

Mr. W Investigation Report

Independent Investigation

into the

Care and Treatment Provided to Mr. W

by the

Mersey Care NHS Trust

Commissioned by

NHS North West

Strategic Health Authority

Independent Investigation: Health and Social Care Advisory Service

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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. W was commissioned by NHS North West Strategic Health Authority pursuant to *HSG (94)27*.¹ This Investigation was asked to examine a set of circumstances associated with the death of Ms. Y who was killed on the 29 December 2006. Mr. W was subsequently convicted of her murder by Liverpool Crown Court.

Mr. W received care and treatment for his mental health condition from the Mersey Care NHS Trust. It is the care and treatment that Mr. W received from this organisation that is the main subject of this Investigation.

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

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

1. Health service Guidance (94) 27

2. Condolences to the Family and Friends of Ms. Y

The Independent Investigation Team would like to extend its condolences to the family and friends of Ms. Y.

3. Incident Description and Consequences

Background for the Care and Treatment of Mr. W

Mr. W was born in Manchester. He reported that his childhood was unhappy. He was placed in care from around age of 11 years and it was suggested that he was abused.

Mr. W served a number of prison sentences although the full extent of his forensic history was never known to those providing care and treatment to him as he was reluctant to discuss this aspect of his life. He reported that he had attempted to kill himself in 2002 and 2003. At least one of these attempts occurred while he was serving a prison sentence and he subsequently received some psychiatric input.

Mr. W was in contact with the substance misuse services in Liverpool from *circa* September 2004 and also under the care of the Lighthouse substance misuse project based in Knowsley/Newton-Le-Willows from at least 2006. Furthermore it appears that he was in contact with the Five Boroughs NHS Trust Mental Health Services at some point between July 2005 and July 2006.

Mr. W first came to the attention of mental health services in Liverpool when his GP referred him with “*chronic depression*” and suicidal thoughts in July 2006. In September 2006 Mr. W was assessed under the Mental Health Act (1983) but was not found to be detainable. However following a further suicide attempt he was admitted to hospital as an informal patient. At the beginning of October 2006 Mr. W was transferred, as an in-patient, from Broadoak to Windsor House partially due to his therapeutic relationship with the ward staff having broken down.

Although Mr. W was assessed as being at continued risk of impulsively harming himself or attempting suicide neither evidence of on-going depression nor any symptoms of psychosis were identified during his admission. Diagnoses of depression and adjustment disorder were considered, however Mr. W was discharged with a diagnosis of Emotionally Unstable Personality Disorder. It was concluded that his impulsive self-harming behaviour was exacerbated by his social circumstances and probably by his continued drug misuse. Mr. W’s girlfriend reported that both she and Mr. W had been threatened and Mr. W had been attacked on at least one occasion. Mr. W reported that he had debts of around £30,000.

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Following his discharge from hospital Mr. W attended only one follow up appointment. He failed to respond to a letter asking him to make contact with the mental health service and was subsequently discharged.

In mid December 2006 Mr. W was convicted of driving whilst disqualified. At his hearing he informed the Court that he was engaged with mental health services, was being prescribed anti-depressant medication, and was attending weekly psychotherapy. None of this was true.

Incident Description and Consequences

The body of a colleague of Mr. W's girlfriend was found in her flat on 6 January 2007. The Pathologist concluded that she had been killed on or around 29 December 2006. It was alleged that between these two dates Mr. W had withdrawn money from the victim's account and returned to her flat on several occasions and taken goods which he sold.

Mr. W was convicted of murder at Liverpool Crown Court on 4 July 2007 and sentenced to 26 years of imprisonment on 25 July 2007.

Mr. W was found hanged in his prison cell on 21 August 2009.

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

The Health and Social Care Advisory Service was commissioned by NHS North West (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94) 4*, issued in 1994 to all commissioners and providers of mental health services. In discussing ‘when things go wrong’ the guidance states:

“... in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved”.

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

- i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.
- ii) When it is necessary to comply with the State’s obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.
- iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

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

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The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident. The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and Independent Investigation Team.

5. Terms of Reference

The Terms of Reference for this Independent Investigation were set by the NHS North West. They were:

1. To examine:

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

2. To identify:

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

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3. To make:

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

4. To report:

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

6. The Independent Investigation Team

Selection of the Investigation Team

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

Independent Investigation Team Leader and Chair

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Chair, Nurse Member and co-report author
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Investigation Team Members

Dr. Len Rowland	Director of Research HASCAS Health and Social Care Advisory Service. Psychologist Member of the Team and co-report author
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Dr. David Somekh	Consultant Psychiatrist Member of the Team
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Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service
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Mrs. Fiona Shipley	Stenography Services
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7. Investigation Methodology

On the 18 April 2011 NHS North West (the Strategic Health Authority) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in Section Five of this report.

This Independent Investigation was graded as a 'C' type review by NHS North West. A 'C' type review is principally a documentary analysis review which utilises:

- clinical records;
- Trust policies and procedures;
- the Trust Internal Investigation report;
- the Trust Internal Investigation archive.

A 'C' type review does not seek to reinvestigate a case from the beginning if it can be ascertained that the internal review was robust. In a 'C' type review the Independent Investigation is charged with building upon any investigative work that has already taken place. After careful consideration the Independent Investigation Team found the work of the Internal Investigation to have been fit for purpose and a robust foundation for a 'C' type investigation to build upon.

It is usual for a 'C' type review to be conducted by a single person with the support of a peer reviewer. As the Health and Social Care Advisory Service had been asked to work on one other Investigation within the Trust at the same time it was decided that a multidisciplinary team would be recruited to work upon both cases simultaneously. Due to the economy of scale a multidisciplinary team was deployed to examine the care and treatment that Mr. W received.

Communication with the Victim's Family

As the lead commissioning body for the Independent Investigation process NHS North West wrote to family members of Ms. Y to invite them to participate in the Independent Investigation process. This initiated the communication process that is required by *HSG 94* (27) and the National Patient Safety Agency Guidance to ensure that families are consulted with in relation to:

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- contributions they may wish to make to the Independent Investigation;
- dissemination and sharing of the findings of the Independent Investigation;
- publication and distribution of the report.

No communication had been received from the family at the time of writing this report.

Communications with the Family of Mr. W

It was not possible for the Strategic Health Authority to make contact with the family of Mr. W.

Communications with the Mersey Care NHS Trust

On the 14 July 2011 NHS North West wrote to the Mersey Care NHS Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of *HSG (94) 27* had been commissioned to examine the care and treatment of Mr. W.

On the 13 September 2011 the Chair of the Independent Investigation Team met with the Mersey Care NHS Trust Executive Team which included the Chief Executive and the Director of Patient Safety, who was identified as being the Trust Liaison Person for the Investigation. On this occasion the Investigation process was discussed and an invitation was made for a workshop to take place to provide a briefing opportunity for all those who would be involved with the Investigation.

Workshops were held on the 17 and 18 November 2011 for all those witnesses who had been identified as needing to be called for interviews by the Investigation Team. The workshop provided an opportunity for witnesses to have the process explained to them in full. Advice was given regarding the writing of witness statements and the interview process was discussed in detail.

Between the first meeting stage (held on the 13 September 2011) and the formal witness interviews (held on 28 November and 1 December 2011) the Independent Investigation Team Chair worked with the Trust Liaison Person to ensure:

- all clinical records were identified and dispatched appropriately;

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- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished.

Formal interviews were held on 28 November 2011 and 1 December 2011.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. An Investigation briefing pack was made available for each witness. The Investigation was managed in keeping with Scott and Salmon processes.

Table One
Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
28 November 2011	Trust Chief Executive Trust Director of Nursing Trust Medical Director Trust Director of Finance Trust Director of Patient Safety Trust Director of Service Development Trust Non-Executive Director ***** Head of Service Governance and Risk Head of Risk and Resilience	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
1 December 2011	Consultant Psychiatrist 1* Specialist Registrar 1* Member of the Internal Investigation Team	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer

* Identified in this manner to further protect anonymity

Scott and Salmon Compliant Procedures

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

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1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:
 - (a) of the terms of reference and the procedure adopted by the Investigation; and
 - (b) of the areas and matters to be covered with them; and
 - (c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and
 - (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and
 - (e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and
 - (f) that it is the witness who will be asked questions and who will be expected to answer; and
 - (g) that their evidence will be recorded and a copy sent to them afterwards to sign;
 - (h) that they will be given the opportunity to review clinical records prior to and during the interview.
2. Witnesses of fact will be asked to affirm that their evidence is true.
3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.
4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

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5. All sittings of the Investigation will be held in private.
6. The findings of the Investigation and any recommendations will be made public.
7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.
8. Findings of fact will be made on the basis of evidence received by the Investigation.
9. These findings will be based on the comments within the narrative of the Report.
10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication Processes

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

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

The Team Met on the Following Occasions:

12 October 2011. On this occasion the Team examined the timeline based on what could be ascertained from analysing the documentary evidence. The witness list was confirmed and emerging issues were identified prior to the interviews.

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28 November 2011 and 2 December 2011. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine clinical governance and service structure issues, re-evaluate emerging issues and to discuss additional evidence as it arose. The Independent Investigation Team members contributed to the drafting of the report and read and made revisions to the final draft.

Investigation Team members worked together to conduct a desk top review and to work through the findings and conclusions of the Investigation.

Root Cause Analysis (RCA)

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

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

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

- 1. Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.
- 2. Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.

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- 3. Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the Decision Tree and the Fish Bone.
- 4. Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

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

Anonymity

The identities of all clinical witnesses have been made anonymous. All have been identified by their designation. The service user is referred to as Mr. W and the victim as Ms. Y.

8. Information and Evidence Gathered (Documents)

During the course of this investigation the following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. W's Mersey Care NHS Trust records
2. Mr. W's GP records
3. The Mersey Care NHS Trust Internal Investigation Report and action plan
4. The Mersey Care NHS Trust Internal Investigation Archive
5. Secondary literature review of media documentation reporting the death of Ms. Y
6. Independent Investigation Witness Transcriptions.
7. Mersey Care NHS Trust Clinical Risk Clinical Policy
8. Mersey Care NHS Trust Incident Reporting Policy
9. Mersey Care NHS Trust Being Open Policy
10. Mersey Care NHS Trust Operational Policies
11. Healthcare Commission/Care Quality Commission Reports for Mersey Care NHS Trust services
12. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm*: a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006
13. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed* September 2005

9. Profile of the Mersey Care NHS Trust (Past, Present and Transition)

Mersey Care NHS Trust was established on 1 April 2001 to provide specialist mental health and learning disability services for the people of Liverpool, Sefton, and Kirkby. The Trust's purpose is to enable people with learning disabilities and mental health difficulties and their carers to optimise their health, life experience and citizenship.

The Trust:

- typically provides care, treatment and support to 28,409 service users a year;
- is dispersed across more than 32 sites;
- has 649 inpatient beds;
- has a combined total of 388,369 outpatient attendances and contacts during the course of a year;
- serves a local population of one million people from Liverpool, Sefton and Kirkby and sub regionally and nationally for specialist secure services;
- the Trust also provides medium secure services for Merseyside and Cheshire and high secure services for the North of England and Wales.

*(Statistics are based on audited figures for 2010-2011, figures correct as of 31 March 2011)

The Trust accomplishes this by:

- leading a network of services to meet the health and social care needs of individuals and their carers;
- working with other agencies and the community to promote mental well-being and social inclusion;
- championing the rights, needs and aspirations of people with mental health difficulties and learning disabilities, tackling discrimination and stigma.

Mersey Care is one of only three Trusts of its kind in the country providing the entire range of specialist mental health services. Mersey Care has a wider role too, offering medium secure services for Merseyside and Cheshire, and high secure services for England and Wales.

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Services provided by the Trust are managed and delivered through clinical services led by a clinical director and service manager. These have been organised on the basis of service user groups:

- mental health services for adults and older people, primarily community and in-patient services for people either living in Liverpool, or those in Sefton and Kirkby;
- people with learning disabilities;
- people with substance misuse (drugs and alcohol) problems;
- a forensic service with its in-patient unit based at Scott Clinic, Rainhill;
- high secure services based at Ashworth Hospital, Maghull.

Where practicable, Trust services are organised within the boundaries of the Primary Care Trusts for local services, but on a sub-regional basis for forensic services and national basis for high secure services.

10. Chronology of Events

This Forms Part of the RCA First Stage

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

Mental Health Chronology

On **14 August 2001** Mr. W was released from Armley Prison, Leeds. It was recorded that he was not suffering from a mental illness but was identified as abusing: heroin, cocaine and Diazepam.²

On **21 September 2004** Mr. W's was assessed for a community detoxification programme at the Gateway, Liverpool. He reported that he experienced "fits" approximately four times a year and while in prison he had been investigated for epilepsy and diabetes. When asked if he had ever been convicted of any crime associated with violence Mr. W said the he had not.³

On **2 October 2004** Mr. W's urine sample was found to be positive for opiates and he asked to be prescribed Naltrexone.⁴

A letter from the Substance Misuse Team in Wormwoods Scrubs Prison, London dated **13 October 2004** confirmed that Mr. W had been on a detoxification programme while in prison. However the planned substitutions and drug reductions had not been completed as Mr. W had been released earlier than the team had anticipated.⁵

Mr. W was admitted to the Kevin White Unit in Liverpool from **15 October 2004** to **25 October 2004** for detoxification. He had spent the previous week in prison.⁶ On admission Mr. W had denied that he had been prescribed methadone. However the ward staff contacted Mr. W's GP who informed them that Mr. W was prescribed 20ml of methadone daily.⁷

2 GP record Vol. 1 p 23 of 33

3 Clinical notes Vol. 8 p 356ff

4 Clinical notes Vol. 7 p 322

5 Clinical notes Vol. 2 p 52; Vol. 7 p 346

6 Clinical notes Vol. 3 p 127

7 Clinical notes Vol. 3 p 127

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During his assessment Mr. W reported that he had had two psychiatric admissions while in prison, in Stoke and in London. He reported that he had tried to hang himself in 2002 “*the first time [he had] ever withdrawn [from drugs]*”. The reason Mr. W gave for his admission was “*non-compliance and rebelliousness*”. He had been placed in a locked room in the hospital and smeared faeces on the walls and refused to eat or drink. He had been seen by a Psychiatrist and been prescribed antidepressant and antipsychotic medication. Mr. W had subsequently won an appeal and had left from Court without any medication.

Mr. W reported that during Christmas 2003 he had again attempted suicide. He had written a letter and injected himself with heroin. He was found by his partner. He was not assessed by a doctor or admitted to hospital on this occasion.

Mr. W said that he did not want to be a heroin addict but had started using it again when his Grandmother died in November 2003. He reported that his “*Mother died 2 weeks ago having committed suicide*”. He said that four other family members had committed suicide and his sister has been detained under the Mental Health Act (1983) after trying to commit suicide.⁸

On admission to the Kevin White Unit (KWU) Mr. W was using six to seven bags of heroin, six to seven rocks of crack cocaine and 70 mg of Diazepam daily.⁹ While in hospital he was occasionally verbally abusive to both staff and other patients and he discharged himself against medical advice on **25 October 2004**.¹⁰

On **1 November 2004** Mr. W attended the KWU in a distressed state. He was feeling suicidal and his partner was worried for his safety. However Mr. W said that he would not harm himself. He had an appointment to see his GP the next day and was advised to contact the Crisis Team if he felt that he could not cope.¹¹

On **29 December 2004** Mr. W was again referred to the KWU by his General Practitioner as he was continuing to misuse illicit drugs and needed help to come off these.¹²

Mr. W was in prison from **7 January to 9 February 2005**. He attended the KWU when he left prison and his assessment for Naltrexone, an opioid receptor antagonist, was begun.¹³

⁸ Clinical notes Vol. 2 p 53; Vol. 7 p 347

⁹ Clinical notes Vol. 8 p 360

¹⁰ Clinical notes Vol. 9 p 425

¹¹ Clinical notes Vol. 7 p 323

¹² GP record Vol. 1 p 20

¹³ Clinical notes Vol. 7 p 325; GP record Vol. 2 p 47

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Mr. W was three hours late for his appointment on **11 April 2005** and failed to attend his appointment on **22 April 2005** and was discharged from the service.¹⁴

Mr. W contacted the KWU on **23 May 2005** and was prescribed a test dose of Naltrexone on **27 May**. He reported that he was going to Spain the following week and was hoping to stay there for the summer. He was given 14 x 50mg Naltrexone tablets and advised to attend the unit before his next prescription was due.¹⁵ On **2 June 2005** Mr. W telephoned the KWU to inform them that he was in Majorca and asked if his partner could collect his Naltrexone prescription on his behalf. This was agreed to.¹⁶

On **8 July 2005** Mr. W again contacted the KWU requesting a further supply of Naltrexone. He reported that he was doing well and was due to go to the Caribbean the next day. He attended the unit and was given 28 x 50mg Naltrexone tablets.¹⁷

It appears that Mr. W was a service user of the Five Borough Partnership NHS Trust at some point between July 2005 and July 2006. There is no record, however, that Mr. W disclosed this to the staff of the Mersey Care NHS Trust.¹⁸

Mr. W's next recorded contact with Health Services was on **6 July 2006** when he was referred to Windsor House by his GP. He was described as being chronically depressed and having attempted suicide in the past. The GP reported that Mr. W had no current plans to commit suicide but that he might feel suicidal in the future.¹⁹ The CMHT wrote to Mr. W inviting him to make contact within a two-week period.²⁰ There is no record that he did this. He did, however, contact the crisis line on **26 August 2006**. He reported that he felt "*fed up*" and could not see a way out of his current situation.²¹

Mr. W said that he had married in August 2005 whilst working in Majorca and the Caribbean. He had returned to England to sort out his finances, however when he returned to Spain he found that his wife had met someone else. He had cut his wrists and was taken to a hospital in Spain and subsequently returned to the United Kingdom and to his ex-partner. Mr. W reported that he had debts of £30,000.

14 GP notes Vol. 2 p 38

15 Clinical notes Vol.7 p 325

16 Clinical notes Vol. 7 p 325, 326

17 Clinical notes Vol. 7 p 326

18 Mersey Care NHS Trust Internal Investigation into the Care and Treatment of Mr. W

19 Clinical notes Vol. 2 p 60

20 Clinical notes Vol. 2 p 60

21 Clinical notes Vol. 9 p 444ff

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The previous Friday Mr. W had planned to kill himself by driving into a wall. He had been questioned by Police but had not disclosed his intention to kill himself. He reported that he was “*devastated*” to be alive.

He informed the staff that had taken 6 x 12mg Subutex tablets and 6 x 15mg Diazepam with the intention of ending his life. Mr. W made this telephone call from a work colleague’s house as his partner was at work. He said that he would ask his colleague to take him to the Accident and Emergency (A&E) Department.

When Mr. W failed to arrive at the A&E Department the staff telephoned him and spoke to his girlfriend who said that he had not returned home but that he would be attending the A&E Department. The staff telephoned Mr. W again when he had not arrived at the A&E Department by 2.30 pm. As they were unable to make contact with Mr. W they informed the Police and asked them to make a welfare check on Mr. W.²²

A letter from the A&E assessment team to Mr. W’s GP reported that Mr. W had attended the A&E Department on **29 August 2006** but he had left before he was assessed.²³

On **2 September 2006** Mr. W was referred to the Crisis Team at 23.00 hours. He reported having suicidal thoughts. His girlfriend reported that he had thoughts of hanging himself. Mr. W was telephoned at home. He said that he had been to the A&E Department but had been too tired to wait to be assessed. He denied any on-going suicidal thoughts or plans about harming others. He was advised to present to the A&E Department or to call the Crisis Team if he felt suicidal.²⁴

Mr. W was admitted to ward 3X, a medical observation ward, on **5 September 2006** following alleged overdoses of Paracetamol, Diazepam and Subutex.²⁵

On **19 September 2006** Mr. W presented at the A&E Department where he was assessed by an Approved Social Worker and two Psychiatrists.²⁶ Mr. W reported that he was “*fed up with life*”; he claimed that had gone out to his buy a gun to shoot himself but was mugged and his money was stolen. His girlfriend had told him to present to the A&E Department.

Mr. W reported that he lived with his partner. He said that his parents were alive and he had a brother and sister. However Mr. W had no contact with his family. He had worked as a sales

22 Clinical notes Vol. 9 p 444

23 Clinical notes Vol. 10 p 501

24 Clinical notes Vol. 9 p 445

25 Clinical notes Vol. 3 p 113, GP record Vol. 2 p 30

26 Clinical notes Vol. 3 p 64

Mr. W Investigation Report

representative for a time share company in Spain and the Caribbean and was currently a sales manager for Tesco's mobile telephones where he managed ten people. He had debts of around £30,000.

Mr. W reported that his mood was low but he had no suicidal ideas. No evidence of psychosis was detected. He denied drug dependency although it was noted that he was under the care of the Drug Services.

Mr. W had been observed laughing and joking with friends when he had arrived at the A&E Department and he had asked to be assessed under the Mental Health Act (1983). The assessors felt that Mr. W was under the influence of some unknown substance but Mr. W denied this.

“It was considered that he would benefit from referral to the local CMHT. Mr. W would undergo further assessment and identify issues i.e. self harm and selfharm reduction.”

