in this report as 'we') comprised Chris Brougham, senior investigator, and Colin Vose, associate, both of Verita. Professional psychiatry advice was provided by Dr Junais Puthiyarackal, a consultant psychiatrist from Humber NHS Foundation Trust. Biographies for the team are given in appendix A.

Mr N gave his written consent for us to access his medical and other records for the purposes of the investigation. We met him at the beginning of the investigation to share the terms of reference and again at the end to share the findings of our report.

NHS England contacted the victim's daughter to tell her about the investigation. She indicated that she did not want to participate actively in the review or to meet with the investigation team but that she would like to be kept informed of the investigation. We fully respect her decision. We will share the final report with her on completion.

We examined a range of national good practice benchmarks, trust documentary evidence, including policies and procedures, the serious untoward incident investigation report and supplementary information, such as the action plan and records of meetings with staff. We interviewed staff only where we found a gap in information or an area that required clarification and to gain an understanding of how the Trust has developed services since this incident.

We interviewed the following staff:

- Director of Nursing, Clinical Governance and Safety;
- Clinical lead for the Crisis Resolution Home Treatment Team (CRHT);
- Pathway manager for the CRHT;
- CPA manager;
- Assistant Director of Nursing (Safeguarding);
- Head of Service, Kirklees;
- Director of Corporate Development; and
- Head of Involvement and Inclusion.

We also held two focus groups with staff from:

- Older People's Services;
- Single Point Of Access Team;
- Intensive Home Based Treatment Team;
- Community Therapy Pathway;
- Care Management Pathway;
- Acute Care Pathway;
- Dual Diagnosis Service;
- Crisis Resolution Service; and
- General Psychiatry.

4 Executive summary and recommendations

On 18 June 2011 Mr N robbed and assaulted an 89-year-old woman who died from the injuries sustained in the attack. He was convicted of manslaughter and two counts of robbery. At the time of the offence Mr N had been discharged from the Early Intervention In Psychosis (EIP) team and other mental services. Discharge from services occurred on 7 April 2011.

4.1 The independent investigation

NHS England, North Regional Team, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr N.

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

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

4.2 Overview of care and treatment

At the time of the incident Mr N was 26 years old, unemployed and living in rented accommodation with his partner. His three children, aged nine (his partner's child), two and six months, had been removed from their parents and placed with relatives for safeguarding purposes in March 2011 following concerns of neglect.

Mr N's GP first referred him to mental health services in September 2008. He was assessed by the Community Mental Health Team (CMHT). This highlighted that Mr N had difficulties in childhood, periods of talking to himself and acting out ideas, thoughts and roles while looking in mirrors. Mr N was prescribed antipsychotic medication.

Mr N sought help from mental health services again when both he and his partner gave up drugs while she was pregnant with their first child together.

The EIP team carried out further visits and assessments. The consensus was that Mr N did not show any evidence of psychosis. His presenting features were suggestive of borderline personality disorder and substance misuse. Despite this EIP team remained the principal mental health team involved in his care rather than the CMHT or any other service.

The EIP team attempted to involve psychology in Mr N's assessment and care but no psychology led assessment was completed due to difficulty of engagement.

Mr N did not engage with services on a consistent basis. Staff made several home visits but they were unable to gain access to the house.

In June 2009 Mr N's partner had her baby at home. The health visitor reported to the EIP team that she had been unable to check on mother and baby because Mr N had barricaded them and himself inside their house. It also emerged that Mr N was in dispute with the landlord over rent arrears, but their relations improved after the local authority commissioned the tenancy support service to intervene.

In February 2010 the council's duty and assessment team contacted the social care team about Mr N's stepchild's prolonged absence from school. This prompted a social care review.

In December 2010, Mr N's partner gave birth at home to her third child with Mr N but did not call an ambulance until after the baby was born. The social care team was contacted anonymously due to concerns about the state of the house and alleged drug abuse. All three children were subsequently removed by social services to the care of their maternal grandparents.

There was no evidence that Mr N was experiencing psychosis throughout the care episode, so the EIP team discharged him back to the care of his GP on 7 April 2011 with a diagnosis of social anxiety and traits of personality disorder.

4.3 Overall conclusions

Overall, Mr N received a comprehensive service from the Trust. He was assessed by a range of professionals and received risk assessments and a plan of care. He had a named care programme approach (CPA) coordinator who consistently attempted to engage with Mr N.

Mr N presented with potential substance misuse issues and mental health issues, a dual diagnosis (mental illness and comorbid substance misuse problem). The EIP team was cognisant of Mr N's substance misuse history and deployed suitably experienced clinicians to treat him; however, he was not subject to routine drug screening or a referral to substance misuse services by the Trust.

Mr N may also have benefited from access to psychological therapies and a psychological assessment.

The Trust worked closely with the local authority agencies to ensure that safeguarding issues were addressed and policies and procedures adhered to. However, Mr N and his family would have benefited from closer multi-agency working. The Trust acknowledged this in its internal review. Further integration of the Trust's electronic records and systems would produce closer cooperation between the agencies responsible for safeguarding'.

We found there was no evidence from Mr N's words, actions or behaviour prior to the fatal incident that could have alerted professionals that he might engage in criminal activity involving violence. Therefore we did not find any evidence to indicate that the incident was predictable. We did not find a specific intervention or set of actions that should have taken place to prevent the incident. We have found that the incident was not preventable.

4.4 Recommendations

1. To ensure the efficacy of the EIP team and the appropriateness of care delivery to patients, the Trust should routinely audit case files to ensure that the EIP team is focused on those patients with psychosis, or at risk of psychosis. Those patients with a presentation suggestive of personality disorder should be transferred to other trust services such as the CMHT or psychological therapies.
2. The Trust should seek further to refine and develop its electronic record systems to ensure greater integration of systems in regard to safeguarding, care planning and care delivery.
3. The Trust should review its dual diagnosis policy and capacity to ensure appropriate access to specialist knowledge and drug screening when services are responding to presentations that include both a mental disorder and active substance misuse.
4. The Trust should seek to provide assurance to commissioning bodies of compliance with NICE *Guidance in the treatment and management of personality disorder* (appendix C) through an audit process.
5. The Trust should maintain and improve on current performance in delivery of psychological therapies to ensure that 18 weeks is the maximum waiting time rather than, as at present, the average.
6. Commissioning bodies should ensure the Trust to adequately resourced to meet population demand to enable it to comprehensively achieve the 18 week target.

5 Chronology of care and treatment

In September 2008, when Mr N was referred by his GP to the CMHT at South West Yorkshire Partnership NHS Trust, he was living with his partner and her son, then aged seven years. The CMHT wrote to Mr N asking him to contact the team to arrange an appointment. An incorrect address had been given, so Mr N could not respond. Mr N's GP made a second referral on 24 November 2008 with the correct address. During his assessment on 27 January 2009, Mr N reported that he had difficulties in his childhood and that he was talking to himself, acting out parts, thoughts and ideas, looking in mirrors and catching himself in reflective surfaces – he said this was affecting his daily functioning. The assessing practitioner did not consider that there was evidence of psychosis, but thought that further assessment was required with a view to cognitive behavioural therapy (CBT) or anxiety management. An outpatient appointment was arranged for a psychiatric opinion.

When seen by an associate specialist psychiatrist attached to the CMHT on 10 March 2009, Mr N described disturbed mood, poor sleep with nightmares, low appetite and fluctuating energy and motivation. He reported thoughts of self-harm including scratching himself. Mr N denied any current substance misuse but described a lengthy history of using multiple substances.

Having concluded that this could be a first episode of psychosis, a drug-induced psychosis or an organic condition, the psychiatrist requested blood tests, prescribed antipsychotic medication and referred Mr N to the EIP team.

Mr N attended a follow-up appointment on 24 March 2009. His symptoms continued and had not improved so the psychiatrist increased his medication.

5.1 Care delivery involving the EIP Team

5.1.1 EIP assessment

Mr N was assessed by an EIP practitioner on 26 March 2009. He described having low self-esteem and confidence. He claimed to have nine alternative selves, between which he switched when looking in reflective surfaces.

