Independent Investigation

into the

Care and Treatment Provided to Ms X

by the

Avon and Wiltshire Mental Health Partnership NHS Trust

Commissioned by NHS South West

Executive Summary

Report Prepared by HASCAS Health and Social Care Advisory Service
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1. Incident Description and Consequences

Background for Ms X

Ms X became involved with the Bristol Mental Health Services in **May 2009**. She had left her two young children aged four years and twenty-two months respectively unattended at her sister's house without first having informed her sister or having checked that she was there. The Police and the Children and Young People's Service became involved. Ms X was cautioned by the Police and her two children were reported to be 'Children in Need'. Following this incident Ms X was seen by her GP and was referred to the City-wide Home Intervention Team which assessed her and promised to provide some support as she was thought to be exhibiting psychotic symptoms.

Ms X presented with paranoid ideas and appeared chaotic, unpredictable and believing that songs on the radio had been written by her. She was assessed at home by the Crisis Resolution and Home Treatment Team and after a few days was admitted to hospital. She was admitted as an informal patient but was soon placed under a Section 5(4) and later a 5(2) followed the next day with a Section 2 of the Mental Health Act 2007. Ms X rapidly calmed down in hospital and was always asking to be allowed home and often tried to abscond and on occasions succeeded. As soon as she was discharged Ms X stopped taking her medication and did not engage with the Early Intervention Service.

At first the Clinical Team thought she was suffering from a psychotic condition, but after three further admissions to hospital between **July 2009** and **March 2010**, the clinical view was that Ms X had an Emotionally Unstable Personality Disorder which was aggravated by the use of illicit drugs and alcohol. Throughout this time it was apparent that she would not engage with services and that she had bizarre wishes to become pregnant and had absconded from hospital to find men to impregnate her. She had no sense of responsibility for her own actions, and had become homeless in the past because she could not manage her finances.

Ms X was a vulnerable adult and, as she refused to follow any advice from the Mental Health Services, she was discharged to supported accommodation managed by a Housing Association. The terms of the tenancy stated that no men were allowed on the premises, and no drugs or alcohol were to be consumed on the property. Given her lifestyle and her wish to

become pregnant and to use drugs and alcohol the conditions of residence at the Housing Association flat would not be successfully followed. She met Mr Z who she took back to her flat where they used drugs and alcohol and damaged the property and therefore her tenancy was terminated and she was evicted.

Background for Mr Y

Mr Y had a criminal record and had been committed to Broadmoor Hospital for an offence of false imprisonment and grievous bodily harm. He was subject to a conditional discharge under Section 41 of the Mental Health Act 1983 and was under the care of the local Community Mental Health Team (CMHT).

Incident Description and Consequences

Ms X was homeless and had to find accommodation which entailed her using friends' floors and settees. One night she met a friend of her stepfather's, Mr Y, and decided to take up his offer of a room for the night. Ms X stated that Mr Y subsequently raped her and she told her boyfriend. Ms X and her boyfriend went to Mr Y's flat where Mr Z assaulted Mr Y and caused his death while Ms X stayed outside the room. The post mortem found 43 wounds to Mr Y's body which had caused his death, with other wounds being defensive injuries to his hands and his legs.

2. Terms of Reference

The Terms of Reference for this Investigation were set by NHS South West (now NHS South of England). The Terms of Reference were as follows:

1. *"To draft a chronology relevant to the issues and circumstances. This should include reference to information available following the conclusion of Crown Court proceedings in order to determine the circumstances leading up to the homicide.*
2. *The quality of healthcare provided by the Trust, to include whether it complied with statutory guidance, statutory obligations, relevant Department of Health guidance and Trust policies.*
3. *The appropriateness and delivery of treatment and medication, this should include consideration of the appropriateness of discharge under the Mental Health Act on 5th July 2010, the after care plan and the actions then taking place to include a professionals' meeting held on 20th August 2010.*
4. *Inter-agency information sharing/communication and coordination of services.*
5. *The assessments of risk to include the recording and actions taken.*
6. *Documentation, including recording of clear plans/assessments and meetings, decisions on frequency of contact and visits and actions taken by all services.*
7. *The internal investigation, its definitions and findings, methodology, recommendations and actions subsequently taken.*
8. *To identify learning points for improving systems of care, together with practical recommendations for implementation.*
9. *Report findings and recommendations to NHS South".*

The SHA requested that the care and treatment provided to Mr Y was also reviewed as part of this Investigation.

