

Independent Investigation

into the

Care and Treatment Provided to Mr X, Ms Y and Mr Z

by the Dorset HealthCare University NHS Foundation Trust

Commissioned by NHS England

Report Prepared by: HASCAS Health and Social Care Advisory Service

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1. Investigation Team Preface

1.1. The Independent Investigation into the care and treatment of Mr X (the victim of homicide), Ms Y and Mr Z (the perpetrators of the homicide) was commissioned by NHS England pursuant to *HSG (94)27*.¹ The Investigation was asked to examine a set of circumstances associated with the death of Mr X who was found dead on 27 July 2012. The decision was made to investigate the care and treatment received by each of the three individuals as all three were service users with the Dorset HealthCare University NHS Foundation Trust.

1.2. Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of the 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.

1.3. 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 to those who have supported them. We would also like to thank the Trust's Senior Management Team who granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has engaged fully with the root cause analysis ethos of this work.

2. Condolences to the Family and Friends of Mr X

2.1. The Independent Investigation Team would like to extend their condolences to the family and friends of Mr X. We met with Mr X's younger brother and are grateful to him for the time that he gave to us and the insights that he offered which supported the work of the Investigation.

3. Incident Description and Consequences

Background for Mr X (deceased)

3.1. Mr X was originally from Portugal and born on 29 October 1967. He was a registered sex offender who was placed on level 1 of the Multi Agency Public Protection Arrangements (MAPPA). At the time of his death he was known to the Bournemouth North Community Mental Health Team (CMHT). He had also been known previously to the local addictions team. Mr X had 24 convictions relating to 42 offences. Dorset police noted that of these offences:

- six were against the person;
- two were of a sexual nature;
- 19 related to theft;

1. Health Service Guidance (94) 27

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- two related to public order;
- nine were against the police;
- two were drug related;
- two involved offensive weapons.

3.2. Mr X was single and at the time of his death was 44 years old. He had been diagnosed as having Schizophrenia and substance misuse problems.

Background for Ms Y (perpetrator of the homicide)

3.3. Ms Y was born on 29 December 1956. She was known to Bournemouth-based CMHT services for several years between 1998 and her eventual discharge in April 2012; she had a diagnosis of Emotionally Unstable Personality Disorder/Borderline Personality Disorder and it was recognised that she also had substance misuse problems. It would appear that Ms Y had been in trouble with the law on several occasions and it was recorded within her clinical files that she had a significant forensic history. Ms Y has three convictions for seven offences, mostly drug related (possession and supply of cannabis and heroin). She was first convicted in 1991. Ms Y has also been arrested and charged on several additional occasions these include:

- a charge of grievous bodily harm when aged 21 years (1977);
- having been in prison on remand in 1989 *“for a murder inquiry”*;
- stabbing two men whilst under the influence of Cocaine for which offence she received a Court Order and Drug Rehabilitation as an alternative to prison (1990s);
- stabbing her boyfriend in the thigh with a fork in 2009, for which she was arrested;
- seven charges for drug dealing, some with threats of violence;

3.4. Ms Y was discharged from mental health services in April 2012, three months prior to the killing of Mr X. She had a long-standing relationship with Mr Z who she had known for at least twelve years. This relationship was chaotic and the police had been involved in several domestic violence incidents in which she was alternatively both the victim and the perpetrator.

Background for Mr Z (perpetrator of the homicide)

3.5. Mr Z was born on 8 March 1972. He first came to the attention of Bournemouth-based mental health services in 1998 when he was referred by his GP for his alcohol problems. Mr Z had a diagnosis of Emotionally Unstable Personality Disorder - Borderline Type. Mr Z's contact with services ceased in 2009. He has several convictions for theft and public order offences. In total he has 10 convictions for 12 offences. These are broken down as; one offence against property, two theft offences, seven against police and Courts and two miscellaneous offences. He was first convicted in 1991.

Incident Description and Consequences

3.6. Mr X and Ms Y lived in the same block of flats. Witnesses to the murder trial stated that a feud had been running between them for years as a result of Mr X making a great deal of noise on an ongoing basis. Neighbours reported to the police that arguments had been taking place *“for months”* prior to the homicide.

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3.7. On the night of 27 July 2012 Ms Y had been drinking heavily. When she heard noise coming from Mr X's flat she became angry. Ms Y ran to Mr X's flat holding a scissor blade; Mr Z went with her. After Mr X opened his front door Ms Y and Mr Z pushed him backwards through his hallway. Mr Justice Males said: "... [Mr Z] and ... [Ms Y] pushed ... [Mr X] backwards through his hallway and into his bedroom and got him down on the bed... [Mr Z] sat astride him, punching his face repeatedly and pinning his arms so that he couldn't defend himself while ... [Ms Y] stabbed him in what must have been a frenzied attack. She inflicted a total of 25 injuries with a scissor blade".

3.8. As a consequence Mr X died of his wounds. Ms Y and Mr Z were convicted of murder and sentenced to life imprisonment to serve a minimum of 16 and 14 years respectively.

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

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

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

4.2. 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"*.

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

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4.4. 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.

4.5. The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and independent investigation team.

5. Terms of Reference

1. Purpose of the Investigation

5.1. To identify whether there were any aspects of the care Ms Y, Mr Z and Mr X received, which could have been predicted and/or prevented the incident from happening. The investigation process should also identify areas where improvements to services might be required, which could help prevent similar incidents from occurring.

5.2. The overall aim is to identify common risks, best practice and opportunities to improve patient safety and make recommendations for individual, organisational and system learning.

1.1. Main Objectives

1. To establish if the risk assessment and risk management of Ms Y, Mr Z and Mr X was sufficient in relation to their needs including the risk of self-harm or harm to others (wider safeguarding issues).
2. To evaluate the mental health care and treatment from primary and secondary care that Ms Y, Mr Z and Mr X received, including the adequacy of the risk assessments and risk management.
3. To identify key issues, lessons learnt, recommendations and actions by Dorset Healthcare University NHS Foundation Trust and all those directly involved in providing the care plan.
4. To independently assess and provide assurance on the progress made on the delivery of action plans following the submission of the Trust's Individual Management Reviews.
5. To identify lessons and recommendations with wider implications so that they are disseminated to other services and other agencies such as housing, police and local authorities.
6. Identify care or service delivery issues, along with the factors that might have contributed to the incident including engagement with services and staff.

2. Terms of Reference

1. Review the assessment, treatment and care that Ms Y, Mr Z and Mr X received from Dorset HealthCare University NHS Foundation Trust up to the time of the incident.
2. Review the care planning and risk assessment, policy and procedures and compliance with national standards.
3. Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment.
4. Review the documentation and recording of key information.
5. Review the communication, case management and care delivery.
6. Review the Trust's Individual Management Reviews (which acted as the Trust's internal investigation) and to assess the adequacy of their findings, recommendations and action plan and identify:
 - if these reviews satisfied the terms of reference;
 - if all key issues and lessons have been identified and shared;
 - whether recommendations are appropriate and comprehensive and flow from the lessons learnt;
 - review progress made against the action plan;
 - review processes in place to embed any lessons learnt.
7. Review any communication and involvement with families of the victim and perpetrator before and after the incident.
8. Establish appropriate contacts and communications with families/carers to ensure appropriate engagement with the internal investigation process.
9. Review the relevant agencies involvement from Ms Y, Mr Z, and Mr X's first contact with services to the time of the offence.
10. Consider if this incident was predictable or preventable.

3. Level of Investigation

- 5.3. **Type B:** a focused investigation by a team examining a single case.

4. Timescale

- 5.4. The investigation process should be completed within six months of receipt of all clinical and social care records up to the time of the incident.

5. Initial Steps and Stages

NHS England will:

- Arrange an initiation meeting between the Trust, commissioners and other agencies willing to participate in this investigation (provisional dates in June/July 2014).
- Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved.

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- Seek full disclosure of the perpetrator's medical records to the investigation team and with a view that the report will be published in the public interest.

6. Outputs

1. A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.
2. A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.
3. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).
4. Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference.
5. At the end of the investigation, to meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation.
6. A concise and easy to follow presentation for families.
7. A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.
8. We expect the investigators to include a lay/family member/service user on the panel to play a meaningful role and bring an independent voice and challenge to the investigation and its processes.
9. We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assess and assure NHS England and the commissioners if the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public.
10. The independent investigator may consider other issues that warrant further investigation and comment.

6. The Independent Investigation Team

Selection of the Investigation Team

6.1. The Investigation Team was comprised of individuals who worked independently of the Dorset HealthCare University NHS Foundation Trust. 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 work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Chair

Dr Androulla Johnstone

Health and Social Care Advisory Service
Chief Executive - Chair, nurse member
and report author.

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Investigation Team Members

Dr Liz Gethins

Health and Social Care Advisory Service associate and consultant psychiatrist member of the team.

Mr Frank Mullane

Chair AAFDA and Victim support advisor to the team and lay member.

Mrs Tina Coldham

Health and Social Care Advisory Service associate and service user member of the team.

Support to the Investigation Team

Mr Greg Britton

Health and Social Care Advisory Service Investigation Manager

Independent Advice to the Investigation Team

Kennedys Solicitors

7. Investigation Method

7.1. In May 2014 NHS England commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section five of this report. The Investigation Methodology is set out below. It was the decision of NHS England that full anonymity be given to Mr X, Ms Y and Mr Z, and all witnesses to the Investigation.

Communications with Ms Y and Mr Z

7.2. NHS England wrote to Ms Y and Mr Z at the inception of the Investigation explaining the reasons for the Investigation and the processes that would be deployed. The letters invited both Ms Y and Mr Z to meet with the commissioner and the Investigation Chair. On 27 October 2014 a visit was made to Ms Y who was at that time detained in prison; on this occasion Ms Y was given more information about the process and was given the opportunity to contribute to the Investigation. At the time of writing the report a meeting was in the process of being arranged at the prison in which Mr Z was detained. Both Ms Y and Mr Z were offered an opportunity to discuss the completed Investigation report prior to publication.

Communications with the Families of Mr X, Ms Y and Mr Z

7.3. NHS England wrote to the families of Mr X, Ms Y and Mr Z at the inception of the Investigation explaining the reasons for the Investigation and the processes that would be deployed. The letters also invited the families to meet with the commissioner and Investigation Chair. On 6 January 2015 the youngest brother of Mr X agreed to meet with the commissioner and members of the Investigation Team. The findings of the Investigation were shared with him and offers of support made. At the time of writing this report the three families had been offered an opportunity to

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meet with the commissioner and Investigation Chair to discuss the findings and conclusions prior to publication.

Communications with the Dorset HealthCare University NHS Foundation Trust

7.4. NHS England made contact with the Dorset HealthCare University NHS Foundation Trust following the appointment of HASCAS. This communication 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 X, Ms Y and Mr Z. A formal meeting was held between NHS England, the Investigation Chair and the Trust on 7 July 2014. The Trust-held records were released in August 2014 and the primary care-held records were released in October 2014. In March 2015 it was established that additional records were also held by third sector addictions services. These were released shortly thereafter. Communications also took place with the Chair of the Bournemouth Adult Safeguarding Board.

7.5. 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 (the Trust decided that a briefing workshop would not be necessary for witnesses and so the offer was made for each witness to contact the Investigation Chair directly in order to receive a briefing and support);
- that interviews were held on 21, 22 and 23 October 2014 at the Trust Headquarters and that the Investigation Team were afforded the opportunity to interview witnesses and meet with the Senior Managers of the Trust.

7.6. Factual accuracy and headline findings communications were held between the Independent Investigation Team and the Dorset HealthCare University NHS Foundation Trust in accordance with Investigation best practice.

7.7. The draft report was sent to the Trust for factual accuracy checking in May 2015. Clinical witnesses were also sent key sections of the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

Witnesses Called by the Independent Investigation Team

7.8. 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 national best investigation practice.

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Table One
Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
21 October 2014	<ul style="list-style-type: none"> ▪ Associate Director for Community Mental Health Services ▪ Team Leader Community Services ▪ Integrated Service Manager for West Bournemouth Adult Community Mental Health Team <p>*****</p> <p>Internal Investigation Team Members (x 3)</p> <p>*****</p> <ul style="list-style-type: none"> ▪ Trust CEO ▪ Trust Director of Nursing ▪ Trust Medical Director ▪ Trust Locality Director and Lead for Mental Health 	<p>Investigation Chair/Team Nurse Investigation Team Psychiatrist Investigation Team Service User Investigation Team Victim Support Advisor/ Lay Member</p> <p>In attendance: Stenographer</p>
22 October 2014	<p>Associate Specialist Psychiatrist 1</p> <p>*****</p> <p>Consultant Psychiatrist 1</p> <p>*****</p> <p>Occupational Therapist Community Addictions Service</p> <p>*****</p> <p>Approved Mental Health Professional CMHT</p>	<p>Investigation Team Nurse/Chair Investigation Team Psychiatrist Investigation Team Service User Investigation Team Victim Support Advisor/ Lay Member</p> <p>In attendance: Stenographer</p>
23 October 2014	<p>Care Coordinator 1 (for Mr X & Ms Y)</p>	<p>Investigation Team Nurse/Chair Investigation Team Psychiatrist Investigation Team Service User Investigation Team Victim Support Advisor/ Lay Member</p> <p>In attendance: Stenographer</p>
17 November 2014	<p>Team Leader Community Addictions Team</p>	<p>Investigation Team Chair (telephone Interview)</p>

Investigation Procedures

7.9. The Independent Investigation Team adopted accepted good practice during the course of its work. This is 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

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- (b) of the areas and matters to be covered with them; and
 - (c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and
 - (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and
 - (e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and
 - (f) that it is the witness who will be asked questions and who will be expected to answer; and
 - (g) that their evidence will be recorded and a copy sent to them afterwards to sign; 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.
 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.

Communications with the Bournemouth Adult Safeguarding Board, the Bournemouth Drug and Alcohol Team and the Dorset Clinical Commissioning Group

7.10. The Independent Investigation Team received information in the form of the draft Serious Case Review report and Independent Management Reviews (IMRs) from the Bournemouth Adult Safeguarding Board. The Chair of the Safeguarding Board was notified of the Independent Investigation findings during the factual accuracy stage of the Investigation.

7.11. The Health-based internal investigation procedures included primary care during the IMR process. From an examination of the IMRs and the GP-held health records no additional issues could be identified by the Independent Investigation Team. In the interests of proportionality a decision was made by the Independent Investigation Team that the GP practice would not be required to give additional evidence in the form of face-to-face interviews but that key personnel would be invited to be part of the factual accuracy and recommendation development. This ensured that essential

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feedback was obtained in an inclusive manner. The Dorset Clinical Commissioning Group was also invited to be part of the factual accuracy and recommendation development process.

7.12. The Independent Investigation received several timely and helpful inputs from the Bournemouth Drug and Alcohol Team (DAAT - commissioners of local drug and alcohol services). The DAAT was invited to take part in the recommendation development process.

Independent Investigation Team Meetings and Communication

7.13. 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 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.

7.14. Prior to the first meeting taking place each clinical team member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference (non-clinical team members received a timeline in lieu of the clinical records to preserve patient confidentiality). It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

First Team Meeting 20 August 2014

7.15. The Investigation Team examined and discussed the chronological timeline which had been produced following the receipt of the full clinical records. The Investigation 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 23 October 2014

7.16. There was opportunity during the interview schedule which allowed the Investigation Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the organisation and systems of the teams that had contact with Mr X, Mr Z, and Ms Y and also management and governance issues.

7.17. Following the witness interviews the Team received the transcriptions and were able to add to the chronological timeline to reflect upon the additional information. There were also additional policies and procedures sent from the Trust which were examined. The Investigation Team was able to work in a virtual manner in order to complete the Root Cause Analysis methodology and develop the report findings and conclusions.

Other Meetings and Communications

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

Root Cause Analysis

7.19. 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 NHS England when investigating critical incidents within the National Health Service.

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

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.
2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
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', the 'Five Whys' and the 'Fish Bone'.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

7.21. 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.

8. Information and Evidence Gathered (Documents)

8.1. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Trust clinical records for Mr X, Mr Z, and Ms Y.
2. GP records for Mr X, Mr Z, and Ms Y.
3. Trust Internal Investigation Reports (Independent Management Reviews - IMRs) and investigation archive.

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4. Safeguarding Board Serious Case Review.
5. Police IMR report.
6. Records supplied by the Bournemouth DAAT (including service user records and policy documentation).
7. Trust assurance and governance documentation.
8. Secondary literature review of media documentation reporting the death of Mr X.
9. Independent Investigation witness transcriptions.
10. Independent Investigation witness statements.
11. Difficult to Engage Patient Policy 2003 to date.
12. Pan Dorset Adult Safeguarding Policies and Procedures 2011.
13. Trust Clinical Risk Clinical Policies, past and present.
14. Trust Care programme Approach Policies, past and present.
15. Trust Incident Reporting Policies.
16. Trust Being Open Policy.
17. Trust Operational Policies.
18. Care Pathway for Service Users with Borderline Personality Disorder December 2008.
19. Healthcare Commission/Care Quality Commission Reports for Dorset HealthCare University NHS Foundation Trust services.
20. 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).
21. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed* (September 2005).

9. Profile of the Dorset HealthCare University NHS Foundation Trust

9.1. Dorset HealthCare University NHS Foundation Trust provides integrated community health and mental health, specialist learning disability services, community brain injury, community dental services including community hospitals and prison healthcare. The Trust provides local services across a range of locations throughout Dorset. It serves a population of almost 700,000 people across the county of Dorset. Its income is approximately £200 million and it employs around 5,000 staff.

9.2. Most Trust services are provided in local communities, in people's homes, community hospitals or in local centres through locally based integrated health and social care teams and facilities. The Trust also provides specialist assessment and treatment inpatient centres.

9.3. Dorset HealthCare University NHS Foundation Trust became a Foundation Trust on 1st April 2007 and is regulated by Monitor. Monitor is an independent body which authorises and regulates NHS Foundation Trusts and supports their development, ensuring they are well-governed and financially robust. Monitor helps to ensure the Trust remains compliant with its terms of authorisation; these are a detailed set of requirements covering how Foundation Trusts must operate – in summary they include:

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- the general requirement to operate effectively, efficiently and economically;
- requirements to meet healthcare targets and national standards; and
- the requirement to cooperate with other NHS organisations.

9.4. The Trust is also registered without restrictive conditions with the Care Quality Commission.

10. Chronology of Events

Root Cause Analyses First Stage

10.1. 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 death of Mr X and to provide a history of the care and treatment that all three service users received. It also gives a greater understanding of some of the external factors that may have impacted upon the lives of Mr X (the victim), Ms Y and Mr Z and their care and treatment from mental health services.

10.2 This chronology provides a factual summary of events taken from over 10,000 pages of clinical records and other supporting documentation. The Independent Investigation Team took the decision to include a significant amount of personal detail, including criminal history, as it not possible to understand the issues relating to the care and treatment provided without this degree of context. The chronology is set out year-by-year and contains information pertaining to all three service users; each section is prefixed with the service user's identifier. The outdated terms 'Enhanced' and 'Standard' CPA are used throughout as this is the terminology used by the Trust.

1993

Mr X On **23 March 1993** Mr X was fined at Bournemouth Magistrates Court for an assault causing actual bodily harm. On 26 May 1993 Mr X was fined at Jersey Magistrates Court for being a foreign legal in possession of drugs. On 29 September 1993 Mr X was imprisoned at Jersey Magistrates Court for:

- assault on an adult - leading to two weeks imprisonment;
- possessing an offensive weapon in public - leading to one week imprisonment (concurrent);
- assault on an adult causing actual bodily harm – leading to two weeks imprisonment (consecutively).²

1998

Mr X On 4 August Mr X was imprisoned for one month at the Bournemouth Magistrates Court for shoplifting.

2. X notes 1 p 204

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Mr Z On **7 February 1998** Mr Z's GP referred him to the Community Addictions Team for assessment; Mr Z wanted to stop drinking. It is not clear what happened to this referral but Mr Z was referred once again on **24 September**. Mr Z had had his ear bitten off in a fight the year previously and this caused him to be depressed and to binge drink. In **October** the Community Alcohol Team wrote to the GP to say that Mr Z had been assessed. On assessment it was noted that Mr Z had been drinking heavily since he was 16 years old but this had grown worse since the ear biting incident just before Christmas **1997**. The Sedman Unit was thought to be the best treatment option to offer Mr Z. However in **November** the Sedman Unit felt that due to Mr Z's physical problems (epilepsy) he was not suitable to follow their programme. Mr Z was given the names of other agencies that could support him.³

Ms Y On **3 April** the GP at the Providence Practice referred Ms Y to secondary care mental health services for eating disorder input. The GP was informed that there was no eating disorder service in the area but that Ms Y might benefit from psychological therapy. On **18 June** a Social Worker with the drug team wrote to the GP to say that the service had tried to assess Ms Y on **17 June** but that this had not been possible due to her distressed state. Her depression and eating disorders appeared to have commenced at the age of 10 years (evidence taken from a self report). There was also evidence of current self harm. Ms Y had a history of taking street drugs but claimed to have been drug free for five months. It was not thought that the drug service could help her and that psychological therapy would be best.⁴

On **9 September** the GP wrote to mental health services once more asking for a follow up appointment. At this stage Ms Y had been made homeless. Consequently when seen by the drug service on **30 September** it was noted that Ms Y was using about £60 of street drugs daily. She was also noted to be very low in mood with nowhere to live.⁵

On **23 October** Ms Y was prescribed 50mg of Methadone daily. In **November** the drug service commenced Ms Y on Fluoxetine 20mg once daily. She was also taken to Stonham Housing for an assessment and a bed was offered to her.

On 27 November Ms Y was admitted to St Ann's Hospital on an informal basis. She was recorded as being low in mood with suicidal ideas. She did not like living at the new hostel, had anger issues and difficulties trusting others. On admission it was noted that Ms Y had been reduced from 60 to 30 ml of Methadone a day. She was also smoking Heroin, taking Coproxamol for headaches, Cannabis ¼ oz each night with friends, Nytol, and Crack (five days earlier). She also claimed to drink alcohol on occasions. Her prescribed medication was Fluoxetine 20mg daily; however she had missed several doses as she thought it made her "nervous". At this stage it was determined that Ms Y had a forensic history. This had involved stabbing two men whilst

3. Z notes 2 pp 63 - 80

4. Y notes 1 pp 195 - 203

5. Y notes 2 pp 39 - 52

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under the influence of Cocaine some years previously (established from a self report). She received a Court Order and Drug Rehabilitation as an alternative to prison. It was noted that Ms Y could get angry and smashed objects. She rarely harmed others and was not violent when not on drugs. Ms Y had no friends other than drug users and no contact with her family. Ms Y had a 12 year old son who lived with his father. It was noted that she had recurrent depression and that she probably met the criteria for a Personality Disorder.⁶

On **5 December** Ms Y was discharged and allocated a Community Psychiatric Nurse and was placed on Care Programme Approach (CPA) level 1. A CPA review was held on **8 December**. Ms Y's medication had been changed to Paroxetine 20mg. It was noted that her risk of harm to both herself and others was high especially when under the influence of drugs and alcohol. Her feelings of anger and violence were usually directed towards men and so she was to be allocated a female worker and followed up by the community drug team.⁷

1999

Mr X On **2 February** Mr X appeared at the Bournemouth Magistrates Court charged with shoplifting; he had stolen clothes with the intention of selling them for money to buy drugs. It was noted that Mr X had been convicted and sentenced to prison two times the previous year for similar offences. As he had also been convicted of several other offences since then there was a clear pattern of offending. On **1 December 1998** Mr X was subject to a Community Order which he did not fulfil due to his drug taking. Whilst it was acknowledged he had been guilty of violent offences in the past he was not thought to be a risk of such activities in the present. The Probation Officer respectfully suggested to the Court a Probation Order rather than a custodial sentence.

In **March** Mr X commenced a drug treatment programme and was prescribed Methadone. However by **April** it was noted he did not attend regularly and by **May** he was serving a three-week prison sentence.⁸

Mr X was released from prison in **June**. After his release Mr X did not attend his appointments with the Drug Team and it was noted he was in breach of his Probation Order.⁹

Mr Z Mr Z was assessed by the Central Bournemouth CMHT on **22 April**. He was depressed and angry and also showing some signs of obsessional compulsive behaviour. On **3 June** the CMHT Psychiatrist wrote to the GP to say that Mr Y was depressed and had taken an overdose four weeks earlier but had been discharged from hospital before he had received a psychiatric

6. Y notes 1 pp 3 – 10, 13- 14, 327 - 332

7. Y notes 1 pp 216 - 221

8. X notes 1 pp 3 – 6, 13, 114

9. X notes 1 p 184

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assessment. He was reported to be glad the attempt was unsuccessful but he still had thoughts of repeating it. Mr Z's epilepsy was described as poorly controlled and he said that he smoked Cannabis and took amphetamines, Ecstasy and Cocaine. Mr Z was reluctant to consider an inpatient admission and denied that he would self-harm again.¹⁰

On **13 August** Mr Z was referred to the addictions service. It was noted that Mr Z had been drinking heavily since **1988**. Mr Z was not considered to be ready for therapy (it was recognised that he probably had been not been ready the year previously when an earlier referral had been made). It was noted that Mr Z suffered from "*gross insecurity*" and an immature personality.¹¹

Between **October** and **December** Mr Z attended the Sedman Unit. Mr Z was drinking up to 14 cans of lager each day. Mr Z talked about his relationship with Ms Y which was causing him many problems. However by **December** Mr Z had stopped attending the unit and was discharged.¹²

Ms Y Ms Y continued to be followed up by the CMHT (via the Outpatient Clinic) and the Drug Service. Ms Y continued to use Heroin and other street drugs.¹³

On **14 March** Ms Y took an overdose and was taken to A&E by a friend. Ms Y was low in mood and felt hopeless; she had recently been charged with dealing drugs with violence and had also been fined for breaching her probation. The plan was to admit informally and to discharge as soon as possible. The ward was informed that Ms Y was no longer on probation for a stabbing that had taken place two years previously. A risk assessment was conducted. It was noted that she had threatened to kill someone in the past. The plan was to assess her mood and mental state. However this was a short term only plan for use on the ward.¹⁴

A few days after her admission Ms Y took an overdose of Piriton tablets. The medical impression was recorded as:

- Borderline Personality Disorder;
- opiate dependency;
- threats of self harm.

It was not thought that her behaviour could be treated or that the CMHT could help her. A CPA review recorded that Ms Y was considered to be a high risk of violence to others and also a high risk of suicide and self harm.

Ms Y was discharged from the inpatient unit at the end of **March**. The Stonham Housing association no longer felt that it could support Ms Y due to her high levels of risk and she was supported to find alternative accommodation. On **31 March** Ms Y was discharged from the Drug Service,

10. Z notes 1 pp 51 - 56

11. Z notes 1 p 61

12. Z notes 2 pp 50 – 51, 54, 56 – 58, 99

13. Y notes 2 pp 26 – 27, 75, 188

14. Y notes 1 pp 16 – 18, 275, 304 - 309

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and despite earlier misgivings, Ms Y was placed under the care of the GP and the CMHT.

In **April** due to Ms Y's change of address (she was now living at a YMCA hostel) she was registered with a new GP practice and was also referred to a new CMHT. The new Consultant wrote to the GP to ascertain Ms Y's risk profile. It was noted that the case was complex and that Ms Y was at risk of suicide. There were concerns that Ms Y's heavy drinking could lead to a break down of her YMCA placement which was seen as a last resort.¹⁵ There was some confusion at this time as to whether or not Ms Y should be transferred to a new CMHT at this stage.

On **10 May** Ms Y was admitted to St Ann's Hospital by her GP for an emergency three-day admission. She was low in mood with suicidal ideation and staff at the YMCA hostel had expressed concerns about her safety. The following day a scalpel and pair of sharp scissors were found in her bag and confiscated. On **13 May** Ms Y was discharged. The decision was made to transfer her to the care of the Central Bournemouth CMHT. Ms Y was placed on level 2 CPA and was followed up by a nurse and social worker in the community.¹⁶

For the rest of the year Ms Y was assessed and issues regarding drug misuse, anxiety and suicidal thoughts were identified. The plan was for her to attend an anxiety management group to help her build up coping skills. Due to a self-harm attempt in **September** and her continued use of illicit drugs it was thought that Ms Y was not yet ready for psychological therapy input. She continued to be followed up by the CMHT on a regular basis.

2000

Mr X In **June** the Community Drug and Alcohol team wrote to Mr X to say that he had been referred to them by his GP. He was told that if he did not get in touch by the **17 July** it would be assumed that he was not in need of their services.¹⁷ It is not clear what happened to this referral.

On **21 December** the GP wrote to the Community Drug Team to ask for an appointment for Mr X. It was noted that Mr X had a polysubstance misuse problem and was using a gram of Heroin each day. He was using his neck veins to inject. When he could not obtain Heroin he was using imported Benzodiazepines which he got from Portugal.¹⁸

Mr Z On **28 February** the GP referred Mr Z to the Drug and Alcohol Team for assessment. Mr Z had come out of the Sedman Unit (day facility for abstinence support) three months previously and had started drinking heavily

15. Y notes 1 p 145 – 146

16. Y notes 1 pp 39 – 42 & 86 - 87

17. X notes 1 p 184

18. X notes 1 p 182

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again.¹⁹ In **August** Mr Z was assessed and accepted by the Sedman Unit but due to non attendance he was discharged from the programme in **October**. The GP was written to and told that Mr Z's detoxification was complete, however it was noted that he suffered from a social phobia and poor self esteem. A referral to the CMHT was suggested. However by **December** Mr Z had once again been referred back to the Community Drug and Alcohol Team.²⁰

Ms Y In **January** Ms Y was admitted informally to St Ann's Hospital from Bournemouth Hospital following an overdose of five Temazepam 10mg tablets, four Tramadol 200mg tablets and half a bottle of vodka. Prior to this she had been warning the YMCA staff that she was going to take an overdose. She was admitted for observation.²¹ A risk assessment ascertained that Ms Y had been involved in a previous stabbing incident, had a violent history, previous convictions for drug dealing and that she continued to have suicidal thoughts. On the **23 January** Ms Y left the ward and refused to return. She was discharged by medics on **27 January**.²²

Following her discharge Ms Y was followed up in the Outpatient Clinic. Her leg was in plaster because of an injury sustained six months earlier when she claimed her boyfriend had pushed her down some stairs. Due to her non attendance at Outpatients and the absence of any detectable mental illness Ms Y was discharged from both the clinic and CPA in **June**.²³ Ms Y asked her GP to re-refer her but the CMHT questioned her motives and refused to assess her.²⁴

However by **September** another referral was made by the GP. Ms Y told CMHT workers that she had been self harming and cutting from the age of 12. Apart from a medication review no further action was deemed to be appropriate. However when Ms Y was seen in the Outpatient Clinic on **12 December**, whilst no mental illness could be detected, the plan was to see if the CMHT could provide further help.²⁵

2001

Mr X Mr X was arrested for shoplifting on 24 February.²⁶ In **March** Mr X failed to attend an assessment appointment with the Community Drug Dependence Team following a referral from his GP.²⁷ On **29 April**, Mr X was arrested for shoplifting. On **14 June 2001** a PNC report shows that Mr X was sentenced to three months imprisonment and that on **9 October** he was arrested for shoplifting. He received a term of imprisonment (this is not detailed in his

¹⁹. Z notes 2

²⁰. Z notes 2 pp 16 - 24

²¹. Y notes 1 pp 81 – 83 & 111

²². Y notes 1 p 131

²³. Y notes 1 p 77

²⁴. Y notes 1 pp 69 - 70

²⁵. Y notes 1 pp 46 – 47 & 62 - 64

²⁶. Police IMR

²⁷. X notes 1 p 179

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clinical record).²⁸

Mr Z On **25 January** Mr Z was referred to the Addiction Services.²⁹ It is not clear what happened to this referral.

Ms Y On **5 January** the CMHT wrote to the GP to say that Ms Y had been diagnosed with a Borderline Personality Disorder and poly-substance misuse; however no mental illness had been detected. It was thought that she would progress best with a psychologist and she was referred for an assessment.