The EIP practitioner concluded that there were no clear signs of psychosis; however, he considered that Mr N fulfilled the criteria of being 'at risk' of developing psychosis and therefore should be taken on for a period of continued assessment. Mr N was placed on the CPA and was allocated a psychiatric nurse from the dual diagnosis team as care coordinator.

The EIP consultant psychiatrist saw Mr N on 29 April 2009. Mr N reported he was prompted to seek help with his problems after he and his partner had both decided to give up drugs when she had become pregnant with his child. Mr N talked further about his experiences with reflective surfaces – he described a process of looking into the mirror to try to change and prepare himself for meetings with different people, including the rehearsal of conversations. Mr N also reported a degree of paranoia and fear of leaving the house by himself.

The psychiatrist concluded that Mr N appeared to have a number of features suggestive of a borderline personality disorder, in particular issues regarding identity, pseudo-hallucinations and fears of abandonment. There were no clear features of a psychotic illness. It was agreed by the clinical team to continue with antipsychotic medication.

The care coordinator developed a multidisciplinary care plan for Mr N to provide him with a structured day and strategies for coping with his anxiety. A further outpatient appointment was made for Mr N to see the psychiatrist in three months' time.

A multidisciplinary team meeting took place to discuss the psychiatrist's diagnosis and formulation. The team agreed with the psychiatrist's opinion. Home visits were attempted on 7 and 21 May and on 10 and 22 June 2009 but there was no reply.

A care plan was developed for Mr N with sections relating to the assessment of his mood and mental state, the development of coping strategies and medication management, and the provision of support to help him engage in meaningful activities and build the confidence to go out of the house. The care coordinator had started to work with Mr N on developing coping strategies using the stress vulnerability model and felt that psychology input would be beneficial. He and the EIP psychologist undertook a joint visit in July 2009. They found no evidence of a psychotic illness or that EIP was actually the best service for Mr N, so they decided to refer him to the CMHT and the Adult Psychological Therapies Service (APTS). The EIP team would continue to deliver the care plan in the interim until the transfer of care management was completed.

5.1.2 Ongoing care

On 15 September 2009 a health visitor contacted the EIP team to say that she had not been able to see Mr N's partner's baby. The EIP team told her that it had not been able to contact Mr N since 30 July. The EIP team tried to visit Mr N's home on 1 October but there was no reply. The EIP team informed the health visitor of this failed visit.

On 9 October 2009 the housing department informed the EIP team that Mr N had barricaded himself and his family in his house. The housing department believed that he had done so because the landlord was seeking to evict them. The housing department and the CMHT subsequently made a joint visit and arranged specialist housing advice. The EIP practitioner noted that Mr N did not appear to present with any mental health issues and advised him that the EIP team was planning to transfer his care to the CMHT.

Mr N contacted the EIP team by text on 15 October 2009 about the behaviour of the landlord, whom he accused of harassing him and of using sticks to tap on the window, frightening him. The CMHT advised Mr N to call the police. The CMHT also referred Mr N to the tenancy support service and the supporting people service.

The EIP team visited Mr N at home on 22 October 2009. The situation with the landlord had improved. Mr N reported looking in the mirror and changing personalities more often during periods of harassment. He was informed that his care coordinator would be leaving, and that the EIP team would continue to work with him pending a decision regarding the transfer of his care to the CMHT.

A CPA review held on 11 November 2009 was attended by the consultant psychiatrist, a CMHT team member, Mr N and his partner. Mr N's general mental health was noted to have deteriorated, with low mood, sleep disturbance, little motivation and occasional suicidal thoughts. He cited his causes of stress as housing problems and increasing debt. He reported being frightened of going out, and that he had recently been assaulted in what he described as an unprovoked attack. He had continued with his habitual retreat from reality by exploring different aspects of his personality, which he saw as being distinct personalities. He said this was worse when mirrors or reflective surfaces were present and better when he was engaged with other people or constructively occupied. He had been hoping to take a plumbing course with a view to future employment but had not felt well enough to do so.

The multidisciplinary team concluded that Mr N's difficulties were largely the result of damaged development of his personality, and noted that he displayed both elements of schizoid personality and emotionally unstable borderline personality present; together with at that time a superimposed depressive illness. The psychiatrist prescribed Mr N an antidepressant and advised him to continue taking his antipsychotic medication.

The multidisciplinary team felt that Mr N would eventually be better managed by the CMHT but as the care coordinator was unable to be present at the review it was decided not to transfer at that time.

The multidisciplinary team subsequently decided that Mr N should remain with the EIP team pending transfer to CMHT.

A new care coordinator was allocated to Mr N, and he visited him on 2, 14, 21, and 23 December 2009 but there was no response on any of these occasions. He also visited Mr N's house in January, February and March 2010 but again there was no response. The care coordinator also wrote letters to Mr N and texted him, and contacted his GP and other professionals involved with the family to try to locate him, but all his efforts were unsuccessful.

On 26 February 2010, the Duty and Assessment Team (DAT) from the local council informed the EIP team that it had received a referral from the health visitor who had been unable to see the baby. There were reports from the school of the older child's poor attendance at school. Social workers had twice tried to see the family and now planned a further visit. If there was still no access, the police would be requested to force entry. The EIP team shared the assessment information with the DAT and made them aware of the engagement issues with Mr N and of the fact that the care coordinator had never actually met him.

On 1 March 2010, the DAT managed to access Mr N's house via his partner's great-grandmother. Mr N was present, along with the oldest child. Mr N explained that he was being harassed by his neighbour and landlord so he didn't want people to come into the house. The older child had been off school with an ear infection. The children were reported to appear fine, but the house was cluttered. The DAT planned to carry out further assessments.

The care coordinator liaised with the other professionals involved with Mr N and his family. He established that Mr N would prefer to attend an appointment at the EIP base rather than be seen at home, because he was said to be concerned about answering the door.

Mr N attended an appointment at the EIP team base on 22 March 2010. He described his character switching, and said that he was avoiding reflective surfaces. He talked again about his difficult childhood. He was advised about the appropriate use of his medication, which he was not taking consistently. He denied any suicidal thoughts and cited his family as protective factors. The care coordinator arranged for a further assessment to be undertaken to determine if Mr N's problems were because of a personality disorder or a psychosis. Mr N identified his coping strategies as looking after his children, playing computer games and household activities such as washing up.

When the EIP team visited Mr N at home on 29 April 2010, he stated that he still had difficulty leaving the house and thought that other parents at his son's school had derogatory thoughts about him. He was advised to maintain and increase his trips out. When asked, Mr N denied any use of substances.

Mr N attended a planned review with the consultant psychiatrist on 5 May 2010. The consultant psychiatrist concluded that Mr N had issues with his personality and displayed occasional depressive symptoms but no signs of a psychotic illness.

The DAT advised the EIP team that a multiagency meeting with the family had taken place on 13 May 2010. Records showed that the child had been attending school, there had been fluctuations in Mr N's mood and that there was a query about whether he was misusing substances. The DAT was likely to discharge the family, and requested that the EIP team inform it in future if Mr N disengaged or if any changes took place that could increase the risk to the children.

Mr N was seen at home on 17 May 2010 by the community psychiatric nurse (CPN). He talked about altering his character shifting in order to please people, and discussed confidence-building strategies. He identified singing as a positive activity and it was agreed by the CPN and Mr N that the CPN would pursue an individual budget/self-directed support through social care to have singing lessons. Mr N reported that he had recently experienced intrusive mental images of him hurting his children. He reported finding these distressing, but not of a command nature, stating he had no intention of acting on them. He said it was harder for him to go out because the estate on which he lived was busier. He was encouraged to take his medication.

On 18 June 2010 the health visitor advised the EIP team that Mr N's children were currently well looked after, and that she had no plans to visit again for 12 months. She asked that EIP team contact her with any concerns.

