

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

Investigation Conducted by: HASCAS the Health and Social Care Advisory Service
Report Authored by: Mr. Jon Allen

Contents

1. Investigation Team Preface	Page 4
2. Condolences to the Family and Friends of Mr. Y	Page 5
3. Background and Context to the Investigation	Page 6
4. Terms of Reference	Page 8
5. The Independent Investigation Team	Page 9
6. Investigation Methodology	Page 10
7. Profile of the Avon and Wiltshire Mental Health Partnership NHS Trust	Page 18
8. Chronology of Events	Page 21
9. Exploration and Identification of Contributory Factors and Service Issues	Page 34
- 9.1.1. Diagnosis	Page 36
- 9.1.2. Medication and Treatment	Page 39
- 9.1.3. Use of the Mental Health Act (1983 & 2007)	Page 43
- 9.1.4. The Care Programme Approach	Page 43
- 9.1.5. Risk Assessment	Page 48
- 9.1.6. Referral, Transfer and Discharge	Page 53
- 9.1.7. Safeguarding Children and Vulnerable Adults	Page 57
- 9.1.8. Carer Assessment and Carer Experience	Page 72
- 9.1.9. Service User Involvement in Care Planning	Page 74
- 9.1.10. Housing	Page 76
- 9.1.11. Documentation and Professional Communication	Page 78
- 9.1.12. Adherence to Local and National Policy and Procedure	Page 81
- 9.1.13. Management of the Clinical Care and Treatment of Mr. A	Page 83
- 9.1.14. Clinical Governance and Performance	Page 87
10. Summary of Findings and Conclusions	Page 93
11. Avon and Wiltshire Mental Health Partnership NHS Trust Response to the Incident and the Internal	Page 102

Investigation

12. Lessons Learned	Page 111
13. Recommendations	Page 112
14. Glossary	Page 122

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. A was commissioned by NHS South of England Strategic Health Authority pursuant to *HSG (94)27*.¹ This Investigation was asked to examine a set of circumstances associated with the death of Mr. Y who was found killed on 9 September 2009.

Mr. A received care and treatment for his mental health condition from the Avon and Wiltshire Mental Health Partnership NHS Trust. It is the care and treatment that Mr. A received from this organisation that is the 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 Mr. Y

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

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

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South of England (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *HSG(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.

Mr. A Independent Investigation Report

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.

4. Terms of Reference

To review

1. The quality of health care provided by the Trust, to include whether it complied with statutory guidance, statutory obligations, relevant Department of Health guidance and Trust Policies.
2. The appropriateness 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 perpetrator 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.

5. 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
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Investigation Team Members

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

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

Mr. Ashley Irons	Solicitor, Capsticks
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6. Investigation Methodology

In September 2011 NHS South of England (the Strategic Health Authority) commissioned the HASCAS 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. The investigation methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. A and all witnesses to this Investigation.

Consent and Communications with Mr. A

Mr. A was written to by the Strategic Health Authority (SHA) requesting his consent to access clinical records. Mr. A did not reply. In the event the Strategic Health Authority made a Data Protection Application to the Avon and Wiltshire Mental Health Partnership NHS Trust Caldicott Guardian to release Mr. A's clinical records to this Investigation.

Communications with the Victim's Family

Mr. Y's family were written to and met by representatives from the Strategic Health Authority at the outset of the investigation. The Strategic Health Authority and the Investigation Chair met with Mr. Y's mother, father and sister at their home on 15 October 2012.

Communications with the Family of Mr. A

The Strategic Health Authority wrote to Mr. A's family at the outset of the investigation, and again in July 2012. Mr. A's family did not reply to any of the correspondence sent to them.

Communications with the Avon and Wiltshire Mental Health Partnership NHS Trust

The SHA wrote to the Avon and Wiltshire Mental Health Partnership NHS Trust Chief Executive in the autumn of 2011. 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. A. As the Avon and Wiltshire Mental Health Partnership NHS Trust was familiar with the procedure for Independent Investigations the Trust decided, after discussion with the Independent Investigation Team, that a meeting to explain the process and how HASCAS worked would not be necessary.

The Independent Investigation Team worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- 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;
- that a workshop for witnesses to the Independent Investigation was held on 24 July 2012. The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible;
- that interviews on 1 October and 2 October 2012 were held at the Avon and Wiltshire Mental Health Partnership NHS Trust's Offices at Windmill House in Clevedon. The Investigation Team were afforded the opportunity to interview witnesses and meet with the Trust Corporate Team;
- that two transcribed telephone interviews were held with two witnesses from the Trust who had been unable to attend for interview during the first week in October. These interviews took place on 5 November 2012.
- that on 3 December 2012 a meeting was held between the Chair of the Independent Investigation, the CEO of the HASCAS Health and Social Care Advisory Service and the Trust Corporate Team, in order to discuss the findings and to invite the Trust to contribute to the development of recommendations.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon processes.

The witnesses who attended for interviews are set out below in table one.

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
1/10/2012	<ul style="list-style-type: none"> • Crisis and Home Treatment Care Coordinator and Mental Health Support Worker; • Crisis and Home Treatment Team Social Worker; • Team Managers; • Internal Investigation Team. 	Investigation Team Chair; Investigation Team Psychiatrist; Investigation Team Nurse; Investigation Team Social Worker. In attendance: Stenographer.
2/10/2012	<ul style="list-style-type: none"> • Crisis and Home Treatment Team staff who had telephone contacts with Mr. A; • Consultant Psychiatrist 1; • Housing Officer and Manager. 	Investigation Team Chair; Investigation Team Psychiatrist; Investigation Team Nurse In attendance: Stenographer.
3/10/2012	<ul style="list-style-type: none"> • Chief Executive and Director of Nursing, Compliance, Assurance and Standards. 	Investigation Team Chair; Investigation Team Psychiatrist; Investigation Team Nurse. In attendance: Stenographer.
5/11/2012	<ul style="list-style-type: none"> • Community Mental Health Team, Team Leader – telephone interview; • CMHT Psychiatrist – telephone interview. 	Investigation Team Chair; Investigation Team Psychiatrist; Investigation Team Nurse; Investigation Team Social Worker. In attendance: Stenographer.

Salmon and Scott Compliant Procedures

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

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

Mr. A Independent Investigation Report

- (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; and
 - (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.
 5. All sittings of the Investigation will be held in private.
 6. The findings of the Investigation and any recommendations will be made public.

Mr. A Independent Investigation Report

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

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, a set of clinical policies and procedures, 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 made aware in advance of their interview of the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

First Team Meeting 17 September 2012

The Team examined and discussed the Chronological Timeline which had been produced following the receipt of the full clinical records. The Team decided which staff they wished to interview and agreed questions they would ask. The list of documents required was made; this consisted of various Trust Policies and Operational Policies together with information about the Trust.

Second Team Meeting 2 October 2012

There was a gap in the interviewing schedule which allowed the Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the running of the various teams which had contact with Mr. A and also management and governance issues.

Third Team Meeting 5 November 2012

The Team had received the transcriptions and were therefore able to add to the Chronological Timeline to reflect the additional information received *via* the interviews. There were also additional policies and procedures from the Trust which were examined.

Other Meetings and Communications

The Independent Investigation Team Chair met on a regular basis with NHS South of England throughout the process. Communications were maintained in between meetings by email, letter and telephone.

Root Cause Analysis

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 throughout this process.

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. From this, causal factors or critical issues can be identified.
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.

Information and Evidence Gathered (Documents)

During the course of this Investigation 310 pages of clinical records have been read and some 1000 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. A's clinical records;
2. Avon and Wiltshire Mental Health Partnership NHS Trust Clinical Polices;
3. Clinical Witness/Witness transcriptions;
4. Healthcare Commission/Care Quality Commission Reports for the Avon and Wiltshire Mental Health Partnership NHS Trust services;
5. 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;

Mr. A Independent Investigation Report

6. Guidelines for the NHS: National Patient Safety Agency, Safer Practice Notice, 10, *Being Open When Patients are Harmed*. September 2005;
7. Trust policy and procedures relating to the Care Programme Approach, and Risk Assessment and Management;
8. NICE clinical guidelines;
9. ICD 10 diagnostic guidelines and criteria.

7. Profile of the Avon and Wiltshire Mental Health Partnership NHS Trust Services (Past, Present and Transition)

The Avon and Wiltshire Mental Health Partnership NHS Trust's (The Trust) description of its services is reported below.

The Trust exists to provide high quality mental health and social care services to people of all ages, and to those with needs relating to drug or alcohol misuse. The Trust promotes health and wellbeing through the recovery model, supporting individuals to reach their potential and to live fulfilling lives. As one of the largest providers of mental health services in the country, the Trust continuously works hard to ensure those in our communities receive help when they need it.

The Trust operates across a geographical span of 2,200 square miles, encompassing a population of 1.6m people and covering six Primary Care Trusts (PCTs). Services are centred upon 11 main in-patient sites, 97 community bases and four community mental health houses. The Trust has an operating budget of £194m per year and employs in excess of 3,500 staff.

The Trust is overseen by a Board of Directors with joint responsibility for the governance, leadership and strategic direction of the Trust. The Chief Executive is responsible for the day-to-day management of the Trust. The Chief Executive is supported by five Executive Directors, each of whom manages a Directorate with responsibility for an area of the Trust's operations and performance. The Operations Directorate leads the delivery of services across the Operational Strategic Business Units (SBUs), covering:

- Specialist Drug and Alcohol Service SBU;
- Adults of Working Age SBU;
- Liaison and Later Life SBU;
- Specialised and Secure Services SBU.

This structure is currently under review to create more of a local focus.

The Trust's strategic objectives are:

- A Sustainable Value for Money Business

Mr. A Independent Investigation Report

- Excellent Service User Access and Experience.
- Excellent Partnership Working with Other Organisations
- Effective Staff Engagement and Improvement in Staff Satisfaction.

North Somerset has a population of 212,200. There are high levels of morbidity within the Weston Super Mare area. The Avon and Wiltshire Mental Health Partnership NHS Trust's Mental Health Services work in close partnership with the Primary Care Trust, North Somerset Council and the Voluntary Sector.

The North Somerset Primary Care Liaison team provides the integrated single point of entry into secondary mental health services. This team also provides shorter term work with service users.

The Recovery team is based at Coast Resource Centre and works with service users who have more complex mental health conditions. The majority of people however will have time-limited conditions and will be referred back to their GP's when their condition has improved. A substantial minority of people with more complex and enduring needs will remain with the Recovery team for ongoing specialist care and monitoring for a longer period of time.

North Somerset has an Intensive team (formerly Crisis and Home Treatment). The service works with individuals, with an acute psychiatric crisis of such severity that, without their involvement, hospitalisation would be necessary. The team acts as a 'gate keeper' to acute in-patient services and for those individuals for whom intensive support would be appropriate and provides immediate multi-disciplinary, community based treatment 24 hours a day, seven days a week. Where hospitalisation is necessary the team is actively involved in discharge planning and provides intensive short term care at home to enable people to leave hospital at the earliest possible opportunity.

North Somerset has an Early Intervention team. This service works with individuals aged from 14 to 35 years of age who are experiencing a first episode of psychosis. The service aims to reduce the stigma associated with psychosis and raise awareness of the symptoms of psychosis and the need for early assessment in order to reduce the length of time young people remain undiagnosed and untreated. Providing a user centred service it is focused on

Mr. A Independent Investigation Report

meaningful engagement and promotion of recovery during the early phase of illness. The Early Intervention team provides a service for young people in the first three years following a first episode of psychosis. They offer intensive evidence based psychosocial interventions, including Cognitive Behavioural Therapy (CBT) and family work for psychosis. The team works flexibly but quite intensively with service users and will see people at weekends and evenings. This is usually in the service users own preferred environment where they feel most comfortable and at ease.

8. 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. A and on his care and treatment from mental health services. The following chronology condenses over 300 pages of clinical records.

Background Information

Mr. A was born in 1990 and was brought up in the Clevedon area. His GP records record him as having an uneventful early childhood from a health perspective, other than a period as a very young infant when he would scream for an hour or so at a time at night, and was prescribed Phengren. He was also diagnosed as suffering from asthma as a young child and received treatment for this. The Independent Investigation did not have information about Mr. A's primary school days. In the earliest stages of his secondary school career, at the age of 12 or 13, his mother took him to his GP because Mr. A was getting into fights and was being excluded from school for periods of time because of his behaviour. His parents were concerned that he might have ADHD.

At times Mr. A reported that he did not have a good relationship with his mother and that his family were a difficult and challenging family. At other times Mr. A reported that he had a good childhood and a supportive family but that he had got into difficulty by 'sticking up for himself' when he was being bullied.

Early Psychiatric History

Throughout his adolescence Mr. A misused drugs and alcohol and got into fights. His GP referred him to Child and Adolescent Services in 2004, when he was 14, and requested that Mr. A be assessed for Attention Deficit Disorder (ADD), after he had been excluded from school. Mr. A attended three appointments with a Clinical Psychologist from the Child and

Mr. A Independent Investigation Report

Adolescent Mental Health Services (CAMHS) and then did not attend any further appointments. There was no record of whether he was assessed for ADD.

When he was 16 Mr. A presented to his GP reporting that he was feeling low in mood. He obtained a PHQ9 score of 26. He had taken a small overdose. He was seen as an urgent referral at the Adult Community Mental Health Team by a Social Worker and another Mental Health Worker. He was offered two follow-on appointments for assessment of his lowered mood and consideration for treatment by a Psychiatrist. Mr. A did not attend either of these appointments. He was discharged to the care of his GP.

20 February 2003: Mr. A attended his GP surgery with his mother. She reported that Mr. A was on his tenth exclusion from school for getting into fights. His parents were concerned that Mr. A suffered from ADD. He was impulsive and able to concentrate only for short periods. Shortly before this consultation an Educational Psychologist had diagnosed Mr. A as suffering from dyslexia. Mr. A was referred to the community paediatric service.²

22 May 2003: It is noted in Mr. A's GP record that he had not attended an appointment with the community paediatric service.³

23 July 2003: Mr. A attended his GP with a cut lip and bruising. He told the GP he had been attacked by two older boys on his way home from school.⁴

25 June 2004: Mr. A attended his GP. He reported that he had experienced some mental disturbances as a result of abusing solvents. He was perceived by his GP to be boasting about his drug knowledge. Mr. A reported that he was losing weight and experiencing mood swings. He was also on 'level 3 exclusion' from school. Mr. A said that he had not received the appointment letter from the community paediatric service the previous year and this was why he had not attended the appointment. The GP made an urgent referral to the community paediatric service⁵.

2 GP records p4

3 GP records p4

4 GP records p5

5 GP records p5

21 July 2004: A letter was sent by the community paediatric service advising Mr. A and his mother that there was a 21 week waiting list for Child and Adolescent Mental Health Services consultation appointments.⁶

26 October 2004: Mr. A attended his GP following a needle stick injury. His mother reported that the needle was from a home tattoo kit which had been used by someone who claimed to be HIV positive. The Consultant Virologist who was consulted assessed the risk of infection as low and no further action was taken.⁷

17 November 2004: Mr. A was seen by the Child and Adolescent Mental Health Team Clinical Psychologist. She recorded that Mr. A had resolved his solvent abuse problems with the help he had received from school. She noted he had serious problems with his temper, impulsiveness, attitude and lack of control. He was “*hanging around*” with a group of older boys and was entrenched in his role as a “*hard guy*”. Mr. A’s mother reported that Mr. A had learning problems, poor concentration and that he was easily led.⁸

27 January 2005 and 25 February 2005: The Internal Investigation reported that there were further appointments with the CAMHS Clinical Psychologist on these dates. There was no record of these in the clinical records made available to the Independent Investigation.⁹

March 2005: The Internal Investigation reported that Mr. A missed a CAMHS outpatient appointment on this date. The family were written to and asked to make contact with the service to arrange a further appointment.

Clinical History with the Avon and Wiltshire Mental Health Partnership NHS Trust

5 December 2006: Mr. A attended his GP. He said that he had felt depressed for over a year, but had felt worse recently. His mother had recently informed him that she was seriously ill. He reported that: he frequently cried, he was not able to enjoy life, his appetite was poor and he was waking early. Mr. A reported that he had thought about taking an overdose, but did

6 GP records – Green Practice p5

7 GP records – Green Practice p5

8 GP records – Green Practice p25

9 Trust internal investigation report p17-18

not think he would do this. The GP referred Mr. A to secondary care mental health services seeking advice as to whether Mr. A would benefit from antidepressant medication.¹⁰

7 December 2006: Mr. A attended his GP with his girlfriend, following him self-harming the previous evening. He presented with cuts on his arms and smelling of alcohol. He reported that his relationship with his mother was problematic and that he spent a lot of time at his girlfriend's house, where there were also problems. The GP recorded the need to expedite Mr. A's mental health referral. He planned to review Mr. A again the following week and have Mr. A complete a PHQ9, a depression screening questionnaire.

11 December 2006: Mr. A attended an appointment with the Community Mental Health Team. He was seen by a social worker and another practitioner. They found him to be low in mood. Mr. A reported that he had been drinking alcohol and smoking cannabis but that he had stopped this recently. He also reported that he had thought about taking his own life, but did not currently have any plans to do this. He told the practitioners that he was worried about his future because of his lack of education. The practitioners noted that although Mr. A said he would walk away from trouble, they felt he would find this difficult given his history of getting into fights and poor anger management. It was noted that Mr. A had had some anger management training when he was under the care of the CAMH services, but that he had found this unhelpful.

It was concluded that Mr. A should be assessed by a team psychiatrist and be offered further appointments by one of the practitioners.¹¹

13 December 2006: Mr. A's GP recorded that his PHQ9 score was 26.

15 January 2007 and 1 February 2007: Mr. A failed to attend his appointments with the Community Mental Health Team.

23 May 2008: Mr. A attended his GP requesting pain relief for stab wounds to his head and ear. He had been assaulted the previous night and had attended the local General Hospital where his wounds were sutured.

10 GP records p5

11 GP records p5

5 January 2009: Mr. A attended his GP. He informed the GP that his ex-partner had given birth to their baby and he wanted to resume their relationship. However Social Services had stated Mr. A must have a negative drug screen before he could have access to the child. This was because of his history of violence when intoxicated. He reported that he was using only cannabis at that time, but that he had been using “*mdma*”, cocaine and other pills until a month earlier. Mr. A said that he would seek information on stopping smoking, and about anger management counselling. The GP recorded that Mr. A appeared to be committed to changing. He was started on nicotine replacement therapy.