Mr. W, however, would not accept the referral to the CMHT. It was concluded that Mr. W was not detainable under the Mental Health Act. A diagnosis of Borderline Personality Disorder was recorded.²⁷ Following this assessment Mr. W tried to hang himself in the toilets of the A&E Department and was subsequently admitted to hospital, as a voluntary patient.²⁸

Under the heading: ‘Aggression/Violence’ on the assessment form it was noted that Mr. W used drugs, had acted impulsively in the past and was awaiting sentencing for a driving offence. He was identified as being at risk from others as a result of his debts. Risk to self was rated as moderate to high, risk to others was rated as low to moderate and risk of neglect was rated as low to moderate.²⁹

In a further assessment on the same day it was recorded that Mr. W had reported that he was abused by his father and that he had been in care between the ages of 11 and 18 years of age. He said that he had also been abused whilst in care. This assessment recorded that Mr. W's risk to himself was moderate, risk to others “*appears low*” and risk of self neglect “*appears low*”. Mr. W was diagnosed as suffering from a moderate depressive disorder and Cluster B personality trait.³⁰

27 Clinical notes Vol. 3 p 64, Vol. 10 p 489

28 Clinical notes Vol. 2 p 77

29 Clinical notes Vol. 10 p 505, Vol. 2 p 81

30 Clinical notes Vol. 3 p 139, Vol. 4 p 181

Mr. W Investigation Report

In the nursing notes for **21 September 2006** it was recorded that Mr. W had recently given up his job because he could not cope. He reported that he had been threatened by a drug dealer the previous year and had told the Police about this but they did not take the matter further. He also reported that he had recently sold his car to two different people in Toxteth and consequently wanted to avoid this area.³¹

By **22 September 2006** Mr. W was reporting that his mood had improved and was asking for leave from the ward.³² The plan recorded following the ward round on this day was:

- allow half hour leave two times a day;
- leave will be cancelled if Mr. W does not comply with his half hour restriction;
- Mr. W to be searched on his return to the ward and provide a urine sample;
- if any sign of drugs were found Mr. W should be discharged.³³

On **25 September 2006** the aims of Mr. W's ward care plan were recorded as follows: short term aims: prescribed Subutex and nurse on level 4 observations; long-term aims: detoxification and reduce crisis presentations.³⁴ It was recorded that Mr. W's girlfriend believed that he was depressed and would kill himself if given the opportunity. She reported that Mr. W was upset at the way staff had spoken to him, though the staff denied that they had behaved inappropriately.³⁵

The Specialist Registrar (SpR) attempted to assess Mr. W but was unable to complete the assessment as he appeared to be intoxicated.³⁶ However she recorded that Mr. W had last felt well in 2001. He had put his money into a time share business but was "*ripped off*" by his partner. He lost his house, villa, and a sales office. He had then returned to London where he left his belongings in a left luggage office and slept on the streets. On returning to Liverpool a Jamaican neighbour had "*carjacked*" him. This neighbour was subsequently arrested and imprisoned. Mr. W reported that he felt that people were "*out to get him*". He did not feel safe at his current address and intended to go to stay with an uncle in Manchester.

31 Clinical notes Vol. 3 p 142

32 Clinical notes Vol. 3 p 146

33 Clinical notes Vol. 3 p 146

34 Clinical notes Vol. 2 p 70

35 Clinical notes Vol. 4 p 197

36 Clinical notes Vol.2 p 75

Mr. W Investigation Report

The recorded plan was to assess Mr. W under the Mental Health Act (1983) if he wanted to leave the hospital.³⁷

On **26 September 2006** Mr. W asked to be discharged. He attributed his previous low mood to relationship difficulties but said that these had now been resolved and he and his girlfriend had become engaged. He denied any thoughts of self harm. Mr. W complained that the focus of his treatment while in hospital had been on his drug misuse and he believed that this should not have been the case.

Mr. W was assessed as being at risk of impulsive self harm and consideration was given to detaining him under Section 5(2) of the Mental Health Act (1983), however he agreed to remain in hospital as an informal patient.³⁸

On **29 September 2006** the Consultant Psychiatrist caring for Mr. W agreed to him having week-end leave and the ward staff contacted his girlfriend to inform her. She told the ward staff that she would have preferred Mr. W to come home on Saturday rather than Friday as she was at work and could not supervise him.³⁹

On **29 September 2006** Mr. W and his girlfriend met the Specialist Registrar (SpR). Mr. W reported that he had experienced numerous family deaths: his father died on Boxing Day and his sister was in hospital following an attempted suicide. Mr. W's brother had told him that his mother had committed suicide but this was not true; she was alive. Mr. W had also been told that his sister had died; again this was untrue. Mr. W's brother wanted Mr. W to stay out of the lives of family members. At this time Mr. W was in contact only with a parental uncle and his parental grandmother. He reported that he been told that his uncle was his father.

The plan agreed at this meeting was that:

1. Mr. W's care would be transferred to Windsor House because it was felt that the therapeutic relationship with the staff on Greenbank ward had broken down;
2. he would stay with girlfriend at weekends;
3. there would be a period of stabilisation before he was discharged.⁴⁰

When Mr. W returned to the ward his girlfriend challenged the staff when they requested a urine sample. She said that they could not stop Mr. W's leave as it was her judgement

37 Clinical records Vol. 3 p 149

38 Clinical notes Vol. 4 p 153

39 Clinical notes Vol. 4 p 155

40 Clinical notes Vol. 4 p 157ff, Vol. 5 p 205

Mr. W Investigation Report

whether he presented a risk. She threatened to sue if the ward staff tried to interfere in a care plan agreed between her and the doctor.

Mr. W accused another patient of stealing £20.⁴¹

On **2 October 2006** Mr. W reported that his mobile telephone had been stolen but he did not want this reported to the Police.⁴² On the same day he was transferred to Windsor House.⁴³

The care plan recorded on **3 October 2006** was:

1. reduce Buprenorphine to 10 mg daily;
2. continue current care plan;
3. confirm with the drug service how Buprenorphine will show up in urine.⁴⁴

Mr. W was due in Court on **6 October 2006** in relation to his driving offence, as he was on leave the ward staff telephoned him to remind him of this Court appearance. They also informed the Criminal Justice Liaison Team.⁴⁵

On **7 October 2006** Mr. W's girlfriend telephoned the ward and informed the ward staff that Mr. W had been "*found hanging in the cathedral grounds*". He had been taken to the general hospital.⁴⁶

On **9 October 2006** Mr. W informed the SpR that whilst on leave he had gone out to get a new mobile telephone. He had been seen by some people who were "*after him*". They forced him into a car and tied his neck and feet but did not beat him up. Mr. W was taken to the grounds of the cathedral where he was left. He was found by a member of the public and taken to the general hospital where he was admitted over night.⁴⁷

On the same day Mr. W's girlfriend telephoned the ward and informed the staff that a gang of men had been threatening Mr. W and herself over recent weeks. The Police were aware of the situation.⁴⁸

At the ward round on **10 October 2006** it was reported that Mr. W had cut his arms the previous evening but was refusing to let staff see the wounds. He denied on-going thoughts of

41 Clinical notes Vol. 5 p 203

42 Clinical notes Vol. 5 p 207

43 Clinical notes Vol. 5 p 207

44 Clinical notes Vol. 4 p 163, Vol. 5 p 208

45 Clinical notes Vol. 5 p 209

46 Clinical notes Vol. 5 p 210

47 Clinical notes Vol. 4 p 165

48 Clinical notes Vol. 5 p 211

Mr. W Investigation Report

self harm but his girlfriend was worried that Mr. W might harm himself in the future. She was unhappy that Mr. W might be discharged as she believed that he was still a danger to himself. However it was felt that Mr. W was not depressed but that he was manifesting personality difficulties. It was explained to Mr. W's girlfriend that the in-patient admission had been to manage the risk Mr. W was posing to himself and was not a therapeutic intervention.

Mr. W said that he would be interested in counselling and it was suggested that he might be referred to the Rotunda Service which would provide psychotherapy one day *per* week for a year.

The plan agreed was that:

- Mr. W could go on leave to his girlfriend;
- he would be discharged the following day subject to arrangements being made to continue his prescription of Buprenorphine;
- he would have a seven-day follow up appointment with the SpR following discharge;
- Mr. W would consider attending the Rotunda or other psychotherapy input.⁴⁹

Mr. W was discharged on the **11 October 2006** and given an appointment to see the SpR on **16 October 2006**.⁵⁰

The SpR wrote a discharge summary for this admission on **25 October 2006** which was sent to Mr. W's GP. Mr. W's diagnosis was recorded as Emotionally Unstable Personality Disorder. He was being prescribed Subutex and Diazepam by the Newton-Le-Willows drug service. It was recorded that Mr. W had been admitted as an informal patient because of an increase in his self harming behaviour.

Mr. W had returned from Spain in June. In the preceding month he had taken two Paracetamol overdoses, both overdoses had required medical attention but he had left the Accident & Emergency Department before he was seen by the Mental Health Team. However on the current occasion Mr. W's girlfriend had asked that Mr. W was seen by the Mental Health Team because of his self-harming behaviour. He had tried to kill himself by crashing his car. As a result of the car crash he was facing a charge of driving whilst disqualified and driving without insurance. He also had £30,000 worth of debt, mainly credit

⁴⁹ Clinical notes Vol. 4 p 175, Vol. 5 p 213

⁵⁰ Clinical notes Vol. 1 p 23, 38

Mr. W Investigation Report

card debt. On admission Mr. W had complained being low in mood, weepy, with poor sleep and poor appetite.

Mr. W reported that he was born in Manchester. His childhood was unhappy and he had been taken into care when he was 12 years of age. His relationship with his family had been sporadic. Mr. W had experienced an “*On/off*” relationship with his current girlfriend for four or five years. He had worked for a time share business in the Caribbean where he became involved with another woman who had had an abortion. Mr. W moved to Tenerife and to Spain and finally returned to England where he resumed his relationship with his girlfriend.

Mr. W said that he had started using heroin in 2000 in an attempt to kill himself. On returning from Spain he was opiate free but his girlfriend wanted him to be on opiate blockers if they were to resume their relationship.

At the time of his admission Mr. W was living with his girlfriend in her property which was subject to a compulsory purchase order. Mr. W hoped to be able to use the money from the sale of the house to pay off his debts.

Mr. W’s girlfriend reported that Mr. W had served a prison sentence. Her view of Mr. W was that he suffered from low self esteem, low self confidence and was very impulsive.

“During the in-patient admission it became clear that there were few consistent signs of depression and the main factors were the chaotic elements of [Mr. W’s] life style such as the outstanding debts and his up and down relationship with his girlfriend”.

Mr. W had requested his discharge and, as he was not detainable under the Mental Health Act (1983) this was agreed to. However he was regarded as being at on-going risk of suicide.⁵¹

Mr. W attended his appointment with the SpR on **16 October 2006** at the insistence of his girlfriend. He denied having any suicidal thoughts but requested a referral for detoxification. He was informed that it might be some time before an in-patient detoxification place became available but he could refer himself for a home detoxification programme. Mr. W was given some reading material about the Rotunda psychotherapy group.⁵² The SpR wrote to Mr. W’s GP on **18 October 2006** informing him of this out-patient appointment. She reported that Mr. W felt unsafe following his kidnapping; his girlfriend had reported that Mr. W appeared pre-occupied and did not feel safe when he went out. Mr. W’s concentration and appetite were

51 Clinical notes Vol. 1 p 32, GP records Vol. 2 p 20

52 Clinical notes Vol. 5 p 222

Mr. W Investigation Report

poor and he was not his usual self. *“He denied any suicidal or homicidal ideation”*, and was not reporting any hallucinations or delusions.

The SpR reported: *“He told me that Newton-Le-Willows CDT had prescribed Subutex and were happy to continue to do so.”*⁵³

Mr. W was due in Court on **23 October 2006** charged with driving whilst disqualified. The plan recorded was:

1. to follow Mr. W up in one month;
2. to send him information on the Rotunda psychotherapy group;
3. Mr. W was to refer himself to Gateway for home detoxification.⁵⁴

On **20 October 2006** Mr. W presented at the Accident & Emergency Department saying that he was suicidal. He had presented the previous day saying that he had experienced a seizure when he had been ‘medically’ assessed and discharged.

He had also called the Police and said the he had been kidnapped and left for dead in a ditch. The Police were still searching for him when he presented at the Accident & Emergency Department.

Mr. W reported that he had made numerous suicide attempts in the past but had not succeeded in killing himself. On this occasion he said that he had tried to inject air into his vein. He denied that he had any current plans for suicide and was able to identify some protective factors. Mr. W was discharged to the Police so that his kidnap and attempted murder claims could be investigated. It was noted: *“Police feel his allegation of kidnapping was query an elaboration on [Mr. W’s] part this does not however appear to be a delusion”*.⁵⁵

It was noted that Mr. W *“was inconsistent throughout the assessment and economical with what he stated during the assessment”*.

The plan recorded following this assessment was to liaise with Mr. W’s Consultant Psychiatrist to see how he might be *“managed”*.⁵⁶ However a handwritten note on the fax from the Accident & Emergency Mental Health Team to the Consultant Psychiatrist said:

53 GP record Vol. 20 p 18

54 Clinical notes Vol. 10 p 487

55 Clinical notes Vol. 1 p 47

56 Clinical notes Vol. 1 p 25

Mr. W Investigation Report

“Bit early to arrange a case conference. If discharge summary is on EPEX that will perhaps be sufficient”. The signature cannot be read.⁵⁷

There is an undated Threshold Assessment Grid (PRISM) form in Mr. W’s clinical records which appears to have been completed at this assessment. This records:

- Intentional Self Harm: no concerns about risk of deliberate self harm or suicide attempts;
- Unintentional Self Harm: no concerns about unintentional risk to physical safety;
- Risk from Others: minor concerns about risk of abuse or exploitation from other individuals or society;
- Risk to Others: no concerns about risk of physical safety or property of others;
- Survival: no concerns about basic amenities or living skills;
- Psychological: minor concerns or distressing problems with thinking feeling and behaviour;
- Social: minor disabling problems with activities and relationships other people.

Mr. W denied any substance misuse but it was noted that his case notes suggested this was not true.⁵⁸

Mr. W failed to attend his out-patient appointment on **11 November 2006** and was sent a further appointment for **17 November 2006**.⁵⁹ ⁶⁰ He failed to attend both this appointment and a further appointment on **8 December 2006**.⁶¹

On **12 December 2006** Mr. W was brought into the Accident & Emergency Department after collapsing in the street. He denied using any drugs other than those he was prescribed and denied using alcohol. *“His mother reported that he has had two previous fits, one a tonic clonic seizure lasting 4 minutes”*. Mr. W’s ECG was normal and his GP was asked to follow Mr. W up.⁶²

On **13 December 2006** the SpR wrote to Mr. W asking him to make contact within two weeks otherwise he would be discharged from the service.⁶³

57 Clinical notes Vol. 1 p 40

58 Clinical notes Vol. 1 p 26

59 Clinical notes Vol. 5 p 225

60 Clinical notes Vol. 1 p 21

61 Clinical notes Vol. 5 p 225

62 GP records Vol. 2 p 15

63 Clinical notes Vol. 1 p 19

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On **14 December 2006** Mr. W was convicted of driving while disqualified at Liverpool Magistrates Court.

A nurse from the Criminal Justice Liaison Team interviewed Mr. W and wrote to his Consultant Psychiatrist. She reported that Mr. W had informed her that he had seen the SHO the previous Friday and had discussed starting anti-depressant medication. He said that his mood was low and his anxiety high. He reported that he was compliant with Subutex and Diazepam and was drug free. Mr. W said that he had taken an overdose of sleeping tablets and analgesics two weeks previously but had not told anyone at the time. He told his partner two days later. No trigger was identified and he had not subsequently thought of suicide.

Mr. W had reported feeling hopeful about the future. He had plans to get a job and continue attending weekly group therapy. Although low in mood he showed no signs of psychomotor retardation or flattening of affect.

“There was no evidence to suggest aggressive or violent behaviour”.

Mr. W had received a 12 month Community Rehabilitation Order with supervision, a two-month curfew from 19.00 to 7.00 hours and was banned from driving for six months.⁶⁴

On or around **29 December 2006** Ms. Y, Mr. W’s victim, was killed.

On **6 January 2007** Ms. Y’s body was discovered.

On **8 January 2007** Mr. W was discharged from the care of the Mental Health Team to the care of his GP.⁶⁵

On **9 January 2007** the SpR wrote to the Criminal Justice Liaison Nurse who had assessed Mr. W informing her that it appeared that Mr. W had misled the Court. Mr. W had failed to attend all his recent appointments and had failed to respond to a follow up letter. Similarly he had not been referred to and was not attending weekly psychotherapy.⁶⁶

Mr. W was sent to Liverpool Prison on **9 January 2007** and started on a methadone detoxification programme.⁶⁷

64 Clinical notes Vol. 1 p 17

65 Clinical notes Vol. 5 p 225

66 Clinical notes Vol. 1 p 29

67 GP records Vol. 2 p 10

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Account of the Incident

The body of a colleague of Mr. W's girlfriend was found in her house on 6 January 2007. The Pathologist concluded that she had been killed on or around 29 December 2006. It was alleged that between these two dates Mr. W had withdrawn money from the victim's account and returned to her house on several occasions and taken goods which he sold.

Mr. W was convicted of murder at Liverpool Crown Court on **4 July 2007** and sentenced to 26 years imprisonment on **25 July 2007**. No connection was made between any abnormality of mind Mr. W may have experienced and the murder of Ms. Y. The motive for the murder was given as being financially driven.

Mr. W was found hanged in his prison cell on **21 August 2009**.

11. Identification and Exploration of Contributory Factors and Service Issues

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

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

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

- Mr. W killed Ms. Y (ask why?)
- Because he needed money to buy Heroin.

RCA Third Stage

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

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

In the interests of clarity each issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms ‘causal factor’, ‘contributory factor’ and ‘service issue’ are used in this section of the report. They are explained below.

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Causal Factors. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term ‘causal factor’ is used to describe any act or omission that had a direct causal bearing upon the failure to manage a mental health service user effectively and a consequent homicide. No such finding was made in relation to the care and treatment Mr. W received.

Contributory Factors. The term is used to denote a process or a system that failed to operate successfully thereby leading an Independent Investigation Team to conclude that it made a direct contribution to the breakdown to a service user’s mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party. No such findings were made in relation to the care and treatment Mr. W received.

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

The findings in this chapter analyse the care and treatment given to Mr. W by the Mersey Care NHS Trust.

11.1.1. Referral and Discharge Procedures

11.1.1.1. Findings of the Internal Investigation Team

The Internal Investigation concluded:

“10.5 A key area for discussion within the E.C.C policy, across services, is in respect of cases like [Mr. W’s], in which there is a significant risk to self, but where there is no mental illness diagnosis, which prohibits referral to C.M.H.T. Drug services operate on an open door, client self-determination basis. Under the Community Care Act, the Local Authority’s duty is to assess and provide services to ‘vulnerable adults’. Some Local Authorities have separate Vulnerable Adult Teams, from which [Mr. W] may have been eligible for support. In Merseyside, it appears that Social Workers, within C.M.H.T.s can carry only cases of people with an actual diagnosis of mental illness”.

“8.5 It is of concern that [Mr. W] was discharged home on 5th September 2006 as a Mental Health Assessment was not possible, in view of his presentation at the time, with no community follow up, other than to advise his General Practitioner”.

“Clear and focused management by the Specialist Registrar in Psychiatry and a thorough management plan and 7-day follow-up upon [Mr. W’s] admission to the Broadoak Mental Health Unit, and thereafter”.

11.1.1.2. Findings of the Independent Investigation Team

There is little evidence that Mr. W was willing to engage in a constructive manner with the services that were available to him. In October 2004 he was admitted to the Kevin White Unit for detoxification but discharged himself against medical advice. In December of the same year his GP again referred him to the substance misuse service. When this service tried to contact him he was in prison and he was therefore discharged. Mr. W did make contact in February 2005 and was prescribed Naltrexone between May and July but again disengaged from the service. This time because he was working abroad.

There are reports that he had some contact with the Five Boroughs Partnership NHS Trust at some point between July 2005 and July 2006 but the Independent Investigation did not have access to the records of this contact.

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In July 2006 Mr. W's GP referred him to the Mersey Care Mental Health Services but he failed to respond to the invitation to make contact. Instead during August and September he presented on a number of occasions to the Accident and Emergency Department (A&E) and it was not until 19 September 2006, following a further presentation at the A&E Department that he was admitted to hospital. However while in hospital his relationship with the ward staff broke down and he was transferred to another unit, though his care remained the responsibility of the same Consultant Psychiatrist and SpR, so there was continuity of care and approach to Mr. W.

When Mr. W was discharged from hospital he was given a seven day follow-up appointment with the SpR who had overseen his in-patient care. He attended this appointment, by his own admission, only at the insistence of his girlfriend and failed to attend his subsequent appointments resulting in him being discharged in January 2007. Rather than attend the planned appointments Mr. W again attended the A&E Department in October and December 2006. In the event by the time Mr. W was discharged he was already in custody in connection with the homicide.

11.1.1.3. Conclusions of the Independent Investigation Team

The Consultant and SpR, who were responsible for Mr. W's care from the time he was admitted as an in-patient in September 2006, when interviewed by the Independent Investigation said that the reason Mr. W was not more intensively followed up was not because he could not be referred to the CMHT but that they were unconvinced that he was committed to addressing his problems and that being given the option to see the SpR was an opportunity to gauge his commitment. In the event he attended only one follow up appointment and he admitted that, even this, was at the insistence of his girlfriend.

Mr. W was given the opportunity of a referral to the Rotunda (Personality Disorder) psychotherapy service but he never took up this offer.

The Consultant and SpR had concluded that Mr. W remained at significant risk of (impulsive) self harm. However their assessment was that this was determined, to an extent, by his social circumstances: debt, relationship with his girlfriend and what was happening in the drug/criminal environment he frequented, rather than being primarily determined by a mental health problem. They reported that they had also considered issues of resourcing and

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the consequent prioritisation when making their decision about the level of follow-up intervention it would be appropriate to offer to Mr. W.

The Internal Investigation report raises the possibility that Mr. W might have been viewed as a vulnerable adult and had this been done he might have had greater access to services. This appears to stem from the observation that social workers in the CMHT could only see people with a diagnosable mental illness. However Mr. W was given a diagnosis: Emotionally Unstable Personality Disorder. The Best Practice guidance is clear that this should be treated in Mental Health Services. The Consultant responsible for Mr. W's in-patient care was also the Consultant for the CMHT. She reported that Mr. W was eligible for referral to the CMHT. The reason he was not referred to the multi-disciplinary team are noted above. Perhaps the issue is less one of whether Mr. W should have been considered as a vulnerable adult and more one of adopting a more integrated approach to his care, especially at the point of discharge, involving drug services, Personality Disorder Services and social care in joint assessment and care and risk management planning.