When the care coordinator visited Mr N on 29 June 2010, Mr N again reported character-switching but acknowledged that he had some control over it. He claimed that he was 90 percent sure that on two occasions people had followed him. He described holding on to a key-ring with an attached nail-clipper and knife. He said this was for his partner's use for manicure purposes when they were out together, but admitted that he would use it in self-defence, although he stated that he had no intention of harming anyone.

The care coordinator visited Mr N at home again on 16 and 28 July 2010 but there was no reply. On 3 August 2010 the care coordinator saw Mr N in his garden. Mr N said he had lost his key and was waiting for his family to get in. The care coordinator noted that he had poor eye contact. Mr N reported nightmares of being chased and also talked about the stigma he felt about being mentally ill. Mr N remained compliant in taking prescribed medication. The care coordinator reassured him and encouraged him to take up positive activities including walking regularly and music. A further visit was planned for 24 August 2010 and a visit regarding an application for singing lessons arranged for 31 August 2010.

The EIP team tried to contact Mr N on his home phone on 8 September 2010. His partner answered and said he was "having funny do's" and not sleeping well. Four unsuccessful home visits were made, with numerous letters sent and telephone calls made to land lines and mobiles. The EIP team liaised with the GP and the health visitor to seek their support in establishing contact.

A CPA review on 20 October 2010 was attended by the care coordinator and the consultant psychiatrist. Mr N had been notified by letter and offered a lift to the meeting but he was not at home when someone had gone to collect him. The psychiatrist concluded that Mr N's problems were to do with his personality rather than a psychotic illness and that the EIP team was not appropriate for him. In earlier discussions, the CMHT had advised that Mr N's lack of engagement would be an issue, and it was agreed by those attending the CPA review, if it persisted Mr N would be discharged back to the care of his GP, with a recommendation that any re-referral be made to the CMHT.

The EIP team wrote to Mr N offering him another appointment in four weeks' time, with notification that only one further appointment after this would be offered before he would be discharged.

The EIP reviewed Mr N's care plan and considered it appropriate for continuation at this stage. It covered the issues of non-engagement with activities he enjoyed. The aim of the care plan was:

- to provide interventions to build up confidence;
- to support him to develop coping strategies;
- to promote his engagement with services;
- to consider his planned transfer to the CMHT;

- to continue assessment of his mental state; and
- to prescribe medication.

On 23 November 2010 the care coordinator made the planned home visit but was unable to gain access. On 26 November 2010 the coordinator received a text from Mr N saying he had missed him at the door and didn't want to be "kicked off", and that he was scared of not getting help.

On 9 December 2010 Mr N was seen for the first time since August. When the care coordinator explored the reasons for the absence of contact Mr N said that he was scared of people he didn't know knocking on the door, saying he had been afraid of the loudness of the care coordinator's particular knock and had found this threatening. He asked in future that the care coordinator use three spaced knocks. Mr N reported that his partner was pregnant. Although he still had difficulty leaving the home, this had been less of a problem recently. He was only switching personalities around once daily, rather than 10 times a day as before. His mood had improved and he described a group of supportive friends with whom he felt he had no need to switch in order to fit in.

Mr N said that he had smoked one joint of cannabis the previous night which he thought had led to an argument with his partner. He admitted he had tried what he thought was MCAT (mephedrone) three months previously, but later believed it was talc. He said he had no plans to smoke cannabis in the future.

The care coordinator made an arrangement for Mr N to get a lift to the next CPA review on 22 December 2010. Mr N knew the EIP team would consider a move to the CMHT at that meeting.

The DAT contacted the EIP team on 17 December 2010. Mr N's partner had given birth on 11 December 2010 but an ambulance had not been called until afterwards. The family had not contacted the GP until very late in the pregnancy. Mr N's partner was known to have been in contact with a drugs agency in 2008 for methadone prescribing. The DAT had found that the house was very dirty. The DAT had also received information from an unnamed caller that both parents were using heroin. The clinical record does not record if safeguarding concerns were further investigated.

On 22 December 2010 Mr N phoned the EIP team to say that he had got his dates mixed up for the CPA review. He requested an alternative date in the new year. This was agreed.

A multidisciplinary discussion was held on 30 December 2010 as part of the team caseload review. A worker had already been allocated from the CMHT and the plans for a gradual handover were outlined. Mr N's partner's history of heroin use was mentioned, but there is no indication that the reports regarding Mr N's possible substance misuse were considered.

The CMHT and the EIP team undertook a joint visit on 17 January 2011. Mr N described his stress and agitation at the recent involvement of the DAT and his distress at the potential loss of the children. He claimed the children had been

stripped and examined by the police. He said that his stepson was being bullied at school and had been fire-setting upstairs in the house – but that he no longer had access to a lighter. Mr N was encouraged to seek support from the DAT. He said that he continued to have trouble leaving the house, believing that others would report or challenge him. He also admitted irregular usage of his medication. Mr N agreed to the handover to the CMHT and also to a series of further joint visits.

A meeting between the CPN and a social worker from the DAT took place on 31 January 2011. The following matters were discussed:

- the DAT's concerns that Mr N was dealing in illicit drugs from home (however, EIP practitioners noted that there had been no evidence of this during their home visits);
- the stepson's fire-setting;
- the DAT's inability to gain access to the house in December¹;
- since the last visit from the DAT, the parents had been cooperative and the house had been cleaned and tidied; and
- the DAT was considering discharging the children.

The EIP team and CMHT staff visited Mr N at home on 8 February 2011. Mr N was leaving to take his stepson to school and asked if they would accompany him. Mr N suggested that talking outside would give the staff an opportunity to observe how he was away from the home. There was nothing remarkable about his presentation, although he spoke about his anxiety, the type of people he was afraid of and his switching behaviour. He mentioned having been to visit an aunt further afield than the estate and how he chose to go out at quieter times of the day. Further visits were planned with a view to handing over to the CMHT in six weeks' time.

The EIP team subsequently had difficulty in re-establishing contact with Mr N, and therefore wrote to him on the 18 March 2011 offering a joint visit with a CPN from EIP and a staff member from the CMHT. The letter explained that if Mr N was not available, only one further appointment for a CPA meeting would be offered; if he failed to keep that, he would be discharged.

On 26 March 2011 the council's Emergency Duty Team (EDT) contacted the Trust's Crisis Resolution Service (CRS) advising that Mr N's partner's child had not attended school since 8 March 2011. The school had expressed concerns about the boy's welfare prior to his absence. There were reports of drug dealing and drug use at his home. The police had visited on 25 March 2011. They were unable to gain access, so upon hearing the children inside, had broken the door down. The house was found to be neglected, and the children to be living in what were described as poor conditions. Police took photographs and the children were removed to the care of the maternal grandmother, and were to have no unsupervised contact with their parents. Mr N was found by the police to be under the influence of drugs and had a hammer in his back pocket. The CRS undertook to ensure the information was passed on to the EIP and the CMHT before a planned visit on 28 March 2011. This visit was later

¹ They had shouted through the letterbox that if Mr N didn't open the door they would ask the police to break it down. Mr N had a pickaxe handle and said that he intended to use this against staff if they attempted to remove the children.

rearranged because it clashed with that of the police and the DAT. The children remained with their grandmother but now had supervised contact with Mr N and his partner. The house was reportedly much cleaner; an explanation of family illness had been given for the absence from school. It was agreed that a worker from the DAT would attend the forthcoming CPA review.

The EIP and the CMHT saw Mr N at home on 4 April 2011. He reported switching characters more due to recent stress. Some inconsistency was noted in his description of his experiences. He was upset about the removal of the children, and claimed he had not heard the police at the door and thought his stepson was joking when he told him they were there. He denied being intoxicated. He also denied dealing drugs, but admitted to dealing small amounts of cannabis for about three months seven years previously. He asserted that the police had made the house more untidy before they photographed it.

Mr N reported feelings of extreme anger and talked about thoughts of hurting others, giving as examples having wanted to harm a local shopkeeper after he believed he had been sold faulty goods and of wanting to attack the police officers who were involved in removing his children. He was able to recognise the adverse impact on his access to the children were he to become violent.