28 February 2009 and 13 March 2009: Mr. A’s urine drug screen was recorded as been “*satisfactory*”.¹²

10 April 2009: Mr. A was admitted to Bristol Royal Infirmary Intensive Treatment Unit after being found hanging in an alleyway by an off-duty paramedic. He was intubated and sedated.¹³

12 April 2009: Mr. A was assessed by the Liaison Psychiatry Senior House Officer and deemed medically fit for discharge from hospital. He concluded that the attempted suicide was an impulsive act in response to stress over debts, and that Mr. A had no plans to harm himself. He found Mr. A to be low in mood but not clinically depressed. He did not find evidence of psychosis. The Psychiatrist noted Mr. A’s drug misuse history but understood that Mr. A had not used illicit drugs for a number of months. He recorded the family support Mr. A had available to him. Mr. A said that he did not want to be referred to Mental Health services and would not attend any appointments. Mr. A’s risks were recorded as “low to moderate” risk of repeated self-harm or suicide attempt and as “none” for risk to others. Mr. A was discharged to the care of his family with advice on how to use the Out of Hours GP service and information about the Out of Hours Crisis Service. The Liaison Psychiatrist informed the Crisis Team, the GP and the CMHT, to ensure they were aware of events.¹⁴

14 April 2009: Mr. A visited his GP feeling anxious and shaky. He said that he regretted his suicide attempt but was afraid that he might do it again. He could see no way out of his debt

12 GP records p5

13 GP records p5

14 Trust Records p80

and unemployment situation. The GP prescribed Diazepam 2mg and Zopiclone 7.5mg. He also discussed Mr. A with the Crisis Team who agreed to see him the same day.¹⁵

14 April 2009: Staff Nurse 1 and Support Worker 1 from the Crisis Team visited Mr. A at his mother's home and completed an assessment. Mr. A was seen accompanied by his girlfriend. A history was taken and mental health and risk assessments were completed using Trust form 'ecp1d'. This form was not fully completed and there were important omissions from Mr. A's recorded history, for example no history of violence or previous history of using mental health services were recorded. Mr. A was found to be low in mood but no evidence of other psychiatric symptoms was identified. A CPA care plan was documented following this meeting. Two goals were documented in the care plan. The first was to promote Mr. A's personal safety, the safety of others and to prevent admission to hospital. The second goal was to support Mr. A through his mental health crisis and reduce his suicidal intent and thoughts. Some actions to support Mr. A achieve these goals were documented.

16 April 2009: Mr. A was visited by Support Worker 1. He was positive about the future and talked about moving back to his girlfriend's flat. He said that he was finding it stressful living with his mother as they were arguing a great deal. A Child Safeguarding Risk Assessment form (CPe2) was completed because Mr. A's baby daughter lived at his girlfriend's flat and it was a requirement that he was not using illicit drugs if he was to have access to his daughter. The form included details of who his girlfriend's Social Worker and Parenting Worker were. However it was not clear whether these professionals were contacted by the Mental Health Crisis Team at this time.

The Crisis Worker documented a plan to follow this visit up with a telephone call on 18 April and to make another home visit on 21 April.^{16 17}

18 April 2009: Mr. A was telephoned by Support Worker 2 from the Crisis and Home Treatment Team. The Support Worker recorded that Mr. A seemed reluctant to talk but said he was feeling "*alright*". He denied that he had any plans to harm himself. The plan to do another home visit on 21 April was reiterated.¹⁸

15 GP Records p9

16 Trust Records p47

17 Trust Records p7

18 Trust Records p47

22 April 2009: Mr. A was visited at home by Support Worker 1 from the Crisis and Home Treatment Team. He had been started on the antidepressant Citalopram by his GP and had started reducing his Diazepam. Support Worker 1 recorded that Mr. A appeared to be “OK” and was talking about future plans. It was planned that Mr. A would be seen again on 25 April.¹⁹

23 April 2009: A 10 page Integrated Care Programme Approach (ICPA) document, dated the week commencing 23 April, is in Mr. A’s clinical records. However this document does not provide any information indicating whether a review had taken place. The document repeats the information that was captured in the earlier ICPA documents. There are two pages of hand written notes within the document. These pages are titled “*Acute Enhanced ICPA Review (professional evaluation of last ICPA plan)*”. These entries are a contemporaneous record of the contacts with Mr. A on 22 and 26 April. There is no evaluation of care contained in these documents. Staff Nurse 1 is identified as Mr. A’s Care Coordinator. The majority of the 10 pages were not completed. Other than the entries relating to the contacts with Mr. A this document is not signed.²⁰

26 April 2009: The Crisis Team was paged by an ambulance crew to inform them that Mr. A was being taken into hospital following him taking an overdose of Citalopram, Zopiclone and alcohol. The Crisis Team was contacted later by the Accident and Emergency Department and advised that Mr. A had taken a small overdose that did not require treatment. The Senior House Officer (SHO) advised that Mr. A had taken an impulsive overdose after an argument with his girlfriend and he was no longer feeling suicidal. He and his family were happy for him to be discharged to the care of his family, with follow-up from the Crisis Team. The SHO did not feel that a psychiatric review was required. The Crisis Team agreed to contact Mr. A once he returned home and to review him next morning.²¹

26 April 2009: The Crisis Team Staff Nurse 2 telephoned Mr. A’s mobile telephone but it was switched off. He then telephoned Mr. A’s mother’s house. She advised him that Mr. A had gone to his girlfriend’s house. He then telephoned Mr. A’s girlfriend’s house and spoke to his girlfriend. She said that she was making sure Mr. A did not drink as this was when he

19 Trust Records p38

20 Trust Records pp36-43

21 Trust Records p38

Mr. A Independent Investigation Report

tended to take overdoses. Mr. A said that he was not feeling suicidal and he would be happy to talk to the team again next morning.²²

27 April 2009: Support Worker 2 discussed Mr. A with the Team Community Psychiatric Nurse (CPN). He asked if he thought Mr. A should be reviewed by a qualified member of staff before he, Support Worker 2, reviewed him again. The CPN (Staff Nurse 3) said he did not think this was necessary as the doctor in Accident and Emergency had not thought that Mr. A needed a psychiatric assessment on the previous evening. The Support Worker called Mr. A and found that he had gone to his GP to get antidepressant medication. He was feeling low in mood. A home visit was arranged for later in the day.²³

27 April 2009 14.00 hours: Support Worker 2 visited Mr. A at home, his girlfriend was present. Mr. A appeared very low and tearful. He said that he was not sure whether he was sorry about taking an overdose. He sometimes felt it would be better if he was not there. Mr. A said he *“felt like a jar with the lid stuck on that could explode at any time”*. Mr. A’s girlfriend said that a friend was now managing Mr. A’s medication and giving him the medication only when he required it, so he could not take an overdose. Mr. A discussed some of his recent stressors and during the conversation became more relaxed and responsive. He identified that arguments with his brother and his girlfriend were triggers to his suicide attempt and recent overdose. He felt that would be *“okay”* because his girlfriend was helping him stay away from alcohol and his friend was looking after his medication. The plan was to do another home visit on 29 April.²⁴

28 April 2009: The Specialist Registrar agreed to see Mr. A on 1 May to review his care. Staff Nurse 3 in the Crisis Team noted the need to provide someone to take Mr. A to this appointment.²⁵

28 April 2009: Mr. A’s girlfriend telephoned the Crisis Team to inform them that Mr. A had taken six Diazepam tablets; he had been drinking alcohol and was threatening to drink

22 Trust Records p39

23 Trust Records p85

24 Trust Notes P38

25 Trust Notes p87

Mr. A Independent Investigation Report

bleach. He had run off and she had found that money from her purse was missing. Support Worker 1 advised her to telephone the police or an ambulance if she was concerned.²⁶

28 April 2009, 21.00 hours: Support Worker 1 made a follow-up telephone call to Mr. A's girlfriend. Mr. A had returned and was sleeping on the sofa. Support Worker 1 asked if Mr. A needed medical attention. His girlfriend said that there did not appear to be any problems with his breathing. She said that she did not think he warranted a visit to the Accident and Emergency Department but that she would "*keep an eye on him*". Support Worker 1 told her that she could call back if she needed help.²⁷

29 April 2009: Support Worker 1 visited Mr. A at home. He was quiet and did not want to talk about the events of the day before. He told the Support Worker that he would talk to the doctor when he saw her on 1 May.

1 May 2009: Mr. A attended an outpatient appointment with the Specialist Registrar. Support Worker 1 and a Social Worker from the Crisis Resolution and Home Treatment Team (CRHT) had accompanied him to the appointment. The Specialist Registrar found Mr. A to be subjectively low in mood but he was not expressing any suicidal ideas at that time. She referred him to the local CMHT, as he was no longer in the catchment area for the Windmill House CMHT. The Specialist Registrar wrote to Mr. A's GP recommending that he increase Mr. A's antidepressant medication, Mirtazapine, to 30mgs daily. She asked the CRHT to continue seeing Mr. A twice a week. She wrote that she hoped that the CMHT would accept Mr. A in the next week but that if not she would see him for a further appointment.²⁸

3 and 5 May 2009: Support Worker 1 had telephoned Mr. A and visited him at home. On both occasions he found Mr. A to be feeling "*okay*". He spoke positively about his future. Support Worker 1 agreed to accompany Mr. A to his second appointment with the Associate Specialist.²⁹

26 Trust Notes p86
27 Trust Notes p86
28 GP Records p134
29 Trust Note p91

8 May 2009: Mr. A attended an outpatient appointment with the Associate Specialist. The Associate Specialist recorded in her letter to Mr. A's GP that he appeared to have improved in mood and was sleeping better since the doses of Mirtazapine had been increased. She also recorded that Mr. A had recently been involved in a fight with his brother. Mr. A said that he did not search for trouble but if he saw his brother he might be violent again. He said that he was like other members of his family who had a bad reputation for fighting. The Associate Specialist felt that Mr. A's problems and his suicide attempt were more mal-adjusted coping mechanisms rather than suicidality secondary to depression. She suggested that the Crisis Team saw Mr. A twice a week until he had an appointment at the CMHT which should still go ahead because of the serious nature of his suicide attempt.³⁰

10 May 2009: a Social Worker from the Crisis Team telephoned Mr. A to check how he was. Mr. A said that he was feeling better but had been feeling "*snappy*" and agitated over the previous few days. He wondered whether this could be caused by his medication. Mr. A had not been going out but he had no thoughts of harming himself. The Social Worker recorded a plan to visit Mr. A at home on 13 May.³¹

13 May 2009: Staff Nurse 3 visited Mr. A at home. Mr. A said he was feeling safe in himself but was still having a lot of "*down days*". His medication was making him sleep heavily. Mr. A said that he would have preferred his appointments to stay at the Windmill CMHT because he would find it hard to get to Weston. Staff Nurse 3 discussed Mr. A being discharged from the Crisis and Home Treatment Team and promised to provide him with information about the Primary Care psychological therapy service, Positive Steps.³²

18 May 2009: Support Worker 1 telephone Mr. A. He said that he was in a good mood and was cooking for his family. The Support Worker informed Mr. A that he would telephone him again the next day with an outpatient appointment date and to arrange a visit.³³

22 May 2009: Staff Nurse 4 telephoned Mr. A to inform him of the date for his outpatient appointment at the CMHT. It was recorded in Mr. A's notes that he was discharged from the Crisis Team with a follow-up outpatient appointment at the Coast CMHT.³⁴

30 GP Records p132

31 Trust Records p93

32 Trust Records p93

33 Trust Records p95

2 June 2009: Mr. A attended an outpatient appointment with a first year Trainee Psychiatrist in the Coast CMHT. He was escorted to his appointment by a student from the Crisis and Home Treatment Team. The Trainee Psychiatrist reviewed Mr. A's care and treatment to date. She noted that although Mr. A was still feeling low, his medication was helping and he was no longer feeling suicidal. She recorded a diagnosis of moderate to severe depression and wrote in her letter to the GP that he could increase Mr. A's dose of Mirtazapine to 45mg a day if required. In her notes from the interview the Trainee Psychiatrist recorded the need for additional services such as Step 3 Primary Care services. In her letter to Mr. A's GP which she wrote after she had discussed Mr. A in supervision with Consultant 1 (the Consultant Psychiatrist to whom Mr. A had been referred) she discharged him from the secondary care service. Although this was not clear in her letter as she wrote "*He will need to be maintained on medication for 18 months. Subsequently he will be discharged*".³⁵

16 June 2009: Mr. A attended a review with GP 2. The GP recorded that Mr. A was still feeling stressed and that he was prescribed only Mirtazapine. He also recorded that he thought Mr. A's treatment was still being monitored by Secondary Mental Health services.³⁶

9 July 2009: Mr. A attended an appointment with GP 2. He reported that his mental state was stable but that he felt hopeless. The GP reported that he was going to refer Mr. A to Step 3 Primary Care Mental Health services, although he thought he was still under the care of Secondary Mental Health services.³⁷

15 August 2009: Mr. A telephoned and spoke to GP 3. He stated he was still feeling low and that he was thinking about moving to Cumbria. He had received a letter from the Housing Department which he said he needed to give to the GP.³⁸

24 August 2009: Mr. A was reviewed by GP 2. Mr. A reported that his sleep pattern was poor and he felt agitated during the day. He reported that some days he felt he would be "*better off dead*" but he had no definite plans to harm himself. GP 2 recorded that Mr. A had not had any follow-up from the Secondary Mental Health services since June 2009. GP 2

34 Trust Records p95

35 Trust records p136

36 GP Notes Yeo Valley p2

37 GP Notes Yeo Valley – p2

38 GP Notes Yeo Valley p2

recorded that he thought it would be more appropriate for Mr. A to be seen by the Positive Steps Primary Care Mental Health service and wrote a referral letter for this.³⁹

25 August 2009: Mr. A visited the Housing Advice Team at North Somerset Council with his girlfriend. He and his girlfriend were separating and he had nowhere to live. His parents had agreed that he could live with them for two weeks. He told the Housing Advice Officer that he was taking medication for depression and that he had previously had drug problems. She referred him to the Stonham Housing Association which provided supported housing including for those with mental health problems.⁴⁰

27 August 2009: Mr. A saw GP 3 and reported that he had left his partner to “*sort his head out*”. He said that he and his girlfriend were arguing a great deal and he was finding coping with the baby difficult. He had thrown his medication away and needed another prescription.

3 September 2009: Positive Steps wrote to Mr. A informing him that he had been referred for an assessment for individual psychological treatment. However there was a waiting list and they would contact him once he was near the top of the waiting list. The letter advised that if, in the meantime, Mr. A experienced further problems he should contact his GP.⁴¹

3 September 2009: GP 3 spoke to the Positive Steps Team regarding Mr. A’s referral. It was agreed there should be a joint assessment meeting involving the CMHT and Positive Steps to decide which service was most appropriate to meet Mr. A’s needs.⁴²

5 September 2009: Mr. A attended an assessment appointment for a supported housing placement with Stonham Housing. Stonham Housing did not offer Mr. A a place because he said he felt suicidal at times and was not safe to manage his own medication. They reported that he appeared agitated and anxious. Staff at Stonham Housing, with Mr. A’s permission, referred him to Elm Housing Support, an organisation which provided floating support to homeless people, particularly people with mental health problems. Elm Housing Support telephoned Mr. A on his mobile telephone but he never answered or returned their calls.⁴³

39 GP Notes Yeo Valley p2

40 Housing Advice Officers statement

41 GP Notes Yeo Valley p124

42 GP Notes Yeo Valley p2

43 Housing Advice Officers statement

8 September 2009: Mr. A met his Housing Advice Officer following Stonham Housing not having accepted his referral. He was no longer able to stay at his parents' home. The only option available to the Housing Advice Officer was placing Mr. A in an emergency hostel for homeless people. Mr. A told the Housing Advice Officer that he had previously had input from the Coast CMHT. She contacted the CMHT as she was concerned about Mr. A's mental health and spoke to a duty worker who confirmed that Mr. A had been referred by his GP for assessment and that he would be offered an appointment for assessment on 14 September.

At some point after this the Coast CMHT team leader, who had recently worked in the Crisis Team, recognised Mr. A's name. She reviewed the case and arranged to bring his assessment forward to 10 September, as she recognised that he might be at risk of serious self harm if he had broken up with his girlfriend. She asked the appointments secretary to telephone Mr. A to inform him of the appointment. A number of telephone calls were made and messages were left on Mr. A's mobile telephone but he did not respond to these calls.⁴⁴

9 September 2009: Mr. A went to see his Housing Advice Officer to complain about his accommodation being dirty. He thought there were bed bugs in the sheets. The Housing Advice Officer contacted the owner of the accommodation who agreed to address the problems that day.⁴⁵

9 September 2009: Mr. A spent the day with his girlfriend and daughter. He returned to his accommodation and then went to a public house for a drink. On his return from the public house Mr. A continued drinking in the hostel with other residents including Mr. Y. Mr. A had an altercation with Mr. Y and assaulted him. Mr. Y died from the injuries he sustained.⁴⁶

10 September 2009: The Weston CMHT wrote to Mr. A advising him that he had been referred by his GP. They invited him to an appointment on 14 September with the Psychiatrist from the CMHT and a practitioner/team leader from the Positive Steps service.⁴⁷ Mr. A had been referred to the Mental Health Services when he assaulted Mr. Y. Mr. Y died of his injuries. Mr. A was convicted of murder and sentenced to life imprisonment on 4 May 2011.

44 Witness interview transcripts

45 Housing Officers interview transcript

46 Court Records

47 GP Notes Yeo Valley – p123

9. Exploration and Identification 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. A it would look like this:

- Mr. A killed Mr. Y (ask why?)
- Because he got into a fight after drinking alcohol and killed Mr. Y.

A root cause is an initiating cause of a causal chain which leads to an outcome, in this case the death of Mr. Y. In order for causality to be attributed to a service it has to be shown that the service had complete control over the outcome of the events in question. The purpose of using root cause analysis is to seek out lessons that can be learned from the examination of a single case to try to establish how incidents of this kind can be prevented from occurring in the future. No Investigation Team should endeavour beyond a sensible limit to make connections where they cannot reasonably be made.

This Investigation has developed a detailed narrative which chronicles the events that occurred during the time Mr. A was under the care of the Avon and Wiltshire Mental Health Partnership NHS Trust. It has assessed whether services worked in accordance with extant national and local best practice guidance and detailed where interventions could have been improved.

RCA Third Stage

This section of the report examines all of 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 contributory and service issue factors.

In the interests of clarity each thematic 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 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’ and ‘contributory’ factors, and ‘service issues’ are used in this section of the report. They are explained below.

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 perpetrated by them. The term ‘causal factor’ is used to describe an act or omission that is concluded to have had a direct causal bearing upon the failure to manage a service user effectively and that this as a consequence impacted directly upon an incident occurring.

Contributory Factors. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown of Mr. A’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 Service and the act of homicide perpetrated by a third party.

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 Mr. 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.

Avon and Wiltshire Mental Health Partnership NHS Trust Findings

The findings set out in this Section analyse the care and treatment given to Mr. A by the Avon and Wiltshire Mental Health Partnership NHS Trust between April and September 2009.

9.1.1. Diagnosis

9.1.1.1. 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 (tenth 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.