3. The Independent Investigation Team

Selection of the Investigation Team

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

Independent Investigation Team Leader

Ian Allured	Director Adult Mental Health, Health and Social Care Advisory Service. Chair, Social Worker Member and Report Author

Investigation Team Members

Dr Louise Guest	Consultant Psychiatrist Member of the Team, South West London and St George's Mental Health NHS Trust
Jon Allen	HASCAS Associate and Nurse Member of the Team
Dr. Len Rowland	Health and Social Care Advisory Service Director of R & D. Report Lead for the care and treatment of Mr Y

Support to the Investigation Team

Greg Britton	Investigation Manager, Health and Social Care Advisory Service
Fiona Shipley Transcriptions Ltd	Stenography Services

Independent Advice to the Investigation Team

Ashley Irons	Capsticks Solicitors

4. Findings of the Independent Investigation

1. Diagnosis.

Ms X was first admitted to hospital in **June 2009** having been assessed in the community as requiring Olanzapine which she had been refusing, thinking she was well. The Care Plan had been to visit her daily and to allow her to express her feelings and for staff to observe for paranoid ideas, bizarre beliefs and delusional thoughts. Ms X was diagnosed as having an Acute Transitory Psychotic Episode.

On **14 June 2010** Doctor 2 revised his opinion and stated at a Professional Meeting that Ms X suffered from a Personality Disorder, Emotionally Unstable Personality Disorder of a borderline type. The diagnosis had taken a considerable time to determine. The influence of alcohol and illicit drugs was taken into account, given that Ms X appeared to recover from her psychotic-type symptoms very rapidly on admission to hospital.

2. Medication and Treatment

Due to uncertainty about her diagnosis, Ms X was prescribed medication throughout her care, both antidepressants (Fluoxetine) and oral antipsychotics, at low dose (Risperidone and Olanzapine) and depot antipsychotic medication (Risperdal Consta), along with Lorazepam and Haloperidol for rapid tranquilization. It is not unusual for individuals presenting with Borderline Personality Disorder, and those presenting with affective instability and self-harm, to be prescribed antidepressants to attempt to improve their mood, although the evidence base to support this practice is limited.

Antipsychotics were prescribed due to the ongoing concerns that Ms X may have had psychotic symptoms, but she was rarely compliant with them so they were of minimal worth in treating her effectively.

The Early Intervention Team continued to work with Ms X and offered her a range of therapeutic interventions but she declined them all after introductory explanation of what was involved, or stopped them after only one session. She did not engage with the Crisis Resolution and Home Treatment Team during her periods in the community and never engaged fully with the Early Intervention Service Team. On the Open Ward and the High

Dependency Ward she very rarely discussed any issues of a therapeutic nature with the ward staff.

3. Use of the Mental Health Act (1983 and 2007)

Ms X's inpatient care was characterised by frequent short admissions under the Mental Health Act (1983 and 2007). She declined to engage in therapeutic activity, and frequently absconded, and was preoccupied by wanting to be discharged throughout most of her five admissions to hospital.

Following her first contact with Adult Mental Health Services Ms X was admitted quickly, initially informally, and then placed under Section 5(4) of the Mental Health Act (1983 and 2007) followed by Section 5(2) and then a Section 2. Given the lack of clarity over her diagnosis, it was surprising that when admitted under the Mental Health Act she was not assessed more thoroughly, with the use of the full 28 days, rather than being discharged somewhat precipitously as happened on four occasions. This care pathway was unfortunate as it appeared to have had a detrimental effect on her future engagement. The second admission on **22 July 2009** further adversely affected Ms X's views of hospital care and treatment as she was forcibly given medication under control and restraint procedures despite her having been described as not presenting any real concerns to staff and being on an assessment Section not a treatment Section. In addition Section 17 leave was not used, so her community tenure was not tested.