Workers reassured Mr N that the current work being undertaken by the DAT was at the assessment stage for his children and of the emphasis placed on providing support for the family. Mr N said that his partner's mother, with whom the children were staying, was currently "blackmailing" his partner into looking after the children while she went out. A referral to the APTS was discussed. Mr N was advised of waiting times to access the service.

A CPA review was held on 7 April 2011. The care coordinator, consultant psychiatrist, social worker from the DAT, health visitor and the CMHT worker attended. Mr N did not attend despite being invited. His engagement with services was recognised as consistently poor. It was agreed that his presentation continued to be the result of a combination of social anxiety, paranoia, dissocial and histrionic personality disorder traits, along with the possibility of substance misuse, which he currently denied.

The review found no cause for concern about Mr N's risk of harm to himself, but identified his potential for violence against others, particularly professionals or police visiting the house against whom he had previously made threats, including to attack them with a baseball bat or a hammer. However, the threats had not translated into any recorded incidents. There was evidence that Mr N had been in possession of a pickaxe handle and a hammer. Lone working by trust staff was not considered appropriate. He was known to be in £6,000 rent arrears. The suspicion that Mr N had been using drugs was discussed. Although he had denied this, his gaunt appearance when last seen supported the supposition that there was ongoing drug use. The current situation regarding the children, who remained away from home, was also discussed.

5.1.3 Discharge from services

Mr N continued not to engage with mental health services despite intensive and assertive efforts, so it was not thought appropriate to continue with the transfer of his care to the CMHT. It was recognised that Mr N could benefit from some psychological work; however, it would be necessary for him to establish some degree of effective engagement with services for this to be feasible.

A discharge plan was formulated and communicated to the GP on 7 April 2011. This included the following:

- Mr N's care to be discharged back to the GP for ongoing support;
- the current prescription of the antidepressant sertraline, 100mgs daily, and the antipsychotic olanzapine¹, 5mg daily plus 5mg as required, could be continued if the GP was happy to do so (the antipsychotic medication to be gradually curtailed at any time over a two- to three-month period);
- agencies involved with the children would be present at the CPA review; risk assessment would be shared and all would be aware of the discharge;
- the DAT would continue to assess risks to the children; and
- Mr N would be informed of his discharge from services by letter.

¹ Olanzapine is used for the treatment of psychoses including schizophrenia and bipolar disorder.

6 Issues arising

In the following sections of the report we provide our comment and analysis on the issues we consider relevant to the care and treatment of Mr N.

The issues we examine are as follows:

- formulation of diagnosis;
- risk assessment and management;
- the role of substance misuse services;
- interagency working and communication;
- safeguarding;
- predictability and preventability; and
- the Trust's internal investigation and progress made against the recommendations.

7 The formulation of diagnosis

We examined documentary evidence to find out whether Mr N's diagnosis was properly considered and formulated.

Records show that Mr N initially presented with features suggestive of an episode of psychosis. However, in further assessment and engagement with the key worker, it became apparent that his problems were best explained by the presence of traits of personality disorder of different types. Mr N grew up in a chaotic home environment. He witnessed domestic violence. He described difficulty coping when his parents separated when he was 13 years old. He reported being a loner at school and of having difficulty mixing with others and expressing himself. He had difficulty with self-image and issues regarding self-esteem, confidence and a sense of abandonment in his relationship with others.

Medical staff considered whether Mr N had a drug-induced psychosis at the initial assessment. There is no evidence in the notes though to indicate if he was ever screened for substance misuse or referred to the specialist services for substance misuse problems. We discuss this further in section 9.

7.1 Finding

The initial diagnostic formulation was appropriate given Mr N's presentation.

8 Risk assessment and risk management

We reviewed national policy and guidance relating to risk management and risk assessment in reference to the care and management of Mr N.

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

A clinical risk management tool developed by the Sainsbury Centre in 2000 advised NHS trusts that, in order to assess risk accurately, information must be gathered from relevant parties to build up an accurate picture including:

- the patient;
- carers, friends;
- relatives;
- other team members/other teams;
- other statutory or voluntary sector mental health agencies; and
- criminal justice services including the police, probation, courts.

8.1 Clinical risk assessment and risk management of Mr N

Records show that Mr N received a detailed and comprehensive assessment of his mental health problems and had risk assessments at various points in his care. The last risk assessment was carried out on 6 April 2011. This identified his main risk factors as:

- previous attempt on life;
- misuse of drugs and alcohol;
- significant life events;
- unemployed status;
- previous history of neglect;
- difficulty managing physical health;
- experiencing financial difficulties;
- previous use of weapons;
- male under 35 years old;
- expressing intent to harm others;
- signs of anger and frustration;
- self-harm; and
- risk to children.

There is no evidence in the notes to indicate that any investigation was undertaken into his forensic history or involvement with the criminal justice system. There is no evidence that the risk assessment was informed by discussions with other agencies. Although some specific risks were identified (disclosing thoughts to harm a local

shopkeeper; thoughts to harm the professionals if his children were removed), the care plan lacked detailed analysis of these risks to inform a specific management plan to deal with them. The team generally perceived the patient as a vulnerable person rather than as someone who posed a risk to others.

Mr N received care from the mental health services until April 2011. The team tried to engage with the patient using an assertive community approach that included frequent attempts to visit him and contact him by text and phone. Mr N had a care coordinator and access to other professionals, including a consultant psychiatrist. Mr N was referred to the EIP team following his initial assessment, at which he was tentatively diagnosed as having suffered a psychotic episode. However, the team subsequently concluded that his main problems were social anxiety and traits of personality disorders of various types. Hence it is unclear why Mr N continued to receive care from the psychosis team and continued to be prescribed olanzapine

8.2 Findings

Mr N received detailed and comprehensive assessment of his mental health problems and had risk assessments at various points in his care, but there was no evidence to show if any investigation undertaken into his forensic history or his involvement with the criminal justice system.

The EIP team generally perceived the patient as a vulnerable person rather than someone who posed a risk to others.

It is not clear from records why Mr N continued to receive care from the psychosis team after his diagnosis changed to anxiety with traits of personality disorder.

Mr N's formal diagnosis was of social anxiety, paranoia, dissocial and histrionic personality disorder traits.

The action plan introduced in the aftermath of this incident addressed the method of discharge from the EIP, risk management processes and the clarity of roles and responsibilities in relation to care planning and communication with service users via mobile technology. From the evidence reviewed and interviews undertaken it is clear that these actions are now embedded in current practice. This is further explored in Section 13.1.1 below with one recommendation.

9 Substance misuse services

At the time of the incident, drug and alcohol services in Kirklees were delivered by Lifeline, an independent agency. However, the Trust did have some joint working arrangements in place through its dual diagnosis specialist. Mr N had a reported history of using heroin, along with ecstasy, cocaine, amphetamines and cannabis. Mr N claimed to have ceased using drugs and he was not in touch with drug or alcohol services.

On initial assessment Mr N was allocated to a care coordinator who was a dual diagnosis practitioner, reflecting Mr N's history of substance misuse. Other agencies, including the eldest child's school and the local authority duty assessment team, suspected that Mr N had practised further substance abuse while under the care of the EIP team, these suspicions were confirmed by Mr N's own account. Mr N should have been referred to the drug and alcohol services for a comprehensive assessment; he should also have been regularly screened for substance misuse in view of the fact that one of his differential diagnoses was drug-induced psychosis. Also there were reports of possible intoxication on substances, evidence of drug usage in the house and allegations of dealing drugs.

9.1 Recommendation

The Trust should review its dual diagnosis policy and capacity to ensure appropriate access to specialist knowledge and drug screening when services are responding to presentations that include both a mental disorder and active substance misuse.

10 Interagency working and communication

Mr N received support from housing, social care and mental health services.

Records show that there was a suitable level of communication and collaborative working between mental health services and the children and family services. However, the following incidents should have been communicated robustly with the children's social care team with a clear plan of action to follow.