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.

9.1.1.2. Findings

Between 2004 and 2009 Mr. A saw his General Practitioners on 11 occasions with behavioural and mental health problems. When Mr. A first presented with behavioural problems his GP referred him to the Community Paediatric Service. Mr. A failed to attend his initial appointment in 2003. Mr. A's GP re-referred him to the Community Paediatric Service in 2004 with a request to consider whether Mr. A suffered from Attention Deficit Disorder (ADD). In November 2004 Mr. A was seen by a Clinical Psychologist from the Child and Adolescent Mental Health Service (CAMHS). However Mr. A failed to attend subsequent appointments and therefore never received a full assessment and diagnosis of his difficult adolescent behaviour. Mr. A claimed, at that time, to be using a wide range of street drugs but there is no evidence in the clinical records supplied to the Independent Investigation that he was referred to any substance misuse service for assessment.⁴⁸

In 2006 Mr. A attended his GP, reporting that he was low in mood. His GP recorded that Mr. A obtained a score of 26 on the PHQ9, a screening tool for depression. A score of 15 or greater on this device is regarded as indicative that the individual is suffering from depression. Mr. A was referred to his local Community Mental Health Team for assessment, diagnosis and treatment. His initial appointment was with a Social Worker who advised that Mr. A would need to have an appointment with a Psychiatrist for assessment and treatment. Two follow-up appointments were offered but Mr. A did not attend either of them.⁴⁹

In April 2009 Mr. A attempted to take his own life. He was subsequently seen on four occasions by three Psychiatrists. He was assessed by a Liaison Psychiatrist when he regained consciousness and requested to be discharged from hospital. He was subsequently seen by a

48 GP records Vol. 1
49 GP records Vol. 2

Specialist Registrar on two occasions. This Psychiatrist provided a medical review while Mr. A was being supported by the Crisis and Home Treatment Team. Mr. A's final appointment with a Psychiatrist was with a first year Trainee Psychiatrist who saw him for an outpatient appointment following his discharge from the Crisis and Home Treatment Team.

The Liaison Psychiatrist found Mr. A to be subjectively low in mood. He concluded that Mr. A's attempted suicide was an impulsive act and he found no evidence of clinical depression.⁵⁰ The Specialist Registrar, on her second appointment with Mr. A, concluded that his problems stemmed more from mal-adjusted coping mechanisms than from depression. Despite this the Psychiatrist increased Mr. A's dose of antidepressant medication.⁵¹ The third, and most junior Psychiatrist, concluded that Mr. A was suffering from a moderate to severe depression in conjunction with challenging social circumstances.⁵²

None of the Psychiatrists used any of the standardised, validated devices which are recommended for assisting in the diagnosing of depression. The Psychiatrists did not provide a clear record of the evidence on which they based their conclusions.

9.1.1.3. Conclusions

Mr. A had a poor level of engagement with services when he was younger and in consequence the opportunities for early assessment, diagnosis and intervention were missed. When he did engage with services following his suicide attempt when he was 19 years old he was not seen consistently or for long enough by one clinical team to enable a reliable and full diagnostic formulation to be undertaken.

Mr. A was seen by three psychiatrists who each recorded a different conclusion about his mental health issues and behaviour. Mr. A's GP, who knew him well, asked Mr. A to complete a PHQ9. His score suggested that Mr. A might be suffering from depression and he prescribed antidepressant medication, though no formal diagnosis was recorded at this time. There was no suggestion by any of the Psychiatrists who subsequently saw Mr. A that this medication was inappropriate or should be stopped, though two of them concluded that he was not depressed.

⁵⁰ Trust records p80

⁵¹ GP records p 28

⁵² Trust Records p136

Mr. A Independent Investigation Report

Mr. A's description of his lowered mood and hopelessness, his repeated presentations to his GP and to other services, his attempts to harm himself and his reported poor sleep pattern and loss of appetite are all consistent with a diagnosis of depression. However a fuller formulation which took into account other factors such as Mr. A's misuse of illicit drugs and alcohol, his conflict with his family, the fact that he was unemployed and in debt, the fact that he had no secure accommodation and the fact that his girlfriend had had a baby to whom, at least at times, Mr. A had limited access because of his illicit drug use, would have been more clinically helpful.

The Independent Investigation concluded that the lack of a clear and comprehensive diagnostic formulation resulted, at least in part, from the fact that the Crisis and Home Treatment Team had only limited access to medical input. This lack of medical input meant that formulations were not based on robust multi-disciplinary conversations.

- *Contributory Factor 1. Mr. A did not receive comprehensive assessment, a clear diagnosis or a comprehensive formulation of his problems which informed the care and treatment he received. Had such a diagnosis and formulation been in place it is likely that Mr. A would have received more effective treatment. However it would not be reasonable to conclude that the absence of such a formulation had a direct, causal relationship with the events of September 2009.*
- *Service Issue 1. The Crisis and Home Treatment Team had only limited access to medical input. This limited the assessment, formulation and interventions the team could undertake. The result of this was that the users of this service had less than optimal care and treatment.*

9.1.2. Medication and Treatment

9.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (for example cognitive behaviour therapy and supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, and family interventions), in-patient

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 prescriber 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.

The patient’s ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation, that is to say do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals, for example weekly or monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and/or who may be non-compliant for whatever reason. It can be a way of ensuring that the patient has received medication and therefore a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called ‘extra pyramidal’ side effects, that is to say tremor, slurred speech, akathisia (restlessness) and dystonia (involuntary muscle movements). Other side effects include weight gain and

Mr. A Independent Investigation Report

Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

9.1.2.2. Findings

Medication

Mr. A was prescribed psychotropic medication for the first time in 2009. This was prescribed by his GP shortly after he had attempted to kill himself by hanging. He was prescribed antidepressant, anxiolytic and hypnotic medication. Approximately a week later Mr. A took an overdose of these medications. Subsequently Mr. A's antidepressant was changed from Citalopram to Mirtazapine, a drug which has less toxic side effects. Following his overdose, Mr. A's family and girlfriend agreed with the GP to help manage his medication to reduce the risk of further overdose. His medication was reviewed by the Psychiatric Specialist Registrar at an outpatient appointment and the GP was asked to increase the dose of his antidepressant medication as the Registrar found him still to be subjectively low in mood.

Mr. A was seen by a Trainee Psychiatrist in June 2009. She advised the GP, after this outpatient appointment, that Mr. A should be maintained on his antidepressant medication for at least 18 months and that the dose could be increased from 30mg to a maximum of 45mg if required.

Given the symptoms Mr. A was describing, and his self-harming behaviour although he was not always given a formal diagnosis of depression, prescribing Mr. A with antidepressant medication was appropriate. However not enough consideration was given, at least initially, to the risks associated with providing Mr. A with medication of this kind given his risk of suicide. Following his overdose a more clinically appropriate and safer medication plan was adopted which involved his family and girlfriend.

Psychological Treatment

The NICE Clinical Guidelines on the treatment of depression comments:

“A range of psychological and psychosocial interventions for depression have been shown to relieve the symptoms of the condition and there is growing evidence that psychosocial and psychological therapies can help people recover from depression in the longer-term (NICE, 2004a)...People with depression typically prefer psychological and psychosocial treatments

to medication (Prins et al., 2008) and value outcomes beyond symptom reduction that include positive mental health and a return to usual functioning (Zimmerman et al., 2006)”.⁵³

The guidance recommends:

“8.11.3.2 For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT)

8.11.3.3 The choice of intervention should be influenced by the:

- *duration of the episode of depression and the trajectory of symptoms;*
- *previous course of depression and response to treatment;*
- *likelihood of adherence to treatment and any potential adverse effects;*
- *person’s treatment preference and priorities”.*⁵⁴

In 2006 Mr. A had obtained a PHQ9 score of 26. This was consistent with him suffering from a moderate to severe depression. Following his attempted suicide in April 2009, Mr. A was identified as feeling subjectively low in mood. In June 2009 he was described as suffering from moderate to severe depression. The NICE guideline for moderate to severe depression recommends that cognitive behaviour therapy (CBT) be made available to the individual, in addition to medication. In 2009 CBT was available through the Positive Steps service. Mr. A was not referred to the Positive Steps programme until September 2009.

9.1.2.3. Conclusion

The Independent Investigation concluded that in addition to the Crisis and Home Treatment Team referral Mr. A should have been referred at an earlier stage to a psychological treatment service to help him with his low mood and impulsivity. 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, even though he claimed he was managing abstinence without external help.

- ***Contributory Factor 2. A more comprehensive care and treatment package should have been provided in order to manage the ongoing problems that Mr. A presented***

⁵³ NICE (2009) *Depression; Treatment and management of depression in adults, including adults with chronic pain*. CG 90 p. 157

⁵⁴ *Ibid* p 298

with. The package offered was not able to effect the changes to Mr. A's lifestyle and mental health problems that were required.

9.1.3. Use of the Mental Health Act (1983 & 2007)

9.1.3.1. 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.⁵⁵

9.1.3.2. Findings

The Mental Health Act was not employed in this case and was not identified through the thematic analysis as being relevant to the care and treatment of Mr. A.

9.1.4. The Care Programme Approach (CPA)

9.1.4.1. 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.⁵⁶ Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care*

⁵⁵ Mental Health Act Commission 12th Biennial Report. 2005-2007

⁵⁶ The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

*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.*⁵⁷

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. Its primary function is to minimise the possibility of patients losing contact with services and to 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;
- 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.

⁵⁷ Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

Avon and Wiltshire Mental Health Partnership NHS Trust CPA Policy

The Trust's extant CPA policy was ratified in January 2009 and was incorporated into the Trust's Policy to Manage Care Pathways and Risk. This policy was reviewed in light of the Department of Health's guidance *Refocusing the Care Programme Approach (2008)*. The policy required all service users to be on the Care Programme Approach as the default policy for the management of care. This required them to have a comprehensive assessment of health and social care needs, a risk assessment and a nominated Care Coordinator. Two other levels of care are described in the policy, standard care and shared pathways.

9.1.4.2. Findings

During Mr. A's involvement with secondary specialist mental health services between 14 April and 2 June 2009 he was identified as being subject to the Care Programme Approach (CPA). At this time the Crisis and Home Treatment team used a version of CPA known as the "*Acute Integrated Care Programme Approach*". The Investigation understood that this version of the CPA was in most respects the same as the Trust's main version of CPA but that it required a weekly review to be completed.

The Crisis Team Nurse who had initially assessed Mr. A was allocated as his Care Coordinator. An initial comprehensive assessment form, which included a risk assessment, was partially completed. This form captured most of the details of Mr. A's circumstances but the assessment summary section and sections on risk formulation and risk management plans were not completed.

An initial care plan had been completed by the Care Coordinator following Mr. A's first appointment. This identified two areas which would be addressed: 1) to promote Mr. A's personal safety and the safety of others, and to prevent hospitalisation; 2) to support Mr. A through his mental health crisis and reduce his suicidal thoughts and ideation.⁵⁸ The care plan identified six actions including: telephone support, helping Mr. A to engage with other agencies to get support with drug and alcohol problems, to help Mr. A find employment, and to arrange a psychiatric assessment. There was no documented evidence in the two months that Mr. A was in receipt of services that he received any support to access other services to

58 Trust Notes p16

assist him with his problems. The actions identified in the care plan are not explicitly linked to the identified goals.

There were five sets of CPA review documents available in Mr. A's clinical notes dated 14 April,⁵⁹ 23 April,⁶⁰ 2 May,⁶¹ 8 May⁶² and 22 May 2009.⁶³ These review documents provide boxes to record the service user's views of his situation, carers' views and the Care Coordinator's views. A range of other boxes are provided to comment on changes to medication, Mental Health Act status and employment. There is also a box in which to provide comments on updates to the service user's risk assessment. This is followed by evaluation of care notes and then care plans.

9.1.4.3. Conclusion

The Independent Investigation found that the Acute CPA process and the documentation associated with it was not implemented in a way that provided a clear and effective weekly review of care which demonstrated progress against plans, evaluated risks or involved the service user and/or carer.

The Investigation Team found that although the CPA review document appeared to be comprehensive it was in fact lengthy, cumbersome and was not used well in practice. It appeared to be used as a continuation record to record contacts and interventions. Most of the information recorded on the form did not change from week to week. However the whole 10 pages of the form were printed each week and all pages had to be read carefully to identify any changes. Much of the documentation was not completed and it was often not signed.

Although the form provided a space to record who was present at the review meetings, which assumed a review meeting had taken place, this was never completed. Mr. A was never recorded as having had the document shared with him. The box to confirm that the risk assessment had been reviewed and updated was never completed.

The role of the Care Coordinator is a key element in the Care Programme Approach. It is the responsibility of this individual to ensure that a comprehensive assessment of the service

59 Trust Notes p45
60 Trust Notes p36
61 Trust Notes p27
62 Trust Notes p18
63 Trust Notes p10

user's needs is undertaken; that this assessment informs a care plan; that the care plan is delivered in a coordinated fashion and that the service user's needs and the efficacy of the care plan is reviewed on a regular basis. The role of the Care Coordinator is not to be the primary care deliverer. Mr. A was allocated a Care Coordinator as part of the assessment process. However, after the initial assessment and the development of the first care plan there is no evidence that the Care Coordinator had anything to do with the management of Mr. A's care. The Investigation was told that the Crisis and Home Treatment Team operated a team approach to the care of service users and care coordinators were allocated on a nominal basis only. This is a significant weakness in the way in which this team operated. The absence of a robust approach to care coordination resulted in a weak implementation of the Care Programme Approach. No one individual in the team saw it as their responsibility to own, manage and coordinate Mr. A's plan of care. There was confusion between the roles of Care Coordination and service delivery. It is not uncommon when there is such confusion that there is a great deal of well meaning activity but this is not planned to address the needs of the individual and the efficacy of the action is not evaluated.

In Mr. A's case, as has already been noted, there was no comprehensive multi-disciplinary assessment. There was no clear and robust diagnosis and formulation which explicitly informed a care plan to address his needs. There were no structured, regular reviews of his needs, risks and the efficacy of the interventions that had been put in place.

- ***Contributory Factor 3. The CPA process was poorly implemented in the Crisis and Home Treatment Team. The lack of proper care coordination meant that no one individual took responsibility for ensuring that Mr. A's needs were comprehensively assessed, an appropriate care plan was developed, that this was delivered in a coordinated fashion and the efficacy of the care plan was reviewed on a weekly basis. In the absence of adherence to good practice in relation to the CPA it seems likely that Mr. A received less than optimum care and treatment. However it would not be reasonable to conclude that the absence of a robust CPA process had a direct causal relationship with the events of September 2009.***
- ***Service Issue 2. At the time Mr. A was under its care the Crisis and Home Treatment Team did not employ robust care coordination with the result that no one individual in the team was responsible for ensuring that assessment, care***

planning, service delivery and review were undertaken in line with national Best Practice guidance. The result of this is that it is probable that the users of the Crisis Team's services received less than optimal care and treatment.

9.1.5. Risk Assessment

9.1.5.1. 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.

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”⁶⁴.*

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. 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 multi-disciplinary 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.

Avon and Wiltshire Mental Health Partnership NHS Trust Clinical Risk Policy

In 2009 the Trust Policy on managing clinical risk formed part of its Policy to Manage Care Pathways and Risk. This policy embedded statements about the requirements to complete risk assessments within a wider section on assessment. The policy refers to the Trust’s core assessment and its comprehensive assessment. All service users were required to receive a core assessment which “*must identify historical and current risks to the service user, carer(s) their family and community networks*”.⁶⁵

The policy required all service users eligible for secondary mental health services to have a core assessment. Those with more complex needs or identified as having higher-level risks were identified as requiring a comprehensive assessment of needs and risks.

The policy advises that all risk assessments must reflect the principles identified in the Department of Health’s 2007 publication *Best Practice in Managing Risk*. Further guidance

64. Best Practice in Managing Risk; DoH; 2007

65 AWP policy to Manage care Pathways and risks – section 3.2 p20.

regarding documentation to be used in completing risk assessments was contained in the Trust's Practice Directive and Guidance 38: *Assessment, Risk Assessment Tools (Core and Comprehensive) and Recording*; and in Practice Directive and Guidance 39: *Specialist Assessment and Risk Assessment Tools*.

The policy states explicitly that risk assessments should be completed at each review and before discharge from CPA or transition to standard care.

9.1.5.2. Findings

There were three documented risk assessments in Mr. A's clinical records, all of which related to his initial referral to the Crisis Team. The first core risk assessment, a brief checklist risk assessment which requires the practitioner to record whether a range of risk factors are currently present, or have been present in the past, was completed on 12 April 2009.⁶⁶ It appears to have been completed in response to a telephone call from the liaison psychiatrist. The form records current risks of self harm and drug use but most of the document has been left blank. The form is unsigned.

The same assessment form was completed by Care Coordinator 1 on 14 April 2009.⁶⁷ This was completed more thoroughly and identifies four risk areas: 1) risk of self harm/suicide, 2) current or historical drug abuse, 3) environmental stressors: owing money as a result of his drug use, 4) Child Protection issues: Mr. A had a three-month old child who was living with his girlfriend and Child Protection agencies were involved. It recorded that Mr. A's history of violence or criminal convictions was unknown. There is a space at the bottom of the document for recording how to lessen the risk. This was left blank on both documents.

There is no opportunity on the core risk assessment form to provide a formulation of the risk or to identify what the assessor is going to do with the information recorded. This core risk assessment was followed by a comprehensive risk assessment on the same day, 14 April 2009.⁶⁸ The Trust's comprehensive risk assessment comprises 10 discrete areas of risk. The outcome of this risk assessment is summarised below.

66 Trust Notes p66

67 Trust Notes p64

68 Trust Notes p73-76

Risk Area	Outcome
Suicide and Self Harm	<i>Yes</i> <i>Recent life threatening suicide attempt by hanging</i>
Risk from others	<i>Yes</i> <i>Owes drug dealers a lot of money</i>
Risk to others	Current risk “No”. Historical risk has been left blank
Risk to Children	<i>Yes</i> <i>Child on a safeguarding plan, has a dependent child, who he has significant access to.</i>
Driving	<i>Not Known</i>
Self neglect	<i>No</i>
History of detention or supervision	<i>No</i>
Additional Risk Factors	<i>Historical drug use</i>
Risk of Loss of Contact	<i>No</i>
Social Risk Factors	<i>Yes</i> <i>Significant debts, poor management of finances.</i>

Section 12 of the comprehensive risk assessment requires the assessor to identify any further information or actions required to complete the risk assessment and to document those identified risks that will need risk management plans put in place. This section of this document has not been completed.

The Independent Investigation Team noted that in the core risk assessment it was documented that Mr. A’s past history of violence or aggression was not known. In the comprehensive assessment completed on the same day, it was recorded that there was no risk of violence or aggression. No plan to gather more information to corroborate the assessment is recorded.