4. Care Programme Approach (CPA)

The Care Programme Approach (CPA) was adhered to and used appropriately within the context of Ms X's care and treatment. The Independent Investigation Team concluded however that the risk assessment within the CPA was largely a chronological list of risks which were not explored fully. The Risk Management Plan should have explored the potential risk Ms X posed to her children who were being looked after by her mother. She had had a deep desire and conviction that she would be able to have a two- or three-bedroomed house where she and her children could live. The main emphasis of the Risk Management Plan was about minimising the risks she presented to herself but the Plan did not explore the risks she posed to her children should she decide to act impulsively and remove them from her mother's care.

5. Risk/Clinical Assessment

The staff from the Early Intervention Team (EIT) did identify risks and sought to prepare plans to manage them. They had problems in engaging Ms X which made it difficult to fully understand and monitor her.

Ms X was described by Doctor 2 as being the person who was the most passionate in wanting to leave the hospital he had ever encountered. Ms X absconded 16 times from the Open Ward or the High Dependency Unit or when out on escorted leave or unescorted leave.

The risk assessments and risk management plans mentioned that Ms X presented a high risk of absconding but they did not take into account the risks Ms X placed herself in once she had left the ward. There was little evidence of the ward staff taking firm action over her absconding and the only details of staff confronting her about this was on **7 June 2010**. Ms X was warned about her behaviour on escorted leave and told that if she absconded she would be seen by the Duty Medical Officer to check whether she had taken drugs or alcohol. She was further warned that if she did not return within the hours of Section 17 leave agreed all her leave would be cancelled.

The suspension of leave following her absconding from staff when she was granted escorted leave for an hour on **9 June 2010** was too little too late. Within 12 days of Ms X having her leave suspended she was moved from the High Dependency Unit to the 'open' Ward with the Section 3 of the Mental Health Act 2007 rescinded.

It was clear at the Care Programme Approach Meeting held on **21 June 2010** that Ms X "*did not accept any of these risks [the risks identified by staff] and thought all would be well in the future. She said she would borrow other people's couches and floors and all would be well".*

6. Referral, Admission and Discharge Processes.

Referral

It is unclear from the Clinical Records quite what happened to Ms X's referral to Mental Health Services from her GP on **28 May 2009**. It is likely that the referral from GP 1 went to the Assessment Team where a Core Assessment Form was completed. It appears that following the Assessment it had been thought that the Citywide Home Intervention Team would be the appropriate service to become involved. This obviously had not occurred as Mrs

W and her daughter made direct contact with the Crisis Resolution and Home Treatment Team (CRHTT) where Doctor 1 also completed an assessment and prescribed medication for Ms X. Ms X continued with the Crisis Resolution and Home Treatment Team until it became clear that she needed to be admitted to hospital. Ms X's mother had intervened effectively to ensure a service was received.

Transfer and Discharge

The transfer and discharge processes were not dealt with as well as they should have been. The Independent Investigation Team concluded that the care and treatment provided to Ms X could have been better from the time of her final admission to hospital on **5 March 2010** until her eviction from the Housing Association Accommodation. The Ward and Community Mental Health staff had a 'duty of care' to Ms X, but little appears to have been done to ensure her health, safety and wellbeing whilst she was absconding or when she was discharged to the Housing Association Accommodation.

7. Service User Involvement in Care Planning and Treatment

Mental health services tried to work with Ms X and involved her as far as they could. Letters and case summaries were sent to Ms X which were written sensitively and gave clear information.

The Early Intervention Team staff worked hard to try to adhere to the care plans which were agreed with Ms X. They were concerned about her and wanted to help her cope better with her life and to gain secure accommodation. The Team did involve her and Care Coordinator 2 visited her weekly in hospital during the 18 week admission. The staff in the community and on the ward did what they said they would do but Ms X did not give them the opportunity to meet with her, or if they did she would not agree to participate.

