Independent review into treatment and care provided by Avon & Wiltshire Mental Health Partnership Trust

Confidential

East of England Collaborative Procurement Hub

Contract reference:	2014/29544
Incident type:	Homicide
Date of Incident:	10 September 2014

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Date of report: 22nd October 2016

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EXECUTIVE SUMMARY

1. Introduction

1.1. This is the report of an investigation commissioned by NHS England to assess the care provided by Avon and Wiltshire Mental Health Partnership Trust (`the Trust') over the period of eight years from the point when Rachel (not her real name), the patient, was first referred to the Trust, to the point when she was charged with arson and murder of Mr. Y on 10 September 2014. Our aim in conducting the investigation was to understand what happened, set out any necessary recommendations for change, and provide assurance about current services for similar patients provided by the Trust.

1.2. We hope that the report will assist all those who were involved, including the family and friends of the victim, the family of the perpetrator, and the staff of the Trust and other services who were involved in providing care and support for Rachel. We would like to thank all those who helped us during the course of our work and we would like to express our sincere condolences to Mr. Y's family.

1.3. A more detailed account of the methods used and background about the team itself is provided in the main report. Information was collected from NHS records about the NHS care and treatment provided for Rachel and about her current regime in prison. We reviewed notes and files provided by the Police for the Court, including assessments undertaken at that time by forensic experts. A number of witnesses, including Rachel and staff who supported her were interviewed and policies currently being followed within the Trust were examined.

1.4. Rachel was arrested on 11 September 2014 on suspicion of murder following the death of Mr. Y in a house fire at his home and on 16 December the following year, Rachel was convicted of murder at Winchester Crown Court. The Court did not consider that there were any circumstances relating to Rachel's mental health that should be taken into account in mitigation and she was sentenced to life imprisonment without parole for a minimum of 20 years.

1.5. Appendix 5 of the main report contains a chronology of the care provided for Rachel by the Trust between 2007 and 2014. In summary, a picture is presented of a chaotic and vulnerable woman who had experienced mental health and other difficulties all her life. Rachel also had an eight to ten-year history of drug addiction, criminal behaviour, homelessness and mental ill health. However, as an adult, Rachel failed to engage consistently with NHS services. For example, when Rachel was arrested she was found to have alcohol, cocaine and crack cocaine in her blood; she had not taken her prescribed medication for the past two weeks, and she had missed her last appointment at the Trust.

1.6. Now, in prison, Rachel is receiving input from the prison community mental health team and a team specializing in the treatment and management of people with personality disorder. Rachel seems currently to be well engaged with the team; is

remorseful about the tragic death of Mr. Y, and her mental state is more stable than it was.

2. Findings

2.1. TOR for the work undertaken by the team are provided in Appendix 1 of the main report. In addition to a requirement to review the care provided for Rachel, these contain a requirement to address a number of important questions about:

- Communication between agencies
- Rachel's level of risk
- Whether further multi-agency working would have helped in the assessment of risk
- Documentation and record keeping
- The Trust's internal investigation, findings, recommendations and progress
- Contact with families
- The degree to which the incident could have been predicted or prevented

2.2. Our team undertook a desktop review of Rachel's case notes and Trust policies for the two periods (2006-2010 and 2012-2014) when she was in contact with mental health services. We interviewed staff from the Trust, local drug services, and Probation, and we interviewed Rachel and her mother. Mr. Y's family was approached but, still too distressed about the death of their relative, they declined to be involved.

2.3. We found that the NHS case notes written about Rachel provided a good account of the medical facts and summarise the social and behavioural issues relevant to the risk that she posed. However, there was only limited evidence of effective communication outside the Trust with others involved in providing treatment and support. This was partly due to the fact that services and staff were very stretched at the time, and partly due to uncertainty about Rachel's diagnosis and whether she was able to be treated. It seemed that staff were unclear about who should take `lead' responsibility for providing care and how Rachel's risk to herself and others or her vulnerability to abuse should be managed.

2.4. The uncertainty about Rachel's treatability is partly explained by the challenge to diagnosis which some of her symptoms presented. For example, over time, Rachel was given a diagnosis of schizophrenia, schizo-affective disorder, emotionally unstable personality disorder (EUPD), obsessive compulsive disorder (OCD), epilepsy, possible learning difficulties, and anxiety.

2.5. By 2014, staff had reached a consensus that Rachel had a personality disorder (PD) as well as problems relating to substance misuse. The voice which Rachel reported hearing since her teenage years was described as a `pseudo-hallucination' (not uncommon in personality disorder). More information about what the term `pseudo hallucination' means is contained in the main report. It

does not imply no voice is present; it does not imply that Rachel has fabricated it, or that she is not genuinely distressed by it. But together with a lack of services available at the time for people with personality disorder, Rachel's diagnosis, her apparent lack of motivation to engage, and her periodic non-compliance with medication led to the decision that she should be discharged.

2.6. We therefore concur with the authors of the first report that more effective inter-agency communication could have helped to clarify lead responsibility for and ways to manage Rachel's mental health and how her assessed level of risk should be managed.

2.7. Our team is also able to report that since 2015, Trust services as a whole have been re-structured and strengthened and it is evident that there have been significant improvements in the service since the time of Mr. Y's death. For example:

- RiO (an electronic system for maintaining clinical notes) has been established. This makes access to notes easier, and enables a printable Care Plan to be developed which outlines medication and all decisions, symptoms and risk management plans.
- Now, the Primary Care Liaison Service (PCLS) is the first point of contact for new referrals and patients are referred on to the most appropriate team.
- There is now a named dual diagnosis worker funded by the Trust who visits the CRI (drugs) team twice a week to assess and potentially refer on clients who need mental health treatment and care.
- Drugs-related death meetings now happen as a matter of course to strengthen learning.
- There is a learning forum available for staff from various agencies to come together to discuss issues relating to the care of people with complex needs who may be in contact with several agencies at once.
- CRI has worked closely with the Trust to raise awareness about issues and risks associated with dual diagnosis and this has been associated with an improvement in knowledge and communications (written and verbal) since 2014.
- There is a CARS (criminal justice liaison) team working in the Police custody suite to help ensure that people with mental health problems are picked up earlier.
- The Early Intervention Service (EIS) includes a part time (3 days per week) clinical psychologist and there is access to all the therapists in the Psychological Therapies Team. Although the staff we spoke to reported that this is working well, we believe that support for patients and staff could be improved by the addition of dedicated consultant time.