- On 15 September 2009, the EIP team told the health visitor that it had had no contact with the family since June 2009. The health visitor was subsequently informed of a further failed visit.
- On 26 February 2010 the council's duty and assessment team raised concerns following a referral from the health visitor as she was unable to see the baby. There were reports of poor attendance at school for the older child. Later, the social worker gained access to the house through Mr N's partner's great-grandmother. The social worker reported that the children appeared fine and that the house was a bit cluttered.
- On 13 May 2010 Mr N's son's school raised concerns about Mr N's erratic mood and queried if this was related to substance use. The baby had not been seen for health checks and there were concerns relating to the wellbeing of the children.

10.1 Comment

The concerns relating to the children should have prompted a clear plan to promote their wellbeing.

On 9 October 2009, the housing team informed the EIP that Mr N had barricaded himself and his family in his house due to him owing money to his landlord and on 16 October 2009 there was a text message from Mr N stating that he had barricaded himself in his property due to harassment by the landlord.

10.2 Comment

Mr N's actions should have been a cause for concern and discussed at a joint agency meeting.

On 15 December 2010, the duty assessment team found during a home visit that Mr N had a pickaxe handle. Mr N said he would use it against social services staff if they attempted to remove his children.

10.3 Comment

Given the threats made by Mr N and the pending birth of another baby, services should have developed a coordinated approach to ensure that the family was safe and supported at this point.

On 17 December 2010 the social worker telephoned the EIP team to report that Mr N's partner had given birth at home and had not called an ambulance until after the baby was delivered. Social services found that the home was dirty. An unnamed caller had informed social services that both the patient and his partner were using heroin. This was considered at a multidisciplinary discussion on 30 December 2010 and a CMHT worker was allocated to Mr N.

10.4 Finding

A joint agency approach between children's services and adult services was not developed.

11 Predictability and preventability

We would consider that the homicide would have been predictable if there had been evidence from Mr N's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

We would consider that the homicide would have been preventable if the professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but didn't take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

11.1 Analysis

Mr N had undergone a risk assessment which was periodically updated. The risk assessment did identify some potential risks but focused on risks threats to the children. While Mr N had verbalised thoughts of aggression to others, these were specific and related to social workers visiting his children and to a local shopkeeper. None of these thoughts was acted upon. There was no evidence of Mr N carrying out actual violence while in contact with mental health services. While Mr N's level of drug use remained uncertain, he did not appear chaotic during this period and there was no evidence of theft of property or robbery against the person to support his drug use.

Mr N's mental health state did not warrant use of the powers of the 1959, 1983 or 1995 Mental Health Acts since throughout his care he was not considered to be a danger to himself or others. This is consistent with his presentation as recorded in the care records reviewed.

In March 2011 the police visited Mr N's home in response to concerns relating to his children's welfare. Following this visit the police instigated actions relating to child welfare which resulted in the children being cared for by their maternal grandmother. Although the police did not at this time have evidence of criminal activity, they made services aware of the potential risk to staff visiting Mr N at home. Services subsequently responded by ensuring that staff visited in pairs (which was consistent with the Trust's lone worker policy).

There is no evidence in Mr N's words, actions or behaviour that would indicate he would engage in criminal behaviour involving violence to others.

11.2 Finding

We found that this incident was neither predictable nor preventable.

12 The Trust's internal investigation

The good practice guidance *Independent investigation of serious patient safety incidents in mental health services* (NPSA February 2008) advises that, following a homicide, an internal NHS mental health trust investigation should take place to detail the chronology and identify underlying causes and any further action that needs to be taken. The Trust policy also advises that an internal investigation should take place following a serious incident to see if any lessons can be learned. In this case the Trust did commission an internal review into the care and treatment of Mr N. The investigation was led by the Trust's practice governance lead.

The terms of reference for the Trust internal review were:

1. The care the service user was receiving at the time of the incident and the suitability of that care in view of his history and assessed health and social care needs.
2. The extent to which that care corresponded with statutory obligations, relevant national guidance, Trust policies, including any team or service operational policies and professional standards.
3. Relevant professional and clinical judgements and decision making.
4. The adequacy of the risk assessment and care plan and their use in practice.
5. The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs, with particular reference to the Care Programme Approach (CPA) referral and discharge processes.
6. The actions taken following the incident to manage the immediate situation, provide support to those affected and to improve service.
7. To identify any areas of good practice.

The Trust's internal review was completed in April 2012 and ran to 27 pages. It addressed all the above terms of reference comprehensively. The report focused on the care delivered by the Trust to Mr N and incorporated all care delivery managed through the Trust. The report did not show evidence of engagement with the other agencies with which Mr N and his family were in contact, most notably health visiting services involved with the children.

13 Recommendations and action plans

13.1 Recommendations

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

1. When working with service users, the EIP team should fully utilise the range of specialist assessments which are readily accessible on the RiO system¹ and form part of the service user electronic patient record; they are thus available to all practitioners and support the safe and effective management of care and risk.
2. The EIP team should review its discharge process and practice to ensure that the administrative caseload record is an accountable and accurate reflection of clinical caseload at all times.
3. Clear guidelines and specific timeframes on the use of the Sainsbury level 1 and level 2 risk assessment should be embedded in the CPA policy and the clinical risk assessment, management and training policy. Team managers should review practitioners' understanding of these requirements and ensure the appropriate use and consistency with the required standards thus promoting best practice and providing the opportunity to review risk and draw together various professional perspectives.
4. Practitioners in EIP could benefit from the opportunity to reflect upon and review their approach to working with people with substance misuse issues who do not present with dual diagnosis but who may have needs in this area which, if openly established, could be receptive to intervention to preclude antisocial or illegal behaviour. Reflection and review may also promote staff safety and wellbeing when working with such service users and could form part of a team development session or be facilitated by the Trust's dual diagnosis specialists or nurse consultants.
5. Where child protection issues exist and practitioners agree to take responsibilities and actions, these should be incorporated into the service user's care plan with explicit, specific and timed actions underpinned by a shared risk assessment which clarifies each agency's expectations and thresholds for action. All issues regarding the wellbeing of children and potential risk should be included in the Sainsbury risk assessment and passed on to the appropriate agencies immediately and a record made of this in accordance with the appropriate trust and inter-agency policies and procedures relating to safeguarding.
6. There should be clarification of expectations, roles, responsibilities and purpose when planning case transfers between teams. This should be achieved by the effective delivery of the principles, practice and processes of

¹ RiO is the trust's electronic clinical record system

CPA. Team managers should be reminded of the need to ensure that transfers between teams are effective and purposeful.

7. Appropriate access to the APTS for service users in EIP should be clarified and any pathway issues or barriers to individuals having the opportunity to receive a suitable service for their needs should be addressed.
8. Guidance should be provided to practitioners in relation to intervention in and management of situations where service users have weapons, including the safe and accountable removal, storage and disposal of weapons. A trust-wide protocol is currently being developed to inform practice in relation to service users who are known to own or have access to firearms; this should be made available to all teams.
9. The EIP team should review the process regarding the offer of carers' assessments. All eligible carers should be offered a carer's assessment and a carer's plan if appropriate, and a record of this having been done should be made. This record and associated documentation should form part of the service user electronic patient record to ensure optimum and effective communication of service user need and risk.
10. The EIP operational policy should include clear standards for ongoing monitoring of service users' physical wellbeing and the side-effects of medication.
11. The EIP operational policy in its reference to expectations around blurring professional boundaries should be reviewed and its wording offer a safe and accountable framework for practice.
12. Consideration should be given to producing practice guidance addressing communication with service users by mobile phone and by text, and should incorporate the disclosure of individual's numbers and the safety and accountability implications of this. This could also include email communication.
13. Practitioners should be reminded of the Trust's expectations with regard to record-keeping standards and the need for timely and comprehensive entries to be made in the electronic patient record. All processes and interventions around the service user pathway should be fully recorded and reflected including those of psychology practitioners.

An action plan was developed to take forward these recommendations. Each recommendation was allocated to a lead person and a timescale was identified for its implementation.