8. Documentation and Professional Communication

Documentation

In examining the documentation regarding the absconding from the ward by Ms X there were some instances where the return section of the notification was not completed. The lack of analysis of the risks posed by Ms X was discussed in the Section of the Report dealing with Risk Assessment and Risk Management. The risks were listed but were not then extended to the risk of Ms X taking her children away from her mother and absconding with them.

Professional Communication

There was good liaison between Mental Health Services and the Children's and Young People's Service. At the initial appointment with Doctor 1 it was evident that Ms X was having difficulties in coping with her children, and that the Police and the Children's and Young People's Service was already involved. Doctor 1 wrote in the Core Assessment form that the Care Coordinator should make contact with the Social Worker responsible for the safety of Ms X's children.

When Ms X was offered a place with the Housing Association on **6 July 2010** the Early Intervention Team (EIT), particularly Care Coordinator 3, became involved and made contact with Senior Support Worker 1 from the Housing Association. She was involved in the discussions the EIT had about Ms X and attended the discharge planning meeting. Some joint visits were arranged with Care Coordinator 3 but often failed to result in meeting with Ms X as intended due to her avoiding contact with services.

From the clinical records and the Internal Investigation it was evident that when Ms X was evicted from her flat with the Housing Association, due to breaking the rules and not having made any effort to arrange payment of the rent, the liaison between the Housing Association and the EIT did not work as well as it should have done and the EIT had no knowledge of the eviction until four days after it had occurred on **Friday 1 October**.

9. Safeguarding Children Issues

The overall management of the care and treatment of Ms X did take into account the needs of her children aged four and 22 months in **May 2009** when Ms X was referred to the Bristol Mental Health Services. The Team Leader of the Mental Health Services was given the responsibility for making sure that any Safeguarding Children issues were discussed with the appropriate staff in the Bristol City Council.

A Safeguarding Children Form had been partially completed and under the Section on Parenting it had been noted that Ms X had a significant and prolonged deterioration in her ability to look after her children. It was also noted that both she and another family member (her mother) had expressed concern about her ability to care for her children. It was evident that Care Coordinator 1 had contacted the Children and Young People's Service as Social

Worker 1 was named on the form as were her contact details. A Children in Need Conference had been arranged for **8 July 2010** and Care Coordinator 1 was listed to attend.

Throughout the rest of the time Ms X was being provided with care and treatment from the EIT and in the Open Ward and the High Dependency Unit good communication with the Children and Young People's Service was maintained by telephone and in writing and was noted in the Clinical Records. This was good practice.

When Ms X moved to the accommodation provided by the Housing Association, Senior Support Worker 1 was in contact with both Care Coordinator 3 and the Children and Young People's Service, and in particular with Social Worker 3. Senior Support Worker 1 attended the Discharge Plan Meeting on **1 July 2010**. Throughout the period Ms X was accommodated by the Housing Association there was frequent contact between Care Coordinator 3, Social Worker 3 and Senior Support Worker 1 to ensure all three agencies were aware of the current situation with Ms X.

10. Vulnerable Adult Process

It was clear from the Clinical Records that Ms X could be considered a vulnerable adult as she continued to place herself in dangerous situations throughout the time she was receiving care and treatment from the Avon and Wiltshire Mental Health Partnership Trust (the Trust). She had a history of making shallow and rapid relationships and becoming pregnant and had sought protection in Women's Refuges following domestic violence in Newcastle under Lyme and Birmingham.

Ms X had what can only be described as a very poor childhood having described herself as *"having never been happy"* during a meeting with the Child and Adolescent Mental Health Service (CAMHS) in 1998.[1]

There is no evidence in her clinical records to suggest that the mental health staff considered Ms X to be a vulnerable adult as defined in the Local Adult Safeguarding Policy. This was despite knowing about her difficult and disrupted childhood, her history of abuse and the

[1] GP Records Page 86

recent history of absconding and placing herself in very dangerous situations in order to become pregnant. This was a missed opportunity to provide more realistic support for Ms X.

