

# **An independent investigation into the care and treatment of a mental health service user (Patient M) in Liverpool**

**September 2014**

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## **1. Executive Summary**

- 1.1 NHS England, North commissioned Niche Patient Safety (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Patient M). Niche is a consultancy company specialising in patient safety investigations and reviews. The terms of reference are at Appendix A.
- 1.2 It is usual for independent investigations such as these to cover the period of care provided up to the date of the incident. However, the final months of care and treatment took place in Scotland, which is outside the jurisdiction of NHS England. We have included analysis and commentary on services provided in England only.
- 1.3 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005.
- 1.4 The main purpose of an independent investigation is to identify whether there were any aspects of the care that could have altered or prevented the incident. The investigation process will also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.5 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.
- 1.6 We would like to express our sincere condolences to Mr G's family.

### **Offence**

- 1.7 On Wednesday 9 January 2013 Patient M assaulted Mr G, punching and kicking him on the head and body, and stamping on his head. The incident took place in Mr G's home in New Pitsligo, Aberdeenshire. On Saturday 12 January 2013 Mr G died of his injuries.
- 1.8 Patient M and his girlfriend, L, had been living with Mr G and his partner E since June 2012. L is the daughter of E. Throughout this time there had been ongoing arguments between Patient M and L and Mr G and E. The summary of evidence indicated that the incidents appeared to have been fuelled by alcohol.

### **Patient M's mental health history**

- 1.9 Patient M had a long history of contact with mental health services and had been diagnosed with paranoid schizophrenia. Patient M also had a history of drug and alcohol misuse, often with his twin brother K who was also known to mental health services. Patient M had made some attempts to address his drug use by contacting a Liverpool based charity, the Lighthouse Project, however he stated he found it difficult to address his drug use when he was in contact with his twin brother K.
- 1.10 Patient M had been receiving intensive support from the Assertive Outreach Team<sup>1</sup> for treatment of paranoid schizophrenia and drug use prior to the death of his brother J in May 2012.
- 1.11 Information about J's death was given to the Assertive Outreach Team on 9 May 2012 by the care co-ordinator for Patient M's other brother K who had been with J when he died. Following receipt of this information, staff tried to contact Patient M to see how he was coping and to find out if he needed any additional support but they were unable to contact him despite two attempts at home visits on 11 May and 14 May 2012.
- 1.12 A chance contact with Patient M took place on 18 May 2012 when L1, a community psychiatric nurse walked past Patient M whilst taking her children to school. L1 advised Patient M that the team had been trying to contact him. Patient M told L that the police had taken his phone and provided his girlfriend's phone number saying that both he and his girlfriend were happy for staff to contact him on that number. At this time Patient M stated that he sometimes felt anxious and had been hallucinating when he was asleep.
- 1.13 L1 said that she would pass on the telephone number to his care co-ordinator but Patient M said that staff should not visit until at least the following Friday (seven days hence) as he would be drunk on the Wednesday and Thursday following the funeral.
- 1.14 On 30 May 2012 Patient M's care co-ordinator, R contacted him to arrange to visit him at home on the Friday, 1 June 2012. At the home visit Patient M stated that he was well despite the recent death of his brother and advised that he was planning to move to Aberdeen with his girlfriend on 12 June. Patient M asked for three months' medication and stated he was not giving up his flat, that his sister would be moving in to look after it and that he planned to return to Liverpool every three months in order to get more medication. Patient M was informed that it was unlikely the doctor would agree to prescribe three months' supply

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<sup>1</sup> *The purpose of an Assertive Outreach Team is to work with individuals who find it difficult to work with services, have been admitted to hospital a number of times and may have other problems such as substance abuse. Assertive Outreach Teams offer an intensive, long term relationship to build up trust and the support they provide can include help with shopping, budgeting, taking medication, access to training, education and employment – Rethink Mental Illness website*

of medication but that R would try to get an appointment for him before he was due to leave on 12 June 2012 but that it might be difficult as his doctor, Dr M1, was on leave until 11 June 2012.

- 1.15 There were no further entries in Patient M's ePEX (electronic) notes until 7 November 2012 when Dr M1 recorded that information had been obtained that Patient M was now registered with a GP in Scotland, but the details of the GP had not been ascertained. The same day there is an entry in Patient M's notes to indicate that a discussion in the Assertive Outreach Team meeting had taken place which had concluded that Patient M was to be discharged from the service and that Dr M1 would write to Patient M's new GP in Scotland.
- 1.16 A two-page letter was sent on 12 November 2012 from Dr M1 to Patient M's new GP in New Pitsligo. This letter provided a brief summary of Patient M's diagnosis, treatment, forensic history and family history. Dr M1 recommended that the GP refer Patient M to local psychiatric services.
- 1.17 On 16 November 2012 Patient M's new GP Dr H referred Patient M to Adult Psychiatry services at NHS Grampian. Patient M had been to see his GP complaining of feeling very low. The GP noted that although Patient M had been registered with the practice since June 2012 he had not been taking any medication in that time.
- 1.18 An outpatient appointment was made for Patient M to see a local consultant psychiatrist on 18 December 2012. However Patient M presented for an emergency assessment on 28 November 2012 after he had assaulted three members of his girlfriend's family. Patient M had indicated at this assessment that they had all been drinking. A full psychiatric history was taken and the assessment concluded that there was no evidence of acute mental illness and that the argument was fuelled by alcohol. The assessing doctor felt that Patient M was fit to go home with follow up by the community mental health team (CMHT).
- 1.19 Patient M did not attend the appointment on 18 December 2012 and a further outpatient appointment was offered for 15 January 2013.
- 1.20 On 9 January 2013 Patient M assaulted Mr G and on 12 January Mr G died of his injuries.
- 1.21 On 12 January 2013 Patient M was charged with murder.

### **Sentence**

- 1.22 On 10 October 2013 Patient M was sentenced to nine years imprisonment after he pleaded guilty to the culpable homicide of Mr G. In sentencing Lord Steward said:

*“Had you been convicted of murder you would have been sentenced to imprisonment for life, subject to a very long period in custody before you could apply to the parole board for release. In respect of your conviction for culpable homicide, exercising such leniency as I can, I shall sentence you to a term of imprisonment of nine years.*

*My understanding is that your plea to the lesser offence of culpable homicide has not been accepted on the basis of your diminished responsibility, but has been accepted on the basis that you did not intend to take the victim’s life.”<sup>2</sup>*

### **Internal Investigation**

- 1.23 Staff at Mersey Care NHS Foundation Trust became aware of the incident after a member of staff read an item in the Liverpool Echo on 15 January 2013. A service user had also informed the same member of staff that Patient M had been charged with murder.
- 1.24 Mersey Care NHS Foundation Trust (the Trust) subsequently conducted an internal investigation, which concluded that; overall, Patient M had received significant care and treatment from the Assertive Outreach Team who showed considerable care throughout Patient M’s engagement with services. However a number of care and delivery problems were highlighted, specifically from the time of the death of Patient M’s brother J in May 2012 and the transfer to Aberdeenshire.
- At the time of his brother J’s death in May, Patient M had started to see less of the staff in the Assertive Outreach Team as his medication had been changed and clozapine<sup>3</sup> had been discontinued. Therefore weekly monitoring had ceased at a time when he had significant life events occurring.
  - In reviewing the Care Programme Approach documentation, including the risk assessment, there does not appear to have been a review of Patient M’s management plan as a result of the bereavement and the discontinuation of Clozapine. Also the risk assessment was not altered to reflect the predictable increase in risk potential at that time.
  - Between June and September there was no contact with services and the team kept a “watching brief” with the intention of making contact with Patient M if he returned to the area. There was no active search for Patient M to determine his whereabouts during this period of time. During the investigation the GP Dr M2 revealed that Patient M’s records were transferred on 7 August 2012.

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<sup>2</sup> Judiciary of Scotland website <http://www.scotland-judiciary.org.uk>

<sup>3</sup> Clozapine is an antipsychotic medication used in the treatment of schizophrenia, [www.patient.co.uk](http://www.patient.co.uk)

- In September 2012, due to changes within the Assertive Outreach Team, a new care co-ordinator B was allocated. B felt very uneasy with not having any contact with Patient M. In October, B contacted the GP, Dr M2, and soon discovered Patient M's new GP and the surgery address. The Assertive Outreach Consultant, Dr M1 wrote a letter of transfer to Patient M's new GP, Dr H, on 7 November 2012 recommending the involvement of local mental health services, but no Care Programme Approach transfer arrangements were made.
- With the discontinuation of clozapine there does not appear to have been any discussion with regard to the potential benefit of a depot form of medication.
- The last Care Programme Approach care plan review was undertaken in Patient M's absence, in Liverpool on 12 October 2012. Whilst it referred to disengagement from services and the action to try and make contact with Patient M, the latter part of the plan was copied from previous documents and appears to be out of date.

1.25 The internal investigation identified that there was significant evidence of appropriate care and treatment offered to Patient M over many years:

- For a number of years Patient M had been having weekly visits from the Assertive Outreach Team in order to support him in the management of his clozapine treatment. This involved ensuring he had regular blood tests, compliance to treatment and that the appropriate prescription was administered;
- Regular contact enabled the staff from the team to support Patient M with his social and physical wellbeing and to offer him advice and education with regard to his drug and alcohol use.

1.26 Despite this significant support, there were a number of contributory factors identified:

- It appears that because Patient M had been stable in symptoms and social circumstances for a number of years, with no evidence of relapse or disengagement, the team did not actively pursue Patient M's whereabouts in Aberdeen and did not carry out a transfer of care in accordance with Care Programme Approach policy and guidance.
- It appeared that Patient M was quite settled in his mental state whilst under the care of the Assertive Outreach Team. Adversely this may have contributed to a lack of scrutiny of the potential predictable risk factors at a time when there was a substantial change in Patient M's medical treatment, the loss of his brother J and plans to move to Aberdeen. It appears that a multi-disciplinary

review of Patient M's risk assessment to reflect these significant changes had not been undertaken.

- A further contributory factor may well have been that at this time the team were going through a significant organisation change process which led to the necessary change in Patient M's care co-ordinator. This would have led to a lack of continuity at least at a staffing level.

1.27 The internal investigation also developed a number of lessons to be learned and recommendations. The recommendations of the internal investigation are in Section 6 of this report and the action plan is at Appendix C.

### **Independent investigation**

1.28 This independent investigation has drawn upon the internal process and has studied clinical information, witness statements, interview transcripts and policies. The team has also interviewed senior staff members at Mersey Care NHS Trust who are responsible for ensuring that the action plan is implemented.

1.29 Whilst we agree that all actions within the Trust's recommendations are appropriate we note that three of the recommendations (1, 2 and 4) were processes set out in existing policies at the time of Patient M's move to Aberdeen and should therefore already have been in place.

1.30 In addition, our independent investigation has developed further findings in the following areas:

- recording of information in care plans;
- monitoring of organisational compliance with policies;
- management of transfer of care arrangements outside of Trusts within England;
- management of information by GPs when a patient who is being treated under Care Programme Approach transfers to another practice;
- commissioning of serious investigations where there could be public interest in a bi-lateral agreement between the NHS in England and Scotland, Wales or Northern Ireland.

1.31 In the light of our findings we believe that it was predictable that the absence of medication would cause Patient M to become increasingly paranoid, difficult to engage and potentially violent. However it is our opinion that this tragic event was neither predictable (in the nature and seriousness of the event) nor preventable by mental health services in England.



## Recommendations

- 1.32 The independent investigation team believes there are lessons to be learnt and has made a number of recommendations.
- 1.33 Good practice and existing Trust policy states that if a patient loses contact with services, timely action should be taken to locate the patient. This did not happen in this case.