The Internal Investigation comments on Mr. W's presentation to the A&E Department on 5 September 2006 and no mental health assessment being completed on this occasion and no community follow-up put in place. Mr. W presented relatively frequently to the A&E Department following self harming, suicide attempts and overdoses. On some occasions it proved difficult to complete an assessment as Mr. W appeared to be intoxicated, on other occasions he left before he could be assessed. There was a consistent pattern of transient distress which led to Mr. W self harming. However by the time of assessment he no longer had suicidal ideas and was no longer planning to harm himself. Perhaps the issue is one of having in place a system which identifies repeated crisis presentations and a mechanism which allows services to respond to individuals presenting in this way.

Mr. W was appropriately referred to both mental health services and substance misuse services by his GP on a number of occasions. The services responded to these referrals but, for a variety of reasons, usually failed to engage Mr. W. When he was admitted to hospital the records suggest that he was not fully engaged in addressing his problems and at the point of discharge a plan was put in place which offered continuity of care, regular appointments with the SpR, and the opportunity of addressing his identified mental health problems by referring him to the Rotunda Personality Disorder Psychotherapy Service. Mr. W did not

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avail himself of either of these opportunities. At interview the Independent Investigation Team was informed that consideration had been given to referring Mr. W to the Community Mental Health Services but given his lack of engagement and commitment to addressing his problems it was decided to take an approach which required less commitment on his part, appointments with the SpR, with the opportunity to revise this decision should Mr. W show more interest or commitment to addressing his problems. While, in an ideal world, it might be desirable to explore every possible approach to treating a service user's problems, in the real world with limited resources clinicians have to make a decision based upon what is most likely to be clinically useful. It appears that in Mr. W's case, at the point of his discharge from hospital, the clinical team did consider the options open to them and the Independent Investigation Team concluded made a reasonable decision about his on going care.

11.1.2. Diagnosis

11.1.2.1. Context

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

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

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

Personality Disorders

ICD 10 defines Emotionally Unstable (Borderline) Personality Disorder (F60.3) as follows:

“A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or “behavioural explosions”; these are easily precipitated when impulsive acts are criticized or thwarted by others. Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control.

Impulsive type:

The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.

Borderline type:

Several of the characteristics of emotional instability are present; in addition, the patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)”.

11.1.2.2. Findings of the Internal Investigation Team

The Internal Investigation concluded that:

“10.6 Services for people with personality disorder such as [Mr. W's] are underdeveloped nationally. The learning in this case is that, if a comprehensive Personality Disorder Service

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had been available, then there would have been a better chance of engagement and follow up”.

11.1.2.3. Findings of the Independent Investigation Team

When Mr. W was released from Armley Prison, Leeds in August 2001 it was recorded that that he was not suffering from a mental illness but was misusing heroin, cocaine and Diazepam.⁶⁸

During an assessment in October 2004 Mr. W reported that he had had two psychiatric admissions whilst in prison, in Stoke and in London. He had tried to hang himself in 2002 following a withdrawal from illicit drugs. He was seen by a psychiatrist at the Doncaster Royal Infirmary and prescribed antidepressant and antipsychotic medication.⁶⁹ At Christmas time in 2003 Mr. W once again attempted suicide. He was not assessed or admitted to hospital on this occasion.⁷⁰ There are no clinical notes of these episodes available and no diagnoses are recorded.

Between September 2004 and July 2005 Mr. W was under the care of the Drug Misuse Services (the Kevin White Unit) in Liverpool and no psychiatric diagnosis was recorded for him during this period. In July 2006 Mr. W was referred to the Mental Health Services in Liverpool by his GP. He was described as being chronically depressed and having attempted suicide in the past. The referral notes stated that Mr. W reported that he had been ‘sectioned’ in the past following suicide attempts but there was no record of this in Mr. W’s medical notes.^{71 72}

In August 2006⁷³ Mr. W reported that he had attempted to kill himself by driving into a wall and had subsequently taken an overdose of Paracetamol, Diazepam and Subutex.^{74 75} A full mental health assessment could not be carried out as Mr. W was sedated and no diagnosis was recorded. However in September 2006, when Mr. W again presented at the A&E Department a Mental Health Act assessment was undertaken. It was concluded that Mr. W was not

68 GP record Vol. 1 p 23 of 33

69 Clinical notes Vol. 7 p 347

70 Clinical notes Vol. 9 p 425

71 Clinical notes Vol. 2 p 60

72 Clinical notes Vol. 2 p 60

73 Clinical notes Vol. 9 p 444ff

74 Clinical notes Vol. 9 p 444

75 Clinical notes Vol. 3 p 113, GP record Vol. 2 p 30

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detainable under the Mental Health Act (1983) and a diagnosis of Borderline Personality Disorder was recorded.⁷⁶

In October 2006, when Mr. W was discharged from hospital following a four-week admission, the discharge summary noted:

*“During the in-patient admission it became clear that there were few consistent signs of depression and the main factors were the chaotic elements of [Mr. W’s] life style such as the outstanding debts and his up and down relationship with his girlfriend”.*⁷⁷ His diagnosis was recorded as Emotionally Unstable Personality Disorder.

At his follow up appointment a week after his discharge the SpR noted that Mr. W *“described his mood as subjectively OK and objectively he was low. He denied any suicidal or homicidal ideation. There were no delusions or hallucinations. He demonstrated reasonable insight”.*⁷⁸ No formal diagnosis was recorded on this occasion.

11.1.2.4. Conclusions of the Independent Investigation Team

From the first recorded contact with health services Mr. W’s presentation was characterised by the misuse of illicit substances and impulsive acts of self harm and attempted suicide. His first contact with services provided by the Mersey Care NHS Trust were with the substance misuse services which attempted to work with Mr. W to address his substance misuse problems. Mr. W reported that at some point prior to his coming into contact with the Mersey Care services he had been prescribed both anti-depressant and anti-psychotic medication and that his GP referred him diagnosed as suffering from chronic depression with suicidal ideation.

Mr. W was assessed as an in-patient over a four-week period when the clinicians looking after him considered the diagnosis of depression as an explanation of his self harming and suicidal behaviour and his frequent reports that he felt *“fed up”*. However it was concluded that: *“During the in-patient admission it became clear that there were few consistent signs of depression and the main factors were the chaotic elements of [Mr. W’s] life style such as the outstanding debts and his up and down relationship with his girlfriend”.*⁷⁹ They reached the conclusion that Emotionally Unstable Personality Disorder was a more appropriate diagnosis and better explained Mr. W’s behaviour.

⁷⁶ Clinical notes Vol. 2 p 64, Vol. 10 p 489

⁷⁷ Clinical notes Vol. 1 p 32, GP records Vol. 2 p 20

⁷⁸ GP records Vol.2 p 31

⁷⁹ Clinical notes Vol. 1 p 32, GP records Vol. 2 p 20

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The Independent Investigation concluded that the clinical teams looking after Mr. W considered the relevant diagnostic categories and arrived at a reasonable conclusion that the most appropriate diagnosis was that Mr. W was suffering from a Personality Disorder, his impulsive behaviour being exacerbated by his social circumstances and his, probable, continued misuse of illicit substances.

11.1.3. Medication and Treatment

11.1.3.1. Context

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

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

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

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

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All medication prescribed and administered should be monitored for effectiveness and also side effects.

Assessment and Treatment of Drug misusers

The Department of Health in its Good Practice Guide on services for those with a mental illness and a substance misuse problem noted:

*“1.1.2 A fundamental problem is a lack of clear operational definitions of “dual diagnosis”. In many areas a significant proportion of people with severe mental health problems misuse substances, whether as ‘self medication’, episodically or continuously. Equally, many people who require help with substance misuse suffer from a common mental health problem such as depression or anxiety. Sweeping up all these people together would result in a huge heterogeneous group many of whom do not require specialist support for both mental health and substance misuse issues. Integrating services therefore requires a clear and locally agreed definition of dual diagnosis supported by clear care pathways (care coordination protocols). It is essential to acknowledge that gatekeeping by specialist services is a valid activity which enables them to focus their efforts, and agreed and justifiable gatekeeping practice with clear accountability should ensure that clients are included in the right services, rather than excluded from services they desperately need”.*⁸⁰

Commenting on the impact of substance misuse the Guidance notes:

“1.5.1 Substance misuse among individuals with psychiatric disorders has been associated with significantly poorer outcomes including:

- Worsening psychiatric symptoms*
- Increased use of institutional services*
- Poor medication adherence*
- Homelessness*
- Increased risk of HIV infection*
- Poor social outcomes including impact on carers and family*
- Contact with the criminal justice system.*

Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified

⁸⁰ DoH (2002) *Dual Diagnosis Good Practice Guide* p6

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*substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide”.*⁸¹

Commenting on the assessment and planning of care for individual service users the guidance recommends:

*“Specialised assessments are undertaken to determine the nature and severity of substance misuse and mental health problems, and to identify corresponding need. The more comprehensive and focused the assessment the better the understanding will be of the relationship between the two disorders. Since substance misuse can itself generate psychological and psychiatric symptoms, assessment of this relationship should be longitudinal and open to revision”.*⁸²

In describing the four tier model of service delivery that was being advocated in its “*Models of Care for the Treatment of Drug Misusers*” (2002) the National Treatment Agency (NTA) guidance says:⁸³

“Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care planned treatment and drug specialist liaison....

Tier 3 interventions that should be commissioned in each local area include...

- *Community care assessment and case management for drug misusers;*
- *Harm reduction activities as integral to care-planned treatment;*
- *A range of prescribing interventions, in the context of a package of care and in line with Drug Misuse and Dependence – Guidelines on Clinical Management, known as “the clinical guidelines”. This will be updated alongside the relevant forthcoming National Institute for Clinical Excellence (NICE) guidelines and technology appraisals, and in line with other evidence-based clinical standards with specific interventions, including:*
 - *prescribing for stabilisation and oral opioid maintenance prescribing;*
 - *community based detoxification;*
 - *injectable maintenance prescribing; and*
 - *a range of prescribing interventions to prevent relapse and ameliorate drug and alcohol-related conditions;*

81 Ibid p 9

82 DoH (2002) *Dual Diagnosis Good Practice Guide* p 17

83 National Treatment Agency (2002), “*Models of Care for the Treatment of Drug Misusers*”

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- *A range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour;*
- *Structured day programmes and care-planned day care (e.g. interventions targeting specific groups);*
- *Liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health and hepatitis services);*
- *Liaison services for social care services (e.g. social services (child protection and community care teams), housing, homelessness ;)*
- *A range of the above interventions for drug-misusing offenders.”*

The evidence-based psychosocial interventions identified in the NTA’s 2006 Model of care guidance include:

- cognitive behaviour therapy (CBT);
- coping skills training;
- relapse prevention therapy;
- motivational interventions;
- contingency management;
- community reinforcement approaches;
- some family approaches.

In December 2010 the incoming coalition government introduced its new drug strategy: *“Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life”*.

This strategy places an emphasis on recovery. It:

- puts more responsibility on individuals to seek help and overcome dependency;
- places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing;
- aims to reduce demand;
- takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad;

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- puts power and accountability in the hands of local communities to tackle drugs and the harms they cause.

Personality Disorders

Personality disorder problems are not uncommon in the population served by mental health services. In *New Horizons*⁸⁴ the Department of Health noted:

“Personality disorders are common conditions. Estimates of prevalence rate vary between 5 and 11 per cent of adults in the community. Among community mental health patients this rises to between 30 and 40 per cent, and 40 to 50 per cent of mental health inpatients”. (p. 72).

The document observes that: *“People with complex problems make frequent and often chaotic use of inpatient mental health, primary care, A&E, social care, and criminal justice and other services. Emerging evidence from the new personality disorder services demonstrates that this can be reduced, and people with this diagnosis can engage in training and work if they receive appropriate support to address their problems. Outcomes from the new services demonstrate the benefits of multi-agency, cross-sector commissioning and collaborative working”.* (p.72)

The most recent NICE guidance (2009)⁸⁵ on the treatment and management of people with personality disorders makes it clear that personality disorder is not only a treatable disorder but that it is the responsibility of the mental health services, usually the CMHTs, to provide a broad-based assessment of needs and to institute appropriate interventions. The guidance acknowledges, however, that if clinical staff are to fulfil this role competently then training and support are required.

“Mental health professionals working in secondary care services, including community-based services and teams, CAMHS and inpatient services, should be trained to diagnose borderline personality disorder, assess risk and need, and provide treatment and management in accordance with this guideline.... Training should be provided by specialist personality disorder teams based in mental health trusts.

84 DoH (2009) *New Horizons: Towards a shared vision for mental health*

85 NICE (2009) *Borderline Personality Disorder: Treatment and Management*

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Mental health professionals working with people with borderline personality disorder should have routine access to supervision and staff support”. (p. 380/1)

The guidance recommends that Trusts should set up specialist teams to assess and treat those who have particularly complex needs or are at particular risk. These teams should provide consultation and training to those clinicians who do not specialise in the treatment of personality disorder as well as offering a direct clinical service.

11.1.3.2. Findings of the Independent Investigation Team

Substance misuse

Mr. W's initial contact with services in Liverpool was with the Substance Misuse Services and the initial interventions were aimed at helping him deal with his substance misuse problems. Mr. W's first recorded contact with this service was when he asked to be considered for the community detoxification programme, later he asked to be prescribed Naltrexone. In October 2004 he was admitted to an in-patient detoxification programme at the Kevin White Unit but discharged himself before this was completed. In February 2005 he was assessed for the Naltrexone programme but again was discharged as he failed to attend his appointments. Up to this point Mr. W appears to have had irregular contact with the Substance Misuse Services where a number of approaches to helping him with his use of illicit drugs had been considered but they had all failed to deliver the desired outcomes as Mr. W was unable or unwilling to adhere to the programmes suggested. However in May 2005 he was given a test dose of Naltrexone and as he displayed no adverse effects he was prescribed this drug throughout May, June and July 2005 although he was abroad, in Spain and the Caribbean, for much of that time.

The 2007 NICE guidance on prescribing Naltrexone states:

“Naltrexone is recommended as a treatment option for people who have been opioid dependent but who have stopped using opioids, and who are highly motivated to stay free from the drugs in an abstinence programme.

It should only be given to people who have been told about the problems associated with treatment, and with proper supervision. Treatment with naltrexone should be given as part of a support programme to help the person manage their opioid dependence.

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*Healthcare professionals should regularly review how well naltrexone is working to help people stay off opioids. If there is evidence that the person has been using the drugs again then healthcare professionals should consider stopping Naltrexone treatment”.*⁸⁶

In the context of the support that should be provided the guidance observes:

“2.8 Psychosocial and behavioural therapies play an important role in the treatment of drug misuse. They aim to give people the ability to resist drug misuse and cope with associated problems. For opioid-dependent people, these therapies are often an important adjunct to pharmacological treatments”.

From the notes that were available to the Independent Investigation it appears that Mr. W’s girlfriend was, at least at times, insistent that Mr. W remain drug free if their relationship was to continue. This proved to be, at least when he was in a relationship with her, a significant motivation to remain opiate free. Mr. W appears to have met this criterion for the prescribing of Naltrexone.

The recommendation on the importance of making available supportive interventions such as psychological and behavioural interventions echoes the guidance of the National Treatment Agency (NTA) (2002) quoted above. When Mr. W was first assessed in October 2004 the worker offered him ‘intensive support’. However Mr. W did not engage with the service at that time and, indeed spent five weeks in prison in early 2005. When he was again assessed for the Naltrexone programme in May 2005 he was informed about Naltrexone both verbally and in the form of a leaflet, as the guidance recommended. However given that he was out of the country for much of the time that he was prescribed Naltrexone it is improbable that he availed himself of any intensive or structured support. His contacts with the service were infrequent and at times there was only telephone contact. So supervision would appear to have been at best infrequent and cursory. There is no record in Mr. W’s clinical notes as to why the substance misuse team decided to prescribe Naltrexone even though they knew that he would be abroad for prolonged periods and so we are not in a position to comment on the reasoning or clinical strategy adopted by the substance misuse team at this time. We can only note that there appears to have been a discrepancy between the NICE and NTA guidance and practice in the case of Mr. W.

⁸⁶ NICE (January 2007) TA 115: *Naltrexone for the Management of Opioid Dependence*

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When Mr. W was admitted to hospital in August 2006 he informed the SpR that he was being prescribed Subutex (Buprenorphine) by the St Helens Substance Misuse Services. He reported that they could not prescribe Naltrexone because of abnormal liver function test results, although he was less forthcoming about his actual use of opiates at this time. A Senior House Officer (SHO) contacted the St Helens Substance Misuse Services on 20 September to confirm which drugs Mr. W was being prescribed and at what dosages. The St Helens Substance Misuse Services were able to confirm that the information Mr. W had provided was correct. The care plan was to continue to prescribe Buprenorphine with the longer term aim of abstinence. Mr. W said that he wanted to remain under that care of the St Helens Team as he did not want to have to associate with Liverpool drug addicts. His care plan on 3 October 2006 noted that Buprenorphine was to be reduced to 10mg daily. However, there is no record of the on-going involvement of, or advice from, the Substance Misuse Services in Mr. W's care during the in-patient admission; though contact was made with the St Helens Substance Misuse Services on 20 September 2006 and 11 October 2006, following the decision to discharge Mr. W subject to arrangements being made to ensure his continued prescription of Buprenorphine. The SpR contacted the Newton-le-Willows/St Helens/Knowsley Substance Misuse Team who confirmed that they were willing to resume prescribing Buprenorphine and Diazepam for Mr. W and had arranged an appointment for him for 12 October 2006.

In her letter to Mr. W's GP following Mr. W's outpatient appointment on 16 October 2006, the SpR reported that Mr. W had informed her that the Newton-Le-Willows Community Drug Team had prescribed Subutex for him following his discharge from hospital and were happy to continue to do so.

Service Issue 1

There appears to have been a discrepancy between the NICE and NTA guidance and the practice of the Substance Misuse Services in the case of Mr. W. The supervision, support and interventions recommended in the Best Practice guidance were not evident. Although it has to be acknowledged that Mr. W did not show any consistent commitment to address his substance misuse problems.

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Service Issue 2

While Mr. W was an in-patient his prescription of Buprenorphine was continued. However, there is no record, in Mr. W's clinical notes, of any joint planning as to how Mr. W's substance misuse and mental health problems might be addressed in a collaborative and co-ordinated manner by the two services.

Mental Health

In July 2006 Mr. W was referred by his GP to the CMHT with a diagnosis of chronic depression. Mr. W however did not respond to the invitation to make contact with the mental health team so on this occasion no assessment or treatment was initiated.

Following this Mr. W presented to the A&E Department on at least two occasions in August and September 2006 before he was assessed under the Mental Health Act (1983) in the A&E Department on 19 September 2006. Those assessing Mr. W on this occasion did not deem him to be detainable under the Act. He was diagnosed as suffering from a moderate depressive disorder and a personality disorder, with his repeated self harming behaviour exacerbated by social stressors. Mr. W declined the offer of a referral to the CMHT and informal admission to hospital. It was suggested to Mr. W that psychological therapies might be beneficial to him. However it appears that he did not respond positively to this suggestion. Following this assessment Mr. W attempted to hang himself and subsequently accepted admission to hospital as a voluntary patient.

By 22 September Mr. W was asking for leave, saying that his mood had improved and on 24 September it was agreed that he could have 30 minutes of leave twice a week. On 25 September the aims of Mr. W's care plan were recorded as being: short term: prescribe Subutex, nurse on level 4 observations; and long term: detoxification and reduce crisis presentations. On the same day it was recorded that the SpR could not complete her assessment of Mr. W because he appeared to have taken illicit substances and was intoxicated.

The strategy at this point in time appears to have been to contain the risk Mr. W was presenting to himself by closely monitoring him and to reduce, as far as possible, his use of illicit drugs, and in this more controlled environment to assess Mr. W's mental state. However by this time Mr. W's relationship with the ward staff was breaking down. On the 25 September Mr. W's girlfriend complained that Mr. W was unhappy about the way the staff

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had spoken to him, though the staff denied that they had behaved inappropriately. On 26 September Mr. W complained about the level of observations he was on, while the staff suspected that he was using illicit substances. Mr. W asked to be discharged and consideration was given to detaining him under Section 5(2) of the Mental Health Act (1983) but agreed to remain in hospital on a voluntary basis and asked to be referred to psychology services.

On 29 September the SpR met Mr. W and his girlfriend and it was agreed that Mr. W would: move to Windsor House, stay with his girlfriend at the week-end and have a period stabilisation prior to discharge. However there appears to have been some confusion over the week-end leave arrangements. As she was working Mr. W's girlfriend would have preferred him to commence his leave on Saturday. Mr. W, however, left the ward on Friday evening without the knowledge of the ward staff. Mr. W's girlfriend was unhappy to find him at home when she returned from work. She complained. The nursing notes record that Mr. W's girlfriend challenged the staff when they requested a urine sample from Mr. W when he returned from leave. She said that staff could not stop his leave as it was at her discretion whether he presented a risk. She threatened to sue if the ward staff tried to interfere with the care plan agreed between her and the doctor.

On 2 October Mr. W was transferred to Windsor House, remaining under the care of the SpR. On 3 October the care plan recorded was to reduce Mr. W's Buprenorphine to 10mg daily, continue with his current care plan and confirm with the drug service how Buprenorphine shows up in urine.

On 10 October Mr. W cut his arms but refused to allow the staff to examine the wounds. At the ward round Mr. W said that he would be interested in a referral to psychological services and it was suggested that he might be referred to the Rotunda Psychotherapy Services. This is a Personality Disorder service which offers group psychotherapy one day a week for a year.