On **20 February** a psychological assessment was conducted and it was noted that Ms Y had low self esteem and problems with her anger, especially towards men. It was noted she liked to smash things and that she “*used to like being nasty to people*”. When she felt angry and sad she would drink to excess. Her drug problems and cutting behaviour started at the age of 12. The formulation recognised the longstanding issues with Heroin addiction. When lonely Ms Y wanted to kill herself, when she became angry she could not control her feelings. She became angry towards men who she believed were letting her down.³⁰

On **26 February** Ms Y was seen in the Outpatient Clinic. She was waiting for a psychotherapy appointment and said she had stopped taking Heroin and had also stopped drinking, it was noted however that she smelled of alcohol. Her mood was still up and down and she still had violent thoughts. No psychotic symptoms were detected. Her risks were recorded as being low and her medication was:

- Sulpiride 200mg twice daily;
- Trazodone 100mg twice daily and 200 mg at night.³¹

In **March** Ms Y was accepted for Cognitive Analytical Therapy (CAT) – there was however a waiting list of nine months. The plan was for Ms Y to work with the CMHT in the meantime to stabilise her prior to the programme commencing. It was noted that Ms Y was due to be evicted from the YMCA to Bed and Breakfast accommodation.³²

In **May** Ms Y contacted the CMHT over the telephone to say that she was having “*traumatic problems*”. She sounded upset and said that she was having problems with her alcoholic boyfriend. On **21 May** she was seen in the Outpatient Clinic where she said that she was having problems with housing and could not tolerate loud noises. She had no suicidal thoughts or symptoms of psychosis. Her risks were recorded as being low and she was to be followed up in Outpatients in three months. Her medication was:

- Sulpiride 200mg twice daily;

28. SCR report p 9

29. Z notes 2 p 20

30. Y notes 3 pp 174 - 178

31. Y notes 1 pp 47 – 49 & 55 - 56

32. Y notes 3 p 44

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- Trazodone 100mg twice daily and 200mg at night.³³

On **19 June** Ms Y was admitted to St Ann's Hospital for a short crisis and assessment admission. She was discharged three days later. She felt that the admission had helped her. She claimed not to have taken Heroin for one year, and that she drank only occasionally.³⁴

2002

Mr X A Police National Computer (PNC) record made on **1 February** notes that Mr X was sentenced to 12 months in prison (this information was only known to the Trust after the death of Mr X). Mr X was released in **August 2002**. This was not detailed in his clinical records. The Serious Case Review report states that "*X made a homelessness application on **9 September** and was interviewed as homeless by the Housing Officer from the Housing Options team on **10 September 2002**. X was placed into bed and breakfast accommodation in the Bournemouth area on the day of the interview*".³⁵

Ms Y On **13 March** an adult risk screen assessment was conducted and Ms Y's risk to others was deemed to be low and the risk of suicide and self-harm to be moderate. In **April** Ms Y commenced CAT. She told the therapist that she was drinking 12 double shots of spirits a day (around 600 mls). She was also looking for Heroin.³⁶

Ms Y continued to be followed up in the Outpatient Clinic. Her risks to others continued to be low and her risk to self low/moderate. However Ms Y continued to drink and use Cocaine and Cannabis, as did her boyfriend.³⁷

2003

Mr X In **March** an assessment form was completed by the drug addiction therapy team. At this stage Mr X was smoking and injecting Heroin in any vein that he could find. He had been using Heroin for 10 – 15 years. He also smoked Cannabis and drank alcohol to help him sleep. The risk management plan stated that Mr X would try to seek support from his brother who lived locally if he started to feel unsafe. Mr X was unemployed and currently doing community service whilst on a conditional discharge.³⁸

On **7 May** an assessment was completed by the drug addiction therapy team. Mr X was living at Perren Court Hotel. Mr X had stopped injecting Heroin but was still smoking it. He was low in mood at times but denied suicidal thoughts. Mr X was still drinking but was attending appointments. His risks were all deemed to be low. He was assessed again on **2 June**. Mr X had

33. Y notes 1 p 17 49 - 54

34. Y notes 3 pp 35 – 36 & 142

35. SCR report p 9

36. Y notes 3 p 67

37. Y notes 3 pp 59 – 60 & 114, 133, 144

38. X notes 1 pp 82 – 85 & 104 – 107 & 108 - 113

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reached week 11 of his programme and he reported no illicit drug use. It was thought that Mr X might have to be admitted in order to increase his Methadone and stabilise him. He was not happy with this idea.³⁹

Throughout the rest of the year Mr X continued with his addiction programme. He was moved into secure and appropriate accommodation where he felt happy and safe. By **September** it appeared that Mr X had stopped using illicit drugs and the plan was for the primary care additions team to monitor him four weekly. He continued with Methadone and complied with his treatment plan.⁴⁰

Ms Y Ms Y continued with her CAT programme. However when followed up in **January** at the Outpatient Clinic she did not appear to be well. She was low in mood, suicidal and due to be evicted from the YMCA hostel. During the interview she smelled of alcohol. She said her boyfriend beat her and took her money. The CAT therapist wrote to the Council seeking accommodation for Ms Y.⁴¹

In **March** Ms Y moved to Bed & Breakfast accommodation. The Outpatient Clinic noted Ms Y was feeling anxious and paranoid. The diagnosis was Emotionally Unstable Personality Disorder.⁴²

Ms Y completed her CAT sessions in the summer. At a follow up meeting in **September** all of her risks were deemed to be low and she was discharged from the service. Ms Y had moved into her own flat and her relationship with her boyfriend appeared to be good. She was not taking Heroin, although she still participated in binge drinking. She felt she had learned a lot from CAT.⁴³

2004

Mr X Throughout **2004** Mr X adhered to his programme with the addictions service. On **25 March** it was noted that Mr X had been given an eviction notice as he had lost his temper and on one occasion smashed things up in his flat and thrown things out of the window. He was hoping that his brother would intervene with the Landlord. He said he would go to the night shelter as a last resort.⁴⁴

In **May** Mr X was moved to a shared house where he felt reasonably settled - there were no other users at the accommodation. Mr X was complying with his treatment programme and reported no illicit drug use and was stable on his medication.⁴⁵

In **August** Mr X was noted to be expressing paranoid thoughts of a

39. X notes 1 p 86

40. X notes 1 p 86 - 88

41. Y notes 4 pp 145 & 351 & Y notes 3 pp 28 & 136

42. Y Notes 4 pp 145 & 349 - 350

43. Y notes 3 pp 11 - 12

44. X notes 1 pp 88 - 89

45. X notes 1 p 89

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delusional nature. The plan was for both a psychological and psychiatric review. On **2 September** it was decided to refer Mr X to the CMHT so that his mental state could be assessed; Mr X was not happy with this plan and so the decision was deferred. By **24 September** Mr X had reached week 82 of his programme. Mr X reported using Heroin for the first time in many months. The trigger had been stress in relation to a pending Court appearance. He was facing numerous charges related to numerous offences - some of which were possibly of a violent nature. Mr X gave permission for the service to talk to his solicitor and was made aware that this was necessary for risk assessment purposes. It was planned to send the risk assessment to the CMHT along with a referral. Mr X gave his permission.⁴⁶

By **October** Mr X was no longer taking illicit drugs and had been moved into a one-bedroomed council flat. He continued to be worried about his Court case. He said he was still happy to be referred to the CMHT.

On **16 November** Mr X said he had not taken illicit drugs and that his medication was 'holding' him; however it was noted that Mr X smelled of alcohol. He had been drinking up to 32 units a day for the past four days. He was given advice as to how to reduce his drinking and was reminded that his drinking could invalidate his contract with the addictions team. Mr X said he was depressed and the plan was to liaise with the GP about changing his prescribed antidepressant. Mr X's Court case had been adjourned until January; he had since been caught and charged with shoplifting.⁴⁷

Ms Y On **24 November** Ms Y came to the attention of services because the GP made a referral due to Ms Y's increasingly aggressive and unpredictable behaviour towards her boyfriend. She had stopped taking her medication. She was highly aroused and agitated. She claimed to be hearing voices telling her to harm others. She had recently smashed her flat up.⁴⁸ Ms Y was seen at Hanneman House. She told the doctor and Community Psychiatric Nurse (CPN) that she had stabbed three people in the past. One of these people had been a former boyfriend; another was a man in a pub whom she had stabbed with a broken bottle. Her risk to others was deemed to be significant and to herself low. During the interview Ms Y waved a knife in a threatening manner and said she heard voices telling her to stab the CPN. It was noted that she had poor impulse control and a low frustration threshold especially around males.⁴⁹

Ms Y was admitted to St Ann's Hospital; her diagnosis was Emotionally Unstable Personality Disorder. At the point of admission the Senior House Officer recorded that she was hearing voices inside her head (described as "*? Pseudo hallucinations*"). She was feeling paranoid and noted to be violent and screaming. Ms Y continued to warn people that she would stab them. Her risks were deemed to be significant but not related to any mental illness.⁵⁰

46. X notes 1 p 90

47. X notes 1 p 91

48. Y Notes 4 pp 149 - 152

49. Y Notes 4 pp 149 - 152

50. Y Notes 4 pp 153 - 167 & Y Notes GP 3 p 10

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Ms Y continued to threaten to stab people and she was warned that the police would be involved if this continued. On the **29 November** a 'prosecutor's printout' was set to the Bournemouth Forensic Team. It noted that Ms Y had seven convictions for drug offences.⁵¹

On **2 December** Ms Y was discharged. She said the threats to stab were a cry for help and she was advised this was not an appropriate way to get it. Following her discharge she was admitted to the day hospital for short-term support. The day hospital had been contacted in advance with a warning about her violence and threatening behaviour. The plan was to hold a discharge CPA and to refer Ms Y to the drug and alcohol team. At this time her risks were assessed as being low when not drinking.⁵² She was to remain with the West Bournemouth CMHT for follow up.

2005

Mr X In **January** Mr X missed several appointments with the addictions team and his Methadone was suspended for one month. It was noted that Mr X had been given the contact details of support agencies and that his risks were all deemed to be low at this present time.⁵³

In **February** Mr X recommenced his Methadone programme. The six week plan was for Mr X was to attend weekly meetings with his drug worker. He was to have daily supervised consumption of Methadone at his pharmacy with take home medication for the weekends. Mr X was made aware that if he did not attend appointments his Methadone would be stopped. It was noted that compliance was deemed to be the client's responsibility.⁵⁴

On **23 March** Mr X was noted to be distressed and he voiced "overvalued" beliefs and ideation of persecutory and paranoid nature. He gave permission for a referral to the North Bournemouth CMHT to be made.⁵⁵

On **10 April 2005**, X was arrested for indecent exposure; on **17 October** he received a three-year Community Order with a requirement to attend a Thames Valley Sex Offender Programme; he also became a registered sex offender for five years (this is not detailed in his clinical record). Throughout **April** and **May** Mr X continued to voice paranoid thoughts and was tearful and depressed. It was noted that he was not attending addiction service meetings and it was decided that his Methadone prescription should be stopped. Mr X had also failed to make contact with the CMHT. On **16 May** Mr X was referred back to the care of the GP.⁵⁶

The Serious Case Review states that "*Dorset Police note that on 6 June*

51. Y Notes 4 pp 243 - 248

52. Y notes 4 pp 31, 204 & 315 - 317

53. X notes 1 p 92

54. X notes 1 pp 92 - 93

55. X notes 1 p 93

56. X notes 1 pp 98 - 99

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2004, X was arrested for assault. He was charged with assaulting two police officers and charged with two assaults by beating offences. A PNC record on 4 February 2005 notes that he received four months imprisonment". This is not detailed in his clinical record but was probably the reason for his disengagement with both the addictions service and the CMHT.⁵⁷

Ms Y On **14 January** Ms Y had an informal referral to the Crisis Service. Her risks were noted as being Cocaine use, perceived abandonment and the fact she carried a knife. It was noted she was aggressive, especially towards men. The plan was for Ms Y to attend Alcoholics Anonymous and to be referred to the Drug Team. Her risks were deemed to be low, with the exception of vulnerability of harm from others. It was also noted she had been non-compliant with medication. There was a CPA plan to reduce Ms Y's dependency on the Crisis Service and to get her more involved in the community. All future home visits were to be conducted by two staff. Psychological services were happy to work with Ms Y providing she stopped drinking and taking drugs.⁵⁸

In **February** Ms Y was discharged from the day hospital as she was not attending and was transferred to the North Bournemouth CMHT.⁵⁹

On **7 April** Ms Y was seen by the North Bournemouth CMHT she promised not to carry a knife again. She was to have Dialectical Behavioural Therapy (DBT) and Haloperidol PRN.⁶⁰

On **22 June** Ms Y was seen by Consultant Psychiatrist 1 with the North Bournemouth CMHT. The plan was to continue with the DBT and her medication (Trazodone 300mg and Risperidone 3mg). Her risks were thought to be significant as her impulse control was poor. For the remainder of the year her attendance to Outpatients and for DBT was poor.

2006

Mr X The Serious Case Review Reports states that "On 2 June 2006 X was arrested for indecent exposure after showing his genitals to children. On 19 July 2006, X was sentenced to 5 months imprisonment. His sex offender status was extended to 7 years and would expire in 2013. On 18 August 2006 X was released from prison". It was also stated that "On 7 September 2006, X assaulted three police officers. He received a term of imprisonment and was released on 27 October 2006". None of this information is detailed in the clinical record.⁶¹

On **28 September** Mr X was in prison and detained in the segregation unit. It was thought that he should be transferred to hospital on a Section 47/48 of

57. SCR report p 10

58. Y notes 4 pp 6 – 11 & 320 - 321

59. Y Notes 4 p 211 & 310 - 314

60. Y Notes 4 pp 217 - 218

61. SCR report p 11

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the Mental Health Act because he was psychotic. Mr X thought that Buddhists and religious fanatics could read his thoughts and he had also been experiencing command hallucinations. He had been involved in a fight the previous day with another prisoner as a result of hearing voices.

Mr X's solicitor had been informed and it was noted that Mr X was due in Court the following week facing charges of assaulting a police officer. It was noted that Mr X drank heavily probably in an attempt to manage his voices. The prison service had not been able to access his previous history and it was noted that Mr X had been neglecting himself and was emaciated.⁶²

During **October** the prison service thought Mr X was mentally ill and had been at the time of his coming to prison and also for some time before that. It was recognised that he had a Court appearance soon and that something needed to be sorted out, either a hospital transfer or CMHT follow up, if he was to be released. The prison service wrote to Consultant Psychiatrist 1 to say that Mr X continued to show the first rank symptoms of Schizophrenia. Whilst Mr X accepted that his symptoms might be due to a mental disorder he was not prepared to accept medication. Mr X had opened up to the prison service about his psychotic symptoms and the three voices that he heard several times a day. Mr X had a *“marked emotional reaction”* to these voices; for example he would smash crockery and lock himself up for days at a time. Most recently he had heard a voice from a car telling him to *“kiss my arse”* and this had led to his conviction for indecent exposure. He also described thought broadcasting and delusional thinking. The prison service was of the view that Mr X had Schizophrenia and had experienced some kind of breakdown which would require input from his area team on release from prison.⁶³

On **27 October** Mr X was released from prison. He was to be followed up by the CMHT on **14 November**. Mr X did not attend the appointment set for the **14 November**. The police contacted the CMHT on **17 November** as they were concerned about Mr X because of his mental illness and had tried to make a home visit.⁶⁴

In the event Mr X was lost to service until **27 November** when his new GP practice contacted the Bournemouth Assessment Team for help with his addictions. It was noted that Mr X's main drug for illicit misuse was Heroin. Mr X was also noted to be drinking 3.5 litres of vodka, 14 cans of lager and 14 bottles of wine each week. It was recorded that Mr X had previous convictions but was motivated to change his drug habit.⁶⁵ At this stage the CMHT was still trying to contact Mr X and he was removed from the GP list due to his verbal abuse.⁶⁶

On **4 December** Mr X was visited at his home by the CMHT. It was noted that he was finding it difficult to concentrate. He had apparently only taken

62. X notes 2 pp 64 - 68

63. X notes 2 pp 55 - 57

64. X notes 2 pp 49 & 72, 48 - 50

65. X notes 1 pp 146 - 157

66. X notes 2 pp 47 - 73

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three days of his medication and he agreed to see a psychiatrist at the CMHT and an appointment was planned for him. Mr X's English was thought to be poor and that an interpreter would be needed for him.⁶⁷ There are no records that detail why this was not taken forward.

On **6 December** the Bournemouth Assessment Team requested an assessment for a Methadone prescription to be made for Mr X. At this time although he was drinking heavily his risks were deemed to be low.⁶⁸

Ms Y Throughout **2006** Ms Y's attendance at the CMHT was poor. It was noted however that she was currently compliant with Risperidone and her temper appeared to have been better controlled by it. Her relationship with her partner was stable.⁶⁹

On **30 October** Ms Y wrote to Bournemouth Council to say she was experiencing severe harassment from a neighbour which was detrimental to her mental health.⁷⁰

2007

Mr X Mr X failed to attend the addictions service and in **January** he was referred back to care of his GP.⁷¹

Ms Y Ms Y continued on standard CPA and was followed up in the Outpatient Clinic.

2008

Mr X In **January** Mr X saw Specialist Associate Psychiatrist 1 and told him that he had been hearing voices all of his life, and since he was a teenager one voice had told him to commit murder. The voices troubled him a lot. His forensic history was noted to be primarily for shoplifting. His substance misuse at this time was significant. It is not clear what action, if any, was taken.⁷² It was noted by the Trust internal investigation (IMR) that in January 2008 Mr X was seen by a worker at the Department for Work and Pensions and expressed concerns that the voices were telling him to rob, kill others and harm himself. This information was sent to the GP.⁷³

On **6 November** Mr X appeared at the Bournemouth Magistrates Court charged with theft. A drug service assessment was sought. It was also noted that Mr X had previous convictions.⁷⁴

67. X notes 2 p 74

68. X notes 1 pp 140 & 143 - 163

69. Y Notes 4 pp 230 & 289 - 290

70. Y Notes 4 p 287

71. X notes 1 p 135

72. X notes 2 pp 40 & 75 - 83

73. Trust Internal Investigation IMR

74. X notes 1 p 63

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On **20 November** Mr X's new GP practice wrote to the Bournemouth North CMHT thanking it for seeing Mr X. The GP explained that Mr X was relatively new to the practice and that any information about his mental state would be appreciated.⁷⁵

Mr Z On **20 March** Mr Z was referred by his GP to the North Bournemouth CMHT. Mr Z was showing symptoms of depression which appeared to be reactive and related to a set of difficult circumstances. The referral was for counselling. He had apparently been arrested under Section 136 of the Mental Health Act on 16 March after he threatened suicide. Mr Z had called the police himself and was in possession of two knives. He claimed that he had had an argument with his girlfriend although no one else was present. He also explained that he had been drinking, he was depressed and on medication, but not taking it. Mr Z handed over the knives to police officers and was then detained. He was taken to a police station, seen by a police medical practitioner and assessed as not having psychotic symptoms. As a consequence Mr Z was released by the police.⁷⁶

The CMHT placed Mr Z on Standard CPA and Mr Z had a crisis plan which allowed both in hours and out of hours contact; he had also been given the contact details for the Samaritans. Mr Z's diagnosis was Emotionally Unstable Personality Disorder - Borderline Type. Mr Z had periods of intermittent low mood and thoughts of self harm; he drank to cope with his distress. Five weeks earlier he could no longer cope and had thoughts of suicide; he had telephoned the police who kept him in custody overnight. Mr Z described himself as a nice person, quiet and caring. The plan was to review again in eight weeks and to provide Cognitive Behaviour Therapy (CBT).⁷⁷

On **2 July** an assessment was conducted as part of the referral process. It was recorded that Mr Z had overdosed five times in the past (one being within the past six months). The overdoses had been significant and had required A&E intervention. There were no recorded incidents of Mr Z causing harm to others. Mr Z's risk behaviours were described as:

- binge drinking;
- bulimic behaviours;
- shoplifting, gambling, impulsive and potentially harmful sexual behaviour;
- drug abuse and dangerous driving.

Mr Z was currently in an unstable relationship which he constantly said he wanted to end. Mr Z wanted therapy to help him move on.⁷⁸ It was noted there was a 10 – 12 month waiting list for therapy.

Ms Y Ms Y continued to be followed up at the Outpatient Clinic on Standard CPA. Her risk of suicide and self harm was deemed to be low, but her risk to others

75. X notes 2 pp 45 - 46

76. Serious Case Review Report

77. Z notes 3 p 26

78. Z notes 3 pp 15 - 18

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was deemed to be significant. The risk factors were identified as being Ms Y's impulsive nature, drinking and feelings of abandonment. The management plan was to:

- treat the Borderline Personality Disorder;
- provide DBT (Dialectical Behavioural Therapy);
- provide Olanzapine.⁷⁹

The Serious Case Review report states that *“On 9 December 2008, Z was arrested after he stabbed Y in the hand with a knife. Y was also arrested as she had stabbed Z in the leg with a fork. It is stated that neither assisted the police and no further action was taken”*.⁸⁰

2009

Mr X On **26 January** Mr X was seen by Associate Specialist Psychiatrist 1 at the North Bournemouth CMHT. During the assessment it was noted that Mr X had heard voices all of his life and one voice told him to commit murder. At this stage the plan was to obtain a Police National Computer (PNC – this does not appear to have been achieved) check and to allocate Mr X to Enhanced CPA. Consideration was also to be given to an inpatient detoxification programme and extended period of assessment of his mental state. During the next three months support was offered and psychoeducation commenced.⁸¹

By **June** Mr X appeared to be more settled. However Mr X continued to be troubled by voices that told him to harm himself and others. Mr X emphatically said he would not act on the voices. Mr X was asked if he would like to attend sessions at Turbury Park Centre which were earmarked for DBT; he said he did not want to attend any groups. The plan was to hold another outpatient appointment with Consultant Psychiatrist 1 to address the issue of diagnosis. Mr X's risks were deemed to be low. The clinical record noted that no psychotic symptoms appeared to be present. A *“fictitious disorder”* was considered.⁸²

On **23 July** A Borderline Personality Disorder Information Sheet was compiled for Mr X. It was thought that Mr X was a good match for having this kind of disorder. It was recorded in the clinical record that Mr X remained uncertain whether his hallucinations were real or unreal and that whilst there were psychotic symptoms present there were also features of Borderline Personality Disorder.⁸³

On **17 December** the Care Coordinator referred Mr X to the Drug and Alcohol Action Team. He explained that Mr X had a long history of hearing voices and paranoia. It remained unclear what role Mr X's substance misuse

79. Y Notes 4 pp 266 - 267

80. SCR report p 21

81. Clinical records and Witness statements

82. X notes 2 pp 36 & 87

83. X notes 2 pp 88 – 97

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played in his psychosis. He was currently on Methadone and occasionally smoked Cannabis and still drank alcohol in binges. The plan was to admit him to St Ann's Hospital in the new year as a precaution regarding withdrawal. Mr X's risk of vulnerability and self harm was deemed to be low although it was recognised that this risk increased when he was psychotic. It was noted that Mr X's voices often took the form of command hallucinations which told him to harm others and harm himself. It was hoped that the drug team and the CMHT could work together on a planned admission.⁸⁴

Mr X agreed for information to be shared between the CMHT and the Drug Team following a referral being made. A risk screen identified that Mr X had:

- a history of serious mental illness;
- attempted suicide in the past;
- a history of violent and abusive behaviour and was known consequently to criminal justice teams;
- no history of carrying weapons.

Mr X was not thought to be vulnerable or at risk from other people.⁸⁵

On **22 December** a risk screen was conducted. It was noted that Mr X was not thought to be a risk to children (there is no mention of his convictions for sex offending, one of which had involved children).⁸⁶ It would appear that the CMHT was not fully briefed about Mr X's two prison sentences in 2006 and the first detention was incorrectly attributed to shoplifting and not sex offending; however it was noted that the assault of a police officer had been involved. A major omission is no mention of the previous prison-based forensic assessment report (2006) which had stated Mr X's offences had been directly related to his psychosis.

Mr Z In **January** it was noted that Mr Z was not attending appointments at the CMHT. The plan was to offer no further appointments but to keep Mr Z on the books for the time being. Mr Z had been transferred to the Intensive Psychological Therapy Services and there was a waiting list of several months. Once the therapy commenced he would need to be able to access the CMHT in case he needed additional support. Mr Z was advised that he could contact the CMHT for another outpatient appointment should he need one.⁸⁷ **There are no other clinical records for Mr Z.**

Ms Y On **8 January** a CPA review was conducted. Ms Y's risks to herself were deemed to be low and significant to others. She was on Enhanced CPA. Risks were noted to be exacerbated by drugs and alcohol and dysregulated [sic] emotion. The plan was to improve her self esteem. This was to be achieved by support groups, PRN medication (Olanzapine 15mg) and DBT. No other agencies were noted as being involved in Ms Y's care and treatment.⁸⁸

84. X notes 2 pp 29 - 30

85. X notes 1 pp 34 - 58

86. X notes 1 pp 34 - 58

87. Z notes 3 p 5

88. Y Notes 5 pp 5 - 11

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On **19 January** a risk assessment was conducted. All risk fields were deemed to be low. The factors relating to Ms Y's violence were identified as arguing with her boyfriend, being under the influence of drugs and alcohol, and becoming frustrated. Mitigation was identified as being DBT and working with the CPA care plan. Ms Y's risk of harm to others was thought to be significant in the long term; however it was thought that Ms Y was responsible for her own behaviour. It was also noted that Ms Y understood the need to stop taking drugs and drinking alcohol. The police were aware of her domestic situation and were to be notified if there were any concerns. Ms Y was aware of the management plan.⁸⁹

Ms Y attended the CMHT but attended groups sporadically. During **June** she claimed her boyfriend had assaulted her, in July she stabbed him in the thigh with a fork. In **September** she asked her Care Coordinator to write to the Council to complain about a noisy neighbour and to see if she could be moved on medical grounds. On **23 October** the CMHT recorded that "*difficult week nearly stabbed neighbour due to disputes +++*". Throughout the remainder of the year her condition remained the same.

2010

Mr X In **January** Mr X re-commenced his Methadone programme; he was seen by the addictions team fortnightly. Mr X appeared to make good progress with his addictions however through **February** and **March** he reported psychotic phenomena such as hearing voices. On **4 February** Care Coordinator 1 and Consultant Psychiatrist 1 discussed Mr X and it was advised that Risperidone should be started.

On **13 May** Mr X was seen by the Bournemouth Assessment Team (BAT). He was noted to have diagnoses of Schizophrenia and Heroin dependence. He had been on a Methadone replacement programme for 19 weeks and had tested negative for opiates for the past six appointments. Care Coordinator 1 at the CMHT (the same as that for Ms Y) confirmed that Mr X had an untreated Schizophrenia which was improving with antipsychotic medication. He appeared to have improved since his assessment in **December 2009**. It was noted that Mr X saw Care Coordinator 1 at the CMHT fortnightly. Mr X had reported hearing three voices which in the past had told him to kill/harm others and then kill himself. He had damaged his property in an attempt to get rid of the voices, he would also shout at them. He felt he was currently managing the situation better. It was noted that in the past he had violent behaviour which could be random.

The plan was to continue to monitor and to ensure that Mr X had the Crisis Team contact details. Mr X would be encouraged to recognise his triggers and those who help him manage them. The Drug team was to continue to prescribe Methadone and to assess/act if there were any changes to Mr X's

89. Y Notes 5 pp 32 - 41

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risk profile.⁹⁰

Between **May** and **July** Mr X was followed up by the CMHT. Plans were to focus on occupation and providing a meaningful structure to his days. He was stable on his Methadone and receiving CBT for his psychosis.⁹¹ On **22 July** a care plan was developed. Fortnightly contact was to be maintained with Mr X to help provide structure and to lessen the impact of his psychotic symptoms on his day-to-day living (CBT). If the police were called to his flat due to aggressive incidents then a Section 136 was considered appropriate. In a crisis Mr X was to call the CMHT base in hours and the Crisis Team out of hours. He was also encouraged to telephone his Care Coordinator. Relapse indicators were identified as being agitation, anxiety, anger and aggression.⁹²

Mr X continued with the Addictions Team and the CMHT for the rest of the year. However he continued to hear voices which made it difficult for him to concentrate. During this period he had a change of Care Coordinator.

Ms Y In **January** Ms Y attended for DBT. Over Christmas the police had to be called as she was threatening to stab her boyfriend. On **6 April** the Domestic Violence Unit called the CMHT to say that Ms Y had been assaulted by her boyfriend and fallen out of bed and broken her leg.

On **26 April** a CPA review was held by Consultant Psychiatrist 1 and Care Coordinator 1. Ms Y was noted to be on Enhanced CPA. She was on Quetiapine 100mg twice daily, 200mg at night, and Citalopram 40mg at night. Her risks were deemed to be low. Ms Y appeared to be doing well and drinking less alcohol, even though she used Cannabis everyday. The plan was for her to continue with her medication and her therapy which was held twice a week. Whilst Ms Y described fleeting psychotic phenomena no psychosis could be detected. The plan was to review her in four months.⁹³ On **9 July** a CPA review was held. It was recorded that Ms Y was to receive DBT to include weekly 1:1 sessions, a weekly skills group and a weekly support group. Telephone coaching was also to be made available when Care Coordinator 1 was available. This treatment regimen was intended to reduce suicidal behaviour, substance misuse and violence. Relapse indicators were identified as being:

- agitation;
- high expressed emotion;
- thoughts of harm to others;
- thoughts of harm to self and of using Heroin;
- paranoia;
- tactile hallucinations.

90. X notes 1 pp 19 - 23

91. X notes 2 p 110 - 111

92. X notes 3 pp 20 - 24

93. Y Notes 5 pp 14 – 15 & Y Notes 6 pp 115 - 116

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The contingency plan was to maintain Ms Y in DBT but it was recognised that maladaptive behaviour would probably increase her risks in the medium and long term.⁹⁴

For the rest of the year Ms Y continued in a chaotic manner. She failed to attend the CMHT on a regular basis. However when Ms Y was seen she was described as hyper-vigilant and she expressed thoughts of harming others. The CMHT noted that Ms Y's levels of chaos and disorder were increasing her risk. The team wished to pursue MARAC – but in the event this was not done. Ms Y agreed to re-start DBT which she attended sporadically.⁹⁵

2011

Mr X On **23 May** Consultant Psychiatrist 1 wrote to the North Bournemouth Team Leader requesting a PNC check as there were concerns about Mr X murderous fantasies and rages (it appears this was not achieved).⁹⁶ The reason for this was so that the team could extend its knowledge about Mr X's risk factors.

On **24 June** Consultant Psychiatrist 1 met with Mr X's drug worker from the Park Lodge Service (BCAT). There had been concerns about Mr X's mental state and the BCAT was finding it difficult to work on his addiction problems due to his partially treated psychosis.⁹⁷ The outcomes of this meeting were to:

- continue with inputs from the Care Coordinator;
- review the medication and to trial antipsychotic medication.

Up until **September** Mr X continued the same; he was paranoid and at times depressed, he was compliant with the Addictions Service but had started to disengage with the CMHT. At this stage Care Coordinator 1 was reallocated to Mr X as he knew him well and had a good rapport with him. By September Mr X said his voices were becoming difficult to manage and on **28 September** when a review was held it was agreed that a Mental Health Act assessment would be considered in a few weeks time if Mr X did not improve. The police had been called to Mr X's flat because a complaint had been made about his behaviour. The police were told that if an incident was to happen in relation to Mr X again he should be taken to St Ann's Hospital under a Section 136. Mr X continued with the CMHT. He described fewer voices but he remained as deluded as ever. He expressed doubts about an inpatient admission and he asked for more time to decide.⁹⁸

Mr X continued to be paranoid for the rest of the year. However an inpatient admission was not progressed as it was decided to see if Mr X improved with

94. Y Notes 6 pp 110 - 114

95. Y Notes 6 pp 72 - 74

96. X notes 3 p 47

97. Clinical records, witness statements and interview transcripts

98. X notes 3 pp 6 - 7

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CBT. This was commenced in **December**.

Ms Y On **27 January** Ms Y was discharged from the CMHT due to non-attendance. A letter was written to her GP advising him of this. It was noted that her risk to others was significant due to the stress that Ms Y was experiencing. It was noted that DBT was the only safety strategy available as Ms Y refused to change her lifestyle.⁹⁹

On **16 February** Care Coordinator 1 wrote to the GP to say that the team now thought its former approach may not have been in Ms Y's best interests and that Whilst DBT was the correct treatment approach for Borderline Personality Disorder her contact with the team may have been reinforcing Ms Y's maladaptive behaviour. It was considered that a break in therapy would allow Ms Y to reevaluate her motivations for continuing with therapy in the future. Her continued reliance on Cannabis was recorded. The plan was:

- for Ms Y to try to tackle her substance misuse;
- for Ms Y to contact domestic abuse services;
- for Ms Y to be re-referred for therapy at a point in the future.¹⁰⁰

On **30 March** the GP re-referred Ms Y back to the North Bournemouth CMHT. An appointment was offered to her for **14 April**. The subsequent plan was for the GP to investigate her many physical problems and to refer Ms Y to the Bournemouth Assessment Team to see if she could get some help with her addictions. It was noted that nothing could be done therapeutically to help Ms Y until she had tackled her addictions. There was no plan for another appointment at this stage.¹⁰¹

On **17 June** Ms Y went to the GP. She was stressed due to ongoing issues with her neighbour. The council had asked her to keep a diary of events. The GP planned to send a letter of support.¹⁰²

On **31 August** Ms Y was admitted to Poole Hospital NHS Foundation Trust following a mixed overdose; her boyfriend had left her. Ms Y was discharged the next day and referred to the CMHT by Liaison Psychiatry. On **6 September** Ms Y was assessed by Associate Specialist Psychiatrist 1 at the CMHT. Ms Y had split from her partner some five months previously. She continued to be disturbed by her upstairs neighbour which upset her. She was still smoking Cannabis (£20 - £40 worth daily) and was not eating or sleeping well. It was noted that when she got angry she would break things. Ms Y was not thought to be significantly depressed and the management plan was:

- to continue on current medication (Quetiapine 100mg bd and 200mg at night and Citalopram 40mg daily);
- Ms Y was to be reviewed on the 14 October;
- Ms Y motivation to stop drinking and smoking Cannabis would be

99. Y Notes 6 p 78

100. Y Notes 6 pp 123 - 125

101. Y Notes 6 pp 131 - 132

102. Y notes GP 1 p 4

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discussed at the next appointment.

Ms Y's risks were considered to be low although her medium and long-term risks were raised due to her lifestyle and personality issues.¹⁰³

On **24 September** Ms Y told Care Coordinator 1 that she was having problems with a noisy neighbour. The police had been called the day before. Ms Y was worried about her temper; she felt it was unfair that she had to deal with this because of her stress. She was still smoking Cannabis heavily. She wanted to re-start DBT.¹⁰⁴

For the rest of the year Ms Y continued the same. She re-started DBT in **December**.

2012

Mr X Between **January** and **July** Mr X was followed up on a regular basis by the Addictions Service and the CMHT. At the time of his death Mr X appeared to be becoming more stable. He was still hearing voices but he had managed to socialise more and make improvements to his flat. In **July** he went on a one week holiday to Madeira and had had a good time swimming and enjoying the sun.

On **27 July** Mr X was stabbed to death in his flat by Ms Y who was aided and abetted by Mr Z.