2.8. There has been significant strengthening of policy in relation to the involvement of carers and relatives in the care provided by the Trust. A weblink[1] published by the Trust contains extensive information and a carers pack, including a `jargon

[1] http://www.awp.nhs.uk/advice-support/service-users/carers-families

buster', information about drugs, care and treatment, getting help in an emergency, carers' entitlements, and other areas of interest to families and friends of patients.

2.9. The Trust also has clear guidance for managers on how to support and work with the families of both perpetrators and victims of homicides and about how to manage incidents and independent inquiries, Domestic Homicide Reviews, Serious Case Reviews, and liaise with the Coroner and the Police. Our team believes that this material is of a very high standard and appears to demonstrate that significant learning and development in these areas has taken place although current practice was not assessed directly.

2.10. Importantly, there is now a personality disordered (PD) offender pathway in place. However, whilst this is a very positive development for people with PD who are serious offenders, our team was concerned that it may not provide a safety net and/or treatment and support for people with personality disorder (PD) who, like RACHEL prior to the index offence, do not meet its high offending threshold and we have made recommendations in relation to this.

3. Was the incident predictable or preventable

3.1. Our team does not believe that the tragic murder of Mr. Y by Rachel could have been predicted specifically, or actively prevented. This is partly because there were no warnings for either the NHS Trust staff or other staff involved more closely at the time to indicate that what appears to have been an argument with Mr. Y would result in his violent death, and partly because Rachel and the Trust staff had begun to disengage from one another.

3.2. At the time of Mr. Y's tragic death Rachel, who had a criminal record, was on Probation following another violent attack; she was in contact with various local teams and services, including her GP. The decision by the Trust to discharge Rachel from specialized care was consistent with their policy to discontinue treatment that is failing, or keep patients `on the books' of teams with an explicit remit to manage other conditions. For her part, Rachel's diagnosis actively mitigated against the view that she was treatable within the Trust services available at the time; she had missed her last appointment, and she'd stopped taking her medication.

3.3. Since the time of the index offence there have been important changes in local NHS services, including for people with PD, which provide some reassurance that people with PD and a history of serious offending will be managed more actively and managed in close partnership across agency boundaries. Furthermore, there is evidence of a much better level of appropriate and coordinated inter-agency communication and joint working which provide reassurances concerning the assessment and communication of risk, and also of support for families and carers.

4. Conclusion and recommendations

4.1. This report was commissioned by East of England under HSG (94) 27 to assess the care provided by Avon and Wiltshire NHS Partnership Mental Health Trust up to the point on 10 September 2014 when their patient Rachel was charged with arson and murder of a 63 year old man (Mr. Y). It represents a verification and elaboration of the internal investigation that was undertaken at the time, and provides an assessment of the extent to which recommendations made by those investigators have been, or are being met. It concludes that a number of important steps have been taken to strengthen Care Planning and Risk Assessment and to communicate effectively across inter-agency boundaries. It concludes that the tragic death of Mr. Y could not have been predicted or prevented.

4.2. However, a number of concerns arise directly from the investigation into care provided by the Trust for Rachel prior to the sad death of Mr. Y. These relate primarily to the way that people with personality disorder and related mental health issues are managed and supported. Our report therefore makes five recommendations:

Recommendation 1. There is an impediment to multi-agency working reported to our team concerning the difficulty that external agencies experience when trying to communicate with Trust employees whose contact details will not be disclosed by the Trust switchboard for reasons of confidentiality. We recommend that the Trust develop a means to remedy this important obstacle to inter-agency communication.

Recommendation 2. The Personality Disordered Offender Pathway is clear and is operating effectively in Swindon. However, there appears to be a gap in provision for people with Personality Disorder who are not so severe that they meet criteria for inclusion because, like Rachel, they are generally too complex to be managed in primary care and/or their symptoms fail to meet criteria for treatment by the EIS, PCLS, Recovery or Crisis teams whose focus is predominantly upon psychosis. We recommend that the Trust consult on, and identify ways to remedy the gap in provision of an effective needs-based care pathway for such patients, and communicate effectively to all potential stakeholders to whom and how they may refer.

Recommendation 3. We are concerned that staff working in general mental health services who find themselves with responsibility for patients with personality disorder may not have sufficient training or support to deliver the most effective care. We therefore recommend that work is undertaken to provide training, consistent with the NICE 2009 guideline, and advice contained in the 2015 DPD Strategy, to raise awareness and reduce risks that staff and/or patients are vulnerable to errors, miscommunications and isolation, and to ensure that they know to whom such patients may be referred.

Recommendation 4. Whilst access to psychiatric cover by the Early Intervention Service (EIS) in an emergency is now provided (as at the time of the index offence) by consultants working in other teams or, depending on where the patient

is registered, by the patient's own consultant, consideration should be given to the provision of dedicated consultant time in this specialized area.

Recommendation 5. To ensure that the above recommendations are considered and implemented, we recommend that Swindon Clinical Commissioning Group in partnership with the Trust (the provider) undertake an assurance follow up and review of progress, six months after our report is published.

REPORT OF THE INDEPENDENT INVESTIGATION INTO CARE AND TREATMENT OF RACHEL BY AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST

1. Introduction

1.1. The importance of a rigorous investigation following a death caused by someone in contact with mental health services is set out clearly in a variety of NHS and other guidance[2,3.] Families who are affected by such tragedies, and NHS and social care staff all agree that processes should be in place to monitor, investigate and learn lessons so as to reduce risk in the future.

1.2. This is the report of an investigation commissioned by NHS England under HSG (94) 27 to assess the care provided by Avon and Wiltshire Mental Health Partnership Trust (`the Trust') over the period of eight years from the point when Rachel the patient was first referred to the point when she was charged with arson and murder of Mr. Y in 2014.