Mr. W's girlfriend was unhappy that Mr. W might be discharged as she believed that he was still a danger to himself. However it was felt that Mr. W was not depressed rather he was manifesting personality difficulties. It was explained to her that the in-patient admission had been primarily to manage the risk Mr. W was posing to himself and was not, in itself, a therapeutic intervention.

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Mr. W was discharged on 11 October on the Enhanced level of CPA. A care co-ordinator was identified; Mr. W was given an appointment with the SpR for 16 October and it was noted that he had an appointment with the Newton-Le-Willows Substance Misuse Team on 12 October.

Mr. W attended his out-patient appointment on 16 October, by his own admission, at the insistence of his girlfriend and his referral to the Rotunda Psychotherapy Service was discussed. Mr. W failed to attend his subsequent out-patient appointments and was discharged on the 9 January 2007 without any further input, although he again presented at A&E on a number of occasions.

The only real opportunity for therapeutic intervention was during Mr. W's in-patient admission from 19 September to 11 October 2006. However given the circumstances surrounding his admission the primary focus of the admission was to manage the risk Mr. W presented to himself and to manage his substance misuse. Both these goals required that Mr. W be closely monitored. It appears that Mr. W was not comfortable with this and this placed a strain on his relationship with the nursing staff. Despite his denial the clinical staff believed that Mr. W was continuing to use illicit drugs. This appears to have placed a further strain on his relationship with the ward staff while he was in the Broadoak Unit. The clinical notes convey the impression that Mr. W was not co-operative and tended to test the boundaries that were set. This is a state of affairs that is not uncommon with people who have a diagnosis of personality disorder.

After a period of observation the clinical team concluded that Mr. W was not suffering from an affective disorder but rather that his impulsive, self harming behaviour was a manifestation of a personality disorder, specifically an Emotionally Unstable Personality Disorder. Given this diagnosis the treating team, appropriately, refrained from prescribing Mr. W additional medication. They concluded that he continued to present a significant risk to himself but that a continued in-patient admission would not be beneficial. This again appears to have been a reasonable decision.

At this point the treating team suggested that Mr. W might be referred to the only Personality Disorder Service that was accessible to them at that time. Mr. W, however, appears to have been ambivalent and he disengaged from the service before a referral was made.

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From his first contact with Mental Health Services it was evident that Mr. W's misuse of illicit drugs played a significant part in his presentation, however, in line with best practice guidance the clinical team continued to offer him a service from within mainstream Adult Mental Health Services. Having concluded that Mr. W's problems could be viewed as a manifestation of his personality disorder, exacerbated by drug misuse and social stressors it was appropriate that his in-patient admission was not continued indefinitely, especially as Mr. W was asking to be discharged and was spending increasing amounts of time away from the ward. However prior to discharge it would have been good practice to have sought the advice of the substance misuse service and those with expertise in personality disorders. Mr. W was given a follow up out-patient appointment and referral to a year long psychotherapeutic programme was discussed with him but Mr. W had a history of failing to engage with services and not adhering to programmes of intervention which were suggested to him. His preferred mode of contact was to present at times of crisis. This is not unusual for people with a diagnosis of personality disorder and it was a pattern that continued after his discharge from in-patient care.

As noted above the guidance on personality disorder is clear that this is a treatable disorder and should be addressed within mainstream adult mental health services. However the guidance goes on to point out that if competent services for those with personality disorders are to be delivered then (i) staff need to have appropriate training and (ii) expert advice, consultation and supervision need to be available. The Independent Investigation was informed that neither was available to Mr. W's treating team at that time.

Having said this, given Mr. W's long established pattern of behaviour, even had a co-ordinated plan informed by and shared with Substance Misuse Services and Personality Disorder Services been put in place at this time it could not be concluded with any degree of confidence that this would have significantly altered Mr. W's behaviour in the short term.

Service Issue 3

The Best Practice guidance recommends that individuals with a diagnosis of personality disorder are treated in mainstream mental health services. To achieve this clinical staff in mental health services need to have appropriate training and have access to expert advice, consultation and supervision. These were not available to Mr. W's treating team at that time he was under its care.

11.1.4. Use of the Mental Health Act (1983)

11.1.4.1. Context

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

At any one time there are up to 15,000 people detained by the Mental Health Act. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.⁸⁷

The Department of Health summarises the Mental Health Act as follows:

“1. The main purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

2. Part 2 of the Act sets out the civil procedures under which people can be detained in hospital for assessment or treatment of mental disorder. Detention under these procedures normally requires a formal application by either an Approved Mental Health Professional (AMHP) [Formerly an Approved Social Worker, ASW] or the patient’s nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies....

⁸⁷ Mental Health Act Commission 12th Biennial Report. 2005-2007

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In addition a person can be detained under what are sometimes referred to as emergency sections: sections 5(2) and 5(4) of the Act. The Code of Practice describes these as follows:

“Section 5(2)

12.2 The power can be used where the doctor or approved clinician in charge of the treatment of a hospital in-patient (or their nominated deputy) concluded that an application for detention under the Act should be made. It authorises the detention of the patient in the hospital for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made....

12.8 Section 5(2) should only be used if, at the time, it is not practicable or safe to take the necessary steps to make an application for detention without detaining the patient in the interim. Section 5(2) should not be used as an alternative to making an application, even if it is thought that the patient will only need to be detained for 72 hours or less...”⁸⁸

The Mental Capacity Act (2005) states that “...everyone should be treated as able to make their own decisions until it is shown that they are not”. It also aims to enable people to make their own decisions for as long as they are capable of doing so. A person's capacity to make a decision will be established at the time that a decision needs to be made. A lack of capacity could be because of a severe learning disability, dementia, mental health problems, a brain injury, a stroke or unconsciousness due to an anaesthetic or a sudden accident. The Act also makes it a criminal offence to neglect or ill-treat a person who lacks capacity.⁸⁹

11.1.4.2. Findings of the Independent Investigation Team

Mr. W's was referred to Windsor House 6 July 2006 by his GP. He was described as being chronically depressed and having attempted suicide in the past. The GP reported that Mr. W had no current plans to commit suicide but that he might feel suicidal in the future.⁹⁰

Mr. W contacted the crisis line on 26 August 2006. He reported that he felt “*fed up*” and could not see a way out of his current situation.⁹¹ He was advised to attend the A&E Department. The staff tried on several occasions to contact Mr. W by telephone, when he failed to arrive at the A&E Department by 2.30 pm. The staff informed the Police.⁹² A letter

⁸⁸ Department of Health (2008) *Code of Practice: Mental Health Act 1983*

⁸⁹ National Archive.gov.uk

⁹⁰ Clinical notes Vol. 2 p 60

⁹¹ Clinical notes Vol. 9 p 444ff

⁹² Clinical notes Vol. 9 p 444

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from the A&E assessment team to Mr. W's GP reported that Mr. W had attended the A&E Department but he had left before he was assessed.⁹³

On 19 September 2006 Mr. W presented at the A&E Department where he was assessed by an Approved Social Worker and two Psychiatrists.⁹⁴ Mr. W reported that he was “*fed up with life*”; he claimed that had gone out to buy a gun to shoot himself but was mugged and his money was stolen.

Mr. W had been observed to be laughing and joking with friends when he had arrived at the A&E Department and he had asked to be assessed under the Mental Health Act. The assessors felt that Mr. W was under the influence of some unknown substance but Mr. W denied this.

“It was considered that he would benefit from referral to the local CMHT. Mr. [X] would undergo further assessment and identify issues i.e. self harm and self harm reduction”.

Mr. W, however, would not accept the referral to the CMHT. It was concluded that Mr. W was not detainable under the Mental Health Act. A diagnosis of Borderline Personality Disorder was recorded.⁹⁵ Following this assessment Mr. W tried to hang himself in the toilets of the A&E Department and was then admitted to hospital as a voluntary patient.⁹⁶

On 25 September 2006 the Specialist Registrar (SpR) attempted to assess Mr. W but was unable to complete the assessment as he appeared to be intoxicated.⁹⁷ The recorded plan was to assess Mr. W under the Mental Health Act if he wanted to leave the hospital.⁹⁸

On 26 September 2006 Mr. W asked to be discharged. He denied any thoughts of self harm. He complained that the focus of his treatment while in hospital had been on his drug misuse and he believed that this should not have been the case. Mr. W was assessed as being at risk of impulsive self harm. The on-call SHO, who had assessed Mr. W, discussed his assessment with the on-call SpR and it was agreed that it would be appropriate to detain Mr. W under Section 5(2) of the Mental Health Act (1983). This was discussed with Mr. W and he agreed to remain in hospital as an informal patient.⁹⁹

93 Clinical notes Vol. 10 p 501

94 Clinical notes Vol. 3 p 64

95 Clinical notes Vol. 3 p 64, Vol. 10 p 489

96 Clinical notes Vol. 2 p 77

97 Clinical notes Vol.2 p 75

98 Clinical records Vol. 3 p 149

99 Clinical notes Vol. 4 p 153

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Mr. W continued to request his discharge and as he was not detainable this was agreed to on 11 October 2006. However he was regarded as being at on-going risk of suicide.¹⁰⁰

11.1.4.3. Conclusions of the Independent Investigation Team

Mr. W presented on a number of occasions to the A&E Department following reports that he had tried to harm or kill himself. His girlfriend also reported on a number of occasions that she was concerned that he might kill himself. On 19 September Mr. W himself asked to be assessed under the Mental Health Act, however when he was assessed by a social worker and two psychiatrists he was not deemed to be detainable under the Act. While in hospital consideration was given to detaining Mr. W under an emergency section of the Mental Health Act, Section 5(2), as there was concern about his safety but he, again agreed to remain in hospital informally. As the clinical staff got to know Mr. W better they concluded that although he posed a significant risk to himself this was a manifestation of a personality disorder rather than an affective or psychotic disorder and as such it was not appropriate to detain him in hospital against his will. In her discharge letter to Mr. W's GP the SpR reported that Mr. W had requested his discharge and as he was not detainable under the Mental Health Act this was agreed to, though he continued to be at on-going risk of suicide.

The clinicians looking after Mr. W considered using the Mental Health Act, assessed him and found him not to meet the criteria for detention. They offered him on-going assessment and treatment on a voluntary basis. As they became more familiar with Mr. W's presentation and developed a clearer formulation of his problems they identified that Mr. W presented an on going risk to himself but concluded that he did not meet the criteria for detention under the Act. The Independent Investigation Team concluded that appropriate use was made of the Mental Health Act (1983).

11.1.5. The Care Programme Approach

11.1.5.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.¹⁰¹ Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care*

100 Clinical notes Vol. 1 p 32, GP records Vol. 2 p 20

101 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

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*Co-ordination in Mental Health Services: Modernising the Care Programme Approach to incorporate lessons learned about its use since its introduction and again in 2008 Refocusing the Care Programme Approach.*¹⁰²

*“The Care Programme Approach is the cornerstone of the Government’s mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services”.*¹⁰³ This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

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

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

The essential elements of any care programme include:

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

¹⁰² Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

¹⁰³ Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

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- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need. Currently service users in contact with secondary care with complex needs are placed on CPA, and service users in contact with secondary care services are placed on 'Standard Care'.

Mersey Care NHS Trust Policy

The Mersey Care NHS Trust's Operational Policy for CMHTs in force at the time of the incident stated:

"In 1999 the Department of Health published 'Effective Care Co-Ordination in Mental Health Services'. This policy called for the integration and rationalisation of the Care Programme Approach and Care management along with user and carer involvement in the assessment and care planning process. In response to this Mersey Care NHS Trust, Liverpool City Council, Sefton MBC, and local service users have developed a structure for the delivery of services in accordance with Effective care Co-ordination in 'Mental Health Services'. CMHT's will work within this Effective Care Co-ordination framework".¹⁰⁴

11.1.5.2. Findings of the Internal Investigation Team

CPA

The Internal Investigation concluded:

"9.10 The designation of C.P.A., under which [Mr. W] was placed was in accord with Mersey Care NHS Trust protocols in place at that time. However, as a complex patient under assessment for mental illness, with a history of poor engagement, enhanced C.P.A, would have been the most appropriate designation, rather than the standard level at which he was, eventually, designated and consideration should be given to reviewing existing E.C.C. protocols".

104 Mersey Care NHS Trust (2002) Operational Policy for Community Mental Health Teams, p. 2

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“7.6 It is concluded that the service’s inability to obtain a full and precise history of [Mr. W], to enhance his care plan, was caused by three elements:

- The chaotic nature of [Mr. W’s] lifestyle and his constant disengagement from services, together with him being evasive and giving varying accounts of his background history when questioned*
- [Mr. W’s] movement between services providers, both statutory and non-statutory*
- The volume of service users coming into contact with mental health services via the A&E department of [the Royal Liverpool University Hospital] (250 reported contacts in January 2007 and 250 reported contacts in December 2006) puts undue pressure on staff members...*

8.6 ...It is of concern to note that, during one ward round, whilst [Mr. W] was a patient at Windsor House, on 23rd October 2006, Mr. W was not, given the opportunity to discuss his feelings with purely his presentation being noted. This is considered to have been a missed opportunity to look at the reasons behind his actions, rather than just ‘plan to’...

9.4 ...A number of care services were involved with [Mr. W], across the NHS; at least one non-statutory organisation and the police and probation services. At the time [Mr. W] was engaging with Mersey Care NHS Trust, involvement of others was not always known or his history pursued and, therefore, there was little or no comprehensive information available to aid his care and treatment plan”.

11.1.5.3. Findings of the Independent Investigation Team

CPA and Care Planning

Level of CPA

The Internal Investigation noted that Mr. W was placed on the standard level of CPA and while this was compliant with the Trust policy of the time given that Mr. W was *“a complex patient under assessment for mental illness, with a history of poor engagement, enhanced C.P.A, would have been the most appropriate designation”.*

The Independent Investigation is in agreement with the Internal Investigation. Mr. W would have been most appropriately placed on enhanced CPA. However the Independent Investigation Team did not have access to the CPA policy in force at that time and so is not in

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a position to comment on the Internal Investigations observation that “*consideration should be given to reviewing existing E.C.C. protocols*”.

Unfortunately the Internal Investigation did not reference their observation that Mr. W had been placed on the standard level of CPA. In the documentation made available to the Independent Investigation it would appear that when Mr. W was discharged from his in-patient admission on 11 October 2006 he was recorded as being placed on enhanced CPA, a care co-ordinator was identified, a seven-day follow up out-patient appointment was made for Mr. W to be reviewed by the SpR and it was recorded that he had an appointment with the Newton-le-Willows Community Drug Team on 12 October 2006.¹⁰⁵ The ‘Discharge Follow-up Plan’ form recorded that an enhanced care plan had been issued on discharge. However, there was no evidence of a formal care plan, recorded on Trust forms, in the records available to the Independent Investigation, nor a copy of any documentation which might have been given to or signed by Mr. W.

Assessment and Care Planning

Mr. W was assessed under the Mental Health Act when he presented to the A&E Department on 19 September 2006. There are three accounts of this assessment in Mr. W’s clinical notes. In addition to Mr. W’s current symptomatology his personal and mental health history and his social circumstances were recorded. Mr. W was not deemed to be detainable under the Act and the plan suggested to him at this time was that he would be referred to the CMHT so that a fuller assessment could be undertaken and appropriate services to meet his needs put in place. However, Mr. W was not in agreement with this course of action and, following him attempting to hang himself in the toilets of the A&E Department, he was admitted to the Broadoaks Unit as a voluntary in-patient.

Mr. W was an in-patient from 19 September until 11 October 2006. By the 22 September Mr. W was reporting that his mood had improved and was asking for leave from the ward.¹⁰⁶ On the 24 September 2006, following discussion with Mr. W’s Consultant Psychiatrist, as there was no evidence of suicidal ideation it was agreed that he should have a half hour leave from the ward twice a week.¹⁰⁷

105 Clinical notes Vol. 1 p. 38

106 Clinical notes Vol. 3 p 146

107 Clinical notes Vol. 2 p 75

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An initial care plan was recorded in Mr. W's clinical notes on 21 September 2006. This recorded that:

- an appointment should be made for Mr. W with the Citizens Advice Bureau;
- that background information should be obtained for the Criminal Justice Service and from his old notes;
- that contact should be made with the Community Drugs Team;
- that Mr. W's partner should be seen;
- that consideration should be given to commencing antidepressant medication; and
- that Mr. W should be placed on level 2 observations with the agreement of the nursing staff.

The next care plan recorded in the notes available to the Independent Investigation Team was for the 25 September 2006. This plan recorded that Subutex was to continue to be prescribed for Mr. W and he was to be nursed on level 4 observations. The longer-term aims were: detoxification and to reduce the frequency of Mr. W's crisis presentations.¹⁰⁸ There is no record of what actions the clinical team intended to take to achieve these aims.

The Specialist Registrar (SpR) attempted to continue her assessment of Mr. W on 25 September but this proved to be impossible as he appeared to be intoxicated.¹⁰⁹ She did, however, obtain some information about his history and personal circumstances. Following this aborted assessment the recorded plan was to assess Mr. W under the Mental Health Act if he wanted to leave the hospital.¹¹⁰ The next day Mr. W complained that that the focus of his treatment was on his drug misuse and he believed that this should not have been the case. He asked to be discharged and attributed his previous low mood to relationship difficulties but said that these had now been resolved. He denied any thoughts of self harm. Mr. W was assessed as being at risk of impulsive self harm and consideration was given to detaining him under Section 5(2) of the Mental Health Act (1983), however he agreed to remain in hospital as an informal patient.¹¹¹

Three days later, 29 September 2006, the SpR met Mr. W together with his girlfriend. The SpR sought corroboration of some of the information Mr. W had given about his history and it was agreed that:

108 Clinical notes Vol. 2 p 70

109 Clinical notes Vol.2 p 75

110 Clinical records Vol. 3 p 149

111 Clinical notes Vol. 4 p 153

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- Mr. W's care would be transferred to Windsor House because it was felt that the therapeutic relationship with the staff on Greenbank ward had broken down;
- he would stay with his girlfriend at weekends;
- there would be a period of stabilisation before he was discharge.¹¹²

The next care plan recorded for Mr. W was on 3 October 2006. This plan was to:

- reduce Mr. W's Buprenorphine to 10mg daily;
- continue his current care plan;
- confirm with the Substance Misuse Service how Buprenorphine shows up in urine.¹¹³

On 7 October 2006 Mr. W's girlfriend informed the ward staff that Mr. W had been attacked and left in the grounds of the cathedral whilst on leave. He had been taken to the general hospital.¹¹⁴ The SpR assessed Mr. W on the 9 October 2006 Mr. W following his return to the ward.¹¹⁵

Mr. W was reviewed at a ward round on 10 October 2006. It was reported that he had cut his arms the previous evening but was refusing to let staff see the wounds. He denied any ongoing thoughts of self harm. Mr. W said that he would be interested in counselling and it was suggested that he might be referred to the Rotunda Psychotherapy Service which would provide psychotherapy one day a week for one year.

The plan agreed was that:

- Mr. W could go on leave to his girlfriend;
- Mr. W would be discharged next day, 11 October, subject to arrangements being made to continue his Buprenorphine prescription;
- Mr. W would attend the ward daily for medication until he was discharged.¹¹⁶

Mr. W was discharged on the 11 October 2006 and given an appointment to see the SpR on 16 October 2006.¹¹⁷ In the discharge summary for this admission Mr. W's diagnosis was recorded as: Emotionally Unstable Personality Disorder. It was recorded that he had been admitted as an informal patient because of an increase in his self harming behaviour.

112 Clinical notes Vol. 4 p 157ff, Vol. 5 p 205

113 Clinical notes Vol. 4 p 163, Vol. 5 p 208

114 Clinical notes Vol. 5 p 210

115 Clinical notes Vol. 4 p 165

116 Clinical notes Vol. 4 p 175, Vol. 5 p 213

117 Clinical notes Vol. 1 p 23, 38

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“During the in-patient admission it became clear that there were few consistent signs of depression and the main factors were the chaotic elements of [Mr. W’s] life style such as the outstanding debts and his up and down relationship with his girlfriend”.

Mr. W had requested his discharge and as he was not detainable this was agreed to. However at the time of his discharge from hospital he was regarded as being at on-going risk of suicide.¹¹⁸

Mr. W attended his appointment on 16 October 2006 at the insistence of his girlfriend. He denied having any suicidal thoughts but requested a referral for detoxification. He was informed that a referral was not needed as he could refer himself to the community detoxification programme. Mr. W was given some information about the Rotunda psychotherapy group.¹¹⁹ The plan recorded was:

- to follow Mr. W up in one month;
- to send him information about the Rotunda psychotherapy group;
- Mr. W was to refer himself to Gateway for home detoxification.¹²⁰

Assessment

Mr. W was effectively under the care of Mental Health Team only from 19 September 2006 to 16 October, approximately a month, although he was not discharged until January 2007.

The Mental Health Act assessment was appropriately conducted on 19 September 2006 and did identify historic factors and Mr. W’s social circumstance. However the function of a Mental Health Act assessment is primarily to determine whether it is appropriate and in the best interests of an individual to be compulsorily detained for the purposes of assessment and treatment; it is not to assess the needs of the individual in a comprehensive manner. In contrast this comprehensive approach to identifying needs and putting in place interventions to meet those identified needs is the focus of the CPA process. The comprehensive nature of the assessment and care plan, especially for those individuals on enhanced CPA, usually requires multi-disciplinary involvement.

During the month Mr. W was an in-patient the SpR met and assessed Mr. W on a number of occasions. She also met Mr. W’s girlfriend on at least two occasions during that month.

118 Clinical notes Vol. 1 p 32, GP records Vol. 2 p 20

119 Clinical notes Vol. 5 p 222

120 Clinical notes Vol. 10 p 487

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Again the SpR collected information on Mr. W mental state, personal and mental health history and social circumstances.