### Recommendation 1

**The Trust must ensure that a systematic process is implemented to allow management oversight of patients who have been out of contact with services, that regular audits of that process are undertaken and that an assertive approach is taken to tracking any patient who has been out of contact with services.**

- 1.34 The Trust policy on clinical risk assessments and risk management was not implemented at a time when significant changes were taking place for Patient M.
- 1.35 Trust policy in place currently and at the time states that regular audits of compliance with the supervision requirements should take place. When we asked for this information we were told it was not available.

### Recommendation 2

**The Trust must ensure that clinical risk assessment, risk management and supervision policies are consistently implemented, that a systematic process is in place to monitor compliance and that regular audits are undertaken.**

- 1.36 On a number of documents Patient M's MHA status was incorrect. It is not known whether this is an isolated case or whether it is more widespread.

### Recommendation 3

**The Trust must implement a programme of audits to provide assurance that the recorded Mental Health Act status is correct.**

- 1.37 There was no active communication from the GP to the Trust when Patient M's GP records were sought by Patient M's new GP.

### Recommendation 4

**GPs must implement a process to notify the local mental health trust when a patient who is on Care Programme Approach moves outside the Trust area.**

- 1.38 During the organisational change process the Trust did not identify, mitigate or manage the risk of patients who had already, or were beginning to disengage with services.

**Recommendation 5**

**The Trust must ensure that a systematic approach is taken when planning organisational change, to ensure risks are identified, mitigated and managed for all groups of patients, particularly those who are already disengaging with services.**

- 1.39 It has not been possible to gain the whole picture of Patient M's care and treatment because in the final seven months prior to the incident Patient M was living in Scotland.

**Recommendation 6**

**It is recommended that a Memorandum of Understanding be developed between NHS England and partner NHS agencies in the UK to ensure that serious incident investigations that cross NHS borders are commissioned jointly. This should allow all aspects of care and treatment to be explored and for system learning to be shared across public services regardless of where they are delivered.**

- 1.40 There were some factual inaccuracies contained within the internal investigation report, and the internal investigation failed to identify inaccuracies within Care Programme Approach paperwork.

**Recommendation 7**

**The Trust must implement a quality control system in order to provide assurance that when serious incident reports are produced they are factually correct and identify all relevant learning.**

**Good Practice**

- 1.41 We found that the Assertive Outreach Team provided regular and intensive support to Patient M. This gave Patient M the support he needed to be able to take some control of his life. It enabled him to access education and physical activities both of which Patient M valued.

## 2. Introduction

- 2.1 On Wednesday 9 January 2013 Patient M assaulted Mr G, punching and kicking him on the head and body, and stamping on his head. The incident took place in Mr G's home in New Pitsligo, Aberdeenshire. On Saturday 12 January 2013 Mr G died of his injuries.
- 2.2 Patient M and his girlfriend, L, had been living with Mr G and his partner E since June 2012. L is the daughter of E. Throughout this time there had been on-going arguments between Patient M and L and Mr G and E. The summary of evidence states that "*the incidents appear to have been alcohol fuelled and numerous witnesses speak to [the] deceased being a provocative and abusive individual*".

## 3. Approach and Structure of the Investigation

- 3.1 The independent investigation follows the Department of Health guidance (94) 27<sup>4</sup>, on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix A.
- 3.2 The main purpose of an independent investigation is to discover whether there were any aspects of the care, which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 3.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.
- 3.4 The investigation was carried out by Naomi Ibbs, Independent Investigator for Niche, with expert advice provided by Dr Mark Potter. The investigation team will be referred to in the first person in the report.
- 3.5 The report was peer reviewed by Carol Rooney, Senior Investigations Manager, Niche.
- 3.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance<sup>5</sup>.

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<sup>4</sup> Department of Health (1994) HSG (94)27: *Guidance on the Discharge of Mentally Disordered People and their Continuing Care*, amended by Department of Health (2005) - *Independent Investigation of Adverse Events in Mental Health Services*

<sup>5</sup> National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

- 3.7 We used information from Patient M's clinical records and evidence gathered from the internal investigation report. As part of our investigation we interviewed:
- the Director of Patient Safety at Mersey Care NHS Trust;
  - the Director of Nursing & Secure Services at Mersey Care NHS Trust;
  - the Director of Medical Services at Mersey Care NHS Trust.
- 3.8 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature.
- 3.9 We wrote to Patient M at the start of the investigation, explained the purpose of the investigation and asked to meet him. Patient M gave written consent for us to access his medical and other records. We met with Patient M in prison and subsequently shared the report with Patient M prior to publication.
- 3.10 Contact was made with Patient M's partner but no response was received.
- 3.11 The victim's sister was identified as the point of contact for the victim's family. We spoke to her on the telephone and met with her to share the report prior to publication.
- 3.12 A full list of all documents we referenced is at Appendix D.
- 3.13 The draft report was shared with Mersey Care NHS Trust and NHS England prior to publication. This provided opportunity for those whom we interviewed to review and comment upon the content.

#### **Structure of the report**

- 3.14 Section 4 sets out the details of the care and treatment provided to Patient M. We have included a full chronology of his care at Appendix B in order to provide the context in which he was known to services in Liverpool.
- 3.15 Section 5 examines the issues arising from the care and treatment provided to Patient M and includes comment and analysis.
- 3.16 Section 6 provides a review of the trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.
- 3.17 Section 7 sets out our overall analysis and recommendations.

## 4. The Care and Treatment of Patient M

### Childhood and family background

- 4.1 Patient M was born in Bootle, Liverpool in 1973 and was brought up there. Patient M has a twin brother (K), Patient M was very close to K when they were children and *“they did everything together”*<sup>6</sup>. Patient M had one sister and two other brothers, D, J both of whom died in adulthood.
- 4.2 Patient M told Dr B, Consultant Psychiatrist that he had a *“stable upbringing but that he was always in trouble as a child”*, his punishments being ‘grounded’ and on one occasion being expelled from school just before sitting his exams at the age of 15.
- 4.3 Patient M attended mainstream schools in Liverpool. Patient M has said that he was a ‘bad’ pupil and that he was part of a ‘wrong crowd’.
- 4.4 There were fights between Patient M and his older brothers, but no evidence has been found that there was any violence between his parents.
- 4.5 Patient M’s mother died whilst he was an informal patient in a mental health hospital in Liverpool in 2007. Although they had been estranged, arrangements were made for Patient M to have some time out of hospital to visit his mother in hospital prior to her death.
- 4.6 Patient M’s father has continued to remain in contact with Patient M throughout his adult life.
- 4.7 In 2009 Patient M’s brother D committed suicide by hanging, this happened when D was living at a hostel for the homeless in Liverpool.
- 4.8 Patient M’s brother J died after taking drugs in May 2012. Patient M’s twin brother K was with J at the time J died. Brother K was arrested and was subsequently admitted to a psychiatric intensive care unit<sup>7</sup>. There are no reports of any charges being brought against K following the death of J.
- 4.9 When the team met with Patient M in September 2014 Patient M confirmed that although he was in contact with his girlfriend and family members, he had not received visits since being in prison due to the distance of the prison from Liverpool.

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<sup>6</sup> *Psychiatric Report dated 21 January 2013 completed by Dr B, Consultant Psychiatrist at the Blair Unit, Royal Cornhill Hospital, Aberdeen at the request of the Procurator Fiscal Depute, Peterhead.*

<sup>7</sup> *A psychiatric intensive care unit provides is an inpatient unit for people who in an acute, disturbed phase of serious mental disorder, where there is an increased risk and whose needs cannot be met on an acute ward. Mersey Care NHS Trust Psychiatric Intensive Care Unit Eligibility Criteria July 2013*

### **Training and employment**

- 4.10 On leaving school Patient M took part in training schemes and Youth Training Scheme placements, he also had a number of short term jobs working as a kitchen porter, general labourer and a removals man. Patient M had been more often unemployed than employed during his adult life and his longest job lasted for around a year when he worked as a painter and general labourer. Patient M's last job was in 2009 or 2010 when he worked as a kitchen porter.
- 4.11 Prior to moving to New Pitsligo in June 2012 Patient M had been attending college for about a year on a part-time basis, two days a week, studying maths and English. Patient M's aspiration at this time was to be able to enrol on an electrician's or joinery course. At this time Patient M was in receipt of benefits, namely Employment Support Allowance and Disability Living Allowance.

### **Relationships**

- 4.12 At the time of the offence Patient M had been in a relationship for about 14 months with L, daughter of the partner of the victim Mr G. L and Patient M met in Liverpool where L had been living, they had subsequently lived together in Patient M's flat prior to moving to live with L's family in New Pitsligo.
- 4.13 On moving to New Pitsligo Patient M and L had stayed with L's mother and her partner Mr G. Patient M had some difficulties with the frequency and amount of alcohol that was consumed within the family and was uncomfortable with the number of visitors to the house who came to use illicit drugs.
- 4.14 In the interview in January 2013 with Dr B, Consultant Psychiatrist<sup>8</sup> Patient M said that he and his partner had intended to return to his flat in Liverpool in the near future, to get away from the difficulties within L's family home.
- 4.15 At the time of the offence Patient M's partner, L was three months pregnant. Baby J was born in August 2013 and in September 2014 Patient M confirmed family members in Liverpool were fostering him.

### **Psychiatric history**

- 4.16 Patient M's first contact with mental health services was in about 2001 when he was informally admitted to a psychiatric ward. Initially it was thought that his problems were related to his history of drug taking and anti-social personality traits.

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<sup>8</sup> *Psychiatric Report dated 21 January 2013 completed by Dr B, Consultant Psychiatrist at the Blair Unit, Royal Cornhill Hospital, Aberdeen at the request of the Procurator Fiscal Depute, Peterhead.*

- 4.17 Mental health professionals found it difficult to engage Patient M in services. He often did not attend appointments and was chaotic in his lifestyle and was therefore someone with whom mental health staff found it difficult to consistently engage in treatment.

**2006-2008**

- 4.18 In February 2006 Dr N wrote to Patient M's GP, Dr M2 following an outpatient review. The diagnoses at that time were drug induced psychosis and traits of anti-social personality as well as an emotionally unstable personality borderline type.
- 4.19 Throughout 2006 Patient M was offered a number of appointments to which he did not attend. Subsequently there was a discussion at the Did Not Attend Meeting that concluded that no further input would be offered at that time and Patient M was discharged back into the care of his GP.
- 4.20 In November 2006 Patient M presented to the emergency department accompanied by the police. It was reported that he had attended the local police station complaining of his house being haunted and claiming that his neighbours had 'serviced' his house. At this time the Accident & Emergency Department Liaison Team assessed Patient M. He informed them that he had a diagnosis of personality disorder and that he was not being prescribed any psychotropic medication.
- 4.21 In January 2007 Patient M was assessed by the Acute Care Team following referral by his GP, Dr M2. Patient M was seen both individually and with his brother at this appointment. Patient M reported that he had been in prison from November 2006 to January 2007 for alleged threats to his ex-girlfriend. The specialist registrar assessing Patient M described it as a difficult assessment as *"the brothers were arguing during the assessment and were clearly under the influence of alcohol."*<sup>9</sup>
- 4.22 Between January and April 2007 Patient M presented to the emergency department more than 11 times, reporting symptoms of psychosis, feelings that his flat was haunted and requesting hospital admission. At this time it was noted that it was difficult to establish if Patient M had an underlying mental health problem, whether he was using drugs as a maladaptive coping mechanism or if he had a mental health problem that was being exacerbated by his drug use.
- 4.23 On 16 March 2007 Patient M was admitted to an inpatient unit for a full mental health assessment. Around this time Patient M's mother died, and leave was agreed for him to attend her funeral.