1.3. Terms of Reference for the investigation can be found in Appendix 1. They emphasise the importance for all those involved of understanding what happened; of learning lessons, and of assuring the public that NHS care systems are safe and working effectively.

1.4. This report represents a verification of the internal investigation that was completed shortly after this tragic incident and it provides an assessment of the extent to which recommendations made at that time to improve the quality of care have been or are being met. It also sets out some concerns about how services are provided going forward.

1.5. Information about our team is provided at Appendix 2.

1.6. We hope that the report will assist all those who were involved, including the families and friends of the victim and of the perpetrator, and the staff of the Trust. We would like to thank all those who helped us during the course of the investigation.

1.7. We would like to express our sincere condolences to Mr. Y's family.

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[2] `Serious Incident Framework: Supporting learning to prevent recurrence' (March 2015) NHS England Patient Safety Domain. Gateway reference: 03198.

[3] Casey, L., CB, Commissioner for Victims and Witnesses, (July 2011)`Review into the Needs of Families Bereaved by Homicide.' Ministry of Justice.

2. Methodology

2.1. An initial `scoping' meeting was held on 16 November 2015 with the commissioner of the investigation (NHS England) and representatives from the Trust and local commissioning team to agree the methodology and review the Terms of Reference. Agreement was reached concerning the use of an approach based upon Root Cause Analysis to examine the facts of the case, identify ways in which care might have been altered or improved, and understand how systems for delivering care and managing risk are currently working.

2.2. Information was then collected from the paper based and electronic care records about the care and treatment provided for Rachel whilst she was receiving care from the Trust, and information was gathered about her current regime and treatment in prison. In addition, and to get a clearer picture of Rachel's needs, the team reviewed notes and files provided by the Police for the Court, including the assessments undertaken at that time by forensic experts. Copies of current policies used by the Trust were examined, including guidance on Care Planning, Risk Assessment, and information sharing. A full list of the policies that were reviewed can be found in Appendix 3.

2.3. A number of witnesses (see Appendix 4) were interviewed and/or conversations on the telephone were arranged to help the team to understand more about how services were and are provided by the Trust. Although Rachel's GP declined to be interviewed personally, the team was able to review the primary care notes. Salmon Principles[4] were adapted for this non-judicial investigation which meant that all those interviewed were contacted in writing with information about the investigation and they were invited to be accompanied, if they wished.

2.4. Interviews were undertaken with Rachel, her mother, with clinical staff and representatives from services outside the Trust from the Police and teams supporting people with drug and related problems. A member of the victim's family was also approached (by letter and via communication with the Police Family Liaison Officer (FLO) but, still too distressed about the death of Mr. Y, they declined to be involved.

3. The incident

3.1. Rachel was arrested on 11 September 2014 on suspicion of murder following the death of Mr. Y in a house fire at his home the night before. The Court heard that Rachel and Mr.Y, himself a vulnerable unemployed man with alcohol and other problems, had met a few weeks earlier. They had been heard to argue over

[4] **The Salmon Principles** are six requirements set out under the Tribunals and inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations.

money and, on the evening of the 10th, after arguing again, Rachel took his keys, set fire to a shirt which she then threw to the bottom of the stairs, locked the door and left. She disposed of the keys and Mr. Y's Post Office bank card in a drain in a nearby alleyway.

3.2. When Rachel was arrested she was found to have alcohol, cocaine and crack cocaine in her blood and, in some distress, she was referred to the Court Assessment and Referral (CARs) team which provides mental health liaison between local health and criminal justice systems for an assessment of her mental state. The CARs team report indicates that Rachel had not taken her prescribed medication for the past two weeks and that she was reporting visual and auditory hallucinations – a man screaming at her. Rachel is also reported to have said that she did not attend her last appointment at the Trust (5 September) because she did not want to be discharged, a matter which had previously been discussed with her in August.

3.3. Information collected at this time suggests that there were a variety of other factors which potentially contributed to Rachel's level of disturbance at this time. For example, Rachel had recently split from her boyfriend; she was regularly using a significant volume of cocaine, and she was expecting to be arrested following a raid by Police on her flat at which time a large volume of cocaine was found. Added to a background of vulnerability to abuse from sex work and domestic abuse, and a failure to take her medication, it appears that Rachel was not in a stable state when the confrontation with Mr. Y occurred.

3.4. After a lengthy period of assessment whilst on remand, and after a short stay at a psychiatric facility, Llanarth Court for a period of assessment, Rachel's case was concluded in December 2015. Together with clear evidence of a previous conviction for violence and witness statements to describe an earlier attack on Mr. Y (kicking him on the ground and a fracas involving his refusal to part with his PIN number) a conviction for murder was the result. The Court did not consider that there were any circumstances relating to Rachel's mental health that should be taken in mitigation and she was sentenced to life imprisonment without parole for a minimum of 20 years.

3.5. Now, in prison, Rachel is receiving input from the prison community mental health team and a team specializing in the treatment and management of people with personality disorder. She is relatively well engaged with this; she is apparently remorseful, and her mental state is more stable than it was.

3.6. For Mr. Y's family the death of their relative was inordinately distressing. They are currently in receipt of support via the Victim Liaison Service managed via the Police and Probation services. Sadly, too, Mr. Y's mother passed away before the verdict was reached so they have had a particularly large burden of grief to bear.

4. Background and findings

4.1. Appendix 5 contains a chronology of the care provided for Rachel by the Trust in the periods 2007 to 2010, and 2012 to 2014 when Mr.Y died. In summary, a picture is presented of a chaotic and vulnerable woman with an eight to ten year history of drug addiction, criminal behaviour, homelessness and mental ill health who, over time, failed to engage consistently with NHS services. For example, there are frequent reports of missed appointment and of failing to take prescribed medication.

4.2. There is also evidence of a good level of care provided by services within and outside the Trust and that Trust staff endeavored to provide help for RACHEL at a time when, as it was reported to us, some teams were very stretched. However, the most consistent support was probably provided by the Drugs team and local Authority homelessness, Vulnerable Adults, and Criminal Justice Domestic Violence teams who were involved with Rachel over this period.