However, at least within the clinical records available to the Independent Investigation, no Trust CPA assessment forms were completed. The aim of these would have been to structure the assessment to ensure comprehensiveness and facilitate the development of a care plan. (Trust risk assessments were completed and these will be discussed below in the section on risk)

In the discharge summary dated 25 October 2006 the SpR did provide a clear structure for her assessment: circumstances leading to admission, psychiatric history, personal history, social history, forensic history, premorbid personality, and progress while on the ward. However, while this is a useful and traditional way of organising information on its own it does not reflect a comprehensive assessment of need.

11.1.5.3. Conclusion

There was on-going assessment, particular by the SpR, and much of the information one would have expected to be available was collected. However, this was not organised or recorded within the notes in a manner that reflected the comprehensive and multi-disciplinary assessment which characterises CPA.

Care planning

Six care plans are recorded in Mr. W's notes:

Initial Care Plan: 21 September 2006

- an appointment should be made for Mr. W with the Citizens Advice Bureau;
- that background information should be obtained for the Criminal Justice Service and from his old notes;
- that contact should be made with the Community Drugs Team;
- that Mr. W's partner should be seen;
- that consideration should be given to commencing antidepressant medication; and
- that Mr. W should be placed on level 2 observations with the agreement of the nursing staff.

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Care plan 2: 25 September 2006

- Subutex was to continue to be prescribed for Mr. W;
- he was to be nursed on level 4 observations;

Longer term aims:

- detoxification and reduction of Mr. W's crisis presentations.¹²¹

However there is no record of what actions the clinical team intended to take to achieve these longer-term goals.

Care Plan 3: 29 September 2006

- Mr. W's care was to be transferred to Windsor House because it was felt that the therapeutic relationship with the staff on Greenbank ward had broken down;
- he was to stay with his girlfriend at weekends;
- there would be a period of stabilisation before he was discharge.¹²²

Care plan 4: 3 October 2006

- reduce Mr. W's Buprenorphine to 10mg daily;
- continue his current care plan;
- confirm with the drug service how Buprenorphine shows up in urine.¹²³

Care plan 5: 10 October 2006

- Mr. W could go on leave to his girlfriend;
- Mr. W was to be discharged the next day, 11 October, subject to arrangements being made to continue his Buprenorphine prescription;
- Mr. W would attend the ward daily for medication until he was discharged;
- the SpR would discuss a possible referral to the Rotunda psychotherapy service with Mr. W;¹²⁴
- Mr. W was given an follow-up appointment with the SpR for the 16 October 2006.

Care plan 6: 16 October 2006

- to follow Mr. W up in one month at an out-patient appointment;
- to send Mr. W information on the Rotunda psychotherapy service;

121 Clinical notes Vol. 2 p 70

122 Clinical notes Vol. 4 p 157ff, Vol. 5 p 205

123 Clinical notes Vol. 4 p 163, Vol. 5 p 208

124 Clinical notes Vol. 4 p 175, Vol. 5 p 213

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- Mr. W was to refer himself to Gateway for community detoxification.¹²⁵

That six care plans were drawn up in the space of a little over a month shows a degree of conscientiousness, however none of the plans display the typical structure of a CPA care plan characterised by: identification of need, identification of goals that would meet the need, identification of actions to meet the need/attain the goal, evaluation of progress and revising of the goal. Perhaps this is because the plans were not recorded on Trust CPA forms.

The plans are not comprehensive and multidisciplinary, rather they deal, predominantly, with the immediate issues for providing care and maintain the safety of Mr. W.

General Conclusion

The Internal Investigation observed that Mr. W was placed on standard CPA and it would have been more appropriate if he had been placed on enhanced CPA. We noted above that the documentation available to the Independent Investigation records that he was placed on enhanced CPA. However, we would agree with the Internal Investigation that the unidisciplinary nature of the on-going involvement with Mr. W and the focus on monitoring his symptomatology is more characteristic of standard CPA than an enhanced CPA care plan. Nevertheless the Department of Health in its *Refocusing the Care Programme Approach* (2008) guidance said:

*“It is clear that all service users should have access to high quality, evidence-based mental health services. For those requiring standard CPA it has never been the intention that complicated systems of support should surround this as they are unnecessary. The rights that service users have to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be good practice for all”.*¹²⁶

Four issues were identified by the clinical team caring for Mr. W:

- his impulsive self-harming behaviour and his frequent presentations to the A&E department at times of crisis;
- his chaotic life style;
- his relationship with his girlfriend;
- his misuse of drugs.

¹²⁵ Clinical notes Vol. 10 p 487

¹²⁶ Department of Health (2008) *Refocusing the care Programme Approach: Policy and positive Practice Guidance*. p 11

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In the context of the Care Programme Approach it would have been good practice to have held a multidisciplinary meeting, involving the substance misuse team and perhaps a representative from the Personality Disorder Service, when Mr. W's discharge was being planned, and to draw up a co-ordinated plan agreed with Mr. W and his girlfriend. This plan should have been comprehensive enough to address the issues identified by the clinical team.

The Independent Investigation took note of the observations made during interviews with clinical witness that given Mr. W's apparent poor motivation to engage with services and his history of poor collaboration with the services offered to him it was felt that it would be most appropriate to put in place a relatively undemanding programme of interventions. If Mr. W then appeared to be motivated to address his problems a more comprehensive range of services and interventions could have been introduced as appropriate. The Independent Investigation concluded that this was not an unreasonable approach given their assessment of Mr. W's problems and his history of poor engagement with services. Nevertheless, a more comprehensive CPA review meeting might have provided an opportunity to integrate the delivery of mental health and substance misuse services and to explore how services might have been best delivered to an individual identified as having personality and substance misuse problems. This was a missed opportunity.

Service Issue 4

A more comprehensive CPA review meeting might have provided an opportunity to integrate the delivery of mental health and substance misuse services and to explore how services might have been best delivered to an individual identified as having personality and substance misuse problems. This was a missed opportunity.

11.1.6. Risk Assessment

11.1.6.1. Context

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

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

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

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

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

Best Practice in Managing Risk (DoH June 2007) states that “*positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach ... any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed*”.¹²⁷

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

¹²⁷ Best Practice in Managing Risk; DoH; 2007

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

11.1.6.2. Findings of the Internal Investigation

“9.4 A number of care services were involved with [Mr. W], across the NHS; at least one non-statutory organisation and the police and probation services. At the time [Mr. W] was engaging with Mersey Care NHS Trust, involvement of others was not always known or his history pursued and, therefore, there was little or no comprehensive information available to aid his care and treatment plan.

9.5. There was some doubt expressed that [Mr. W's] initial risk assessment asked appropriate questions, to highlight past history, with particular regard to his criminal record. It is acknowledged that [Mr. W] was not always willing to divulge information, and when he did so it was often contradictory. However, it is unfortunate that when information was identified it was not always passed on or recorded.

9.6. Overall there was no available evidence of [Mr. W] being at risk of harming others, during his assessment, whilst engaging with Mersey Care NHS Trust. There were, however, indications of him displaying manipulative behaviour at times. However this review has highlighted that his criminal record included acts of violence although it is acknowledged that his care team was not privy to this information”.

“9.9. The rationale behind granting [Mr. W] leave from Greenbank Ward was not clearly documented in an easily accessible way. There was no clear indication, in the documentation, of a contingency plan, should leave go awry. There was no clear documentation of any understanding of the antecedents of potential harm to self or others, which ought to be made explicit prior to granting leave. This was important, as [Mr. W] was granted unescorted

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leave within two or three days of an ostensibly serious self-ligature attempt. Leave was not discussed with [Mr. W's] partner or carer prior to it being granted".

"10.3. When assessing [Mr. W's] risk to others, there was little or no background information known, at that time which could indicate any significant risk to others being posed by [Mr. W]. This included risk to women. The main concern from all services was of self-harm. The alleged homicide involving [Mr. W] could not, therefore have been predicted by staff involved in his care. Nor, with the information available was it appropriate for a referral to be made to the Mersey Forensic Psychiatry Service".

11.1.6.3. Findings of the Independent Investigation Team

Forensic history and risk posed to others.

Mr. W was known to have served a number of prison sentences. At the time of his first assessment by the Substance Misuse Services it was known that Mr. W had been released from Armley Prison, Leeds in August 2001. The Prison Services recorded that he was abusing: heroin, cocaine and Diazepam but the reason for Mr. W imprisonment was not recorded.¹²⁸

Mr. W was known to have spent a week in Wormwood Scrubs (prison) in October 2004 prior to starting a detoxification programme at the Kevin White Unit.¹²⁹ During his assessment for this programme Mr. W reported that he had had two psychiatric admissions whilst in prison, in Stoke and in London. Mr. W was in prison from 7 January to 9 February 2005.

The ward staff were in contact with the Criminal Justice Liaison Team on 6 October, when Mr. W was an in-patient, as he was due in Court that day in connection with his driving offences. Mr. W was convicted of driving while disqualified at Liverpool Magistrates Court in 14 December 2006.¹³⁰

Mr. W's girlfriend reported that he had served a number of prison sentences but no further information is recorded in the clinical notes.

128 GP record Vol. 1 p 23 of 33

129 Clinical notes Vol. 3 p 127

130 Clinical notes Vol. 7 p 325; GP record Vol. 2 p 47

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When he was assessed for a community detoxification programme in Liverpool in September 2004 Mr. W denied that any of his convictions had been associated with violence.¹³¹

This appears to have been all that was known about Mr. W's forensic history by those providing care and treatment for him.

The staff of the Kevin White Unit noted in October 2004 that Mr. W had been verbally abusive to both staff and other patients¹³² however, other than this there appears to have been no information available to the clinical staff caring for Mr. W that he posed a danger to others.

Risk from Others

It was recorded during Mr. W's assessment in September 2004 that he had some facial reconstruction in the 1990's following him being beaten up in Manchester.¹³³ When he was assessed on 19 September 2006, prior to his admission to hospital, Mr. W was identified as being at risk from others as a result of his debts.¹³⁴ In the nursing notes two days later it was recorded that he had sold the same car to different people at the same time in Toxteth and wanted to avoid this area.¹³⁵

Mr. W reported that whilst on weekend leave from the ward, on 7/8 October 2006, he was abducted. He was forced into a car, his neck and feet were tied and he was left in the grounds of the cathedral. He was found by member of the public and taken to the general hospital where he was admitted over night.¹³⁶ ¹³⁷ Mr. W's girlfriend informed the ward staff that a gang of men had been threatening Mr. W and herself over recent weeks. The Police were aware of the situation.¹³⁸

When Mr. W was reviewed by the SpR following his discharge from hospital in October 2006, his girlfriend reported that Mr. W felt unsafe following his kidnapping; he appeared

131 Clinical notes Vol. 8 p 356ff

132 Clinical notes Vol. 9 p 425

133 Clinical notes Vol. 8 p 356

134 Clinical notes Vol. 10 p 505, Vol. 2 p 81

135 Clinical notes Vol. 3 p 142

136 Clinical notes Vol. 5 p 210

137 Clinical notes Vol. 4 p 165

138 Clinical notes Vol. 5 p 211

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pre-occupied and did not feel safe when he went out. However, “*He denied any suicidal or homicidal ideation*”, and was not reporting any hallucinations or delusions.¹³⁹

When Mr. W presented to the A&E Department on 20 October 2006 he reported that he had been kidnapped and left for dead in a ditch. He was discharged to the Police so that his kidnap and attempted murder claims could be investigated. It was noted: “*Police feel his allegation of kidnapping was query an elaboration on [Mr. W’s] part this does not however appear to be a delusion*”.¹⁴⁰

Risk to self

When Mr. W was admitted to the Kevin White Unit in October 2004 he reported that he had tried to hang himself in 2002, “*the first time [he had] ever withdrawn [from drug]s*”, and at Christmas 2003 he had tried to kill himself by injecting heroin. He was not assessed nor admitted to hospital on this occasion. In November 2004 Mr. W attended the KWU in a distressed state. He reported that he was feeling suicidal and his partner was worried for his safety. However Mr. W said that he would not harm himself and he had an appointment to see his GP the next day.¹⁴¹

Mr. W married in August 2005 whilst working in Majorca and the Caribbean. He returned to England to sort out his finances, however when he returned to Spain he found that his wife had met someone else. He cut his wrists and was taken to a hospital in Spain.¹⁴²

In July 2006 Mr. W was referred to mental health services by his GP. He was described as being chronically depressed and having attempted suicide in the past. The GP reported that Mr. W had no current plans to commit suicide but that he might feel suicidal in the future.¹⁴³

In August 2006 Mr. W contacted the KWU. He reported that the previous Friday he had tried to kill himself by driving into a wall. He had been questioned by Police but had not disclosed his intention to kill himself. He reported that he was “*devastated*” to be alive. He said that he felt “*fed up*” and could not see a way out of his current situation.¹⁴⁴ He had taken 6 x 12mg Subutex tablets and 6 x 15mg Diazepam with the intention of ending his life. Mr. W agreed to attend the A&E Department and when he failed to arrive the staff telephoned him and

139 Clinical notes Vol. 10 p 487

140 Clinical notes Vol. 1 p 47

141 Clinical notes Vol. 7 p 323

142 Clinical notes Vol. 9 p 444

143 Clinical notes Vol. 2 p 60

144 Clinical notes Vol. 9 p 444ff

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spoke to his girlfriend who said that he had not returned home but that he would be attending the A&E Department. As he had still not arrived at A&E Department by 2.30 and they were unable to contact him by telephone the A&E team informed the Police and asked them to check Mr. W's welfare.¹⁴⁵

A letter from the A&E assessment team to Mr. W's GP reported that Mr. W had attended the A&E department on 29 August 2006 but he had left before he was assessed.¹⁴⁶

On 2 September 2006 Mr. W was referred to the Crisis Team at 23.00 hours with thoughts of suicide. His girlfriend said that he had thoughts of hanging himself. Mr. W was telephoned at home and said that he had been to the A&E Department but was too tired to wait to be assessed. He denied any current thoughts of suicide or harming others.¹⁴⁷

On 5 September 2006 Mr. W was admitted to a medical assessment ward following an alleged overdose of Paracetamol, Diazepam and Subutex. Whilst on the ward he informed the staff that he had taken a further overdose of Paracetamol. The Crisis Team were unable to complete their assessment because Mr. W appeared sedated. Their plan was to inform Mr. W's GP and the Consultant who Mr. W had informed them was responsible for his care.¹⁴⁸

On 19 September 2006 Mr. W presented at the A&E Department and a Mental Health Act assessment was conducted.¹⁴⁹ Mr. W reported that he was "*fed up with life*"; he claimed that he had gone out to buy a gun to shoot himself but was mugged and his money was stolen. Mr. W reported that his mood was low but he had no suicidal ideas. It was concluded that Mr. W was not detainable under the Mental Health Act,¹⁵⁰ however following this assessment Mr. W tried to hang himself in the toilets of the A&E Department and was then admitted to hospital as a voluntary patient.¹⁵¹

A risk assessment at this time recorded that Mr. W was at risk from others as a result of his debts. The risk he posed to himself was rated as moderate to high; risk to others was rated as low to moderate and risk of neglect was rated as low to moderate.¹⁵² In a further assessment

145 Clinical notes Vol. 9 p 444

146 Clinical notes Vol. 10 p 501

147 Clinical notes Vol. 9 p 445

148 Clinical notes Vol. 3 p 113, GP record Vol. 2 p 30

149 Clinical notes Vol. 3 p 64

150 Clinical notes Vol. 3 p 64, Vol. 10 p 489

151 Clinical notes Vol. 2 p 77

152 Clinical notes Vol. 10 p 505, Vol. 2 p 81

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on the same day Mr. W's risk to himself was rated as moderate, risk to others rated as: "appears low" and risk of self neglect: "appears low".¹⁵³

Although by 22 September 2006 Mr. W was reporting that his mood had improved and he was requesting leave from hospital, his girlfriend believed that he was depressed and would kill himself if given the opportunity.¹⁵⁴ It was decided that if Mr. W wanted to leave hospital he should be assessed under the Mental Health Act.¹⁵⁵ On 26 September 2006 he was assessed by the on-call SHO who discussed his assessment with the on-call SpR and it was decided that Mr. W could be detained under Section 5(2) of the Act because he was at risk of impulsively harming himself. However, when this was discussed with Mr. W, he agreed to remain in hospital as an informal patient.¹⁵⁶

On 10 October 2006 it was reported that Mr. W had cut his arms the previous evening but was refusing to let staff see the wounds. At this time the clinical team concluded that Mr. W was not depressed but that he was manifesting personality difficulties.¹⁵⁷ He was discharged from hospital at his request although he was regarded as being at on-going risk of suicide.¹⁵⁸

At his out-patient review on 16 October 2006 "[Mr. W] denied any suicidal or homicidal ideation".¹⁵⁹ However on 20 October 2006 he presented at the A&E Department saying that he was suicidal. He reported that he had tried to inject air into his vein. However when assessed he denied that he had any current plans for suicide.

There is an undated Threshold Assessment Grid (PRISM) form in Mr. W's clinical records which appears to have been completed at this assessment. This records:

- Intentional Self Harm: no concerns about risk of deliberate self harm or suicide attempts;
- Unintentional Self Harm: no concerns about unintentional risk to physical safety;
- Risk from Others: minor concerns about risk of abuse or exploitation from other individuals; or society;
- Risk to Others: no concerns about risk of physical safety or property of others;
- Survival: no concerns about basic amenities, recourses or living skills;

153 Clinical notes Vol. 3 p 139, Vol. 4 p 181

154 Clinical notes Vol. 4 p 197

155 Clinical records Vol. 3 p 149

156 Clinical notes Vol. 4 p 153

157 Clinical notes Vol. p 175, Vol. 5 p 213

158 Clinical notes Vol. 1 p 32, GP records Vol. 2 p 20

159 Clinical notes Vol. 10 p 487

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- Psychological: minor concerns or distressing problems with thinking feeling or behaviour;
- Social: minor disabling problems with activities or in relationships other people.¹⁶⁰

At the time of his Court hearing, on 11 December 2006, Mr. W was assessed by a nurse in the Criminal Justice Liaison Team. She concluded: “*There was no evidence to suggest aggressive or violent behaviour*”.¹⁶¹

Mr. W was found hanged in his prison cell on 4 August 2009.

Reliability of the information available to those assessing Mr. W

Much of the information available to those caring for Mr. W was his own report of events, although the SpR did meet his girlfriend on at least two occasions and she was able to corroborate some of what he had reported. Mr. W was not a reliable historian and there are a number of examples in the clinical notes of Mr. W refusing to provide information when being assessed, as well as a number of examples of Mr. W being less than accurate when questioned. Perhaps the most striking example of Mr. W’s lack of candour was when he informed the Criminal Justice Liaison Team Nurse, and via her the Court, that he had seen a psychiatrist a few days earlier and discussed starting anti-depressant medication and that he was attending weekly group therapy. None of this was true. He also reported that he was illicit drug free. In the light of subsequent events this seems unlikely.

A further example of Mr. W’s lack of candour is his denial, in October 2004 when he was admitted to the KWU, that he had been prescribed Methadone. His GP had been prescribing 20ml of Methadone daily;¹⁶² in September 2006 Mr. W denied drug dependency although it was noted that he was under the care of the Drug Services;¹⁶³ when he was assessed in October 2006 it was noted that Mr. W “*was inconsistent throughout the assessment and economical with what he stated during the assessment*”;¹⁶⁴ in December 2006 Mr. W was brought into the A&E Department, he denied using any drugs other than those he was prescribed and denied using alcohol.¹⁶⁵

160 Clinical notes Vol. 1 p 26

161 Clinical notes Vol. 1 p 17

162 Clinical notes Vol. 3 p 127

163 Clinical notes Vol. 3 p 64

164 Clinical notes Vol. 1 p 25

165 GP records Vol. 2 p 15

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11.1.6.4. Conclusions of the Independent Investigation Team

Although it was known that Mr. W had served a number of prison sentences the nature of his offences was not known to those caring for Mr. W. The Internal Investigation observed:

*“Obtaining a reliable forensic history was difficult throughout this case. Again, the importance of this could be stressed within the E.C.C. policy and reinforced to practitioners. This needs to include indicators as to when a forensic history should be sought, via the Criminal Justice Liaison Team, i.e. what is the basis of the ‘need to know’, in terms of risks”?*¹⁶⁶ The Independent Investigation agrees with this recommendation. With the benefit of hindsight one might argue that those assessing the risk Mr. W posed might have sought information on his offending history especially as he, himself, was noted to be reluctant to provide this information and was known to be less than candid when providing information to those assessing him. However, it has to be noted that Mr. W was effectively under the care of the mental health services for a little over a month. He presented in crisis and the immediate risk which the clinical team had to deal with was Mr. W’s attempt to harm himself. When he was assessed at the time of his admission to hospital the risk of him harming others was perceived as being low. During his in-patient admission the SpR met Mr. W’s girlfriend on at least two occasions, although there is no record of the SpR asking her about either Mr. W’s likelihood of harming others or whether he had a history of violence, it is clear from the clinical notes that she, like the clinical team, perceived the major risk that Mr. W posed was to himself.

Indeed, rather than posing a risk to others Mr. W was perceived as being at risk from others because of his drug habit and the social context in which he moved. He claimed, on two occasions, that he had been abducted by drug dealers, although on one of these occasions it was recorded that the Police believed that he might have elaborated what had happened.

Adequacy of risk assessment

When Mr. W was initially in contact with the Substance Misuse Services in Liverpool they employed their own assessment protocols which focused, not unreasonably, on Mr. W’s history of drug misuse. At least in the notes available to the Independent Investigation there is no record of a more comprehensive assessment being conducted.

¹⁶⁶ Mersey Care NHS Trust (2007) Internal review into the Care and Treatment of Mr. W

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When Mr. W was assessed on 19 September 2006 prior to him being admitted to hospital the Trust's Effective Care Co-ordination Risk Assessment form was employed and when he was assessed on the 20 October 2006 a Threshold Assessment Grid (PRISM) form was employed. While no risk assessment device is ideal for all situations and while it is acknowledged that risk assessment has to be both on-going and dynamic it would have been helpful to those assessing and monitoring Mr. W if some common device had been used both across services and across time.