Ms Y Ms Y continued to be chaotic and she engaged with the CMHT in a sporadic manner. It was recorded on **14 March** that she was finding therapy sessions difficult and it was decided to place her back on Standard CPA for a while.

On **12 April** Ms Y telephoned Duty at the CMHT to say she was having violent thoughts towards someone: She had visual thoughts of slashing him.¹⁰⁵ On **13 April** Ms Y was formally discharged from the CMHT.

On **27 July** Ms Y was arrested and charged with the murder of Mr X.

10.3. A PNC report was obtained for Mr X in **August 2012** after his death. This report detailed 24 convictions and 42 offences between **1993** and **2008**. Mr X was also a registered sex offender on MAPPA level 1. There were:

- six offences against the person;
- two sexual offences;
- one offence against property;
- 18 thefts and kindred offences;
- two public order offences;
- nine offences relating to the police/Court/prison;

103. Y Notes 6 pp 143 - 144

104. Y Notes 6 p 83

105. Y Notes 6 p 90

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- two drug offences;
- two firearms/weapons convictions.

10.4. A PNC report was obtained for Mr Z on **30 August 2012** that showed he had a series of minor convictions relating to theft and being drunk and disorderly.

11. Identification of the Thematic Issues

Thematic Issues

11.1. The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Mr X, Ms Y and Mr Z received from the Dorset HealthCare University NHS Foundation Trust. These thematic issues are set out below.

1. **Diagnosis.** Ms Y and Mr Z received appropriate and timely diagnostic assessment. Mr X however had a five-year delay in the provision of a formal diagnosis. This meant that on occasions the care and treatment provided to him was not optimal and his Schizophrenia went only partially treated for a number of years.
2. **Medication and Treatment.** The care and treatment provided to all three services users was delivered by both primary and secondary care services with kindness and compassion. It is also evident that both Ms Y and Mr Z received, on the whole, an evidence-based approach to their care and treatment needs.

The Dialectical Behaviour Therapy (DBT) model provided by the CMHT provided an innovative approach to the care and treatment of chaotic service users with Personality Disorder. However this model, at times, served to displace the approach taken with other service users with severe and enduring mental illness. Mr X was provided with robust input for his Heroin addiction by the Bournemouth Addiction Team, but his care and treatment from the CMHT was hampered by poor diagnostic processes. This meant that his Schizophrenia went partially treated, up until late 2011 and the care and treatment package he was offered did not address his needs in a holistic manner.

3. **Use of the Mental Health Act (1983 and 2007).** There were no issues identified regarding the use of the Mental Health Act in relation to Ms Y or Mr Z. Neither met the criteria for detention either before the homicide or after - this was also a finding of the Court.

It would appear that on occasions Mr X did meet the criteria for detention under the Act. However Mr X was allowed to continue in a self-directed manner in the community and his risks, either to himself or to others, were not primarily viewed through the lens of his Schizophrenia. Whilst eventual decisions not to assess Mr X under the Act had no bearing on his death, opportunities were missed that would have afforded an in-depth period of assessment of his mental state on an inpatient unit.

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- 4. Care Programme Approach (CPA).** There were generic, systemic and service user specific issues found in relation to CPA and Care Coordination. There was poor adherence to, and understanding of, CPA and Care Coordination within the North Bournemouth CMHT. This was compounded by resourcing issues and a disproportionate focus upon the DBT model. The Trust acknowledges that there remains a culture within many of its community teams of viewing CPA as a bureaucratic process only which takes them away from patient care. This has historically led to non-compliance with Trust CPA policy.

The North Bournemouth CMHT appears to have understood the notion of Enhanced or full CPA to have meant additional levels of monitoring and support. This is an entirely appropriate core function of CPA. However CPA within the CMHT did not always extend to meet another of its core functions; that of interagency/service and multidisciplinary assessment of need, ongoing communication and holistic care planning.

Limited care planning did take place but did not extend, in the case of Mr X, to either a medium or long-term plan to support his ongoing social functioning, recovery and wellbeing needs.

- 5. Risk Assessment.** There were generic, systemic and service user specific issues found in relation to risk assessment.

Systemic issues included a lack of a risk assessment culture within the North Bournemouth CMHT. There was a prevailing notion that risks could not always be managed and were dynamic in nature; this led to the view that risk assessment processes had a limited level of use and so were not focused upon. Risk assessment policies went unread and clinical staff within the CMHT had not received risk assessment training for many years. Another systemic issue was that of risk screens only being completed which meant that events of a serious nature and/or significant changes in a service user's mental state did not lead to a full risk assessment being undertaken.

Generic issues for all three service users included:

- the lack of Police National Computer (PNC) information being sought (save on one occasion in November 2004 for Ms Y);
- a lack of forensic psychiatry referral – even when indicated;
- a lack of diagnostic and risk formulation and risk management crisis/contingency planning.

Service user specific issues are manifold. In summary: they included Multiagency Public Protection Arrangements (MAPPA)); Multi-Agency Risk Assessment Conference (MARAC) processes; and safeguarding.

- 6. Referral and Discharge Planning.** Prison referral and discharge processes were weak and in November 2006 led to Mr X being lost to service for several weeks following his release from detention.

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General referral processes were unremarkable. However discharge procedures often did not include a risk assessment and a comprehensive transfer of risk information back to primary care.

- 7. Safeguarding.** The Bournemouth, Dorset and Poole Multi-Agency Adult Safeguarding Policy is a clear, evidence-based and useful document. It could be argued that Mr X, Ms Y and Mr Z on occasions all met the criteria for an 'Adult at Risk of Abuse' as defined within the policy. Whilst the use of safeguarding process was not as clearly indicated as MAPPA, MARAC, risk assessment and CPA, it would have provided a useful additional framework to have assessed vulnerability and risk against.

However whilst the adult safeguarding process could have been selected as an appropriate vehicle by which to manage the vulnerability and risk of Mr X, Ms Y and Mr Z the decision not to do so did not make a contribution to the death of Mr X.

- 8. Interagency Working.** Interagency working was poor with organisations operating in silos. This was exacerbated by weak Care Coordination processes.
- 9. Service User Involvement in Care Planning and Treatment.** A key finding of the Independent Investigation Team is the kindness and compassion that was evident in the delivery of care and treatment to all three service users across all Health provision. Each of the three service users were consulted in full about the care and treatment that was offered to them and it is evident that, where possible, informed consent was sought and the subsequent approach agreed with them. This was good practice. However services need to consider the following:
- it is sometimes necessary to intervene, even if it is against a service user's wishes;
 - cultural awareness can be a complex process especially when conducting in-depth clinical assessment;
 - person-centred care and treatment plans are always required for service users with severe and enduring mental illness and should encompass social functioning, recovery and wellbeing.
- 10. Carer and Family Concerns.** The needs, risks, and roles of families and carers were neither understood nor addressed by Trust services over time. There were missed opportunities to:
- gather corroborative information;
 - strengthen care plans for the service users (especially in the case of Mr X in relation to his brother's input);
 - ensure the safeguarding and general safety of relatives and carers;
 - undertake carer assessments;
 - explore family dynamics and provide education and support.
- 11. Documentation and Professional Communication.** Professional communication across primary and secondary care services was poor. There are three main reasons for this, each one exacerbating the others.

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- Clinical record keeping was, and is, weak within the North Bournemouth CMHT. Currently this appears to be due, in part, to the RiO system which – staff report - is cumbersome and difficult to use. This means that the clinical record does not accurately represent the work that is being undertaken.
- The different electronic clinical recording systems currently in use across services do not speak to each other. This means that information is difficult to access in a timely manner.
- There is a prevailing culture of informal professional communication which does not foster either a multidisciplinary or interagency approach. This culture is fostered by the poor use of CPA and Care Coordination which should act as a communication and liaison link across all disciplines, services and agencies.

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

There are long-standing issues in relation to policy compliance within the Trust and these are still ongoing at the present time. The issues indicate problems with both process and culture and appear to be deeply ingrained. The failure to adhere to policy and procedure has meant that the services under investigation have not adhered to either local or national good practice guidance. This failure compromised the quality and effectiveness of the care and treatment Mr X, Ms Y and Mr Z received.

13. Clinical Governance and Performance. At the time Mr X, Ms Y and Mr Z were service users with the Trust it is evident that significant policies were not adhered to and this compromised the effectiveness and quality of the care and treatment that they received. No single practitioner was responsible for this because systems were inadequate and failed to ensure staff had a clear understanding of what was expected of them. This was compounded by poor staffing levels, heavy caseloads and a monitoring and regulation process that was too weak to detect failings.

12. Further Exploration and Identification of Contributory Factors and Service Issues

12.1. In the 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.

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12.2. Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. The Court found Ms Y and Mr Z guilty of murder and they were sentenced to life imprisonment. Their history as service users with the Dorset HealthCare University NHS Foundation Trust was not seen as mitigation.

RCA Third Stage

12.3. This section of the report will examine 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. Causal, contributory and service issue factors.

12.4. The terms 'causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

12.5. **Causal Factors:** in the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used to describe any act or omission that had a direct causal bearing upon the failure to manage a mental health service user effectively and a consequent homicide. No direct causal factors were found by the Independent Investigation Team in relation to the care and treatment provided to all three services and the death of Mr X.

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

12.7. **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 X 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.

12.8. The findings in this chapter analyse the care and treatment given to Mr X, Mr Z, and Ms Y. The reader is referred to the narrative chronology for supporting information.

12.1. Diagnosis

Context

12.9. 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 and 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.

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

12.11. Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework that can allow conceptualisation and understanding of their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis should never take away from the treatment and management of the service user as an individual, but can provide a platform on which to address some care, treatment and risk management issues. The nature of the individual's personality can also often shape the presentation of the illness.

12.12. A substantial number of service users may well meet the diagnostic criteria for more than one diagnosis at any given time, for example, a person may have a Personality Disorder, a Depressive Disorder and substance misuse problems. For those service users with a number of concurrent diagnoses, or who have very complex presentations, a case formulation can be an invaluable aid to understanding the service user and providing guidance for treating teams in terms of prioritising treatment goals.

Personality Disorder

12.13. The diagnosis of Personality Disorder is a central issue in this case. ICD10 describes Personality Disorder as being:

“...comprised of deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations, they represent either extreme or significant deviations from the way the average individual in a given cultural context perceives, thinks, feels and particularly relates to others

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Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance”.

12.14. ICD10 defines specific Personality Disorders as “*a severe disturbance in the characterological constitution and behavioural tendencies of the individual, usually involving several areas of the personality and nearly always associated with considerable personal and social disruption. Personality Disorder tends to appear in late childhood or adolescence and continues to be manifest into adulthood*”. There are several specific Personality Disorders described in ICD10: Paranoid, Schizoid, Dissocial, Emotionally Unstable, Histrionic, Anankastic, Anxious/Avoidant and Dependent. Service Users may have a mix of disordered personality traits with overlap in diagnostic criteria. In practice the Personality Disorder is generally defined by the most prevalent symptoms or behaviours present.

Paranoid Schizophrenia

12.15. Schizophrenia is a major mental illness characterised by delusions, hallucinations, abnormality of thought process and form and emotional blunting. It can also be characterised by a lack of insight. The ICD 10 classification for Paranoid schizophrenia is set out verbatim below.

“This is the commonest type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition, and speech, and catatonic symptoms, are not prominent.

Examples of the most common paranoid symptoms are:

- *delusions of persecution, reference, exalted birth, special mission, bodily change, or jealousy;*
- *hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form, such as whistling, humming, or laughing;*
- *hallucinations of smell or taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.*

Thought disorder may be obvious in acute states, but if so it does not prevent the typical delusions or hallucinations from being described clearly. Affect is usually less blunted than in other varieties of schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, sudden anger, fearfulness, and suspicion. "Negative" symptoms such as blunting of affect and impaired volition are often present but do not dominate the clinical picture”.

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Findings

Findings of the Trust's Internal Investigations (Health IMRs) and the Serious Case Review

12.16. This subject was not specifically examined by the Health IMRs. The Serious Case Review noted that Mr X's records cite clear evidence of psychosis and a diagnosis of Schizophrenia from 2006 but does not examine this further.

Findings of the Independent Investigation

Mr X

12.17. Two years before his death Mr X was diagnosed as having Schizophrenia with co-morbid drug misuse. This combination is not uncommon in that a number of service users can 'self medicate' with illicit drugs as a means of managing their psychotic experiences. Unfortunately this can mask their early presentation as illicit drugs can in their own right cause psychotic symptoms.

12.18. Mr X's initial contact with services in March 1999 was in the context of his drug misuse, and the intention at that time was to stabilise him on a Methadone programme. However by March 2003, on assessment, he was noted to be smoking and injecting Heroin, he was also smoking Cannabis and drinking alcohol. There was mention in the assessment record of a previous diagnosis of a psychotic illness, although there was no evidence of that in his clinical presentation at the time.¹⁰⁶

12.19. Over the next few years Mr X's drug misuse was stabilised but the records often refer to him having paranoid and delusional thoughts.¹⁰⁷ When he was detained in custody in September 2006, prison medical staff noted a year long history of abnormal positive psychotic experiences including delusional ideas and auditory hallucinations. Unfortunately Mr X would not take anti-psychotic medication in prison and was lost to follow-up when he was released from custody. He was however diagnosed at this time as clearly having a psychotic illness and first rank symptoms of Schizophrenia.¹⁰⁸

12.20. ICD 10 outlines the diagnostic criteria for Schizophrenia. It divides symptoms into a number of groups that are particularly important for diagnosis and often occur together. Several groups of symptoms are identified including: thought disorder, thought echo, thought insertion, withdrawal and thought broadcasting, delusional experiences, hallucinatory experiences, persistent delusions that are culturally inappropriate or completely impossible, etc. The diagnostic guidelines stipulate *"the normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear cut), belonging to any one of the above listed eight groups, should be clearly present for most of the time for a period of one month or more"*. At the time Mr X was in custody, he very clearly had a number of positive psychotic symptoms including auditory hallucinations and paranoid delusional ideas, and they had been present for a substantial period of time.

12.21. When Mr X re-engaged with the North Bournemouth CMHT during the summer of 2009, his presentation was seen in the context of a Personality Disorder and co-morbid substance abuse. At this time he was allocated to different members of the

106. X notes 1 pp 5 – 6 & 82 - 113

107. X notes 1 pp 90, 93, 95 & 99

108. X notes 2 pp 64 – 65 & pp 56 - 57

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CMHT who did not know his history. The Investigation was told that the hard copy prison referral information was not accessible to CMHT workers and Mr X still needed his diagnosis to be determined. An assessment of some kind was conducted by a Community Psychiatric Nurse against a Borderline Personality Disorder Information Sheet. From this exercise it would appear a diagnosis of Borderline Personality Disorder was made. During the months that ensued Mr X was encouraged to believe that his hallucinations were the product of his imagination.

12.22. However as the months went by Mr X's psychosis increased. By December 2009 Mr X's psychosis worsened to the point that an inpatient admission was considered in order to understand the diagnosis better (in the event this did not take place). The clinical records note that he was experiencing auditory hallucinations on an almost constant basis commanding him to either kill himself or harm others.

12.23. In February 2010 Risperidone 3 mg was prescribed for Mr X but throughout 2010 and 2011 Mr X continued to be psychotic. On occasions his inability to engage on a consistent basis was noted and it was suggested that he should be discharged back to the care of his GP. However he remained with the CMHT and Cognitive Behaviour Therapy was trialled. This was good practice.

12.24. On 24 June 2011 Consultant Psychiatrist 1 met with Mr X's Addictions Service Worker. He was told that the addictions service found it difficult to engage with Mr X because of his mental illness. Mr X began to disengage from the CMHT and consequently Mr X was allocated to Care Coordinator 1 who had experience in assertive outreach. Mr X's diagnosis was confirmed as being Schizophrenia although it is not clear exactly when the diagnosis was formally changed.

Mr Z

12.25. Mr Z's first presentation to services in October 1998 was secondary to alcohol abuse and dependence with a background of poor social confidence. His epilepsy was also noted to be poorly controlled and he had bouts of depression and low mood. When re-referred to services and reviewed in April 2008, his diagnosis was reviewed to include Emotionally Unstable Personality Disorder/Borderline type. Mr Z presented with a history of overdose, low self esteem, alcohol abuse and depressed mood. He had learned to cope with his feelings by masking them, or using alcohol and drugs. Further assessment in July 2008 identified the following features of his behaviour; overdose, binge drinking, bulimic behaviours, shoplifting, gambling, impulsive sexual behaviour, drug abuse, dangerous driving and an unstable relationship with his girlfriend Ms Y, all characteristics of an Emotional Unstable Personality Disorder. He was offered psychological and substance misuse services but ultimately did not choose to avail of them.¹⁰⁹

Ms Y

12.26. Ms Y was diagnosed as having an Emotionally Unstable Personality Disorder; this is defined as *"a marked tendency to act impulsively without consideration of the consequences together with affective instability. The ability to plan ahead maybe minimal and outbursts of intense anger may often lead to violence or "behavioural explosions"*. These are easily precipitated when impulsive acts are criticised or thwarted by others. Two variants of this Personality Disorder are specified and both

109. Z notes 2 pp 56 – 58, 70 – 71 & Z notes 3 pp 15 – 18, 26

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share this general theme of impulsiveness and lack of self control, i.e. impulsive type and borderline type.

12.27. Ms Y presented initially to her GP with a history of an eating disorder, but it became apparent that these symptoms were part of a more complex presentation in a woman with a history of deliberate self harm and drug dependency. During her presentation to services over a number of years there was evidence of an attachment disorder, difficulty in interpersonal relationships, substance misuse (often used as a way of managing/avoiding difficult emotional states), eating disorder (often associated with issues around control/self hatred/a wish for self annihilation), depression and deliberate self harm. There was co-morbid homelessness.¹¹⁰

12.28. Throughout Ms Y's contact with services she variously presented with substance misuse problems, including Heroin, Cannabis and Crack Cocaine. 'Behavioural explosions' are a common feature of service users with Emotional Unstable Personality Disorder, and Ms Y was no exception. Early in her presentation she was angry with doctors for planning to discharge her from hospital and threatened to overdose, and as late as March 2011 she threatened to "*smash staffs face in*", in anger. She also had a history of violence, having stabbed men in the past in the context of drug and alcohol misuse. During 2001/2003 Ms Y had substantial psychological assessment and input; this in turn helped to clarify the formulation of her difficulties with which staff could work. It is clear from the entries in her later records that staff understood her well and had a good sense of the diagnostic and treatment challenges she posed.

Conclusions

12.29. The Investigation concludes that all three service users in this case had complex presentations with co-morbid conditions which complicated their presentation and treatment. We agree that in all cases the given diagnoses were appropriate, although we are of a view that Mr X's diagnosis should have been made sooner than it was. The Court did not make any link between the diagnoses of Mr Z or Ms Y and the killing of Mr X. The Investigation made no causal links between diagnostic issues and the death of Mr X.

12.30. However the Independent Investigation Team concludes that in the case of Mr X a differential diagnosis should have been given and this should have been evaluated in a more comprehensive manner as it was evident his psychosis was causing him significant distress and was acting as a barrier to both engagement and treatment. The delay in providing an appropriate diagnosis led to a delay in an effective care and treatment package being provided. Consultant Psychiatrist 1 told the Investigation that the CMHT was pressured and the Personality Disorder diagnosis may have lessened the perception of Mr X's ongoing need. He also thought that on reflection the team's response was "*crude*" in relation to Mr X and that the finer details were not looked at.

12.31. Mr X was not understood in the full context of his mental illness for many years and consequently the approach and package offered to him did not always address his needs. The interplay between his substance misuse and Schizophrenia was

110. Y notes 1 pp 201 – 203 & Y notes 2 p 49

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never examined in an appropriate manner because the Addictions Service and the CMHT worked separately with little cross communication and care planning occurring. The Independent Investigation Team concludes that this was detrimental to Mr X's health, wellbeing and quality of life. A diagnosis of Schizophrenia should have led to a different approach being taken to his care and treatment. On occasions Mr X's psychotically driven behaviour and chaotic lifestyle made him vulnerable; his treating teams did not appear to understand this. This is explored in depth in the report sections below.

- ***Contributory Factor 1. Mr X did not receive the correct diagnosis for many years. This had a direct impact on the care and treatment model offered to him as he was not understood appropriately in the context of his mental illness and poly-substance misuse.***

12.2. Medication and Treatment

Context

12.32. The treatment of any mental disorder should have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho-education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions - medication. This section concentrates on the issues of medication and psychological treatments in relation to the care and treatment delivered.

12.33. Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments fall into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety) and mood stabilisers. In substance misuse services, medications fall into a number of categories: those used in detoxification and withdrawal (e.g. Benzodiazepines), medication used for substitution and maintenance (e.g. methadone) and medication supporting abstinence (e.g. Acamprosate or Disulfiram / Antabuse).

12.34. 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. Specific guidance is available from NICE for the treatment of Schizophrenia, Emotionally Unstable Personality Disorder and Drug misuse, amongst other clinical conditions.

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

12.36. 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*

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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.

12.37. The patient's ability to comply with recommended treatments can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time, are they motivated to engage in the process of change, to attend appointments, etc.

Dialectical Behavioural Therapy

12.38. Dialectical Behavioural Therapy (DBT) is a talking therapy based on Cognitive Behavioural Therapy (CBT) and was developed by Marsha Lineham. The focus is placed upon behaviour change and is used to treat problems associated with Borderline Personality Disorder. The therapy works toward helping people change maladaptive patterns of behaviour such as self-harming, suicide attempts and substance misuse.

Care Pathways

12.39. A Care Pathway for Borderline Personality Disorder was developed within the Trust in 2008. The primary function was to try to provide a care pathway for people who were frequently in crisis and presented with behaviours which constituted a risk of harm to self. The ethos was to enable people to engage with a service as it frequently encountered people who were difficult to engage within traditional therapy settings. The modified approach aimed to prepare patients to be able to engage effectively with therapeutic work, ultimately through referral to the Trust's specialist intensive Psychological Therapies Service as this forms the main evidence-based treatment for people with a Personality Disorder of this kind. It is not clear what the formal status of the pathway was during the time Mr X, Ms Y and Mr Z were receiving their care and treatment from the Trust.

National Institute for Health and Clinical Excellence (NICE) Guidance – Personality Disorder

12.40. The principles of good quality of care for people with Personality Disorder are currently laid out in NICE Guidance (2009). It includes as specific points of good practice:

- access to services;
- comprehensive assessment;
- involving families or carers;
- developing an optimistic and trusting relationship;
- psychological treatments;
- treatment of co-morbidities;
- management of crises;
- limited use of medication for co-morbid conditions;
- risk assessment.

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National Institute for Health and Clinical Excellence (NICE) Guidance - Schizophrenia

12.41. NICE first published Schizophrenia treatment guidelines in 2002. These guidelines were published in full in 2003, and updated in 2009. The 2002/3 Guidelines included the following:

1. *"In primary care, all people with suspected or newly diagnosed schizophrenia should be referred urgently to secondary mental health services for assessment and development of a care plan. If there is a presumed diagnosis of schizophrenia then part of the urgent assessment should include an early assessment by a consultant psychiatrist. Where there are acute symptoms of schizophrenia, the GP should consider starting atypical antipsychotic drugs at the earliest opportunity – before the individual is seen by a psychiatrist, if necessary. Wherever possible, this should be following discussion with a psychiatrist and referral should be a matter of urgency".*
2. *"It is recommended that the oral atypical antipsychotic drugs amisulpride, olanzapine, quetiapine, risperidone and zotepine are considered in the choice of first-line treatments for individuals with newly diagnosed schizophrenia".*
3. *"The assessment of needs for health and social care for people with schizophrenia should ... be comprehensive and address medical, social, psychological, occupational, economic, physical and cultural issues...Psychological treatments [to include]*
 - *Cognitive behavioural therapy (CBT) should be available as a treatment option for people with schizophrenia.*
 - *Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service user.*
 - *Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available".*¹¹¹

Findings

Findings of the Trust's Internal Investigations (Health IMRs) and the Serious Case Review

12.42. The findings focused upon the models of service delivery. No particular analysis was undertaken by the Trust in relation to care and treatment. However the IMR for Mr x noted that he was assessed and that key treatment decisions were made with his informed consent and that clinical decisions were made proportionate to his needs. However the Serious Case Review noted that the first active treatment for Mr X's psychotic symptoms appears to date from March 2010 when he was treated with Risperidone which the Review thought to be the first reference to treatment for psychosis or Schizophrenia.

Findings of the Independent Investigation

12.43. In order to evaluate the approach taken to the care and treatment provided to Mr X, Mr Z and Ms Y it is necessary to understand the service models that were in operation at the time.

111.NICE Schizophrenia Core interventions in the treatment and management of schizophrenia in primary and secondary care (2002/3) P. 12-13

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The CMHT

12.44. The North Bournemouth CMHT covered a geographical area that comprised nine General Practitioners and a population of 77,000 people. The area has been designated as one of the most socio-economically deprived areas in England. During the period under examination the CMHT received 400 new referrals each year as well as providing ongoing treatment for 200 and 400 service users. Witnesses told the Investigation that there were a significant number of people presenting with impulse problems and co-existing drug and alcohol problems in keeping with the diagnosis of Borderline Personality Disorder (approximately 40 per cent). Because of this population profile there was *“a concerted effort to develop services within the CMHT to cater for this client group”*. Consequently a Care Pathway was suggested as a template for working and DBT was implemented to varying degrees of fidelity.

12.45. A 2011 proposal for the CMHT recognised that demand for services could outstrip the resource available and that the Care Programme Approach policy provided criteria that were too broad to give clear clinical direction as to who should be treated within a CMHT. At this stage the North Bournemouth CMHT was seeking clarity of purpose from commissioners and the Trust (the Independent Investigation was provided with discussion papers). It was recognised that care and treatment needed to be offered to people with severe and enduring mental illness and personality disorder. The team sought to provide structured clinical care within the resource available and within the framework of a Care Pathway which was evidence-based, resourced adequately and formally adopted by the Trust (the Independent Investigation Team was able to ascertain that the Trust had invested in implementing the DBT track but that central oversight and regulation was lacking).

The Bournemouth Community Addiction Team

12.46. The Bournemouth Community Addiction Team (BCAT - a service provided by the NHS Trust during the time the three services users were receiving their care and treatment) provided substitute prescribing care and treatment to adults who misused opiates. The clinic operated in a busy outpatient setting and workers had approximately 80 – 90 service users on the caseload. Each service user would be offered standard 30 minute appointments. The service was divided into two sections: shared care and specialist prescribing. Both sections were run by GPs (one with a specialist interest in addictions) rather than a Consultant Psychiatrist. The approach of the team was based on harm reduction and low-level psychosocial interventions such as motivational interviewing. Treatment for severe and enduring mental illness would be provided by the CMHT. The BCAT did not share the same clinical recording system as the CMHT and information could only be shared if services made a specific effort to do so.

Mr X

12.47. Mr X was engaged with mental health services for over 13 years. As has been said in the report section above assessment around diagnosis was poor and this had a direct impact on the appropriateness of the care and treatment that he received over the years.

12.48. The treatment of Mr X's addiction was good in that the BCAT successfully got him off Heroin and stabilised him on Methadone, therefore the overall management of Mr X's addictions can be seen as positive. However it is a matter of fact that BCAT

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found him difficult to engage and that his underlying mental illness and psychotic symptoms appeared to be preventing the efficacy of the treatment programme offered. This was eventually remedied in the autumn of 2011 when a meeting was held between the BCAT Worker and Consultant Psychiatrist 1. It is entirely probable that had a meeting of this kind been held several years earlier then Mr X may have been weaned off his Heroin addiction in a timelier manner. It was evident from the clinical record that Mr X took Heroin in an attempt to stop his auditory hallucinations which went either untreated, or partially treated, for years.¹¹²

12.49. The treatment of Mr X's Schizophrenia was not optimal due to the delay in confirming the diagnosis. However from late 2009 a plan was in place to assess and treat Mr X's psychosis. Initially it was thought that an inpatient admission would provide an appropriate opportunity, but Mr X did not agree to this. From February 2010 the decision was made to prescribe Risperidone 3mg daily and later on in the year Cognitive Behaviour Therapy was introduced. This was good practice.

12.50. Despite these changes to Mr X's treatment programme he continued to be paranoid and deluded and to experience auditory hallucinations. Whilst his anti-psychotic medication was appropriate there is a question as to whether or not he was on enough as he was still symptomatic. It was good practice that the team were working with Mr X on his terms and giving primacy to the therapeutic relationship, but this may have interfered with the ability to treat his psychosis more assertively.

12.51. On review of the clinical records there did not appear to be a clear treatment pathway and no evidence of consideration of full NICE guidelines (this will be addressed further in the Care Programme Approach report section below). The CMHT did not develop a Wellness and Recovery Action Plan (WRAP) and there was limited evidence of the implementation of a holistic approach that focused on quality of life and issues around social inclusion. Whilst Mr X's engagement was an issue there did not seem to be any consideration of involving the Assertive Outreach Team which would have been an appropriate response for an individual with Schizophrenia such as Mr X who found it difficult to comply with an ongoing care and treatment programme.

12.52. Managers told the Investigation that the Trust is a national demonstration site for Implementing Recovery through Organisational Change (IMROC). The Trust also has a community recovery service. We were told that this service is provided for individuals with higher levels of psychosis than Mr X apparently presented with. This service uses WRAP but managers told us that this process is not robust at the present time within CMHTs "*for people like Mr X*". The Investigation found that Mr X had Schizophrenia and experienced high levels of uncontrolled psychotic symptoms which he found distressing and led him to self medicate with illicit drugs. Clearly someone "*like Mr X*" should have been in receipt of such a process – sadly he was not.

12.53. Consultant Psychiatrist 1, when interviewed, reflected that Mr X lived a life with co-morbid drug use and partially treated psychosis. It was felt that the patient was getting a high level of expertise and input from a committed Care Coordinator who had the clinical skills to engage the patient and work collaboratively. However it was

112. X notes 3 p 4

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apparent that the systematic review of patients at CPA meetings was never fully embedded into the CMHT's practice and that there was a culture of making do and doing the best with the resources it had. Consultant Psychiatrist 1 also reflected upon whether a more coercive mode of treatment would have perhaps brought Mr X a better quality of life and perhaps have led to different social circumstances which in the end contributed to him being killed by his neighbours.

Mr Z

12.54. Mr Z's care and treatment was straight forward in nature. There were clearly defined emotional and social reasons behind his life choices and presentation. When he did present to mental health services, treatments for his addictions were available to him as was access to psychological support. The Investigation found that Mr Z's care and treatment fell within contemporaneous good practice guidance. Treatment options were realistically discussed with him and he was able to make an informed decision about the approach he wished to take.

Ms Y

12.55. One of the challenges when treating and managing service users with a diagnosis of Emotionally Unstable Personality Disorder is achieving a balance between treating concurrent mental illness (e.g. depression), not medicalising distress, managing arousal states so as to enable the service user to access therapy, whilst at the same time promoting independence, autonomy and empowerment.

12.56. Ms Y presented many treatment and management challenges. Her presentation was complicated by her substance misuse. This in turn altered her mood states (anger), contributed to her changeable presentation and limited her ability at times to work with therapy. The Investigation found that Ms Y's addictions were recognised and managed well overall.

12.57. Ms Y had a range of psychological treatment interventions available to her - this was good practice. She was assessed by psychological services in 2001 and between March 2002 and June 2003 she attended Cognitive Analytic Therapy (CAT) sessions reasonably regularly. There is an impression from reading the clinical records and from discussions with witnesses that therapy seemed to have provided a strong element of containment for Ms Y at that time. When she was discharged from CAT she was noted to be presenting as "*reasonably well*", she was not taking Heroin - although she was still binge drinking, her relationship with her boyfriend was good and she felt that she had learned a lot from therapy.¹¹³

12.58. Unfortunately Ms Y did not maintain those improvements for very long and a pattern of crisis/distress/anger/substance and alcohol misuse presentations quickly re-emerged. Over the ensuing years Ms Y was managed in an empathic way, with firm boundaries for the most part, using a DBT (Dialectical Behaviour Therapy) informed approach. This is recognised as an appropriate psychological therapeutic intervention in the management of Emotionally Unstable Personality Disorder, and it is positive that the CMHT had those skills and was able to use them. The intention however was not to retain Ms Y within the team indefinitely but to trial the DBT with the intention of assessing her suitability for referral to Psychological Services. This

113. Y notes 3 pp11 – 12, 23, 31

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was not achieved due to Ms Y's chaotic lifestyle and overall reluctance to take responsibility for her mental health.

12.59. Ms Y's substance abuse, over arousal states and depressed mood were variously managed using the addiction services and medication (including anti-psychotics to reduce arousal states, and anti-depressants to help with low mood). Her medications were reviewed regularly at the outpatient clinic for efficiency and side effects. The treating team was clear that the goal of medication use was to ameliorate some of Ms Y's most troublesome symptoms, but the role of changing her life remained firmly within her own area of responsibility. The mainstay of her treatment was psychological which was wholly appropriate.

12.60. By February 2011 it was acknowledged in the clinical records that the attempts of the CMHT to 'hold' Ms Y, even when she was not engaged in therapy, may with hindsight not have been the best long-term approach with her. Although well motivated it was thought that continued therapy and engagement may have played a part in re-enforcing her maladaptive behaviours. At that time it was decided that she should have a break from therapy, concentrate on tackling her substance misuse and issues around domestic violence, with the option of being referred into treatment again sometime in the future.¹¹⁴ Ms Y's behaviour meant that the team was constantly drawn back to supporting her in some way or another. This highlights the reality of the problems many teams face with individuals like Ms Y when addressing what to do and how to help individuals who will not take full responsibility for their lives and subsequent life choices.

Conclusions

12.61. A key issue for the Investigation to consider was the service delivery model within the CMHT. The North Bournemouth CMHT had adopted a DBT model. This was good practice in ensuring that Personality Disorder was not a diagnosis of exclusion within the CMHT. However the pressure placed upon the team to manage service users with Personality Disorder may on reflection have served to displace a key role and function of the Care Programme Approach regarding the care and treatment of service users with severe and enduring mental illness.

12.62. The CMHT provided compassionate and sensitive care and treatment to Mr X, Mr Z and Ms Y. It was evident that an innovative approach was taken to ensure chaotic service users could be supported in an evidence-based manner by local mental health services. However as can be seen from the 2011 proposal for the CMHT it was recognised that the team could not sustain its efforts as demand threatened to outstrip the available resource. It would appear that the CMHT, either could not or would not, refer service users to other services, such as Psychological Therapies and Assertive Outreach, which could have lessened the pressure on the caseload. Neither did the CMHT appear to consider discharging service users back to the care of the GP once they were stable. Individuals such as Ms Y may have been better placed within a different service as was finally realised by practitioners in 2011. This is examined in more detail in the section on CPA below.

114. Y Notes 6 pp 123 - 125

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12.63. Witnesses told the Investigation that the complex caseload and limited resources led to an inability to provide either a formal Care Programme Approach or WRAP. In the case of Mr X this was detrimental to his ongoing care, treatment and sustainable recovery. The Independent Investigation Team understands that Mr X was followed up and was provided with a great deal of support. It is also evident that on occasions he was provided with CBT and efforts were made to look at his social functioning. However in the event these approaches were neither sustained nor provided in a consistent manner designed to promote his ongoing wellbeing and recovery.

- ***Contributory Factor 2. Mr X did not receive a full and appropriate care and treatment package in keeping with his complex presentation and ongoing psychotic symptoms.***

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

Context

12.64. 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.

12.65. At any one time there are up to 15,000 people detained by the Mental Health Act in England. 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.¹¹⁵

Section 136

12.66. Section 136 of the Mental Health Act allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours. The place of safety could be a police station or hospital (often a special Section 136 suite).

Findings

Findings of the Trust's Internal Investigations (Health IMRs) and Serious Case Review

12.67. The Health internal investigation reports (IMRs) do not specifically explore the use of the Mental Health Act in relation to Mr X, Ms Y or Mr Z; however there is mention of the CMHT failing to consider a Mental Health Act assessment for Mr X following advice given to the police to detain him under Section 136 of the Act if he created a disturbance at his flat. The Serious Case Review also discusses this issue

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

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and cites other occasions when all three service users were considered in relation to the Act.

Mr X

12.68. The Serious Case Review notes that on 28 September 2006 whilst Mr X was in prison, his mental state was thought to require transfer to a psychiatric facility under Sections 47/48 of the Act. In the event this was not achieved. The report also notes that on 30 September 2011 following an altercation with his brother the police were involved and advised by the CMHT that if any further disputes were to take place Mr X should be placed under a Section 136. The report states *“This was clearly a deficient action plan”*.

Ms Y

12.69. The Serious Case Review appears to state that on 28 September 2011 the CMHT was considering an assessment of Ms Y under the Mental Health Act due to her loss of temper following an episode with a noisy neighbour (Mr X) but that no further action was taken by the CMHT. It was in fact Mr X who was being considered for a Mental Health Act assessment and not Ms Y.

Mr Z

12.70. The Serious Case Review mentions that Mr Z was arrested under Section 136 on 16 March 2008 because he was suicidal and found by the police to be carrying knives. He was released by the police shortly afterwards and no further action was taken (this was because following medical assessment no signs of mental illness could be found).

Findings of the Independent Investigation

12.71. The Independent Investigation found that any issues pertaining to the Mental Health Act in relation to either Ms Y or Mr Z were relatively insignificant in nature and of no relevance to the assessment of the quality of their ongoing care and treatment. It would appear that at no stage either service user’s mental state warranted assessment under the Act.

12.72. Of concern however is the fact that there were three occasions when Mr X’s mental state deteriorated to the point where the Mental Health Act was considered.

- 1.** In 2006 when Mr X was in prison a transfer was considered under Sections 47/48 of the Act due to the deterioration of his mental health.
- 2.** On 22 July 2010 a care plan was developed in which the police were advised to detain Mr X under Section 136 of the Act if they were called out to any incidents at his accommodation.
- 3.** On 30 September 2011 when the police were involved in an altercation between Mr X and his brother they were advised to detain Mr X under Section 136 of the Act if any other incident occurred.

12.73. It was not possible to examine the circumstances in relation to Mr X’s 2006 detention in prison. However his mental state at this time (delusions, paranoia and violent outbursts) suggests that a period of inpatient assessment was indicated and was of such concern that the Mental Health Act was being considered. It is important to understand the later events of 2 July 2010 and 30 September 2011 in the context

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of Mr X's ongoing mental state. Mr X's symptoms and behaviour continued largely unabated over a period of many years. By 28 September 2011 the CMHT recorded concerns about Mr X and had decided that a Mental Health assessment should be considered if his mental state did not improve. It was hoped that a planned hospital admission could be arranged in order to conduct an in depth examination and assessment of Mr X.

12.74. In the event Mr X refused a voluntary hospital admission. The Independent Investigation concurs with the findings of the Serious Case Review in that the advice given to the police to use Section 136 represented a deficient action plan. If the CMHT was concerned about Mr X's behaviour and risks in the context of his mental state then a proactive clinical stance should have been taken - such as an assessment under the Mental Health Act - with the possibility of a hospital admission as the outcome.

Conclusions

12.75. Based on the evidence available to the CMHT it was evident that Mr X's symptoms were ongoing and resistant to the care and treatment offered to him. Once the CMHT had decided to confirm Mr X's diagnosis of Schizophrenia (sometime in 2010 or 2011), and once antipsychotic medication was being used, an in-depth period of assessment was indicated. On reflection, at interview, Consultant Psychiatrist 1 considered whether a more coercive method of engaging Mr X should have been taken in order to bring him into hospital at this stage. It was evident that the CMHT had advised the police on two occasions to detain Mr X under Section 136 of the Act which indicates that the clinical view at the time was that Mr X was mentally disordered and met the criteria for statutory intervention. It is clear that by September 2011 the Trust had the knowledge (about Mr X's mental state) and the legal means to intervene (an assessment under the Act). However Mr X was allowed to continue in the community in a self-directed manner and was not brought into hospital as he consistently declined the offer. Mr X continued to be aggressive, paranoid and actively psychotic until March 2012 when his mental state appeared to improve.

12.76. It is a consistent feature of Mr X's care and treatment that over the years he was never viewed primarily through the lens of his Schizophrenia. Instead it appears that he was viewed as an addict with disruptive behaviour that required criminal justice or police intervention (the only exception to this was when Mr X was assessed by a forensic psychiatrist during his detention in prison). Whilst it was good practice to try to engage Mr X and seek a voluntary admission into hospital it would appear that his capacity to make this decision was not assessed. Had his capacity been assessed a more robust course of action might have been taken and detention sought. A period of assessment could then have taken place and an effective care and treatment package developed to treat Mr X's ongoing and difficult to treat psychotic symptoms.

12.77. The Independent Investigation concluded, that whilst no causal link could be made regarding the decision not to assess Mr X under the Act and the events that led to his death, his mental state suggested that a more assertive and coercive approach was indicated on occasions. This was a missed opportunity. Mr X went on to 'recover' from the worst of his symptoms without detention, however they did not

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disappear completely and he continued to hear voices and to respond to them. It is possible that had the opportunity been taken to assess Mr X in an inpatient facility a better care and treatment plan could have been developed and this would have potentially lessened his problematic symptoms and made him less susceptible to violent and confrontational situations in general.

12.4. The Care Programme Approach

Context

12.78. 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.¹¹⁶ Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care 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*.¹¹⁷

12.79. “*The Care Programme Approach is the cornerstone of the Government’s mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services*”.¹¹⁸ (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

12.80. 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.

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

12.82. 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

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

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

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

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- to take immediate action if it is not
- ensuring regular review of the patient's progress and of their health and social care needs.

12.83. 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.

Local Policy

12.84. The Trust's policies dated 2008 - 2010 and 2011 were examined. The 2008 - 2010 policy was agreed between five statutory agencies across Dorset and agreed by the Dorset-wide CPA Steering Group. The policy stated that training was in place for all staff including medical staff.

"Individuals with a wide range of needs from a number of services, or that are at most risk, should receive a higher level of co-ordinated support. These individuals will receive their care under the Care Programme Approach (CPA)".

Key principles as stated in the 2008 – 2010 Trust policy said CPA:

- *"is person centred, promoting choice and recovery;*
- *is consensual and based on partnerships between the Service User, Carers and other agencies as fully as possible;*
- *recognises Carers vital contribution to the support to aid a person's recovery and should be involved as fully as possible in all aspects of care planning;*
- *clarifies responsibility for implementation;*
- *ensures clear assessment and management of risk, to promote safety;*
- *provides an effective co-ordination of care from a number of agencies and services;*
- *promotes recovery and social inclusion, including the use of community resources;*
- *promotes services that are gender and diversity sensitive".*

"...[for those service users on CPA] there should be ongoing review with formal multidisciplinary, multi-agency review at least once a year, but likely to be needed more regularly (where there are major changes in Service Users' circumstances or when other information comes to light), and at the end of the episode of care a HoNOS rating scale should be completed".

"The care plan will reflect the assessment detail, including risk, and has the following functions:

- *is a description of the process of care planning;*
- *it summarises identified needs and how they are to be met;*
- *it is a formal record setting out what is going to be done, why, when and by whom;*

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- *it provides information to the Service Users and Carers to enable them to contact the service at any time;*
- *includes clear indicators of relapse, contingency and crisis plans where the Service User is on CPA”.*

The Care Coordinator Role

12.85. The role of the Care Coordinator was listed as follows:

- *“Assess the needs of the Service User, in partnership with other members of the multi-disciplinary team, where appropriate;*
- *Use professional skills collaboratively to co-ordinate/facilitate the care of the Service User, liaising with other involved professionals, the Service User and Carer(s) and other service providers;*
- *To assess eligibility of local authority funding under Fair Access to Community Care Services ... To seek approval for funding from their community care budget where needs have been identified;*
- *To provide support and care in a positive, assertive manner, in a way that is as acceptable to the Service User as possible;*
- *To work with Service Users to identify the range of services available and agree the appropriate personalised care plan offering choice where available;*
- *Ensure that the care plan is implemented effectively, review progress and adjust the plan as required;*
- *To act as a consistent point of contact for Service Users, Carers and other professionals;*
- *Ensure that Section 117 aftercare needs are reviewed at each review where applicable;*
- *Continually assess and manage risk, in accordance with the Clinical Risk policy;*
- *Ensure that HoNOS reviews are completed and recorded electronically;*
- *Assess and review the needs of Carers, where the Carer is unpaid and provides regular and substantial care... Consult with and support Carers;*
- *To maintain contact with the Service User, as agreed in the care plan, until they are transferred to another lead professional/Care Coordinator or discharged”.*¹¹⁹

12.86. The 2011 policy underpinned the importance of the Recovery Model and stated:

“The aim of our service is to promote personal recovery by providing people with the tools (eg coping skills, psychosocial interventions, medication, recovery skills) for them to build the life they wish to live. Recovery is not a passive process; people will need to be actively engaged and involved. Best practice would ensure authentic collaboration with the service user is essential.

*If a person has a wide range of needs from a number of services, or if there are concerns about their ability to keep themselves safe or maintain the safety of others they should receive a higher level of co-ordinated support. This is called the Care Programme Approach (CPA). Otherwise a person will receive their support through a process called Standard Care”.*¹²⁰

119. Trust CPA Policy (2008-2010) p 32

120. Assessment and CPA policy 2011

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12.87. The Independent Investigation Team found the policies to be evidence-based and fit for purpose. However the policies were very long and several witnesses to this Investigation suggested that a shortened version would be useful in the clinical setting.

Findings

Findings of the Trust's Internal Investigations (Health IMRs) and Serious Case Review

12.88. The Health investigations (IMRs) do not analyse CPA in detail. However the reports do state that Care Coordination was consistent but that in future CPA reviews and meetings need to be conducted in face-to-face sessions so that progress and actions can be made by a team rather than the individual Care Coordinator working in relative isolation. The Health IMRs also state that CPA reviews should have included addictions services, the police and housing in order to improve risk management and care planning. The Serious Case Review report was more critical and stated that:

"... the evidence points to at best an interdisciplinary approach, with no confirmation of an interagency approach. Evidence [IMR's] suggests mental health services appeared to rely on a reactive response, rather than a proactive response to episodes of both antisocial and psychotic behaviour. It is also not clear why a link was never made between X's antisocial behaviour and the psychotic formulation. A more rigorous and substantial CPA may have assisted to make the above links".

12.89. The report also stated that recommendations should ensure that Trust services work with the full principles of CPA and that in future it should be multidisciplinary, interagency and multiagency in nature. The Independent Investigation Team concurs with the findings and recommendations of the IMRs and the Serious Case Review. Additional findings are set out below.

Findings of the Independent Investigation Team

12.90. The Independent Investigation Team found that there were many *systemic* and *generic* issues relating to the management of CPA within the CMHT that affected the quality of the care and treatment provided to all three service users, but principally to Mr X and Ms Y. It is important to note that these issues should be owned by the whole team and are not specific criticisms of any particular individual's practice. **The reader should note that the term 'Enhanced CPA' is used throughout this section. Whilst this is technically not the correct term for CPA post 2008; however the Trust did not change its terminology.** The systemic and generic issues are as follows:

1. **Lack of inter and multi-agency working:** Whilst each of the three service users received consistent follow up over time from Care Coordinators and other CMHT staff, little actual linkage was made between other services and agencies (such as police, probation, housing and addictions teams) and therefore poor coordination and management ensued. The provision of therapy was good, but on its own this was not enough as holistic assessments were not conducted within a CPA framework. Assessment, such as it was, did not lead to appropriate management plans and multi-agency working. The Independent Investigation

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Team found the lack of interagency communication and working between the CMHT and the addiction services to be a significant omission which robust CPA should have addressed. For example; this lack of communication meant that Mr X was known to service for at least four years before a care and treatment programme could be negotiated across his separate treating teams (see chapter subsection on medication and treatment above).

- 2. Accommodation and home-based assessment:** It is important to note that both Mr X and Ms Y had the same Care Coordinator (CCO 1) for a significant period of the time they were receiving care and treatment from the CMHT. CCO 1 did not connect Mr X and Ms Y together regarding the problems that both were facing with their accommodation. This left Mr X and Ms Y vulnerable with an ongoing situation neither could resolve. The Independent Investigation Team was told that service users were not always seen at their homes (there are only two identified home visits to Mr X made over a six year period). This meant that no connection was made at the time that the person Ms Y was complaining about in her block of flats was in fact Mr X. Had this connection been made then CCO 1 might have understood that Mr X's hallucinations were problematic and that his Schizophrenia management required a review (in relation to his disruptive behaviour and the noise he was making in his flat).

The Independent Investigation Team heard that another reason Mr X was not visited at his home was because of his forensic history. At interview CCO 1 also told the Investigation that he did not visit Ms Y at her home for the same reason. The history of both service users was obviously seen as presenting a potential 'risk' of some kind; however no assessment was specifically formulated regarding either Mr X or Ms Y's risk to CMHT workers, or to the other people who were domiciled in the same block of flats, several of whom were also service users with the same CMHT.

It should be recognised that a holistic assessment of need must always take a service user's social needs and living conditions into consideration. Home visits provide an important and ongoing part of any dynamic risk assessment and care planning process. The fact that this did not happen for either Mr X or Ms Y represents a significant omission and illustrates well the CMHT's focus upon therapy sessions on Trust premises as the main vehicle for intervention as opposed to community-based health and social care assessment in a person's own home.

- 3. CMHT model of working:** The CMHT used an adapted DBT model; this was appropriate for Personality Disordered service users, but meant that the basic building blocks of CPA often went unaddressed for other individuals with severe and enduring mental illness. This was described by witnesses as being primarily due to resourcing issues. During the time Mr X, Ms Y and Mr Z received their care and treatment from the Trust no WRAP model was utilised by the CMHT. The Independent Investigation Team found the care and treatment emphasis was on therapy rather than recovery. A WRAP would have provided a better and more holistic approach for a service user like Mr X who had a diagnosis of Schizophrenia. Therapy is important, but should have been delivered within the context of a holistic wellness and recovery plan. Both approaches should have

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been managed by CCO 1 with the DBT model being provided in addition to - and not instead of - Care Coordination and CPA.

We were told that DBT took place weekly and was time consuming. The Independent Investigation Team heard that capacity was limited and over allocated. This provided a resource conflict as the other core functions of the CMHT (such as CPA) could often not be achieved. We heard that CMHT CCO caseloads were on average 25 – 30 service users at this time and were within nationally set limits; however the resource implications represented a challenge as a significant number of these service users were receiving DBT.

DBT became the favoured model and CPA and risk assessment became subordinate to it. CCO 1 had a caseload of 25 complex and challenging cases. We were told that the North Bournemouth CMHT had a Personality Disorder caseload of 40 per cent as opposed to 15 – 20 per cent in other CMHTs and that DBT was a local initiative particular to the North Bournemouth CMHT. At the beginning there was enough of a resource, but as time went on the function of the DBT track became more intense and staff were pulled away from their core CMHT roles. The DBT track was eventually stopped because it could no longer be delivered safely. When interviewed many witnesses did not know whether the DBT track approach had been agreed formally by the Trust or whether it was simply the product of a local response.

- 4. Care planning and risk assessment:** This was difficult to assess due to the relatively poor standard of documentation which was either incomplete or entirely non-existent much of the time. No regular evaluation appears to have taken place and neither does there appear to have been a regular review process to monitor and reassess need.

In the case of all three service users there was a lack of holistic care planning and formal process; the DBT model should not have removed this. There was a reliance on DBT and support work to *contain* risk, and to some extent this was probably a good approach, but risks can't be *assessed and managed* in this manner. Witnesses told the Independent Investigation Team that the CMHT was often asked to manage risks that it thought were not manageable, this was given as an explanation as to why risk assessment was not focused upon. The Independent Investigation Team found this to be an entirely inappropriate and unsafe stance. Risks, no matter how 'unmanageable', still need to be articulated clearly, formulated and a rationale given for treatment and a management plan provided.

When interviewed the Trust Board acknowledged there were similar issues between this case and an earlier published homicide investigation report looking at Trust service failures (2013) in that the CPA process was not working properly. The Independent Investigation Team was told that this represents an ongoing cultural challenge for staff. Apparently staff still regard care planning and risk assessment as bureaucratic tasks that have limited value that serves to take them away from patient care.

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In short; the Independent Investigation Team found that care planning and risk assessment was limited and assessment was not holistic and did not meet either the Trust CPA policy or the NICE guidelines for the management of Schizophrenia.

- 5. Role specification and leadership:** It was evident that the role of the CCO in general was not clear. There was a lack of real multidisciplinary working which led to 'too much work with too little focus'. Management leadership appeared to have been weak and this meant that role adherence and capacity were neither monitored nor reviewed.

Witnesses said at interview that CCOs would be required to cover for the Duty on Call Service across two CMHTs every couple of weeks or so which took them away from their caseload (HASCAS had recommended that this system cease in an earlier published homicide investigation report looking at Trust service failures: 2013). CCOs also carried out activities such as swimming and gym sessions, which, whilst integral to a good care and treatment package, would have been better provided by a support worker post. In addition the Independent Investigation Team was told that the CMHT worked hard to prevent service users being referred to the Crisis Team and would 'hold' them even when very unwell. This provided an additional increase in pressure on the CMHT and was another factor which took CCOs away from their CPA role.

CCO 1 described meeting with service users who were on CPA up to twice a week. He had 15 Personality Disordered patients on his caseload when DBT first started for which he would provide weekly 1:1 sessions. He also provided two x two hourly teaching groups a week. The ethos was to work with service users on CPA until they were "stable" at which point they would be passed back to the lead care of the Consultant Psychiatrist and CPA would cease. There was no understanding of the long-term benefits and rationale for CPA in relation to ongoing severe and enduring mental illness and multiagency working.

Across all three cases there appeared to have been lots of activity, lots of good work, but outside of a framework that held it all together. What was missing was the clear steady hand of the Care Coordinator liaising and communicating with all other disciplines and services (primary care, BAT, BCAT, housing, police, probation etc). One Care Coordinator, one plan, one telephone is all that was needed. The role of the CCO is crucial and appears to have been subsumed into many other roles that led to the inability to provide proper CPA.

- 6. Policy adherence:** the Independent Investigation Team found that witnesses had a poor understanding of the CPA policy and their role within it. It was evident that no formal and Trust approved CPA process was followed.

12.91. In addition to generic and systemic issues there were also issues that were specific to each of the three service users. These are set out below.

Mr X

12.92. Mr X was not in receipt of a robust CPA package in keeping with either local or national policy expectation. Local policy (see paragraph 12.86 above) states that service users on Enhanced CPA should be in receipt of a personalised recovery

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plan. Local Trust CPA policies over the years have stressed the importance of a multiagency approach in order to manage high risk and complex presentations in a robust and person-centered manner. It is evident that Mr X met the criteria for an Enhanced CPA/full CPA package (however from a careful read through of his clinical records it remains unclear what his CPA status was much of the time). He was:

- on the sex offenders register and had been in prison (MAPPA should have been considered - but prison liaison had failed);
- in receipt of addiction service input;
- diagnosed with Paranoid Schizophrenia which was resistant to the treatment offered;
- identified with ongoing risks to himself and/or others;
- identified as having a history of self-neglect and impulsive behaviour when actively psychotic;
- socially isolated.

12.93. Mr X was first referred to CMHT services by the Addictions Service in April 2005. At this time Mr X was experiencing high levels of distress, had delusional ideas and was socially isolated. He was reluctant to attend for a CMHT assessment and in the event, due to non-compliance with his Addiction Service prescribing contract, was discharged from the Bournemouth Addictions Team back to the care of his GP. This meant Mr X was lost to secondary care services at this stage.

12.94. In September 2006 Mr X was in prison and in the Segregation Unit. He was actively psychotic and Prison Healthcare wanted to transfer him to hospital on a Section 47/48 of the Mental Health Act. Prior to his detention Mr X had become increasingly psychotic, was emaciated and had been drinking heavily (it was thought his alcohol consumption was a self-medication attempt to manage his voices).

12.95. Prison services wrote to Consultant Psychiatrist 1 at the CMHT and enclosed a report compiled by a Forensic Psychiatrist. It was thought that Mr X required a secure placement and had probably been mentally ill for some time before his arrest, sentencing and subsequent detention in prison. It was evident that Mr X had acted upon auditory hallucinations which took the form of voices from a passing car telling him to *"kiss my a**e"* which had led to the conviction of indecent exposure. It was the view of the Forensic Psychiatrist that Mr X had Schizophrenia. In the event no action was taken and Mr X was released from prison in October 2006 with no follow up in place.

12.96. In November 2006 Mr X was re-referred to the Bournemouth Assessment Team by the GP for his illicit substance misuse. At the same time the North Bournemouth CMHT was trying to trace Mr X to action an incomplete referral made by the prison service. After an initial meeting at his home on 4 December 2006 Mr X was once again lost to secondary care services. No further records are available to determine why this occurred.

12.97. On 20 November 2008 Mr X registered with a new GP practice and the GP wrote to the Bournemouth North CMHT requesting background information. At this time Mr X was in trouble with the police again and probation services were involved. Ultimately Mr X was seen by the Bournemouth North CMHT on 26 January 2009. The Serious Case Review identified that CPA commenced from this time. Mr X was

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allocated a Care Coordinator but it is unclear exactly what kind of CPA Mr X was actually in receipt of.

12.98. Between January 2009 and May 2010 it was apparent that little was achieved by way of assessment, care planning and risk assessment, the focus being on whether Mr X had a Personality Disorder or not. By 13 May 2010 (eighteen months later) the thinking around Mr X's diagnosis had changed and it was acknowledged by the CMHT that he had an untreated Schizophrenia which was improving with antipsychotic medication.¹²¹

12.99. On 28 May 2010 a CPA review took place and it was recorded that there was an increase in Mr X's anxiety and depression. A recovery plan was to be developed which would focus on meaningful structure and the occupation of Mr X's days. Mr X was reported to have been happy with the plan.¹²² However in actuality the plan was nothing more than fortnightly regular monitoring contact. This was to continue until the time of his death. No further in-depth review was undertaken, even when Mr X's mental health relapsed in 2011 and a hospital admission was being considered.

12.100. At no stage did Mr X's severe and enduring mental illness appear to have been the primary lens through which his care and treatment was viewed. A psychotic and difficult to engage service user should have received a full CPA care and treatment package with a view to social inclusion and full engagement with the service.

Ms Y

12.101. Ms Y came to the attention of Bournemouth secondary care mental health services in 1998; she was to be intermittently on CPA of some kind from this time. Little is known about her psychiatric history and there is no recorded evidence to demonstrate that attempts were made to find out about it.

12.102. Ms Y received CPA, on and off, over a 12-year period. It was good practice that secondary care mental health services did not automatically view her diagnosis of Emotionally Unstable Personality Disorder/Borderline Personality Disorder as a diagnosis of exclusion.

12.103. In the early years of Ms Y's contact the Independent Investigation Team could find evidence for recorded CPA reviews and care planning processes. It was apparent however that care plans were under developed and it was not possible to find evidence for how these plans were either implemented or monitored.

12.104. As the years went by the decisions to place Ms Y on either level 1 or level 2 CPA (Enhanced or Standard) appear to have been made based upon the severity of her impulsive behaviour and consequent risk events rather than any relapse relating specifically to her mental health.

12.105. As can be determined from the chronology and timeline, Ms Y was reliant upon services to intervene on the occasions when she experienced episodes of social crisis. Examples of this can be found in relation to her loss of accommodation

121. X notes 1 pp 19 - 23

122. X notes 2 pp 110 - 111

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in 2002 and 2003 and the ongoing issues in relation to her chaotic and often violent relationship with Mr Z. The Independent Investigation Team found most interventions, and CPA in general, were reactive in nature and tended to focus upon the short-term immediate management of any crisis in which Ms Y found herself.

12.106. There were no specific medium or long-term plans developed to help Ms Y manage her high risk behaviours and social situation. DBT was eventually provided in 2005 in an attempt to support Ms Y and to manage her ongoing risks. Witnesses said that DBT was effective and provided the opportunity for the CMHT to manage with a high degree of success the often chaotic and impulsive presentation of service users with Personality Disorders. However as has already been mentioned above, this was put into place without any robust assessment, risk formulation or ongoing care planning structure.

12.107. On occasions Ms Y was placed on 'Enhanced CPA'. It is recorded for example that she was on 'Enhanced' CPA in 2010. It is however unclear why. At this time Ms Y had no mental health diagnosis, was assessed to be at low risk in all fields, was stable with regards to her social situation and no longer under the care of the Addictions Service. When Ms Y was discharged from the CMHT in January 2011 due to prolonged non attendance, she was readily accepted back in March 2011 even though a discharge summary sent to the GP on 16 February 2011 recognised that the previous CMHT involvement with Ms Y may not have been in her best interests as it had fostered dependence and reinforced her maladaptive behaviour.¹²³ At this stage it would not have been unreasonable for a case conference of some kind to have been held to make a decision about the appropriateness of further CMHT medium and long-term care and treatment for Ms Y and how best to proceed.

Mr Z

12.108. The Independent Investigation Team did not find any issues of relevance pertaining to CPA and the care and treatment that Mr Z received. Mr Z was not diagnosed as having a severe and enduring mental illness. He was assessed by the CMHT in July 2008 and placed on Standard CPA whilst a referral was sought with the Psychological Therapies Service. This was considered by the Independent Investigation Team to be an entirely appropriate and evidence-based response.

Conclusions

12.109. The Independent Investigation Team concluded that CPA was neither understood nor implemented by the CMHT over time in keeping with successive Trust CPA and Care Planning policies. There was a general consensus between clinical and corporate witnesses that further work was required on an ongoing basis to improve the understanding of how best to implement CPA within the Trust.

12.110. It is not easy to understand why so much Care Coordination and CPA resource was allocated to Ms Y when it is doubtful that for much of the time she would have met the criteria for either 'Enhanced' or 'Standard' CPA. Neither is it easy to understand why Mr X, on the other hand, failed to meet the threshold for consistent Care Coordination and 'Enhanced' CPA even though he most certainly did meet the criteria from 2006 onwards. The Independent Investigation Team

123. Y notes 6 pp 123 - 125

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reflected upon the evidence that was presented by witnesses. It would appear that Ms Y was universally liked and could be viewed as a 'popular patient'. Mr X on the other hand was not described in such a warm or affectionate way. When a framework like CPA is not applied in a uniform manner, subjective decisions can often be made about thresholds and in this case it would appear that a valuable and limited resource was allocated to Ms Y and not to Mr X. This is of particular relevance as the decision to not work with Mr X in such an intensive manner was described by witnesses as being primarily resource, and not needs, led.

12.111. It is without doubt that the CMHT tried to provide a caring and comprehensive service. However the CMHT had a particular working ethos - there was a focus upon DBT coupled with an active avoidance of referring patients to the Crisis Service. The focus upon service users with Personality Disorders and the DBT model appears to have contributed to a displacement of professional attention from those with severe and enduring mental illness.

12.112. The evidence suggests that Mr X was not understood by the service. He was seen on a regular basis but he did not have a detailed diagnostic risk formulation and neither did he have a comprehensive care plan that addressed his wellbeing and recovery needs. This was unfortunate and would most certainly have affected both his quality of life and his vulnerability when actively psychotic.

12.113. The DBT track ceased (it is not clear when) as it was felt it was not safe to continue (this was due to resourcing issues). The Independent Investigation Team concluded that the DBT track in itself was innovative and offered a robust and evidence-based care and treatment pathway for service users with Personality Disorder. However such an intensive DBT programme, as operated by the CMHT, should have perhaps been provided by either an independent primary care or psychological therapy service. This would have left the CMHT the resource to have been able to provide robust CPA processes which is one of its foremost core functions.

12.114. The primary ethos within the CMHT was one of medical and therapeutic management. This appears to have taken place at the expense of robust medium and long-term holistic care planning that could address ongoing wellness and recovery needs. Service users with severe and enduring mental illness would not necessarily have been supported adequately by this model. The approach undertaken was not multidisciplinary or multiagency in nature and left Mr X in the situation where his Schizophrenia was left largely untreated and unmanaged for many years.

- ***Contributory Factor 3. The CMHT did not implement CPA in keeping with Trust policy guidance. This was exacerbated by the DBT service model as operated by the CMHT which required extensive input and reduced the capacity of the team. Whilst this did not have a direct causal link to Mr X's death it created the circumstances where his mental health was neither managed nor monitored appropriately and left him over time in a position of increased vulnerability especially when actively psychotic.***

- **Service Issue 1. CPA processes were weak and did not adhere to policy expectation.**

12.5. Risk Assessment

Context

12.115. 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.

12.116. 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.

12.117. 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.

12.118. 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.

12.119. *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.”¹²⁴*

12.120. 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.

12.121. 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,

124. *Best Practice in Managing Risk*; DoH; 2007

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or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Local Trust Policy (2004, 2008, 2010 and 2011)

12.122. The Trust Clinical Risk assessment policies and processes were (and are) aligned closely with those for the Care Programme Approach. The CPA policy stated that *“A good risk assessment depends crucially on the assessor having taken an adequate history and made an appropriate assessment. Where possible and appropriate information should be sought from the Service User’s Carer and other information or sources. Information from previous records should be sought...The CMHT Operational Policy provides guidance as to the importance of multi-disciplinary team discussion where a Service user poses a significant risk or is not responding to the treatment outlined in the care plan”*.¹²⁵

12.123. The Trust risk policy relevant to this Investigation was initially developed in 2004, amended in 2008, reviewed in 2009, 2010 and November 2011. The policy states that in order to be effective it has to be delivered by appropriately trained and supported clinicians working in conjunction with all other relevant clinical Trust policies and guidelines.

12.124. The policy documentation supported the Trust ethos of positive risk management and acknowledged that it is not possible to completely eliminate risk. It was written:

- *“Best quality risk assessments occur with the full involvement of the multi-disciplinary Team.*
- *Risk assessment must pay particular attention to the experience and opinions of both the service user and their carers.*
- *Risk assessment informs risk management and there should be a direct follow-through from assessment to management.*
- *Risk management must recognise and promote the patient’s strengths and should support recovery.*
- *The risk assessment involves clinicians making a judgement about risk in both the short-term (over one month) and the medium term.*
- *The documentation of risk should include the reasons why decisions are made about the degree of risk and also the management plans.*
- *A consultant psychiatrist must be included in all clinical decision making for service users who may pose a risk to children”*.¹²⁶

Trust Policy Guidance Prior to the Introduction of RiO (Trust Electronic Record System)

12.125. The policy stated that all service users should receive a risk screen within two weeks of the first contact with services, at each CPA review, following leave/admission, transfer, discharge, or when significant changes to mental state occurred. This risk screen had three fields:

125. Trust CPA Policy (2008-2010) p 39

126. Trust Risk Policy p 2 (post RiO)

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- suicide;
- harm to others;
- self neglect/vulnerability to abuse.

12.126. Following assessment, risks were recorded as being either “*low/minimal*” (when risk was thought to be either low or absent) or “*significant*” (when risk was thought to be at least moderate). The clinician was required to make a judgement about whether risks were deemed to be “*current*” (over the following month) or “*medium term*” (over the longer term).

12.127. The policy stated that if any one of the three risk domains were identified as being significant, in either the current or medium term, then a full risk assessment was indicated (the ‘Gold’ Risk form).¹²⁷

12.128. The policy stated that if a significant risk was identified then the Care Coordinator was required to complete a full risk assessment within four weeks (this changed in 2010 when the full assessment of risk was replaced with the RiO assessment form). At the point of discharge from an inpatient facility the ‘Gold’ risk assessment should be completed by the Named Nurse and Care Coordinator. Following the completion of the full risk assessment the formulation was expected to lead to an “*explicit management plan which sets out:*

1. *[What] specific treatment and interventions can best reduce the risk.*
2. *The management plan needed to reduce the risk.*
3. *Arrangements for monitoring the risk.*
4. *An explanation as to why decisions have been made.*
5. *The limitations of the risk management plan i.e. risk factors which cannot be reduced, together with the reasons for this.*

The management plan should identify circumstances under which risk is likely to be increased and the actions needed to reduce risk. These should include:

1. *Frequency and content of contact.*
2. *Arrangements for promoting compliance and engagement with treatment.*
3. *Pharmacological, psychological and social interventions.*
4. *Medical treatments and management of physical conditions/pain.*
5. *Plans to manage environmental factors (e.g. access to weapons or means of self-harm, need for single room, risk of falling).*
6. *Actions to manage stressors and any specific risk triggers.*
7. *Communications (including crisis contacts).*
8. *A contingency plan (incl. plans in the event of loss of contact with services) and poor compliance.*
9. *Advance statements where appropriate.*

Trust Policy Guidance Post the Introduction of RiO (Trust Electronic Record System)

12.129. Following the introduction of RiO (the Trust electronic record system) the five areas of risk to be assessed were:

127. Trust Risk Policy pp 4-5 (pre RiO)

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- *“harm to self*
- *harm from others*
- *harm to others*
- *accidents*
- *other risk behaviour”*.¹²⁸

12.130. The main difference between pre and post-RiO practice was the change from a two tier system (the risk screen and the full ‘Gold’ risk assessment process) to a single electronic risk assessment form. A risk assessment was advised at:

- the point of entry into service;
- on admission, leave, transfer and discharge from inpatients services;
- on readmission from unauthorised leave;
- at ICPA reviews;
- on transfer to different parts of the service;
- when downgrading a risk from ‘significant’ to ‘low’;
- when there were other significant changes in circumstances;
- when the difficult to engage patients’ policy was followed;
- when likely to resume/have contact with children.¹²⁹

12.131. Most of the post-RiO risk policy guidance remained the same as the pre-RiO policy guidance with the exception of the risk assessment documentation format. The Independent Investigation Team found the policy to be evidence-based and fit for purpose.

Findings

Findings of the Trust’s Internal Investigations (Health IMRs) and Serious Case Review

12.132. The Health investigations (IMRs) focused primarily upon safeguarding issues as this is a requirement of the Serious Case Review template. However key findings pertaining to generic risk included:

Mr X

- the GP practice had no knowledge of Mr X’s previous offending and this could have placed them at risk over the years – the CMHT did not pass this information on;
- Police National Computer (PNC) checks were not requested by the CMHT even though it was known Mr X had an offending history - this was found to be an omission. It was noted that Addictions Services would not have been expected to request PNC checks;
- Mr X’s potential vulnerability was not assessed by the CMHT;
- the CMHT incorrectly graded Mr X’s risk as low on 25 June 2009 when it was known that he had previous convictions and command hallucinations telling him to harm both himself and others;
- opportunities were missed to understand Mr X’s domestic stressors;
- it was noted that there are no formal risk assessment or planning processes in primary care and that this may have led to the GP not being aware of Mr X’s risks or what to do about them – however referrals were thought to be appropriate;

128. Trust Risk Policy p 2 (post RiO)

129. Trust Risk Policy p 2 (post RiO)

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- the Trust should have flagged up that Mr X was vulnerable to assault from Ms Y - this should have led to a safeguarding review;
- the IMR also states that Mr X had “*extensive criminal convictions for sexual and violent behaviour*”.

Ms Y

- MARAC processes were not followed up by the GP practice as there were no formal risk assessment procedures for domestic violence in primary care;
- Trust services did not refer Ms Y to MARAC as it was thought that she had capacity and could make this decision for herself; Trust services did not consider in full Ms Y’s risk of perpetrating domestic violence on Mr Z;
- there were missed opportunities to assess and manage Ms Y’s threats to unspecified neighbours in response to ongoing conflicts;
- Ms Y’s violence towards Mr Z, general threats towards men and knife carrying habits were not risk assessed appropriately;
- Ms Y was assessed as being at risk of suicide, self harm and domestic violence.

Mr Z

- there were no indications during the time Mr Z was receiving his care and treatment from the Trust that he was either perpetrating or subject to domestic abuse that would have necessitated a safeguarding plan.

12.133. The Health IMRs provide a breakdown of events however they do not offer an analysis that explains why services responded in the way that they did or what could have been done to provide better care and treatment packages. No consideration is given to underpinning systemic issues and no detailed examination of interventions is made against either local or national policy guidance.

12.134. The Serious Case Review report provides a chronology of events based upon the Health IMRs (please see above). The report found that there were multiple risk events recorded in relation to all three service users’ violent behaviour and ‘missed opportunities’ in relation to a MARAC referral not being progressed (regarding the ongoing domestic violence between Ms Y and Mr Z). There is a limited amount of analyses and no systemic issues are examined or particular lessons for learning identified in relation to the risk management provided by the NHS to all three service users.

Findings of the Independent Investigation Team

12.135. The Independent Investigation Team found that there were many *systemic* and *generic* issues relating to risk assessment and management within the CMHT that affected the quality of the care and treatment provided to all three service users, but principally to Mr X and Ms Y. The systemic and generic issues are as follows:

- 1. CMHT culture (including CPA):** The chapter subsection above sets out the issues relating to the non-adherence of the CPA process in the North Bournemouth CMHT at the time all three service users were receiving their care and treatment. A key function of CPA is to ensure that service users have regular risk assessments and management plans which are monitored and reviewed and shared between all relevant stakeholders. The Independent Investigation Team established that CPA processes did not provide a framework for central care and

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treatment provision and that risk assessment and management functionality suffered as a result.

This was compounded by an underlying ethos within the North Bournemouth CMHT that did not favour formal risk assessment processes. The reason behind this was a strong belief that many of the risks presented by service users with Personality Disorders could neither be mitigated against nor managed by traditional means. This belief appears to have moved the whole team away from structured risk assessment and management process. The Independent Investigation was told that professional thinking in the “*PD world*” was that risk assessment was a poor prediction of risk behaviour. This thinking prevailed in the CMHT and meant that risk was not regularly updated in a formal manner as the view was also held that service users with Personality Disorders were so unpredictable that this traditional approach would not be helpful. The focus was placed instead on expecting the service user to share the responsibility for their behaviour with the CMHT and there was a conscious move away from risk assessment into a therapy model that was hoped would help people to change and be better able to maintain safety.

Some witnesses told the Independent Investigation Team that they were uncertain as to whether or not the Trust had endorsed the approach that the North Bournemouth CMHT had taken. The Independent Investigation was able to ascertain that the Trust had invested in implementing the DBT track but that central oversight and regulation was lacking.

- 2. Assessment and corroborative information gathering:** The Independent Investigation Team found there to be a general lack of professional curiosity on the part of the CMHT about Mr X, Ms Y and Mr Z’s psychiatric and forensic histories. On viewing the clinical records of each of the three service users it was evident that Bournemouth-based treating teams did not have any clinical information that pre-dated the service users’ first entry to the service and no corroborative information appears to have been sought.

It was known by Trust services that Mr X, Ms Y and Mr Z each had a forensic history. Whilst it is noted that in November 2004 a ‘Prosecutor’s Printout’ was obtained for Ms Y, at no time was a PNC check acquired - even though this was a standard Trust expectation for CMHTs when working with service users with this kind of suspected background - and neither was a forensic psychiatry opinion considered. The forensic history of each of the three service users was extensive, and had this been known in full to the treating teams at an earlier date then a more proactive risk management stance would probably have been taken. The full forensic history of each service user is of great significance and should have been taken into account before any decision was made to provide a therapy-led approach to both assess and manage risk.

- 3. Formulation, risk management and multidisciplinary working:** The documentation examined by the Independent Investigation Team provided evidence to suggest that potential risks were identified by both the Addictions Service and the CMHT. It is relatively easy to track the ‘lists of risks’ that were identified over the years as part of ongoing risk screening processes for all three service users. However there is no evidence of a diagnostic formulation process

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and assessment of risk that took into account each service user's history and social circumstances. Neither is there evidence that these 'lists of risks' ever triggered a formal 'Gold Risk Assessment' (as indicated in the Trust's policy documentation) nor is there evidence that these risks were ever consolidated into a series of risk management plans.

Witnesses explained that the CPA process was not the main mechanism by which risk was managed. At interview witnesses described weekly CMHT meetings in which service users who were of concern could be discussed with the whole team. However whilst there were weekly meetings and the opportunity for case conferences we were told that time was "restricted" and that cases would get "bumped back". Some witnesses described a culture that prevented risks being discussed in a multidisciplinary forum and the reluctance to discuss cases was exacerbated by time pressures. In the event most risk assessments and management processes were managed by lone Care Coordinators in isolation from the rest of the multidisciplinary team.

4. **Information sharing between services and agencies:** Over time both the Addictions Service and the CMHT, as separate entities, gained a degree of understanding about the risks posed by Mr X, Ms Y and Mr Z. However these risks were not routinely shared between one service and another; it is of particular note that the GP Practice was not always kept informed regarding the risks posed by the service users as new information presented itself. It is evident from an examination of the chronology that services passed on information (albeit of a limited kind) during the referral process; however communication was focused on this stage of the pathway and was not maintained.
5. **Multi Agency Public Protection Arrangements (MAPPAs), MARAC and Domestic Violence:** MAPPAs are the statutory arrangements for managing sexual and violent offenders. MAPPAs do not constitute a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated way. Agencies at all times retain their full statutory responsibilities and obligations. MAPPAs were introduced by the Criminal Justice and Courts Services Act 2000 and were strengthened under the Criminal Justice and Courts Act 2015. In practical terms this duty imposes the following obligations:
 - a general duty to cooperate in the supply of information to other agencies in relation to risk assessment and risk management;
 - a duty on professionals to consider, as part of the care planning process, whether there is a need to share information about individuals who come within the MAPPAs criteria;
 - the need to develop protocols between agencies for exchanging information and other forms of cooperation.

There are three levels of MAPPAs management. They are based upon the level of multiagency cooperation required with higher risk cases tending to be managed at the higher levels ('1' being low and '3' being high). Offenders are moved up and down levels, as appropriate. Mr X was on Level One which was the 'ordinary agency management'. This level is for offenders who can be managed by one or

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two agencies (e.g. police and/or probation/health). It should involve sharing information about the offender with other agencies if necessary and appropriate. Mr X had also been placed on the Sex Offenders register for seven years following his second sex offending conviction. This information appears not to have been known by Health services. It represents a significant omission on the part of all of the agencies involved.

The Independent Investigation found that at the time of Mr X's second release from prison in 2006 (November) the police were searching for him as he had gone missing and they were concerned about his mental health. At this point the police were in contact with the CMHT to whom he had been referred. This was an opportunity for Health Services to have been engaged with the MAPPA process because at this stage both police and health services understood Mr X's ongoing risks were related to his mental health; this was as a direct result of the forensic psychiatry assessment that had been conducted whilst Mr X was in prison. Unfortunately MAPPA was not pursued and neither service took the opportunity to learn more about Mr X; a simple set of conversations at this stage could have made a great deal of difference to the future course of Mr X's care, treatment and risk management.

The Multi-Agency Risk Assessment Conference (MARAC) is a monthly risk management meeting where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan. Over time the CMHT was aware of the ongoing domestic violence between Ms Y and Mr Z. Ultimately it was considered by the team that Ms Y did not meet the threshold of being a vulnerable adult and she was encouraged to raise a MARAC alert in a self-directed manner. This was a reasonable stance to take, but it would have been good practice for the CMHT to have made contact with the police in order to share information at this stage. Had this been achieved then the full extent of the domestic violence between the two service users would have been understood better and a risk assessment process/support plan developed.

- 6. Training and the RiO system:** At interview few of the witnesses when asked knew about the Department of Health's *Best Practice in Managing Risk* (DoH June 2007) guidance. It was also evident that many key members of staff from the CMHT had not attended risk assessment and management training in recent years and that their understanding of Trust policy documentation was weak.

Trust Service Managers told us that they thought risk assessment and management processes still represented a challenge. Whilst RiO (the Trust's electronic clinical record system) had been adopted and training provided, risk assessment processes still required a more in depth approach to be taken, especially around formulation and risk management planning.

12.136. In addition to generic and systemic issues there were also issues that were specific to each of the three service users. These are set out below.

Mr X

12.137. It is evident when examining the chronology that Mr X had an extensive forensic history. It is also evident that what Health Services knew about him differed

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quite considerably from what the police service knew. Following Mr X's death the Serious Case Review was given access to PNC information. At this juncture it was known that he had 24 convictions relating to 42 offences. These 42 offences can be broken down into; six offences against the person, two sexual offences, 19 theft offences, two public order offences, nine offences against police and the Courts, two drug offences and two offensive weapon offences. He was first convicted in 1993.

12.138. However there were several opportunities that occurred prior to Mr X's death when services could have worked together to understand Mr X better. In August 2004 Mr X was noted to be expressing paranoid thoughts of a delusional nature. The plan was for both a psychological and psychiatric review. On 2 September it was decided to refer Mr X to the CMHT so that his mental state could be assessed; Mr X was not happy with this plan and so the decision was deferred. By 24 September Mr X had reached week 82 of his programme. Mr X reported using Heroin for the first time in many months. The trigger had been stress in relation to a pending Court appearance. He was facing numerous charges related to numerous offences - some of which were possibly of a violent nature. Mr X gave permission for the service to talk to his solicitor and was made aware that this was necessary for risk assessment purposes. It was planned to send the risk assessment to the CMHT along with a referral. Mr X gave his permission.¹³⁰ This was good practice. However it would have been better practice to have followed this up in a more proactive manner – in the event nothing further was done.

12.139. When Mr X was in prison in October 2006 a detailed forensic psychiatry assessment was conducted. This assessment made it quite clear that Mr X was suffering from Schizophrenia and that he had probably been mentally unwell for a considerable period of time. The assessment also stated the view of the Forensic Psychiatrist that Mr X's criminal behaviours had by and large been psychotically driven and that he would require CMHT follow up on his release from prison. Mr X was eventually followed up by the CMHT in December 2006 but appears to have been lost to secondary care mental health services until January 2008. By this time all knowledge of the forensic psychiatry assessment conducted in 2006 appears to have been lost.

12.140. Once Mr X re-entered secondary care mental health services in 2008 risk assessment processes were weak. On several occasions Mr X stated that his voices took the form of command hallucinations which told him to harm others and harm himself. This was recorded on:

- 26 January 2009 (on this occasion the plan was to obtain a PNC check as the voices were telling Mr X to commit murder - this was not done);
- 17 December 2009 (Mr X was experiencing command hallucinations telling him to harm himself and others);
- 22 December 2009 (when it decided to share risk information with the Addictions Service - this did not include his sex offending history);
- 23 May 2011 (a PNC check was sought due to Mr X's "*murderous fantasies*" – it is not clear what happened to this information).

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12.141. Alongside the information the CMHT knew about Mr X's command hallucinations went an understanding (albeit limited) about his contacts with the criminal justice system. The CMHT listed what was known about Mr X's offending history on a regular basis, often alongside what was known about his command hallucinations. At no stage were full or 'Gold' risk assessments conducted and/or a multidisciplinary/agency review considered. It was poor practice for the information regarding Mr X's prison assessment to have been 'lost' to the CMHT. It is apparent when examining the Serious Case Review documentation that the police had also 'lost sight' of this information. This meant that during their numerous contacts with him (when conducting the sex offending checks and following various domestic incidents) there was no understanding of Mr X in the light of his Schizophrenia.

12.142. On an entirely different but no less significant note, is the issue of Mr X's vulnerability. Whilst Mr X may not have met the threshold in the legal sense as being a 'Vulnerable Adult' his mental illness on frequent occasions lessened his insight and increased his high risk behaviours. It is evident from reading through the documentation made available to the Independent Investigation Team that he often neglected himself and that his living conditions were not optimal. Mr X's psychosis often led him to make poor decisions and made a significant contribution to aggressive and volatile behaviour. This aspect of Mr X's presentation was understood poorly and should have been subject to a detailed assessment in conjunction with a diagnostic formulation and risk management plan.

Ms Y

12.143. A great deal of Ms Y's risk related information, as recorded by primary care, the addictions service and the CMHT, was sourced from her self-reported social history. Ms Y claimed to have been abused as a child by both her mother and father and to have perpetrated three separate stabbing incidents - one of which had included a murder charge which had been apparently dropped due to a lack of evidence. The Independent Investigation Team found it remarkable that none of these self reports were rigorously and independently investigated by any of her treating teams and that no PNC checks or corroborative evidence was sought (save a 'Prosecutor's Printout' in November 2004). Ms Y was 42 years of age when she first came to the attention of Bournemouth-based services in April 1998. Both her primary care and other clinical records appear to have commenced from this point; there is no background history contained within them. The Independent Investigation Team was of the view that an individual with the consistently chaotic presentation Ms Y had would most probably have had an extensive psychiatric history prior to her arrival in Bournemouth. This was not sought and this was a significant omission.

12.146. As early as 14 March 1998 it would appear that services knew about Ms Y's violent past which included both a stabbing and dealing drugs with violence. Whilst this era pre-dated the Police National Computer system her risks should perhaps have been identified and a more proactive psychiatric history sought at this stage. It is difficult to consider what the best course of action would have been when examining the norms and appropriateness of clinical practice in 1998. However this information, when coupled with her behaviour throughout the next decade should have triggered a more proactive stance with regard to risk assessment.

12.147. During the earlier years of Ms Y's contact with secondary care services it would appear that, whilst no in-depth risk assessments were conducted, a more

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proactive stance was taken in relation to her potential risk of violence. An example of this is when Ms Y was admitted to an inpatient facility in November 2004. On this occasion she was aggressive and waved a knife towards the admitting doctor and nurse in a threatening manner. It was noted that she routinely carried a locked hunting knife with her and that she had carried out previous assaults when under the influence of alcohol and drugs. At this stage the police were involved and the Bournemouth Forensic Team provided a 'Prosecutor's Printout' which noted Ms Y had seven convictions for drug offences. This was good practice. However it is unfortunate that this level of follow up was not pursued once Ms Y was discharged from the inpatient ward back into community-based services.

12.148. The Chronology in Chapter 10 and Timeline in Appendix One demonstrate that a great deal was recorded about Ms Y in relation to her risk profile. It is not necessary to list everything here; however there are several key events/issues that require further examination.

1. Ms Y was known to carry weapons and by her own admission had been involved in three stabbing incidents - proving that she not only carried weapons but used them.
2. Ms Y had a Personality Disorder, substance misuse issues and considerable social functioning deficits.
3. Ms Y had impulse control issues and could not control her temper. She was known to be volatile and aggressive especially when under the influence of alcohol and drugs.
4. Ms Y had ongoing issues with men in general and often focused her violence on them when aroused.
5. Ms Y was in a chaotic and dysfunctional long-term relationship with her partner Mr Z necessitating a high degree of police intervention. She was noted to be both the victim and perpetrator of extreme physical violence in the home. For example: it was her increasing levels of violence towards Mr Z that had led to a GP referral being made to secondary care services in November 2004 which in turn led to her inpatient admission (please see directly above).
6. Ms Y had made several suicide and self harm attempts.
7. Ms Y had a son who was under the age of 18 years for much of the time she was receiving care and treatment from the Trust. Whilst he did not live with her it was known that he came to stay with her on occasions and that both Ms Y and Mr Z were abusing street drugs and in a violent relationship.
8. Ms Y had an elderly mother with whom she had a troubled relationship. On occasions Ms Y went to stay with her frail elderly mother to 'look after her'. No consideration was given to the vulnerability of Ms Y's mother and any potential for physical, emotional or financial abuse being perpetrated by Ms Y.
9. Ms Y was known to have made complaints about a noisy neighbour. On 23 October 2009 she said she had had a difficult week and that she had "*nearly stabbed a neighbour due to disputes*" (presumably Mr X). On 12 April 2012, only a few weeks before Mr X's murder, Ms Y telephoned the Duty Team at the CMHT to say that she had visual thoughts of slashing someone. She did not specify who.

12.149. Despite what was known about Ms Y and her violent and impulsive behaviour she was primarily viewed through the lens of being a 'victim' a great deal of the time.

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Her potential risks to others, for example Mr Z, her son, her mother and the unknown neighbour - Mr X, were never properly identified and so were neither assessed nor managed. Based on what was known and should have been known this was remiss.

12.150. Over the years the CMHT was consistent in the view that Ms Y was responsible for her own behaviour. The DBT track ethos was very much about supporting service users to change their behaviour and work in partnership with services. This was good practice. However secondary care mental health services retain a duty to protect: service users; families, health and social care staff and members of the public. Ms Y's risk profile, as can be seen in the numbered bullet points above, was complex and extensive. As the decision had been taken to retain Ms Y within secondary care mental health services the responsibility to work within a structured and multiagency CPA and risk assessment framework was also retained.

Mr Z

12.151. Mr Z has 10 convictions for 12 offences, these are broken down as; one offence against property, two theft offences, seven offences against police and courts and two miscellaneous offences. He was first convicted in 1991.

12.152. Mr Z had a less intensive input from secondary mental health services than did either Mr X or Ms Y. Mr Z had a history of alcohol and substance misuse, self harm attempts and depression; he also had a diagnosis of Emotionally Unstable Personality Disorder. It was known from Mr Z's self reports that he was in an unstable relationship (with Ms Y) that he wanted to end and that he needed help in order to move on. His risk behaviours were listed as being:

- binge drinking;
- bulimic behaviours;
- shoplifting, gambling, impulsive and potentially harmful sexual behaviour (not made explicit);
- drug abuse and dangerous driving.

12.153. It was not possible to undertake a full analysis of the risk assessment and management processes that Mr Z was subject to as he was with secondary care mental health services for a limited period of time. However based upon what has been given to the Independent Investigation Team it would appear that assessment and care planning process was limited and that no exploration was made regarding the ongoing domestic violence between him and Ms Y.

Conclusions

12.154. All three service users had mental health problems, substance misuse difficulties and social functioning deficits. Set alongside this was a significant history of criminal offending often involving acts of violence and general public disorder. Individually and collectively all three presented consistently high levels of risk to both themselves and to others. As can be seen from the findings set out above, a great deal was known about Mr X, Ms Y and Mr Z. The additional information that has come to light since the death of Mr X could easily have been accessible had mental health services liaised with the police in a more assertive manner as was indicated over the years. This additional information would have served to highlight the need for an additional focus on both risk assessment and management.

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12.155. Risk assessment and management processes were reactive and it is clear that formal multidisciplinary and multiagency working did not occur. The Independent Investigation Team concludes that systemic, generic and service user specific failures occurred against a backdrop of general poor policy adherence and communication and liaison processes.

12.156. Activity levels were high and it is evident that the treating teams over the years were hard working and committed to the service users that they provided care and treatment for. However formal processes were not adhered to and this removed essential basic building blocks of care that would have provided a robust safety framework for the high risk service users that services were working with. Whilst risk can never be entirely removed when working with individuals such as Mr X, Ms Y and Mr Z, local and national evidence-based guidelines have been developed in order to ensure that a systematic approach is taken and that everything that can conceivably be done is identified and put into place. Whilst these guidelines are in operation NHS-based treating teams should adhere to them and Trust governance functions should ensure compliance.

12.157. It was good practice for the CMHT to consider the responsibility for risk behaviours jointly with service users. However this ethos on its own does not remove the duty to protect that secondary care mental health services retain. The CMHT should have adhered to the Trust's CPA and risk assessment policies and ensured that Mr X, Ms Y and Mr Z had robust risk assessments and management plans in place. As part of this process it would have been entirely appropriate for the CMHT to have made explicit any limitations the process had in relation to specific service users and to have identified any risks that could not be mitigated against by Health Services. At this juncture it would have been good practice to have discussed those risks and limitations (especially if they were in relation to violence) with the police.

12.158. The Independent Investigation Team concludes that risk assessment and management processes were not adequate and left the risks of Mr X, Ms Y and Mr Z without formulation and robust management planning. The Investigation also concludes that Mr X's psychosis often led him to make poor decisions and this made a significant contribution to his aggressive, volatile and, at times, antisocial behaviour. The failure to both identify and manage Mr X's risks made a contribution to the increased likelihood that a violent incident of some kind could have been predicted in the future. Had Mr X's Schizophrenia been managed better then it is reasonable to assume that more work would have been undertaken in order to control his psychotic symptoms. This in turn should have increased his social functioning and reduced the antisocial behaviour which often led to altercations with the people around him. The Independent Investigation Team however makes no causal link between the lack of risk assessment and Mr X's death.

12.159. The reason no direct causal link has been made is because it is evident that the actual homicide of Mr X did not occur due to any mental health deficits regarding Mr X, Ms Y or Mr Z. At the time Mr X was killed all three service users were experiencing a high degree of stability regarding both their mental health and social functioning. The Court convicted Ms Y and Mr Z of murder and no mitigation based on the mental health of the three service users was accepted.

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- **Contributory Factor 4. Mr X's risks and resulting antisocial behaviour were not understood fully in the context of his Schizophrenia. This meant that no strategies could be developed to maintain his safety and the safety of those around him.**
- **Service Issue 2. Risk assessment and management processes were weak and did not adhere to policy expectation.**
- **Service Issue 3. Interagency working was weak and important opportunities were missed in relation to MAPPA and information sharing.**

12.6. Referral and Discharge Planning

Context

12.160. 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.

Findings

Findings of the Trust's Internal Investigations (Health IMRs) and Serious Case Review

12.161. This aspect was not examined by either the Health IMRs or the Serious Case Review. However the Health IMRs do state that primary and secondary care services were readily available to each of the three service users.

Findings of the Independent Investigation Team

Referral

12.162. Referrals were made by primary care, the CMHT and Prison Services over the years. Not surprisingly most of the referrals were made by primary care and these took place in an entirely appropriate and timely manner. Referrals were made to Psychological Therapy Services, Addictions Services, the CMHT and inpatient services.

12.163. At the point of referral services provided a summary of the information held for each of the three service users. When examining the care pathways of Mr X, Ms Y and Mr Z it appears that this juncture was when the bulk of assessment and risk information was communicated. The Independent Investigation Team found nothing of note in relation to the referral process provided to either Ms Y or Mr Z.

12.164. However the referral made by the Prison Service to the North Bournemouth CMHT in October 2006 did not work well. Despite a letter being written to Consultant Psychiatrist 1 and a referral being made, Mr X was lost to service for several weeks following his release from prison. Whilst it is evident that Mr X was eventually assessed by the CMHT in December 2006 it appears that he was lost to service

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once again until he was re-referred by his GP in January 2008. The Independent Investigation Team was told that the prison discharge system is still not robust and requires further work.

12.165. The Independent Investigation Team was told that the Bournemouth Assessment Team (BAT) triaged all referrals made to the addictions service. The BAT and Bournemouth Community Addictions Service (BCAT) had huge caseloads and were not mental health professionals. *“Those people were qualified in addictions but weren't necessarily all professionally qualified, for instance. So although the local treatment system puts on risk training for them they don't necessarily have that kind of background of training that someone from a professional background would have”*. When interviewing witnesses and reviewing the clinical records it became evident that not all risk information had flowed through the BAT and onto the BCAT in an effective manner. This meant some of Mr X's risk information was not been shared in full during the referral process.

Discharge

12.166. It was a consistent feature of all three service users to periodically disengage from service. This would nearly always lead to the decision to discharge them back to the care of the GP. At this point detailed information about risk was not always provided as part of the discharge summary and risk assessments were not usually conducted in keeping with the Trust's risk policy.

12.167. It is evident that both Ms Y and Mr Z had the capacity to decide whether or not they wished to continue with secondary care services. Their decision to disengage was always recognised and they were always accepted back into service when they were ready to re-engage.

12.168. Mr X also periodically disengaged from service and would be lost to follow up by default and/or actively discharged. Mr X had Schizophrenia and was understood to be paranoid about receiving services much of time. There was no consideration about an Assertive Outreach approach as an alternative to discharge. This approach might have prevented the long gaps between Mr X's engagement with service when his mental health was subject to decline.

Conclusions

12.169. The Independent Investigation Team concludes that referral and discharge processes were by and large unremarkable. However prison referral and discharge processes were ineffective and require an ongoing review. We were told that the BAT and BCAT triage and referral system has now changed due to service reconfiguration.

- ***Service Issue 4. Prison referral and discharge processes were not robust in the case of Mr X. The Independent Investigation Team was told that these processes are still problematic.***

12.7. Safeguarding

Context

National Context

12.170. Safeguarding Adults is a responsibility placed on Local Authorities by 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, the NHS and the police, to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice. The Department of Health issued its guidance No Secrets in 2000. This guidance notes:

“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”.

12.171. Following national consultation in October 2008, 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. By 2010, Local Authorities were expected to have an Adult 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 familiar with adult safeguarding policies and procedures.

12.172. There was a clear expectation from the Department of Health that No Secrets would apply to all statutory agencies; however it took sometime before it was fully implemented in the NHS. In the preamble to the Safeguarding Adults: A National Framework of Standards it is noted that:

“All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include Article 2: ‘the Right to life’; Article 3: ‘Freedom from torture’ (including humiliating and degrading treatment); and Article 8: ‘Right to family life’ (one that sustains the individual).

Any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse. It follows that all citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services”.

Local Policy in Place at the Time Mr X, Ms Y and Mr Z were Receiving Care and Treatment from the Trust

12.173. The Bournemouth Dorset and Poole Multi-Agency Adult Safeguarding Policy uses the term ‘Adult at Risk of Abuse’ in preference to vulnerable adult. This policy echoes the national guidance defining a person at risk of abuse as:

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“... an adult aged 18 or over years or over who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself, or unable to protect him or herself from significant harm or exploitation”.

12.174. An adult at risk may therefore be a person who:

- is frail due to age, ill health, physical disability or cognitive impairment;
- has a learning disability;
- has a physical disability and/or a sensory impairment;
- has mental health needs including dementia or a personality disorder;
- has a long-term illness/condition;
- misuses substances or alcohol;
- is a victim of domestic violence or abuse;
- is a carer such as a paid or unpaid family member/friend who provides personal assistance and care to adults and is subject to harm;
- is unable to demonstrate the capacity to make a decision and is in need of care and support;
- is aged 18 or over and is continuing within the Special Education system.

12.175. The policy emphasises that this list is not exhaustive. It also notes that a person should not be considered vulnerable or at risk merely because s/he fits into one of these categories. Vulnerability is seen as related to how able an individual is to make and exercise his/her own informed choices, free from duress, pressure or undue influence of any sort and protect themselves from harm, neglect or exploitation. The policy adds that people with capacity can also be at risk.

12.176. The policy identifies what sort of actions and omissions might constitute abuse. These are listed below:

- hitting, injuring or restraining;
- threatening, intimidating or humiliating;
- sexual attention or activity that is not wanted;
- not giving the correct medicine;
- not providing food or clothing;
- not arranging the right care;
- keeping someone on their own;
- stealing or misusing money or property;
- pressure about wills or inheritance;
- treating someone less favourably because of race, ethnicity, religion, age, gender, disability or sexual orientation.

12.177. Where a safeguarding concern exists the local policy has a seven-stage response process, which runs from raising an alert and responding to that alert, through to multiagency investigation of concerns and developing plans, to first and second stage reviews of safeguarding plans and arrangements.

The policy identifies that 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;

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- staff who deal directly with safeguarding will pick up the referral and respond to it (within a short agreed timescale, for example four hours in an emergency situation) in order to ensure the safety of the individual;
- immediate action/referral to the Police if necessary will take place where a crime has been committed; they 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 will be put in place, after discussion with the individual;
- investigation would occur;
- 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 would be closed once the issue had been resolved and ongoing safety assured.

Mental Health and Safeguarding

12.178. It is recognised that in the context of safeguarding adults, people with mental illness can have fluctuating mental capacity to make decisions in relation to their own safety. The Mental Capacity Act (2005) and the Mental Health Act (1983/2007) are available to help protect the individual who may be vulnerable, lack capacity to make an informed decision or present a risk to themselves or others.

Findings

Findings of the Trust's Internal Investigations (Health IMRs) and Serious Case Review

12.179. This section of the report should be read in conjunction with the three Health IMRs and the Serious Case Review report. The safeguarding issues for all three service users have been examined during the Serious Case Review. The terms of reference for the Independent Investigation do not require a duplication of this investigative process and safeguarding is only to be considered in a “wider” context.

The Serious Case Review

12.180. The findings of the Serious Case Review in summary conclude that all agencies ought to have been aware of:

1. Mr X's psychotic behaviour and alcohol/drug habits.
2. Mr X's antisocial behaviour.
3. Ms Y's violent history.
4. Ms Y's consistent threats to Mr X.
5. Mr Z's frequent violence to Ms Y; and
6. The close proximity of Ms Y and Mr Z to Mr X together in the same block of flats.
7. The Housing relocation requests and their urgency.

12.181. The Serious Case Review reports states in relation to Mr X:

“There is no evidence of a seamless service between addiction services and mental health services. Only one communication relating to X was forthcoming between the Mental Health and Addiction Services, the Police

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and housing. All four organisations appeared to be functioning in total isolation in relation to X”.

12.182. The Serious Case Review reports states in relation to Ms Y:

“Y had a history of borderline personality disorder, alcohol misuse and illicit drug use. Y also had a history of threats of violence and had, on several occasions threatened X. Y had also been found in possession of a knife on at least two occasions.

No communication relating to Y was forthcoming between the Mental Health Services and the Police. Both organisations appeared to be functioning in total isolation in relation to Y.

There were serious failures in communicating requests for Y to be relocated. Three communications from the health agencies appear not to have reached housing authorities”.

12.183. The Serious Case Review reports states in relation to Mr Z:

“Z had a history of alcohol abuse, illicit drug use and borderline personality disorder. Z was violent towards Y on a regular basis, often at Flat A, 4 Anyplace Road”.

12.184. The Serious Case Review does not consider whether or not Mr X, Ms Y or Mr Z either could, or should, have been regarded as vulnerable adults, or ‘Adults at Risk’ as defined in the local Safeguarding Policy. Neither does the Serious Case Review report discuss Safeguarding legislation, local policy, threshold criteria or local management processes. It is therefore not possible to understand whether the Review established any short fallings in these areas.

12.185. Conclusions and recommendations focus upon:

1. Risk assessment and management: partner agencies are required to review the effectiveness of CPA with particular regard to information sharing, communication, multidisciplinary working and risk assessment.
2. CPA: all CMHTs should ensure that they are fully implementing the principles of CPA including multi-disciplinary/ agency CPA reviews involving all relevant agencies engaged in the patients health, social, housing and offender care and informed by up to date risk assessments.
3. Assertive follow up should take place following prison referrals.
4. Staff were to be reminded as how to initiate the MARAC process.
5. Data Sharing and inter-agency communication: all agencies should revisit their internal communication processes and evaluate their effectiveness. All agencies should urgently consider how inter-agency communications can be enhanced. This is especially important in situations where violence by or to other individuals is assessed as a potential risk.

The Health IMRs

12.186. The Health IMRs consider safeguarding and vulnerability in a little more detail than the Serious Case Review. For example, it was noted that all GP and secondary care services received the 2011 safeguarding policy and that awareness raising was carried via practice nurses and a Lead Adult

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Safeguarding Nurse. It was also noted that the Trust has in place ongoing training for safeguarding and capacity and that there are lead Trust safeguarding post holders who work closely with the Local Authority.

Mr X

12.187. The Health IMR for Mr X points out that he was usually viewed as being at risk of harming others rather than of being harmed himself. Mr X's sex offending and criminal past was mentioned in the report (however it was not mentioned that neither primary nor secondary care health services knew about the sexual offending until after his death).

12.188. The IMR pointed out that Ms Y had made threats towards Mr X (however the report does not make it clear that services did not know Ms Y was referring to Mr X). Based on the evidence available to them health services did not consider Mr X to be a vulnerable adult.

Ms Y

12.189. The Health IMR examined Ms Y's accidental injuries and vulnerability of self neglect through the lens of both primary and secondary care assessment. It was concluded that services had both the experience and knowledge to have acted appropriately on Ms Y's behalf. It was recognised that primary care did not have a formal risk assessment process for domestic violence but it was also noted that Ms Y did not wish to discuss her home situation in detail. However a good example of intervention was provided regarding the GP referral of Ms Y to secondary care services in November 2004 due to her extreme aggression and violence towards Mr Z.

12.190. The IMR identifies that Ms Y was not considered to be significantly vulnerable by primary care and that for this reason insufficient risks were identified in relation to MARAC. It was also identified that secondary care services paid insufficient detail to safeguarding in the light of the risks Ms Y presented to Mr X, particularly in the light of the threats she made about him.

12.191. The IMR for Ms Y discusses the fact she was deemed to have the capacity to initiate MARAC process for herself if she had wanted to. There is no discussion in the report in relation as to whether or not she met the 'Adult at Risk' threshold as set out in the Bournemouth Dorset and Poole Multi-Agency Adult Safeguarding Policy

Mr Z

12.192. The Health IMR identified that primary care services were not aware of any domestic violence involving Mr Z. Mr Z and Ms Y saw different GPs and the connection between them was never made. The IMR also states that secondary care services had no idea about Mr Z and any domestic violence he might have been involved in and that there was no evidence to suggest he was a vulnerable adult, subject to abuse, or likely to perpetrate abuse.

Findings of the Independent Investigation Team

12.193. The Health IMRs and Serious Case Review identify issues relating to CPA, risk assessment, interagency working and information sharing. Domestic violence and the management of MARAC processes are also detailed. The Independent

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investigation concurs with these findings. It is not clear however why the issues specifically relating to safeguarding, capacity and vulnerable adults were not directly addressed.

12.194. When the Independent Investigation interviewed witnesses most said that they did not think Mr X, Ms Y or Mr Z met the threshold to be considered as Vulnerable Adults and that safeguarding processes would not have been appropriate. Based on what was known by services this may *not* have been an adequate response. The Bournemouth Dorset and Poole Multi-Agency Adult Safeguarding Policy uses the term 'Adult at Risk of Abuse' in preference to vulnerable adult. This is a helpful distinction and it is evident from the criteria (as set out in paragraph 12.174 above) that on occasions all three service users, and Mr X in particular, did in fact meet the criteria.

12.195. It is uncertain how safeguarding processes could have been used to better effect to support Mr X, Ms Y and Mr Z in the community. However it would have been reasonable to have expected a multiagency approach to have been taken (incorporating health, the police and housing) to have promoted their safety.

12.196. The Independent Investigation will not re-rehearse the findings and conclusions of the Health IMRs and the Serious Case Review. However there are four issues that were not considered appropriately and these are set out below.

- 1.** Ms Y had a son who was under the age of eighteen during the early years both she and Mr Z were receiving care and treatment from the Trust. It was known that he came to stay with her and Mr Z when they were both addicted to street drugs and living a chaotic lifestyle. No child safeguarding assessment was considered. The Independent Investigation notes that this visit took place early on in the couple's care and treatment when child safeguarding processes were not as rigorous as they are now.
- 2.** Ms Y had an elderly mother who was unwell and lived in Devon. Ms Y went on a prolonged visit in order 'to look after her'. It was known that Ms Y had a difficult and volatile relationship with her mother and that services had often advised her to stay away from her due to the difficult dynamic. Safeguarding should have been considered in relation to any potential physical, emotional or financial abuse of her mother. In August 2007 it was recorded in Ms Y's CMHT record that the visit to her mother had been stressful and that she was going to be subject to some kind of Court appearance in Devon. There was no further exploration of this. On 18 February 2010 Ms Y visited her mother again and telephoned the CMHT to say she was experiencing nightmares because being around her mother had triggered stressful memories; she was advised to contact a local GP. Once again there was no further exploration of this.
- 3.** Mr Z suffered from mental health problems and severe epilepsy. He had described being in a volatile relationship with Ms Y, one that he wanted to escape from. Even though the police were involved following sustained attacks upon Mr Z by Ms Y (for example in November 2004 these attacks were severe enough to warrant Ms Y's admission into an inpatient unit as she could not control her violence) he was never seen as a victim of domestic violence. Services never

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sought to provide a carer assessment for him which would have been totally appropriate in the circumstances. This was a significant omission.

4. Mr X's sex offending was not known to either primary or secondary care services. Better interagency working could have revealed this so that any risks pertaining to female Health workers, children living in his block of flats, and female neighbours could have been evaluated and managed if necessary. Whilst the nature of the offending was of a relatively low level and connected to Mr X's psychotic state it is a demonstration that the system failed regarding its ability to communicate important information that should have been shared in order to safeguard staff and members of the public.

Conclusions

12.197. The Independent Investigation Team concludes that the Bournemouth, Dorset and Poole Multi-Agency Adult Safeguarding Policy is a clear, evidence-based and useful document. It could be argued that Mr X, Ms Y and Mr Z on occasions all met the criteria for an 'Adult at Risk of Abuse'. Whilst the use of safeguarding process was not as clearly indicated as MAPPA, MARAC, risk assessment and CPA, it would have provided a useful additional framework to have assessed vulnerability and risk against.

12.198. The Independent Investigation Team concludes that whilst adult safeguarding process could have been selected as an appropriate vehicle by which to manage the vulnerability and risk of Mr X, Ms Y and Mr Z the decision not to do so did not make a contribution to the death of Mr X.

12.8. Interagency Working

Context

Drug and Alcohol Action Team (the following information has been taken from the DAAT website)

12.199. The Drug and Alcohol Action Team (DAAT) is the local multi-agency strategic partnership responsible for implementing the National Drugs Strategy across the Borough of Bournemouth and support the implementation of the Alcohol Strategy. Together with Public Health, who moved into the local authority on 1 April 2013, the DAAT will also contribute to the Public Health Outcomes Framework. The DAAT is also the accountable body for reporting nationally to Public Health England on local performance against the national picture.

12.200. There is a requirement of each Local Authority area to have a substance misuse commissioning team to ensure coordination, effective contracting and integration of services across the main aims of the National Strategy. Through the DAAT Executive Board, the partnership undertakes to:

- work with the community to identify the key local issues around drug misuse;
- prepare local actions plans and strategies to tackle drugs;
- commission treatment and other interventions to help people who have problems with substances;
- support partners in delivering alcohol interventions;

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- tackle issues around drug supply and crime and disorder related to drug use;
- promote and develop the recovery agenda to assist service users to contribute positively to the local community; and
- provide a range of interventions through Schools and Children's Services that help children and young people deal with substance misuse.

Findings

Findings of the Trust's Internal Investigations (Health IMRs) and Serious Case Review

12.201. The Serious Case Review found interagency working to be of a poor standard and this was a key finding; the report stated: *"There is no evidence of a seamless service between addiction services and mental health services... Only one communication relating to X was forthcoming between the Mental Health and Addiction Services, the Police and housing. All four organisations appeared to be functioning in total isolation in relation to X"*.¹³¹

12.202. The Health IMRs found that there was some evidence of communication between the CMHT, Addiction Services and Primary Care but that this was not as consistent as it could have been with the GP not always being informed of all CMHT and Addiction Service activity. Other aspects of interagency communication and working were not examined in detail.

Findings of the Independent Investigation Team

12.203. The Independent Investigation Team concurs with the findings of both the Serious Case Review and the Health IMRs. It is evident that interagency arrangements such as MAPPA, MARAC and safeguarding were not initiated, and with the exception of the MAPPA arrangements, this was not unreasonable. However the decision not to initiate these approaches meant that services were principally reliant on CPA to coordinate the sharing of information and to ensure interagency working was managed in a seamless way. As has already been ascertained in Section 12.4 above a CPA did not operate at an optimal level and was therefore unable to promote interagency working.

12.204. During the course of this Investigation it became clear that services in Dorset have been working together to improve interagency communication and working since the death of Mr X. A good example of this is the 2014 joint working processes developed by the Trust with Dorset Police and associated Criminal and Youth Justice Partners (please see Appendix Two).

12.205. However of concern is the ongoing lack of communication and shared working arrangements between Addictions and Health Services. Prior to the death of Mr X Bournemouth Addictions Services formed part of the Trust's provision. The Independent Investigation was told by witnesses that even when these services were managed by the Trust ongoing communication processes were poor and that dual diagnosis pathways were never agreed. Since the death of Mr X commissioners have re-tendered the Addictions Services in Bournemouth and as a consequence they are no longer provided by the Trust.

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12.206. As things currently stand the Bournemouth Assessment Team is now managed by the Third Sector. When asked by the Independent Investigation Team to attend for interviews the organisation refused to take part. The DAAT was approached by the Independent Investigation so that the issues regarding poor communication processes between services could be examined further. We were told that communications between Addictions Services and other agencies remains an ongoing problem at the present time.

Conclusions

12.207. The Independent Investigation concludes that poor interagency communication and working was detrimental to the ongoing health and wellbeing of Mr X and Ms Y, and by default, Mr Z who was Ms Y's designated next of kin. This lack of interagency working also meant that risks were not identified in either a holistic or timely manner. Whilst the Investigation made no causal connection between poor interagency communication and working and the death of Mr X, this made a contribution to the suboptimal management of Mr X and Ms Y over time.

12.208. The importance of CPA should not be underestimated in the Coordination of Care which places the service user at the centre of the pathway. This is of particular importance when several services and agencies are involved. This essential task of CPA is relied upon even more heavily when service users present in a complex and chaotic manner.

12.209. Of particular concern is the knowledge that current communication processes between Addictions Services and other Health and Social Care Services are still not optimal. Also of concern is the increased effort that will be required in the future when attempting to engage Addictions Services with any forthcoming Investigation process. It will be essential to resolve this issue in the future so that interagency lessons can be learned when things go wrong and patient and public safety can be maintained.

- ***Contributory Factor 5. Interagency working was poor with organisations working in silos. This made a contribution to the poor overall management of Mr X and Ms Y.***
- ***Service Issue 5. Poor ongoing communication and working processes between Addictions Services and other agencies may limit the learning from this Investigation and others in the future.***

12.9. Service User Involvement in Care Planning and Treatment

Context

12.210. 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*".

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

12.212. Good practice also requires care and treatment planning and delivery to be person-centred and sensitive to both cultural and social diversity issues.

Findings

Findings of the Trust’s Internal Investigations (Health IMRs) and Serious Case Review

12.213. This aspect of care and treatment is not examined by the Serious Case Review. However the Health IMRs provide some findings. The IMR for Mr X states that primary and acute care services were sensitive to his physical, addictions and mental health needs. It also states that secondary care mental health services maintained a good rapport with Mr X and gave the example of the Care Coordinator allowing him “*space*” in order to support his engagement and reduce his paranoia. The IMR findings support the notion that Mr X’s English was good and that he did not need an interpreter or any particular interventions in relation to his cultural background and ethnicity. Care Coordinator 1 had apparently undertaken a skills training programme in relation to respecting cultural differences and this was thought to have been beneficial in his engagement and treatment planning with Mr X.

12.214. The Health IMR for Ms Y states that health services remained responsive and sensitive to her needs over the years despite her often chaotic presentation when she was often intoxicated and volatile. The treating teams sustained interventions and developed a high level of engagement with her whilst endeavouring to set boundaries to help her manage her life and mental health issues better.

12.215. The Health IMR for Mr Z states that health services were delivered to him in a responsive manner that was proportionate to his need.

Findings of the Independent Investigation Team

12.216. A key finding of the Independent Investigation Team is the kindness and compassion that was evident in the delivery of care and treatment to all three service users across all Health provision. Each of the three service users were consulted in full about the care and treatment that was offered to them and it is evident that, where possible, informed consent was sought and the subsequent approach agreed with them. This was good practice.

12.217. However there are three issues in relation to Mr X that require consideration. **First:** on occasions the stance taken with Mr X may not have been in his best interests. It is evident that the decision to maintain him in the community was upheld even when he probably met the criteria for assessment under the Mental Health Act between the summers of 2010 and 2011. This position was maintained because it was known that Mr X had an aversion to the idea of an inpatient admission. However this meant that he continued unwell with his Schizophrenia poorly understood and only partially treated. It is important to note that during this period no additional

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resource appears to have been put into place to manage his psychosis and support him in the community.

12.218. Second: There is clear mention in Mr X's clinical record that his English was poor (this is at odds with some of the other assessments made about him and the findings of the Health IMR). In 2006 when Mr X first entered the service it was clearly stated that he would need an interpreter; this was not followed up.¹³² It is entirely probable that for ordinary day-to-day communication Mr X's English was perfectly adequate. However, in general, during periods of clinical assessment it is essential that clinical teams are certain the person they are assessing can truly understand what is being said and that the assessment not only takes into account a person's language skills but is also culturally appropriate. The Independent Investigation Team could not determine exactly how Mr X was assessed against Personality Disorder criteria in 2009. However it is clear that an incorrect diagnosis was made at this point. It was not good practice to conduct such an assessment with a person whose first language is not English without considering his language needs and cultural background. A more in-depth approach was indicated and this should have been understood at the time.¹³³

12.219. Third: Despite Mr X being consulted about care and treatment approaches he did not have a holistic care plan developed that recognised his needs in a person-centred manner that could specifically help to support his social inclusion, recovery and wellbeing. The Independent Investigation Team recognised that his levels of engagement fluctuated and that his compliance with any plan could not be guaranteed, however this represents a significant omission.

Conclusions

12.220. The Independent Investigation Team concludes that all three service users were involved with the care and treatment approaches and decisions taken about them and that they were treated with kindness and sensitivity. However lessons for learning include:

- understanding when it is necessary to intervene, even if it is against a service users wishes;
- understanding that cultural awareness can be a complex process especially when conducting in-depth clinical assessment;
- providing person-centered care and treatment plans for service users with severe and enduring mental illness that encompass social functioning, recovery and wellbeing.

12.10. Family Concerns and Involvement

Context

Carer involvement

12.221. The recognition that all carers require support, including carers of people with severe and/or enduring mental health problems, has received more attention in

132. X notes 2 p 74
133. NICE Guidance

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recent years. The Carer (Recognition and Services) Act 1995 gave carers a clear legal status. It also provided for 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.

12.222. 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 cared for.

12.223. 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.

12.224. 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.

Findings

Findings of the Trust's Internal Investigations (Health IMRs) and Serious Case Review

12.225. The Health IMRs state that there was no contact with family or carers for any of the three service users. The Serious Case Review does not address this issue.

Findings of the Independent Investigation Team

Mr X

12.226. Mr X was of Portuguese origin and had lived in England for several years as had two of his brothers; they did not live together and it is unclear how much contact they had with each other. It is evident from reading through Mr X's clinical records that he held a significant number of deep-seated delusions about his family and his past. It is also evident that Mr X's treating teams took a great deal of what he said at face value. However the Independent Investigation Team learned, during a meeting with one of Mr X's brothers, that most of the information Mr X had offered about both his family and history was untrue (such as having been married and having a son who died).

12.227. Whilst Mr X expressed paranoid ideas about his family and did not want them involved with his care, it would have been good practice for Mr X's treating teams to have tried to establish contact with them. It was evident that Mr X was socially isolated and was suffering from a severe and enduring mental illness. Whilst the treating team could not share information about Mr X with his family without his consent, corroborative evidence could have been sought from them. Had this been

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done the extent of Mr X's paranoia and delusional world would have been made apparent at a much earlier stage than it was.

12.228. Despite Services lack of contact with Mr X's family his care plan on occasions included his brother as a protective factor. In March 2003 a risk management plan was developed by the drug addiction therapy team which stated that Mr X would try to seek support from his brother (it did not state which one) who lived locally if he started to feel unsafe (this was in relation to his general drug taking and social isolation). Services had not involved Mr X's brother and did not establish the appropriateness of this course of action.

12.229. In March 2004 services knew that Mr X was depending upon his brother (it is not clear which one) to intervene with his landlord to prevent his pending eviction. In September 2011 the CMHT knew that the police had been called to Mr X's address due to an altercation between him and one of his brothers in relation to legal papers that needed to be signed. There are several issues that were not considered by Mr X's treating teams. They are:

- the opportunity to have sought collateral information from Mr X's brothers about his psychiatric history;
- the support network that his family could have offered to Mr X had they been aware of his mental health problems;
- the potential risk Mr X may have been subject to from his family in relation to legal papers and financial matters (the reason the dispute between him and his brother had become violent necessitating police intervention but was never explored by the CMHT in the context of possible financial abuse);
- the potential risks posed by Mr X towards his brothers as it was obvious he had deep seated feelings of antagonism and paranoia towards them and was noted to harbour "*murderous thoughts*" in general and had experienced command hallucinations that told him to kill.

12.230. It is a fact that no one from the NHS had met with either of Mr X's brothers until a Senior Officer from NHS England accompanied the Independent Investigation Chair to a meeting with Mr X's youngest brother on 6 January 2015. On this occasion Mr X's brother expressed great surprise and concern when he was told the extent of Mr X's severe and enduring mental illness. Up until this time the family had assumed Mr X was responsible for both his addictions and his lifestyle choices and that these had contributed to his death. Had the family known more about his mental illness Mr X's brother reflected that they would have kept in closer communication with him and would have supported him more.

Ms Y

12.231. Ms Y was reported to have an elderly mother who lived in Devon, a son (who would now be in his twenties) and a brother with whom she did not maintain contact. It is evident from reading through Ms Y's clinical record that she had a turbulent relationship with her mother who she blamed for her unhappy childhood. It is also evident from reading through the clinical record that Ms Y's mother was elderly and in poor health.

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12.232. Ms Y's chaotic lifestyle, addictions, and violent behaviour were known by her treating teams. It was also known that she did not get on with her mother whom she claimed made her unhappy and stressed. It is therefore surprising to find that on two occasions Ms Y went on extended visits to 'look after' her mother who was ill. It would appear that services expressed no curiosity about this and neither did they consider any safeguarding risks that Ms Y may have posed to her elderly and physically unwell mother.

12.233. Throughout most of the time that Ms Y received her care and treatment from the Trust Mr Z was her live-in-partner and designated next of kin. Services understood that Ms Y and her partner were locked into a cycle of extreme domestic violence which on occasions had necessitated both inpatient admissions and police intervention. As can be determined from reading the clinical records services were aware that Ms Y was not only the victim of domestic abuse but also the perpetrator of it.

12.234. As the partner and designated next of kin Mr Z should have been offered a carer's assessment. This kind of intervention should be offered to the carers and families of any service user who is on Enhanced CPA. It is evident that this was not offered to Mr Z and his needs as Ms Y's partner were not explored. It is also evident that Mr Z was not viewed as a victim of domestic violence even though Ms Y had once stabbed him in the leg. Had a carer's assessment been offered then the pattern of domestic violence could have been explored and help provided.

Mr Z

12.235. Even though Mr Z had been engaged with services on several occasions it would appear that Ms Y's treating teams did not know who he was. Had the connection been made then services would have realised that Mr Z suffered from depression, frequently drank heavily, had made five suicide attempts and had a diagnosis of Emotionally Unstable Personality Disorder - Borderline Type. Mr Z had significant needs of his own and had told mental health services in the past that he found his relationship with Ms Y difficult as he found the burden of constantly having to be the 'giver' draining. This difficult relationship had contributed to his mental health problems and during his previous contacts with mental health services he had asked for help to end it.

Conclusions

12.236. The Independent Investigation Team concludes that the needs, risks, and roles of carers were neither understood nor addressed by Trust services over time. There were missed opportunities to:

- gather corroborative information;
- strengthen care plans for the service users (especially in the case of Mr X in relation to his brother's input);
- ensure the safeguarding and general safety of relatives and carers;
- undertake carer assessments;
- explore family dynamics and provide education and support.

12.237. The Independent Investigation Team acknowledges that it is sometimes difficult for services to intervene when service users do not want their families either

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notified or involved. However, whether the service user consents or not, the above five bullet points should always be considered by secondary care mental health services. It is not possible to ascertain what the effects, if any, were of these omissions in relation to the families and carers involved. However it is a lesson for learning that this kind of omission should not occur in the future if the ongoing safety and wellbeing of families and carers are to be maintained.

- **Service Issue 6. Families and carers were ‘invisible’ to secondary care mental health services. Potential risks were neither identified nor managed and carer assessments when indicated were not provided.**

12.11. Documentation and Professional Communication

Context

Documentation

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

*“Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off”.*¹³⁴

12.239. Pullen and Loudon writing for the Royal College of Psychiatry state that: *“Records remain the most tangible evidence of a psychiatrist’s practice and in an increasingly litigious environment, the means by which it may be judged. The record is the clinician’s main defence if assessments or decisions are ever scrutinised”.*¹³⁵

Professional Communication

*“Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion”.*¹³⁶

Jenkins *et al* (2002)

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

12.241. 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

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

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

136. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) p121

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offences cannot be met by one agency alone.¹³⁷ The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.¹³⁸ 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.

Findings

Findings of the Trust's Internal Investigation (Health IMR) and Serious Case Review

12.242. The Health IMRs found that whilst there was evidence to show that there was some communication between the CMHT, Addiction Services and Primary Care, it was not as consistent as it should have been with the GP not always being kept up to date. The Serious Case Review made a key finding that services and agencies worked in “silos” and that communication was generally poor. Specific findings and conclusions about the quality of the clinical record and clinical recording systems were not made.

Findings of the Independent Investigation Team

Documentation

12.243. The Independent Investigation Team found the general quality of the clinical record to be very basic and under developed in nature. At times it was impossible to understand whether key risk assessment and care planning processes had been accomplished because the record was so lacking.

12.244. Witnesses to the Investigation told us that that there was a general culture within the team of holding meetings and having informal conversations where key decisions were made. Unfortunately most of these meetings and conversations went unrecorded.

12.245. In recent years the Trust has adopted an electronic clinical record system (RiO). According to witnesses there remain many problems with this system which causes a high degree of dissatisfaction among clinical staff. We were told:

- 1.** The RiO system – at the present time - enables the audit of compliance rather than quality. Currently there is no process to ensure risk assessments and care plans meet either professional standards or Trust policy requirements.
- 2.** Staff told the Investigation that entering information onto the RiO system is slow and difficult. The most recent update has made the system very slow. This means that staff never manage to achieve reporting targets and are subject to a “*never ending drip of feedback*”.¹³⁹ It should be noted that the RiO system itself is not at fault but the network connection to some sites makes its functionality problematic.
- 3.** The RiO system used to ‘times out’ and often failed to save information. This caused a great deal of frustration for busy clinical staff. Apparently this issue has now been resolved with an auto-save function being introduced.
- 4.** There were issues importing the old paper records over onto the new electronic system. No paper records were uploaded onto the new system and

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

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

139. Witness Transcript

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consequently over time older clinical information became inaccessible to treating teams. This appears to be the reason why Mr X's forensic psychiatric assessment (sent to the CMHT in 2006) was not readily available to the team when Mr X re-entered the service as it was not entered onto RiO.

5. There are several different electronic systems in place. Historically VISION (local services aligned to GP system) and HALO (DAAT database) recording systems were used by the Addictions Team. Most clinicians working in this service do not have full access to RiO and can only see referrals and discharges. Because of this CMHT-based risk assessment and CPA processes could not be accessed by other treating teams. A Witness from the Addictions Team said: *"We would only really know what the Bournemouth Assessment Team, who was the referrer, would have passed on and then the information obviously that we gleaned directly from clients when they came for assessment"*.¹⁴⁰
6. Trust Managers who spoke with the Independent Investigation Team agreed that there were ongoing problems with the RiO system.

Professional Communication and Interagency/Service Liaison

12.246. The Independent Investigation was told that within the CMHT there was a facility for a case conference to be held once a week. However there were 400 service users on the caseload and it was unclear how individuals were prioritised. Once again it was not clear where this kind of activity would have been recorded. Within the CMHT there was also a weekly supervision meeting and this provided an opportunity to discuss cases. However this meeting was uni-disciplinary and the weekly meeting was overburdened.

12.247. By and large the CPA process was uni-disciplinary in nature and with little involvement from other services and agencies. This meant that the opportunity for discussing cases with everyone involved was limited. There was also no process for communicating with other services or agencies in advance of the CPA in order to update the Care Coordinator in relation to either progress or problems.

Conclusions

12.248. The Independent Investigation concludes that professional communication across primary and secondary care services was poor. There are three main reasons for this, each one exacerbating the others.

- Clinical record keeping was, and is, weak within the North Bournemouth CMHT. Currently this appears to be due, in part, to the RiO system which is cumbersome and difficult to use. This means that the clinical record does not accurately represent the work that is being undertaken.
- The different electronic clinical recording systems currently in use across services do not speak to each other. This means that information is difficult to access in a timely manner.
- There is a prevailing culture of informal professional communication which does not foster either a multidisciplinary or interagency approach. This culture is fostered by the poor use of CPA and Care Coordination which should act as a communication and liaison link across all disciplines, services and agencies.

140. Witness Transcript

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12.249. The Independent Investigation concludes that had robust documentation and professional communication processes been in place many of the opportunities to have managed Mr X, Ms Y and Mr Z better would not have been lost.

- **Service Issue 7. Documentation and professional communication processes were, and are, weak. This prevents the sharing of information in a timely manner and also acts as a barrier to joint working.**

12.12. Adherence to Local and National Policy and Procedure

Context

12.250. 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*”.¹⁴¹ 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.

12.251. **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 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. This is a key function of Clinical Governance which is explored in section 12.13 below.

12.252. **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.

12.253. **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.

Findings

Findings of the Trust’s internal Investigations (Health IMRs) and Serious Case Review

12.254. This particular aspect was not examined by the Serious Case Review. The Health IMRs explain that safeguarding policies were supported by a training programme and designated safeguarding lead practitioners.

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

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Findings of the Independent Investigation Team

12.255. It was evident to the Independent Investigation Team that Trust and Local Authority policies in relation to Safeguarding, clinical risk and CPA (Care Planning) were evidence-based, robust and fit for purpose. However there are two areas of feedback to be given. **First:** policies tend to be very long and are not easily accessible to clinical staff. **Second:** the risk and CPA policies have not been supported by training. It was evident that many of the witnesses we spoke to have never received clinical risk management training. This organisational lack of focus on policy and procedure has perhaps fostered a culture of non-compliance.

12.256. During interviews Trust Managers made it clear that there was a consistent issue within the Trust in relation to policy non-compliance (this was also the finding of an earlier HASCAS homicide investigation with this Trust published in 2013). The prevailing feeling amongst staff was that risk and CPA processes were bureaucratic in nature which took them away from patient care. We were told that at the current time a review is being undertaken to examine practice in this regard.¹⁴²

12.257. The clinical witnesses who spoke with the Independent Investigation Team had a poor understanding of Trust Integrated Operational, Risk and CPA policies and their roles within them. This, when coupled with a lack of training, meant that policy compliance was unlikely. The RiO electronic system monitors data inputting but does not audit the quality of the content or process deployed. This means that while staff receive a constant negative feedback about the lack of data entry, none is provided in relation to professional standards.

12.258. During interviews it became apparent that there was a strong counter-culture that resisted the notion and value of risk assessment. It was also apparent that an alternative model (the DBT track) had been put in place that was not being centrally monitored and regulated by corporate governance process. This alternative model also served to displace CPA as the central framework for care and treatment delivery.

Conclusions

12.259. The Independent Investigation concludes that there are long-standing issues in relation to policy compliance within the Trust and these are still ongoing at the time the Independent Investigation interviews took place. The issues speak to problems with both process and culture and appear to be deeply ingrained. The failure to adhere to policy and procedure has meant that the services under investigation have not adhered to either local or national good practice guidance. This failure compromised the quality and effectiveness of the care and treatment Mr X, Ms Y and Mr Z received.

- ***Contributory Factor 6. Poor understanding of, and compliance to, Trust policy and procedure led to a situation where the care and treatment of Mr X was suboptimal and where the risks presented by Mr X and Ms Y were poorly identified and therefore poorly managed.***

142. Witness Transcript

12.13. Clinical Governance and Performance (to include clinical supervision, professional leadership and organisational change)

Context

12.260. *“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”.*¹⁴³

12.261. 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.

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

12.263. 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 X. The issues that have been set out below are those which have relevance to the care and treatment that Mr X, Ms Y and Mr Z received.

Findings

Workforce Issues

12.264. During the period that Mr X, Ms Y and Mr Z were receiving their care and treatment from the Trust there were staff shortages and vacancies that could not be filled; the CMHT recently lost a Band 5 post which is not going to be replaced. The service users with the CMHT are challenging and the caseloads are high.

12.265. Training is not regularly provided for staff and this has led to many of them becoming out of date in relation to key policies and processes.

Clinical Supervision

12.266. The Independent Investigation Team was told by clinical witnesses that whilst Manager expectation was it should be conducted quarterly this was not in fact happening in practice: *“Well our standard it's kind of like quarterly but in reality most of the supervision in between those times is informal so that may involve perhaps providing advice over the telephone, doing a joint visit occasionally, or just adult conversations so I am looking after two sites so normally I aim to spend time with people after a multidisciplinary team meeting if there are particular issues that can't be managed within that meeting”.*¹⁴⁴

¹⁴³ Department of Health http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

¹⁴⁴. Witness Transcript

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12.267. The Trust Board told us that the Senior Leadership team has undergone immense change since the time of the incident. There has been increased investment in leadership training and clarity around competency requirements for leaders alongside a major reorganisation. Improved systems for the recording and monitoring of supervision are currently being developed.

Corporate Governance Systems - CMHT Operational Policy Compliance

12.268. The Trust had an Integrated Community Mental Health Team Operational Policy (2010 – 2014). This policy set out key requirements for the service. It said that:

“The CMHTs have a single line management structure and are managed through an Integrated Services Manager who is responsible for the provision of day to day management, including the performance of Health & Social Care staff and meeting statutory responsibility and overall performance within the CMHTs. The Integrated Services Manager will report to the Joint Management Board at specified intervals in respect of the performance of the CMHT and is accountable to the relevant DHFT Director. Where appropriate the Integrated Manager will be supported by a link manager from the relevant Local Authority”.

12.269. The policy also said that:

“The Integrated Services Manager, in conjunction with the relevant team member, will be responsible for:

- *Managing team performance and budgets within the agreed priorities.*
- *Achieving set contact targets and monitoring performance against these*
- *Signing off care management packages through delegated authority.*
- *Ensuring work is allocated according to demands and resources.*
- *Ensuring the review of caseload to determine the effectiveness of the interventions through appropriate supervision arrangements.*
- *Monitoring that joint working is taking place where appropriate.*
- *Ensuring that managerial, clinical supervision and appraisals take place in accordance with the appropriate policies and procedures of the Authority and/or Dorset HealthCare NHS Foundation Trust.*
- *Promoting safe working environment.*
- *Ensuring CMHTs work collaboratively across teams”.*

12.270. Management processes within CMHTs did not include doctors *“Medical staff are not managed through the Single Line Management arrangements. There currently are separate arrangements for medical staff with lead consultants with responsibility to the Medical Director. It is expected however, that medical staff will work collaboratively with the Integrated Managers and the CMHT”.*

12.271. The Policy provided specific guidance to CMHTs.

“It is expected that each team will have a clinical meeting once per week. All discussions relating to service users will be recorded directly into the IESUR as a progress note. Any decisions made should include details of the most senior clinician present. The agenda will include as a minimum:

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- *Discussion of new assessments and a review on the IESUR of unallocated referrals with a view to them being allocated or discharged.*
- *Service Users whose care requires multi-disciplinary (MDT) discussion.*
- *Service Users identified at significant risk should be discussed as a minimum on a monthly basis unless there is a documented reason in the clinical notes to discuss less frequently because of the stability of their clinical state.*
- *Service Users not responding to treatment.*
- *Service Users who are difficult to engage – refer to the Policy for Difficult to Engage Patients.*
- *Service Users who are being considered for discharge from the CMHT.*
- *Service Users currently under the care of the Crisis and Home Treatment Team.*
- *All Service Users discharged from hospital or the Crisis/Home Treatment Team within the past week to ensure full compliance with 7 day follow-up from discharge Inpatients.*
- *Discussion of carers assessments and requested carers assessments.*
- *Relevant Clinical Governance issues including Serious Adverse Incident (SAI) reports, policy development, changes and training opportunities”.*

12.272. The policy also stated that each service user would receive a comprehensive risk assessment and care plan in keeping with Trust Risk, CPA and Difficult to Engage Patients’ policy. There was also a strong focus on social functioning and communication between all other agencies and services. It is evident that the standards set out in this policy were not met by the North Bournemouth CMHT and that Trust corporate governance systems were not able to detect this. The reasons for this are set out below together with the actions that have been taken to remedy the situation. .

Governance and Performance Issues

12.273. Since 2012 Dorset HealthCare has been subject to significant challenge and transformation. The organisation was independently scrutinised and found to be failing in a number of areas critical to ensuring high quality care for patients. Between June 2011 and April 2013 the Care Quality Commission (CQC) inspected 14 Trust sites. Four locations were assessed as fully compliant and 10 sites were assessed as noncompliant with a number of the essential standards assessed. Several locations were found to be non-compliant on successive visits, with significant failings in some areas (notably Forston Clinic and Blandford Hospital).

12.274. There was a lack of response from the then leadership in responding to CQC concerns regarding significant gaps in governance and assurance. This resulted in Monitor taking enforcement action. In April 2013 Dorset HealthCare was found by the regulator Monitor to be in breach of its licence conditions and subject to Enforcement Undertakings to address a number of failings identified by the Care Quality Commission. A review by Deloitte LLP during May and June 2013 found that

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the Board needed to address the significant challenge of bridging the cultural gap between legacy organisations. The Trust responded with an Action Plan in August 2013, which, in conjunction with the outcome of the Deloitte Governance Review, led Monitor to conclude that the Trust board was failing to take sufficient action to secure a return to compliance with its licence conditions. As a result, Monitor imposed an additional licence condition on 4 September 2013 relating to governance requirements.

12.275. A more substantial Trust Recovery Plan was established in September 2013. The plan comprised a total of 331 actions, which included tasks and actions from the Deloitte review (253 actions), further actions identified internally by the Trust, plus actions in response to the CQC Outcome 16 review (April 2013).

12.276. On the 17 June 2014 Monitor issued the Trust a certificate of compliance confirming the Trust was no longer in breach of its licence condition and was now content with the leadership of the organisation and was satisfied that the leadership will do the right things but, recognised also, how much work needs to be done.

Governance Arrangements and Responsibilities

12.277. The Trust is run by a Board of Directors, made up of Non-Executive and Executive Directors. Together they are responsible for overseeing the running of the organisation and the delivery of its objectives and wider strategy.

12.278. The Board discharges the day-to-day management of the Trust through an approved scheme of delegation to individual Executive/Associate Directors and senior staff. This consists of a Directors Management Team and Directorate Management Groups of senior managers and clinicians.

12.279. The Council of Governors provides overall support and guidance for the Trust through its elected Public Governors, Staff Governors and Appointed Governors from Partner Organisations. Over the past eighteen months the Trust has continued to strengthen its systems and processes and this will continue going forward. The Trust Blueprint document sets out the actions to develop the Trust vision, values and strategic objectives alongside the governance and quality assurance processes and systems. The Blueprint carries forward the small number of outstanding actions from the 'turnaround' period, combined with newly identified priorities, to set out a clear direction of travel for organisational excellence, grouped under six key themes:

- Board and leadership development
- Organisational development and our people
- Governance, quality and risk management
- Staffing
- Performance and information reporting
- Partnership working and participation

Vision and Values and Strategic Objectives

12.280. The current Trust vision is to *"provide care all of us would recommend to family and friends"*. The previous Board of the organisation signed off a Trust strategy for 2013-16. The new Board are revisiting that strategy to develop with staff and partners a renewed set of strategic objectives that will have the full commitment

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of the Council of Governors, the new leadership team and local people. The Trust will do this by January 2015. It will develop key performance indicators to enable the Trust to monitor and report progress against our strategic objectives.

12.281. During 2014/15 the Trust is undertaking a programme of governor, staff and wider stakeholder engagement to refresh vision and articulate purpose, reaffirm values and renew strategic objectives. The Trust will revisit its strategic objectives in engagement with patients, staff, local people and partners, to articulate a renewed set of objectives. The Trust will expect these will stem from the following overarching areas of vision and ambition:

- Improve the quality of services across the three domains of patient safety, patient experience and clinical effectiveness.
- Improve staff satisfaction and experience and become an employer of choice.
- Develop and deliver clinical service models that integrate physical and mental health services.
- Develop new relationships and improve existing relationships.
- Manage services in a financially sustainable way.
- Be a valued provider, retaining existing and winning new contracts.

Locality Restructure

12.282. In 2012 the Trust managed the delivery of operational services through three directorates - mental health, community services and children and families, led by a Service Director. Over the past year the Trust has recognised that it has reached the limits of what it can achieve within existing service delivery and structural constraints, and the way in which it has worked historically will, if continued, impede development of truly integrated and community-specific services. In particular, the Trust will not be able to deliver the high quality it is seeking.

12.283. The Trust is now in the process of implementing a transformational restructure moving from a business model that was service and speciality-led to one that is locality-led, in line with current innovative thinking in mental health and community services. The Trust is now implementing a locality-based service delivery model and a locality management structure that will enable clinical teams to operate at a local level, in conjunction with key GP and local authority partners.

12.284. This new model encompasses all the services currently offered by the three Directorates (Mental Health, Community Health Services, Children and Young People). Care will be delivered via three 'super localities' (Poole, Bournemouth and Dorset), which will further subdivide into 13 localities based on GP locality boundaries. This will ensure that decisions are made locally and are tailored to the specific requirements of each area. The management structure of the locality care model is designed to improve patient experiences and the quality of our care offering. The Trust believes that the adoption of a locality-based model will deliver significant service quality and experience improvements, as well as broader financial and commercial benefits.

An Overview of how Clinical Governance Works Now

12.285. The management and governance of the Trust has changed and is still in transition. Trust Executive Group was established in October 2013 to meet on a

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monthly basis. This group brings together senior and key clinicians and Directors in a unique forum that focuses on the strategic direction of the Trust, looking across physical and mental wellbeing and across all ages. The following has been achieved:

1. The establishment of a Serious Incidents Requiring Investigation Panel, chaired by the Medical Director. Clinical teams present their RCA review findings to the panel (Medical Director, Director of Nursing and Quality, Head of Patient Safety and Risk), and review the learning identified and agree recommendations. The Clinical Effectiveness and Regulation, Patient Safety and Patient and Carer Experience groups report to the Quality Assurance Committee on matters relating to Quality and Patient Safety.
2. The Trust has been engaged with the South West Quality and Patient Safety Improvement Programme on a variety of topics such as pressure ulcers, catheter acquired infections, management of the deteriorating patient, Safe wards in Mental Health, falls and suicide reduction. With the establishment of the Academic Health and Science Networks (AHSN) the Trust are engaging with the Wessex AHSN.
3. Integrated Dashboard – the Trust has done much to improve the monitoring and reporting of performance at team, Directorate, Committee and Board level, taking best practice into consideration as highlighted in the Monitor Quality Governance guidance. The integrated corporate dashboard has been significantly updated to include directorate performance set against updated quality metrics, as well as overall Trust performance that is now tracked with trend analysis over a 13 month period.
4. Patient safety issues continue to be reported in the monthly Quality Report. The National Reporting and Learning System (NRLS) sends regular reports in relation to all patient safety incidents that have been reported by the Trust - including rate and frequency of reporting, level of harm and type of incident and this is reviewed by the Directors. The report shows that the Trust is a high reporting organisation with larger numbers of no/low harm, which demonstrates an open culture of reporting all incidents. All incidents continue to be reported on a monthly basis from ward/team to Directorate and the Patient Safety Meeting. A Quality Newsletter has been developed for front line staff in order to share and promote Quality and Patient Safety topics.
5. The Trust continues to be an active member of the local Child and Adult Safeguarding Boards and sub groups and works in an integrated way to develop a holistic family approach to safeguarding.
6. The Trust has established a NICE assurance group, co-chaired by the Medical Clinical Audit lead and the Head of Clinical Effectiveness to gain full assurance of NICE compliance and to ensure the guidance is well understood by Trust staff and evidenced in practice.
7. The Trust's Annual Clinical Audit programme has been developed taking into account; learning from internal and external events, the Clinical Audit Programme Guidance Tools published by Healthcare Quality Improvement Partnership (HQIP), NICE baselines, contractual agreements, national clinical audits and CQUIN agreements.

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The Trust's Blueprint Document (2014 – 2015)

12.286. The Trust has developed a Blueprint Document. This document sets out in a detailed action plan how the organisation will move forward in the future and improve patient services. The purpose of The Blueprint is to record how Dorset HealthCare responded to significant failings in both governance and in the quality of patient care in its plans and ambition for the future, to become an exemplar in the delivery of personalised, integrated care in localities.

12.287. The Blueprint explains how during 2014/15 the Trust would undertake a programme of Governor, staff and wider stakeholder engagement to refresh its vision, articulate its organisation's purpose, reaffirm its values and renew its strategic objectives.

12.288. It identifies the six key themes where the Trust continues to develop towards organisational excellence and signposts the more detailed strategies and plans that will follow:

- Board and leadership development;
- Organisational development and its people;
- Governance, quality and risk management;
- Staffing;
- Performance and information reporting;
- Partnership working and participation.

12.289. The Blueprint sets out thirty-six deliverables; thirty-two were completed by 30 April 2015 leaving four ongoing. Of the four deliverables yet to be completed two are waiting papers to go to the Board (*The Estates Strategy* and the *Performance measures for the new Strategic Plan*) and therefore RAG rated Amber/Green. The remaining two rated Red are the; *To carry out a root and branch review of Recruitment and Retention*, although a lot of work has been undertaken in this area recruitment and retention are still a major risk for the Trust. Again, although a lot of work has been undertaken in *Review of Mandatory Training*, as of March 2015 the Trust has a compliance rate of 91.19 percent against a target of percent.

12.290. The top ten risks identified within The Blueprint have been evaluated and, within the wider piece of work on risk management undertaken last year, have been incorporated into those systems where still relevant. In January 2015 the Trust Board approved its refreshed Strategy 2015-2020. The six key themes in The Blueprint are areas that will continue to be taken forward and monitored within this framework. For the purpose of this update there are two areas of specific relevance to the governance and quality improvements that the Trust has taken forward:

Governance, Quality and Risk Management

12.291. From the beginning of June 2014, PM Governance worked with the Trust to develop risk management, assurance processes and governance arrangements across the Trust. This work was summarised at the September 2014 Board workshop and a number of key decisions about future governance arrangements were agreed.

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12.292. The Implementation Steering Group oversaw delivery of key decision points through to the Board which 'went live' on the 1 April 2015. The work with PM Governance has now been completed and the Trust is implementing and embedding the revised risk and quality assurance processes. Chief Risk Officer responsibilities are split between the Director of Nursing & Quality (clinical risk) and the Trust Board Secretary (non-clinical risk).

12.293. Embedding of assurance processes via Board Committees is underway and it is acknowledged that this is not a quick fix. Milestones have included:

- a Trust Board Workshop on risk horizon scanning with the output set out in a strategic risk plot, to more readily identify the strategic risks for new financial year. This facilitated the population of the Board Assurance Framework (BAF) for 2015/16, and the acquisition of assurances throughout the year from internal and clinical audit teams. This process and full Board involvement and engagement has given confidence about the design and operation of controls which mitigate these significant risks;
- between January and March 2015, agreement by the Audit Committee of the internal audit programme for 2015/16 and by the Quality Assurance Committee of the Clinical Audit Plan. The Audit Committee reviewed both plans in March 2015;
- a revised Risk Management Policy approved by the Executive Quality and Clinical Risk Group and Executive Performance and Corporate Risk Group in February 2015, noted by the Audit Committee in March;
- the senior groups of the Executive as from 1 April 2015 are the Executive Quality and Clinical Risk Group and an Executive Performance and Non-Clinical Risk Group. These Groups have been forming over the past two months and are now established and operational working to their Terms of Reference;
- as from 1 April 2015 two Assurance Committees reporting to Board; the terms of reference of these and the Executive's senior groups will be reviewed by the steering group on 19 November 2015;
- the introduction of letters of assurance from Assurance Committee Chairs to the Trust Chair at the end of each financial year, setting out their review of assurances of control systems during the year. Letters of management representation by Executives and their direct reports to the Chief Executive about disclosure of quality failings and unmitigated risks has been discussed but will not be introduced yet.

Conclusions

12.294. At the time Mr X, Ms Y and Mr Z were service users with the Trust it is evident that significant policies were not adhered to and this compromised the effectiveness and quality of the care and treatment that they received. The Independent Investigation concludes that no single practitioner was responsible for this because systems were inadequate and failed to ensure staff had a clear understanding of what was expected of them. This was compounded by poor staffing levels, heavy caseloads and a monitoring and regulation process that was too weak to detect failings.

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12.295. As has been discussed above, the Trust was found to be failing against key standards. Since this time a great deal of work has been done in conjunction with external regulation and inspection to ensure that the organisation is functioning in keeping with the standards set by Monitor and the Care Quality Commission. We understand that significant improvements have already taken place and that work is currently in train to ensure policy compliance and a corporate approach to patient safety and quality care is implemented and maintained.

- ***Contributory Factor 7. There was failure of Trust governance systems to ensure an evidence-based approach was taken and maintained in keeping with both local and national good practice expectation.***

13. Conclusions Regarding the Care and Treatment Mr X, Ms Y and Mr Z Received

Overview

13.1. The Independent Investigation Team concludes that the care and treatment Mr X, Ms Y and Mr Z received was delivered with kindness and compassion by all staff from primary and secondary care teams. We do not seek to single out the practice of any individual as either 'failing' or being responsible for any of the care and treatment shortcomings that this Investigation has identified.

13.2. Through conducting a Root Cause Analysis process it has been possible to understand the identified shortcomings are systemic in nature and we have endeavoured to explore this within the report in sufficient detail so that the necessary changes can be made in an effective manner.

13.3. HASCAS Health and Social Care Advisory Service also conducted an earlier Independent Investigation into the care and treatment of another service user at the Trust. This report was published in 2013. Many of the issues and service shortcomings identified in this previous Investigation are similar to those identified in this one. This serves to strengthen our conclusion that the shortcomings were systemic in nature. Key comparable findings are:

- poor levels of compliance with policy and procedure;
- weak governance processes that were unable to detect policy non-compliance;
- poor levels of understanding of CPA and Care Coordination processes;
- poor levels of understating of clinical risk assessment and management processes;
- a Duty on Call system that takes Care Coordinators away from their caseloads;
- a lack of carer assessment and support;
- poor standards of documentation and professional communication which prevented joined-up care from taking place;
- problems with interagency linkages regarding potential safeguarding issues.

13.4. The death of Mr X took place nearly three years ago. However many of the managers and clinical witnesses we spoke to described aspects of practice that are still current which are directly comparable to the poor practice of the past. This would

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indicate that despite the work the Trust is engaged in at the present time there is still a great deal of work to do in order to ensure a quality and safe patient service is guaranteed.

Predictability and Preventability

Predictability

13.5. Based upon what *was* known and what *should* have been known about all three service users it is easy to ascertain that Mr X, Ms Y and Mr Z were complex and presented with high levels of risk to both themselves and to others. It was entirely predicable, based upon historic fact that an untoward incident of some kind was likely to occur in the future to one or all three of the service users. However the Independent Investigation concluded that the death of Mr X could not have been predicted by services under the circumstances in which it occurred.

Preventability

13.6. Based upon what *was* known and what *should* have been known about all three service users the Independent Investigation Team concludes that the death of Mr X could not have been prevented. At the time of his death all three service users appeared to have been stable and there were no concerns in relation to their mental health. In order for an incident of this kind to be preventable three criteria have to be met. They are:

- knowledge;
- opportunity;
- legal means to intervene.

13.7. Knowledge: During the period immediately before Mr X's death there was no indication to suggest that the relationship between Mr X, Ms Y and Mr Z had deteriorated to the point where any act of violence would take place. Services therefore did not have the knowledge and there was no warning which might have prompted an intervention.

13.8. Opportunity: None of the services or agencies involved had the opportunity to intervene as there was no knowledge that this would be necessary.

13.9. Legal Means: As far as can be ascertained, at the time of Mr X's death none of the service users involved met the criteria for either assessment or detention under the Mental Health Act. Mr Justice Males convicted Ms Y and Mr Z of murder and sentenced them to life imprisonment to serve a minimum of 16 and 14 years respectively. No mitigation was found in relation to their mental health.

Summary

13.10. The Independent Investigation Team concludes that Mr X met his death through no act or omission on the part of either primary or secondary care NHS services. Six contributory factors have been identified in relation to shortcomings in the care and treatment provided, most of which had a direct impact on the failure to promote Mr X's quality of life, recovery and wellbeing. Seven service issues have been identified, which whilst having no specific bearing on the care and treatment of

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Mr X, Ms Y and Mr Z, demonstrate the need for actions to be taken in order to ensure effective and safe patient care and treatment in the future.

14. Dorset Healthcare NHS Foundation Trust's Response to the Incident and Internal Review

14.2. The Trust Internal Review (Health IMRs)

The Commissioning Process

14.1. On 14 August 2012 a Serious Case Review was commissioned by Bournemouth and Pool Safeguarding Adults Board and Dorset Healthcare University NHS Foundation Trust. Agreement was reached with the Southern Strategic Health Authority (the predecessor body to NHS England South Region) that the Serious Case Review would serve as a local NHS Serious Incident Review. It was thought that this approach would meet the Trust's obligations under HSG (94) 27 guidance.

The Internal Investigation Review Team comprised the following personnel:

14.2. Bournemouth-based services put a review team together that was senior and represented key services.

- Dr. Laurence Mynors-Wallis Consultant Psychiatrist, Medical Director;
- Jane Elson Director, Quality and Older People's Mental Health Services;
- Joe Jackson Associate Nurse Executive;
- Michelle Hopkins Lead for Patient Safety and Safeguarding;
- Stan Sadler CMHN – Chronology writer;
- Tina Crosby Complaints' Coordinator;
- Matt Wain Head of Patient Safety NHS Poole Bournemouth and Dorset.

The Terms of Reference

14.3. The terms of reference were not inserted into any of the three IMRs for Mr X, Ms Y and Mr Z. However the terms of reference for the overarching Serious Case Review were:

"The SCR Panel consisting of members from Bournemouth and Poole Adult Safeguarding Board and Dorset HealthCare NHS Foundation Trust asked the IMR Authors to follow the agreed template and the guidance notes from Bournemouth and Poole Adult Safeguarding Board and also to give consideration to the following points:

- a) *How far had agencies working with Y and Z considered the impact of their behaviours on immediate neighbours and community.*
- b) *To what extent did any cultural issues influence agencies responses both in terms of ethnicity (X) but also arising from the diagnostic "labels" carried by those involved specifically "borderline personality disorder" (Y) Substance Misuse (Y, X and Z) and the victim's status as a registered sex offender (MAPPA Level 1).*

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The time period to be reviewed was set from 01.01.1998 or from when the agency had initial contact”.

Methodology

14.4. The methodology followed was that set out for adult Serious Case Reviews and the Health sector was charged with developing three IMRs for Mr X, who was the victim of the homicide and also for Ms Y and Mr Z who were the perpetrators of the homicide.

Key Findings, Analysis and Conclusions

14.5. It was not possible to identify what these actually were with ease within either the IMRs or the Serious Case Review as they are not readily identifiable.

Recommendations

14.6. The recommendations from the Health IMRs are as follows:

1. Mr X:

- The Trust should set clear auditable standards for CPA meetings so that those patients who are at significant risk either to themselves or others, have CPA meetings where the relevant professionals meet face to face, rather than the care co-ordinator collecting information from other professionals/agencies, separately.
- A CPA review should always result in a written communication to primary care with an update of events and an updated management plan.
- The Trust should provide training to clinicians in how to accurately record significant events and the action taken. The SBAR methodology provides a framework for this to occur.
- Safeguarding training to incorporate staff considering the impact of the known dynamics between service users on the CMHT case load where there may be a potential of violence and action to be taken.

2. Ms Y and Mr Z:

- All Teams should identify a clinician to be trained in MARAC procedures in order to guide team decision making with regard to MARAC implementation.
- The Trust to implement a care pathway for the assessment and treatment of patients with Borderline Personality Disorder. This pathway to include standards for assessment, patient engagement, interventions, outcomes and communication with other agencies.
- All teams to review the thoroughness of the risk history in the risk assessment for all those patients who have a history of self harm, violence to others or vulnerability. Once this has been undertaken, the Trust to undertake an audit of risk assessments to ensure that they contain a summary of all the key information, formulation and management plan.
- All teams to be reminded that all patients can self refer back to the CMHT within 6 months of discharge without requiring to go back to the GP.
- The Trust to draw up guidance for clinicians setting out actions to be taken if patients make an explicit threat to another individual.

14.7. The recommendations from the Serious Case Review are:

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Risk assessment and management

- Partner agencies should review and improve the effectiveness of the process of CPA in the areas of information sharing, communication, multi-disciplinary work and risk assessment, especially in situations where violence is a known risk factor. (Multi-Agency Action)
- All staff in CMHTs should receive management supervision on a minimum of a bi-monthly basis to include a sampling of case notes for those on CPA to ensure up to date risk assessments and management plans, CPA reviews and Care Plans.
- All CMHTs should ensure that they are fully implementing the principles of CPA including multi-disciplinary/ agency CPA reviews involving all relevant agencies engaged in the patients health, social, housing and offender care and informed by up to date risk assessments.
- The Policy and Guidance on working with Adults at Risk who do not wish to engage with services and are at serious risk of harm, should be reviewed, updated, disseminated and action taken to ensure it is understood and followed. (Multi-Agency Action)
- CMHTs receiving referrals from the Prison In-reach Team, should ensure that an assertive approach to follow up takes place in line with the Trust Policy & Guidance on working with Adults at Risk who do not wish to engage with services and are at serious risk of harm.
- Where a patient presents with both substance misuse and psychotic symptoms the CMHT should ensure that a focus on the treatment of psychotic symptoms occurs simultaneously to working in partnership with the Addiction services regarding substance misuse issues.
- All staff should be reminded of the need to consider the effect of domestic violence in all aspects of risk management and to initiate the Multi-Agency Risk Assessment Conference (MARAC) process when indicated (Multi-Agency Action). The Borderline Personality Disorder Care pathway should be updated to include referral to MARAC where appropriate.

Data sharing

- Partner agencies, especially Mental Health and Police should review their information sharing protocols and ensure they are fit for purpose in relation to safeguarding adults at risk. This should include how data is stored and accessed in line with the Data Protection Act. Where information sharing protocols do not exist (for example Level 1 MAPPA), the possibility of sharing should be speedily explored. (Multi-Agency Action)

Intra-agency and Inter-agency communication

- All agencies should revisit their internal communication processes and evaluate their effectiveness.
- All agencies should urgently consider how inter-agency communications can be enhanced. This is especially important in situations where violence by or to other individuals is assessed as a potential risk.
- When the Prison In-reach Team refer prisoners for follow up by local services this should include confirming and communicating their MAPPA status to the local team so that they can ensure that relevant agencies are engaged in CPA reviews. This should be incorporated into the annual audit of patients under the MH In-reach team being referred on to local services for follow up.

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Training and insight management

- All agencies should consider how they might develop training strategies to enhance the understanding of working styles, appropriate interventions and best practice models across and between agencies. For example, 'Is effective training in place for police forces to understand and manage mental illness?'; 'Do all agencies fully understand CPA and have effective mechanisms to contribute to this care approach?'; 'Is safeguarding training offered in multi-disciplinary, multi-agency forums? Other forms of cross agency/discipline training and staff awareness if noted to be less than optimal should be quickly addressed with appropriate training.

Independent Investigation Team Feedback on the Internal Investigation Report Findings

14.8. The Independent Investigation Team found that the Health IMRs for Mr X, Ms Y and Mr Z provide a detailed set of information regarding care and treatment interventions. The IMRs also provide a reasonably detailed chronology and history for the three service users. However there is little analysis offered in order to help the system understand exactly why the identified care and treatment weaknesses occurred and how they can be prevented in the future. The investigations offer no analysis and no underpinning systems issues are examined. This is an inherent weakness and the Independent Investigation Team concluded that this has severely limited the ability of the IMRs to establish important lessons for learning in order to ensure that patient safety is improved within Bournemouth-based services. This is a significant weakness.

14.9. The IMR Investigation Team is aware that the Serious Case Review process did not offer the opportunity for a Root Cause Analyses process to be followed and that this was a particular weakness in the methodology. The Trust was concerned that the final Serious Case Report (owned by the Bournemouth Safeguarding Board) remained in draft for over two years. This has prevented multiagency learning from taking place in a timely manner and has also prevented the implementation of important service change and lessons for learning dissemination. This is clearly an unacceptable situation.

14.10. The Independent Investigation Team concluded that in this particular case the Serious Case Review format was not the correct process under which to investigate the effectiveness of the care and treatment that Mr X, Ms Y and Mr Z received. The format does not lend itself to an examination of important health related issues and the template headings require that the key issues for investigation are addressed within the context of safeguarding only. Consequently it is the conclusion of the Independent Investigation Team that this process was not fit for purpose and has not been able to ensure patient safety and service improvement.

14.11. If this format is to be used in the future then a significant review of additional health related factors must be included in order to meet the requirement of the new NHS England Serious Incident Framework (March 2015). Points for future consideration:

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- there should be a systematic method developed to help commissioners decide under which framework independent investigations should be led (e.g. Health Serious Incidents, Serious Case Reviews, Domestic Homicide Reviews);
- homicides should not automatically trigger Serious Case Reviews; the statutory responsibility of the NHS should be taken into account and decisions should be based proportionally on the weighting of learning and accountability of each statutory agency;
- consideration should be given to joint Health, Serious Case and Domestic Homicide Reviews, whereupon negotiation can take place as to both method and methodology;
- under-pinning systems should be explored in more detail by the IMR/Serious Case Review process and a greater reliance should be placed on interviewing witnesses, especially corporate and service manager witnesses, instead of the predominately desk top review process which was deployed on this occasion.

14.3. Being Open

14.12. The National Patient Safety Agency issued the original Being Open guidance in September 2005; the guidance was then updated in 2009. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and expected to have their action plans implemented and a local Being Open policy in place by June 2006. The Being Open safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The Being Open guidance ensures those patients and their families:

- 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.

14.13. 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.

14.14. On 20 August 2012 the Chair of the Bournemouth & Poole Safeguarding Adults Board wrote to both of Mr X's brothers (who live in England) to express her condolences and to explain that a Serious Case Review would be held to examine the circumstances that led to his death. Mr X's brothers were invited to take part in the Review and contact details were given to them. As far as the Independent Investigation Team is aware the family has not yet been briefed regarding the findings of either the Health IMRs or the Serious Case Review.

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14.15. The Trust explained to the Independent Investigation Team that it did not contact the family as this was to be managed by the Adult Safeguarding Board. The Independent Investigation Chair and a Senior Officer from NHS England visited Mr X's youngest brother on 6 January 2015. It was evident that he had been given limited information throughout the process and had not been previously informed about the depth of his brother's mental health problems. He, and the rest of his family, has to adjust to this information and he is reflecting on the additional support he could have given to his brother had he known about this whilst he was still alive. The Independent Investigation concludes that the family were not managed in keeping with the *Being Open* guidance and that this caused additional pain and distress to them.

14.4. Staff Support

14.16. There is significant learning for the Trust to consider in relation to the management of witnesses to investigations. Witnesses perceived a culture of blame and several told us that they were initially informed about the incident in what they perceived to be an angry manner. Subsequently several witnesses felt that they had been unfairly blamed and their practice criticised. However feedback from the original investigation process was patchy and witnesses are collectively of the view that they still do not know exactly what the deficits in their practice were or how they should be addressed.

14.17. The Trust did not take up the offer of a witness briefing workshop made by the Independent Investigation Team. Consequently many witnesses were ill prepared and did not receive the letters that had been sent to them by the Independent Investigation Team (via the Trust) several weeks earlier until a few days before their interviews. Many witnesses were anxious and tearful. The Independent Investigation Team fed this back directly to the Trust Board at the end of the Interview process in order to ensure lessons were learned as swiftly as possible and this would not happen again.

14.5. Progress against the Trust Internal Review Action Plan

14.18. The Multiagency action plan is set out below. The progress made to date is as follows:

1. A Care Plan focus day held 4 August 2014.
2. A Care Plan Task & Finish Group established – developed care plan audit and care plan dashboards currently in use.
3. Serious Incident Management Support (SIMs) established to offer post incident support to staff - training delivered in June 2015.
4. A Mental Health Learning Pathway was developed and launched in Nov 2014. This is mandatory for all new joiners and mandatory three yearly updates have been agreed
5. The CMHT Review commenced in December 2014; this will initiate a cultural change and streamline service delivery across all CMHTs in a systematic and equitable way.

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6. September 2014 Quality Matters Newsletter - summary of learning from homicides re-issues of care planning and risk assessments.
7. Learning from incidents events - April, May and June 2015.
8. Developed podcast process for staff for sharing learning from incidents - 2015 onwards.
9. Prison In-reach team share caseload details monthly with Offender Management Team to identify those on MAPPA and to support joint working. Prison In-reach team closure summary amended to include section on MAPPA with a prompt to contact probation/OMU if not known.
10. Joint work with Police re-streamlining access to MAPPA information.
11. All teams identified a clinician to be trained in MARAC procedures in order to guide team decision making with regard to MARAC implementation. Reference to MARAC included in internal safeguarding training update to provide general awareness to staff and MARAC training delivered.
12. Difficult to Engage Policy reviewed and explicit reference made to provide an assertive approach to individuals who have been released from prison.
13. All teams reminded that all patients can self-refer back to the CMHT within 12 months of discharge without requiring going back to the GP. Template letter was developed as an editable letter in RiO.
14. Specialty Manager Offender Health attends monthly Joint Operational Boards, reporting on progress with Forensic Caseload.

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BOURNEMOUTH AND POOLE ADULT SAFEGUARDING BOARD

MULTI-AGENCY ACTION PLAN FOR BPSCR4 (Mr X, Ms Y and Mr Z)

This following multiagency action plan has been produced by representatives from Dorset Clinical Commissioning Group, Dorset HealthCare University Foundation Trust, Dorset Police and the Poole and Bournemouth Adult Safeguarding Board on 15 August 2014. The multiagency action plan set out below is drawn from learning identified from Independent Management Reviews and the Draft overview report. The recommendations referred to in the Overview report have been linked into themes and below sets out how these areas will be taken forward. Individual agency action plans have also been developed.

Organisations are asked to complete the 'Progress' column below and work towards the 'Action' section by the timescale indicated. Monitoring of progress to be carried out by the Board (Quarterly) via the Serious Case Review panel, and audited internally by various agencies.

Table Two

Recommendation	Action	Time-scale	Progress
CARE PLANNING/RISK ASSESSMENT/RISK MANAGEMENT			
1, Review of the application of the Assessment and Care Planning policy and principles across partner agencies in regard to:	Set up a Multi-Agency Task and Finish Group to include representatives from: <ul style="list-style-type: none">▪ DHCUFT▪ Dorset CCG▪ Bournemouth, Poole and Dorset Local Authorities	Jan 2015	

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Recommendation	Action	Time-scale	Progress
<ul style="list-style-type: none"> ▪ Service User/Carer Involvement ▪ Care planning ▪ Risk assessment and risk management ▪ Involvement of all relevant parties in the Care Programme Approach process 	<ul style="list-style-type: none"> ▪ Housing representation (commissioners) ▪ Drug Action Teams <p>The group is asked to review:</p> <ul style="list-style-type: none"> ▪ whether application of the policy is robust and fit for purpose ▪ make any recommendations for change ▪ Clarify the purpose and use of the CRIMP tool and how it links with the CPA process ▪ Consider whether there is a monitoring role required by the Quality Assurance Group ▪ case workers to review their caseload as a whole to enable them to consider any interactions between clients, especially those at high risk. 		
<p>2. To ensure that identified staff groups within each agency are aware of when and how to make a referral to Multi-Agency Risk Assessment Conference (MARAC)</p>	<p>This recommendation to be shared with the MARAC steering to confirm:</p> <ul style="list-style-type: none"> ▪ Each agency has a training programme and target group identified and progress against training is monitored. ▪ That the training programme is fit for purpose 	Dec 2014	Pete Little (Dorset Police) Lisa Dowry (P), Rachel Young (B) and Nicola Pengelly (Dorset) to update.
<p>3. Partner agencies, especially Mental Health and Police should review their information sharing protocols and ensure they are fit for purpose in relation to safeguarding adults at risk. This should include how data is stored and accessed in line with</p>	<p>Set up a task and finish group to:</p> <ul style="list-style-type: none"> ▪ review how many MAPPA one cases are known to health ▪ consider scale of information sharing system required and what benefits this would bring in addition to effective use of the Care Planning Approach. 	Jan 2015	Scoping meeting has taken place and access to data is being agreed.

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Recommendation	Action	Time-scale	Progress
the Data Protection Act. Where information sharing protocols do not exist (for example Level 1 MAPPA), the possibility of sharing should be speedily explored.			

15. Notable Practice

15.1. The death of Mr X took place in July 2012 – over three years ago. Since this time Dorset HealthCare University NHS Foundation Trust has undertaken many service improvements. There were several areas of notable practice highlighted during the course of the Investigation. These areas of notable practice are significant and of relevance to other mental health providers across the country. HASCAS Health and Social Care Advisory Service has significant experience of working with mental health Trusts across the country and is of the view that work currently being undertaken in Dorset is of an exceptionally high standard and truly innovative in approach. Examples are as follows:

Pre Homicide

- 1. Care and Compassion:** Over time the treating teams for each of the three service users provided compassionate care and treatment. Services worked hard and engaged with Mr X, Ms Y and Mr Z in a respectful, professional and non-judgemental manner at all times. It is apparent that for at least a decade Personality Disorder has not been regarded as a diagnosis of exclusion and a robust care and treatment pathway has been developed and implemented.

Post Homicide

- 2. Working with the Police and MAPPA Processes:** The Trust has an excellent example of notable practice regarding the work that it has conducted in conjunction with the Dorset Police and associated Criminal and Youth Justice Partners (please see appendices two and three). Dorset mental health services have also developed a street triage pilot which has recently been extended and works with the police to get people into health services rather than custody. Dorset police and mental health services are now working together to ensure mental health service users with emergency acute episodes of care are managed appropriately and not confined in police cells. To this end a “*Staying Safe*” workbook has been developed and training provided to the police in relation to mental health issues and management. There is a police and mental health forum working at grass roots level across agencies to address needs of vulnerable individuals - such as Mr X - whose situation would now be highly visible to services and managed differently
- 3. CPA:** The Trust currently conducts regular audits and operates a robust dashboard system to monitor CPA compliance across the organisation. Of note is the development of a service user CPA guidance leaflet and a staff CPA Review Guidance Pack. Both documents set out clearly the key roles and responsibilities of both service users and Trust and provides a practical set of instructions about to get the most out of the CPA process. These documents are of an excellent quality, easy to work through and full of evidence-based best practice guidance.
- 4. Carer Strategy:** A three-year Carer Strategy has been developed. The strategy acknowledges that carers, service users and mental health services need to work in partnership in order to promote recovery. The strategy states that “*We believe that carers should be able to seek the support they need at the time that they need it and that they should be recognised as expert partners in care*” and sets

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out how this should be achieved. This strategy has been shaped by the updated Triangle of Care document (Worthington et al, 2013). The Triangle of Care identifies 6 core elements to effectively support carers.

- Carers and the essential role they play is identified at first contact or as soon as possible thereafter.
- Staff are 'carer aware' and trained in carer engagement strategies.
- Policy and practice protocols regarding confidentiality and sharing information are in place.
- Defined post(s) responsible for carers are in place.
- A carer introduction to the service and staff is available, with a relevant range of information across the acute care pathway.
- A range of carer support services is available.

The Triangle of Care also calls for regular assessment and auditing of providers to ensure these six elements are in place.

HASCAS is of the view that this strategy could form a sound basis for other organisations who are currently reviewing carer support and assessment practice.

- 5. Adult Mental Health Care Pathway:** The Trust is currently in the process of developing an Adult Care Pathway. The pathway is being developed with the Clinical Commissioning Group and via a series of public consultation forum events to ascertain early feedback. The consultation process will be completed by April 2016. This work is notable, not only in that it seeks to provide a robust pathway through referral, transfer and discharge processes, but due to its inclusivity and consultation with the public and partner organisations.
- 6. Mental Health Foundation Learning Pathway:** The draft pathway document states that *"In recent years, the need for a foundation learning pathway has become increasingly apparent in order to ensure that mental health staff new to the trust are provided with a standardised platform of learning and development in the first year of being in post. This pathway has, therefore, been developed to provide a range of level one courses which are considered fundamental to effective practice in mental health"*. The pathway will become fully operational by the time of the publication of this Investigation report and will apply to all registered and non-registered clinical staff.

16. Lessons for Learning

16.1. There are three key significant lessons for learning. These lessons are pertinent to the Trust and are also transferable to other mental health providers across the country.

- 1. CPA, Risk Assessment and the taking of a Psychiatric History:** The development of a comprehensive psychiatric history is of the utmost importance. Over the years - due to such things as *News Ways of Working*, the advent of the electronic clinical record and the fragmentation of mental health services - many

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service users no longer have a detailed history compiled and/or updated. In the case of Mr X and Ms Y this served to present a distorted view of the risks that they presented both to themselves and to others. It is probable that had services been able to access a full history of these individuals a different approach would have been taken regarding care and treatment decisions.

CPA and clinical risk assessment constitutes basic building blocks of care and treatment. These processes should be a dynamic and should take into account a service user's history and current presentation. The assessment and management of risk should always be managed in accordance with Trust policy no matter how challenging services may be to deliver.

Basic building blocks of care should consist of:

- a sound knowledge of the patient;
- a psychiatric history to be taken;
- an assessment of mental state;
- an assessment of need;
- an assessment of risk;
- a diagnostic and risk formulation;
- clear and well communicated care plans;
- clear and well communicated risk management plans;
- clear and well communicated crisis and contingency plans.

Omissions in the provision of these basic building blocks cannot be countenanced as they form the core processes of evidence-based mental health care provision. Every health and social care professional has a duty of care to ensure that they are achieved. Every statutory service has a duty of care to ensure that they are carried out and that the resource available is adequate to do so.

2. Interagency Working and Professional Communication: HSG (94) 27

independent homicide investigations of this kind have consistently found causal factors in relation to homicides perpetrated by mental health service users and failures in levels of professional and inter agency communication. It is common for members of a treating team to know a service user well. It is also common for documentation to not always record all of the pertinent details known about any one individual. When service users are handed over from one treating team to another it is often the case that only partial information is imparted. In the case of Mr X it is evident that information was not always shared between treating teams and agencies, and whilst this did not make a direct causal contribution to his death, it represents a significant omission that had a negative affect on his quality of life and recovery.

3. Internal Investigation Process: The internal investigation process was aligned to that of the Safeguarding Adult Review and this was at the direct instigation of the Strategic Health Authority (now NHS England). In principle the commissioning of joint investigation processes is a good idea. It encourages joint working and joint lessons for learning opportunities across the health and social care continuum. However on occasions joint commissioning can yield investigations that are not as insightful as they need to be due to the adoption of frameworks

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that may not be a 'best fit'. In this case the Safeguarding Adult Review process and report template did not lend itself to the full examination and understanding of the underlying mental health management issues. This has led to a delay in services receiving a robust set of findings, conclusions and recommendations. In future investigation commissioning should be based upon the primacy of the issues - this should then lead to the assignment of the most appropriate investigation lead body or agency.

17. Recommendations

17.1. 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.

17.2. The Independent Investigation Team worked with the Dorset HealthCare University NHS Foundation Trust and the NHS Dorset Clinical Commissioning group to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress, development and good practice have also 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.

17.3. Each recommendation is set out below in accordance with the relevant progress that the Trust has already made since the time of the incident. The reader should note that most of the identified contributory factors and service issues will be addressed as part of the Trust's new Adult Care Pathway. However the Adult Care Pathway is still under development and the recommendations below - whilst acknowledging the good work already in train - sets out areas that should be incorporated into this work.

Recommendation One: Diagnosis, Medication and Treatment

Investigation Findings

- ***Contributory Factor 1. Mr X did not receive the correct diagnosis for many years. This had a direct impact on the care and treatment model offered to him as he was not understood appropriately in the context of his mental illness and poly-substance misuse.***
- ***Contributory Factor 2. Mr X did not receive a full and appropriate care and treatment package in keeping with his complex presentation and ongoing psychotic symptoms.***

Progress Made to-date

17.4. Work is currently ongoing with the construction of an Adult Care Pathway. However the Independent Investigation findings in relation to diagnosis, medication and treatment need to be made explicit within its development.

Recommendation

- ***The new Adult Care Pathway should make explicit the need for, and benefits of, a clear diagnosis/differential diagnosis for service users. The diagnosis, combined with service user presentation, should inform any ensuing care and treatment package which should comply with current NICE best practice guidance.***

Recommendation Two: The Care Programme Approach (CPA)

Investigation Findings

- ***Contributory Factor 3. The CMHT did not implement CPA in keeping with Trust policy guidance. This was exacerbated by the DBT service model as operated by the CMHT which required extensive input and reduced the capacity of the team. Whilst this did not have a direct causal link to Mr X's death it created the circumstances where his mental health was neither managed nor monitored appropriately and left him over time in a position of increased vulnerability especially when actively psychotic.***
- ***Contributory Factor 6. Poor understanding of, and compliance to, Trust policy and procedure led to a situation where the care and treatment of Mr X was suboptimal and where the risks presented by Mr X and Ms Y were poorly identified and therefore poorly managed.***
- ***Service Issue 1. CPA processes were weak and did not adhere to policy expectation.***

Progress Made to-date

17.5. The Trust has made significant progress in this area since the time of Mr X's death. Services have now changed in relation to the DBT approach and work has been ongoing to ensure full compliance with Trust CPA expectations. It has been a significant finding of the Independent Investigation that historic poor CPA practice has been exacerbated by a culture of poor policy compliance.

17.6. The Trust now has in place a comprehensive process of audit which monitors CPA and risk assessment compliance. Compliance can be tracked to each individual clinical team and dashboard findings are made available on a monthly basis. The data from current audits suggest that the Trust is achieving a 95 - 100 per cent success rate.

17.7. The Trust is not only monitoring compliance in relation to the CPA process - it is also actively managing quality. As has been set out in the notable practice section above - a detailed CPA guidance toolkit is available to all staff which is supported by training update programmes. This approach sets out the Trust's expectation clearly together with practical advice as to how to achieve CPA policy requirements and best practice guidance.

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17.8. HASCAS has been able to access significant evidence regarding CPA service improvement and following discussion with NHS Dorset Commissioning Group concludes that significance progress has been made.

Recommendation

- ***The Trust should continue to undertake its audit programme and should in addition work with NHS Dorset Clinical Commissioning Group to increase the CPA compliance statistics still further. This to be examined in the light of the Trust's CPA guidance toolkit and revised training programme – the effectiveness of which should be subject to evaluation.***

Recommendations Three (a), (b) and (c): Clinical Risk Assessment

Investigation Findings

- ***Contributory Factor 4. Mr X's risks and resulting antisocial behaviour were not understood fully in the context of his Schizophrenia. This meant that no strategies could be developed to maintain his safety and the safety of those around him.***
- ***Service Issue 2. Risk assessment and management processes were weak and did not adhere to policy expectation.***
- ***Service Issue 3. Interagency working was weak and important opportunities were missed in relation to MAPPAs and information sharing.***
- ***Service Issue 4. Prison referral and discharge processes were not robust in the case of Mr X. The Independent Investigation Team was told that these processes are still problematic.***

Progress Made to-date

17.9. Clinical risk assessment is now subject to regular compliance audits in the same manner as CPA. Currently the Trust has a 95 per cent compliance rate; the figures for which are endorsed by NHS Dorset Clinical Commissioning Group.

17.10. There is a new training pathway for mental health and MARAC champions in each CMHT; there is also MAPPAs training in place. There is ongoing work taking place between the Trust, the police and probation services to ensure that offenders who fall 'sub MAPPAs' are not lost to the attention of service. Had Mr X and Ms Y been open to service today their cases would have been managed differently in that information would have been gathered, risk alerted and a multi-agency process identified to manage them. However despite the progress made there remain information sharing difficulties as inter agency protocols are not yet aligned.

Recommendations

- ***3 (a) The Trust should continue to undertake its audit programme and should in addition work with NHS Dorset Clinical Commissioning Group to***

increase clinical risk assessment and management compliance statistics still further.

- ***3 (b) The Trust and its partners from the police, MAPPA and probation services should consider the findings and conclusions of this Independent Investigation and route Mr X and Ms Y as case studies through current processes to ensure that service users with a similar profile would not be 'lost' to service today and that their management would be proportionate and robust. Information sharing protocols should be examined as part of this process to assess if they are fit for purpose.***
- ***3 (c) The new Adult Care Pathway should make explicit prison referral, transfer and discharge processes to ensure that service users with severe and enduring mental illness are managed in a seamless way between different agencies.***

Recommendation Four: Interagency Working

Investigation Findings

- ***Contributory Factor 5. Interagency working was poor with organisations working in silos. This made a contribution to the poor overall management of Mr X and Ms Y.***
- ***Service Issue 5. Poor ongoing communication and working processes between Addictions Services and other agencies may limit the learning from this Investigation and others in the future.***

Progress Made to-date

17.11. There is an acknowledgement that the new Adult Care Pathway will address to a large extent interagency and inter-service operational issues. However it is apparent that detailed work will be required in order to reconcile the manner in which mental health services, commissioners and the DAAT work with independent and third sector providers. This will be essential in order to guarantee a seamless care pathway for service users and to also ensure that in future lessons for learning can be determined when things go wrong.

Recommendation

- ***NHS Dorset Clinical Commissioning Group, the DAAT and the Dorset HealthCare NHS Foundation Trust should work with partner organisations to determine how best a multiagency approach can be taken to the Adult Care Pathway in order for it to be developed in the best interests of service users who access services and also in the best interests of public safety.***

Recommendation Five: Documentation and Professional Communication

Investigation Findings

- ***Service Issue 7. Documentation and professional communication processes were, and are, weak. This prevents the sharing of information in a timely manner and also acts as a barrier to joint working.***

Progress Made to-date

17.12. The Trust has recently moved to an upgraded version of RIO which should ensure better compatibility with the needs of clinical staff inputting onto the system. Net books are in the process of being issued to staff to ensure maintaining an interface is easier. However it is acknowledged that in parts of rural Dorset connectivity is set to remain an issue for some time. There remain several different electronic clinical record systems in place; VISION (local services aligned to the GP system) and HALO (DAAT database). This means that professional communication processes must 'work harder' if important patient information is to be shared in a consistent and timely manner.

Recommendation

- ***Information sharing protocols need to be built into the new Adult Care Pathway. This will be a complex task but will be essential in order to underpin new ways of working in the best interests of service users.***

Recommendation Six: Clinical Governance and the New Adult Care Pathway

Investigation Findings

- ***Contributory Factor 6. There was failure of Trust governance systems to ensure an evidence-based approach was taken and maintained in keeping with both local and national good practice expectation.***

Progress Made to-date

17.13. The Trust has completely reorganised its governance systems. This is detailed in section 12.13 above – HASCAS has confidence in the improvements made and conclude that these improvements will have a positive impact upon the areas of poor practice identified by this Investigation. At the time of writing this report the Trust was subject to Monitor and CQC inspections the outcome of which will not be known in time for inclusion into this Investigation.

Recommendation

- ***The Trust should act upon any recommendations set by Monitor and the CQC following the publication of their findings. HASCAS has no recommendations to make in connection with this Investigation.***

Recommendation Seven: Internal Investigation Process

Investigation Findings

17.14. The Independent Investigation found the internal investigation processes deployed were not detailed or robust enough to identify lessons for learning in a timely manner. This was in part due to the decision made by the strategic Health Authority (now NHS England) for the process to be aligned with that of the Safeguarding Adult Review.

Recommendation

- *In future investigation commissioning should be based upon the primacy of the issues - this should then lead to the assignment of the most appropriate investigation lead body or agency.*

18. Glossary

Care Coordinator	This person is usually a health or social care professional who coordinates 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 occurs 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.
Care Coordination	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
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.
Mental Health Act (1983 and 2007)	The Mental Health Act 1983/2007 covers the assessment, treatment and rights of people with a mental health condition.

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Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care.
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.
PRN	The term "PRN" is a shortened form of the Latin phrase <i>pro re nata</i> , which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
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.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
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.
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.

Appendix One

A Dorset HealthCare University NHS Foundation Trust Paper

A summary of our joint working with Dorset Police and associated Criminal and Youth Justice Partners

Dorset HealthCare University NHS Foundation Trust Criminal Justice Liaison and Diversion Service

Dorset Healthcare University Foundation Trust (DHC) Criminal Justice Liaison and Diversion Service is principally concerned with the assessment and identification of people with mental health problems within the Criminal Justice System (CJS), and assisting criminal justice agents to ensure that effective and appropriate outcomes accrue for the individual.

As such, we manage the interface between criminal justice and health and social care to the benefit of all agencies and more importantly the service user.

The service is intended to be accessible at the earliest stage once an individual is suspected of having committed a criminal offence, be available at the point of need, and be available at, but not limited to, the following locations:

- Community settings, including schools and restorative justice, where police engage with children and young people
- Police custody suites
- Police stations (or other prosecuting authorities) where voluntary attendance occurs
- Magistrates' Courts
- Youth Courts and referral order panels
- Probation to assist with the production of Pre-Sentence Reports (PSR)
- Youth offending teams (YOTs)

The overall strategy for the DHC Criminal Justice Liaison and Diversion Service has recently been set out in national guidance within the operating model for liaison and services across NHS England September 2013. The liaison and diversion service is intended to improve the health and criminal justice outcome for adults and children who come into contact with the criminal justice system. The liaison and diversion service will ensure that individuals connect with appropriate interventions in order to reduce health inequalities, improve physical and mental health, tackle offending behaviour including substance misuse, reduce crime and re-offending, and increase the efficiency and the effectiveness of the criminal justice system.

The key aims of the liaison and diversion service are to improve the system of health care and support services for vulnerable individuals for effective liaison with appropriate services, and for the diversion of individuals where appropriate, out of the youth and criminal justice system into health or other supported services with an expectation that there occurs a reduction in overall offending.

The liaison and diversion services will ensure that these individuals connect with appropriate interventions in order to reduce health inequalities, improve physical and mental health, tackle offending behaviour including substance misuse, reduce crime and re-offending, and increase the efficiency and effectiveness of the criminal justice system. The key aims of the DHC Liaison and Diversion Service are set out as follow:

- Improve access to healthcare and support services for vulnerable individuals through effective liaison with appropriate services and a reduction in health inequalities.
- Diversion of individuals, where appropriate, out of the youth and criminal justice systems into health or other supported services.
- Delivery of efficiencies within the youth and criminal justice systems.
- The reduction of reoffending.

DHC Criminal Justice Liaison and Diversion Service trial scheme delivers identification, triage, and assessment.

The Liaison and Diversion Service will use case identification and screening to identify a wide range of health issues and vulnerabilities including, but not limited to the following:

Adult population

Mental Health
Learning Disabilities
Autistic Spectrum
Substance Misuse
Physical Health
Personality Disorder
Acquired Brain Injury
Speech, Language and Communication needs

Children and young people

Mental Health (including conduct disorder, emerging symptoms and multiple risk factors for poor mental health)
Speech, Language and Communication needs
Attention Deficit Hyperactivity Disorder
Learning Disabilities
Learning Difficulties
Autistic Spectrum
Substance Misuse
Physical Health
Acquired Brain Injury
Safeguarding Issues/Child Protection Issues

Locality and hours of operation

The Criminal Justice Liaison and Diversion trial scheme will endeavour to be located alongside colleagues from the respective disciplines.

In each location, an identified administration and consultation environment will be utilised in order for the service to screen and where necessary assess individuals and collate and review confidential information.

Locality Police Custody

Bournemouth and Weymouth Police Custody Suites

- Bournemouth and Weymouth core hours of operation: 07.00 – 20.30hrs, 7 days a week.
- Urgent referrals not within core hours e.g. hospitalisation to prevent imminent risk to self/others due to mental health or learning disability or the need for a Mental Health Act (MHA) assessment should be made via the Crisis Home Treatment Team or via local authority engagement during requests for formal assessment under the MHA. For children and young people referrals should be made using the normal out of hours arrangements via requests through local authority engagement.
- Referral to the externally commissioned forensic medical examiner should be considered where there are urgent concerns out of hours.
- For non-urgent referrals within custody, discussion should take place with a Liaison Practitioner when they commence their shift and a schedule of intervention agreed that appreciates priory.

Locality Court

Bournemouth and Weymouth Magistrates' Courts with provision to support Bournemouth Crown Court should circumstance dictate.

Hours of operation: 08:30 – 16:30hrs Monday - Friday

Bournemouth only

Saturday 08:30 – 12:30hrs

Locality Non-custodial / Voluntary Attendance

Hours of operation:

07.00 – 20.30 hours 7 days a week via custody response; additional support accessible via liaison with our office administration 08:30 – 16:30hrs Monday - Friday

Locality Youth Justice

Primarily located at our office base but with daily deployment into youth justice settings.

Hours of operation: 09:00 – 17:00hrs Monday – Friday

Locality Street Triage

Please note from the 27th June 2014 the CJLD Service have provided an evaluative street triage pilot scheme. This project is locally commissioned and operates alongside existing provision.

The project is for a first response team which will at the request of the police, attend situations involving 'Mental Health Issues' and triage people of all ages, whether they have learning disabilities, personality disorder, substance misuse, or mental health issues. This response will be at the first point of contact with the police, at the street level and prior to a decision to detain a person under the Mental Health Act.

The team is open and accessible to anyone coming into contact with the police outside of custody and be responsible for ensuring that there is engagement with services and if not then they will re-engage with that person in an assertive manner. If the person is taken into custody they will ensure their health needs are known, enabling the police and courts to make informed decisions about charging and sentencing.

The implementation of this team will lead to more timely intervention by mental health professionals and avoid unnecessary detention either in a police station or hospital which would equate to a better experience for these individuals.

Hours of operation: 19:00 - 08:15hrs 3 days a week (Friday, Saturday & Sunday)

Appendix Two

Pilot to Reduce the Number of people with Mental Health Problems Being a Victim of Crime

1.0 Introduction

- 1.1 The Dorset Police and Crime Commissioner (Martyn Underhill) has secured funding for a pilot to reduce the number of people with mental health problems becoming victims of crime.
- 1.2 This additional funding will also see the development of a designated Mental Health Lead within Dorset Police, with whom Dorset HealthCare and Dorset Mental Health Forum are delighted to be able to work in partnership with to deliver this project in partnership with other key agencies.
- 1.3 This paper outlines proposals on how best to deliver this pilot project within the timescale (one year), by working with the new designated Dorset Police mental health lead and building on existing expertise, knowledge and networks to achieve the required outcomes.
- 1.4 The objectives of the pilot are:
- To carry out a local needs analysis
 - To reduce the number of individuals with mental health problems being a victim of crime
 - To reduce the number of individuals with mental health problems being a victim of repeat crime
- 1.5 It is recognised that people with mental health problems are three times more likely to be a victim of crime than the general population, five times more likely to be a victim of assault and rises to 10 times more likely if you're a woman, more likely to be a repeat victim of crime and far less likely to be satisfied with the service they receive (*At Risk, Yet Dismissed* - 2014 Mind).
- 1.6 The Mind report also identifies three key risk factors for individuals with serious mental illness to becoming victims of crime:
- Less Engagement with Services
 - Drug misuse
 - History of being violent
- 1.7 With these findings and risk factors in mind it is proposed that Dorset Mental Health Forum (Becky Aldridge CEO) leads the project and is supported by two very experienced and senior Trust staff, Martyn Lewis (Manager, Bournemouth and Poole, Assertive Outreach Team) and Emer Kelly (Team Leader Bournemouth East CMHT) and by the Director of Mental Health, Jane Elson. The Trust Mental Health Recovery Lead (Phil Morgan) will also play a key role in the design and delivery of the project, bringing his expertise in co-production and delivery of programmes via the Recovery Education Centre.

- 1.8 The Assertive Outreach Team already work with individuals who are known to have been subject to crime and who can be identified as having the risk factor identified above. Similarly, Bournemouth East CMHT provides services in the Boscombe area which is recognised as an area of deprivation and has multiply types of accommodation for people at risk of being victims such as the women's refuge, sheltered accommodation and multiply single occupancy dwellings.
- 1.9 Project leadership through the Dorset Mental Health Forum provides will ensure a user focussed, non stigmatised and co- produced approach supporting users to take control of their lives, supporting them to cope, recover and learn
- 1.10 Specific resources for the pilot are:
Peer Specialists - are people who have their own lived experience of mental health problems, whose role is to use their lived experience to inspire hope and belief that recovery is possible. People with similar experiences can help to normalise and validate people's experiences of dislocation and disconnection and support people to develop their own recovery skills. Peer specialists act as a bridge between professionals and people who access services, to enable both parties to build more effective relationships.
Project Support Worker - to provide project capacity within Assertive Outreach and East Bournemouth CMHT

2.0 Project Definition

2.1 Needs Assessment/ Identification of resources

- 2.1.1 As the most likely people to be victims of crime are those who are less likely to be engaged actively in services, be using drugs, and have a history of violence it was decided to target the two teams who have the highest caseloads with people who meet this profile, which are the Bournemouth and Poole Assertive Outreach Team and Bournemouth East Community Mental Health Team.
- 2.1.2 Both teams reported that they already identify victims of crime at the assessment process and have this ingrained into practice. The identification of people who are at risk or who have been victims of crime will be achieved by reviewing all of those on Enhanced CPA and reviewing all individuals subject to safeguarding referrals from those teams. The aim would be to identify all individuals who had been subject to crime within the last 2 years. A core set of data will be collated including:
- ID
 - Nature of crime(s) or Safeguarding
 - Location(s) and time(s)
 - Reported or not Reported – and perceived barriers to reporting
 - Any victim support provided
 - Qualitative feedback from those who have been victims
 - Numbers of individuals at potential risk of crime

2.1.3 In addition, work will also be undertaken to identify other individuals who are not engaged with these teams via the Recovery Education Centre who may also benefit from the interventions delivered via the pilot. However, for those not accessing secondary care mental health services it will be difficult to collate detailed information on their experience of crime.

2.1.4 Within this phase of the project, it will also be important to carry out a community asset mapping exercise, identifying what support and other agencies are available (e.g. the Boscombe shop project where people can seek safety in any shop and they will call the police, Domestic Violence Charities, etc). It will be important that this is carried out in partnership between the peer specialist and mental health professional, in order to use it as a process to establish relationships as well as identify resources.

2.2 Practical Interventions that reduce the number of victims/ repeat victims

2.2.1 It is important that this project is able to become sustainable and rather than creating layers of additional structures, where possible existing provision is enhanced to respond to and meet the needs of this client group. In order to effectively do this the project group has identified the peer specialists could play a key role in working with the individual and promoting multiagency working

2.2.2 Based on research and existing good practice, the project group proposes two elements to the practical interventions delivered within the Pilot. These elements are:

1) Engagement and Support

2.2.7 This will take place on two levels, firstly trying to engage the person who has been or is at risk of being a victim of crime and secondly engaging with various agencies who will offer support to that person to ensure that they follow best practice in supporting people with mental health problems.

A) The person

2.2.8 It is important to note that each person will have their own individual needs, wants and responses following traumatic events and therefore as far as possible people should be given choices in regards to engaging and participating in support.

- Mental Health professional (who they will be seeing as part of their care co-ordination)
- Peer Specialist
- Safeguarding Professional
- Practical Support (e.g. safer homes)
- or any combination of the above (subject to availability)

2.2.9 The role of the peer specialist is pivotal in building the rapport and relationship, however for some people they will not necessarily wish to meet with someone they do not know and it will be important to tailor each approach to each individual.

- 2.2.10 In order to maximise effective engagement it will be important to identify existing good practice and to build on it. Therefore both Mental Health teams will need time to review and reflect on existing practice.
- 2.2.11 Research indicates the importance of listening, validating, believing, being responsive, having an individualised response, taking action and reporting, and supporting people to take steps to prevent becoming a victim of crime again (Mind, 2014).
- 2.2.12 The purpose of this engagement work is to support people going through this process and enable them to effectively seek support from other agencies or engage in education to develop their skills to keep themselves safe. It will be important to help people recognise what they are doing already, for example identifying their own safety plan, thinking of things that the Care Co-ordinator had never considered, for example *wearing a different colour cap everyday so they are less visible and therefore more difficult to target*.
- 2.2.13 There is an opportunity to offer people subject to crime ‘debriefing’ about their experience, by someone who wasn’t there usual worker, this could be beneficial in people being able to reflect on their experience in a different way and forms a further opportunity for potential engagement and building confidence to move to the recovery education phase.

B) Other Agencies

- 2.2.14 The engagement phase also needs to include engagement with other agencies, this needs to build on the work of community asset mapping, in particular, the peer specialists building relationships with the primary agencies (e.g. police, housing association, court liaison, people first, advocacy, women’s refuge, Butterfly foundation) that are currently supporting people or likely to be support people if they become victims of crime. This will identify other organisations to become more directly involved in the project and to build a menu of support options

2) Education

- 2.2.15 It is proposed that there will be three levels of recovery education that could be offered to individuals, these are course that are co-produced and co-delivered by peer specialists and professionals. These are:
- 2.2.16 **Prevention and Resilience Building:** This will consist of a 1 day *Keeping Yourself Safe* Course in the Dorset Recovery Education Centre (REC). This could be delivered in partnership with Dorset Police Mental Health Lead. Recovery Education is a form of learning which brings together professional expertise, the lived experience expertise of a peer specialist and focused on the person identifying their own solutions through exploration. The Wellbeing and Recovery Partnership have developed a Recovery Education Centre which offers this approach in a formal educational setting but as also been piloting more intensive recovery education for those requiring additional support. The Recovery Education Centre is open access to anyone who is 18 and lives in Dorset but is marketed to those who access secondary mental health services.

- 2.2.17 The course would support people to identify what they are doing already to prevent themselves becoming victims of crime, identify what additional things they can do and where to seek additional help from other agencies. The Autumn REC prospectus is to be imminently produced which will enable this course to be published, written and commenced by December. Further courses will be delivered in the Spring and Summer terms of 2015.
- 2.2.18 **Keeping Yourself Safe Skills Workshop:** This would be a future development based on the success of the pilot and capacity being available.
- 2.2.19 **Keeping Yourself Safe 1:1:** These 1:1 sessions would be delivered by a peer specialist (or sometimes 2:1 if a professional was going to be delivering alongside the peer specialist) and would be based on the Skills Workshops but on a 1:1 basis either within a neutral community space or a person's home. These 1:1 sessions will need to be managed within the capacity of the pilot. These would be aimed at people who would not find the Workshops beneficial or may have difficulty accessing community resources, and again would be referral only. These sessions can be specifically tailored to meet specific requirements.
- 2.2.20 This range of options allows specific education to be personalised and tailored to people's specific needs. In addition, education and training would be offered (and potentially co-produced and co-delivered) to the other key agencies on how best to effectively support someone with mental health problems who has been a victim of crime, thereby increasing the efficacy of the agency to support someone and future sustainability.
- 2.2.21 The peer specialist input into the educational delivery will come from the peer specialists who are employed in the engagement phase so it provides a joined up approach and it can be less anxiety provoking to attend a course or workshop when you know the facilitator.
- 2.2.22 Should resource be available the project group could also consider making a coproduced partnership training video for staff of various agencies, on how to effectively support people with mental health problems who are victims of crime and also a video that can be posted on YouTube so people can identify things they can do to keep themselves safe.

2.3 Evaluation

- 2.3.1 The second two objectives of the project are:
- To reduce the number of individuals with mental health problems being a victim of crime
 - To reduce the number of individuals with mental health problems being a victim of repeat crime
- 2.3.2 Whilst it would be difficult to explicitly evidence a reduction in the number of individuals with mental health problems being a victim of crime within a one year pilot, the evaluation could include:

Identification

- Numbers of individuals identified within both mental health teams and via the Dorset Mental Health Forum

Engagement and Support

- Nature and type of engagement strategy and outcome ie Practical support (home safety), development of safety plan, engagement in recovery education, engaged with other community support agency and so on.
- repeat incidents of crime within pilot period.

Education

- Number of attendances at Keeping Yourself Safe Course (REC)
- Qualitative feedback regarding awareness, options and attitudes to keeping safe, knowledge of where to access support and feeling safer
- Number of targeted 1:1 sessions with personal narratives regarding support, education and skills development

3.0 Resources

Peer Specialists -

Dorset Mental Health Forum would be looking to recruit two part time peer specialists to be involved in this project (approximately 1.2 FTE). Peer specialists would have a range of experiences and may well come from existing staff. Peer specialists will have additional training on supporting victims of crime and safeguarding as required. It will be important to have one peer who is skilled at developing others and others who have had direct experience of and recovery from being victims of crime. The rationale for employing peer specialists rather than health professionals is that engagement is such a key need for this client group. The evidence around peer specialists is that they are able to deliver support at least as effectively as traditional staff, that they increase engagement and can reduce admissions to hospital. Emerging studies are showing that peer specialists can increase hope, activation to participate in treatment and activation to self-manage. (Davidson, 2014)

Forum Peer Specialist Team and Project Budget

Senior Peer Specialist Trainer and Engagement (18 hours)	£11,207
Peer Specialist (16 hours)	£8,669
Development of bespoke training package	£850
Development and training sessions with partner agencies	£1,500
Management costs	<u>£2,222</u>
	Total costs
	£24,448
Project Support Worker (Band 4)	£26,486
Total Cost	£50,934

4.0 References:

Davidson, L (2014): Presentation ImROC Conference, March 2014
<http://www.imroc.org/wp-content/uploads/Larry-Davidson-Compatibility-Mode.pdf>

MIND (2014) *At Risk, Yet Dismissed*
<http://www.mind.org.uk/media/642011/At-risk-yet-dismissed-report.pdf>