4.3. The Terms of Reference for this investigation which set out the general requirements to review the care provided for Rachel also set out several specific questions. These are addressed below.

4.3.1. Communication between agencies and whether Rachel's risks to herself and others were fully understood and addressed (especially the two overdoses in October 2007 and sexual abuse and domestic violence reported August and November 2012)

This issue, raised by the authors of the first investigation undertaken immediately after the index offence occurred, concerned the extent to which the Trust communicated effectively with other agencies. Their report says, for example, that other agencies were not invited to participate in CPA (Care Programme Approach) reviews or included in written communications; that staff were unclear about Rachel's Probation conditions; that her MAPPA[5] status was assessed at Level 1 (only low risk) and it suggests that there were potential safeguarding issues in relation to Rachel's child.

Our team solicited information from two sources to investigate this. First, we undertook a desktop review of the GP records, Rachel's case notes and Trust policies for the two periods (2006-2010 and 2012-2014) when she was in contact with mental health services. Secondly, we spoke with representatives from the Trust, local drug services, primary care, and Probation and with Rachel and her mother.

[5] Multi-Agency Public Protection Arrangement (MAPPA) is an arrangement for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.

Our team found no reason to disagree with the report concerning communications between agencies. Although the NHS case notes written about Rachel provide a good account of the medical facts and summarise the social and behavioural issues which have a bearing on the risk she posed to herself and/or other people, there is only limited evidence of effective communication with others outside the Trust who were involved in her care.

Changes in staffing and in the organisation of several different services in the NHS as well as outside it at the time appear to have made communication more difficult, a fact confirmed by several staff working either in the Trust or outside it at the time. However, there also appears to have been a lack of clarity regarding which service should be in the `lead' and how Rachel's risk to herself or her vulnerability to abuse should be managed. Our team believes that this was partly due to uncertainty on the part of NHS staff regarding Rachel's diagnosis and partly due to a lack of services available at the time for people with personality disorder.

That Rachel was vulnerable to sexual abuse and domestic violence, and that these issues threatened her physical and mental health, appears to have been known by all those involved. For example, the clinical records show that Rachel possibly took an overdose in May 2007; she definitely took an overdose in July 2008 following the death of her boyfriend from a heart attack when she was admitted; and another overdose, though less life threatening, in September of the same year. There is also some evidence in the notes that Rachel occasionally self-harmed by cutting herself.

Over the time she was in contact with the Trust, Rachel was given a number of different diagnoses including schizophrenia, schizo-affective disorder, emotionally unstable personality disorder (EUPD), obsessive compulsive disorder (OCD), epilepsy, possible learning difficulties, and anxiety. The notes also record the fact that Rachel had plastic surgery to re-build her jaw after being beaten up; that she has polycystic ovary syndrome, and is deaf in one ear.

A diagnosis of schizophrenia is made when several conditions are met, or when several significant symptoms are present. The significance of the shadowy figure which Rachel says she has heard since childhood is central to this; she reports that it speaks in a mocking and accusatory tone when she is distressed or upset and instructs her in a manner that she can normally resist to self-harm and/or injure others; to check and clean; to be mindful that her food may be poisoned and/or should not be eaten. Rachel says that the voice is distracting, distressing; it is lessened by medication, and that she obeys it from time to time to `make it go away.'

By the time Rachel was being considered for discharge from NHS mental health care in 2014 the `voice' was being described as a `pseudo-hallucination' and clinicians reached consensus that Rachel did not have schizophrenia. Furthermore, experts for both sides consulted by the Court

in 2014 and 2015 when Rachel underwent an intensive and consistent assessment during the period leading up to her trial agreed with this view.

However, the term `pseudo hallucination' is an unfortunate term in some ways. It implies that Rachel recognises the voice to be unreal, that she has `insight' and can resist commands that it gives, even though there have apparently been occasions when she has not. It is important for staff as well as non-experts to understand that the term does not mean the voice is imagined, or that Rachel is telling lies when she reports hearing it. It does not mean the voice is not intrusive or distressing, made worse by stress, or lessened by appropriate drug treatments.

Such `voices' are not uncommon amongst people with a personality disorder and a history of abuse or a background in domestic violence. Furthermore, insight[6] is not always easy to determine in the context of someone like Rachel with a relatively low IQ, a history of violence and relatively unsophisticated understanding of the relationship actions and the consequences, as well as a personality disorder.

Together with Rachel's lack of motivation, non-engagement and non-compliance with medication, the view that she had a personality disorder and was perhaps not even treatable within mainstream NHS services as they existed at the time contributed to the decision that she should be discharged. As is not uncommon in such cases, some Trust staff also believed that Rachel was cleverer than she claimed; that she could look after herself quite well; that her overdoses were `just a cry for help' rather than `serious attempts' and that she was better supported elsewhere.

4.3.2. Whether further multi-agency working may have assisted in assessing the risk of Rachel to others.

In the past, a diagnosis of PD has typically been associated with a failure to identify or develop appropriate treatments in the NHS[7]. We believe that uncertainty in relation to Rachel's diagnosis coupled with a lack of clarity about who should hold responsibility for her management contributed to a lack of care coordination overall. For example, there were gaps in the service for Rachel because she did not meet the criteria for referral to EIS, Recovery, the Primary Care Liaison Service or Crisis Service. Furthermore, the notes make it clear that it was difficult at several points in her care for staff from outside the NHS to get help and advice to manage the mental health problems that Rachel reported.

[6] E. H. Hare (1973) A Short Note on Pseudo-Hallucinations. The British Journal of Psychiatry, vol 122 (569) 469-476.
[7] Borderline Personality Disorder: The NICE guideline on treatment and management. (2009). National Collaborating Centre for Mental Health published by The British Psychological Society and The Royal College of Psychiatrists. ISBN: 978-1-85433-477-0. Also see Quality Standard QS88 published June 2015 www.nice.org.uk/guidance

We therefore concur with the authors of the first report that more effective inter-agency communication might have helped the staff to be mindful of the degree to which Rachel's mental state, her personality disorder, drug use and social circumstances could affect the level of risk she posed and how this should be managed.