As time past a familiar pattern emerged in Mr. W's presentation. He tended to present to emergency services, mainly the A&E Department, at times of crisis, however when he was assessed he would report that the crisis had passed and he no longer felt suicidal. Indeed on some occasions he did not even wait to be assessed having presented at the A&E Department. This was the pattern when he presented to the A&E Department on 19 September 2006 and was admitted to hospital. Within two days of being admitted he was reporting that his mood had improved and he wanted to go on leave from the ward. The clinical staff were appropriately cautious about such a rapid recovery and considered detaining him under the Mental Health Act as they considered him to be at risk of harming himself. This was a view shared by his girlfriend. However after observing Mr. W for some time the clinical team came to the conclusion that while he did continue to present an on-going risk of impulsive self harm this was a manifestation not of depression but of a personality disorder and it would not be in Mr. W's best interests for him to remain in hospital indefinitely. The result of this on-going risk assessment was that Mr. W was at risk of impulsively harming himself and this risk would be best dealt with by addressing Mr. W's personality difficulties.

Contingency Planning

The Internal Investigation observed that there was no clear rationale recorded for allowing Mr. W to have leave from the ward within days of him being admitted and there was no documented understanding of the antecedents of his self-harming behaviour.

The Independent Investigation Team agrees with the Internal Investigation that given Mr. W's known propensity to harm himself impulsively, before granting him unescorted leave from the ward it would have been good practice to have identified the antecedents or triggers for this behaviour and agreed with Mr. W, and with his agreement his girlfriend, a contingency plan to address these. It is a moot point as to whether Mr. W would have

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complied with any plan once it was agreed but this could have been taken into account in the plan itself and been an early step in addressing his impulsivity and personality difficulties.

11.1.7. Service User Involvement in Care Planning

11.1.7.1. Context

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

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

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *“people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care”*. It also stated that it would *“offer choices which promote independence”*.

11.1.7.2. Findings of the Internal Investigation

“8.6 It is of concern to note that, during one ward round, whilst [Mr. W] was a patient at Windsor House, on 23rd October 2006, Mr. W was not, given the opportunity to discuss his feelings with purely his presentation being noted. This is considered to have been a missed opportunity to look at the reasons behind his actions, rather than just ‘plan to’”.

11.1.7.3. Findings of the Independent Investigation Team

Mr. W was an in-patient from 19 September 2006 to 11 October 2006. He transferred from the Broadoaks Unit to Windsor House on 2 October 2006. The Independent Investigation was unable to identify the incident on 23 October 2006 referred to by the Internal Investigation and so is unable to comment on it.

It is common practice to ask the service user to sign his/her care plan as a method of recording that s/he has been involved in the assessment of needs and the drawing up of the care plan. However as has been noted above there are no care plans recorded on Trust forms

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in the clinical notes made available to the Independent Investigation and so no formal record of Mr. W's involvement in the assessment of his needs or his care planning. However it is evident from the clinical notes that, to a significant degree, Mr. W controlled the care he received. He presented himself to the Substance Misuse Services and the Crisis Service and appears to have been clear what he wanted from these services when he presented. Having accessed services at times of crisis he frequently disengaged before consistent, constructive follow up could be organised. In September 2006 he presented at the A&E Department asking to be admitted to hospital, apparently under the Mental Health Act, when he was deemed not to be detainable he proceeded to try to hang himself in the toilets of the department thus ensuring that he was admitted. Soon after he was admitted to hospital he was vocal in asking for leave and, it appears, he left the ward on a number of occasions without informing the staff. Following his discharge from hospital Mr. W attended only one follow up appointment and, by his own admission, this was at the insistence of his girlfriend and so again Mr. W effectively controlled the care and support that was provided to him.

11.1.8. Carer Involvement and Carer Assessment

11.1.8.1. Context

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

Carer Involvement

The recognition that all carers, including carers of people with severe and/or enduring mental health problems, has received more attention in recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for carers who provide a

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substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensures that services take into account information from a carer assessment when making decisions about the cared for persons' type and level of service provision required.

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

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

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

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

11.1.8.2. Findings of the Internal Investigation

“7.4 [Mr. W's] partner was a stabilising and constant influence, and supported [Mr. W] throughout his contact with services. It is of concern that a member of the care team did not, formally, engage with her, as is good practice within the E.C.C. This is not felt, however, to be a causative factor to the alleged incident.

7.5 [Mr. W] was often reluctant to provide a full history to the care team. He often contradicted himself and it is noted on several occasions, in the medical record, that he was evasive and changed his account of his prevailing condition and circumstances. It is the Review Team's view that he should have been challenged, in this regard, and the information provided cross-referenced and clarified. Again, this is not felt to be a causative factor to the alleged incident”.

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11.1.8.3. Findings of the Independent Investigation Team

As the Internal Investigation observed Mr. W's girlfriend appears to have been a stabilising influence on him during the time he was in contact with the mental health services. She was at times also his advocate and, it would appear from the clinical notes, was forceful in putting forward her views and making known her concerns about the risk Mr. W posed to himself.

Whilst he was an in-patient the SpR saw Mr. W's girlfriend on at least two occasions and she was present at the ward round immediately prior to Mr. W being discharged and so was party to the planning of his on-going care. It would appear then that, at least during the period when he was an in-patient, Mr. W's girlfriend was appropriately involved in his care.

Despite her intimate involvement in Mr. W's care his girlfriend was not offered her own carer's assessment. However, as has been noted a number of times above, he was under the care of the mental health services for only a very brief period and once he was discharged from hospital he rapidly disengaged from the services with the result that contact with his girlfriend was also lost. Given this situation it is not surprising and may not have been inappropriate that she was not offered her own carer's assessment

11.1.9. Documentation and Professional Communication

11.1.9.1. Context

Documentation

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professional have adopted similar guidance.

The GMC states that:

*“Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off”.*¹⁶⁷

¹⁶⁷ <http://www.medicalprotection.org/uk/factsheets/records>

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Pullen and Loudon writing for the Royal College of Psychiatry state that:

*“Records remain the most tangible evidence of a psychiatrist’s practice and in an increasingly litigious environment, the means by which it may be judged. The record is the clinician’s main defence if assessments or decisions are ever scrutinised”.*¹⁶⁸

Professional Communication

*“Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion”.*¹⁶⁹

Jenkins *et al* (2002)

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

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone¹⁷⁰. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.¹⁷¹ The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

11.1.9.2. Findings of the Internal Investigation Team

“7.3 [Mr. W] was engaged with more than one service, simultaneously, being Mersey Care NHS Trust, Five Boroughs Partnership NHS Trust and the Lighthouse Project (Non-Statutory Service), and there were unconfirmed issues relating to his attempting to obtain medication from more than one source at the same time, which led to confusion when the Review Team was attempting to determine who was, ultimately, responsible for managing [Mr. W’s] prescriptions. All services failed to communicate proactively and engage with each other. This was considered not to be best practice but not a causative factor to the alleged incident”.

¹⁶⁸ Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) pp 280-286

¹⁶⁹ Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) p 121

¹⁷⁰ Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999). p 144

¹⁷¹ Ritchie *et al* *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

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“9.5. It is apparent that the Lighthouse project (Non-Statutory service) had no contact with the Adult Mental Health Services, Mersey Care NHS Trust until [Mr. W] was being discharged in spite of the fact that he was engaging with both organisations simultaneously. It is acknowledged, however, that this did not impact on the level of care provided”.

11.1.9.3. Findings of the Independent Investigation Team

As the internal Investigation identified Mr. W was under the care of a number of teams and organisations often at the same time.

Within the Trust Mr. W was under the care of the Substance Misuse Team, episodically, between, September 2004 and July 2005. He was formally discharged in November 2005 having not been in contact with the service since July 2005. He was again in contact with this service in August 2006. He was in contact with the Crisis Team based in the A&E Department from August 2006 until December 2006. He was referred to the Mental Health Services in July 2006 but did not engage with the service at this time. He was admitted to hospital, following a crisis presentation, between 19 September 2006 and 11 October but attended only one follow up appointment, on 16 October 2006. He was seen by the Criminal Justice Liaison Team on at least one occasion in December 2006 and this team was contacted on his behalf in October 2006.

External to the Trust Mr. W appears to have been in regular contact with his GP practice, at some point between July 2005 and July 2006 he was in contact with services from the Five Boroughs Partnership NHS Trust and he was in contact with the Community Drug Service variously referred to as: the Knowsley, St Helens, Newton-le-Willows Community Drug Team and the Lighthouse Project.

It is worthy of note that even at the time of the Internal Investigation not all the notes from all these services were available to the Review Team. The Internal Investigation reported that only in the course of their review did the following documentation become available:

- *“Kevin White Unite Nursing Assessment, dated 15th October 2004*
- *Community Detox Assessment with Background information, dated 21st September 2004*

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- *Correspondence from central and North West London Mental Health Trust/H.M.P. Wormwood Scrubs (Working in Partnership). Dated 13th October 2004*
- *Correspondence from the Criminal Justice Mental Health Liaison Team, dated 19th January 2007**
- *Correspondence from the Lighthouse Project, dated 11th December 2006***
- *Clinical Record Sheet and correspondence from Liverpool Drug and Alcohol Directorate, in connection with appointment scheduled for 21st December 2006***
- *Copy of records from Five Borough Partnership NHS Trust**”.*

*A letter dated 31 January 2007 was included in the records made available to the Independent Investigation but not one dated 19 January.

None of the documents marked ** were available to the Independent Investigation.

11.1.9.4. Conclusions of the Independent Investigation Team

For someone who was in contact with services only erratically and for a short space of time Mr. W was involved with a substantial number of services. It is not however an unusual presentation for an individual who has a drug misuse problem and has been given a diagnosis of personality disorder. The lives of these individuals are often chaotic and characterised by both crises and impulsive behaviour.

Internal communication and co-operative working

Because of the pattern of Mr. W's involvement with Mersey Care services there was relatively little overlap of his use of services. However, while Mr. W was an in-patient the ward staff did alert the Criminal Justice Liaison Team (CJLT) when he was due in Court. Similarly when Mr. W was seen in by the CJLT in December the nurse who assessed Mr. W wrote to Mr. W's Consultant Psychiatrist informing her of the information Mr. W had provided to the Court, her assessment and the outcome of the hearing. Mr. W had misled the CJLT nurse and the Court and the SpR promptly responded to the letter correcting the information Mr. W had supplied.

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When Mr. W presented to the A&E Department on 20 October 2006, following his discharge from hospital the Crisis Team sent a Fax to the Consultant Psychiatrist informing her of the presentation and consulting her about his future management. This was good practice.

Communication with External Agencies and Co-operative Working

Communication by all the Mersey Care teams with Mr. W's GP appears to have been both regular and timely. The one area in which communication appears to have failed was with the Community Drug Service based in Newton-le-Willows. It was this service that was prescribing Mr. W medication prior to his in-patient admission and which resumed this role when he was discharged from hospital. Given the important role illicit drugs played in Mr. W's life information on his current pattern of drug use and the strategy being employed to address this, good practice suggests that this should have been a key element both in the assessment of his mental state and needs and in planning his on-going care. We have noted above when discussing care planning that it would have been good practice if the team who had on-going responsibility for addressing Mr. W's drug misuse had been involved in assessing his needs and drawing up a co-ordinated plan of care. There is no record that this was done, nor is there any record of this team being invited to attend the final review prior to Mr. W being discharged from hospital.

There is no record of any communication between the Newton-le-Willows Community Drugs Team and Mr. W's GP. This is in contrast to the regular and timely information the Kevin White Unit provided to the GP when Mr. W was under the care of that service.

The Newton-le-Willows Community Drugs Service was a non-statutory agency which has since been replaced. The Independent Investigation did not have access to the policies of this organisation and so is not in a position to comment on whether the lack of communication was an organisational failure or poor clinical practice. Similarly the Independent Investigation did not have access to the clinical notes of this organisation and so is not in a position to comment on the strategy adopted by the service and whether it had, or attempted to have any contacts with the statutory services caring for Mr. W. The Independent Investigation can only observe that this lack of communication and co-operative working is poor practice and in contrast to the practices of the other services/teams involved in Mr. W's care.

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The other notable lacuna is the absence of any communication between the Mersey Care NHS Trust and the Five Borough NHS Partnership Trust. It appears that Mr. W had some contact with this latter Trust at some point between June 2005 and July 2006. It is unclear from the clinical notes whether the clinical staff at Mersey Care knew of this contact when they were assessing Mr. W. There is no information in the clinical notes as to why Mr. W was seen in the Five Borough NHS Partnership Trust and what intervention had been initiated. However given Mr. W pattern of contact with services and failure to engage or commit himself to a course of treatment it seem likely that his contact was brief and at a time of crisis or when he was seeking medication.

It has already been noted that Mr. W had a substantial forensic history. There was no contact however between the mental health service and the Police. Had Mr. W engaged with the service over a longer period of time it would have been good practice to have established a collaborative approach with the police and criminal justice service dealing with Mr. W. However given his presentation, his reluctance to disclose information, the lack of any information available to those assessing him that he might prove to be a threat to others and the short time he was involved with the service it would be unrealistic to have expected the clinical team to put such a liaison in place.

11.1.10. Clinical Governance and Performance

11.1.10.1. Context

“Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish”.¹⁷²

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

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

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

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

11.1.10.2. Findings

Clinical Governance Processes

The Independent Investigation Team found that the Mersey Care NHS Trust currently has a comprehensive and robust clinical governance system that is assured and reviewed on a regular basis. This Investigation was given a substantial archive of governance documentation and all of the evidence that has been submitted is of a high and verifiable standard. Unfortunately as the events being reviewed here occurred some time ago not all the policies that were in force at that time were available to the Independent Investigation and so the Investigation has not been able to comment on these or on the adherence of staff to these. The Independent Investigation Team acknowledges the significant input of the Mersey Care NHS Trust in providing both the information and documentary evidence for this section.

An Overview of Clinical Governance Working 2008/2009 and Current Working

This section will provide an overview of the corporate governance arrangements, as determined by the Trust Board, for the period 2008 through to the present day. There are numerous documents which provide the underpinning detail but it is anticipated the following information will be of sufficient detail to provide a meaningful overview.

It is important to note that the Trust amended the way in which its organisational structure operated from July 2009 following the establishment of Clinical Business Units (CBUs). Each CBU has established leadership and governance arrangements that have been agreed by the Trust Board and are now monitored by the Integrated Governance Committee.

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Developments in 2008

Constituted Committees of the Board:

1. Audit Committee;
2. Remuneration and Terms of Service Committee;
3. Charitable Funds Committee;
4. Clinical Governance Committee;
5. Business and Resource Committee.

Key highlights of the corporate governance arrangements agreed by the Board for 2008.

1. It was acceptable, where appropriate, for those other than Non-Executive Directors to Chair Committees of the Board.
2. The Ashworth Committee should cease and its responsibilities be explicitly subsumed within the new Committee structure.
3. There should be two new Committees built on established Committees but with greater clarity of their role. These two Committees should be:
 - a Committee concentrating on service user and carer experience. It was designed to subsume the issues of Clinical Governance, service user and carer involvement, the Care Quality Commission service quality areas and so on (the Clinical Governance Committee);
 - a Committee to deal with the business and resource issues of the Trust. This would cover targets, estates, staffing, finance, marketing and specifically the Care Quality Commission's use of resources standards (the Business and Resource Committee).
4. It was important that the arrangements fulfil three significant criteria: that they were comprehensive, clear and effective.

Developments in 2009

Constituted Committees of the Board:

- Audit Committee;
- Remuneration and Terms of Service Committee;
- Clinical Governance Committee.

Sub-committees:

- Mental Health Act Managers' Committee;

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- Health and Safety Committee;
- Infection Control Committee;
- Drugs and Therapeutics Committee;
- Research Governance Committee;
- Information Governance and Caldicott Committee.

Key highlights of the corporate governance arrangements agreed by the Board for 2009 are set out below.

1. In simple terms, the Board's role is to provide leadership and governance.
2. The Chief Executive (as Accountable Officer) through the roles of the Executive Directors and the Services (whether they be line managed or had been approved for the greater freedom of Clinical Business Unit status) is expected to initiate plans for the Board's approval and implement the Board's requirements.
3. The arrangements proposed to give clear expectations of the Accountable Officer supported by the checking mechanisms via Audit, Clinical Governance and the Board itself to ensure that those expectations are fulfilled.
4. The terms of reference of the Committees explain their roles and responsibilities in that endeavour. The Standing Financial Instructions, Standing Orders and Scheme of Delegation give clarity to levels of authority and rules of conduct of business.
5. The arrangements result in the cessation of the Business and Resource Committee.

Developments in 2010

In January 2010 the Board agreed to the establishment of the Integrated Governance Committee to replace the Clinical Governance Committee in response to the findings of the due diligence process of the Foundation Trust application process. All other committees remained in place.

Developments in 2011

Constituted Committees of the Board:

- Audit Committee;
- Remuneration and Terms of Service Committee;
- Integrated Governance Committee.

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Sub-committees:

- Mental Health Act Managers Committee;
- Health and Safety Committee;
- Infection Control Committee;
- Drugs and Therapeutics Committee;
- Research Governance Committee;
- Information Governance and Caldicott Committee.

An annual review of the corporate governance arrangements is now undertaken routinely in March each year through review and approval of the Scheme of Reservation and Delegation prepared by the Trust Secretary and approved by the Trust Board.

The Executive Director for Service Delivery and Development provides executive leadership to five of the six CBUs. The Executive Director of High Secure Service and Nursing has responsibility for High Secure Services, the sixth CBU, and was established to meet the 'line of sight' directive from the Department of Health, a requirement for all High Secure Services in England and Wales.

The Clinical Business Units cover the following Clinical areas:

- **Positive Care Partnerships CBU:** provides Older People and Adult Services to the North Liverpool, Sefton and Knowsley catchment area.
- **Liverpool CBU:** provides Older People's Services and Adult Services to the Central and South Liverpool Catchment area.
- **SAFE Partnerships CBU:** provides Medium and Low Secure Services to Merseyside and Cheshire.
- **Rebuild CBU:** provides Learning Disability, Rehabilitation and Brain Injury Services to Liverpool and Sefton.
- **High Secure CBU:** provides High Secure Forensic Services to the North West of England and to Wales.
- **Addictions CBU:** provides Alcohol and Drug Addiction Services to the Sefton and Liverpool areas.

Specialist Services which are provided by Psychologists and Allied Health Professionals are fully integrated into each CBU and where appropriate their clinical teams.

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Prior to the implementation of Clinical Business Units, the Trust had an established structure of Service directorates which included:

1. **Adult Mental Health Services:** (including Low Secure Services, Rehabilitation and Brain Injury provision) covering Sefton, Knowsley and Liverpool.
2. **Older Peoples' Services** covering Sefton, Knowsley and Liverpool.
3. **High secure Services.**
4. **Medium Secure Services.**
5. **Psychology Services:** covering all local geographies.
6. **Addiction Services:** covering Sefton and Liverpool.
7. **Learning Disability Services:** covering Sefton and Liverpool.

The changes made to the corporate governance process were in response to the changes made to the organisational structure and ensured that the performance of CBUs and the quality of care could be monitored.

Liaison with Commissioners

The Trust has close and effective working relationships with its commissioners. Liaison takes place at a variety of levels within the organisation including at Executive Director, Senior Manager/Clinician level. Systems and processes have been established where concerns or issues from both parties can be raised in a timely fashion.

The outcomes of Adverse Incidents are regularly shared with the Trust's lead commissioning organisation and any actions which may be required to prevent similar ones occurring are agreed.

Clinical Supervision

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.¹⁷³

173. Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses

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The NHS Management Executive defined clinical supervision in 1993 as:

*“...a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations”.*¹⁷⁴

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

Mersey Care NHS Trust Clinical Supervision Policy

The Trust recognises the importance of leadership within clinical practice and has developed systems to ensure that it is available from both a strategic and operational perspective. At Board level, the Directors of Nursing and Medicine are actively involved in the development and implementation of the Trust's strategic direction. Each Director has a leadership team that works together to provide mechanisms that will help:

- practitioners to be confident and effective leaders and champions of care;
- provide clinical practice that is valued, effective and within nationally agreed guidelines;
- support the clinical authority of colleagues in visible roles;
- those individuals in senior management positions champion quality at all levels of the organisation;
- ensure that the training in leadership skills provided by the Trust is appropriate and meets the needs of the clinician.

Systems are in place to ensure that opportunities for sharing best practice and learning within different professional groups are available. Professional leads have been appointed for Allied Health Care Professionals, Social Care, Psychologists, Nursing, and Medicine. These individuals work at a senior level and are responsible directly to the Medical or Nursing Director. They provide individual clinical supervision and support to colleagues within

174. Nursing and Midwifery Council, Advice Sheet C (2006)

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clinical services as well as leading networks of clinicians with the aim of enhancing the leadership and learning of their colleagues within their particular sphere of practice.

Each professional lead will also direct clinically focused projects across the Trust, for example, the Clinical Lead for Psychology has recently developed a strategy that will direct therapeutic engagement with service users. This paper is now out for consultation and all Clinical Business Units are actively involved in shaping the final strategic direction for the Trust.

Each Clinical Business Unit:

- has a Clinical Director in post who has a pivotal role in leading the governance agenda within that Service and providing support and guidance to medical colleagues;
- has Lead Nurses, Psychologists and Allied Health Professional who will work closely with colleagues to ensure that day to day practices are of an acceptable standard and participate actively in the development of the Clinical Business Unit, to ensure that the role and function of their specific professional role is represented.