13.1.1 Finding

In the review report, the terms of reference and the recommendations could have been refined further to ensure a more focused approach that incorporated the principles of SMART (appendix B), thereby providing greater clarity.

13.2 Review of trust recommendations and actions

The recommendations and actions were grouped under the following headings with the addition of a review of the post-incident investigation and governance:

- early intervention;
- safeguarding;
- dual diagnosis;
- personality disorder;
- risk assessment and CPA;
- psychology;
- post-incident support; and
- post-incident investigation and governance.

13.2.1 Early intervention

The early intervention service has maintained its adherence to the service description within the *Mental Health National Service Framework Policy Implementation Guidance 2001*.

Over the past two years the service has reconfigured the access it provides to specialist psychology support. This reconfiguration has ensured a dedicated cognitive behavioural therapist within the EIP team and a dedicated psychologist within the trust-wide psychology service. These changes have ensured increased capacity and increased understanding of early intervention in the wider psychology service, and secured dedicated supervision and professional peer support for the EIP psychologist. All staff within the EIP team are trained in psycho-social interventions. The team uses a specialist assessment tool to establish the presence of psychosis. All assessments are logged in the trust care record system. Audits of assessment modules within the electronic care records have revealed a high compliance rate.

This reconfiguration has addressed the issue raised in recommendation 1 of the Trust's internal investigation into this incident.

The action plan introduced in the aftermath of this incident addressed the method of discharge from the EIP, risk management processes and the clarity of roles and responsibilities in relation to care planning and communication with service users via mobile technology. From the evidence reviewed and interviews undertaken it is clear that these actions are now embedded in current practice.

In view of the significant changes and improvements that the Trust has made since the incident, we make one recommendation about the EIP service to ensure that case management remains focused on those with a psychosis.

Recommendation

To ensure the appropriateness of care delivery to the patient, the Trust should routinely audit case files to ensure that the EIP team is focused on those patients with psychosis, or at risk of psychosis. Those patients with a presentation suggestive of personality disorder should be transferred to other trust services such as CMHT or psychological therapies.

13.2.2 Safeguarding

The Trust told us that it recognises that safeguarding is an evolving agenda shared between itself and local authority colleagues and that significant progress has been made since this incident in improving staff awareness of safeguarding issues and of joint working with other agencies.

When we met with staff they told us that further integration of the Trust's electronic record systems with those of the local authority would help to improve the efficiency of administration and to flag safeguarding issues. We have made a recommendation to develop further the work that the Trust has already done in this area.

Recommendation

The Trust should consider the options available to refine and develop its electronic record systems to ensure greater integration of systems of safeguarding, care planning and care delivery.

13.2.3 Dual diagnosis

The Trust maintains capacity to ensure a response to individuals presenting with a dual diagnosis of mental illness and substance misuse. The Trust has run training programmes for front-line clinicians in mental health services and local drug and alcohol services to ensure clinical competence and confidence.

The Trust has a dedicated dual diagnosis practitioner and a dual diagnosis consultant who work closely with the drug service Lifeline, the alcohol service On Track and the mainstream mental health services. They provide support in assessment, supervision and treatment options and deliver training programmes. There is evidence of clinical confidence in the management of dual diagnosis within the crisis resolution and home treatment teams. There is widespread awareness of this capacity throughout the Trust and it is greatly valued. However, given the size of the Trust and the prevalence of dual diagnosis, the current resource may not be adequate to meet the needs for face-to-face clinical assessment, provision of clinical supervision and focused training relating to dual diagnosis.

The Trust assessment tool includes specific questions that seek to establish service users' relationship with substances, their pattern of use and their associated behaviour as a result both of use and of efforts to obtain the substances. This information is used within the wider risk assessment process and informs the care plan.

Recommendation

The Trust should review its dual diagnosis policy and capacity to ensure appropriate access to specialist knowledge and drug screening when services are responding to presentations that include both a mental disorder and active substance misuse.

13.2.4 Personality disorder

A significant proportion of the Trust's day-to-day clinical business is with individuals with varying degrees of personality disorder. The Trust recognises this and has accordingly augmented the capacity of its psychological therapies. The Trust has demonstrated an ongoing ability to manage individuals with personality disorder through services such as assertive outreach, crisis resolution, the EIP team and the CMHT. These services have been supported by training and supervision by the psychology team, by clinical support from the dual diagnosis resource and by medical leadership.

Personality disorder is managed through the Trust clinical record system, RiO, and incorporates the CPA. Within this there is a risk assessment module. Clinical teams describe a recovery model which promotes independence, autonomy and social inclusion. Teams describe the use of crisis plans and care delivery with the framework of the CPA.

The Trust appears to be compliant with all aspects of NICE *Guidance in the treatment and management of personality disorder* (appendix C), but the Trust did not supply reviewers with an audit report confirming compliance.

Recommendation

The Trust should provide assurance to commissioning bodies of compliance with NICE *Guidance in the treatment and management of personality disorder* through an audit process.

13.2.5 Risk assessment and CPA

National policy and *Best practice in managing risk*, Department of Health (2007), recommend a positive approach to risk management, collaboration with service users and those involved in their care, the importance of recognising and building on the service users' strengths and the organisation's role in risk management. This approach should be central to the use of the CPA. The CPA electronic tool has been subject to revision and expansion which have allowed it to maintain a contemporary feel and incorporate key themes including risk, carers' assessments and dual diagnosis.

The Trust undertakes an annual audit of the CPA and reports to Monitor and to commissioners on performance. The Trust is subject to an external performance target of 95 percent of patients whose care is managed through CPA process are subject to an annual review. The Trust has a process by which it assures itself that

all clinical areas adhere to CPA standards, including completion of risk assessments, and that they are all subject to a performance monitoring process which utilises team dashboards to display performance at business delivery unit level down to individual team level. The approach empowers all tiers of management to proactively engage in the process.

Within the CPA is a module to review carers' needs. The information thus obtained is used to inform the wider care plan. The module is subject to an annual review along with the rest of the care plan.

The Kirklees service uses a family therapist to improve the quality of carers' engagement. Within the wider trust, carers' involvement is supported by the 'Our Commitment to Carers' strategy, which is led by a dedicated member of staff, a carers' development officer. This is replicated with each team with carers network and team champions. Carers' engagement is further supported by the provision of training workshops on carers' involvement and the use of patient experience questionnaires. On acute wards the Trust runs regular carers' meetings.

13.2.6 Psychology

Psychological therapies within the Trust have been subject to considerable expansion since this incident. The principal development has been in the establishment of primary psychological therapies using the nationally recognised step care model. This programme has greatly increased the availability of cognitive behavioural therapy to those service users with depressive-type illnesses.

Complementing this development has been a reconfiguration of psychological therapies serving secondary care. Secondary care psychology capacity can now concentrate its resources on those with psychosis and/or personality disorder. The reconfigured psychology service has ensured that the EIP team has a dedicated psychological therapies resource comprising a principal clinical psychologist and an assistant psychologist. The availability of additional psychological therapies support is facilitated through the revised community therapies pathway that provides psychological case consultation and access to systemic family therapy.

With the expansion of psychology services, waiting times have dropped significantly over the last three years from an average of 18 to 20 months to a current average of 18 weeks for secondary care. This progress is significant but needs to be sustained to ensure timely access to these services, particularly for those with complex presentations for whom psychological therapy is therapeutic and beneficial.

Recommendation

The Trust should maintain and improve on current performance in delivery of psychological therapies to ensure that 18 weeks is the maximum waiting time rather than, as at present, the average.

Commissioning bodies should ensure the Trust to adequately resourced to meet population demand to enable it to comprehensively achieve the 18 week target.

13.2.7 Post-incident support

In the period following the incident, staff described the tiers of support available. This support starts with fellow members of the same team. In addition, psychological therapies staff have been identified to provide a post-incident debrief for teams and individuals. Individual staff members have access to confidential staff counselling on an ongoing basis.