We are also content to report that there have been significant improvements in the service since the time of Mr. Y's death. For example, and whilst the Trust does not have a formal information-sharing policy (which is not unusual) a requirement to list other key contacts is contained in the RiO templates for storing information about risk and care planning. In addition:

- There is now a named dual diagnosis worker funded by the Trust who visits the CRI (drugs) team twice a week to assess and potentially refer on clients who need mental health treatment and care.
- Drugs-related death meetings now happen as a matter of course to strengthen learning.
- There is a learning forum available for staff from various agencies to come together to discuss issues relating to the care of people with complex needs who may be in contact with several agencies at once.
- CRI has worked closely with the Trust to raise awareness about issues and risks associated with dual diagnosis and this has been associated with an improvement in knowledge and communications (written and verbal) has since 2014.
- There is a CARS (criminal justice liaison) team working in the Police custody suite to help ensure that people with mental health problems are picked up earlier.
- The Early Intervention Service (EIS) includes a part time (3 days per week) clinical psychologist and there is access to all the therapists in the Psychological Therapies Team.

However, access to psychiatric cover by the EIS in an emergency is now provided (as at the time) by consultants working in other teams or, depending on where the patient is registered, by the patient's own consultant. Whilst the staff we spoke to reported that this is working well, our team has some concerns that support for patients and staff in this specialised area could be improved by the addition of dedicated consultant time and we urge the Trust to consider this.

It is also notable that services as a whole have been re-structured in the area since summer 2015. Now, the PCLS (Primary Care Liaison Service) is normally the first point of contact for all new referrals; this team will assess and either discharge back to GP with advice, or refer onward to the EIS, Recovery or Crisis team (which is now called Swindon Intensive service) depending on need. LIFT (primary care psychology service) in Swindon (although not in Wiltshire where different arrangements obtain) provides a stepped approach to care, including counseling and psychological

therapies; the Recovery team provides ongoing support (what used to be called assertive outreach) for people with severe mental ill health and the Crisis Team, as the name suggests, provides a ready response for people in crisis, including access to beds.

It was reported that these new roles and team structures coupled with a clear division of roles and responsibility now ensure greater clarity for staff and patients about where they should be seen. In fact, only one impediment to multi-agency working was reported to our team. It concerned a difficulty for external agencies to obtain email addresses for key workers in the NHS when contact needs to be made regarding a patient: it appears that the switchboards will not pass their details on owing to concerns about confidentiality. We therefore urge the Trust to remedy this.

Importantly, there is now a personality disordered offender pathway in place. The challenges of providing treatment for people with severe PD who are dangerous are explored in `The Offender Personality Disorder Pathway Strategy[8]'. This sets out how `those who are unlikely to be willing or able to access other types of services or, at least, are unable to do so without additional support' need `carefully planned management, in addition to any treatment and how people with PD should be set `apart from other offenders' [as] `their personality difficulties can be seen to be at the heart of their offending.'

Whilst this is a very positive development, and staff from other services spoke very positively about it, it was less clear to our team that the pathway and related new staff arrangements provide an appropriate safety net and/or treatment and support for people with personality disorder (PD) who are not such serious offenders that they qualify for inclusion on the pathway, but who may nonetheless be extremely vulnerable.

Indeed, such patients may inadvertently be excluded by operational policies that, rightly, focus on evidence-based and outcomes-focused care for specific (other) groups. For example, the contractual arrangements for provision of primary care psychology services restrict their focus to IAPT[9] and the provision of stepped care for people with so-called `common mental disorders'. Although there is now a psychologist working in the EIS with the Trust and there also is a Recovery Team, it seems that patients with PD would likely be excluded by definition.

In the event that a patient with PD is offered support – as in this case by the EIS CPN without specific skills in the treatment and management of PD who nonetheless wanted to be helpful – there is a risk that the widespread belief that PD is untreatable, coupled with difficulties that are highly characteristic of the condition such as missed appointments or periodic

[8] NHS England (2015)`The Offender Personality Disorder Pathway Strategy' Gateway reference 04272 www.england.nhs.uk/commissioning
[9] IAPT: Improving Access to Psychological Therapies programme. In Swindon, this is provided by LIFT psychology based in primary care.

failure to take medication, may result in discharge from mental health services altogether.

Of course, there is no sense in which it would be appropriate to advocate treatment for, or the inclusion of patients in services for whom they are not designed, or with conditions for which staff are not trained. This is why our team has made two additional recommendations for the Trust and commissioners to consider; the first concerns how to provide services for people with PD who are not so severe that they can be accommodated within the Offenders pathway, and the second concerns training for staff to enable them to maintain levels of appropriate care[10].

In this context, it is important to note that following her conviction and sentencing, Rachel herself is receiving highly appropriate help and support in prison to manage her symptoms and learn more effective strategies to reduce risk to herself and others. She has a clear treatment and Care Plan involving all those involved in providing care and custody and she is receiving treatment for her symptoms from the community mental health team working with a specialised psychological therapies team (Nexus). The teams provide effective, evidence-based treatment such as Dialectical Behaviour Therapy (DBT) consistent with best practice. More information about what such treatment involves can be found in the clinical guideline published by the National Institute for Health and Clinical Excellence (op cit).

4.3.3. Review the documentation and record keeping of key information by the Avon and Wiltshire Mental Health Partnership NHS Trust against best practice and national standards and if record keeping is an issue within the Trust.

Information about documentation and record keeping of key information by the Trust was reviewed by asking a small sample of staff about access to, and the quality of records, and our team was able to review Rachel's case notes for three periods: 2006-2010, 2012-2014 and 2014 to the present.