Mr. A had a history of being expelled from school for violence and was known to be impulsive. This information was available in the GP record. Actuarial factors associated with risk such as Mr. A’s age, his gender, his history of drug abuse, his lack of employment and the early age at which he was first violent towards others, were not recorded as part of Mr. A’s risk assessment. This information was available but it was not used to help formulate the risks that Mr. A might present.

Mr. A Independent Investigation Report

The Trust policy and best practice guidance required that risk assessments were revisited at regular intervals. While Mr. A care was guided by the Trust's Acute CPA policy, the risk associated with him and the risk management plan designed to address these risks should have been reviewed on a weekly basis. His risk factors were not re-evaluated in any of the five documented reviews. The Acute CPA form contained a prompt which asked if the service user's risks had been reviewed and updated. This was left blank in all five review documents.

The Trust's Clinical Risk policy required a full risk assessment to be undertaken prior to discharge from secondary care or when an individual was transferred from CPA to standard care. There was no evidence in the record that this was done.

9.1.5.3. Conclusions

The Trust had an up-to-date policy on clinical risk management that drew on national Best Practice guidance. This provided a clear risk assessment process that was embedded in the wider assessment process.

The Independent Investigation found that the risk assessment documents did not facilitate exploration of the full range of risk information which would include background actuarial risk factors, current and historical clinical risk factors and situational risk factors. This meant that the risk assessments did not bring all relevant information together to assist in the formulation of risk.

The risk assessment documents were not fully completed. They did not lead to the development of a risk formulation or a risk management plan. Mr. A had a care plan in place which identified as its goal the reducing of risk of further self-harm but there is no evidence that this plan was informed by or adequately linked to his risk assessment.

Mr. A's risks were not reassessed at any of his CPA reviews or prior to his discharge as the Trust policy required. The clinical teams did not meet the Trust's own or national policy guidance in this matter.

- ***Contributory Factor 4. Practitioners involved in assessing the risks associated with Mr. A did not collect and collate all the available, relevant information; they did not***

seek corroboration of the information that they had and they did not seek information relating to risk when it was identified that this was not known. They did not reassess the risks Mr. A posed in line with Trust policy and national guidance. They did not develop a clear formulation to help understand the risks Mr. A posed nor did they develop a clear risk management plan to address the identified risks.

- *Service Issue 3. Although the Trust had an appropriate Clinical Risk Management policy in place it did not have in place risk documentation and processes which facilitated best practice. The risk assessment forms available to staff did not facilitate the collation and consideration of all the known risk factors and, therefore, did not support effective risk formulation.*

9.1.6. Referral, Transfer and Discharge

9.1.6.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

9.1.6.2. Findings

Referrals

Mr. A was referred to Mental Health services four times in six years. His first referral was when he was 13 years old when he was referred for a community paediatric assessment following aggressive and disruptive behaviour in school which had led to him being suspended on 10 occasions.⁶⁹ His family did not attend the appointment and later reported that they had never received the appointment letter. Mr. A was referred to the Child and Adolescent Mental Health Services when he was 14 years old following him being expelled

⁶⁹ GP records p 2

Mr. A Independent Investigation Report

from school for violence and fighting. He had an appointment with a Clinical Psychologist when it was agreed that he would be referred for an assessment for Attention Deficit Disorder. There is no record of this assessment having taken place. Mr. A failed to attend further appointments offered by the Clinical Psychologist.⁷⁰

In 2006, when he was 16, Mr. A was referred to a Community Mental Health Team (CMHT) after he presented to his GP reporting that he felt depressed and following him taking a small overdose. He attended an emergency assessment with two workers from the CMHT and he was offered two further appointments. He did not attend these. There is no record of the GP contacting Mr. A following his non-attendance at these appointments.⁷¹

In 2009 Mr. A was referred by his GP to the Crisis Team following a serious attempt to hang himself. He had been offered a referral to the Crisis Team several days earlier, while still in hospital following the suicide attempt, but he had declined this.

Mr. A's GP referred him to both the CMHT and the Primary Care Mental Health service in late August 2009, after he had presented feeling low in mood and anxious. These services determined that on this occasion it was most appropriate for a joint assessment to be undertaken. Shortly after the referral by Mr. A's GP, the Housing Officer who was helping Mr. A find accommodation contacted the Coast CMHT, prior to her placing him in emergency accommodation. The CMHT advised her that Mr. A had not been seen by them previously but that he had been referred and would be offered an assessment appointment in the near future. The Coast CMHT did not appear to have access to records of Mr. A's assessment by the team two months earlier nor knowledge of his previous engagement with the Crisis and Home Treatment Team, when, in theory, he was under the care of a Consultant Psychiatrist in the Coast CMHT.

Transfer

Mr. A was initially referred for a medical opinion to the Windmill House Community Mental Health Team but was identified by them as living in the Coast CMHT catchment area. Before he was assessed by the Coast CMHT the Crisis and Home Treatment Team discharged him

70 GP records p24

71 GP records p18

Mr. A Independent Investigation Report

from their care.⁷² The result of this was that when he was seen by the Trainee Psychiatrist in the Coast Team she was under the impression that Mr. A was being seen for a medical review as part of the discharge process as the decision had already been taken to discharge him.

The Investigation Team heard that the Crisis Team sent an unqualified member of staff and a student nurse to accompany Mr. A to his medical review.⁷³ The Team were surprised these reviews were not facilitated and supported by Mr. A's named Care Coordinator.

Discharge

Mr. A was discharged from the Crisis Team prior to him being assessed by the CMHT. This was not in keeping with the Trust's policy or safe risk management. Consultant 1, to whom Mr. A had been formally referred, stated that if she had realised he had been a Crisis and Home Treatment Team patient she would have ensured that a full CPA review took place prior to agreeing his discharge. In the event Mr. A was discharged to the care of his GP by a first year Trainee Psychiatrist. Her discharge letter was ambiguous in that it stated that Mr. A would be "*subsequently discharged*" which the GP understood to mean that Mr. A would receive a period of treatment and care from the CMHT and then be discharged. This understanding of the situation was recorded several times in the Primary Care record.

9.1.6.3. Conclusions

The Independent Investigation Team found that Mr. A had been difficult to engage in services when he was younger and had a history of not attending outpatient appointments when they were offered. When he presented to his GP after his suicide attempt he had already declined the offer of input by mental health services. The Independent Investigation understood that Mr. A's GP chose to refer him to the Crisis and Home Treatment Team as he was not confident that there would be a timely response from the CMHT. The Crisis and Home Treatment Team referred Mr. A for a medical review by the CMHT with a view to that team deciding whether to accept Mr. A for treatment. Mr. A was discharged from the Crisis and Home Treatment Team before the medical review had taken place. The Independent Investigation found that this care pathway was neither effective nor safe as it left significant opportunity for high risk individuals, such as Mr. A, to fall through the gaps. The Independent Investigation found that Mr. A's discharge arrangements were not in keeping

⁷² Trust Records p 95
⁷³ Clinical Witness Interviews

with Trust policy and were not communicated clearly to Primary Care. This meant that there was confusion and misunderstanding about the services, help and support Mr. A was receiving. When housing staff tried to get support for Mr. A the CMHT which he had last seen him reported that it had no knowledge of his case other than that he had recently been referred and it did not advise the housing worker to make contact with the Crisis Team.

It was unclear to the Independent Investigation why GPs were allowed to refer directly to the Crisis Team when the patient was not in crisis. Community Mental Health Teams are more usually the first point of contact for GPs and the gateway into Secondary Mental Health services. It is normally the CMHT which undertakes assessment and determines if the level of need and risk justifies input by a Crisis and Home Treatment Team. This pathway ensures that the service user is registered with the Community Mental Health Team and improves the likelihood of continuity and coordination of care.

- *Service Issue 4. The referral of Mr. A by his GP to the Crisis and Home Treatment Team without the involvement of the CMHT meant that he did not have an identified psychiatrist or a team that was responsible for his ongoing care. His care was passed between teams, none of which took overall responsibility for the management of his case. The discharge process was not in line with Trust policy and was not managed in a clinically safe way.*
- *Service Issue 5. The use of unqualified members of staff at key review meetings where important transitions in care are being planned is not appropriate. The assessment, planning and coordination of the delivery of care are the responsibility of the Care Coordinator. It should have been this individual who attended review meetings and ensured that there was an efficient and effective transfer of care.*
- *Service Issue 6. The Trust did not have a system in place which enabled staff to: identify, efficiently, whether an individual had had previous contact with the service; access their history and assessments of needs and risks; and identify which service might best meet their needs.*

9.1.7. Safeguarding Children and Vulnerable Adults

9.1.7. 1. Context

Safeguarding Children

The aim of the Safeguarding of Children Policy is to ensure that children and young people are healthy, safe, enjoy life, achieve their potential, make a positive contribution to society and are well prepared to secure their economic well-being in future years. (Every Child Matters (2003); Section 11 of the Children Act 2004).

All Local Authorities are required to have a Local Safeguarding Children Board (LSCB), the prime objective of which is to coordinate and ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children. The Avon and Wiltshire Mental Health Partnership NHS Trust is an important member of the LSCB. It has the responsibility to assist the Local Authority in its work, to identify any children whose safety is considered to be at risk and to help assess and promote the safety such children.

The national background to Safeguarding Policy has, since 2003, comprised the following documents and initiatives:

- Lord Laming's report (2003, Climbié Report) provided safeguarding recommendations and influenced the subsequent developments in Safeguarding Guidance and Policy;
- *Every Child Matters* (2003), the Government's response to the Laming Report, outlined five key improvement outcomes – be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing;
- *National Service Framework for Children* (2004) included a recommendation for Care Programme Approach meetings to take account of children's needs and any risks of harm to them;
- Children Act (2004) stated that all organisations have a responsibility to prioritise safeguarding and to ensure that effective arrangements are in place;
- Working Together (2006) established a benchmark that all organisations should ensure that safeguarding arrangements are in line with national requirements.

Mr. A Independent Investigation Report

The 2010 guidance comments:

“1.11 Effective measures to safeguard children are those that also promote their welfare. They should not be seen in isolation from the wider range of support and services already provided and available to meet the needs of children and families”.

The 2006 guidance, which was in force for the later part of the time Mr. A was under the care of the Trust, comments:

“1.6 Shortcomings when working to safeguard and promote children’s welfare were brought into the spotlight once again with the death of Victoria Climbié and the subsequent inquiry. The inquiry revealed themes identified by past inquiries that resulted in a failure to intervene early enough. These included:

poor co-ordination; a failure to share information; the absence of anyone with a strong sense of accountability; and frontline workers trying to cope with staff vacancies, poor management and a lack of effective training (Cm 5860, p.5)”.

In addressing this problem the guidance emphasises the importance of shared responsibility and joint working:

“1.14 Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm – depends on effective joint working between agencies and professionals that have different roles and expertise...”.

“2.1 An awareness and appreciation of the role of others is essential for effective collaboration between organisations and their practitioners...”.

“2.2 ...it is important to emphasise that we all share a responsibility for safeguarding and promoting the welfare of children and young people. All members of the community can help to safeguard and promote the welfare of children and young people, if they are mindful of children’s needs and are willing and able to act if they have concerns about a child’s welfare...”⁷⁴

74HM Government, Department for Children, Schools, and Families (2010) *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children*

The 2010 guidance elaborates on this:

“2.62 ...Other health professionals who come into contact with children, parents and carers in the course of their work also need to be fully informed about their responsibility to safeguard and promote the welfare of children and young people. This is important as even though a health professional may not be working directly with a child, they may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child’s safety and welfare...”

With respect to the responsibilities of Mental Health Services and mental health practitioners the 2006 guidance comments:

“2.92 Adult Mental Health Services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. This may be as a result of a service’s direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. These staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse. They should follow the child protection procedures laid down for their services within their area. Consultation, supervision and training resources should be available and accessible in each service...”

“2.94 Close collaboration and liaison between adult mental health services and children’s social services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm”.

The Laming Form

Following the Climbié Report NHS Mental Health Trusts were required to record whether users of Mental Health Services had regular contact with children. This applied to:

- people on Enhanced Care Programme Approach (CPA);
- people on Standard CPA where assessment indicates a significant risk;
- anyone who is admitted to an in-patient unit;
- if a patient is regarded as a potential risk.

Mr. A Independent Investigation Report

The form covers a wide range of potential triggers including:

- drug/alcohol abuse;
- domestic violence;
- forensic history;
- past history of severe mental illness;
- past history of sexual/physical abuse;
- serious self-harm attempts;
- a child with a severe physical illness or learning disability in the family;
- unsettled family circumstances;
- any other circumstances where the assessing health or social care professional is concerned about the welfare of children in the family.

In order to realise the goals of promoting the wellbeing and safety of children and young people the Children Act lays specific responsibilities on the Local Authority.

*“Section 10 [of the Children Act] requires each local authority to make arrangements to promote co-operation between the authority, each of the authority’s relevant partners...and such other persons or bodies working with children in the local authority’s area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority’s area – which includes protection from harm or neglect alongside other outcomes. This section of the Children Act 2004 is the legislative basis for Children’s Trust arrangements”.*⁷⁵

“Section 11 of the Children Act 2004, section 175 of the Education Act 2002 and section 55 of the Borders, Citizens and Immigration Act 2009 places duties on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children”.

“The Children Act 1989 places a duty on local authorities to promote and safeguard the welfare of children in need in their area. Section 17(1) of the Children Act 1989 states that: It shall be the general duty of every local authority:

- *to safeguard and promote the welfare of children within their area who are in need;*
- and*

75 HM Government, Dept. for Children, Schools and Families (2006) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*

Mr. A Independent Investigation Report

- *so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.*

Section 17(10) states that a child shall be taken to be in need if:

- a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;*
- b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or*
- c) he is disabled.*

Section 47(1) of the Children Act 1989 states that:

Where a local authority:

- a. are informed that a child who lives, or is found, in their area (i) is the subject of an emergency protection order, or (ii) is in police protection, or (iii) has contravened a ban imposed by a curfew notice imposed within the meaning of Chapter I of Part I of the Crime and Disorder Act 1998; or*
- b. have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm:*

*The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare...".*⁷⁶

Trust Safeguarding Policy

The Trust Safeguarding Children policy in force from 2006 echoed the national guidance. It states:

- 2.1 *"Children of adults accessing Adult Psychiatric Services (including Locality, Forensic, and Specialist Drug & Alcohol Services) need to be routinely identified as part of the overall adult assessment and relevant information sought, using the relevant ICPA risk screen. This screen will include collection of information, which includes each child's name, address, age, the name of each child's primary carer,*

⁷⁶ HM Government, Dept. for Children, Schools and Families (2006) *Working Together to safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*

those with parental responsibility and each child's GP. For children of school age, the name of each child's school must be recorded; gaps in this information should be passed on to the relevant authority in accordance with local arrangements.

- 2.2 *An assessment, using the Trust's ICPA and risk assessment tool, should be made of the impact of the parental mental health difficulties on the adult's ability to protect their children and to parent. In some cases, a joint assessment might be needed with the local Social Services Children and Families Team. If, as a result of the assessment, a child is thought to be vulnerable or at risk of harm, the clinician must discuss the concerns with their Line Manager or Supervisor and the relevant Safeguarding Children Lead. When appropriate, a referral should be made to the relevant Children and Families team (Social Services) and the local LSCB Child Protection Procedures followed".⁷⁷*

9.1.7.2. Findings

Internal Investigation

The Avon and Wiltshire Mental Health Partnership NHS Trust Internal Investigation (Root Cause Analysis Report dated 2 February 2010) concluded that there was a Care Delivery Problem associated with the "*failure to investigate child protection concerns between 14 April 2009 and 2 June 2009*".

The Internal Report stated that:

"When [Mr. A] was first referred to the service by [his GP] staff were informed that the Child Protection Team were involved with his partner... and their three month old daughter, and that [Mr. A] was being required to provide drug urine screens due to Child Protection issues. This information was recorded on the initial referral form, and also in the core assessment on 14 April 2009.

An unqualified member of the CRHTT [Crisis Resolution and Home Treatment Team] staff completed a Safeguarding Children assessment, a CP2e form on 16 April 2009. He noted three parenting concerns in Section 3

⁷⁷ Avon and Wiltshire Mental Health Partnership NHS Trust (2006) *Safeguarding Children and Young People under 18 Years in Adult Mental Health Facilities* p5

Mr. A Independent Investigation Report

CRHTT staff did not liaise with the Social Services Team or General Practitioner to investigate this issue further, and did not inform the Social Services team that they were working with [Mr. A].

CRHTT staff did not discuss the Child Protection issue in a Team Meeting, and the Team Leader was not aware of this until the time of the [Internal] investigation.

Following interviews with North Somerset Social Services staff and with [Mr. A's] General Practitioner in Clevedon in the course of this investigation it has emerged that [Mr. A's child] was not on a S47 Safeguarding Plan, and was being managed as a S17 Child in Need... Social Services had not requested urine screening, but were aware that [the child's mother] was insisting on [Mr. A] being "clean" if she was to continue in their relationship".⁷⁸

Independent Investigation

The Independent Investigation concurs with the findings of the Internal Investigation. The presence of Mr. A in the home of his girlfriend and daughter altered the dynamics of the family and this should have been reported to the Child Protection Team. It was known that Mr. A was impetuous and had had problems with anger management which had not been satisfactorily resolved. His relationship with his girlfriend appeared to be floundering and this was confirmed when Mr. A's girlfriend accompanied him to a meeting with the Homeless People Section of the Housing Department.

Given Mr. A's low mood and his limited ability to control his temper or to avoid confrontation he posed an additional, largely unknown, factor in the relationship between his girlfriend and her daughter. Mr. A's girlfriend was concerned that Mr. A might become aggressive or suicidal when he had been drinking alcohol or taking illicit drugs. The Independent Investigation Panel noted that the Crisis and Home Treatment Team recorded that Mr. A had acquired an ex-fighting dog from a rescue home, and he was keeping this at his girlfriend's flat. This was not reported to the Child Protection Team and did not trigger a review of Child Protection needs.

⁷⁸ Internal Investigation p30

9.1.7.3. Conclusions

The Independent Investigation concluded that the situation in which Mr. A, his girlfriend and their daughter found themselves should have been formally discussed with the Team Leader, who was the nominated member of staff to liaise with the Local Authority regarding Safeguarding Children. Mr. A was, to some extent, an ‘unknown quantity’ and the effect of him being part of the family placed additional demands on his girlfriend as she sought to care for her young child. It is probable that Mr. A was a further stressor for her given his history of unpredictable behaviour following the use of alcohol and drugs.