11. Clinical Supervision

In the interviews the Independent Investigation Team had with clinical witnesses the subject of clinical supervision was discussed. Staff were aware of their responsibilities and described the arrangements for supervision which were consistent with those described in the AWP Staff Supervision Policy.

Staff in the EIT had monthly management supervision with the Team Coordinator or with Team Manager 1 and this was the standard of supervision for the whole Team. Staff with particular skills and professions such as psychology and occupational therapy would also have access to professional supervision. Staff had indicated that there was always a senior team member available in the office should they need to have supervision or a discussion about a case in between the 'fixed' supervision sessions.

The staff interviewed, and their managers, confirmed that the supervision was carried out and that they made checks to ensure that the supervisions were carried out. The one missing element from the perspective of the Early Intervention Team was the difficulty in obtaining timely consultant psychiatric opinion and advice as the Team did not have a dedicated post and had to use the relevant Community Mental Health Team Consultant psychiatrist.

12. Adherence to Local and National Policy and Procedure, and to Clinical Guidelines

The quality of the Avon and Wiltshire Mental Health Partnership NHS Trust policies was good, with an introduction which briefly described the history of the relevant national policies and then incorporated these within the Trust policy. The policies were well written and easy to follow with easy to understand flow charts where appropriate in Safeguarding Children and the Safeguarding Vulnerable Adults Policies.

Local policies and procedures were generally well adhered to and the policies had a section which stipulated the national policy and its requirements. There were a few exceptions:

- dedicated Consultant Sessions in the six Early Intervention Service Teams in the Trust;

- the Safeguarding Adults Policy (AWP Policy to Protect Adults);
- the Mental Health Act 2007 in that Sections 2 and 3 and 117 were not used fully on discharge to afford Ms X additional safeguards by the Clinical Team being able to recall her to hospital and use funding to improve her discharge plan;
- the lack of a clear and achievable Crisis and Contingency Plan.

13. Clinical Governance 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).

Within the context of the policies and processes which the Independent Investigation Team examined, the Trust has an appropriate set of clinical policies and strategic documents which are informed by both best practice guidance and national guidelines. It is also noteworthy that the Trust's clinical policies are informed by the learning accrued from previous events and investigations.

5. Conclusions

The root cause of the homicide of Mr Y was a combination of events which could not have been predicted or prevented.

Ms X did not engage with services and would not accept any help that the mental health services offered. Due to her somewhat chaotic and at times traumatic childhood she was impulsive and wilful and refused to accept advice if it went against her wishes at the time. This directly led to her eviction from the Housing Association accommodation where women in her situation were able to find help and the opportunity to try to overcome the consequences of their domestic violence. Ms X broke the terms and conditions of her tenancy and did not work with the Senior Support Worker at her accommodation to finance the rent for the flat. She also refused help from the EIT.

As a result Ms X was made homeless and did what she had indicated to her Care Coordinator she would do at the time that her Care Plan was drawn up by the EIT, that is she sought floors and sofas where she could spend the night. The incident occurred because she accepted a bed for the night from Mr Y. She told her boyfriend, Mr Z, that Mr Y had raped her. This resulted in a violent attack on Mr Y by Mr Z which caused his death.

The Independent Investigation Team would like to highlight that the quality of the Avon and Wiltshire Mental Health Partnership NHS Trust Internal Review was of a high standard and many useful findings and conclusions were made and recommendations set. This is to be commended when taking into consideration the difficulties that the ongoing Police Investigation presented to the work of the Internal Investigation process by denying access to important witnesses from the family of both the perpetrator and the victim.

The Independent Investigation Team whilst concluding that the death of Mr Y could not have been predicted or avoided has highlighted a number of service issues which the Trust needs to consider and address. It did not find any causal factors. The Trust has worked hard since the time of this incident to learn lessons and to ensure that processes and systems are in place and that services are being delivered in accordance with all the required policies and procedures at the present time. Whilst it cannot ever be stated with confidence that such an

occurrence will never happen again, the Independent Investigation Team, during the course of the Investigation process, was able to identify significant service improvements pertinent to this case and could determine that the Trust is a learning organisation.