The notes show that Risk Assessments were completed and they appear to be thorough. They show that there was communication between Trust staff and Rachel's GP, her Probation Officer and the ISIS worker[11] related to the assessment of Rachel's mental health and social and emotional needs in the period leading up to the index offence. No record of offending is visible in the paper notes covering the first period of Rachel's care (2006-2010), but risk-related episodes (e.g., violence) were infrequent at this time. After 2011, as Rachel's substance misuse escalated and her offending behavior worsened, the records contain the essential facts,

[10] NICE guidance says ` People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed'. P.99 Para. 4.6.1.1.op cit.

[11] ISIS is a team commissioned by Wiltshire Probation Trust focused on working with vulnerable female offenders working on the streets

including information about Rachel's suicide attempt (2008) and self harm (2012) by cutting. There is also periodic mention in the Notes of risks relating to domestic violence and of Rachel's abusive partner (see Sections 4.3.1 for more detail about this).

The notes show a significant improvement in quality over time. We believe that this is partly attributable to a move from paper notes to an electronic record system (RiO) in 2011 and partly due to the development and dissemination of very clear policies on how information should be recorded.

The paper notes for the period to 2010 contain good details of Rachel's care. For example, they show that Rachel's disengagement and non-attendance was discussed; that action was agreed and then recorded in accordance with the `Access to Mental Health Care Assessment and Treatment Policy and the Care Delivery Procedure'. The earlier paper notes do not contain a detailed offence history as is now required by guidance in the Clinical Risk Assessment and Managerial Procedural document,

RiO now also enables a printable Care Plan to be developed which outlines medication and all decisions, symptoms and risk management plans, and it is possible for staff to access notes made by the Trust-funded Prison In-reach team supporting Rachel. These contain an extremely detailed account of the care and treatment currently being provided and the notes are of a very good standard.

4.3.4. Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify if the investigation satisfied its own terms of reference (TOR 2.5)

The initial internal investigation report was thorough in many ways and it highlighted concerns which our team was able to verify as described above. However, and by its own admission, the Trust's internal investigation report was limited in several important respects. For example, no members of the families affected were seen; no details of the incident itself were available; the Court case had not been heard, the outcome was not known, and no conclusion could be drawn regarding the degree to which the murder of Mr. R could have been predicted or prevented.

In other respects, our team believes that the Trust's internal investigation report, its recommendations and notes of Actions were satisfactory and its Terms of Reference were met.

Whilst a concern raised in this report regarding the lack of a dedicated consultant psychiatrist to contribute to EIS team meetings and discussions of risk was not upheld by the staff we spoke to (see paragraph 7.4), we concur with the authors that the Trust should consider ways to provide this.

4.3.5. Consider if the incident was predictable or preventable and comment on any relevant issues that may warrant further investigation

Our team does not believe that the tragic murder of Mr.Y by Rachel could have been predicted specifically, or actively prevented. This is partly because there were no warnings for either the NHS Trust staff - or for other staff involved much more closely with her care at the time - to indicate that what appears to have been an argument with Mr. Y would result in his violent death. In addition, by the time that the index offence took place, Rachel and the Trust staff had already begun to disengage from one another.

The decision to discharge Rachel from specialized care by the Trust was consistent with policy to discontinue treatment that is failing, or keep patients `on the books' of teams with an explicit remit to manage other conditions. Rachel had missed her last appointment, she had stopped her medication; she had refused referrals to the psychology service, and her diagnosis actively mitigated against the view that she was treatable within the Trust services available at the time.

We do consider (as outlined in Section 4.3.2) that levels of inter-agency communication and joint working could have strengthened the coordination of Rachel's care. For example, during the period leading up to the tragic death of Mr. Y, Rachel was seeing her Probation officer; she was in contact with local drugs services, her GP, the Trust and the ISIS team. However, there is no evidence that better care coordination would have made it possible to predict or prevent the tragic death of Mr. Y.

Since the time of Mr. Y's tragic death there have been important changes and developments in local NHS services, including for people with PD which provide some reassurance that people with PD and a history of serious offending will be managed more actively. Furthermore, there is evidence of a much better level of appropriate and coordinated inter-agency communication and joint working which provide reassurances concerning the assessment and communication of risk amongst such patients, and for support for families and carers.

4.3.6. Assess and review the contact made with the victim and perpetrator families and review the Trust's family engagement policy for homicide and serious patient incidents measured against best practice and national standards.

The authors of the first investigation into the circumstances leading up to the death of Mr.Y did not make contact either with Rachel's family or the family of the victim, although the Head of Patient Safety wrote to the

victim's family after the tragic death of their relative. Sadly, the family of Mr.Y. were still too distressed to participate in our investigation.

However, we are grateful to Mrs. M, Rachel's mother who illuminated aspects of Rachel's early life and shared her feelings about the quality of care provided by the Trust for her daughter. Overall, it is fair to report that PM felt let down by services. For example, when Rachel was young, it had been difficult to find support and treatment for her problems which were not well understood until, after a struggle, she was given a place at Crowdys Hill School.

Later, when Rachel became very unwell and needed an admission in 2008, no bed was available. Mrs M said staff had also been critical of her for failing to visit immediately. However, since 2005, Mrs. M has cared for Rachel's daughter who has complex health issues including severe learning disabilities; she cannot leave the house at short notice and the journey is a long one from the north of England.

The best period of care, in Mrs M's view, followed upon Rachel receiving a formal diagnosis of paranoid schizophrenia when she was 24 and when she was given supported accommodation at Albion House. Mrs M was angry and distressed that her daughter had not been diagnosed and treated properly before and she believed that some of the subsequent difficulties for herself, her daughter and her granddaughter could have been avoided if she'd had help earlier.

Mrs. M did not feel that she had been very actively involved by the Trust in the Rachel's care and treatment. Of course, and as she pointed out, Rachel was an adult with rights to confidentiality and she herself lived a long way away. Mrs. M believed her daughter to be as well now as she has been for a long time. She told us that Rachel was taking her prescribed drugs, has settled to her regime in prison, and is remorseful about the death of Mr. Y. Mrs M was very concerned that Rachel might be moved to a facility too far away for her to visit.