The Trust Safeguarding Children policy in force from 2006 states:

“Children of adults accessing Adult Psychiatric Services (including Locality, Forensic, and Specialist Drug & Alcohol Services) need to be routinely identified as part of the overall adult assessment and relevant information sought, using the relevant ICPA risk screen. This screen will include collection of information, which includes each child's name, address, age, the name of each child's primary carer, those with parental responsibility and each child's GP....” It also states that *“If, as a result of the assessment, a child is thought to be vulnerable or at risk of harm, the clinician must discuss the concerns with their Line Manager or Supervisor and the relevant Safeguarding Children Lead. When appropriate, a referral should be made to the relevant Children and Families team (Social Services) and the local LSCB Child Protection Procedures followed”*.⁷⁹

No referral was made and therefore the Crisis Resolution and Home Treatment Team did not follow Trust Policy.

9.1.7.4. Context

Vulnerable Adults

National

Safeguarding Adults is a responsibility placed on Local Authorities through the *No Secrets* guidance which was issued under Section 7 of the Local Authority and Social Services Act 1970. Through this legislation, statutory social care organisations have a duty of partnership to work with other statutory bodies to put in place services which act to prevent abuse of

⁷⁹ Avon and Wiltshire Mental Health Partnership NHS Trust (2006) *Safeguarding Children and Young People under 18 Years in Adult Mental Health Facilities* p 5

vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice.

The *No Secrets* statutory guidance was developed in response to several serious incidents, and states that:⁸⁰

“The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety”. (Paragraph 1.2)

This document was supported by a further document produced by the Association of Directors of Social Services which describes a framework for good practice and outcomes in adult protection.⁸¹

By 2008, based on the content of both of these documents, Local Authorities would have been expected to have had a Safeguarding Board/Committee and a safeguarding framework/procedure in place. Social care staff would be expected to be trained in this area of work and to be familiar with adult safeguarding policies and procedures and should have been clear as to how to respond to issues as they arose.

There was a clear expectation from the Department of Health that *No Secrets* would apply to all statutory agencies, however this is statutory *guidance*; it therefore took some time before it was fully implemented in the NHS.

In October 2008, the Department of Health carried out a large national consultation on the *No Secrets* guidance.⁸² The aim of this consultation was to understand how far *No Secrets* had progressed across agencies and to find out how it could be improved. Over 12,000 people took part in the consultation including 3,000 citizens. There were around 500 responses in total but only 67 of these were from NHS organisations.

80. Department of Health (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, DH, London

81. Association of Directors of Social Services (2005) *Safeguarding Adults A National Framework of Standards for Good practice and outcomes in adult protection work*, ADSS, London

82. Department of Health (2008) *Safeguarding Adult', the review of the No secrets guidance*, DH, London

One of the key findings was the absence of adult safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns are considered in the wider safeguarding arena. In response, the Department of Health published a document which tied existing systems of Clinical Governance into adult safeguarding in order to clarify responsibilities and expectations of NHS staff in relation to this issue.⁸³

The Department also funded an adult safeguarding campaign, run by the Nursing and Midwifery Council in 2010, to raise awareness of adult safeguarding amongst nurses and midwives.

It would therefore not have been common practice for health staff to have been fully aware of, and using, adult safeguarding procedures in 2008/09.

At the current time GPs are not yet engaged nationally with adult safeguarding. Recently, the British Medical Association published a toolkit to support GP Practices in dealing with this issue but, as yet, it has not been implemented in the majority of Practices.⁸⁴

Safeguarding Process

When safeguarding is working effectively the following things are in place:

- all staff have a basic understanding of safeguarding and can make a prompt referral to the right place in order to elicit a response;
- staff who deal directly with safeguarding will pick up the referral and respond to it (within a short agreed timescale, for example 24 hours) in order to ensure the safety of the individual;
- immediate action/referral to the Police if necessary should take place when a crime has been committed. The Police may well lead the process if this is required;
- a strategy planning meeting will be called involving all those who have knowledge of the case to agree what is known and what further investigation should happen (this would usually happen within seven days) and a protection plan should be put in place, after discussion with the individual;
- investigation should occur;

⁸³ Department of Health (2010) Clinical Governance and Adult Safeguarding *An integrated approach* DH, London

⁸⁴ British Medical Association (2011) Safeguarding Vulnerable Adults *A Toolkit for General Practitioners*, BMA London

- Case Conferences will take place at specific intervals both to hear the outcomes of the investigation and to monitor the protection plan. Again the views of the individual should be sought throughout the process;
- the case should be closed once the issue had been resolved and ongoing safety assured.

The Avon and Wiltshire Mental Health Partnership NHS Trust Policy to Safeguard Adults

The Trust Policy to Safeguard Adults was ratified by the Trust Board on 26 November 2008 and follows the National Guidelines and states that the aim of the Policy is to:

“assist staff in effectively meeting their statutory duty to protect and safeguard adults (particularly those who are vulnerable) from the age of eighteen years old onwards.

*It is intended to complement the local multi agency safeguarding adult policies and procedures throughout the Trust, by defining the Trust’s internal arrangements for Safeguarding Adults, informing staff of the general principles to safeguard adults and effectively signposting staff into their local procedures to safeguard adults and to access local contacts and leads. The policy describes the support, advice, policies, and guidance available to staff, both internally and externally, in the effective safeguarding of children within their practice”.*⁸⁵

The Trust Policy applies to all staff including volunteers and temporary staff and states that:

“the purpose of safeguarding adults is to prevent, detect and manage the risk of abuse or neglect of an adult, particularly where there is an increased level of vulnerability (either permanent or transitory”.

“Abuse is a violation of an individual’s human and civil rights by any other person or persons.” (‘No secrets’ Department of Health 2000). Abuse can be a single act or repeated acts.

“Types of abuse include:

Physical – including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.

85 Trust Policy to Safeguard Adults p3

Sexual – including rape, sexual assault, sexual acts carried out without the consent of the individual or where the individual was pressured into consenting.

Psychological – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation, or withdrawal from services or supportive networks.

Financial or material – including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission – including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, withholding of the necessities of life, such as medication, adequate nutrition and heating.

Discriminatory abuse – including racist, sexist, that based on a person's impairment, and other forms of harassment, slurs, or similar treatment.

Institutional abuse – can include any of the above and is characterised by repeated instances of poor care, sometimes intentional, but often unintentional and resulting from a lack of knowledge".⁸⁶

The Trust Policy sets out how Trust staff should seek advice and assistance and what should be reported and to whom. Team Managers are the designated staff member responsible for ensuring the vulnerable adults are identified and are protected via the use of the Policy. It states:

“When an adult protection concern or issue is identified, staff or volunteers can contact the Trust Public Protection and Safeguarding Team to discuss their concern(s) and seek advice on the protection of the person(s) concerned and/or on the need to make a referral under local Safeguarding Adults procedures. They can also seek advice and support within their general clinical, practice or supervision arrangements.

When staff make a referral, this must be reported to the Trust, by submitting an AWP PPS reporting form to the PPS Team and a copy of the referral. Any concern or referral should be recorded in the health and social care record, and flagged as a risk on MHIS.

86 Trust Policy to Protect Adults p4

Mr. A Independent Investigation Report

All Trust staff, including medical staff, and volunteers must undertake the relevant statutory and/or mandatory Safeguarding Adult training and update training relevant for their post, as identified at induction and appraisal.

*AWP Staff must recognise that many service users of secondary mental health services will have a significant level of vulnerability, which must be identified and managed within their Personal Recovery and Well-Being plans. Where they discover or have information disclosed about alleged abuse and/or neglect, they must additionally contact/refer under the local multi-agency safeguarding adult procedures”.*⁸⁷

9.1.7. 5. Findings

Internal Investigation

The Internal Investigation identified a Care Delivery Problem in that Mr. A should have been referred to the Local Authority as a Vulnerable Adult but was not. The Internal Investigation described the issue as follows:

“Placement of a Vulnerable Person in Unsupported Homeless Accommodation (8 September 2009) – On 8 September 2009 [Mr. A] was placed by a Housing Officer for temporary accommodation in a Homelessness Hostel in Weston-Super-Mare. This decision did not follow the assessment made by the Housing Officers that [Mr. A] was a vulnerable person, who required supported accommodation. However he had been turned down from the first supported accommodation he was referred to, and his family were no longer prepared for him to stay with them. The Housing Department were exploring other supported accommodation options, however these were not available immediately.

The telephone conversation between a Housing Advice Officer and the Duty Worker at the Coast Resource Centre on 8 September 2009 handed over the information that [Mr. A] had been placed in homeless accommodation, but crucially did not hand over to the Mental Health Team that this was very inappropriate as he had been assessed by a Mental Health Housing Association and turned down on the grounds that his needs were too high”.

Independent Investigation

The Independent Investigation agrees with the findings of the Internal Investigation.

⁸⁷ Trust Policy to Protect Adults p6

Mr. A Independent Investigation Report

Mr. A had separated from his girlfriend due to her concerns about his drinking and the effect this had on his behaviour and her concerns about the effects of this situation on her daughter. On 5 September 2009 Mr. A attended an assessment appointment with a Housing Association which provided supported housing. He was not accepted because during the assessment he had disclosed that he felt suicidal at times and was not safe to manage his own medication. The staff who interviewed Mr. A reported that he had appeared agitated and anxious. The same staff obtained permission from Mr. A to refer him to another Housing Association which provided floating support to homeless people, and in particular to those with mental health problems. This Housing Association attempted to contact Mr. A on his mobile telephone but he did not respond to their calls or the messages they left for him.⁸⁸

Mr. A met with his Housing Advice Officer on 8 September 2009 following him being refused accommodation by the first Housing Association. It was clear at this time that he was no longer able to stay at his parents' home. The only option available to the Housing Advice Officer was to place Mr. A in an emergency hostel for homeless people. Mr. A told the Housing Advice Officer that he had previously been involved with the Community Mental Health Team (CMHT). She contacted the CMHT as she was concerned about Mr. A's mental health. She spoke to a duty worker and asked if the CMHT had any information about Mr. A. The Duty worker said that they did not have any information about Mr. A but confirmed that he had been referred by his GP for assessment and that he would be offered an appointment for 14 September 2009. The Housing Advice Officer informed the Duty Worker that she was concerned about Mr. A being placed in homeless accommodation as he had informed her that he could not reliably take his medication. The Duty Worker said that the information would be added to Mr. A's referral notes.

The CMHT Team Leader, who had recently moved from the Crisis Resolution and Home Treatment Team recognised Mr. A's name on the duty call log. She reviewed his situation and arranged to bring his assessment forward to 10 September 2009, as she recognised he might be at risk of serious self-harm as he had broken up with his girlfriend. She asked the appointments secretary to telephone Mr. A to inform him of the appointment. A number of telephone calls were made and messages were left on Mr. A's mobile telephone but he did not return the call.⁸⁹

⁸⁸ Witness statement

⁸⁹ Witness interview transcripts

Mr. A Independent Investigation Report

On 9 September 2009 Mr. A went to see the Housing Advice Officer to complain about his accommodation being dirty and that he thought there were bed bugs in the sheets. The Housing Advice Officer contacted the owner of the hostel who agreed to address the problems the same day.⁹⁰ Mr. A spent the rest of that day with his girlfriend and daughter; he returned to his accommodation and later went to a public house with some residents of the hostel. When Mr. A returned to the Emergency Hostel he continued drinking with the other residents. Mr. A had an altercation with Mr. Y, another resident, and seriously assaulted him. Mr. Y died from the injuries he sustained.⁹¹

Mr. A was a young adult with substance misuse problems and a tendency to become depressed when his situation deteriorated. He was no longer able to stay with his parents or with his girlfriend and their daughter. He had been assessed by an experienced organisation offering supported housing to people with mental health issues and was refused a placement because he was considered to be at too great a risk of attempting to harm himself and he was unsafe to manage his medication.

The Vulnerable Adult procedures were not considered in respect of Mr. A. It was clear that Mr. A required more support than the Emergency Hostel could provide.

9.1.7.6. Conclusions

Mr. A should have been referred to the Local Authority as he was a vulnerable young man who had difficulty in taking control of his life and had a history of self-harm and suicide attempts. If Mr. A had been referred to the Local Authority as a vulnerable adult it is likely that this would have triggered a Strategy Meeting where all agencies having contact or knowledge of him would have met to consider what actions they might have taken to lessen the dangers he faced. This was a missed opportunity.

⁹⁰ Housing Officers interview transcript
⁹¹ Court Records

9.1.8. Carer Assessment and Carer Experience

9.1.8.1. 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) 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”*. 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 require support, 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 gave carers who provide a substantial amount of care on a regular basis the entitlement to an assessment of their ability to care. It ensured that services take into account information from a carer assessment when making decisions about the cared-for person’s 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 them. It also gave carers the right to an assessment independent of the person they care for.

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. It also facilitated cooperation between authorities in relation to the provision of services that are relevant to carers.

Mr. A Independent Investigation Report

In particular in mental health, Standard Six of the NHS National Service Framework for Mental Health (1999) stated that all individuals who provide regular and substantial care for a person on CPA should:

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

9.1.8.2. Findings

Following his suicide attempt in April 2009 Mr. A received support from his mother, father and his girlfriend. It is recorded that he frequently argued with his mother and his brother which made it difficult for him to live in his parents' home. For much of the time he was under the care of the Adult Mental Health Services Mr. A stayed with his girlfriend, however this relationship was also strained at times.

There is no evidence in the clinical record made available to the Independent Investigation that any individual involved in supporting Mr. A was identified as a carer or offered a carer's assessment. Mr. A's girlfriend received *ad hoc* support from the Crisis Team. She was given the contact details of the Crisis Team and told that she could telephone the team if she was concerned about Mr. A while the Crisis Team was involved with him.

The sections of the CPA review document which ask for the carer's views were never completed; neither Mr. A's girlfriend's nor his parents' views of his mental health problems, his behaviour or his need for support were ever recorded in the CPA documentation. Mr. A's consent to share information with his parents and his girlfriend is documented in his care plan.

As most of the support Mr. A received while he was under the care of the Crisis Team was from unqualified members of staff and as the role of the Care Coordinator was not functional there was no one available to Mr. A or his family with the skills to conduct a family assessment or offer them education or intervention.

9.1.8.3. Conclusions

Mr. A's episode of care from the Avon and Wiltshire Mental Health Partnership NHS Trust was short; nevertheless his girlfriend and family were involved in supporting him throughout this difficult period. None of the services involved in assessing or supporting Mr. A looked formally at their needs as carers. As Mr. A lived with his girlfriend, who had a young baby, she should have at least been offered an assessment of her needs. However neither her views on Mr. A's needs were sought nor her views on her own needs in relation to supporting him.

- *Service Issue 7. There is no evidence available to the Independent Investigation to indicate that the Crisis Team identified Mr. A's girlfriend as a carer. She was not effectively engaged in identifying his needs or the risks he posed. She was not involved in planning his care. Although Mr. A lived with his girlfriend for much of the time he was under the care of the Avon and Wiltshire Adult Mental Health services she was not offered a carer's assessment. This was poor practice.*

9.1.9. Service User Involvement in Care Planning

9.1.9.1. 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 planning and delivery of care”*. It also stated that services would *“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”*.

9.1.9.2. Findings

Mr. A was under the care of Adult Mental Health Services for only a very brief period of time. He was never an in-patient and was never detained under the Mental Health Act. He

Mr. A Independent Investigation Report

was free to choose whether he took medication as prescribed and whether to attend appointments.

Mr. A was as a young adult who had an interrupted educational history. It is unclear to what extent he appreciated the benefit the services offered, how well he could identify his needs or how these might be best met. It is also unclear how well he could articulate his needs and his preferred method of meeting these. Mr. A was accompanied to most appointments by his girlfriend or by his parent but he was never offered an independent advocate.

The reports to the Court following the homicide in September 2009 identified that Mr. A had a degree of neurological damage as a result of his attempted hanging. This was not identified when he was under the care of the Adult Mental Health Services and it is not clear what the implications of this were on his level of understanding.

There is no documentary evidence that the Crisis and Home Treatment Team tried to engage Mr. A in identifying his needs or planning his care as his care plans were not signed and there is no evidence they were shared with him.

9.1.9.3. Conclusions

It is not evident that Mr. A's care plans were shared with him or that he was involved in the regular review of his care and treatment.

Mr. A was not identified as needing an independent advocate although he had an interrupted educational history and his level intellectual competency was unknown. Mr. A may have benefited from the support of an independent advocate to help identify his needs and how he preferred them to be met.

The Independent Investigation concluded that user involvement, even in this relatively brief episode of care, could have been more robust by ensuring that Mr. A was involved in identifying his needs and developing his care plans, by ensuring that there was documentary evidence of his involvement and by making available to Mr. A the support of an independent advocate.

9.1.10. Housing

9.1.10.1 Context

Local Authorities, under the Housing Act 1996, have a responsibility to provide advice and support to those who find themselves homeless. The statutory responsibilities of Local Authorities in relation to homelessness primarily address the needs of families and they do not have a statutory responsibility to provide long-term accommodation for single people unless they are vulnerable individuals, or individuals who are more likely to be adversely affected by or less able to cope with homelessness. Vulnerable individuals may be people:

- with disabilities and/or mental health problems;
- who have been in care;
- who have been in prison;
- who have been in the armed forces.

If an individual is eligible for assistance, legally homeless or threatened with homelessness, in priority need and not intentionally homeless the Local Authority has to help. It can help by placing the person in housing association accommodation or with private landlords. If a person does not qualify as homeless the local authority does not have a duty to arrange long-term accommodation, however it has to, at least, provide advice and guidance to help the person find accommodation or help them find a temporary solution to their accommodation problems.⁹²

9.1.10.2. Findings

Following his suicide attempt in April 2009 Mr. A moved between his parents' house and his girlfriend's flat. He spent increasing amounts of time at his girlfriend's flat as he reported that his arguments with his mother made him feel depressed and anxious.

Mr. A's GP recorded that Mr. A wanted to escape from the area in which he lived and had asked the GP to support him and his girlfriend in apply for housing in Cumbria. This was shortly before Mr. A and his girlfriend separated in August 2009.

⁹² www.homeless.org.uk downloaded on 10/12/2012

Mr. A Independent Investigation Report

When Mr. A's relationship with his girlfriend broke down in August 2009 he approached the local housing services for help in finding supported accommodation. The Housing Officer assessed Mr. A's eligibility for housing support and placement and referred him to a supported hostel for people with mental health problems. Mr. A's mother agreed that he could stay at her house until his assessment for supported housing was completed. However when he was assessed Mr. A said that he did not feel safe taking his own medication. The Housing Association therefore concluded that Mr. A was not a suitable tenant.

As Mr. A was in urgent need of accommodation, the Housing Officer placed him in an emergency accommodation hostel. While in the process of placing Mr. A, the Housing Officer contacted the Mental Health service. The service was unable to confirm that Mr. A was known to it. However if whoever was responding to the Housing Advice Officer had consulted the CRHT's risk assessment of Mr. A they would have discovered that in this stressful situation he needed urgent input from the Mental Health services as well as appropriate accommodation.