As previously intimated the Trust sees the provision of clinical supervision as a key element in enhancing and maintaining the quality of the services that are provided to service users and their carers. Each Clinical Business Unit is responsible for ensuring that it has systems in place to implement the Trust's policy and procedure on this important aspect of practice. Key statements within the policy framework are:

- that supervision is a core component of best practice that supports individuals in developing their skills and competencies, and enables the maintenance of clinical practice standards;
- the Trust is committed to supporting practitioners in accessing clinical and managerial supervision;
- the Trust considers supervision to be essential to ensure high quality care to service users, enabling the appropriate development and support of staff in challenging situations and to identify training and development needs in pursuit of lifelong learning.

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11.1.10.3. Conclusions

Clinical and Service Directors are accountable to the Executive Director for Service Development and Delivery for the adherence to care and service delivery standards. An accountability framework is in place which clearly sets out the systems that will be used to identify any gaps in provision.

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

The Independent Investigation Team concluded that the Trust has made a great deal of progress in ensuring the quality of service delivery across the Trust.

12. Summary of Findings and Conclusions

12.1. Causal and Contributory Factors

The Independent Investigation did not identify any causal or contributory factors associated with the killing of Ms. Y in December 2006. However a number of service issues were identified as well as lessons that might be learned. These are set out below.

12.2. Referral and Discharge Procedures

Mr. W was appropriately referred to both mental health services and substance misuse services by his GP on a number of occasions. The services responded to these referrals but, for a variety of reasons, usually failed to engage Mr. W. When he was admitted to hospital in September 2006 the records suggest that Mr. W was not fully engaged in addressing his problems and no evidence of depression or psychosis was detected. He was discharged with a diagnosis of Emotionally Unstable Personality Disorder. At the point of discharge a plan was put in place which offered continuity of care, regular out-patient appointments and referral to the Rotunda Personality Disorder Psychotherapy Service. Mr. W did not avail himself of these opportunities. The clinical team caring for Mr. W considered transferring his care to the Community Mental Health Services but given his lack of engagement and commitment to addressing his problems it was decided to take an approach which required less commitment on his part with the opportunity to revise this decision should Mr. W show more commitment.

At the point of Mr. W's discharge from hospital the clinical team considered the options open to them and the Independent Investigation Team concluded that the team made a reasonable decision about his on-going care.

12.3 Diagnosis

From the first recorded contact with health services Mr. W's presentation was characterised by the misuse of illicit substances and impulsive acts of self harm and attempted suicide. His first contact with services provided by the Mersey Care NHS Trust was in September 2004 when he was assessed for a community detoxification programme. In July 2006 Mr. W was referred to mental health services by his GP who described him as suffering from chronic depression with suicidal ideation.

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Mr. W was assessed as an in-patient over a four week period in September/October 2006 when the clinicians looking after him considered the diagnosis of depression as an explanation of his self harming and suicidal behaviour and his frequent reports that he felt “fed up”. However it was concluded that: *“During the in-patient admission it became clear that there were few consistent signs of depression and the main factors were the chaotic elements of [Mr. W’s] life style such as the outstanding debts and his up and down relationship with his girlfriend”*.¹⁷⁵ They reached the conclusion that Emotionally Unstable Personality Disorder was a more appropriate diagnosis and better explained Mr. W’s behaviour.

The Independent Investigation concluded that the clinical teams looking after Mr. W considered the relevant diagnostic categories and arrived at a reasonable conclusion that the most appropriate diagnosis was that Mr. W was suffering from a personality disorder, his impulsive behaviour being exacerbated by his social circumstances and his, probable, continued misuse of illicit substances.

12.4 Medication and Treatment

Substance Misuse

In October 2004 he was admitted to an in-patient detoxification programme but discharged himself before this was completed. Up to this point Mr. W had irregular contact with the Substance Misuse Services where a number of approaches to helping him with his use of illicit drugs had been considered but they had all failed to deliver the desired outcomes as Mr. W was unable or unwilling to adhere to the programmes suggested. However in May 2005 he was given a test dose of Naltrexone and as he displayed no adverse affects he was prescribed this drug throughout May, June and July 2005.

The 2007 NICE guidance on prescribing Naltrexone states that: *“It should only be given to people who have been told about the problems associated with treatment, and with proper supervision. Treatment with Naltrexone should be given as part of a support programme to help the person manage their opioid dependence.*

Healthcare professionals should regularly review how well naltrexone is working to help people stay off opioids”.¹⁷⁶

175 Clinical notes Vol. 1 p.32, GP records Vol. 2 p.20

176 NICE (January 2007) TA 115: *Naltrexone for the Management of Opioid Dependence*

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The Guidance also recommends that psychosocial and behavioural therapies should be made available. This echoes the advice of the National Treatment Agency for Substance Misuse (NTA, 2002). However as Mr. W was out of the country for much of the time that he was prescribed Naltrexone it is improbable that he availed himself of any intensive or structured support. His contacts with the service were infrequent and at times there was only telephone contact. So supervision would appear to have been at best infrequent and cursory. There is no record in Mr. W's clinical notes as to why the substance misuse team decided to prescribe Naltrexone even though they knew that he would be abroad for prolonged periods. There appears to have been a discrepancy between the NICE and NTA guidance and practice in the case of Mr. W.

When Mr. W was admitted to hospital in August 2006 he informed the Specialist Registrar (SpR) that he was being prescribed Subutex (Buprenorphine) by the St Helens Substance Misuse Service. He was reluctant to discuss his use of illicit drugs. His care plan was to continue to prescribe Buprenorphine with the longer term aim of abstinence. However, there is no record of any attempt to involve the Substance Misuse Services in Mr. W's care during the in-patient admission. In her letter to Mr. W's GP 16 October 2006 the SpR reported that Mr. W had informed her that the Newton-Le-Willows Community Drug Team had prescribed Subutex following his discharge and was happy to continue to do so. There is no formal confirmation of this in the notes and no record of any contact between the Mental Health Team and the Newton-le-Willows/St Helens/Knowsley Substance Misuse Team.

Service Issue 1

There appears to have been a discrepancy between the NICE and NTA guidance and the practice of the Substance Misuse Services in the case of Mr. W. The supervision, support and interventions recommended in the Best Practice guidance were not evident. Although it has to be acknowledged that Mr. W did not show any consistent commitment to addressing his substance misuse problems.

Service Issue 2

While Mr. W was an in-patient his prescription of Buprenorphine was continued. However, there is no record in Mr. W's clinical notes of any joint planning as how Mr. W's

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substance misuse and mental health problems might be addressed in a collaborative and co-ordinated manner by the two services.

Mental Health

In July 2006 Mr. W was referred by his GP to the CMHT, on a number of occasions in August and September 2006 Mr. W presented to the Accident & Emergency Department in crisis and on 19 September 2006 he was admitted to hospital following an attempt to hang himself.

This admission was the only real opportunity for therapeutic intervention. However given the circumstances of the admission the primary focus was on managing the risk Mr. W presented to himself and on managing his substance misuse. This required that Mr. W was closely monitored. He was not comfortable with this and this placed a strain on his relationship with the nursing staff.

The clinical team concluded that Mr. W's impulsive, self-harming behaviour was a manifestation of an Emotionally Unstable Personality Disorder. Given this diagnosis the treating team, appropriately, refrained from prescribing additional psychotropic medication. They concluded that although he continued to present a significant risk to himself a continued in-patient admission would not be beneficial. This again appears to have been a reasonable decision. It was also suggested that Mr. W might be referred to a Personality Disorder Psychotherapy Service. Mr. W did not avail himself of the opportunity and he disengaged from the service before a referral was made.

Mr. W attended only one follow up appointment after leaving hospital and was discharged from the mental health services on 9 January 2007 without any further input, although he did present at the A&E Department on a number of occasions.

From his first contact with Mental Health Services it was evident that Mr. W's misuse of illicit drugs played a significant part in his presentation, however, in line with Best Practice Guidance the clinical team offered him a service from within mainstream adult mental health services. Having concluded that Mr. W's problems could be viewed as a manifestation of his personality disorder, exacerbated by drug misuse and social stressors it was appropriate that his in-patient admission was not continued indefinitely. However prior to discharge it would

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have been good practice to have sought the advice of the substance misuse service and those with expertise in personality disorders. Mr. W was given a follow up out-patient appointment and referral to a psychotherapeutic programme was discussed with him but Mr. W had a history of failing to engage with services and not adhering to programmes of intervention. His preferred mode of contact was to present at times of crisis. This is not unusual for people with a diagnosis of personality disorder.

The Best Practice guidance on personality disorder is clear that this is a treatable disorder and should be addressed within mainstream adult mental health services. However the guidance points out that if competent services are to be delivered then staff need to have appropriate training and expert advice, consultation and supervision need to be available. The Independent Investigation was informed that neither was available to Mr. W's treating team at that time.

However, given Mr. W's long established pattern of behaviour even had a co-ordinated plan informed by and shared with Substance Misuse Services and Personality Disorder Services been put in place at this time it could not be concluded with any degree of confidence that this would have significantly altered Mr. W's behaviour in the short term.

Service Issue 3

The Best Practice guidance recommends that individuals with a diagnosis of Personality Disorder are treated in mainstream mental health services. To achieve this clinical staff in mental health services need to have appropriate training and have access to expert advice, consultation and supervision. These were not available to Mr. W's treating team at that time he was under its care.

12.5 Use of the Mental Health Act (1983)

The clinicians looking after Mr. W considered using the Mental Health Act, assessed him and found him not to meet the criteria for detention. They offered him on-going assessment and treatment on a voluntary basis. As they became more familiar with Mr. W's presentation and developed a clearer formulation of his problems they identified that Mr. W presented an on going risk to himself but concluded that he did not meet the criteria for detention under the

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Act. The Independent Investigation Team concluded that appropriate use was made of the Mental Health Act (1983).

12.6 The Care Programme Approach

There was on-going assessment of Mr. W's mental state, particular by the SpR, and much of the information one would have expected to be available was collected. However, this was not organised or recorded within the notes in a manner that reflected the comprehensive and multi-disciplinary approach which characterises CPA.

Several care plans are recorded in Mr. W's mental health clinical notes. That so many care plans were drawn up in the space of a little over a month show a degree of conscientiousness, however none of the plans display the typical structure of a CPA care plan characterised by: identification of need, identification of goals that would meet the need, identification of actions to attain the goal, evaluation of progress and revising of the goal. Perhaps this is because the plans were not recorded on Trust CPA forms. The plans are not comprehensive and multidisciplinary, rather they deal, predominantly, with the immediate issues of providing care and maintain the safety of Mr. W.

In the context of the Care Programme Approach it would have been good practice to have held a multidisciplinary meeting, involving the substance misuse team and perhaps a representative from the Personality Disorder Service, when Mr. W's discharge was being planned to draw up a co-ordinated plan agreed with Mr. W and his girlfriend. This plan should have been comprehensive enough to address the issues identified by the clinical team.

The Independent Investigation took note of the observation that given Mr. W's poor motivation to engage with services and his history of poor collaboration with the services offered to him it was felt that it would be most appropriate to put in place a relatively undemanding programme of interventions. If Mr. W then appeared to be motivated to address his problems a more comprehensive range of services and interventions could have been introduced. The Independent Investigation concluded that this was not an unreasonable approach. Nevertheless, a more comprehensive CPA review meeting might have provided an opportunity to integrate the delivery of mental health and substance misuse services and to explore how services might have been best delivered to an individual identified as having personality and substance misuse problems.

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Service Issue 4

A more comprehensive CPA review meeting might have provided an opportunity to integrate the delivery of mental health and substance misuse services and to have explored how services might have been best delivered to an individual identified as having personality and substance misuse problems.

12.7 Risk Assessment and Management

Although it was known that Mr. W had served a number of prison sentences the nature of his offences was not known to those caring for him. With the benefit of hindsight one might argue that those assessing the risk Mr. W posed might have sought information on his offending history especially as it was noted that he was reluctant to provide this. However, it has to be noted that Mr. W was effectively under the care of the of the mental health services for a little over a month. He presented in crisis and the immediate risk which the clinical team had to deal with was Mr. W's attempt to harm himself. When he was assessed at the time of his admission to hospital the risk of him harming others was perceived as being low. During his in-patient admission the SpR met Mr. W's girlfriend and she, like the clinical team, perceived the major risk to be Mr. W attempting to harm himself.

Rather than posing a risk to others Mr. W was perceived as being at risk from others because of his drug habit and the social context in which he moved. He claimed, on two occasions, that he had been abducted by drug dealers.

Adequacy of risk assessment

When Mr. W was initially in contact with the Substance Misuse Services in Liverpool they employed their own assessment protocols which focused, not unreasonably, on Mr. W's history of drug misuse. There is no record of a more comprehensive risk assessment being conducted.

When Mr. W was assessed in September 2006 prior to him being admitted to hospital the Trust's Effective Care Co-ordination Risk Assessment form was employed and when he was assessed on the 20 October 2006 a Threshold Assessment Grid (PRISM) form was employed. While no risk assessment device is ideal for all situations and while it is acknowledged that risk assessment has to be both on-going and dynamic it would have been helpful to those

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assessing and monitoring Mr. W if some common device had been used across services and across time.

As time past a familiar pattern emerged in Mr. W's presentation. He tended to present to emergency services, mainly the A&E Department, at times of crisis, however when he was assessed he would report that the crisis had passed and he no longer felt suicidal. Indeed on some occasions he did not wait to be assessed. This was the pattern when he presented to the A&E Department in September 2006; he was admitted to hospital and within two days he was reporting that his mood had improved and he wanted to go on leave from the ward. The clinical staff were appropriately cautious about such a rapid recovery and considered detaining him under the Mental Health Act as they considered him to be at risk of harming himself. However after observing Mr. W for some time the clinical team came to the conclusion that while he did continue to present an on-going risk of impulsive self harm this was a manifestation not of depression but of a personality disorder and it would not be in his best interests for him to remain in hospital indefinitely. It was concluded that the risk Mr. W posed would be best dealt with by addressing his personality difficulties.

Contingency Planning

Given Mr. W's known propensity to harm himself impulsively, before granting him unescorted leave from the ward it would have been good practice to have identified the antecedents for this behaviour and agreed with Mr. W, and with his agreement, with his girlfriend, a contingency plan to address these. It is a moot point as to whether Mr. W would have complied with any plan once it was agreed but this might have been taken into account in the plan itself and been an early step in addressing his impulsivity and personality difficulties.

12.8 Service User Involvement in Care Planning

It is common practice to ask the service user to sign his/her care plan as a method of recording that s/he has been involved in the assessment of needs and the drawing up of the care plan. However there are no care plans recorded on Trust forms in the clinical notes made available to the Independent Investigation and so no formal record of Mr. W's involvement in the assessment of his needs or his care planning. However it is evident from the clinical notes that, to a significant degree, Mr. W controlled the care he received. When he presented himself to the Substance Misuse Services and the Crisis Service and he was clear what he

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wanted from these services. In September 2006 he presented at the A&E Department asking to be admitted to hospital. Soon after he was admitted to hospital he was vocal in asking for leave and, it appears, he left the ward on a number of occasions without informing the staff. Following his discharge from hospital Mr. W attended only one follow up appointment and, by his own admission, this was at the insistence of his girlfriend and so again Mr. W effectively controlled the care and support that was provided to him.

12.9 Carer Involvement and Carer Assessment

Mr. W's girlfriend appears to have been a stabilising influence on him during the time he was in contact with the Mental Health Services. She was at times his advocate and was forceful in putting forward her views and making known her concerns about the risk Mr. W posed to himself.

While Mr. W was an in-patient the SpR saw Mr. W's girlfriend on at least two occasions and she was present at the ward round immediately prior to him being discharged and so was party to the planning of his on-going care. It would appear then that, at least during the period when he was an in-patient, Mr. W's girlfriend was appropriately involved in his care.

Despite her intimate involvement in Mr. W's care his girlfriend was not offered her own carer's assessment. However, as has been noted, he was under the care of the mental health services for only a very brief period and once he was discharged from hospital he rapidly disengaged from the services with the result that contact with his girlfriend was also lost. Given this situation it is not surprising that she was not offered her own carer's assessment.

12.10 Documentation and Professional Communication

Although Mr. W was in contact with services only erratically and for a short space of time he was in contact with a substantial number of services. This is not, however, an unusual presentation for an individual who has a drug misuse problem and has been given a diagnosis of personality disorder. The lives of these individuals are often chaotic and characterised by both crises and impulsive behaviour.

Communications between Mersey Care NHS Trust teams was found to be generally appropriate. Communication by all the Mersey Care teams with Mr. W's GP appears to have been both regular and timely. The one area in which communication appears to have failed

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was with the Community Drug Service based in Newton-le-Willows. It was this service that was prescribing Mr. W medication prior to his in-patient admission and which resumed this role when he was discharged from hospital. However there was no ongoing communication with this service or involvement of this service in Mr. W's care while he was an in-patient. There are no communications with this service recorded in Mr. W's GP clinical notes made available to the Independent Investigation. This is in contrast to the regular and timely information the Kevin White Unit provided to the GP when Mr. W was under the care of that service.

The Newton-le-Willows Community Drugs service was provided by a non-statutory agency which has since been replaced. The Independent Investigations did not have access to the policies of this organisation and so is not in a position to comment on whether this lack of communication was an organisational failure or poor clinical practice.

It has already been noted that Mr. W had a substantial forensic history. There was no contact however between the mental health service and the Police. Had Mr. W engaged with the service over a longer period of time it would have been good practice to have established a collaborative approach with the Police and criminal justice service. However given his presentation, his reluctance to disclose information, the lack of any information available to those assessing him that he might prove to be a threat to others and the short time he was involved with the service it would be unrealistic to have expected the clinical team to put such a liaison in place.

12.11 Clinical Governance

At the time Mr. W was under the care of Mersey Care NHS Trust the Trust had in place a number of appropriate policies and procedures informed by Best Practice Guidance and National policy. However the protocols put in place by the Trust were not always followed. It has to be noted, however, that Mr. W was under the care of the Trust's mental health services for a little over a month and since that time there has been a significant re-organisation of Trust services and revision of its protocols.

13. Mersey Care NHS Trust Response to the Incident and Internal Review

13.1. The Trust Serious Untoward Incident Process

The Trust's 2011 Policy relating to the investigation of serious adverse incidents states:

"Initial Safety Check - Reflective Practice Review - 72 hours

This system has been developed by the Trust to be used by the local Team Manager, modern matron and or Clinical Lead to identify the chronology of the incident and identify initial causes of concerns and remedial actions that are required. The Team Manager should: -

- 1. Collate the information on the incident - what happened, when and how.*
- 2. Develop a time line of the incident.*
- 3. Invite staff involved in the care of the individual / incident to share the information they have in a meeting.*
- 4. Assess level of care provided using standardised care matrix.*
- 5. Highlight any gaps in practice to senior managers.*
- 6. Identify remedial action involved and implement".¹⁷⁷*

This is an appropriate immediate response to a serious incident focusing on ensuring that the service delivery system is safe and that the staff involved in the incident are involved in understanding the incident with the aim of identifying and implementing timely and practicable solutions. Unfortunately neither the policy in force at the time nor the 72 hour report for this incident were available to the Independent Investigation.

13.2. The Trust Internal Review

Mr. W was arrested on 9 January 2007 and the Internal Investigation was set up on 22 January 2007. It reported in July 2007.

The relevant Trust policy from the time of the Internal Investigation was not available to the Independent Investigation, however, five months is outside the recommended timescale for

¹⁷⁷ Mersey Care NHS Trust (2011) CORPORATE POLICY & PROCEDURE FOR THE REPORTING, MANAGEMENT AND REVIEW OF ADVERSE INCIDENTS p 18

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Internal Investigations. The current Mersey Care NHS Trust policy states that these investigations should now be completed within 45 days.¹⁷⁸

13.2.1. The Internal Investigation Review Team

The Internal Investigation Review Team was made up of five senior individuals from Health and Social Services: a Non-Executive Director, a Consultant Forensic Psychiatrist, a Deputy Director of Adult Mental Health, a Director of Mental Health, Learning Disabilities and Adult Services and a Nurse Consultant in Drugs and Alcohol. The team was supported by an administrator who had substantial experience in conducting Serious Untoward Incidents reviews.

The team which undertook the Internal Investigation had an appropriate range of expertise, experience and seniority. A number of the team had received training in Root Cause Analysis and the team was appropriately supported.

13.2.2. The Terms of Reference

The Terms of Reference for the Internal Investigation were as follows:

“3.1[sic] To examine all the circumstances surrounding the care and treatment of [Mr. W] provided by Mersey Care NHS Trust.

3.2 [sic] To establish the facts regarding the mental health care of [Mr. W], up to the event of 8th January.

3.3[sic] Identify any care and/or service delivery issues that contributed to the occurrence of the incident.

3.4 [sic] Consider and comment on the appropriateness, or otherwise, of the care and treatment received by [Mr. W], including:

3.4.1 [sic] his assessed health and social care needs

3.4.2 [sic] his risk of potential harm to himself and others

3.4.3 [sic] his engagement with mental health and substance misuse services and the Lighthouse Project (Non-Statutory Service).

3.5.[sic] To provide Primary Care with the opportunity to contribute to the process.

178 Mersey Care NHS Trust (2011) CORPORATE POLICY & PROCEDURE FOR THE REPORTING, MANAGEMENT AND REVIEW OF ADVERSE INCIDENTS p 20

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1.5 To consider any specific issues that [Mr. W], his family or his partner might wish to raise.

1.6 To review the support offered and provided to Mersey Care NHS Trust staff involved in the provision of care and treatment to [Mr. W], following the index offence.

1.7 To make any recommendations where there are any areas for improvement identified.

1.8 Prepare a report of the findings of the Review Team. This report to be presented to the Mersey Care NHS Trust Board”.

The Terms of Reference set out by the Trust were appropriate for an internal investigation although when setting out the Terms of Reference for similar investigations in the future the Trust might consider making explicit reference to national best practice guidance, statutory requirements and Trust policies as the standards against which evidence should be evaluated.