Our team reviewed the notes and the policies which have a bearing on the way that Mrs. M as a close relative might have been engaged in the care provided by the Trust. It is clear from the notes that Rachel's mother and details of her circumstances and those of her granddaughter are limited. For example, her contact details are not provided and little other than the fact of her caring for Rachel's daughter is noted. However, we do not believe that there were significant safeguarding issues in the eight years prior to Rachel's offence given that Rachel's daughter was (and remains) in the formal, legal care of her grandmother, Mrs.M. Furthermore, we are content to report that there has been significant strengthening of policy in relation to the involvement of carers and relatives in the care provided by the Trust, although we should point out that current practice in implementing this guidance was not assessed directly.

A very informative weblink[12] published by the Trust contains extensive information and a carers pack, including a `jargon buster', information about drugs, care and treatment, managing difficult behaviour, getting help in an emergency, carers entitlements, and other areas of interest to families and friends of patients. In our opinion, this material represents very good practice and meets national standards.

The Trust also has clear guidance for managers on how to support and work with the families of both perpetrators and victims of homicides and about how to manage incidents and independent inquiries, Domestic Homicide Reviews, Serious Case Reviews, and liaise with the Coroner and the Police. Our team is content to report that this material is of a very high standard and appears to demonstrate that significant learning and development in these areas has taken place.

5. Conclusion and recommendations

This report was commissioned by East of England under HSG (94) 27 to assess the care provided by Avon and Wiltshire NHS Partnership Mental Health Trust up to the point on 10 September 2014 when their patient Rachel was charged with arson and murder of a 63 year old man (Mr. Y). It represents a verification and elaboration of the internal investigation that was undertaken at the time, and provides an assessment of the extent to which recommendations made by those investigators have been, or are being met. It concludes that a number of important steps have been taken to strengthen Care Planning and Risk Assessment and to communicate effectively across inter-agency boundaries. It concludes that the tragic death of Mr. Y could not have been predicted or prevented. However, it also makes five recommendations to strengthen services in the future.

Recommendation 1. There is an impediment to multi-agency working reported to our team concerning the difficulty that external agencies experience when trying to communicate with Trust employees whose contact details will not be disclosed by the Trust switchboard for reasons of confidentiality. We recommend that the Trust develop a means to remedy this important obstacle to inter-agency communication.

Recommendation 2. The Personality Disordered Offender Pathway is clear and is operating effectively in Swindon. However, there appears to be a gap in provision for people with Personality Disorder who are not so severe that they meet criteria for inclusion because, like Rachel, they are generally too complex to be managed in primary care and/or their symptoms fail to meet criteria for treatment by the EIS, PCLS, Recovery or Crisis teams whose focus is predominantly upon psychosis. We recommend that the Trust consult on, and identify ways to remedy the gap in provision

[12] http://www.awp.nhs.uk/advice-support/service-users/carers-families

of an effective needs-based care pathway for such patients, and communicate effectively to all potential stakeholders to whom and how they may refer.

Recommendation 3. We are concerned that staff[13] working in general mental health services who find themselves with responsibility for patients with personality disorder may not have sufficient training or support to deliver the most effective care. We therefore recommend that work is undertaken to provide training, consistent with the NICE 2009 guideline, and advice contained in the 2015 DPD Strategy[14], to raise awareness and reduce risks that staff and/or patients are vulnerable to errors, miscommunications and isolation, and to ensure that they know to whom such patients may be referred.

Recommendation 4. Whilst access to psychiatric cover by the EIS in an emergency is now provided (as at the time of the index offence) by consultants working in other teams or, depending on where the patient is registered, by the patient's own consultant, consideration should be given to the provision of dedicated consultant time in this specialized area.

Recommendation 5. To ensure that the above recommendations are considered and implemented, we recommend that Swindon Clinical Commissioning Group in partnership with the Trust (the provider) undertake an assurance follow up and review of progress, six months after our report is published.

[13] NICE guidance says: ` There is little doubt that the anxieties and uncertainties of mental healthcare professionals who have not been trained to evaluate or work with people with borderline personality disorder often mean that uninformed treatment may be given to those with the diagnosis.' P339 op cit.
[14] The Offender Personality Disorder Pathway Strategy (2015) op cit.

APPENDICES

APPENDIX 1: TERMS OF REFERENCE

Independent Investigation into the Care and Treatment of Rachel by Avon and Wiltshire Mental Partnership NHS Trust

1. Purpose of the investigation

To identify whether there were any gaps or deficiencies in the care and treatment that Rachel received, which could have been predicted or prevented the incident from happening.

The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

The outcome of this investigation will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

2. Terms of Reference

2.1 Review the contact and communication between agencies: the Probation Services, GP, MARAC and Avon and Wiltshire Mental Health Partnership NHS Trust and assess if Rachel's risks (to self and others) were fully understood and addressed (especially the two overdoses in October 2007 and sexual abuse and domestic violence reported August and November 2012)

2.2 Review the engagement, assessment, treatment and care that Rachel received from Avon and Wiltshire Mental Health Partnership NHS Trust from her first contact with services in February 2006 up to the time of the incident on 10 September 2014 with specific reference to the early intervention model in place at that time.

2.3 To consider whether further multi-agency working may have assisted in assessing the risk of Rachel to others

2.4 Review the documentation and record keeping of key information by the Avon and Wiltshire Mental Health Partnership NHS Trust against best practice and national standards and if record keeping is an issue within the Trust

2.5 Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- If the investigation satisfied its own terms of reference
- If all key issues and lessons have been identified and shared
- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt
- Review progress made against the action plan

- Review processes in place to embed any lessons learnt

2.6 Having assessed the above, to consider if this incident was predictable or preventable and comment on relevant issues that may warrant further investigation

2.7 To assess and review any contact made with the victim and perpetrator families involved in this incident. To review the Trust's family engagement policy for homicide and serious patient incidents, measured against best practice and national standards

3. Level of investigation

Type B: an investigation by a team examining a single case

4. Timescale

The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter

5. Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved including influencing the terms of reference
- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this investigation (provisional dates in July 2015)
- Seek full disclosure of the perpetrator's clinical records to the investigation team

6. Outputs

6.1 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

6.2 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

6.3 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)

6.4 Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference

6.5 At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation and engage the clinical commissioning group with these meetings where appropriate

6.6 A concise and easy to follow presentation for families.

6.7 A final presentation of the investigation to NHS England, clinical commissioning group, provider Board and to staff involved in the incident as required

6.8 We expect the investigators to include a lay person on their investigation panel to play a meaningful role and to bring an independent voice and challenge to the investigation and its processes. NHS England will seek to review the input of the lay person at the end of the investigation.