No assessment of the risks associated with Mr. A was undertaken by the Mental Health service at this time. Similarly there was no evidence in the records provided to the Independent Investigation that an assessment of the risks to the other vulnerable residents of the emergency accommodation was undertaken as part of admitting Mr. A there. However it must be acknowledged that Mr. A was not identified as a danger to others at that time and information from his adolescence, which might have suggested such a risk, was not available to the Housing Officer or to those responsible for the emergency accommodation. Given the options available to those arranging and providing accommodation for Mr. A it is unclear whether this information would have influenced their decision about his accommodation, though a timely risk assessment might have enabled appropriate supports to be put in place. However the absence of such a support or crisis plan cannot reasonably be concluded to have had a causal relationship with the events of September 2009.

Mr. A's victim's family had described the emergency accommodation in which Mr. A had been placed as an 'end of the road' placement. The day after Mr. A had moved into this accommodation he complained that his room was dirty and the bed was infested with bed bugs. It was later the same evening that he went drinking with other residents and fatally assaulted Mr. Y.

9.1.10.3 Conclusion

Housing support services tried to support Mr. A when he presented to them as homeless. They initially tried to place him in supported accommodation for individuals with mental health problems and tried to involve the Mental Health services. Unfortunately the Mental Health services did not respond effectively to the request for help, and the supported housing placement did not accept him. As a result Mr. A was placed in the only accommodation available, an emergency accommodation hostel with other very vulnerable people. It was in this situation under the influence of alcohol that Mr. A assaulted and killed Mr. Y.

- *Contributory Factor 5. Statutory Mental Health services did not provide the housing services with adequate support when they were trying to find a placement for Mr. A, a young man who had made a serious attempt to harm himself, had been under the care of the Crisis Team and had been referred to the CMHT. As a result Mr. A was placed in emergency accommodation without assessment or support from Mental Health services. This lack of support was not in Mr. A's best interests and did not reflect best practice.*

9.1.11. Documentation and Professional Communication

9.1.11.1. Context

*“Effective inter-agency working is fundamental to the delivery of good mental health care and mental health promotion”.*⁹³

Jenkins *et al* (2002)

Jenkins *et al* describe the key inter-agency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both inter-agency 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 alone.⁹⁴ *The Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

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

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

criticised agencies for not sharing information and not liaising effectively.⁹⁵ 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.

9.1.11.2. Findings

Documentation

The format of the weekly 10 page Acute CPA review document was confusing. It was unclear whether this document was being used as an instrument for reviewing Mr. A's care and treatment or as an historical record of contacts with Mr. A. The Independent Investigation found that significant components of the Acute CPA review documents and the core and comprehensive assessment documentation relating to the care and treatment of Mr. A were not fully completed; in particular there was a failure to complete the formulation and summary sections of these documents. These sections provide an overview of the problems, identified risks and changes to interventions. The Acute CPA review was completed on a weekly basis while Mr. A was under the care of the Crisis Team and failure to complete these sections meant that anyone consulting these documents had to read the whole of the review document carefully to identify any changes in Mr. A's presentation or care plan.

Failure to complete the formulation and summary sections meant that there was no recorded synthesis of Mr. A's needs and the risks associated with him. As noted elsewhere in this report the Trust policy requirement to review risk at each review was not complied with. A significant number of entries in Mr. A's clinical record were not signed.

Professional Communication

The Independent Investigation Team found that communication between teams and between the teams and GPs was not effective.

Mr. A's GP was written to by the Psychiatrists when Mr. A was reviewed in outpatients. However when a discharge letter was written to the GP it concluded with an ambiguous statement about discharge. It appears that Mr. A had been discharged from Secondary Mental Health services but the GP understood the letter to be saying that Mr. A remained under the care of Secondary Mental Health services.

⁹⁵ Ritchie *et al* *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

Mr. A Independent Investigation Report

The referral information from Primary Care did not provide a synopsis of Mr. A's history and his contact with services during his adolescence which might have helped Secondary Mental Health services understand Mr. A's needs and risks better.

The Crisis Team sent an unqualified member of staff or a student nurse to Mr. A's medical reviews. Given the importance of these meetings in identifying Mr. A's needs and planning his care and treatment, this was inappropriate. The staff member was viewed as an escort rather than attending the meeting to facilitate an effective review of Mr. A's care and treatment.

The Independent Investigation Team noted that the service did not appear to have effective methods in place to enable it to identify Mr. A's involvement with the service. The Crisis Team did not establish a clear history of Mr. A's involvement with the service in 2006, and did not access his Primary Care records or his CAMHS records to obtain a better understanding of his history. This was despite the fact that Mr. A's care was provided under the Trust's CPA protocols and a comprehensive assessment was required. When the Housing Officer contacted the CMHT it was not able to identify that Mr. A had been involved with the service and had been assessed only two months previously.

9.1.11.3. Conclusions

The Independent Investigation Team found that professional documentation and communication did not meet an acceptable standard. Documentation was not fully completed and frequently not signed. The structure of the documentation was difficult to follow and repetitive and did not support practitioners in accessing important information quickly.

Communication between the psychiatrists reviewing Mr. A in outpatients and the Crisis and Home Treatment Team was hindered by the team sending unqualified members of staff to attend these meetings. It would have been more appropriate for the service user's Care Coordinator to have attended these review meetings.

Communication between Primary and Secondary Care was poor with the information, in each direction, either not being comprehensive or being unclear. The referral information missed out important aspects of Mr. A's history; the information on the treatment and care being provided was limited to two letters from psychiatrists following outpatient reviews and a

discharge letter from the CMHT psychiatrist which failed to make it clear that Mr. A was being discharged to the care of his GP.

- *Service Issue 8. Sending unqualified support workers or students to medical outpatient reviews did not facilitate an effective clinical review between the CMHT and the Crisis and Home Treatment Team.*
- *Service Issue 9. The lack of rigour in professional documentation meant that important summary information and formulations were not completed. This was not helpful to effective communication about Mr. A's needs between groups and professions.*
- *Service Issue 10. There was an ineffective system for accessing previous contacts with the services. This meant that important information about previous involvement with services was not available when staff needed to access those details.*

9.1.12. Adherence to Local and National Policy and Procedure

9.1.12.1. Context

Evidence-based practice has been defined as “*the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.*”⁹⁶ National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the

⁹⁶ Callaghan and Waldock, *Oxford handbook of Mental Health Nursing*, (2006) p 328

capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said policies or procedures or to raise any implementation issues as they arise with immediate effect.

9.1.12.2. Findings

The Independent Investigation Team found the Trust had an appropriate system of governance for the development, maintenance and version control of its policies. The policies reviewed were current date and referenced relevant national guidance. The policies were clear with respect to accountabilities throughout the organisation and what was expected of services was also clear. All policies reviewed had audit mechanisms identified, although the Investigation found some of these to be unclear, as the audits were identified as being undertaken as part of the Trust's process of assurance.

The Independent Investigation Team speculated about the usability of policies that referred, to a significant degree, to secondary documents identified as 'Practice Directives and Guidance'; the Care Pathways and Risk Policy referred to over 50 separate Practice Directives and Guidance documents.

The Investigation found that policies were not always adhered to or rigorously applied. This finding has been discussed above in the documentation section, the risk management section and the Care Programme Approach section.

9.1.12.3. Conclusions

The Trust had up to date well-governed policies, however the Independent Investigation concluded that the use of large numbers of external guidance documents outside of the main policy, may make the policy difficult to use effectively. The Investigation also found that the audit mechanisms identified in the policies did not always effectively define what audits needed to be conducted.

Overall policy implementation in Mr. A's case was found to lack rigour in a number of areas.

- *Service Issue 11. The auditing requirements identified in the Trust's policies were not tightly defined, and did not identify the audits which the service should complete. This may have contributed to the limited policy compliance this Investigation has identified.*

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

9.1.13.1. Context

This report subsection serves as a summary section which considers all the Investigation findings in a way which considers their interrelationships.

9.1.13.2. Findings

The Independent Investigation Team found that following Mr. A's serious suicide attempt in April 2009, he was viewed as a young man in crisis associated with debts he owed to drug dealers. The Liaison Psychiatry Services which saw him following this suicide attempt did not find evidence of depression, but they did offer Mr. A support from the Crisis Team. When this was refused Mr. A was discharged into the care of his parents and information was passed on to the Crisis Team and to Mr. A's GP in case he presented seeking further help.

When Mr. A attended his GP surgery several days later feeling low and anxious the GP referred him to the Crisis Team. This team assessed Mr. A and started to provide him with support. The Independent Investigation was informed that the GP may have referred Mr. A to the Crisis Team rather than to the CMHT as he was not confident that Mr. A would receive a timely response from the CMHT. However the Crisis Team provides only short-term

Mr. A Independent Investigation Report

support during periods of increased risk. The Independent Investigation Team concluded that this was not the most appropriate referral to meet Mr. A's needs, and may have hindered him accessing more appropriate services.

The Crisis and Home Treatment Team did not have dedicated psychiatry sessions and therefore when Mr. A was referred to the team the care, treatment and support he received was not supported by a psychiatrist. The Crisis Team did not take a long-term view of Mr. A's needs and did not undertake a detailed or comprehensive review of his mental health history. This may have been because the Crisis Team typically engaged with people for short periods of acute intervention during crises; the focus of this team's concern was Mr. A's immediate difficulties and risks. The Crisis Team was only able to offer short-term supportive and monitoring interventions. They were not able to offer longer-term structured therapeutic input which may have helped Mr. A with his problems of low mood, poor coping skills, debt, unemployment and drug and alcohol misuse.

The Trust's CPA and Risk Management policies and processes required the Crisis Team to undertake a comprehensive assessment and formulation of Mr. A's history, health and social care needs and risks. The assessment which was undertaken did not fully unearth Mr. A's difficult adolescent history or his risk of impulsivity and violence.

During his time with the Crisis Team two Psychiatrists reviewed Mr. A's care and treatment. The Psychiatrist who first saw Mr. A noted that he was living at his girlfriend's address and had changed his GP and, as a result, now belonged to the catchment area of another CMHT. This psychiatrist saw Mr. A on two occasions, however it was clear from her records that she viewed her seeing him as a temporary measure as she sought to pass Mr. A to the appropriate catchment area CMHT. She assumed that this CMHT would investigate Mr. A's longer-term needs for help and support. However by the time Mr. A was seen by a Trainee Psychiatrist belonging to the second CMHT he had been discharged by the Crisis Team and the psychiatrist believed that Mr. A was being seen as part of the discharge process. The Trainee Psychiatrist recorded in Mr. A's clinical notes that he was suffering from moderate to severe depression and would possibly benefit from Primary Care psychological interventions and from support in developing his skills around gaining employment. Following supervision with the team Consultant Psychiatrist, the Trainee Psychiatrist wrote to Mr. A's GP advising

Mr. A Independent Investigation Report

him that Mr. A had been discharged from secondary care.⁹⁷ However, as previously mentioned the wording of the letter was unclear and led the GP to think that Mr. A was still under the care of the CMHT.⁹⁸ The Independent Investigation was told that at this time the Coast CMHT was not performing well and had a long waiting list of people waiting to be seen and allocated Care Coordinators.⁹⁹

Throughout his brief involvement with Secondary Mental Health services Mr. A's care and treatment were notionally informed by the Care Programme Approach; however this Investigation found that this was not effectively implemented by the Crisis and Home Treatment Team. A key requirement of the CPA is that the service user has a Care Coordinator to oversee and coordinate his care. This requirement was not implemented in any meaningful way in this team, and in consequence, no one took responsibility for managing Mr. A's care and ensuring his needs were fully understood, or that any gaps or inadequacies in his care or treatment were identified and addressed. This resulted in Mr. A being passed between teams without the responsibility for assessment, care planning and co-ordinated delivery of care being identified with any individual. The GP did not have a single point of contact with whom to discuss Mr. A or from whom he could expect to receive updates. No one thought about Mr. A's longer-term needs and risks.

When Mr. A re-engaged with services in August 2009, the GP concluded that Mr. A needed a more structured involvement from Mental Health services, but he was unclear whether Mr. A was still being seen by the Secondary Mental Health services. He felt Mr. A would benefit from being seen by the Primary Care Psychological Therapy services. He tried to organise this and spoke to the recently appointed CMHT team manager. It was agreed that the CMHT and the Primary Care service, Positive Steps, would conduct a joint assessment. Unfortunately Mr. A killed Mr. Y before this assessment could take place.

During the three months Mr. A received services the possibility of referral to Positive Steps was mentioned on a number of occasions. However no referral was made until Mr. A saw his GP in August 2009. It is the view of the Independent Investigation that this referral should have happened some months before, following Mr. A's suicide attempt in April 2009.

97 Clinical witness interview
98 Yeo Valley GP records p8
99 Clinical Witness Interviews

9.1.13.3. Conclusions

This Investigation found that because Mr. A was referred to the Crisis and Home Treatment Team without any involvement by the CMHT he was seen only as a service user who needed support through a period of crisis. As a result he was never viewed in the context of his longer-term history: as a troubled adolescent who had been expelled from school, who had drug and alcohol misuse problems and impulse control problems from an early age, and as someone who had presented twice since the age of 16 with lowered mood, resulting in him making a serious life-threatening suicide attempt.

The operational model of the Crisis Team meant that no one in the Secondary Mental Health service took overall responsibility for Mr. A's care. His care and treatment were not effectively coordinated through the Care Programme Approach. This meant Mr. A was discharged from Secondary Mental Health services two months after almost taking his life without anyone fully understanding his history, his longer-term needs or the longer-term risks associated with him, and without him having been offered appropriate interventions other than antidepressant medication.

The Investigation did not find a causal link between the shortcomings in Mr. A's care and treatment and his actions in September 2009 which led to the death of Mr. Y, however the Investigation Team did identify a contributory link between the failure to undertake an effective assessment of Mr. A's needs and the putting in place of an appropriate programme of care and treatment. This failure contributed to the on-going mental health difficulties and challenges Mr. A faced. This, in turn, contributed to the breakdown in his relationships which led him to being homeless and being placed in emergency accommodation.

As the Judge at Mr. A's trial concluded that at the time of the homicide Mr. A was responsible for his actions, these gaps in care cannot be considered to be causally related to the death of Mr. Y. However this Investigation finds them contributory to the situation that Mr. A found himself in September 2009. If Mr. A had received a more adequate assessment which informed more effective treatment, care and support, Mr. A and his girlfriend would have had access to more consistent support and advice in the days, weeks and months that preceded their relationship breaking down. The breakdown of this relationship resulted in Mr. A being homeless.

- *Contributory Factor 6. Because Mr. A was referred directly to the Crisis and Home Treatment Team no one took the overall responsibility for understanding him in the context of his longer-term history and troubled adolescence. No one facilitated his access to longer-term treatment and support services which might have helped him deal more effectively with the mental health and life problems he was facing. Mr. A was discharged from Secondary Mental Health Services without his presenting problems being effectively addressed, or long-term plans to assist him move on in life being put in place. This absence of effective support and help meant Mr. A's mental health was likely to continue to be vulnerable and therefore there continued to be a reasonable likelihood of him presenting in crisis and acting impulsively at some point in the future. There were no plans, agreed with Mr. A or with Primary Care, to manage future crises should they occur.*

9.1.14. Clinical Governance and Performance

9.1.14.1. 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”.*¹⁰⁰

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.

During the time that Mr. A 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 about how the national performance framework is managed.

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

During the time that Mr. A was receiving his care and treatment the Trust should also have been subject to robust performance monitoring and review from local statutory authorities charged with the commissioning of local Mental Health Services.

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

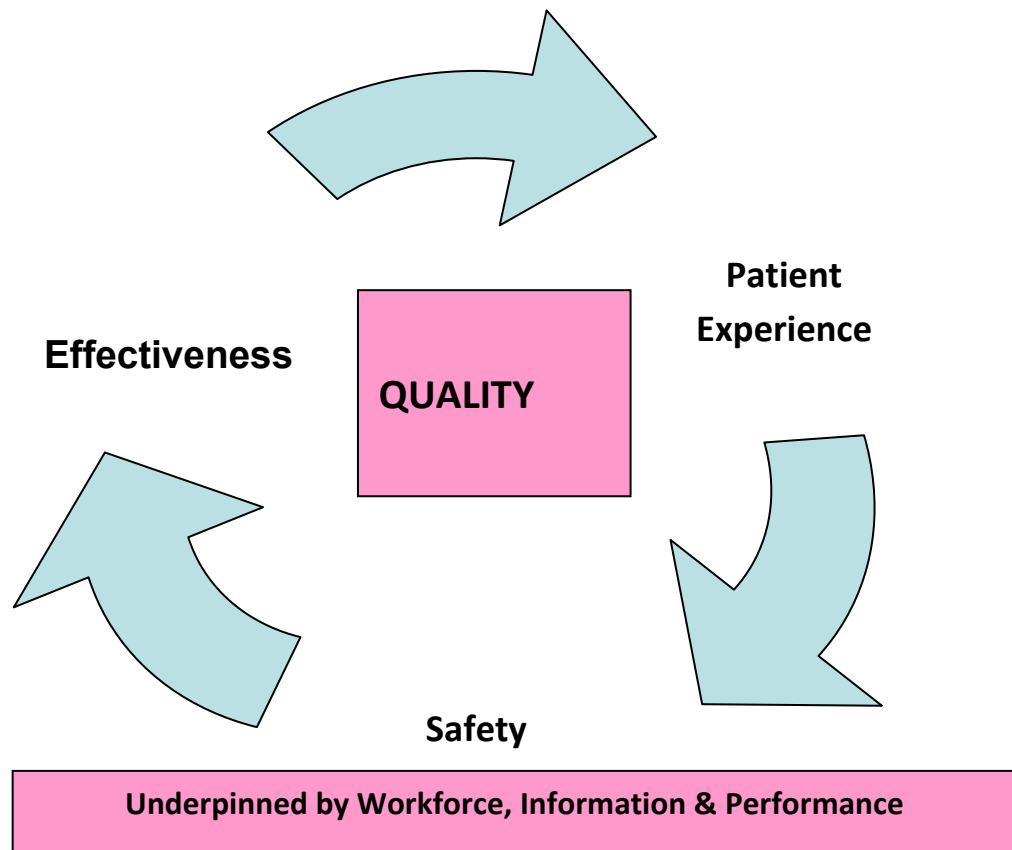
9.1.14.2. Findings

Clinical Governance Systems and Performance

In 2010 the Avon and Wiltshire Mental Health Partnership NHS Trust put in place a five-year strategy for improving clinical quality. This is based on the integration of three core areas of quality improvement: patient experience, effectiveness, and safety. Quality improvement is defined in this strategy document as the combined and continuous process of making the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning). The relationship between these elements is illustrated in the diagram below.