6. Lessons Learnt

It would be foolish to assume that a comprehensive appreciation of the functioning of a service can be gleaned from the examination of a single case, no matter how detailed that examination might be. However the examination of a single case can enable one to identify lessons which, if learned and used to inform future practice, might improve services generally.

Louis Appleby (2007), the then National Director of Mental Health commented:
"Increasingly, services aim to go beyond traditional clinical care and help patients back into mainstream society, re-defining recovery to incorporate quality of life - a job, a decent place to live, friends and a social life". [2]

The delivery of care provided to Ms X, for much of the time she was under the care of the Avon and Wiltshire Mental Health Partnership NHS Trust was characterised by its persistence and flexibility. Ms X did not accept that she had any mental health issues and refused to accept medication in the community and also in hospital at times. She did not engage with services and often made sure she was out when appointments had been made to visit her. The EIT maintained contact as best they could despite Ms X's unwillingness to engage, which was good practice.

The Care Programme Approach emphasises the importance of delivering a planned and co-ordinated service based on the on-going assessment of the individual service user's needs and the evaluation of the efficacy of the interventions provided to meet those needs. In the care and treatment of Ms X several lessons have been identified which highlight the need for more assertive and proactive interventions when required, and the need to use the powers provided in the Mental Health Act (1983 and 2007) to detain people in hospital in order to 'treat' their symptoms and promote recovery. The main lessons learnt from this Independent Investigation are briefly described below.

[2] Appleby. L (2007) *Breaking down the barriers: the clinical case for change.* Department of Health

Corroboration and Sharing Information

The staff caring for Ms X were not aware of the extent of her childhood abuse nor the level of her earlier involvement with mental health services, including Child and Adolescent Mental Health Services, Addiction Services and Adult Mental Health Services. Such knowledge may have altered their perspective of Ms X and her situation. Good practice suggests that whenever possible and appropriate corroborative information should be sought to improve the understanding of an individual's behaviour and to test current formulations. Appropriate, mutual sharing of information with other agencies can, similarly, not only result in a better understanding of an individual's needs and the risks he or she poses and is exposed to, but can also facilitate collaborative co-working.

In the case of Ms X the sharing of information by referring her to the Local Authority Vulnerable Adult Department would have triggered a Strategy Meeting where local agencies would have pooled their knowledge of Ms X and have planned action to address the causes of her vulnerability. This opportunity was missed.

Assessment and Care Planning

The Care Programme Approach (CPA) provides the framework for Assessment and Care Planning in Mental Health Services. One of the cornerstones of CPA is that the assessment is comprehensive because issues in one area of an individual's life impact on those in other areas. Those caring for Ms X were diligent in ensuring that she received the prescribed treatment for her mental health problems, they also tried to help her address her accommodation issues.

The identification of risks was carried out but the subsequent management of those risks through a comprehensive care plan was lacking. The risk management relied on Ms X engaging with services which was exactly what she would not do. It is clear that Ms X did not display any motivation to address her substance misuse problem nor her accommodation problems.

Discharge Planning

It is widely recognised that discharge is a point of particular vulnerability and it is for this reason that protocols are normally put in place relating to the discharge process. It is often said that discharge planning should begin at the point of admission. What is certainly true is

that there needs to be clarity as to why an individual is being admitted to hospital and what the goal of the admission is. This plan should inform the inpatient assessments and interventions should be planned to meet the identified goal. Discharge should be planned in this context. This planned assessment, goal-orientated intervention and coordinated discharge did not characterise Ms X's final hospital admission.