13.2.3. Methodology

The Internal Investigation reported that it employed a Root Cause Analysis methodology in which a number of the team had been trained. The Internal Investigation reported that employing this methodology was *“in line with Mersey Care NHS Trust’s policy and procedure for the Reporting, Management and Review of Adverse Incidents”*.

The Internal Investigation had access to Mr. W’s clinical notes and medical records and relevant Trust policies. It met *“key staff”* from the Mersey Care NHS Trust and Mr. W’s GP. It also met representatives of the Lighthouse Project, the non-statutory Drug Service in Newton-le-Willows, although like the Independent Investigation it did not have access to the clinical notes of the organisation.

13.2.4. Internal Review Team Conclusions

The Internal Investigation did not identify any causal factors associated with the killing of Ms. Y. The conclusions of the Internal Investigation were:

“10.1 In conclusion, it is the Review Team’s view that the underlying, or root cause, which led to the alleged index offence was outside the scope and responsibility of the care and treatment provided to [Mr. W] by Mersey Care NHS Trust.

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10.2 There are areas of concern within his engagement within services that, in different circumstances, could have been considered as contributory factors....

10.3 When assessing [Mr. W's] risk to others, there was little or no background information known, at that time, which could have indicated any significant risk to others being posed by [Mr. W]. This included risk to women. The main concern from all services was of self harm. The alleged homicide involving [Mr. W] could not, therefore, have been predicted by staff involved in his care. Nor, with the information available was it appropriate for a referral to be made to the Mersey Care Forensic Service.

10.4 Better liaison between Mental Health Services and Drug Services would have assisted with a clearer understanding of needs, accurate history taking and risk in [Mr. W's] case. It may have also helped with having a better care plan to promote engagement. An amendment to the E.C.C. policy in Mental Health and within Service Level agreement/contracts with drug services should include reference to liaison across service providers, especially when a patient/service user is seen in a crisis, with significant risk involved, or is admitted to inpatient care.

10.5 A key area for discussion within E.C.C. policy, across services, is in respect of cases like [Mr. W's], in which there is a significant risks to self, but where there is no mental illness diagnosis, which prohibits referral to C.M.H.T. Drugs services operate an open door, client self-determined basis. Under the Community Care Act, the Local Authority's duty is to assess and provide services to 'vulnerable adults'. Some Local Authorities have separate Vulnerable Adult Teams, from which [Mr. W] may have been eligible for support. In Merseyside, it appears that Social Workers, within the C.M.H.Ts, can carry only cases of people with an actual diagnosis of mental illness.

10.6 Services for people with personality disorder such as [Mr. W's] case are underdeveloped nationally. The learning in this case is that, if a comprehensive Personality Disorder Service had been available, then there would have been a better chance of engagement and follow-up.

10.7 The development of a live electronic data base, based on E.C.C. key documentation, which is accessible within, and across, Mental Health Services, at all times and on a need to know basis, by drug services and other statutory services providers, would have been helpful

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in this case. Staff assessing [Mr. W] in crisis would have had immediate access to key data, histories, current care plans and risk factors.

10.8 Obtaining a reliable forensic history was difficult throughout this case. Again, the importance of this could be better stressed within the E.C.C. policy and reinforced to practitioners. This needs to include indicators as to when forensic history needs to be sought, via the Criminal Justice Liaison Team, i.e. what is the basis of the 'need to know', in terms of risk?

10.9 The bundle of papers provided to the Review Team to aid the review process was not in chronological order; there was significant duplication of pages and additional information was sought and located throughout the review. It was of concern to the Review Team that a full chronological history was not available in advance of the review.

10.10 Had the current Mersey Care NHS Trust E.C.C. policy been updated following Department of Health Guidelines around 'Mental Disorder', then [Mr. W] might have been discharged on an enhanced level of care,

10.11 If leave for informal patients was re-structured to one period of leave, with an agreed contingency plan, then it would have been easier for the M.D.T. to monitor the statements made by [Mr. W] concerning what happened to him whilst on leave”.

13.2.5. Recommendations of the Internal Investigation

On the basis of its findings the Internal Investigation made the following recommendations:

- 1. “Areas of good practice should be communicated and shared.*
- 2. A culture of 'respectful enquiry' should be encouraged, to allow practitioners to cross-reference information.*
- 3. Care pathways between Mersey Care NHS Trust and the Lighthouse Project (non-Statutory service) need to be established, which give clear guidelines on communicating and sharing information.*
- 4. All records must be legible, dated and signed, with name and designation of staff printed.*
- 5. Movement towards a single trust-wide electronic clinical record system be advanced and an agreed timetable published.*

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6. *Increased awareness of Vulnerable Adult Procedures is required across the Trust and incorporated into joint E.C.C. policy and documentation.*
7. *Development of a Comprehensive Personality Disorder Service be actively pursued.*
8. *That the process of obtaining documentation, following an adverse incident, be reviewed to ensure that, in future, Review Teams are fully briefed and have available all relevant details prior to a review commencing.*
9. *The Mersey Care NHS Trust policy on E.C.C. should be reviewed, to ensure that it takes account of the latest Department of Health guidance on ‘mental disorders’ to assist with the determination of eligibility for, and level of CPA (Care Programme Approach 1990).*
10. *Mersey Care NHS Trust should agree a policy around leave, for informal patients which supports the ‘early discharge’ principle within C.R.H.T. and ensures that service user going on leave have a contingency plan agreed.*
11. *Significant others (with whom service users live) should always be consulted about leave arrangements prior to granting leave.*
12. *An explanatory written rational in the notes, when a patient is not deemed to be detainable under the Mental Health Act 1983. In cases where the diagnosis is one of ‘Personality Disorder’ it should include reference to the ability to treat the disorder”.*

13.2.6. Conclusion of the independent Investigation

The Team which undertook the internal investigation was appropriately constituted and the investigation was conducted to a good standard.

The findings of the internal investigation are based on the evidence identified in the chronology which is included in the internal investigation report. The Independent Investigation largely concurs with the findings of the internal investigation.

The internal investigation addressed its Terms of Reference with the exception of:

- 1.5 *“To review the support offered and provided to Mersey Care NHS Trust staff involved in the provision of care and treatment to [Mr. W], following the index offence”.*

This was not commented on.

The recommendations of the internal investigation are derived from the findings of the investigation and are appropriate.

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13.2.7. Progress against the Trust Action Plan

It would be normal practice at this point to review the progress the Trust had made with respect to the action plan it had drawn up in response to the recommendations of the Internal Investigations. The object of such a review would be to establish that the Trust had responded appropriately to the findings of the internal investigation, to establish that lessons had been learnt and to establish public confidence in the services provided by the Trust. However the events described in the report occurred between 2004 and 2006 and the internal investigation reported in 2007. In the intervening period significant changes have been made to the organisation of the services provided by the Mersey Care NHS Trust, policies have been revised as has the Trust's Governance structures. Some of these changes have been described above in the sections dealing with the current profile of the Trust and the Trust's Governance structures.

13.3. Being Open

Support to Relatives

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

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

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The Independent Investigation did not have access to the Trust's *Being Open* policy which would have been in force in 2007. However the current policy, ratified in 2010 states:

"Being Open means: -

1. *Acknowledging, apologising and explaining when things go wrong.*
2. *Conducting a thorough investigation into the adverse incident and confirming with service users and/or their carers that lessons learned will help prevent the incident recurring.*
3. *Improving the understanding of incidents from the perspective of the service user and/or their carers.*
4. *Providing support to cope with the physical and psychological consequences of what happened as a result of the safety incident.*
5. *Informing service users/carers about all the safety incidents that affect them.*
6. *Acknowledging the distress the service user/carer may have experienced as a result of the safety incident.*
7. *Providing a sincere and compassionate statement of regret for the distress the service user/carer experienced.*
8. *Providing a timely and factual explanation of what happened.*
9. *Providing a clear statement of what is going to happen following the safety incident.*
10. *Informing the service user/carer of the plan (where appropriate) regarding the repair or redress of the harm done".*¹⁷⁹

There is no reference within the internal investigation report that the investigation team made contact with either Mr. W's family or with the family of Ms. Y.

13.4. Staff Support

13.4.1. Prior to, and During, the Internal Review

There is no record in the internal investigation report of the support which staff received after the incident nor what support those interviewed by the internal investigation were offered.

¹⁷⁹ Mersey Care NHS Trust (2010) *Being Open Policy*. p. 5

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However the current policy notes:

*“The Trust recognises that when an adverse incident occurs, members of the Multi Disciplinary Team involved in the client’s/patient’s treatment and care may also require emotional support and advice. Both clinicians who have been involved directly in the incident and those with the responsibility for facilitating Being Open discussions will be given access to assistance, support and any information they need to fulfil this role”.*¹⁸⁰

13.4.2. During the Independent Investigation

All those called as witnesses to the Independent Investigation were invited to a workshop where the purpose and format of the Investigation was explained; they were provided with an information pack and were given the opportunity to ask questions relating to the process of the investigation.

The Trust worked with the Independent Investigation Team to support staff in practical ways to ensure that information was sent and received, and to advise each witness what was expected of him/her. The Trust also made available support to witnesses during the course of the Investigation.

13.4.3. Dissemination

Clinical witnesses reported that following the internal investigation the Trust put in place an ‘Oxford Event’ to disseminate the findings of the investigation, to discuss the lessons to learned and to identify any desirable changes in practices or service delivery. This was good practice.

13.4.4. Conclusion

Neither the internal investigation report nor the clinical staff interviewed by the Independent Investigation commented on the support that had been available to staff following the incident in December 2006 or during the internal investigation. However the Trust did put in place a mechanism to share with its staff the findings of the internal investigation and the lessons learned. The staff were positive about the opportunity they had been afforded to discuss the findings of the internal investigation and found this a constructive experience.

180 Mersey Care NHS Trust (2010) *Being Open Policy* p 5

14. Notable Practice

14.1. Internal Investigation

The internal investigation noted the following examples of good practice:

1. *“Clear communication between Mersey Care Drug and Mental Health Services with Primary Care services.*
2. *Kevin White Unit (Naltrexone Project) referred [Mr. W] on to the Crisis Team for appropriate help.*
3. *Comprehensive assessment and risk assessment completed in the Accident and Emergency Department at Royal Liverpool University Hospital, by both the Approved Social Worker and the Nurse Manager.*
4. *Clear and focused management by the Specialist Registrar in Psychiatry and a thorough management plan and 7-day follow-up upon [Mr. W’s] admission to the Broadoak Mental Health Unit, and thereafter.*
5. *Clear follow-up and communication by the Criminal Justice Liaison Team, in December 2006....*
6. *Adherence to the D.N.N. policy of the Trust was followed and represented good practice”.*

The Independent Investigation concurred with these findings.

15. Lessons Learned

As has been noted Mr. W was only episodically involved with services delivered by Mersey Care NHS Trust. He was initially in contact with the Substance Misuse Service, though he failed to engage with this service for any prolonged period so that his problems might be addressed in a consistent manner. Later he presented himself to the crisis service via the A&E Department on a number of occasions and between 19 September and 11 October 2006 he was an in-patient in the mental health service. Following his discharge from this admission Mr. W attended only one follow up appointment. With such a pattern of unplanned presentations and an apparent lack of commitment on the part of Mr. W to engage in services and address his problems managing his care in a coherent manner was a significant challenge however a number of lessons which might be learnt can be identified.

Comprehensive Assessment

Mr. W was under the care of the mental health services for a little over a month. He presented in a time of crisis, as he had done on a number of previous occasions, and the focus of his care at this time was on containing the risk he posed to himself. He was assessed on a number of occasions and his drug misuse problems, his chaotic life style and his relationship difficulties were identified as factors exacerbating his distress and acting as triggers to his impulsive self harming. It was concluded that Mr. W was suffering from a personality disorder and while he remained at risk of impulsively harming himself a prolonged in-patient admission was not deemed to be in his best interest nor was this what Mr. W wanted.

Given Mr. W's complex presentation it would have been good practice to have followed more explicitly the protocol of the Care Programme Approach, ensuring that there was a comprehensive assessment involving the services that were involved in Mr. W's care and employing a multi-disciplinary approach. The identified needs should have informed Mr. W's care plan and a system should have been put in place to review his progress and revise his care plan on a planned basis. This would have been facilitated had a Trust protocol been employed.

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One of the key elements of the Care Programme Approach is that it provides a mechanism to bring together all those involved in providing care for an individual to ensure that care is co-ordinated. The responsibility for ensuring that care is delivered in a co-ordinated manner and care plans are reviewed and revised in a timely manner is assigned to the care co-ordinator. Although it was noted that Mr. W had substance misuse as well as mental health problems no co-ordinated plan, involving both services, was drawn up. When Mr. W was identified as suffering from a personality disorder it was identified that he might be referred to the Rotunda psychotherapy service. This would have been an appropriate intervention. However given that it was known that Mr. W had a poor history of engagement and compliance and that both these traits are not uncommon in the populations serviced by Substance Misuse and Personality Disorder Services it would have been appropriate to have capitalised on the expertise of these services when drawing up Mr. W care plan to ensure that a coherent and co-ordinated approach was adopted and increase the likelihood that he might engage in services.

Risk, Contingency Planning and Responding to Crises

A number of triggers associated with increased risks related to Mr. W were identified by the clinical team looking after him however no crisis or contingency plans appear to have been put in place, for example, when Mr. W was on leave from the ward during his in-patient admission. The purpose of assessment is to provide information on the basis of which a formulation is drawn up which provides a shared understanding of the individual's behaviour and informs the interventions of the clinical team. Having identified the triggers associated with increased risk related to Mr. W it would have been good practice to have agreed a crisis plan with Mr. W and, with his agreement, with his girlfriend.

Mr. W's preferred method of dealing with crises was impulsively to self harm and then to present to the crisis services. While presenting to crisis services and them dealing with the immediate situation might be an appropriate method of dealing with infrequent crises, when self harming and threats of suicide become more common dealing with only the immediate crisis is likely to prove to be a less effective strategy. When Mr. W presented to the crisis service following his discharge the crisis team contacted the Consultant Psychiatrist caring for him and suggested that a management plan for dealing with such presentations should be put in place. This was good practice.

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Repeated crisis presentations, particularly following episodes of self harm, are not unusual in people with a diagnosis of personality disorder. This suggests that while it is good practice to have crisis management plans in place and, where appropriate, shared with the crisis service for those already under the care of the mental health services it would be good practice for crisis services also to have in place a mechanism to recognise those who present in crisis repeatedly and engaging them in services in a constructive manner.

As noted above the Department of Health in *New Horizons*¹⁸¹ noted:

“People with complex problems make frequent and often chaotic use of inpatient mental health, primary care, A&E, social care, and criminal justice and other services. Emerging evidence from the new personality disorder services demonstrates that this can be reduced, and people with this diagnosis can engage in training and work if they receive appropriate support to address their problems. Outcomes from the new services demonstrate the benefits of multi-agency, cross-sector commissioning and collaborative working”. (p.72)

This suggests that it would be beneficial to link the strategy for providing services for people with diagnosis of personality disorder and the mechanism for identifying and engaging those who present repeatedly in crisis. This integrating strategy might also be linked to the Dual Diagnosis, Substance Misuse – Mental Health, strategy.

181 DoH (2009) *New Horizons: Towards a shared vision for mental health*

16. Recommendations

Each recommendation is set out below in combination with the relevant service issue and has taken into account the progress that the Trust is already making in the area.

The Executive Directors of the Mersey Care NHS Trust had the opportunity to review the findings of this Investigation and contributed to the recommendations both at the preliminary feedback stage and during the factual accuracy checking stage. The Trust should be given recognition for the work that it has put into this process and the progress that it has already put into place. It was noted by the Independent Investigation Team that due to the passage of time between the killing of Ms. Y and the completion of this Investigation process the Trust had completed an extensive service redesign and had also completed all of the recommendations developed by the internal investigation process. Therefore few recommendations are set out below.

16.1. Medication and Treatment

Substance misuse

Service Issue 1

There appears to have been a discrepancy between the NICE and NTA guidance and the practice of the Substance Misuse Services in the case of Mr. W. The supervision, support and interventions recommended in the Best Practice guidance were not evident. Although it has to be acknowledged that Mr. W did not show any consistent commitment to addressing his substance misuse problems.

Recommendation 1

The commissioners of substance misuse services together with service providers should put in place mechanisms to ensure themselves that best practice guidance on the delivery of substance misuse services is being implemented.

Commissioners and providers of substance misuse should put in place mechanisms to ensure that information on the quality of services is reported in a timely manner and that this information is feedback to practitioners and teams in a meaningful fashion to ensure that the quality of services is maintained.

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Service Issue 2

While Mr. W was an in-patient his prescription of Buprenorphine was continued. However, there is no record in Mr. W's clinical notes of any joint planning as how Mr. W's substance misuse and mental health problems might be addressed in a collaborative and co-ordinated manner by the two services.

Recommendation 2

The Trust and its commissioner should ensure that the Best Practice guidance on the co-ordinated treatment of individuals with a dual diagnosis of mental health problems and substance misuse problems is implemented.

The Trust should ensure that when an individual with a substance misuse problem is admitted to hospital for treatment of a mental health problem a collaborative care plan is put in place, where appropriate, with the substance misuse services to ensure that the individual's needs are addressed in a holistic and coherent manner.

The Trust should ensure that substance misuse problems are routinely addressed as part of the Care Programme Approach discharge plan when an individual is discharged from in-patient care.

16.2. Mental Health

Service Issue 3

The Best Practice guidance recommends that individuals with a diagnosis of Personality Disorder are treated in mainstream mental health services. To achieve this clinical staff in mental health services need to have appropriate training and have access to expert advice, consultation and supervision. These were not available to Mr. W's treating team at that time he was under its care.

Recommendation 3

The Trust should ensure that all clinical staff have relevant, regular training in assessing and treating individuals with a diagnosis of Personality Disorder.

The Trust should ensure that all clinical staff have access to advice, consultation and supervision on the assessment and treatment of individuals with a diagnosis of personality disorder.

The Trust should put in place mechanisms to assure itself that the Best Practice guidance on the treatment of individuals with a diagnosis of personality disorder is being implemented.

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16.3. The Care Programme Approach

Service Issue 4

A more comprehensive CPA review meeting might have provided an opportunity to integrate the delivery of mental health and substance misuse services and to have explored how services might have been best delivered to an individual identified as having personality and substance misuse problems.

Recommendation 2 (repeated)

The Trust and its commissioner should ensure that the Best Practice guidance on the co-ordinated treatment of individuals with a dual diagnosis of mental health problems and substance misuse problems is implemented.

The Trust should ensure that when an individual with a substance misuse problem is admitted to hospital for treatment of a mental health problem a collaborative care plan is put in place, where appropriate, with the substance misuse services to ensure that individual's needs are addressed in a holistic manner.

The Trust should ensure that substance misuse problems are routinely addressed as part of the Care Programme Approach discharge plan when an individual is discharged from in-patient care.

16.4. Risk Assessment and Management

Although it was known that Mr. W had served a number of prison sentences the nature of his offences was not known to those caring for him. With the benefit of hindsight one might argue that those assessing the risk Mr. W posed might have sought information on his offending history especially as it was noted that he was reluctant to provide this.

Adequacy of risk assessment

While no risk assessment device is ideal for all situations and while it is acknowledged that risk assessment has to be both on-going and dynamic it would have been helpful to those assessing and monitoring Mr. W if some common device had been used across services and across time.

Contingency planning

Given Mr. W's known propensity to harm himself impulsively, before granting him unescorted leave from the ward it would have been good practice to have identified the antecedents for

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this behaviour and agreed with Mr. W, and with his agreement, with his girlfriend, a contingency plan to address these.

Recommendation 4

The Trust should ensure the Best Practice Guidance on risk assessment and risk management is being implemented in a consistent manner throughout the Trust.

The Trust should ensure that appropriate corroborative information is sought when a risk assessment is being undertaken.

The Trust should ensure that a clear, explicit formulation is part all risk assessments and risk management planning. This formulation should provide an understanding of the risks that individual poses and is subject to and inform the risk management plan.

17. Glossary

Buprenorphine

Buprenorphine is an opioid used to wean people off their addiction to stronger opioids such as heroin. By acting on the same opioid receptors as other opioids, Buprenorphine prevents the physical withdrawal symptoms that occur when these drugs are stopped. This prevents physical cravings. Over time, the dose of Buprenorphine is gradually reduced until it can be stopped completely.

Care Coordinator

This person is usually a health or social care professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.

Care Programme Approach (CPA)

National systematic process to ensure assessment and care planning occur in a timely and user centred manner.

Care Quality Commission

The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.

Community Mental Health Team (CMHT)

A CMHT provides Care Coordination and care and treatment to individuals with severe and enduring mental illness.

Crisis Resolution and Home Treatment Team (CRHTT)

A CRHTT provide care and treatment to people in crisis 24 hours day seven days a week in their own homes. A primary focus is in the prevention of unnecessary inpatient hospital admission.

Diazepam

Diazepam belongs to a group of drugs known as Benzodiazepines.

Diazepam is used to treat anxiety disorders, alcohol withdrawal symptoms and muscle spasms.

Mental Health Act (1983)

The Mental Health Act (1983) covers the assessment, treatment and rights of people with a mental health condition.

Naltrexone

Naltrexone belongs to a class of drugs known as opiate antagonists. It works by decreasing the craving for alcohol and blocking the effects of opioid drugs. It is recommended that Naltrexone is used along with

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counselling and social support to help people who have stopped drinking alcohol and using street drugs continue to avoid drinking or using drugs. Naltrexone should not be used to treat people who are still using street drugs or drinking large amounts of alcohol.

Primary Care Trust

An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commission them from other providers, and are involved in commissioning secondary care, such as services provided by Mental Health Trusts.

Psychotic

Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.

Subutex

Subutex is the trade name of Buprenorphine. See above.

Risk assessment

An assessment that systematically details a persons risk to both themselves and to others.

RMO (Responsible Medical Officer)

The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.

Service User

The term of choice of individuals who receive mental health services when describing themselves.