The strategy identifies the following areas which underpin the quality improvement strategy:

- quality metrics that will enable the measurement of quality across the whole spectrum of care;
- the implementation of best practice;
- regular clinical auditing and performance monitoring against national and local standards;
- the identification of ways for service users and carers to receive more personalised care;
- the provision of information on the accessibility and quality of services;
- the delivery of services in a safe environment;
- improving feedback from services users and carers and using that feedback to drive quality improvement;
- staffing, training, support and appraisal and continuous professional development.



The Quality Improvement Strategy is complemented and supported by a number of other strategies and policies including:

- Clinical Audit Strategy;
- Risk Management Strategy;
- Community Engagement and Involvement Strategy;
- Strategic Framework for Improving the Patient Experience;
- Performance Management Framework;
- Financial Strategy;
- Information and Data Quality Management Strategy.

The strategy recognises the importance of clinicians and practitioners in improving the quality of clinical care. It recognises that clinicians and practitioners should:

- fully engage with the Trust clinical governance arrangements;
- influence service modernisation and redesign;
- be able to reflect on their practice and actively contribute to quality improvement;

Mr. A Independent Investigation Report

- have access to a full range of educational, training and continuous personal and professional development opportunities.

Engagement with clinical governance arrangements:

Each Strategic Business Unit (SBU) has an Integrated Governance Group led by the Clinical Director and clinicians are involved in local integrated governance activities and reviews.

The Trust Professional Council, the Trust Medical Advisory Group and the Trust Nursing Advisory Group enable clinicians and practitioners to provide professional scrutiny and advice on best practice, clinical effectiveness and service improvement. They also provide support to clinicians.

Service modernisation and redesign:

To ensure clinical involvement and influence in service redesign the Trust has established Clinical Reference Groups and a Practitioners for Change Forum. These groups enable structured and timely engagement and influence in the modernisation and service redesign process. The Trust approach to quality improvement has led to a number of initiatives:

- The productive ward/team programme enables nurses and practitioners to spend more time on clinical engagement and patient care;
- The Manchester Patient Safety Framework (MapSaF) is being used to help the Trust assess its safety culture;
- An annual programme of Chief Executive and Executive Director-led Patient Safety Visits has been established.

Education, training and continuous personal and professional development:

The Trust Learning and Development Policy aims to:

- improve the quality of the service as experienced by users and carers;
- ensure that learning needs are identified in a systematic way linked to service development and organisational priorities;
- promote a philosophy of continuous personal development;
- ensure that the Trust delivers modern and effective services through enabling staff to develop their skills in line with changing national priorities, policy guidance and service development.

Supervision and appraisal processes are identified as important in helping to ensure that staff take appropriate advantage of development options.

Governance and assurance processes and structure:

The Trust Board leads and directs clinical quality and its governance. Lead responsibility for scrutinising and assuring clinical quality, safety and performance is delegated to the Quality and Healthcare Governance Committee. The Committee is composed of three Non Executive Directors, the Chief Executive, the Executive Director for People and the Executive Director of Nursing, Compliance, Assurance and Standards. The Committee is also attended by the Trust SBU clinical directors and two representatives from the Professional Council. The Chair of the Committee reports formally to the Board.

The Trust Mental Health Legislation Committee plays a key role in clinical governance. This Committee is composed of two Non Executive Directors and meetings are attended by the Executive Director of Nursing, Compliance, Assurance and Standards, the Mental Health Act Lead, SBU managers, a social work representative, the Mental Health Act and Mental Capacity Act Manager and a consultant psychiatrist. The Chair of the Committee reports formally to the Board.

To support continuous clinical quality improvement the Trust has established a number of management groups chaired by Executive Directors which report to the Performance Executive Management Team. The management groups:

- scrutinise and review compliance with core quality and safety standards and outcomes;
- peer-review draft policy, guidance, protocol and strategy;
- manage and co-ordinate engagement of Strategic Business Units and relevant corporate leads.

The Strategic Business Units contribute to the clinical governance system by attending the Trust management groups and Board Committees, disseminating good practice, implementing quality improvement plans, coordinating operational activity against set standards, and providing an evidence base of delivery against clinical quality standards.

The Trust has identified the importance of ensuring that it has processes in place that enable the early identification of potential failings in patient care. The Trust's ability to spot the early signs of failings is strengthened by:

- the provision and understanding of regular information on key clinical indicators;
- staff being empowered to engage in management processes, raise concerns and be involved in quality improvement processes;
- service users' and carers' voices and experiences being heard and shared from ward to Board.

9.1.14.3. Conclusions

The Trust has in place an appropriate governance structure and an appropriate set of clinical policies informed by best practice guidance. However, as discussed above, the Trust's policies and procedures were not always adhered to in an appropriate manner.

10. Summary of Findings and Conclusions of the Independent Investigation

1. Diagnosis

Mr. A did not receive a formal psychiatric diagnosis until 2009, several months after his suicide attempt. Between his suicide attempt in April 2009 and June 2009 he was seen by three doctors: a Senior House Officer (SHO), a Specialist Registrar and a first year Trainee Psychiatrist. The SHO who saw Mr. A several days after his suicide attempt did not find him to be depressed and concluded that his suicide attempt was an impulsive response to worries about debt. The Specialist Registrar who assessed him at the request of the Crisis and Home Treatment team found him to be subjectively low in mood. The Trainee Psychiatrist who he saw last found Mr. A to have a moderate to severe depression. Mr. A's history of substance misuse was not factored into the diagnostic considerations of any of the three psychiatrists or of his GP.

Three years previously, in 2006, Mr. A had obtained a PHQ9 score of 26 and his GP referred him to secondary mental health services. He was seen once and offered additional appointments because of his low mood. No formal diagnosis was recorded at this time and Mr. A did not attend further appointments. Several years prior to this he had been referred to Child and Adolescent Mental Health services because of his challenging behaviour and his drug misuse. An assessment for Attention Deficit Disorder was considered but there is no evidence in the records available to the Independent Investigation that this was ever completed.

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

2. Treatment

2.1. Medication

Mr. A was prescribed psychotropic medication for the first time in 2009. This was by his GP shortly after he had attempted to kill himself by hanging. He was prescribed antidepressant, anxiolytic and hypnotic medication. Approximately a week later he took an overdose of these medications. Subsequently Mr. A's antidepressant was changed by his GP from Citalopram

Mr. A Independent Investigation Report

to Mirtazapine, a drug which has less toxic side effects. Following his overdose, Mr. A's parents and girlfriend agreed with the GP to help manage his medication to reduce the risk of a further overdose. His medication was reviewed by the Psychiatric Specialist Registrar at an outpatient appointment and the GP was asked to increase his dose as the Psychiatric Specialist Registrar found him to be still subjectively low in mood.

Mr. A was seen by a Trainee Psychiatrist in June 2009. She advised the GP, after this outpatient appointment, that Mr. A should be maintained on his antidepressant medication for at least 18 months and that the dose could be increased from 30mg to a maximum of 45mg if required.

Given the symptoms he was describing and his self-harming behaviour, prescribing Mr. A with 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

In 2009, following his suicide attempt, Mr. A was identified as feeling subjectively low in mood and in June 2009 as suffering from moderate to severe depression. Previously in 2006 he had obtained a PHQ9 score of 26. This suggested that he might be suffering from a severe depression. The NICE guideline for moderate to severe depression recommends that cognitive behaviour therapy (CBT) be made available to the individual. In 2009 CBT was available through the Positive Steps service. Mr. A was not referred to the Positive Steps programme until September 2009. This Investigation heard that GPs were often unsure where to refer, and would often refer to the Crisis and Home Treatment Team as this service would provide a service reasonably promptly compared to other services.

This Investigation concluded that in addition to the Crisis and Home Treatment Team referral, 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, even though he claimed he was managing abstinence without external help.

3. Care Programme Approach

Once Mr. A was being seen by the Crisis and Home Treatment Team he was considered as being on the Care Programme Approach (CPA) as a matter of Trust policy. Trust policy at that time had a specific approach to CPA for patients in the Crisis and Home Treatment Teams and in acute in-patient care. This required an acute CPA review document to be completed on a weekly basis. There were copies of this document in Mr. A's clinical records, however they were not always fully completed. They were usually completed by a single member of the team and did not reflect a multi-disciplinary consideration of the patient. A care plan was put in place at the outset of Mr. A's contact with the Mental Health services. This focused only on preventing admission and reducing his desire to harm himself. A number of interventions were identified in the care plan, such as identifying additional support services around employment and Mr. A's drug problems. There was no evidence of any of these services being put in place during the period Mr. A received care from the Crisis and Home Treatment Team.

Mr. A's care plan was never subject to formal review. Mr. A was allocated a Care Coordinator, however the Independent Investigation was told at interview that this was a 'paper exercise', as the way the team worked did not match the requirements of CPA care coordination. The acute CPA appeared to focus on short-term needs and did not support consideration of longer-term needs such as periodic low mood, debt, employment and drug and alcohol use.

4. Risk Assessment and Risk Management

Mr. A was initially assessed for risk by the Senior House Officer when he asked to be discharged from the medical ward following a serious suicide attempt. The Psychiatrist did not complete the Trust's risk screening document but he did complete a full mental state examination. He did not find Mr. A to be depressed or at a high risk of further suicide attempts and allowed him to go home with his family. The Trust's standard risk screening was completed by the Crisis and Home Treatment Team following a referral from Mr. A's GP a few days later. A number of indicators of risk of further self-harm were identified but his history of violence towards others when he was an adolescent was not recorded. The Crisis and Home Treatment Team did not attempt to obtain more detail from Primary Care about Mr. A's history when undertaking the risk assessment. Mr. A's brief involvement with mental health services was not consistently recorded. There was no formulation of Mr. A's

risk. This meant there was not an effective appraisal of all Mr. A's risks and protective factors to enable a judgement of the severity of risk associated with him and in what situations he might be a risk to himself or others. From an actuarial perspective Mr. A fell into a higher risk group for both suicide and violence to others. 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 previous self harm. Not all of this was known by the Crisis Team but it was on record. In addition to this, Mr. A had a history of acting impulsively in response to external stressors. This impulsive behaviour was exacerbated by alcohol or drugs. These risks were not fully identified and a risk management plan was not developed to address this.

5. Safeguarding Vulnerable Adults and Children

Mr. A's child was noted to be subject to Child Protection procedures. Mr. A was undergoing regular drug screens which, he had told his GP, were required 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 was no record of the Child Protection Team being informed of changes to Mr. A's presentation or his behaviour in the child's home or of the additional pressure Mr. A's behaviour might expose the child's mother to. The Investigation noted that the Crisis and Home Treatment Team had recorded that Mr. A had recently obtained an ex-fighting dog from a dog rescue home and he was keeping this at his girlfriend's flat. There is no evidence that this information was passed to the Child Protection Team or that it triggered a review of child protection measures.

There is no evidence in the records available to the Independent Investigation that Vulnerable Adult procedures were considered in relation to Mr. A. However, when Mr. A required emergency accommodation he was placed in emergency accommodation with other vulnerable adults. The Investigation did not see documentary 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

Mr. A was admitted to the Crisis Team following a referral by his GP. The Investigation heard that GPs frequently used the Crisis Team instead of referring to the CMHT as they believed their patients would be seen more quickly. They were used to there being long delays and problems in accessing CMHT services. When in the Crisis and Home Treatment

Mr. A Independent Investigation Report

Team, if a service user required a medical review he had to be referred to the CMHT covering the geographical area in which he lived. Mr. A was initially referred to the CMHT in Clevedon. The specialist registrar in the team assessed him and recommended some changes to his medication. However she also identified that he was not in the catchment area of the CMHT and he should be reviewed by the CMHT in Weston Super Mare. A month later Mr. A was seen by a first year Psychiatry Trainee in the Weston Super Mare CMHT. She understood that the Crisis Team had already discharged him and that she was completing the medical review as part of the discharge process. The Consultant for this team told the Investigation that if she had realised that Mr. A had been a Crisis and Home Treatment Team client she would have organised a CPA review meeting with the Crisis Team staff before agreeing discharge.

The Investigation heard that it was normal practice for a member of the Crisis and Home Treatment Team to attend outpatient appointments with the client so they could provide an update on the team's view of the client's risks, needs and progress. In Mr. A's case he was accompanied by a student nurse at the second appointment. This individual was only able to provide an escorting service. She was not able to provide a detailed clinical handover.

7. Carer Involvement

Mr. A's mother and father were with him at the hospital following his suicide attempt and it was at their home that the Crisis and Home Treatment Team first visited him. Apart from these two contacts Mr. A's family had no other involvement with the Mental Health services. Mr. A's girlfriend provided him with a great deal of support in the days and weeks after his attempted hanging. At times he lived at her flat. She supported him when he took an overdose and she managed his medication for him. Mr. A's girlfriend in effect became his carer. However she did not receive a formal carer's assessment and was never involved in identifying his needs or consulted over his care plan.

8. Service User Involvement

Mr. A appears to have been given the opportunity to be involved in all decision about his care. His views about his care are partially documented in his Care Programme Approach documents. It is recorded that he did not require an advocate. However the Court reports indicate that Mr. A had some neurological damage and deficits after his suicide attempt. He might, therefore, have benefited from having an independent advocate to assist him in

thinking more carefully about his needs and the care plan and services which he was being offered at this time.

9. Housing

Mr. A did not have his own accommodation. He lived at his parents' or at his girlfriend's home. He was known to have arguments with his mother and his brother and, as a result, his parents' home was not viable as long-term accommodation. There were also tensions at Mr. A's girlfriend's home and any drug use by Mr. A could have resulted in him no longer being able to stay there. When Mr. A's relationship with his girlfriend broke down he initially moved in to his parents' home but this lasted for only a few days after which he sought emergency accommodation. The Housing Officer was informed that Mr. A had recently experienced mental health problems and she tried to place him in a supported hostel which provided accommodation for people with mental health problems. She also spoke to the Weston Super Mare CMHT. The supported hostel did not offer Mr. A a place as they were advised that he was not safe to take his own medication. The CMHT did not offer support or an emergency assessment at this time, nor did they suggest that the Crisis Team were contacted again. The only option available to the Housing Officer was to place Mr. A in an emergency hostel, which did not provide support. After the first day in this hostel Mr. A complained to Housing Officer about the state of cleanliness of the rooms and the bed clothing. On the second day he met Mr. Y and other residents and started drinking with them. It was in this situation that he lost his temper and attacked and killed Mr. Y. Mr. A should have been reassessed by the mental health team prior to being placed in this hostel. Mr. A's GP had recently assessed him and felt he was depressed and had increased his antidepressant medication. Mr. A had also been referred to the CMHT. All of his protective factors had fallen away. In this situation 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. The ICPA forms were not fully completed, nor were they always signed. Information was at times repeated rather than being updated. Mr. A's GP did indicate in his referral to the Mental Health services that Mr. A had been aggressive in the past and could be a risk to other people. The information provided to the GP on discharge from the CMHT was unclear in that it used

the phrase “*and subsequently discharged*” which created the impression that Mr. A was continuing to receive secondary mental health services.

The use of unqualified members of staff to attend important outpatient 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 appear to 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 the Trust policies, in particular the Risk Assessment and Management policy and the Care Programme Approach policy, were implemented. The Trust policy requirement to hold a CPA meeting prior to discharge was not complied with.

This lack of rigour is perhaps explained by the very brief duration of Mr. A’s contact with the service and the fact that he was seen by the Crisis Team without input from the CMHT.

The way in which the Crisis and Home Treatment Team operated at this time 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

Mr. A did not receive an acceptable level of care and treatment from the Secondary Specialist Mental Health services. He had presented with a depressive episode at the age of 16 and by the age of 19 he had a long history of behavioural and drug and alcohol problems. In 2009 he made a serious attempt to take his own life by hanging. Mr. A refused further help from Mental Health services at this time, nevertheless more consideration might have been given to how he might have been engaged in services and how his needs might have been best met. Crisis Services were informed that Mr. A was not in crisis and that he was not presenting as likely to need an acute hospital admission. However, Mr. A was in debt, had long-term problems with drugs and had suffered low mood and feelings of hopelessness. Even if he was not considered to be an immediate risk he should have been referred, either by liaison psychiatry or by Primary Care, for an assessment by the Primary Care Mental Health services

Mr. A Independent Investigation Report

for psychological and problem solving interventions; consideration should also have been given to introducing antidepressant medication. The Primary Care Mental Health service would have considered whether he required the support of the CMHT.

It appears that neither the referrers nor the service itself had a clear understanding of the pathways of care available. The primary care referrers referred to the Crisis and Home Treatment Team by default as this service had a history of seeing people quickly. This provided a suboptimal treatment response as the Crisis and Home Treatment Team was not able to offer effective, ongoing support or treatment for the problems with which Mr. A presented. The Crisis Team provided short-term support and monitoring at times of crisis and as an alternative to hospital admission rather than the more comprehensive assessment and intervention that should have been associated with the CMHT.

The CMHT to which Mr. A was referred discharged him after one appointment with a junior Psychiatrist. There is no evidence in Mr. A's clinical records that any consideration was given to which services or interventions might have helped address his longer-term problems and problematic behaviour.

13. Clinical Governance

The Trust's clinical governance systems were structured to provide support for a comprehensive approach to managing service quality and providing assurance across the Trust. However the findings of this Investigation suggest that these systems were not functioning effectively to maintain the quality of all services at this time.

The Investigation found that the care pathways and the relationships between them were not understood and were not functioning well. For example, GPs were unclear about referral routes and the services available to them. In addition, GPs did not have confidence that they would receive a response to their referrals in a timely manner.

The Crisis and Home Treatment Team did not have clear arrangements for medical input. The model that was in place at the time Mr. A was under the care of the Trust was not, in the view of the Investigation, clinically safe for the assessment, treatment and monitoring of acutely mentally unwell people in the community.

Mr. A Independent Investigation Report

The Investigation heard that the Coast CMHT in Weston Super Mare had almost ground to a standstill with very long waiting lists and the inability to assign people to care coordination.

The Investigation was provided with a substantial amount of clinical records and documentation. However, these served to illustrate that Trust policies and protocols were only partially complied with, particularly the Care Programme Approach policy and the Risk Assessment and Management policy. These are two of the most important building blocks of a high quality mental health service and in this instance they were not well implemented. That these policies were not being adhered to and that this lapse was not detected in a timely manner raises questions about the effectiveness of the Trust's clinical governance systems. Effective clinical governance should provide a mechanism through which the delivery of high quality care is sustained and which detects and addresses problems quickly when they arise.

Conclusion

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.

11. Avon and Wiltshire Mental Health Partnership NHS Trust Response to the Incident and Internal Investigation

11.1. The Trust Serious Untoward Incident Process

The Trust had a clear policy and procedure in place for reporting, investigating and managing serious untoward incidents. The policy required an initial notification, a 72 hour review and, for the most serious of incidents, a full root cause analysis. The policy was compliant with national guidance and required timelines.