13.2.8 Post-incident investigation and governance

Following the incident, the Trust undertook a thorough review and an analysis in keeping with guidance and standards published by the National Patient Safety Agency (NPSA) *Independent investigation of serious patient safety incidents in mental health services* (NPSA February 2008). The review was extensive in its breadth and comprehensive in its depth. It had terms of reference which addressed the issues relevant to the care and treatment of Mr N and made various recommendations.

The Trust has shown evidence of a systematic approach to ensuring that the recommendations are adopted and of having taken action taken to improve services as appropriate.

In this incident report, both the terms of reference and the recommendations could have been further refined to ensure a more focused approach that incorporated the principles of SMART (appendix B) and thus achieved greater clarity.

The Trust has a comprehensive governance process for the management of serious and untoward incidents. The process uses the Datix reporting system to highlight alerts as incidents occur and to track post-incident reviews and monitor subsequent actions. The process and incident reports are overseen by the Director of Nursing and the Medical Director who has responsibility for patient safety. Completed post-incident reports are reviewed by an incident review sub-committee which ensures the completion of the report within nationally agreed timescales, the quality of the report and the appropriateness of the recommendations made.

The Trust supports this process of post-incident reviews through deployment of four dedicated investigation staff and a programme of training in root cause analysis and report writing. The Trust also delivers a series of learning events to ensure that lessons learned are disseminated.

The Trust's approach to serious incidents is both comprehensive and systematic and there is evidence that it has refined its processes since this incident.

Team biographies

Chris Brougham

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

Colin Vose

Colin Vose has more than 30 years' experience in health and social care, particularly in mental health, learning disability and substance misuse services. He has worked both in commissioning and the provider side of services and carried out many investigations and reviews.

His previous roles included Interim Deputy Director of Nursing Lancashire Care Foundation Trust and Sub Director NHS Merseyside. As an Interim Deputy Director of Nursing his principal duty was to oversee patient safety and governance, including serious incident investigation and risk management systems. In his role as Sub Director NHS Merseyside he reviewed serious untoward incidents and patient safety issues across the North West working with all mental health trusts to advance quality and governance in the light of lessons emerging.

Developing SMART goals

Specific

The first criterion stresses the need for a specific goal rather than a more general one. This means the goal is clear and unambiguous, without vagaries and platitudes. To make goals specific, they must tell a team exactly what is expected, why it is important, who's involved, where is it going to happen and which attributes are important.

A specific goal will usually answer the five 'W' questions:

- What: what do I want to accomplish?
- Why: specific reasons, purpose or benefits of accomplishing the goal.
- Who: who is involved?
- Where: identify a location.
- Which: identify requirements and constraints.

Measurable

The second criterion stresses the need for reliable methods of measuring progress towards the attainment of the goal. The thought behind this is that if a goal is not measurable, it is not possible to know whether a team is making progress towards successful completion. Measuring progress is supposed to help a team stay on track, reach its target dates, and experience the exhilaration of achievement that spurs it on to make the continued effort required to reach the ultimate goal.

A measurable goal will usually answer questions such as:

- How much?
- How many?
- How will I know when it is accomplished?
- Indicators should be quantifiable

Achievable

The third criterion stresses that goals should be realistic and attainable. While an attainable goal may stretch a team in order to achieve it, the goal is not extreme. That is, the goals are neither out of reach nor below standard performance, as these may be considered meaningless. When you identify the goals that are most important to you, you begin to figure out ways you can reach them. You develop the requisite attitudes, abilities, skills, and financial capacity. An attainable goal may

cause goal-setters to identify previously overlooked opportunities to bring themselves closer to the achievement of their goals.

An achievable goal:

- How: how can the goal be accomplished?

Relevant

The fourth criterion stresses the importance of choosing goals that matter. A bank manager's goal to 'make 50 peanut butter and jelly sandwiches by 2:00pm' may be specific, measurable, attainable, and time-bound, but lacks relevance. Many times you will need support to accomplish a goal: resources, a champion voice, someone to knock down obstacles. Goals that are relevant to your boss, your team, your organisation will receive that needed support.

Relevant goals (when met) drive the team, department, and organisation forward. A goal that supports or is in alignment with other goals would be considered a relevant goal.

A relevant goal can answer 'yes' to these questions:

- Does this seem worthwhile?
- Is this the right time?
- Does this match our other efforts/needs?
- Are you the right person?
- Is it applicable in the current socio-economic/technical environment?

Time-bound

The fifth criterion stresses the importance of grounding goals within a timeframe, giving them a target date. A commitment to a deadline helps a team to focus its efforts on completion of the goal on or before the due date. This part of the SMART goal criteria is intended to prevent goals from being overtaken by the day-to-day crises that inevitably arise in an organisation. A time-bound goal is intended to establish a sense of urgency.

A time-bound goal will usually answer the questions:

- When?
- What can I do six months from now?
- What can I do six weeks from now?
- What can I do today?

Guidance in the treatment of borderline personality disorder, NICE

2012

Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user (and his or her family or carers, where agreed with the person). The care plan should:

- identify clearly the roles and responsibilities of all health and social care professionals involved;
- identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them;
- identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term treatment aims;
- develop a crisis plan that identifies potential triggers that could lead to a crisis, specifies self-management strategies likely to be effective and establishes how to access services (including a list of support numbers for out-of-hours teams and crisis teams) when self-management strategies alone are not enough; and
- be shared with the GP and the service user.

Teams should use the CPA when people with borderline personality disorder are routinely or frequently in contact with more than one secondary care service. This is particularly important if there are communication difficulties between the service user and healthcare professionals, or between healthcare professionals.

Risk assessment and management

Risk assessment in people with borderline personality disorder should:

- take place as part of a full assessment of the person's needs;
- differentiate between long-term and more immediate risks; and
- identify the risks posed to the person and to others, including the welfare of any dependent children.

It should also explicitly agree the risks being assessed with the person with borderline personality disorder and develop collaboratively risk management plans that:

- address both the long-term and more immediate risks;
- relate to the overall long-term treatment strategy; and

- take account of changes in personal relationships, including the therapeutic relationship.

When managing the risks posed by people with borderline personality disorder in a community mental health service, risks should be managed by the whole multidisciplinary team with good supervision arrangements, especially for less experienced team members. Be particularly cautious when:

- evaluating risk if the person is not well known to the team and there have been frequent suicidal crises.

Teams working with people with borderline personality disorder should review regularly the team members' tolerance and sensitivity to people who pose a risk to themselves or others. This should be reviewed annually (or more frequently if a team is regularly working with people with high levels of risk).

Psychological treatment

When considering a psychological treatment for a person with borderline personality disorder, take into account:

- the choice and preference of the service user;
- the degree of impairment and the severity of the disorder;
- the person's willingness to engage with therapy and his or her motivation to change;
- the person's ability to remain within the boundaries of a therapeutic relationship; and
- the availability of personal and professional support.

Before offering a psychological treatment for a person with borderline personality disorder or for a comorbid condition, provide the person with written material about the psychological treatment being considered. For people with reading difficulties, alternative means of presenting the information, such as video or DVD, should be considered. So that the person can make an informed choice, there should be an opportunity for him or her to discuss not only this information but also the evidence for the effectiveness of different types of psychological treatment for borderline personality disorder and any comorbid conditions.

When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:

- an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user;
- structured care in accordance with this guideline; and
- provision for therapist supervision.

Although the frequency of psychotherapy sessions should be adapted to each individual's needs and context of living, twice-weekly sessions may be considered.

Do not use brief psychological interventions (of less than three months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder, outside a service that has the characteristics outlined in section 1.3.4.3. of NICE Guidance on Treatment of Borderline Personality Disorder.

For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical behaviour therapy programme.

When providing psychological treatment to people with borderline personality disorder as a specific intervention in their overall treatment and care, use the CPA to clarify the roles of different services, professionals providing psychological treatment and other healthcare professionals.

When providing psychological treatment to people with borderline personality disorder, monitor the effect of treatment on a broad range of outcomes, including personal functioning, drug and alcohol use, self-harm, depression and the symptoms of borderline personality disorder.

