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PUBLICATION OF INDEPENDENT REVIEW INTO THE CARE AND TREATMENT OF MR AS

28 November 2018

Findings are published today of an independent review into the care and treatment of Mr AS.

Mr AS sadly took his own life on 4 October 2013 following a long and complex history of mental health illness. The purpose of the review was to fully consider the care and treatment provided to Mr AS and to make recommendations for further action where appropriate. It was commissioned in response to concerns raised by his family that health care during the last year of his life did not follow his usual care and in the context that Mr AS had contact with multiple care providers during this period.

Mr AS had been supported by mental health services since the age of 18 and experienced difficulties with his mental health throughout his adult life. At times he could become significantly unwell and on more than one occasion this resulted in an inpatient admission.

He had been under the care of Devon Partnership NHS Trust since May 2010, before which he had lived in Scotland. In the last year of his life, Somerset Partnership NHS Foundation Trust and latterly, Derbyshire Healthcare NHS Foundation Trust also provided care and treatment to AS. He was also admitted to Cygnet Hospital Kewstoke (an independent mental health facility), near Weston-Super-Mare, four times between 2012 and 2013.

The review team identifies a number of areas of care which fell short of the standard we would expect.

Key themes identified in the report relate to the following areas of care:

- Risk assessment and risk management
- Care Planning
- Carer involvement
- Inconsistent / inaccurate forensic history
- Police involvement and the use of Tasers
- Continuity of care

This thorough review of Mr AS' care and treatment has identified the following recommendations which will now be taken forward in order to improve services:

- Each of the NHS Trusts should review the manner in which it shares patient information

with external investigators and that consideration should also be given to the implications of sharing such documentation with other third parties e.g. families and other Trusts.
- Patient information should be provided in a clear, structured manner that can be easily referenced and navigated.
- All healthcare professionals should take into consideration the implications of criminal proceedings relating to a service user as part of any broader assessment of mental health and well-being.
- Somerset Partnership NHS Foundation Trust and Devon Partnership NHS Trust should review and ratify a Taser policy for their Trust.
- Trusts should set out a programme of evaluation and assessment, revisiting all aspects of their action plan to ensure that changes have been implemented and are monitored. Particular attention should be is given to:
    - the role of families / carers in developing risk assessments, risk management plans and care plans
    - developing, clarifying and / or ratifying policies in relation to:
        - Section 17 leave
        - the use of Tasers on NHS premises and the aftercare of patients who have been subject to an event involving a Taser
        - the involvement of police on wards (e.g. liaison, individual roles and responsibilities, when to escalate and involve the police on the ward, and, how this should be managed, minimised and situations de-escalated)
        - pharmaceutical oversight of transferred patients with a history of severe mental illness
        - the role of the responsible clinician in patient transfers between Trusts / provider services.

Regional Chief Nurse for NHS England Dr Lynne Wigens said: "We would like to offer our sincere sympathies to Mr AS' family and all the people who have been affected by this tragic case.

"It was important for us to look carefully at the care provided to Mr AS and ensure the providers of his care, and the whole of the NHS, learn lessons and make improvements for the benefit of future patients, their families and their carers."

Since the death of Mr AS a number of improvements have been made following initial investigations into Mr AS's care. The trusts involved are committed to learning from this tragedy and have in place actions plans which address the recommendations set out in this review. NHS England will monitor these action plans to ensure the recommendations are implemented within six months.

Ends

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