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<sup>9</sup> Letter dated 15 January 2007 from Dr S, Specialist Registrar in Psychiatry to Dr M2, GP

- 4.24 On 23 April 2007 Patient M was again admitted to an inpatient unit after he had presented in the clinic with thoughts of stabbing someone. On his admission staff recommended that he not be allowed to leave because of his mental state, threat to the public and his non-compliance with treatment. Staff were advised that if Patient M attempted to leave he should be detained under Section 5(2) of the Mental Health Act<sup>10</sup>. Despite this, on 2 May 2007 Patient M left the ward to collect his benefits spending £100 on cocaine and taking it all. The following day he was discharged from inpatient care with a plan to assess him for detention under Section 3<sup>11</sup> of the Mental Health Act if he presented at the emergency department again.
- 4.25 On 16 May 2007 a Mental Health Act assessment was undertaken after Patient M presented at the emergency department. The first medical assessment was completed and Patient M was interviewed by the Approved Social Worker but Patient M refused to stay and left the building. The staff team assessing did not contact the police, as there were no identified risks to himself or others.
- 4.26 The following day, Patient M presented at the clinic and was coherent and appropriate. There was no evidence of the psychotic symptoms being displayed the previous evening. Patient M admitted to taking cocaine the previous day and was upset about the death of his mother. Patient M left and re-presented to the clinic two hours later. His presentation this time was significantly thought disordered, he believed people were trying to kill him and he said he wanted to cut his own throat. Patient M asked to be admitted to hospital and to receive medication. He was then admitted to an inpatient unit.
- 4.27 Shortly after this admission to hospital an assessment was started by the Early Intervention in Psychosis team. The assessment continued until July 2007 when the assessor reviewed Patient M's old case notes and noted that Patient M had been diagnosed with psychotic episodes since 2002. In light of this information it was concluded that Patient M did not meet the criteria for treatment by the Early Intervention Team.
- 4.28 In early September 2007 it was noted that Patient M had been having leave and taking cocaine whilst being prescribed clozapine. This fact appears to have prompted a change in his care plan and on 19 September 2007 Patient M was discharged from inpatient services. The letter dated 21 September 2007 from the consultant, Dr O'B notes Patient M's diagnoses as paranoid schizophrenia and substance misuse – cocaine. At this point Patient M was being prescribed clozapine 200 mgs in the morning and 300 mgs at night and

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<sup>10</sup> Section 5(2) of the Mental Health Act allows the compulsory detention of a patient already in receipt of inpatient treatment for a duration of up to 72 hours, [www.mentalhealthlaw.co.uk](http://www.mentalhealthlaw.co.uk)

<sup>11</sup> Section 3 of the Mental Health Act allows the compulsory detention of a patient for treatment for a duration of up to six months, provided that grounds are met, [www.mentalhealthlaw.co.uk](http://www.mentalhealthlaw.co.uk)



arrangements were made for continuing blood tests and clozapine collection.

- 4.29 Patient M's compliance with his treatment plan was variable throughout the rest of 2007 and into early 2008. He regularly attended appointments for blood tests but reported that he often missed doses of clozapine and had to be re-titrated<sup>12</sup> in June 2008 after clozapine had to be stopped in March following poor compliance.
- 4.30 Drug and alcohol use continued during this time and in October 2008 Patient M reported feeling depressed and unable to leave the house. Patient M's GP Dr M2 prescribed an anti-depressant, escitalopram.

### **2009-10**

- 4.31 By January 2009 Patient M was reporting that he was still feeling paranoid, but not as severely as he had previously. At this time Patient M admitted only taking half the prescribed dose of clozapine because of the sedating effect it had on him. At this time Patient M continued to report using cocaine and bingeing on alcohol and was frequently informed about the risks of drugs and alcohol use and advised to stop.
- 4.32 Between January and May 2009 Patient M attended nearly all appointments and was most often at home for planned visits by his team.
- 4.33 However on 19 June 2009 Patient M presented at the clinic, accompanied by his brother K, and reported feeling suicidal, low in mood and paranoid. He was reluctant to leave his flat because he believed people were talking about him. Patient M was prescribed Prozac<sup>13</sup> 20 mg and was subsequently advised that it could take three weeks for any positive effects to be seen.
- 4.34 He was seen at home three days later by his social worker, who recorded that he did not seem as distressed as the previous week. However Patient M said that recent events such as *"the release from prison of his brother, the death of his granddad, a prank phone call from a friend concerning his mental health got on top of him."*<sup>14</sup>
- 4.35 Throughout July 2009 there were 15 occasions when Patient M should have attended a clinic appointment or been at home for staff to visit. Contact was made on just five occasions.

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<sup>12</sup> Titration or re-titration is the gradual change in drug dose to determine the best effect or dose of a drug. This process is used when patients start taking clozapine because there are a wide range of adverse effects, many of which are serious or potentially life threatening. Mersey Care NHS Trust Adult Mental Health Inpatient Clozapine Procedure.

<sup>13</sup> Prozac (fluoxetine) is medicine which is used to treat a range of mental health problems, including depression, [www.patient.uk](http://www.patient.uk)

<sup>14</sup> Mersey Care ePEX notes page 27 of 62, entry dated 22 June 2009 15:05

- 4.36 In August 2009 Patient M said that he was less paranoid and asked for a referral to a day centre. Patient M said he felt it was an opportunity for him to build his self-esteem and confidence.
- 4.37 In September 2009 Patient M reported an increased in auditory hallucinations, paranoia and feelings of suicide. He also reported being scared and reluctant to leave his flat because of the paranoia and because he could hear people talking about him. He admitted to using cocaine the previous week and acknowledged that it had a detrimental effect on his mental health, but said that he took it because he felt mentally unwell and described his stomach as being in knots.
- 4.38 On 7 September it was decided that a referral should be made to the Crisis Resolution and Home Treatment team (CRHT)<sup>15</sup> to monitor his mental health. A risk assessment completed at this time stated that two staff should visit at all times due to Patient M's forensic history. The CRHT team saw Patient M five times before discharging him back to the community team on 16 September 2009.
- 4.39 On 24 September 2009 Patient M was seen at home and reported that he felt hung-over, as he had been drinking with his brother K. He complained of the same level of paranoia and auditory hallucinations but denied any further cocaine use.
- 4.40 Throughout October 2009 three attempts were made to visit Patient M at home, none of which was successful and each time a message was left on Patient M's mobile. On 14 October staff discussed transferring Patient M's care to the Assertive Outreach Team (AOT).
- 4.41 In November 2009 a joint home visit was undertaken to arrange for Patient M's care to be transferred from the community team to the Assertive Outreach Team<sup>16</sup>. In December 2009 Patient M was introduced to Support Worker L2 who was to support Patient M to engage with social activities in the community such as going to the gym, football and snooker.
- 4.42 Between November 2009 and May 2010 Patient M attended for blood test monitoring every month and was seen at home at least weekly, many weeks receiving two or three visits from his support worker. Throughout this time Patient M's mental health fluctuated, some days staff reported him as seeming well, others that he appeared anxious, agitated and sometimes depressed. Despite this fact, Patient M was only absent for a planned home visit on four occasions. Patient M was

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<sup>15</sup> "Crisis Resolution and Home Treatment teams provide intensive support at home for individuals experiencing an acute mental health crisis" Crisis Resolution and Home Treatment – A practical guide, The Sainsbury Centre for Mental Health 2006 [http://www.centreformentalhealth.org.uk/pdfs/Crisis\\_resolution\\_and\\_home\\_treatment\\_guide.pdf](http://www.centreformentalhealth.org.uk/pdfs/Crisis_resolution_and_home_treatment_guide.pdf)

<sup>16</sup> "Assertive outreach teams work with people who are aged 18 to 65 years old who have particularly complex needs and need more intensive support to work with services." Rethink Mental Illness <http://www.rethink.org/diagnosis-treatment/treatment-and-support/assertive-outreach/what>

regularly supported to attend church every week and accompanied support worker L2 on a ramble on a number of occasions.

- 4.43 On 4 May 2010 a care plan<sup>17</sup> was created that included a crisis management plan, recorded as being updated on 31 August 2009 and a statement that “*I do not have a problem with substance misuse*” and “*No support required for cultural belief needs*”. In addition Patient M’s Mental Health Act status was recorded as Section 37<sup>18</sup>. This information has subsequently been determined to be inaccurate recording.
- 4.44 In June 2010 Patient M reported an increase in auditory hallucinations and being depressed. Also at this time Patient M admitted drinking large amounts of alcohol with his brother K and not being fully compliant with his medication regime. Following a failed attempt at a home visit by staff, Patient M told staff that his brother K had beaten up their father and that it had distressed him (Patient M).
- 4.45 Between July and September 2010 regular home visits continued on average two or three times weekly. Patient M was supported to go to church and reported that his mood improved after he started taking amisulpride at the end of July 2010. In mid September 2010 Patient M reported still hearing voices, feeling low and paranoid. His support worker L2 recorded that he appeared “harrowed” at a home visit on 23 September 2010. Patient M said he was despondent because he had no qualifications, no job and mental illness, issues that he perceived as stigmatising.
- 4.46 In November Patient M reported that he was experiencing auditory hallucinations and paranoia and that he felt frustrated due to a lack of meaningful activity. He later admitted that he was chaotic when taking his clozaril medication and that he would forget to take it on many occasions. Having missed a number of appointments for blood tests to be done it was agreed that a member of staff would accompany Patient M to blood test appointments from then on.
- 4.47 There were concerns on Christmas Eve 2010 when staff were unable to contact Patient M in order to deliver medication that had not been collected from the pharmacy. Although Patient M reported that he had chosen not to spend Christmas Day with his father and aunt (as they would be drinking in pubs which he did not want to do) over the Christmas and New Year period Patient M’s alcohol consumption increased. He complained of feeling sedated and attributed this to his clozaril medication. Staff agreed to arrange a medical review to discuss his treatment and noted that Patient M seemed reluctant to

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<sup>17</sup> Mersey Care NHS Trust Care Programme Approach 07 Care Plan, generated 25 May 2010 by D.

<sup>18</sup> Section 37. This is a court order imposed instead of a prison sentence, if the offender is sufficiently mentally unwell at the time of sentencing to require hospitalisation. Mental Health Law online [www.mentalhealthlaw.co.uk](http://www.mentalhealthlaw.co.uk)

reduce the clozaril dose, as he was worried his auditory hallucinations would worsen.

**2011**

- 4.48 In early 2011 Patient M was most often at home for planned visits from staff and attended his blood test monitoring appointments. It is unclear what level of support Patient M received from his support worker L2 at this time as between January and May 2011 there are no entries in the ePEX<sup>19</sup> notes.
- 4.49 In March 2011 a care plan was completed that indicated Patient M's Mental Health Act status as Section 37 and stated that his clozaril medication would be delivered weekly by staff in a blister pack and exchanged for the empty blister pack in order to monitor his medication compliance. A risk assessment completed at the same time noted current concerns as substance misuse, socially and culturally isolated and high anxiety levels.
- 4.50 In April 2011 Patient M reported that he was adhering to all prescribed medication and was now feeling the benefit from it. He told staff that his brother K had been admitted to hospital suffering from paranoia. He noted that his brother was a regular user of cocaine and that this probably didn't help him. Patient M said that he wanted to use the opportunity of his brother being in hospital to turn his life around and had joined Cocaine Anonymous.
- 4.51 In May 2011 Patient M asked for some respite or admission to hospital to take him away from a drug and alcohol environment and to help him build up some self-control. During this month he regularly asked for support with his cocaine addiction but there is no information in his patient record to indicate what support, if any, was provided by staff.
- 4.52 In June 2011 Patient M was seen by a new psychiatrist. At this appointment he reported continued hearing of voices and feeling anxious when going out alone. Also noted at this appointment was the fact that his father had recently moved and wouldn't tell the family where he was going. Patient M reported having regular contact with his twin brother K and that they regularly use alcohol and cocaine when together and that Patient M's cocaine use had increased over recent months.
- 4.53 During July and August 2011 there were a number of failed home visits when Patient M was not at home and not answering his phone. When staff saw him it was generally reported that he looked well and no concerns were noted.