Appendix D

South West Yorkshire Partnership NHS Foundation Trust action plan

No	Recommendation	Key Actions	Key Outcome	Agreed Target date	Lead Officer	Progress/Update Rag status	Completion Date	Evidence
South West Yorkshire Partnership NHS Foundation Trust –Updated 14.10.13								
1.	When working with service users, the EIP team should fully utilise the range of specialist assessments which are readily accessible on the RiO system and form part of the service user electronic patient record; they are thus available to all practitioners and support the safe and effective management of care and risk.	EIS to review its discharge process and provide a report to the service manager	Discharge Policy reviewed	November2012	Team Manager, .EIS	Complete	November 2012	Evidence Received Statement from Trust, supported by interviews with staff

2.	The EIP team should review its discharge process and practice to ensure that the administrative caseload record is an accountable and accurate reflection of clinical caseload at all times.	A report to be prepared by the team manager of EIS outlined knowledge / use of specialist assessments in the team.	A comprehensive assessment will dictate the care planning arrangement level of risk assessment and appropriate interventions.	November2012	Team Manager, EIS	Complete	November 2012	<p><u>Evidence Received</u></p> <p>Random audit with a sample of 10 cases during April 2013</p> <p>Statement from Trust, supported by interviews with staff</p>
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3.	<p>Clear guidelines and specific timeframes on the use of the Sainsbury level 1 and level 2 risk assessment should be embedded in the CPA policy and the clinical risk assessment, management and training policy. Team managers should review practitioners' understanding of these requirements and ensure the appropriate use and consistency with the required standards thus promoting best practice and providing the opportunity to review risk and draw together various professional perspectives.</p>	<p>Audit of use of level 2 Risk assessment to be undertaken in EIS.</p> <p>Training session to be held with team on use of level 2 Risk assessments.</p>	<p>Audit completed</p> <p>Training Delivered</p>	November 2012	<p>Team Manager</p> <p>Service Manager</p>	Complete	November 2012	<p><u>Evidence Received</u> Random audit with a sample of 10 cases during April 2013</p> <p>Training session was delivered by the pathway manager in insight team meeting February 2013 and is evidenced in the team meeting minutes.</p>
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4.	Practitioners in EIP could benefit from the opportunity to reflect upon and review their approach to working with people with substance misuse issues who do not present with dual diagnosis but who may have needs in this area which, if openly established, could be receptive to intervention to preclude antisocial or illegal behaviour. Reflection and review may also promote staff safety and wellbeing when working with such service users and could form part of a team development session or be facilitated by the trust's dual	Team development session to be organised.	Team development session to be delivered.	November2012		Complete	November 2012	<p><u>Evidence Received</u></p> <p>Audit of 1/3 of caseload April 13</p> <p>Team has an established dual diagnosis worker with degree level qualification in addictions and substance misuse. Evidenced in team meeting minutes</p> <p>Supported by interviews with staff and dual diagnosis worker</p>
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	diagnosis specialists or nurse consultants.							
5.	Where child protection issues exist and practitioners agree to take responsibilities and actions, these should be incorporated into the service user's care plan with explicit, specific and timed actions underpinned by a shared risk assessment which clarifies each agency's expectations and thresholds for action. All issues regarding the wellbeing of children and potential risk should be included in the Sainsbury risk assessment and passed on to the appropriate agencies immediately and	Team manager to review Child protection capacity and understanding within the EIS	Team manager to prepare a report on the knowledge of and use of child protection procedures.	November 2012	Team Manager	Complete	November 2012	<u>Evidence Received</u> Team manager statement Child protection lead in post Attendance at mandatory training on child protection and safeguarding Staff interviews

	a record made of this in accordance with the appropriate trust and inter-agency policies and procedures relating to safeguarding.							
6.	There should be clarification of expectations, roles, responsibilities and purpose when planning case transfers between teams. This should be achieved by the effective delivery of the principles, practice and processes of CPA. Team managers should be reminded of the need to ensure that transfers between teams are effective and purposeful.	.	Team manager to review CPA processes exercised in transfers by the team.	November2012		Complete	January 2013	<u>Evidence Received</u> Statement from team manager. Interview with Trust lead for CPA Review of Trust CPA policy

7.	Appropriate access to APTS for service users in EIS should be clarified and any pathway issues or barriers to individuals having the opportunity to receive a suitable service for their needs should be addressed.	While psychologists are based in EIS, APTS report that currently there is no commissioned service for service users with psychosis this deficit has been noted in discussion with commissioners.		November 12		Complete		<p><u>Evidence Received</u></p> <p>Establish of Care management pathway to improve access</p> <p>Establishment of IAPT services</p> <p>Interviews with Psychological therapies staff and EIS staff</p>
8.	Guidance should be provided to practitioners in relation to intervention in and management of situations where service users have weapons, including the safe and accountable removal, storage and disposal of such weapons. A Trust wide protocol is currently being developed to support staff and to guide and inform practice in	<p>A Trust wide protocol is being developed to support staff in relation to service users known to access firearms.</p> <p>Alert the team when it is developed.</p>		October 2012		Complete	January 2013	<p><u>Evidence Received</u></p> <p>Trust policy on Searching of Patients</p> <p>Trust policy on use of tasers</p> <p>Trust policy on Management of Violence and Aggression</p>

	relation to service users who are known to own or have access to firearms and this should be made available to teams.							
9.	EIS should review their process regarding the offer of carers' assessments. All eligible carers should be offered a carer's assessment, and a carer's care plan if appropriate, and a record of this having been done should be made. This record and associated documentation should form part of the service user electronic patient record to ensure optimum and effective communication of service user need and risk.	Team manager to review process to ensure all eligible carers are offered a carer's assessment. Method – team to provide report for service manager.	Team manager	Nov 2012		Complete	January 2013	<u>Evidence Received</u> Audit of files in April 13 revealed that 90% of service users have an up to date CPA record Interview with Trust carers lead. Trust carers policy Family therapist employed to support carers, team minutes

10.	This record and associated documentation should form part of the service user electronic patient record to ensure optimum and effective communication of service user need and risk.	EIS operational policy should be reviewed to provide standards around physical wellbeing and medication risk referrals	Team manager	Nov 2012		Complete	January 2013	<u>Evidence Received</u> Operational Policy reviewed
11.	Consideration should be given to producing practice guidance addressing communication with service users by mobile phone and by text, and should incorporate the disclosure of individual numbers and the safety and accountability implications of this. This could also include email communication.	Trust developing a protocol around communication - text and email This recommendation will be taken to the Trust Incident Review Subcommittee to determine process and leadership.	IRSC	Sept 2012		Complete		<u>Evidence Received</u> Practice Guidance on use of mobile technology reviewed
12	The EIS operational policy in its reference to	EIS operational policy to be reviewed with focus on professional	team manager	Nov 2012				Operational policy review team established, copies of minutes and

	expectations around blurring professional boundaries should be reviewed to ensure its wording offers a safe and accountable framework for practice.	boundaries						correspondence reviewed. Interviews with staff
13.	Practitioners should be reminded of the Trust's expectations with regard to record-keeping standards and the need for timely and comprehensive entries to be made in the electronic patient record. All processes and interventions around the service user pathway should be fully recorded and reflected including those of psychology practitioners.	Psychology records are now included on RIO notes – no further action required				Complete	31.5.12	Clinical record keeping audit KPMG audit of records Quality Forum Agenda and minutes

Acronyms used in report

NICE - The National Institute for Health and Care Excellence

EIP - Early Intervention in Psychosis

CMHT - Community Mental Health Team

CPA - Care Programme Approach

NICE - The National Institute for Health and Care Excellence

CRHT - Crisis Resolution Home Treatment Team

CBT - Cognitive Behavioural Therapy

APTS - Adult Psychological Therapies Service

DAT - Duty and Assessment Team

CPN - Community Psychiatric Nurse (full version never written in document)

EDT - Emergency Duty Team

CRS - Crisis Resolution Service

NPSA - National Patient Safety Agency