11.2. The Trust Internal Investigation Processes

The 72 Hour Management Review

The 72 hour management review was completed by a local senior manager. The review included a collation of the timeline and all the critical events leading to the incident. The review at an early stage identified concerns regarding Mr. A's discharge from the secondary mental health services, the management of the referral back into services and the arrangements for medical cover in the Crisis Resolution and Home Treatment Team. Because there had been a homicide a root cause analysis was required.

Terms of Reference

The terms of reference for the internal root cause analysis review were not published with the Internal Investigation report. The Independent Investigation did not see terms of reference for Internal Investigation.

Methodology

The Internal Investigation used a Root Cause Analysis methodology. The methodology section of the Internal Investigation report described the following sequence of events:

- scoping the incident;
- generating hypotheses;
- investigate the hypotheses;
- determining if there were any care or service delivery problems;

Mr. A Independent Investigation Report

- identifying the key factors contributing to the care and service delivery problems;
- analysing the contributory factors to determine if the event would have happened if the factor had not been present;
- making recommendations.

In scoping the incident the Internal Investigation had access to Primary Care, CAMHS and Secondary Mental Health clinical records. The Internal Investigation interviewed 12 witnesses and took statements from a further two witnesses.

Key Findings and Conclusions

The Internal Investigation identified four care delivery problems, one service delivery problem, and contributory factors in seven areas. It made eight recommendations.

The Internal Investigation concluded that although it was not predictable that Mr. A would kill someone, it was predictable that a serious incident, probably that Mr. A would attempt to harm himself, could have occurred when he was placed in emergency accommodation. The Internal Investigation found that: the CPA discharge procedure had not been effectively followed; there was miscommunication between the housing team and the CMHT; and that during Mr. A's contact with Secondary Mental Health Services he was never assessed by a Consultant Psychiatrist.

Independent Investigation Team Feedback on the Internal Investigation Process

The Internal Investigation was carried out by three senior staff from the Trust, who were not involved directly with the services in question. They followed the documented RCA process diligently, and all reported that they had been trained in the process. The Internal Investigation process treated all witnesses appropriately, providing them with access to clinical notes, and with copies of interview notes to correct for factual accuracy prior to these being used in the report. The report was submitted to the Trust Board and to the service commissioner.

The Independent Investigation found this report to be thorough and its findings appropriate to what was known at the time the Internal Investigation was undertaken.

11.3. Being Open

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 that those patients and their families:

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

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

In the case of Mr. A the Internal Investigation did not make contact with the family of either the victim or Mr. A. The information available to the Independent Investigation indicates that the Trust did not have any contact with either family following the homicide. This was not in accordance with Best Practice guidance.

11.4. Staff Support

11.4. Staff Support

Prior to the Internal Investigation

The staff involved in the Mental Health Services which had worked with Mr. A were offered support by the Head of Risk and Compliance and the members of her team. The staff interviewed mentioned that they had largely supported each other but had been given information about the Internal Investigation process and what would be expected of them.

During and After the Internal Investigation

The Head of Risk and Compliance provided information and support during the Investigation.

A member of the nursing staff was seconded for a year from an IT post to work as the Lead Nurse in the Risk and Compliance Team. He was with staff during the period leading up to the Independent Investigation and provided information and support, and acted as the main liaison person with the Independent Investigation Chair. Together with the Head of Risk and Compliance he provided a consistent source of information and a helpful link between the two Investigations.

11.5. Trust Internal Investigation Recommendations

The Internal Investigation Report stated that *“the recommendations set out below are provisional. Following further discussion in the appropriate Trust Governance Forums, including the Critical Incident Overview Group, the final recommendations will be agreed by the Trust Board.*

The recommendations will also be considered alongside the recommendations of other Homicide Inquiries which have been undertaken in the Trust.

We have identified recommendations in two areas which we have found to have already been effectively addressed by the Trust. These were:

- *Safeguarding Children Assessment Tools...*
- *Discharge procedures from the Coast CMHT...*

We make recommendations in the following eight areas:

- *Monitoring of Child Protection/Safeguarding risks of cases on CRHTT caseloads;*
- *Medical staffing in North Somerset CRHTT;*
- *Inter-agency working between North Somerset Health Service and North Somerset Housing Department;*
- *Inter-agency working with [the Mental Health Voluntary Supported] Housing Association;*
- *An inter-agency review of the care received by [the victim];*
- *Audit of discharge procedures from Coast CMHT;*
- *Review of functional medical staffing roles in the North Somerset area;*
- *Primary Care liaison by the Coast CMHT.”*

11.6. Progress against the Trust Internal investigation Action Plan

**Table 2: Implementation Plan following the Internal Investigation
(This Table is taken from the Trust Second Composite Homicide Action Plan
dated 30 August 2012.)**

Recommendation	Agreed Action	Outcome	Done
Audit of discharge procedures from the Coast CMHT. The Team Manager of the Coast CMHT should conduct a retrospective audit, with support from the Trust Audit Department, of discharges from the Coast CMHT. The period of the audit should commence after the Coast Team had introduced regular discharge team review meetings, and should cover a 6 month period.	Agree the audit protocol and undertake audit to test the efficacy of the new discharge review arrangements. To be completed by 01 December 2010	Audit Completed.	Yes by end of 2010
Audit of discharge procedures from the Coast CMHT. The findings of the audit should be published as a Report shared with all Coast Team staff, and also reported at the N. Somerset/S. Gloucestershire Area Governance Group.	Publish findings and disseminate to all Coast Team staff by 01 December 2010.	Audit Completed	Yes by end of 2010
Audit of discharge procedures from the Coast CMHT. Any continuing issues identified in discharge procedures in the	Consider audit report at Area Governance group meeting and identify any further actions required.	Audit completed.	Yes by end of 2010

Mr. A Independent Investigation Report

team by the audit should be addressed by an action plan led by the Team Manager, and progress reported to Area Governance Group.	Develop and implement the resultant action plan		
Monitoring of Child Protection and Safeguarding risks of cases on CRHTT caseloads. CRHTTs should establish a system to note and review any Child Protection and Safeguarding concerns about all cases on the team caseload on an ongoing basis. This review should continue throughout the period of contact with the CRHTT, and a summary of this review should be handed over as part of the handover of care when the case is discharged from CRHTT intervention.	The Safeguarding Team to develop a solution to address this recommendation in consultation with CRHTTs to strengthen any identified weaknesses. To be completed by 01 October 2010.	Register of referrals kept by Safeguarding Team. Ongoing issues picked up through caseload supervision.	Yes
Medical Staffing North Somerset CRHTT. Dedicated medical staffing should be provided for N. Somerset CRHTT, in line with the DoH Mental Health Policy Implementation Guide advice (DoH 2001) and with the staffing of CRHTTs in other PCT Areas in the Trust. Medical staffing should consist of dedicated Consultant Psychiatrist sessions, with support from Junior medical Staff or Staff Grade doctors.	Establish medical staffing in North Somerset CRHTT. To be completed by 01 October 2010	Consultant appointed to Crisis Team on a part time contract, moving to a full time contract as part of re-design. The consultant is supported by a staff grade doctor.	Yes
Review of functional medical staffing roles in N Somerset area. The SBU should undertake an urgent review of the roles of consultant medical staff working in the N Somerset area. This review will probably be required to create the role of dedicated consultant input to the CRHTT, however wider issues of functionalization should be considered.	Conduct a specific review of medical staffing in North Somerset as part of the service redesign. To be completed by 30 April 2012	Review of posts was completed in 2011. All posts now filled and a consultant who had been off on long-term sickness has now returned to work.	Yes by end of 2011
Inter-agency working between N Somerset Mental Health Services and N Somerset Housing.	Establish working group with housing agencies and produce a report on progress to present to the	A meetings structure established with North Somerset	Yes

Mr. A Independent Investigation Report

<p>Association and other supported housing providers in the area should be considered.</p>		<p>included. Consider the establishment of a link worker as part of this review. Housing agencies are represented in the meetings structure.</p>	
<p>Inter-agency review of the care received by the victim of Mr. A. This was beyond the scope of the Mr. A Investigation, however serious concerns about the emergency hostel have been identified, and the placement was considered inappropriate for Mr. A.</p> <p>The Trust should formally request an inter-agency review of the care received by the victim. The review should include all of the relevant agencies. Agreed terms of reference should be developed for the review and an external facilitator should be considered</p>	<p>Formally request that the PCT commission an inter-agency review of the care received by the victim.</p> <p>To be completed by 01 October 2010.</p> <p>To be completed by 01 October 2010.</p>	<p>Being dealt with under the above meeting structure.</p>	<p>Yes</p>
<p>Primary Care Liaison by the Coast CMHT. The Coast CMHT Team Manager and consultant medical staff should visit every GP practice in their area over a 12 month period with the aim of improving communications with Primary Care and identifying problems and potential solutions.</p> <p>The allocation of link workers by the CMHT to groups of practices should be considered as part of a strategy for closer working relationships with Primary Care.</p>	<p>Agree and implement a programme of visits with GP practices.</p> <p>To be completed by 01 December 2010.</p> <p>Consider how to best support closer working relationships with Primary Care on an ongoing basis.</p> <p>To be completed by 01 December 2010.</p>	<p>Programme of visits to all GPs in the area was completed. In April 2012 this will be repeated to brief Primary care workers about future changes to Mental Health Services in the area.</p>	<p>Yes</p>
<p>Primary Care Liaison by the Coast CMHT. The Team Manager should review the distribution of the team caseload across the rural areas covered by the Team, and</p>	<p>Team Manager to review the distribution of the Team caseload.</p> <p>Operations to consider the establishment of an</p>	<p>All staff have undergone a caseload review with the service manager and the workload</p>	<p>No</p>

Mr. A Independent Investigation Report

<p>consider the introduction of outreach clinics. The setting up of outreach clinics in the Yatton area should be specifically considered as part of this project.</p>	<p>Outreach Clinic in the Yatton area.</p> <p>Both areas of work to be completed by 01 December 2010.</p>	<p>distributed appropriately and now handled differently with the move to team based caseloads.</p> <p>Service manager has undertaken an initial review of the locations of service delivery and found no pressing need for the provision of an outreach service in Yatton, but this decision will be revisited as part of the service redesign.</p>	
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From the Table above it can be seen that all but the last recommendation have been successfully completed within the original timescale.

12. Lessons Learned

Although Mr. A's contact with Mental Health Services was limited reviewing the care and treatment that he received serves to illustrate a number of much rehearsed lessons.

Good, efficient and effective care is based on clarity and sound procedures.

Care is most effectively delivered when there is someone who is identified as responsibly for assessing the individual's needs, planning his/her care with him and his/her family and ensuring that the planned care is delivered.

Care is most effective when it is based not only on sound assessment but when the information collected is used to understand the individual, where a clear formulation is arrived at which informs interventions and is shared by all those caring for an individual so that there is coherence and continuity in his/her care.

Holistic and comprehensive care relies on clear and effective communication within teams, when an individual's care is being passing between teams and when several teams or agencies are contributing to the individual's care. Clear and timely communication is the basis of a common understanding of the individual's needs, of joint planning and joint working.

Expressing the lesson in this way may, at first, seem to give pre-eminence to procedures and processes but the aim of these procedures is just the opposite, to put the service user at the centre of things, to get to know him/her as an individual and to respond to his/her unique circumstances in a way that is acceptable and make sense to him/her and is not obstructed by seemingly irrelevant barriers.

13. 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.

13.1. Recommendations for Avon and Wiltshire Mental Health Partnership NHS Trust

13.1 Diagnosis

- *Contributory Factor 1. Mr. A did not receive comprehensive assessment, a clear diagnosis or a comprehensive formulation of his problems which informed the care and treatment he received. Had such a diagnosis and formulation been in place it is likely that Mr. A would have received more effective treatment. However it would not be reasonable to conclude that the absence of such a formulation had a direct, causal relationship with the events of September 2009.*
- *Service Issue 1. The Crisis and Home Treatment Team had only limited access to medical input. This limited the assessment, formulation and interventions the team could undertake. The result of this was that the users of this service had less than optimal care and treatment.*

Service update.

The Trust reports that:

The Adult Community Service has implemented a mandated caseload supervision model. Caseload supervision is in place for all practitioners whereby all team leaders routinely

Mr. A Independent Investigation Report

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 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 100% of clinical staff are being supervised.

There is now a full time substantive consultant psychiatrist based within the team, with staff grade doctor support.

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.

13.2. Medication and Treatment

- *Contributory Factor 2. A more comprehensive care and treatment package should have been provided in order to manage the ongoing problems that Mr. A presented with. The package offered was not able to effect the changes to Mr. A's lifestyle and mental health problems that were required.*

Service update.

The Trust reports that:

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;

Mr. A Independent Investigation Report

- 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

13.3. The Care Programme Approach (CPA)

- *Contributory Factor 3. The CPA process was poorly implemented in the Crisis and Home Treatment Team. The lack of proper care coordination meant that no one individual took responsibility for ensuring that Mr. A's needs were comprehensively assessed, an appropriate care plan was developed, that this was delivered in a coordinated fashion and the efficacy of the care plan was reviewed on a weekly basis. In the absence of adherence to good practice in relation to the CPA it seems likely that Mr. A received less than optimum care and treatment. However it would not be reasonable to conclude that the absence of a robust CPA process had a direct causal relationship with the events of September 2009.*
- *Service Issue 2. At the time Mr. A was under its care the Crisis and Home Treatment Team did not employ robust care coordination with the result that no one individual in the team was responsible for ensuring that assessment, care*

planning, service delivery and review were undertaken in line with national Best Practice guidance. The result of this is that it is probable that the users of the Crisis Team's services received less than optimal care and treatment.

Service update.

The Trust reports that:

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 contingency plan (see the project described above).

The Trust has implemented a key worker system within the Intensive teams which ensures that all service users on the caseload has a named and accountable care co-ordinator, known to them, who is responsible for collaboratively developing a relevant care plan and contingency plan. Both of 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

13.4. Risk Assessment

- *Contributory Factor 4. Practitioners involved in assessing the risks associated with Mr. A did not collect and collate all the available, relevant information; they did not seek corroboration of the information that they had and they did not seek information relating to risk when it was identified that this was not known. They did not reassess the risks Mr. A posed in line with Trust policy and national guidance. They did not develop a clear formulation to help understand the risks Mr. A posed nor did they develop a clear risk management plan to address the identified risks.*
- *Service Issue 3. Although the Trust had an appropriate Clinical Risk Management policy in place it did not have in place risk documentation and processes which*

facilitated best practice. The risk assessment forms available to staff did not facilitate the collation and consideration of all the known risk factors and, therefore, did not support effective risk formulation.

Service update.

The Trust reports that:

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

13.5. Referral, Transfer and Discharge

- *Service Issue 4. The referral of Mr. A by his GP to the Crisis and Home Treatment Team without the involvement of the CMHT meant that he did not have an identified psychiatrist or a team that was responsible for his ongoing care. His care was passed between teams, none of which took overall responsibility for the management of his case. The discharge process was not in line with Trust policy and was not managed in a clinically safe way.*
- *Service Issue 5. The use of unqualified members of staff at key review meetings where important transitions in care are being planned is not appropriate. The assessment, planning and coordination of the delivery of care are the responsibility*

of the Care Coordinator. It should have been this individual who attended review meetings and ensured that there was an efficient and effective transfer of care.

- *Service Issue 6. The Trust did not have a system in place which enabled staff to: identify, efficiently, whether an individual had had previous contact with the service; access their history and assessments of needs and risks; and identify which service might best meet their needs.*

Service update.

The Trust reports that:

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 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

13.6. Safeguarding Children and Vulnerable Adults

Service update.

The Trust reports that:

There has been an emphasis on training staff to enable them to deliver on their safeguarding responsibilities and 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.

13.7. Carer Assessment and Carer Experience

- *Service Issue 7. There is no evidence available to the Independent Investigation to indicate that the Crisis Team identified Mr. A's girlfriend as a carer. She was not effectively engaged in identifying his needs or the risks he posed. She was not involved in planning his care. Although Mr. A lived with his girlfriend for much of the time he was under the care of the Avon and Wiltshire Adult Mental Health services she was not offered a carer's assessment. This was poor practice.*

Service update.

The Trust reports that:

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 that the plan subsequently developed meets the needs of the carers.

13. 8. Housing

- *Contributory Factor 5. Statutory Mental Health services did not provide the housing services with adequate support when they were trying to find a placement for Mr. A, a young man who had made a serious attempt to harm himself, had been under the care of the Crisis Team and had been referred to the CMHT. As a result Mr. A was placed in emergency accommodation without assessment or support from Mental Health services. This lack of support was not in Mr. A's best interests and did not reflect best practice.*

Service update.

The Trust reports that:

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.

13.9 Documentation and Professional Communication

- *Service Issue 8. Sending unqualified support workers or students to medical outpatient reviews did not facilitate an effective clinical review between the CMHT and the Crisis and Home Treatment Team.*
- *Service Issue 9. The lack of rigour in professional documentation meant that important summary information and formulations were not completed. This was not helpful to effective communication about Mr. A's needs between groups and professions.*

- *Service Issue 10. There was an ineffective system for accessing previous contacts with the services. This meant that important information about previous involvement with services was not available when staff needed to access those details.*

Service update.

The Trust reports that:

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

13.10. Adherence to Local and National Policy and Procedure

- *Service Issue 11. The auditing requirements identified in the Trust's policies were not tightly defined, identifying the audits which the service should complete. This may have contributed to the limited policy compliance this Investigation has identified.*

Service update.

The Trust reports that:

The Trust has a new policy framework in place which requires clear 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 then included through regular assurance reports to the relevant overview committee.

Recommendation 7

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

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

Contributory Factor 6. Because Mr. A was referred directly to the Crisis and Home Treatment Team no one took the overall responsibility for understanding him in the context of his longer-term history and troubled adolescence. No one facilitated his access to longer-term treatment and support services which might have helped him deal more effectively with the mental health and life problems he was facing. Mr. A was discharged from Secondary Mental Health Services without his presenting problems being effectively addressed, or long-term plans to assist him move on in life being put in place. This absence of effective support and help meant Mr. A's mental health was likely to continue to be vulnerable and therefore there continued to be a reasonable likelihood of him presenting in crisis and acting impulsively at some point in the future. There were no plans, agreed with Mr. A or with Primary Care, to manage future crises should they occur.

Service update.

The Trust reports that:

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 then 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

14. Glossary

Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service user's 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
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies
Enhanced CPA	This was the highest level of CPA that a person could be placed on prior to October 2008. This level requires a robust level of supervision and support
Mental Health Act (1983 & 2007)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition. The Act was revised and amended in 2007
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines
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 commissions them from other providers, and is 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

Risk assessment

An assessment that systematically details a person's risk to both themselves and to others

Service User

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

SHO (Senior House Officer)

A grade of junior doctor between House Officer and Specialist Registrar in the United Kingdom

Specialist Registrar

A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant