Independent Investigation

into the

Care and Treatment Provided to Mr. A

by the

Avon and Wiltshire Mental Health Partnership NHS Trust

Commissioned by
NHS South of England
Strategic Health Authority

Executive Summary

Investigation Conducted by: HASCAS the Health and Social Care Advisory Service

Report Authored by: Mr. Jon Allen

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1. Incident Description and Consequences

Background

Mr. A was born in 1990. He is one of three siblings and grew up in his parents' home in Clevedon, North Somerset. He had a mainly unremarkable early childhood. There were two medical interventions of note in his primary care records. The first was when his mother attended the GP with him in his first year of life because of prolonged periods of screaming. The second was in his primary school years when he was diagnosed and treated for asthma.

Mr. A first presented with behavioural problems at the age of 13. He attended the GP with his mother who reported that he was on his tenth suspension from school. This was understood to be for fighting with other children. He was also alleged to have been using solvents, alcohol and street drugs from this early age. In 2004 he was on a 'level three' exclusion from school and referrals were made to the Children and Adolescent services to secure an assessment to exclude a diagnosis of Attention Deficit Disorder (ADD). He was seen in December 2004 by a Clinical Psychologist who recorded she would make a referral for specialist ADD assessment. Mr. A had two more appointments and then failed to attend any further appointments. There was no record of follow up after these appointments. Mr. A had a further out-patient appointment with a Community Mental Health Team (CMHT) in 2006, following him presenting to his GP with a low mood. He was offered follow up appointments but he did not attend two appointments and was discharged to his GP.

In April 2009 Mr. A made a serious attempt on his own life by hanging. He was found by an off duty paramedic, hanging from a balcony near his accommodation. It is thought he might have died had it not been for the expert attention and first aid he received. He was in hospital, unconscious for two days. When he regained consciousness Mr. A was found to be well enough to be discharged into the care of his parents by the Liaison Psychiatrist. The hanging attempt was thought to be an impulsive act in response to feeling hopeless about debts to drug dealers which Mr. A had incurred.

Mr. A was subsequently referred to the Crisis and Home Treatment team by his GP. He was supported by this team between the 14 April 2009 and 22 May 2009. He was last seen by secondary care psychiatric services at an outpatient appointment when he was assessed by a trainee Psychiatrist on the 2 June 2009. This Psychiatrist recoded that Mr. A's diagnosis was

moderate to severe depression complicated by his social circumstances. She advised Mr. A's GP that his antidepressant, Mirtazapine, could be increased if required.

Mr. A presented to his GP and to Housing services between the 25 and 27 August 2009. He had left his girlfriend's flat as they argued frequently. He needed accommodation as his parents had agreed that he could live with them for only two weeks. The Housing Officer referred him to the Stonham Housing Association, a supported housing provider. He was assessed on the 5 September 2009. The Housing Association did not offer Mr. A accommodation because he had stated he was not safe to take his own medication and he was a high suicide risk. The Housing Officer placed Mr. A in an emergency housing placement on the 8 September 2009.

Incident

On the 9 September 2009 Mr. A went to see the Housing Officer to complain about the state of his room. He was concerned that his bedding was infested. After this he spent the day with his ex-girlfriend and daughter. He then returned to his accommodation. Mr. A later went to the public house for a drink with some other residents. On his return to the hostel he continued drinking with these residents, including Mr. Y. He had an altercation with Mr. Y, following Mr. Y saying something about Mr. A's relationship with his, Mr. A's, daughter. This resulted in Mr. A assaulting Mr. Y. Mr. Y died from the injuries he sustained. Mr. Y had recently been discharged from hospital having been admitted for physical health complications secondary to his alcoholism. He was waiting for placement in a residential recovery unit.

2. Terms of Reference

To review

1. The quality of health care provided by the Trust, to include whether it complied with statutory guidance, statuory obligations, relevant Department of Health guidance and Trust Policies.
2. The approriateness of delivery of treatment including the adequacy of assessments.
3. The inter-agency information sharing/communication/coordination, to include with the GP services and the North Somerset Housing Department. The efforts to communicate with both the perpertrator and his partner, together with the perpetrator's mother.
4. To consider whether there were safeguarding issues regarding the child of Mr. A, whether they were known and assessed and actions taken.
5. Assessments of risk upon Mr. A, the recording and responses to such by clinical and social care services.
6. Documentation, including documentation of clear plans and risk assessments, decisions on frequency of contacts and visits, actions taken by all services.
7. The internal investigation, its definitions and findings, methodology and recommendations.
8. To identify learning points for improving systems or services with practical recommendations for implementation.
9. To report findings and recommendations to NHS South of England.

3. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of Avon and Wiltshire-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.

Investigation Team Leader and Chair

Mr. Jonathan Allen	HASCAS Health and Social Care Advisory Service Associate, Investigation Chair and Report Author

Investigation Team Members

Dr. Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service and Nurse Member of the Team.
Dr. Louise Guest	HASCAS Health and Social Care Advisory Service Associate and Consultant Psychiatrist Member of the Team
Ian Allured	HASCAS Health and Social Care Advisory Service Director of Adult Mental Health and the Social Worker member of the Team

Support to the Investigation Team

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

Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

4. Findings of the Independent Investigation

1. Diagnosis

No one achieved a robust diagnostic understanding of Mr. A. He was never seen for long enough or consistently enough by a single experienced psychiatrist to reach a considered diagnostic formulation.

2. Treatment

2.1. Medication

Given the symptoms Mr. A was describing and his self-harming behaviour prescribing him antidepressant medication was not inappropriate. However not enough consideration was given, initially, to the risks associated with providing Mr. A with medication. Following his overdose a more clinically appropriate and safe medication plan was adopted.

2.2. Psychological Treatment

The Independent Investigation concluded that Mr. A should have been referred to a psychological treatment service to help him with his low mood and impulsivity at an earlier stage. He would have benefited from services aimed at addressing his practical problems of debt and employment. Mr. A might also have benefitted from treatment and counselling in relation to his long standing drug misuse problems.

3. Care Programme Approach

Trust policy required an Acute CPA review document to be completed on a weekly basis while Mr. A was under the care of the Crisis Team. This document was usually filled in by a single member of the team and was often not completed in full. The care plan put in place focused on Mr. A's short-term needs such as preventing admission and reducing his desire to harm himself and did not address his longer-term more pervasive needs.

Mr. A's care plan was never subject to formal review. Although Mr. A was allocated a nominal Care Coordinator, in practice no one was identified as responsible for fulfilling this role as it is set out in Best Practice Guidance.

4. Risk Assessment and Risk Management

Mr. A's risks and protective factors were not assessed in a comprehensive fashion and additional and corroborative information from Primary Care regarding his history was not sought.

Mr. A fell into a high risk group for both suicide and violence. He was a young man, with a history of substance misuse, in a lower economic class, with financial stressors. He also had a history of violence and self harm. This was not known by the Crisis Team but it was on record. Mr. A had a history of acting in an impulsive manner in response to external stressors, and this impulsivity was exacerbated by alcohol and drugs. This was not identified and a risk management plan was not developed to address this.

5. Safeguarding Vulnerable Adults and Children

Mr. A's daughter was subject to child protection procedures and Mr. A was undergoing regular drug screens to enable him to have access to his child. Little else was recorded about the child protection arrangements in place for Mr. A's child. There is no record of the Child Protection team being informed of changes to Mr. A's presentation or of the additional pressure Mr. A's behaviour might expose the child's mother to.

There is no evidence in the records available to the Independent Investigation that Vulnerable Adult procedures were considered in relation to Mr. A. When Mr. A required emergency accommodation he was placed in accommodation with other vulnerable adults but there is no evidence that a risk assessment was undertaken at this time or that consideration was given to the risks and needs of other residents before Mr. A was placed in the emergency accommodation.

6. Admissions Discharges and Transitions

GPs frequently referred directly to the Crisis Team as they believed their patients would be seen more quickly. When Mr. A was assessed by the CMHT it was identified that he did not live in the catchment area and was referred to a second CMHT. A month later he was seen by a Trainee Psychiatrist in this second CMHT. She was under the impression that Mr. A had been discharged by the Crisis Team and that she was completing a medical review as part of this process. It was normal practice for a member of the Crisis Team to attend outpatient appointments to provide an update on the team's view of the client. In Mr. A's case one of his

two outpatient appointments was attended by an unqualified member of staff who was not able to provide a detailed clinical handover. No discharge CPA was undertaken.

7. Carer Involvement

Only two contacts with Mr. A's parents are recorded in his notes despite the fact that he lived, at least part of the time, in their home and he complained about being distressed by arguments with his mother.

Mr. A's girlfriend provided him with a great deal of support and he lived, at least part of the time, in her flat. Latterly Mr. A's girlfriend took on the role of his carer, however she did not receive a carer's assessment and was never involved in identifying his needs or consulted over his care plan.

8. Service User Involvement

Mr. A appeared to be given the opportunity to be involved in all decisions about his care and his views are partially documented in his Care Programme Approach documents. It is recorded that he did not require an advocate however, given his uncertain cognitive abilities, he might have benefited from the support of an independent advocate.

9. Housing

Mr. A lived at his parents' and at his girlfriend's homes. There were sources of stress in both environments. When Mr. A's relationship with his girlfriend broke down he contacted the Local Authority Housing service where the Housing Officer tried to place him in supported accommodation. She also contacted the Mental Health service for advice and support. The supported hostel did not offer Mr. A a place and the CMHT did not offer support or an emergency assessment.

The only option available to the Housing Officer was to place Mr. A in an emergency hostel which did not provide support. On the second day in this hostel Mr. A went drinking with other residents. It was in this situation that he lost his temper and attacked and killed Mr. Y. Mr. A should have been assessed by the Mental Health Team prior to being placed in this hostel, his protective factors had fallen away and there was a high risk that he would act impulsively and dangerously.

10. Documentation and Professional Communication

The quality of professional documentation in this case was not of a high standard. Forms were not fully completed, nor were they always signed. Information was at times repeated rather than being updated. Mr. A's GP did not indicate in his referral letter that Mr. A had a history of aggression and could be a risk to others. The information provided to the GP on Mr. A's discharge from the CMHT was unclear and created the impression that Mr. A was continuing to receive secondary mental health services when in fact he had been discharged.

The use of unqualified members of staff to attend review meetings meant that these were lost opportunities to share professional clinical perspectives on Mr. A's needs and risks. In addition the services did not have robust processes for tracing previous assessments and episodes of care.

11. Adherence to Local and National Policy and Guidance

Mr. A was under the care of the Avon and Wiltshire Mental Health Partnership NHS Trust for only a short period of time. During this there were significant gaps in the rigour with which some Trust policies were implemented.

The way in which the Crisis and Home Treatment Team operated and its relationship with Community Mental Health Teams did not reflect national guidance on how these services should operate and interface with other local mental health services.

12. Overall Management of Care

Following his attempted suicide in April 2009 a more comprehensive review of Mr. A's needs should have been undertaken and the services which could best meet his needs should have been identified.

The GP referred to the Crisis and Home Treatment Team because this service saw people relatively promptly. However, this team did not provide ongoing support or treatment. Following his referral to a CMHT Mr. A was passed from one CMHT to another and then discharged after one appointment. There is no evidence in Mr. A's clinical records that any consideration was give to what services might have helped address his longer-term problems.

13. Clinical Governance

The Trust's clinical governance system was designed to provide support for a comprehensive approach to managing service quality and providing assurance across the Trust. However this Investigation found that, at least in the case of Mr. A, this system did not function effectively.

Care pathways and the relationships between them were not well understood; Trust policies and protocols were only partially complied with; and the Trust governance system did not always detect these failures to adhere to Trust policy in a timely manner.

5. Conclusion of the Independent Investigation

Mr. A was a young man who had had a troubled adolescence marred by expulsion from school for impulsive behaviour and fighting. He had used alcohol and drugs from a young age. He started to show signs of depression at the age of 16. When he was 19 years old he made a serious attempt to kill himself by hanging. Psychiatric services offered him only short-term support through the Crisis and Home Treatment Team.

This Investigation found that a range of service delivery problems conspired against Mr. A receiving an effective service which assessed his needs in the context of his longer-term history of vulnerability and risk and put in place an effective care plan to address the identified needs.

This Investigation agrees with the Trust's Internal Investigation that services could not have predicted that Mr. A would have killed someone. At the time of the homicide Mr. A was under the influence of alcohol and the Court found him culpable for his actions.

However the Investigation found that the failure of the service to provide an effective assessment of Mr. A's mental health and to provide him with an ongoing programme of interventions and assistance following his suicide attempt contributed to his on-going vulnerability. This vulnerability led to him to present in crisis to the housing services and to seek support from Mental Health services immediately prior to him assaulting and killing Mr. Y.

12. Service Updates and Recommendations

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

The Independent Investigation Team worked with the Avon and Wiltshire Mental Health Partnership NHS Trust to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice has been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can further improve services and consolidate the learning from this inquiry process.

1. Diagnosis

Service update.

The Adult Community Service has implemented a caseload supervision model. Caseload supervision is in place for all practitioners and all team leaders routinely scrutinise all caseloads to ensure appropriate risk assessment, care planning and interventions are in place, on a minimum of a monthly basis.

Caseload supervision is scrutinised and monitored through line management arrangements. Area managers formally report on this through the Trust's monthly Quality Improvement & Performance meeting.

A Clinical Development team has been established to drive up and monitor quality, and members of this team routinely visit each service on a monthly basis and scrutinise patient records to ensure that all clinical staff are being supervised.

Recommendation 1

The Trust should ensure that all relevant clinical staff receive appropriate training in diagnosis and formulation.

The Trust should ensure, as part of the supervision programme that it had put in place, that assessments of need and risk lead to clear formulations and these are used to inform the planned interventions.

2. Medication and Treatment

Service update.

In January 2013 the Trust has launched a project to improve the quality of care planning, with the following objectives:

- to improve collaborative care planning and service user involvement in care planning;
- to ensure all service users have effective crisis and contingency plans;
- to ensure that all service users have risk assessments that are up to date;
- to ensure that carers are offered assessments that are followed up by care plans;
- to ensure that all service users have details of how they can contact their care co-ordinator;
- to ensure that all care plans include interventions to address risk;
- to ensure that service users have signed their care plans;
- to improve capacity management.

This will enable scrutiny of the care plans of all practitioners, and those who have difficulties, will receive additional training, supervision and, if required, performance management. The success of the project will be measured through a peer review audit process.

Recommendation 2

The Trust should put in place appropriate mechanisms to assure itself and its commissioner that the initiatives it has put in place are appropriately scrutinised and reported on in a timely manner to allow appropriate monitoring to take place both within the Trust and by the commissioners of services

3. The Care Programme Approach (CPA)

Service update.

Robust allocation processes are now in place in all teams, to ensure that all service users have a named care co-ordinator and a collaboratively agreed plan of care and a contingency plan.

The Trust has implemented a key worker system within the Intensive teams which ensures that all service users have a named and accountable care co-ordinator, known to them, who is responsible for collaboratively developing a relevant care plan and contingency plan. Both these mechanisms are monitored by the clinical development team as part of the programme of their monthly visits

Recommendation 2

The Trust should put in place appropriate mechanisms to assure itself and its commissioner that the initiatives it has put in place are appropriately scrutinised and reported on in a timely manner to allow appropriate monitoring to take place both within the Trust and by the commissioners of services

4. Risk Assessment

Service update.

All teams have received training within the last six months on risk assessment, risk management, and crisis and contingency planning. The quality of these plans and adherence to the Trust policy is monitored and scrutinised via the caseload supervision process, and struggling practitioners are identified and developed in line with the care planning improvement project described earlier.

Recommendation 3

The Trust should review the documentation that clinical staff employ to assess and record risk. It should ensure that these promote and facilitate best practice.

Recommendation 2

The Trust should put in place appropriate mechanisms to assure itself and its commissioner that the initiatives it has put in place are appropriately scrutinised and reported on in a timely manner to allow appropriate monitoring to take place both within the Trust and by the commissioners of services.

5. Referral, Transfer and Discharge

Service update.

There are now robust allocation methods in place in both Intensive and Recovery teams which allocate each service user to an accountable and responsible practitioner. This

practitioner is required to develop a care plan and contingency plan for each service user on their caseload, and ensure that discharge and 'step down' processes are comprehensive and safe.

This process is monitored via caseload supervision, whereby all step down and discharge arrangements are reviewed. It is explicit that the assessment planning and co-ordination of the delivery of care are the responsibility of the care co-ordinator and that the care co-ordinator must be present at review meetings.

The implementation of RiO, the electronic patient record system has enabled staff to access comprehensive information about service user's history, previous service use, and risk profile, electronically from any Trust site, or remotely on a 24 hour basis.

Recommendation 2

The Trust should put in place appropriate mechanisms to assure itself and its commissioner that the initiatives it has put in place are appropriately scrutinised and reported on in a timely manner to allow appropriate monitoring to take place both within the Trust and by the commissioners of services

6. Safeguarding Children and Vulnerable Adults

Service update.

There has been an emphasis on training staff to enable them to deliver on their safeguarding responsibilities. 93% of staff are trained to level one, with two staff in each team trained to level three in order to promote appropriate leadership of the safeguarding agenda, plus practical advice and support.

Recommendation 4

The Trust, in conjunction with its partner agencies and commissioners, should ensure that the local Safeguarding policies and procedures are being implemented in a consistent manner.

It should ensure that information is communicated to relevant agencies in an agreed and timely manner.

7. Carer Assessment and Carer Experience

Service update.

Trust policy required all identified carers to receive a formal carer's assessment, and this is now monitored through the caseload supervision process.

Recommendation 5

The Trust should put in place an assurance mechanism, perhaps involving the families and carers of service users, to ensure itself and its commissioners that:

- carers are being offered assessment in a timely manner and
- the plan subsequently developed meets the needs of the carers.

8. Housing

Service update.

There are robust allocation and supervision processes in place in community teams, which result in a named care co-ordinator for each service user, who is responsible and accountable for keeping track of service users on their caseload and reviewing the plans in place at the point of any change in circumstances - such as a change of accommodation.

Recommendation 6

The Trust should ensure that protocols are in place to ensure that appropriate communication, information sharing and joint planning between Mental Health Services and Housing and other Local Authority services takes place.

The Trust should put in place mechanisms to ensure that these protocols are being implemented as intended.

9. Documentation and Professional Communication

Service update.

The combination of the care planning improvement project and the implementation of RiO, the electronic patient record system, has systematically improved the quality, comprehensiveness and accessibility of patient records. Care co-ordinators are accountable and responsible for carrying out an assessment and formulation and using this to inform a collaborative plan of care and contingency plan. Comprehensiveness and quality of records

is monitored via the caseload supervision process, which is further scrutinised via the programme of team audits carried out by the Clinical development team.

Recommendation 2

The Trust should put in place appropriate mechanisms to assure itself and its commissioner that the initiatives it has put in place are appropriately scrutinised and reported on in a timely manner to allow appropriate monitoring to take place both within the Trust and by the commissioners of services.

10. Adherence to Local and National Policy and Procedure

Service update.

The Trust has a new policy framework in place which requires clearly stipulated auditing requirements to be included for each policy area. This describes in details the areas to be monitored and the frequency of monitoring. Results of the auditing work are included in regular assurance reports to the relevant overview committee.

Recommendation 7

The Trust should continue its ongoing monitoring of the policy library and adherence to the newly established policy auditing standards.

11. Management of the Clinical Care and Treatment of Mr. A

Service update.

All service users referred and taken on by the Intensive teams are allocated to a named worker who is responsible and accountable for carrying out an assessment and formulation, which informs a collaborative care plan and contingency plan.

On the basis of the outcome of the Intensive team input, when service users are transferred to the Recovery team, this is to a named care co-ordinator who is responsible and accountable for picking up the short term plan from the Intensive team, and working with the service user to develop and co-ordinate a longer term care plan and contingency plan.

Recommendation 2

The Trust should put in place appropriate mechanisms to assure itself and its commissioner that the initiatives it has put in place are appropriately scrutinised and reported in a timely

manner to allow appropriate monitoring to take place both within the Trust and by the commissioners of services.