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<sup>19</sup> ePEX is a clinical information system used by Mersey Care NHS Trust

- 4.54 In September 2011 Patient M was supported to enrol on maths and English courses at college. He appeared really pleased about it and seemed to enjoy the courses.
- 4.55 In November 2011 Patient M reported that he had a new girlfriend and on four occasions appeared intoxicated when staff arrived for a home visit. He admitted poor medication compliance and staff strongly reminded him how dangerous it was to "*mess about with these meds*". Patient M admitted that he "*didn't tell staff enough*", that things were getting no better and that he was back to not going out in the evening. Staff were unclear why he was presenting in this way and speculated that it was because he was due to see the doctor the following week.
- 4.56 In December 2011 a medication review meeting was held as Patient M had been missing doses of both clozapine and amisulpride. The doctor emphasised to Patient M that the medication was to prevent a relapse of schizophrenia and agreed to reduce the dose of clozapine to 250 mgs at night because of the sedating effect of the higher dose.

## 2012

- 4.57 On 5 January 2012 Patient M's community psychiatric nurse R had a discussion about Patient M's compliance with clozaril with Dr M1 as he had again failed to take it properly with four consecutive days remaining in the previous week's blister pack. Staff reported that Patient M seemed ambivalent about when he had last taken his medication and could not provide information about the days when he had not taken it. Dr M1 advised that Patient M could not be admitted to an inpatient unit, as there were no beds available. Staff noted that Patient M had reported that he had taken his medication the previous evening but they were unsure if he was being truthful. The possibility of an alternative treatment plan was discussed and Dr M1 advised that Patient M keep his planned appointment with Dr J in order to review his medical history before she made a decision regarding treatment.
- 4.58 After this discussion between staff Patient M reported that he was more compliant with his medication and that he had joined a gym and was able to describe the benefits he was already experiencing. He also reported that he had significantly reduced both his alcohol and cocaine use.
- 4.59 On 9 March Dr P wrote to Patient M's GP Dr M2 with a summary of an appointment on 29 February. Dr P advised that Patient M had reported that he occasionally forgets to take his clozapine saying, "*I can't be bothered they wipe me out*". Dr P also advised that Patient M had reported no longer doing drugs and only having three pints five days previously.
- 4.60 On 15 March 2012 Patient M advised that he was going to Scotland for a holiday with his girlfriend. Staff gave him three weeks' worth of clozaril and advised him that his blood test was due on his return on 2

April. Staff advised him to take his medication every day and to “*watch his alcohol intake whilst away*”.

- 4.61 On 6 April 2012 community psychiatric nurse L1 called Patient M to advise that his clozaril<sup>20</sup> would not be delivered, as he had not attended for his blood tests. L1 advised Patient M that the team was considering stopping the clozaril, as the levels in his system were so low which was an indication that he was not taking it. Patient M was advised to continue with his current medication and to attend for a final blood test on 11 April.
- 4.62 On 25 April Dr P wrote to Patient M’s GP Dr M2 following an unscheduled appointment on 20 April with Patient M and his partner. Dr P reported that Patient M had shown up in Dr P’s office requesting an increase in his medication, as he was experiencing symptoms of “*anxiety, depression, paranoia and anger*”. Dr P noted that Patient M had recently returned from a holiday to Scotland and admitted drinking large amounts of lager and vodka most days during the two weeks he was there.
- 4.63 Dr P reported that Patient M had been shown the results from the blood test he submitted on 9 March, which indicated mostly non-compliance. Patient M’s response was that the clozapine always left him feeling tired. Dr P had informed Patient M that, following discussion at the multi-disciplinary meeting the previous week; it was decided to stop the clozapine due to cardiac and other complications, were he to take it intermittently. At the appointment on 20 April Patient M said that he continued to hear voices and that this resulted in him feeling unsettled at college. Patient M also said that he hadn’t been going to the gym recently and that he found it difficult to get out of bed. Dr P advised Dr M2 that he had increased the amisulpride from 100 mgs daily to 200 mgs daily.
- 4.64 In May staff made three recorded attempts to contact Patient M after they received news that his brother J had died of a suspected drugs overdose on 9 May.
- 4.65 On 18 May community psychiatric nurse L1 had a chance meeting with Patient M. Patient M told L1 about his brother dying and said that the police had taken his phone. Patient M gave his girlfriend’s mobile number and said that both he and she were happy for staff to use it to contact him. Patient M said that he felt anxious and had been hallucinating “*well before*” his brother died. L1 advised that she would give the new contact number to his care co-ordinator R but Patient M said not to visit until at least the following Friday as he would be “*drunk on Wednesday and Thursday following the funeral*”.

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<sup>20</sup> Clozaril is the brand name for clozapine. Clozapine is the generic name for the medicine. Each medicine has an approved name called the generic name. “A brand name is the name chosen by the company that manufactures the medicine and therefore some medicines have more than one brand name as they are made by more than one manufacturer.” Patient.co.uk

- 4.66 On 30 May R telephoned Patient M to arrange to see him on 1 June. At the home visit on 1 June Patient M reported that he remained well despite the recent bereavement. Patient M asked for three months' medication as he planned to move to Aberdeen with his girlfriend on 12 June, as he wanted to make a fresh start. Patient M advised R that he planned to visit Liverpool every three months in order to get more medication and that the benefit service were not aware of his move. Patient M was advised that R was doubtful any doctor would supply three months of medication and that it may be difficult to get him an appointment with a doctor as Dr M1 was on leave until 11 June.
- 4.67 There are no other entries in the Mersey Care NHS Trust records until 7 November when care co-ordinator B contacted patient services after establishing from Patient M's GP Dr M2 that Patient M was no longer registered with the practice in Bootle. On the same date Dr M1 recorded that a discharge letter would be sent to the new GP in Scotland.
- 4.68 On 12 November Dr M1 wrote a two-page letter to Patient M's new GP Dr H in New Pitsligo. The letter outlined the fact that Patient M had been under the care of the Assertive Outreach Team and had been known to psychiatric services in Liverpool since 2001. Dr M1 reported that the team last had contact with him in June 2012 and that he appeared well. Dr M1 noted that Patient M had been admitted in 2001, 2006, 2007 and 2008 and described the admissions as often being brief, that Patient M was often intoxicated with cocaine and overtly psychotic and disturbed. Dr M1 also advised that "*within a few days there would be a significant improvement and he would be discharged*".
- 4.69 On 16 November 2012 Patient M's new GP Dr H referred Patient M to Adult Psychiatry services at NHS Grampian. Patient M had been to see his GP complaining of feeling very low. The GP noted that although Patient M had been registered with the practice since June 2012 he had not been taking any medication in that time.
- 4.70 An outpatient appointment was made for Patient M to see a local consultant psychiatrist on 18 December 2012. However Patient M presented for an emergency assessment on 28 November 2012 after he had assaulted his three members of his girlfriend's family. Patient M had indicated at this assessment that they had all been drinking. A full psychiatric history was taken and the assessment concluded that there was no evidence of acute mental illness and that the argument was fuelled by alcohol. The assessing doctor felt that Patient M was fit to go home with follow up by the community mental health team.
- 4.71 Patient M did not attend the appointment on 18 December and a further outpatient appointment was offered for 15 January 2013.

### **Contact with criminal justice system**

- 4.72 Prior to the offence related to this investigation, Patient M had 13 convictions relating to 17 offences committed between 1995 and 2007. He was sentenced to 14 months in a young offenders' institution in 1997 for grievous bodily harm and was sentenced to two months in prison in 2007 for threatening/disorderly behaviour.
- 4.73 Patient M's offences included three offences against the person, two offences against property, two public order offences and two offences of possession of offensive weapons.
- 4.74 At no point was an order issued by the courts to detain Patient M under Section 37 of the Mental Health Act.

### **5. Arising Issues, Comment and Analysis**

- 5.1 Patient M has a substantial history of mental ill health having received care, treatment and support from Mersey Care NHS Trust for approximately 11 years from about 2001 to 2012 when he left for Scotland.
- 5.2 Patient M was chaotic in his lifestyle and staff found it difficult to engage him in regular appointments to review his presentation and medication. It was only when Patient M's care was transferred to the Assertive Outreach Team in late 2009, early 2010 that staff were able to work with him regularly through the allocation of a support worker.
- 5.3 Overall the care and treatment Patient M received from Mersey Care NHS Trust was good. Up to the point that Patient M said he was moving to Scotland in June 2012 assertive attempts were made which successfully maintained Patient M's engagement with services.
- 5.4 From June 2012 there is no evidence of any attempt to trace Patient M until November 2012 when contact is made with patient services and Patient M's registration with a GP in Scotland is identified.
- 5.5 The investigation team has identified a number of issues that indicate a lack of adherence to policy, inaccurate recording of information or poor follow up.

### **Risk assessments**

- 5.6 When Patient M started to receive input from support worker L2 in December 2009, staff were regularly visiting him at home alone. There is no evidence of an updated assessment to consider the risk of staff visiting alone, despite the assessment in September 2009 determining that staff from the CRHT should not visit alone.
- 5.7 There is no evidence that Patient M's risk was reviewed at critical points when there was significant change taking place in his life:



- in January 2012 his medication regime was changed;
  - in April 2012 he went on a two week holiday with his new girlfriend - the first time he had gone on holiday and the first significant relationship;
  - in May 2012 his brother died unexpectedly;
  - in June 2012 he moved.
- 5.8 There are at least three points in this five-month period that in our opinion should have triggered a formal review of Patient M's risk and care plan.
- 5.9 Between 1 January and 29 February 2012 Mersey Care staff saw Patient M on 11 occasions. He was seen twice during March 2012, prior to going to Aberdeen on holiday and three times in April 2012. By mid May 2012 staff had made three unsuccessful attempts to contact Patient M following news of the death of his brother. There is no evidence of concerns being escalated or any discussion about a need to review Patient M's care plan and risk assessment.
- 5.10 The Care Programme Approach policy<sup>21</sup> states that *"In the event of relapse, crisis or non-adherence with the care plan, anyone involved in the provision of care, including the service user, carer or relative, may request the care co-ordinator to call an urgent review (three working days or less), to review the appropriate level of support/management given to the service user, including a full risk assessment and a review of the risk management plan."*
- 5.11 The most recent risk assessment we could find was completed on 4 March 2011. This document identifies current concerns as substance misuse, social/cultural isolation and high anxiety levels, no current or past high risks are noted. The document also indicates that Patient M did not agree with his risk assessment but there are no reasons given.

### **Psychological therapy**

- 5.12 Patient M reported hearing voices on most contacts with staff in Liverpool. There was a referral to the Early Intervention Team in 2007 following admission to the ward, however the assessment determined that as Patient M had been hearing voices since 2002 he did not meet the criteria for the Early Intervention Team. There is no evidence that there were any further attempts to secure psychological support for the management of Patient M's psychosis and indeed one member of staff reported to the internal investigation team that it was not necessary to refer Patient M to psychology but in general the *"Assertive Outreach*

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<sup>21</sup> Policy and Procedure for the Care Programme Approach, Mersey Care NHS Trust, ratified March 2011

*Team would not refer to psychology and would not feel able to do so*<sup>22</sup>.

- 5.13 The issue of access to psychology was raised during the external investigation team interviews with senior staff. The Trust was unable to clarify why an individual member of staff would say that they felt unable to refer to psychology as the need for psychology would be discussed and agreed with the team psychiatrist and at the team meeting.
- 5.14 There has been significant organisational change since 2007 and the Assertive Outreach Team has now been amalgamated into the community teams. Clinical psychology resource is available in each of these teams. However the resource is limited and the need for specialist psychology input is identified and agreed at team meetings.