Ms X stayed in the Open Ward or the High Dependency Unit for 18 weeks. Upon discharge she was homeless and stayed in the unit until the Housing Association was able to offer her a supported flat to address her issues surrounding domestic violence. During this period Ms X frequently absconded and returned to the ward having abused alcohol and sometimes drugs. There was good reason to use the powers that the Mental Health Act (2007) provided, namely the use of Section 117 as she had been admitted to hospital on Section 3 of the Act for her final admission. The Section 3 was rescinded immediately she was discharged which meant she could not be recalled to hospital should the need arise. Section 117 was not used despite the gaps in her Care Plan.

It could be argued that the 'powers' provided by the Mental Health Act should have been used to provide the help and support Ms X required. In many ways it was she who dictated the care she received.

Reflective Practice

Ms X's case illustrates the importance of reflective practice. As noted above this is in part achieved through regular reviews, and reviewing diagnoses and formulations based on new information. It is also one of the functions of the multi-disciplinary team. Each discipline brings to the table a different set of skills and a differing emphasis as to what is important. While it is the responsibility of the organisation to ensure that an appropriate set of skills are available within a team to enable it to deliver an effective and efficient service, it is the responsibility of the individual professionals to ensure that their skills are appropriately employed and they have an appropriate input into the formulation and understanding of the individual's difficulties. This was lacking in the situation with Ms X as the management of risk was poor as was the development of an effective care plan with no Crisis or Contingency Plan.

Governance

Finally while it is the responsibility of the organisation to ensure that it has in place a set of policies and procedures that are fit for purpose it is the professional responsibility of clinical staff to comply with these policies. Good governance suggests that there needs to be a mechanism in place which enables the organisation to identify when policies and procedures are not being followed and to address this issue in a timely manner.

7. Notable Practice

During the Independent Investigation there were some examples of good practice identified by the Investigation Team which are listed below:

- the tenacity of the Early Intervention Team in trying to engage Ms X when it was evident she did not wish to accept help from mental health services. The EIT attempted to remain in contact with Ms X even though they realised that she was not taking her medication and was not keeping her appointments with her Care Coordinator or other members of the Team;

- the written notes of the assessments carried out by Doctor 1 in **May 2009**, and the Social Circumstances Report for the Mental Health Act Tribunal written by Care Coordinator 2 dated **7 May 2010**, both of which gave a clear and detailed account of how Ms X had presented and provided a good summary of the interview and the care and treatment being provided;

- the efforts to explain matters to Ms X even when she was not showing any wish to discuss the care of her children or other issues to do with her mental health and her need for accommodation;

- allowing Ms X to stay in hospital until supported accommodation had been identified and a date for moving in to the Housing Association property had been agreed;

- the good liaison between the EIT and the Children's and Young People's Services.

8. 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 improve further services and consolidate the learning from this inquiry process.

1. Diagnosis

Recommendation 1.

Service Users will be informed of diagnosis following assessment. Care Plans will detail the supportive interventions which will be explained to the service user.

2. Medication and Treatment

Recommendation 2

Where there are any identified concerns of a service user becoming non concordant with their medication, a medicines management plan needs to be developed which takes into account the possibility that the Service User will discontinue treatment, and provision should be made for this within the CPA care plan including what may be necessary steps in such circumstances.

Recommendation 3

All prescribing staff should be familiar with the necessary steps to commence oral and depot antipsychotic medication safely, and this should include the risks associated with switching between oral and intramuscular forms of medication. Prescribing staff should have completed mandatory training in medication prescribing.

3. Use of the Mental Health Act (1983 and 2007)

Recommendation 4

Following the review of Section 117 agreements the Trust needs to discuss more effective use of Section 117 with relevant local authorities.

4. Care Programme Approach

Recommendation 5

The Trust should audit the use of the caseload management tool in community teams (including Early Intervention)

5. Risk Assessment and Management

Recommendation 6

In its planned refresher training for staff on clinical assessment and formulations, the Trust should use this situation with Ms X as a training example of what could and should have been done.

6. Safeguarding Vulnerable Adults

Recommendation 7

The Trust must maintain its current model of two practitioners in every community team trained to Level 3 Safeguarding, and ensure availability of Level 2 training for all community practitioners.