#### **Inaccurate information**

- 5.15 The offending history provided in numerous documents clearly indicates that Patient M has never been detained for treatment, either by the courts or as a civil detention. Despite this his Mental Health Act status was recorded as Section 37 in a number of Care Programme Approach documents in 2010, 2011 and 2012. Mersey Care NHS Trust was unaware of these errors prior to us bringing the issue to their attention and was unable to identify how the error occurred. Information about Patient M's previous convictions was provided by the police to the internal investigation team and there is no indication that a court issued a Section 37 order as a disposal.
- 5.16 The internal investigation clearly states that there is no known family history of mental illness despite there being clear documentation of mental illness and substance misuse in Patient M's three brothers.

#### **Follow up and transfer of care**

- 5.17 On 5 January 2012 there was a discussion with Patient M's doctor about his poor compliance with clozaril. Patient M had failed to take his medication for four consecutive days. The decision was taken not to admit Patient M for re-titration as there were no beds available. A discussion took place about an alternative treatment plan but the advice from the doctor was that Patient M should keep his appointment to review his medical history before a decision could be taken regarding changes to his treatment plan. This appointment took place on 29 February 2012 – nearly eight weeks later.
- 5.18 Given that the Assertive Outreach Team had provided sole support to Patient M since 2009, the investigation team is unclear why this information needed to be sought separately in order to then consider a change to Patient M's treatment plan.

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<sup>22</sup> Interview with Care Co-ordinator R held on 26 February 2013, conducted by the internal investigation team.

- 5.19 Following the chance meeting on 18 May it was a further 12 days before staff contacted Patient M on 30 May to arrange to see him on 1 June 2012. The team acknowledge Patient M's statement that staff should not try to contact him around the time of his brother's funeral the following week. However, given the events and the lack of contact Patient M had had with services around that time we consider that a more assertive approach should have been taken.
- 5.20 At the meeting on 1 June Patient M made it clear that he intended to move to Aberdeen on 12 June. He requested three months' supply of medication and although the staff member indicated it was unlikely he would receive this there is no evidence that a broader discussion took place with Patient M or with other members of staff to consider risk or appropriate actions. The member of staff recorded that she would try to get an appointment for Patient M and that she would be in touch. However there is no evidence that this was acted upon, as the next entry on ePEX was not until 7 November 2012 when the new care co-ordinator had taken action to attempt to locate Patient M.
- 5.21 There was no attempt to make arrangements for Patient M's care to be transferred to services in Scotland. Mersey Care's Care Programme Approach policy and procedure<sup>23</sup> dated March 2011 sets out actions to be taken by staff when a service user moves to another area in both a planned and unplanned way stating "*in non-urgent situations, a Care Programme Approach meeting should be called by the originating authority within 10 working days of their notification that the person has moved*".
- 5.22 In addition, the same policy sets out the actions to be taken when a service user loses touch or goes missing from services. Paragraph 8.10.10 states, "*The care co-ordinator should contact any carers, other members of the care team, relatives and known associates to try to locate the service user.*" The policy also makes reference to use of the National Tracking Service to assist in checking the location of the service user via the GP registration. It also specifies that any actions taken should be clearly recorded. These principles are repeated in the Assertive Outreach Team Operational Policy.<sup>24</sup>

### **Communication from primary care**

- 5.23 There is currently no protocol or process to require GPs to notify local health partners when a patient changes practice. Patient M's GP, who contributed to the internal investigation, noted that in this case it would have been helpful if he had notified the Trust that Patient M's GP records had been requested by Patient M's new GP. This would have

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<sup>23</sup> Policy and Procedure for the Care Programme Approach, Mersey Care NHS Trust, ratified March 2011

<sup>24</sup> Operational Specification and Protocol for Assertive Outreach Teams (AOT), Adult Mental Health Directorate, Mersey Care NHS Trust, undated but provided by the Trust as the Assertive Outreach Team Operational Policy in place as at June 2012.

allowed the Trust to take active steps to identify the receiving GP and mental health service to allow a proper transfer of care to take place.

- 5.24 During the internal investigation Dr M2 indicated that he felt this could be a useful change to practice.

### **Organisational change**

- 5.25 The transcripts of the interviews conducted during the internal investigation implied that organisational change was taking place during the summer of 2012.
- 5.26 During the interviews we held with the Director of Patient Safety he told us that in summer 2012 the Assertive Outreach Team was being disbanded and that Patient M's care was being transferred to a community mental health team. We were told that some of the staff were moving from the Assertive Outreach Team into a community health team and that the Assertive Outreach Team was in a state of "flux".
- 5.27 We were also told that during the time the Assertive Outreach Team was being disbanded the focus and memory of the team was lost.
- 5.28 After the interviews the Trust provided us with a briefing paper titled Proposed Model of Care: Positive Care Partnerships dated January 2012. This document provides a brief overview of how acute and community services would be configured in the future.
- 5.29 The Trust also provided a presentation titled Improving Community Mental Health Services Programme. The presentation identifies the vision as being "*to provide integrated community mental health services for adults of all ages...which will ensure choice, social inclusion, promote recovery and independence and effective clinical outcomes.*" The purpose of the organisational change programme was to provide a single community service that could provide a range of interventions for the population it served, without the need for hand-offs to other teams when an individual's needs changed. The need to review the caseload of the Assertive Outreach Team is highlighted under *Service User and Carer Perspective* however it is not clear from the presentation how this review would be undertaken.
- 5.30 We asked what risk assessment process was applied to the organisational change programme and how those risks were mitigated and managed during the period of change. We were told that a formal project management structure (PRINCE2)<sup>25</sup> was developed to ensure appropriate governance and project assurance arrangements were in place to manage the delivery of the programme. The manager of the

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<sup>25</sup> PRINCE2 is an acronym for Projects in Controlled Environments. It is a process-based method for effective project management and is used widely in the public and private sector both nationally and internationally.  
[www.prince2.com](http://www.prince2.com)

Assertive Outreach Team was a core member of the project team and weekly meetings took place to manage progress and identify, manage and mitigate risks.

- 5.31 We have seen the project brief, a briefing report, a status report and the risk register all of which evidence the use of PRINCE2 methodology. The risk register highlights the risk that Assertive Outreach Team patients being transferred to locality teams may disengage with services during the process. This risk was mitigated by plans to transfer patients in line with the Care Programme Approach Policy, make use of the Rapid Access Scheme and ensure effective liaison with GPs, ward staff and Accident & Emergency staff. In addition care co-ordinators hand-delivered letters to patients and met with them to explain the changes that were taking place.
- 5.32 There is no record of identifying those patients who had already disengaged, or were starting to disengage with services at the start of the change management process.
- 5.33 We were told that the Assertive Outreach Team were asked to identify and manage those high risk patients who should be transferred to the receiving locality team using the Care Programme Approach policy. There was no organisational or systemic oversight to ensure that the risks for this group of patients were identified, mitigated or managed.

## **6. Internal Investigation and Action Plan**

### **Internal Investigation**

- 6.1 We have reviewed the internal investigation report guided by the NPSA investigation evaluation checklist.<sup>26</sup> The internal investigation is described by the Trust as a Level 3 Root Cause Analysis investigation and was led by an Executive Director.
- 6.2 The NPSA Root Cause Analysis Investigation Tool<sup>27</sup> describes a Level 3 investigation as one that must be commissioned and conducted by those independent to the provider service and organisation involved. The Trust has stated that their policy identifies four levels of internal investigation with Level 3 being used when service users of the Trust have been involved in an alleged homicide incident.
- 6.3 It is relevant to note, therefore, that the internal investigation is an internal Level 3 investigation not a National Patient Safety Agency Root Cause Analysis Level 3 investigation.

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<sup>26</sup> National Patient Safety Agency, *Root Cause Analysis Investigation Evaluation Checklist*.

<sup>27</sup> National Patient Safety Agency, *Root Cause Analysis Investigation Tools, Three levels of RCA investigation - guidance*

6.4 The care and service delivery problems identified were:

- At the time of his brother's death in May 2012, Patient M had started to see less of the staff in the Assertive Outreach Team as he had had his medication changed and clozapine had been discontinued. Therefore, weekly monitoring had ceased at a time when he had significant life events occurring.
- In reviewing the Care Programme Approach documentation, including the risk assessment, there does not appear to have been a review of Patient M's management plan as a result of the bereavement and discontinuation of clozapine. Also the risk assessment was not altered to reflect the predictable increase in risk potential at that time.
- Between June and September there was no contact with services and the team kept a 'watching brief' with the intention of making contact with Patient M if he returned to the area. There was no active search for Patient M to determine his whereabouts during this period of time. During the investigation the GP revealed that Patient M's records were transferred on 7 August 2012.
- In September 2012, a new care co-ordinator was allocated due to changes within the team who [the new care co-ordinator] felt very uneasy with not having any contact with Patient M. In October 2012 B contacted the GP and soon discovered Patient M's new GP and the surgery address. The Assertive Outreach Team consultant wrote a letter of transfer to Patient M's new GP on 8 November 2012 recommending the involvement of local mental health services, but no Care Programme Approach transfer arrangements were made.
- With the discontinuation of clozapine there does not appear to have been any discussion with regard to the potential benefit of a depot form of medication.
- The last Care Programme Approach care plan review was undertaken on 12 October 2012 and whilst it referred to disengagement from services and the action to try and make contact with Patient M, the latter part of the plan was copied from previous documents and appears to be out of date.
- N.B. After the [internal investigation] report had been drafted the [internal] review team received some clinical information from Grampian NHS, in the form of copied letters that help to confirm the contact that Patient M had with services in Scotland.

6.5 The recommendations made were:

- When a service user who is on Care Programme Approach disengages from services unexpectedly and loses contact with the care team a formal Care Programme Approach review will be held

to agree an action plan and review clinical risks. These discussion and agreed actions should then be recorded in the care plan and risk assessment.

- When a service user who is on Care Programme Approach disengages from services unexpectedly and loses contact with the care team the care co-ordinator should maintain regular contact with the GP and, if appropriate, family members.
- If it is suspected that a service user on Care Programme Approach has unexpectedly moved out of the area then the care co-ordinator will check via the Care Records Clinical Summary (SPINE<sup>28</sup>) whether they have registered with a GP in another area. This should be done on a two to four weekly basis.
- All service users who require a transfer of care and are on Care Programme Approach should have a transfer to a mental health trust according to the guidelines within the Care Programme Approach policy.
- All team managers should ensure that the clinical staff within their service area know how to access the Care Record Clinical Summary (SPINE) and have a good understanding of Care Programme Approach policy.

6.6 Although we would not disagree with the statements made within these recommendations, in our opinion they do not reflect the fact that trust policy was not followed in the following areas:

- risk management and review – Care Programme Approach Policy;
- response to a patient disengaging from services – Assertive Outreach Team Operational Policy and Care Programme Approach Policy;
- transfer of care to other areas – Care Programme Approach Policy.

6.7 Our independent investigation has developed further findings in the following areas:

- assurance of compliance with Trust policies;
- accuracy of information;
- communication from primary care;
- management of transfer of care arrangements outside of Trusts within England;

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<sup>28</sup> SPINE is a collection of national applications, services and directories that support the NHS in the exchange of information across national and local NHS systems, Health and Social Care Information Centre

- process of conducting Root Cause Analysis investigations;
  - commissioning of serious investigations where the period of care crosses country boundaries.
- 6.8 We interviewed the Director of Medicine who stated that the original action plan was not approved initially as he felt that there needed to be better controls in place. During our interview with the Director of Patient Safety he indicated that although the action plan does not focus on audit he confirmed that the Trust would be looking for regular audit of individual actions.
- 6.9 During the internal investigation the newly allocated care co-ordinator indicated that he was unhappy about accepting Patient M onto his caseload, as he was aware that Patient M had not been seen for some time. There was no discussion during the interview about how those concerns were escalated. We raised this concern with the Director of Nursing and Secure Services who said that he felt there is an issue about raising concerns. The Trust response to the Francis report<sup>29</sup> was to evaluate existing processes and systems for staff to raise concerns. The Trust has raised awareness of how staff can share their concerns and has implemented a range of processes from a whistleblowing policy to the ability to “Tell Joe” – an email communication direct to the Chief Executive.
- 6.10 The Supervision Policy<sup>30</sup> in place in 2012 states that: *“The Trust considers supervision to be essential to ensure high quality care to service users, to enable the appropriate development and support of staff in challenging situation and to identify training and development needs in pursuit of lifelong learning.”* In addition the policy states that: *“Modern Matrons/professional leads will engage with the Clinical audit team to undertake an annual audit of adherence to the supervision policy.”*
- 6.11 We asked the Trust to provide information about the organisational or team compliance with the supervision policy however we were told that the Trust does not routinely collect this data. The supervision policy<sup>31</sup> in place from April 2014 places the responsibility on line managers and service managers for ensuring that effective monitoring systems are in place for checking that all staff receive clinical and managerial supervision. The policy also states that records of uptake should be available for external scrutiny.

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<sup>29</sup> The Mid Staffordshire NHS Foundation Trust Public Inquiry was established under the Inquiries Act 2005 and was Chaired by Sir Robert Francis QC who made recommendations to the Secretary of State for Health based on the lessons learned from Mid Staffordshire, [www.midstaffpublicinquiry.com](http://www.midstaffpublicinquiry.com)

<sup>30</sup> Mersey Care NHS Trust Supervision Policy number SD33

<sup>31</sup> Mersey Care NHS Trust Supervision Policy for Clinical Staff (Nursing, AHPs, Social Workers/Care Staff) number SD33



- 6.12 During our interview with the Director of Patient Safety we were told that the Trust had undertaken an audit of supervision about 18 months previously. However the Trust has subsequently advised that this audit was looking at Performance Development Reviews (PDRs) not supervision.
- 6.13 We were told that the Trust has implemented Quality Review Visits in which supervision is an aspect that is reviewed. We were told that to date supervision has not been flagged up as an issue.
- 6.14 The internal investigation report stated that Patient M had no family history of mental illness. This was an inaccurate statement and one which runs counter to a significant number of clinical documents which reference the suicide of Patient M's eldest brother, substance misuse and mental illness in Patient M's brother K and the death of Patient M's brother J whilst taking illicit substances. We discussed this inaccuracy with the Director of Patient Safety who had discussed it with the member of staff who had acted as the internal investigation administrator. No explanation could be identified as to why the statement was included other than it was an error.
- 6.15 We asked whether investigation reports are checked prior to publication and were told that a senior member of the team reviewed the reports, however the reports were not checked for accuracy.
- 6.16 During our interview with the Director of Patient Safety we asked about the Trust approach to internal investigations. He told us that the Trust has about 200 members of staff across the organisation who are trained in Root Cause Analysis but not all of whom regularly undertook investigations. Of those 200 about ten per cent were actively used for investigations but there was no identified minimum number of investigations to be completed by an individual in any one year.
- 6.17 As previously stated in paragraph 6.2, the NPSA Root Cause Analysis Investigation Tool provides guidelines for Level 1, Level 2 and Level 3 investigations.
- 6.18 The Director of Patient Safety told us that the Trust policy identified four different levels of investigation:
- 72-hour safety check – Reflective Practice Review;
  - Level 1 – normal Root Cause Analysis review based on NPSA guidance;
  - Level 2 – normal Root Cause Analysis review based on NPSA guidance;
  - Level 3 – Chief Officer's Review.
- 6.19 We were told that the Level 3 review is used for an inpatient death or homicide and a panel of staff is used to conduct the investigation.

- 6.20 We were also told that the Trust has started to build up a bank of trained individuals who are not employed full time within the Trust. The intention is to work towards a 'bank' of about eight individuals who could provide added objectivity, new skills and increased capacity. It is our opinion that this group of staff could usefully provide objective scrutiny of internal documents and reports, something that was missing from this case.
- 6.21 Care Programme Approach documents in 2010, 2011 and 2012 were not accurate and included a statement that Patient M had been detained for treatment under Section 37 of the Mental Health Act. The Assertive Outreach Team working with Patient M and his new care co-ordinator to whom Patient M's case was assigned in late 2012 did not pick up this inaccuracy. Neither was the error identified during the internal investigation process despite the report stating that Care Programme Approach documentation was reviewed. We discussed this issue with the Director of Patient Safety who confirmed that the Trust was unaware of the error.
- 6.22 Patient M's GP, Dr M2 contributed to the internal investigation and the minutes of one meeting of the review team, held on 15 March 2013 make reference to a meeting one of the internal investigation team members had held with Dr M2. Dr M2 had informed the member of staff that "*Patient M had left the practice on 7 August and in light of this incident [the homicide] he had thought about whether GPs should inform other care providers of issues like this in the future, they wouldn't do so as a matter of course but maybe this should be looked at.*"
- 6.23 When we spoke with Dr M2 about this issue, he confirmed that his view had been correctly represented. Dr M2 said that he felt that proactive communication from primary care to local trusts when a patient moves area would be a positive step forward. In Patient M's case, had Dr M2 communicated Patient M's change of GP at the time, it would have alerted the Trust that Patient M was receiving primary care treatment elsewhere and therefore he would be unlikely to return to Liverpool to receive his prescriptions.
- 6.24 Trust policies clearly indicate the process to be followed for transferring service users to other service providers. These policies were not followed in the case of Patient M. During our interviews with some board members it became apparent that the Trust recognises that staff need to understand the particular importance of specific policy content and that there are plans to undertake an awareness-raising programme. The Trust should also undertake regular audits to provide assurance that no service users are 'falling through the net' or being lost to services.

### **Action Plan**

- 6.25 We have seen the updated Action Plan from the internal report that was updated in July 2014. The updates for four actions include reference to an Oxford Model Event due to take place on 16 September 2014. The event was held to reflect on the themes identified following the internal investigation. The output from the day has been provided to us and we can see that a number of improvements to operational practice were identified by staff who attended.
- 6.26 The final action update includes a requirement for team managers to provide a list of all members of staff who have access to SPINE and confirmation of the competency of those staff. We have been told that team managers have been asked to provide this information and that *“individuals will be allocated access within the new [team] structures”*.
- 6.27 With the exception of the audit of staff referenced in 6.26 above, we can find no evidence of systemic audit in order to provide assurance that lessons have been learned.
- 6.28 It is our opinion that the action plan is incorrectly focussed. There are four actions that, put simply, state that policy in place in June 2012 should be followed. Whilst we do not disagree with this statement there is no content that demonstrates that previous failures to adhere to policy will not happen again.

## **7. Overall Analysis and Recommendations**

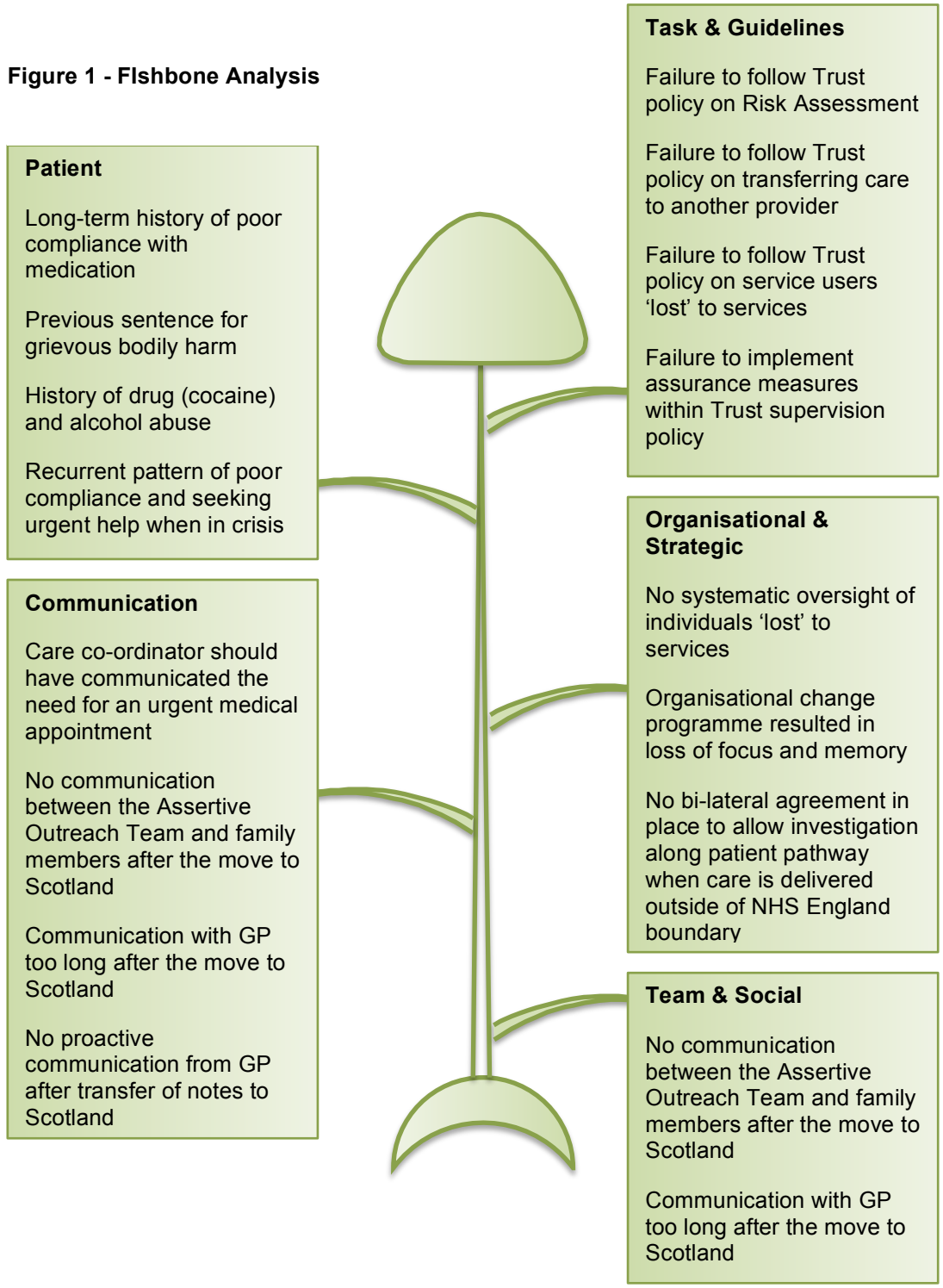
- 7.1 There are several points in which the Trust and individual practitioners could have continued their effective engagement with Patient M in the final six months before he moved to Scotland.
- A more objective approach from the team to reviewing Patient M's risks when the decision was taken to change his medication regime from clozapine.
  - A more assertive approach by the team when it was clear that Patient M was starting to disengage and miss appointments.
  - An urgent multi-disciplinary discussion when Patient M told his care co-ordinator that he planned to move to Scotland within two weeks.
  - An active response from the care co-ordinator to secure an appointment with the consultant and to follow up Patient M when no contact had been made.
  - A systemic approach to maintaining oversight of service users who have not been in contact with services.
- 7.2 The Trust internal investigation focussed predominantly on the care and treatment provided to Patient M whilst he was in Liverpool. When this external report was commissioned by NHS England we discussed

the potential to investigate the whole patient pathway to the point of the offence, as is usual in investigations such as this.

- 7.3 Legal advice was sought by NHS England and it was clear that as the guidance applied to NHS England, NHS England could not commission an investigation into the care and treatment provided in Scotland.
- 7.4 Enquiries made by NHS England with the Department of Health have confirmed that no bi-lateral agreement is in place to allow co-commissioning of independent investigations when the timeline crosses the boundary of NHS England.

7.5 The Fishbone Analysis in Figure 1 below sets out the key issues identified.

**Figure 1 - Fishbone Analysis**



### **Predictability**

- 7.6 In our review of the clinical records and in the interviews that we have carried we have found evidence that demonstrates that the absence of medication would cause Patient M to become increasingly paranoid, difficult to engage and potentially violent.
- 7.7 The perception of the Assertive Outreach Team staff was that Patient M appeared well but this perception seems to have been clouded by familiarity as Patient M was not compliant with his treatment plan and was not engaging with staff.
- 7.8 However it is our opinion that this tragic event was not predictable in either the nature or seriousness of the event.

### **Preventability**

- 7.9 Given the passage of time from the last contact with the Trust it is our opinion that this tragic event was not preventable by mental health services in England.

### **Recommendations**

#### **Recommendation 1:**

The Trust must ensure that a systematic process is implemented to allow management oversight of patients who have been out of contact with services, that regular audits of that process are undertaken and that an assertive approach is taken to tracking any patient who has been out of contact with services.

#### **Recommendation 2:**

The Trust must ensure that clinical risk assessment, risk management and supervision policies are consistently implemented, that a systematic process is in place to monitor compliance and that regular audits are undertaken.

#### **Recommendation 3:**

The Trust must implement a programme of audits to provide assurance that the recorded Mental Health Act status is correct.

#### **Recommendation 4:**

GPs must implement a process to notify the local mental health trust when a patient who is on Care Programme Approach moves outside the Trust area.

#### **Recommendation 5:**

The Trust must ensure that a systematic approach is taken when planning organisational change, to ensure risks are identified, mitigated and managed for all groups of patients, particularly those who are already disengaging with services.

**Recommendation 6:**

It is recommended that a Memorandum of Understanding be developed between NHS England and partner NHS agencies in the UK to ensure that serious incident investigations that cross NHS borders are commissioned jointly. This should allow all aspects of care and treatment to be explored and for system learning to be shared across public services regardless of where they are delivered.

**Recommendation 7:**

The Trust must implement a quality control system in order to provide assurance that when serious incident reports are produced they are factually correct and identify all relevant learning.

## Appendix A – Terms of Reference

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from Patient M's first contact with services to the time of his offence.<sup>32</sup>
- Review the appropriateness of the treatment of Patient M in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of Patient M harming himself or others.
- Examine the effectiveness of the Patient M's care plan including the involvement of the service user and the family.
- 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.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.

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<sup>32</sup> This was subsequently amended to the service user's discharge from services provided within England



## Appendix B – Chronology of Patient M’s contacts with his GP and Mersey Care NHS Trust and events leading up to the homicide

This chronology has been drawn up from medical records from both primary care (GP) and secondary care. A detailed chronology is available for the period September 2006 to May 2011 however it has been excluded from this report to ensure that the focus is on Patient M’s final year in Liverpool.

Date	Source	Event	Details
01/06/2011	Patient notes	Outpatient appointment	<p>Seen by doctor and care co-ordinator for new RC to take over his care. Patient M reported on-going voices which had been present for years but was "<i>unwilling to divulge content of voices</i>". Patient M reported feeling anxious when going out alone but that he no longer believed he was in a relationship with a TV presenter.</p> <p>Noted that mother died 3 years previously and that father moved recently but wouldn't tell the family where he was going. Patient M reported having regular contact with his twin brother K and that they used alcohol and cocaine together, also that cocaine use has increased over recent months. Noted that Patient M did try cocaine anonymous but stopped attending. Some sedation with clozapine reported but no change in medication - clozapine level to be checked.</p>
10/06/2011	Patient notes	Letter to GP, Bootle	<p>Clinic date: 01/06/2011</p> <p>Diagnosis: none mentioned</p> <p>Summary of transfer meeting. Patient M had stated that his cocaine used had increased over recent months, as he regularly met up with brother K to consume alcohol and cocaine together. Patient M reported that he was no longer attending Cocaine Anonymous.</p>
05/08/2011	Patient notes	Telephone contact - failed	15 attempts to contact Patient M but no answer.
06/08/2011	Patient notes	Home visit	Staff accompanied Patient M to church, more relaxed than in the previous visit. Reported that he was compliant with medication.
18/08/2011	Patient notes	Home visit	Patient M reported feeling a bit down but felt it was due to his lifestyle. Staff to organise escorted swimming with the Assertive Outreach Team group. Patient M informed of demand for the service, and that if he agreed to go he must attend.

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15/09/2011	Patient notes	Home visit	Staff supported Patient M to enrol on college courses. Patient M advised that he had heard voices the previous week, coming from outside his head saying both nice and nasty things. He admitted to using some drugs and alcohol the previous week with his brother K and on questioning was unsure if the voices had coincided with this activity.
21/09/2011	Patient notes	Home visit	Patient M reported feeling mentally well, had just heard that he was due to start his maths and English courses, seemed really pleased. Reminded that he should have attended for his bloods the previous Monday, Patient M said he would go that day.
16/11/2011	Patient notes	Home visit	Patient M appeared intoxicated and had a glass of beer. Informed staff that he had a new girlfriend. Reported still enjoying and attending his courses. Patient M had two full weeks' worth of clozaril but denied he wasn't taking them, admitted to not taking the night time amisulpride as he said it " <i>wipes him out</i> " and that he was taking morning medication in the evening. Staff advised Patient M that the doctor would need to be made aware of the situation and Patient M asked for a medication review.
24/11/2011	Patient notes	Home visit	Patient M said he was ill with a stomach upset. Staff noted that he appeared intoxicated and was with his girlfriend, they were drinking lager and there was vodka in the kitchen. Two days left in the blister pack that Patient M exchanged and Patient M provided a further three full packs from May, September and October. Staff strongly reminded Patient M how dangerous it was to " <i>mess about with these meds and that titration would be needed after 72 hours</i> ".
30/11/2011	Patient notes	Home visit	Staff talked about clozapine medication, as it appears that he had spent long periods not taking medication but Patient M denied this was the case. He confirmed he felt well and that he was in a relationship, which he saw as a positive move.
07/12/2011	Patient notes	Medication review	Collected from home by staff. Medication review as Patient M had been missing doses of clozapine and amisulpride. Appeared calm in manner but said he was continuing to experience voices although was vague about describing them. His main concern related to feelings of anxiety in social situations, mainly in pubs as he had been in a fight several months previously. Staff noted that the fight was a result of Patient M drinking a bottle of vodka. Patient M said the voices weren't stopping him from doing anything and that he had no feelings of paranoia or that his home was haunted.

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28/12/2011	Patient notes	Telephone contact	Patient M said Christmas was quiet and that had hadn't even had a drink. Advised that he had asked his girlfriend's brother and partner to leave his flat, which had eased his stress.
29/12/2011	Patient notes	Letter to GP, Bootle	Clinic date: 07/12/2011 Diagnosis: none mentioned Summary of medication review meeting held as Patient M had been missing doses of both clozapine and amisulpride. Doctor emphasised to him that medication is to prevent relapse of schizophrenia. Agreement to reduce dose of clozapine to 250 mgs nocte because of the complaints about sedation.
05/01/2012	Patient notes	Staff action	Staff discussion with doctor about Patient M's compliance with clozaril, as he had again failed to take it properly with four consecutive days remaining in the blister pack. Patient M had appeared ambivalent about when he had last taken his meds and could not provide the days when he had not taken it. Doctor advised it would not be possible to admit Patient M as there were no beds. It was noted that Patient M had reported that he had taken it the previous evening but staff were unsure if he was being truthful. Staff raised concerns and explored the possibility of alternative treatment plan. Doctor advised that Patient M keep his planned appointment in order to review medical history before she could make a decision regarding treatment.
19/01/2012	Patient notes	Home visit	Patient M advised he had joined a gym and was going to his induction that evening. Reported to be keen on eating more healthily and getting fitter. Noted that he remained well and had no concerns.
26/01/2012	Patient notes	Home visit	Staff took Patient M for a drive. Patient M reported that he had taken all the medication and asked staff to drop him at the gym, he commented upon the benefits he was feeling already - he had significantly reduced both alcohol and cocaine use.
02/02/2012	Patient notes	Home visit	Patient M appeared really well and very positive about his future. He had joined a gym and was attending five days per week; he felt it was helping him stay off the alcohol and cocaine. Still attending college course twice a week.
23/02/2012	Patient notes	Home visit	Patient M reported feeling really well and attending the gym regularly. Reported that his relationship was going well.
29/02/2012	Patient notes	Home visit	Staff collected Patient M to escort him to see Dr P who was going to obtain a history to inform future treatment plan.

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07/03/2012	Patient notes	Telephone contact - failed	Staff attempted to call Patient M but got his "girlfriend's, brother's girlfriend" who said that he had left his mobile at her flat. Staff noted that this was "quite unusual" as Patient M "always keeps his phone with him".
08/03/2012	Patient notes	Telephone contact - failed	Call received from clinic to advise that Patient M had not attended for his blood test that Monday. Staff attempted to contact him using his mobile number but spoke to "same lady as last night". She provided Patient M's girlfriend's number so that staff could try to contact him.
09/03/2012	Patient notes	Clinic attendance - DNA	Patient M didn't attend clinic so staff took a sample from him at home and returned it to the clinic. No observations recorded.
09/03/2012	Patient notes	Home visit	Home visit to obtain blood sample for testing. Patient M advised that he would be going to Scotland the following Friday for a fortnight. Staff advised that three weeks' medication would be delivered in case he decided to stay longer in Aberdeen.
09/03/2012	Patient notes	Letter to GP, Bootle	Clinic date: 29/2/12 Diagnosis: none mentioned Summary of review meeting. Patient M reported being unsure about which medication he was being prescribed. Reported no longer doing drugs - stated he "had three pints five days ago" and knows not to mix his tablets with alcohol.
15/03/2012	Patient notes	Home visit	Patient M reported looking forward to going to Scotland for two weeks. Staff gave him three weeks' clozaril and advised his blood test was due on return on 02/04/2012. No concerns noted. Patient M was advised to take medication daily and to "watch his alcohol intake whilst away".
06/04/2012	Patient notes	Telephone contact	Staff called Patient M to advise that clozaril would not be delivered, as he had not attended for his blood tests. It was noted that the clozaril levels in his system were so low it showed he had not been taking it. Patient M was advised to continue with current medication and to attend for a final blood test on 11 April 2012 after stopping the clozaril.
11/04/2012	Patient notes	Clinic attendance	Blood test monitoring - no observations recorded. Patient M advised clinic that he would be coming off clozaril.

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20/04/2012	Patient notes	Outpatient appointment	On 24/4/12 SHO recorded that s/he had recently seen Patient M and advised that the clozapine was to be stopped due to poor compliance. Patient M requested something else for " <i>alleged</i> " breakthrough symptoms so amisulpride was increased to 200 mg. Staff confirmed with Patient M's GP that he was regularly collecting his prescriptions, last one was issued on 3 April 2012.
23/04/2012	Patient notes	Home visit	Patient M stated that he didn't need a visit as his girlfriend was off work and he had her company. Staff agreed to call him the following week.
25/04/2012	Patient notes	Letter to GP, Bootle	Clinic date: 20/4/12 Diagnosis: Paranoid schizophrenia Summary of unscheduled appointment as Patient M had turned up at clinic because he was experiencing " <i>anxiety, depression, paranoia and anger</i> ". Noted that he had recently returned from holiday in Scotland where he had consumed large amounts of alcohol daily but had not used illicit drugs. Noted that clozapine level was 0.06, outside the range of 0.35-0.5, which indicated that he was mostly non-compliant. Team discussion resulted in decision to stop clozapine due to cardiac and other complications.
09/05/2012	Patient notes	Staff action	Staff contacted the police station to enquire whether Patient M had been arrested in connection with his brother's death. Police could not provide definite information but advised that he probably wasn't in custody. Staff concluded that Patient M was probably avoiding her.
09/05/2012	Patient notes	Home visit - failed access	Attempted home visit - no access gained. Purpose to see how he was after receiving the news that his brother J had died of a suspected drugs overdose.
09/05/2012	Patient notes	Staff action	Call received from care co-ordinator for Patient M's brother K, to say that K had been with his brother J taking drugs and alcohol at the weekend. Early on 6 May 2012 brother K realised that brother J was dead. Brother K had called Patient M to ask if he wanted to say goodbye to his brother J. Reported that Patient M then called the police.  Brother K was then arrested for suspected murder. It was noted that press reports stated that two men had been arrested in connection with the death.
11/05/2012	Patient notes	Home visit - failed access	Attempted home visit - no access gained.
14/05/2012	Patient notes	Home visit - failed access	Attempted home visit - no access gained.

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18/05/2012	Patient notes	Chance contact	<p>Staff walked past Patient M whilst taking her children to school. Staff advised Patient M that the team had been trying to contact him for two weeks to see how he was. Patient M talked about his brother's death and said that the police had taken his phone from him. He provided his girlfriend's mobile number and said that both he and she were happy for staff to call on that number.</p> <p>Patient M stated that at times he felt anxious and had been hallucinating when he was asleep. There was a discussion about whether they could have been vivid dreams due his stress but Patient M stated that "<i>it had been happening for weeks, well before my brother died</i>".</p> <p>Staff advised that she would give his care co-ordinator his girlfriend's number but Patient M said not to visit until at least the following Friday as he would be drunk on Wednesday and Thursday following the funeral.</p>
01/06/2012	Patient notes	Home visit	<p>Patient M stated he was well despite the recent death of his brother. Asked for three months' medication as he planned to move to Aberdeen on 12 June with his girlfriend.</p> <p>Staff asked about accommodation plans: Patient M stated he was not giving up his flat and that his sister would be moving in to look after it. Patient M stated he planned to visit Liverpool every three months in order to get more medication and that the benefit service were not aware of his move.</p> <p>Staff informed Patient M that the doctor would be unlikely to provide three months' medication but that she would attempt to obtain an appointment with his doctor before he left, noting that it might be difficult as his doctor was on leave until 11 June. Patient M advised that he continued to take oral medication but could not provide details of when he last collected it or had it delivered.</p>
19/06/2012	GP records	Prescription	<p>Prescription issued by GP Dr M2 for:</p> <p>Amisulpride 100mg, 2 to be taken daily, 60 tablets</p> <p>Omeprazole 20 mg, OD, 28 capsules</p> <p>Fluoxetine 20 mg, one to be taken daily, 30 capsules</p> <p>Peptac liquid peppermint, 10 ml TDS after food, 500 ml</p> <p>Tolterodine 4mg, one to be taken daily, 28 capsules</p>
10/07/2012	GP records	GP registration	<p>Registration with GP in New Pitsligo</p>

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05/10/2012	Patient notes	Care Plan	Document created by Mersey Care staff. Document notes that care co-ordinator had not met with Patient M yet as he " <i>appeared to be living outside of the Liverpool area</i> ". Plan to discuss with Team Manager. Document notes Mental Health Act status as Section 37.
07/11/2012	Patient notes	Staff action	Information obtained via patient services that Patient M was registered with GP in Scotland, but the service was unable to identify which GP. Care co-ordinator to try to identify practice in order that consultant can write to new GP. Patient M to be discharged from Assertive Outreach Team.
07/11/2012	Patient notes	Letter to Patient Services	Letter to Patient Services requesting they provide details of Patient M's current GP.
12/11/2012	Patient notes	Letter to GP, New Pitsligo	Letter sent following information that patient had registered with new GP in Scotland. Confirmed diagnosis as schizophrenia. Stated that Patient M appeared well when last seen in June 2012 and that he had told the Assertive Outreach Team that he was going to Scotland for three months.
16/11/2012	Internal report	Referral	GP Referral to sent to Adult Forensic Team at the Royal Cornhill Hospital. Referral made because Patient M has presented complaining of low mood and because of his past psychiatric history.
28/11/2012	Internal report	Emergency assessment	Emergency assessment following assault on three family members of Patient M's girlfriend. Patient M indicated that they had all been drinking. A full psychiatric history was taken and the assessment concluded that there was no evidence of acute mental illness and that the argument was fuelled by alcohol. The assessing doctor felt that Patient M was fit to go home with support from the community mental health team.
18/12/2012	Internal report	Outpatient appointment	Patient M did not attend this appointment.
09/01/2013	Internal report	Offence	Patient M assaulted Mr G.
15/01/2013	Internal report	Outpatient appointment	Patient M did not attend this appointment as he was in custody.

## Appendix C – Trust Action Plan produced in response to the Root Cause Analysis Investigation of Patient M

Recommendation	Actions Required	Responsibility	Timescale	Update
1. When a service user who is on Care Programme Approach disengages from services unexpectedly and loses contact with the care team a formal Care Programme Approach review will be held to agree an action plan and review clinical risks. These discussions and agreed actions should then be recorded in the care plan and risk assessment.	Alert to be circulated highlighting actions required within the recommendation.	Clinical Services Manager, Community	Complete	
	Community Quality Standards Meeting to explore strategy for implementing the recommendation and the monitoring compliance within the supervision.	Clinical Services Manager, Community	August 2014	Agenda item for meeting on 27 May 2014
2. When a service user who is on Care Programme Approach disengages from services unexpectedly and loses contact with the care team the care co-ordinator should maintain regular contact with the GP and, if appropriate, family members.	Discuss this recommendation in Operational Team Meetings, Community Quality Standards Meeting to explore strategy for implementing the recommendation the monitoring compliance within the supervision.	Clinical Services Manager, Community	August 2014	Agenda item for meeting on 27 May 2014



<p>3. If it is suspected that a service user on Care Programme Approach has unexpectedly moved out of the area then the care co-ordinator will check via the Care Records Clinical Summary (SPINE) whether they have registered with a GP in another area. This should be done on a 2-4 weekly basis.</p>	<p>Community Quality Standards Meeting to explore strategy for implementing the recommendation and the monitoring compliance within the supervision.</p>	<p>Clinical Services Manager, Community</p>	<p>August 2014</p>	<p>Agenda item for meeting on 27 May 2014</p>
<p>4. All service users who require a transfer of care and are on Care Programme Approach should have a transfer to a mental health trust according to the guidelines within the Care Programme Approach policy.</p>	<p>Community Quality Standards Meeting to explore strategy for implementing the recommendation and the monitoring compliance within the supervision.</p>	<p>Clinical Services Manager, Community</p>	<p>July 2014</p>	
<p>5. All team managers should ensure that the clinical staff within their service area know how to access the Care Recording Clinical Summary (SPINE) and have a good understanding of the Care Programme Approach policy.</p>	<p>Training skills analysis to be undertaken of staff understanding of SPINE.</p>	<p>Team Managers</p>	<p>September 2014</p>	
	<p>Strategy to be developed to ensure sufficient key individuals are identified within each clinical team to provide access to the records when required.</p>			

## **Appendix D – Documents Reviewed**

### **Mersey Care NHS Trust documents**

- Action Plan produced in response to the Root Cause Analysis Investigation WEB 26040
- Adult Mental Health Inpatient Clozapine Procedure.
- Improving Community Mental Health Services Programme, Model of Care dated 20 February 2012
- Improving Community Mental Health Services Programme, presentation undated
- Improving Community Mental Health Services Programme, Programme Brief dated 2 June 2011
- Improving Community Mental Health Services Programme, Programme Managers Status Report dated 23 January 2013
- Improving Community Mental Health Services Programme, Risk Register (December 2012)
- Minutes of the Patient M Homicide Review Team Meeting held on Friday 15 March 2013
- National Standards for Record Keeping and Mersey Care NHS Trust Standards, undated
- Operational Specification and Protocol for Assertive Outreach Teams (AOT), Adult Mental Health Directorate, undated but provided by the Trust as the document in use as at June 2012
- Policy and Procedure for the Care Programme Approach, ratified March 2011
- Policy and Procedure for the Management of Service Users who have coexisting problems related to Illicit Substance/Alcohol use, ratified December 2010
- Proposed Model of Care, dated January 2012
- Psychiatric Intensive Care Unit Eligibility Criteria July 2013
- Root Cause Analysis Investigation Report WEB 26040, dated April 2013
- Records of the interviews held with Assertive Outreach Team staff, dated February and March 2013
- Supervision Policy, ratified January 2011
- Supervision Policy for Clinical Staff (Nursing, AHPs, Social Workers/Care Staff), ratified April 2014

### **Other resources**

- Crisis Resolution and Home Treatment – A practical guide, The Sainsbury Centre for Mental Health 2006
- Department of Health (1994) HSG (94) 27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services

- Health & Social Care Information Centre  
<http://systems.hscic.gov.uk/spine/faqs>
- Judiciary of Scotland website [www.scotland-judiciary.org.uk](http://www.scotland-judiciary.org.uk)
- Medication and treatment information [www.patient.co.uk](http://www.patient.co.uk)
- Mid Staffordshire Public Inquiry [www.midstaffpublicinquiry.com](http://www.midstaffpublicinquiry.com)
- National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services
- National Patient Safety Agency, Root Cause Analysis Investigation Evaluation Checklist.
- National Patient Safety Agency, Root Cause Analysis Investigation Tools, Three levels of RCA investigation - guidance
- Mental Health Law online [www.mentalhealthlaw.co.uk](http://www.mentalhealthlaw.co.uk)
- PRINCE2 [www.prince2.com](http://www.prince2.com)
- Rethink Mental Illness <http://www.rethink.org/diagnosis-treatment/treatment-and-support/assertive-outreach/what>
- Sainsbury's Centre for Mental Health  
[http://www.centreformentalhealth.org.uk/pdfs/Crisis\\_resolution\\_and\\_home\\_treatment\\_guide.pdf](http://www.centreformentalhealth.org.uk/pdfs/Crisis_resolution_and_home_treatment_guide.pdf)

## **Appendix E – Profile of the Service**

Mersey Care NHS Trust is a single Mental Health Trust providing specialist inpatient and community mental health, learning disability and substance misuse services for adults in Liverpool, Sefton and Kirkby.

It also has a wider role, providing medium secure services for Merseyside and Cheshire, and high secure services covering the North West of England, the West Midlands and Wales.

### **Assertive Outreach Team**

The Trust's Assertive Outreach Team was established to offer a community based service to provide support, care and treatment to a small number of people with severe mental health problems and complex needs, who have difficulty engaging with services and often require repeat admissions to hospital.

Assertive Outreach is a flexible and creative approach to engaging service users in a practical delivery of a wide range of services to meet complex health and social needs. It involves taking service to the patients rather than requiring them to attend hospitals and clinics. The model is one of a high staff to service user ratio offering comprehensive health and social care.

Entry into the service was via a multi-disciplinary meeting that reviewed all referrals to the Assertive Outreach Team.

Mersey Care NHS Trust undertook a change management programme during 2012, which saw the function provided by the Assertive Outreach Team being moved into more generic community locality teams. The assertive outreach model of care continues to be provided by staff working within the new community locality teams.