6.9 We will require the investigator to make clear recommendations to Swindon Clinical Commissioning Group and formally advice that they undertake an assurance follow up and review, six months after the report has been published to ensure all key recommendations have been implemented by the Provider Trust. This should include any recommendations that are identified following this investigation for any other CCG commissioned provider or NHSE commissioned service. The CCG will be required to escalation any concerns to the Quality Surveillance Group, ensuring the provider(s) are made aware of any concern being shared.

6.10 NHS England will require the investigator to independently assure NHS England the report's recommendations have been fully to ensure all key recommendations have been implemented by the Provider Trust and effectively monitored by the Clinical Commissioning Group. The investigator should produce a short report for NHS England and families and this may be made public.

6.11 We will require monthly updates and where required, these to be shared with families

6.12 The investigator will deliver learning events/workshops for the Trust, staff and commissioners

KEY:

Type A: a wide-ranging investigation by a panel examining a single case

Type B: an investigation by a team examining a single case

Type C: an investigation by a single investigator examining a single case (with peer reviewer)

APPENDIX 2: THE INVESTIGATION TEAM

Anne Richardson Consulting Ltd (ARC) is a group of senior professionals, including people with lived experience of mental ill health and of providing care (lay members) who come together with a unique combination of knowledge, skills and experience in delivering investigations under HSG (94) 27 and other related work. We share a passion about the quality and safety of mental health services; about supporting staff constructively, and about the importance of involving families and carers who so often feel excluded from the investigatory process.

Anne Richardson, Director of ARC, is a clinical psychologist by training. Specialising in work with adults with severe mental ill health and long term needs, she is an experienced clinician, trainer and communicator. As head of mental health policy at the Department of Health, she was instrumental in the development of the National Service Framework for Mental Health and for the development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008).

Lawrence Moulin has over 30 years' experience working in the NHS and at the Department of Health. His most recent post in the NHS was as the West Midlands Strategic Health Authority Lead for mental health and learning disabilities, with oversight of homicides and suicides, safety and service performance. Prior to this he worked as a clinician, a service manager and, in London, as a commissioner of services for people with mental health problems and/or with a learning disability. In addition, he worked on the delivery of national policy with the National Institute for Mental Health in England, in the Department of Health and more recently with the Care Quality Commission as a Specialist Advisor.

Hugh Griffiths is a former consultant psychiatrist in the North-East of England where he carried responsibility for in-patient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework.

Lisa Haywood (our lay member) has worked as a Mental Health Act Tribunal Member since 2006. She also has a formal role as an appraiser within the tribunal service. Lisa has lived experience of mental health services and extensive experience in the field of service user and carer involvement and services. She has worked on a number of serious incident inquiries and for the Health and Social Care Advisory Service. Lisa was Vice Chair of national MIND for 12 years and has held roles with several local Service User Networks. Lisa supports the team to bring an independent voice and challenge to our methodology and findings.

APPENDIX 3: TRUST POLICIES REVIEWED

CPA and Risk Policy

Incident Policy

Risk Management Procedural Document

Care Delivery Procedural Document

CPA Dual Diagnosis Procedure

Policy on management of Multi Agency Public Protection Arrangements (MAPPA policy)

Carer Pack (http://www.awp.nhs.uk/advice-support/service-users/carers-families/?tabid=2146)

APPENDIX 4: WITNESSES INTERVIEWED

Perpetrator (RACHEL)

Perpetrators mother (Mrs. M)

Community Psychiatric Nurse

Consultant Psychiatrist

DC, Major Crime Investigations Team, Wiltshire Police

DS, Wiltshire Police

Team Leader for Criminal Justice and Engagement (CRI)

CMHT Team Leader HMP Eastwood Park and Leyhill

Telephone conversations were also held with the following people:

Offender Manager, Wiltshire

Clinical Psychologist, Nexus Team, HMP Eastwood Park

ISIS team member, Wiltshire Police

NHSE Adviser and Clinical Psychologist, Avon and Wiltshire MH Partnership Trust

The GP with whom Rachel was registered declined to be interviewed

APPENDIX 5: CHRONOLOGY OF CARE

PERSONAL HISTORY

Rachel was born in December 1984, in the north of England, the second daughter of three. Rachel also has an older half-brother from her father's previous relationship whom she reports also has schizophrenia. Rachel's father is reported to have a diagnosis of schizophrenia although her mother doubts that this is true; a maternal aunt has bipolar disorder and a paternal uncle has schizophrenia. Rachel's older sister has severe obsessional compulsive disorder (OCD) and her younger sister also has mental health problems.

Rachel's birth was a complex caesarean resulting in a head injury and two black eyes. Her mother felt that there was `something wrong' with Rachel even when she was small. For example, she slept poorly, cried a lot and was difficult to settle; Rachel also had some symptoms of OCD, even as a child and her moods could change very quickly. She could be quick to anger. However, she could also be very loving and warm.

Mrs M left Rachel's father when Rachel was five or six years old to escape his violence and they came to a refuge in Swindon. Very protective of her mother, Rachel would repeatedly check on her mother's presence and her safety, challenging anyone she thought might be a threat. Mrs. M thought that Rachel had heard a voice for most of her life, which she sometimes obeyed. For example, she related that as a child she was compelled by a voice to punch her sister.

On starting school, Rachel was seen by the school doctor and also by a school psychologist. She was dyslexic, had behavioural problems at school (e.g., headbanging and fighting) and she had some difficulty learning: she was `statemented' at this time. The family attended therapy sessions for a while at Marlborough House, a CAMHS inpatient service, and when Rachel was aged about 8, it was suggested that she might be taken into care, a suggestion which angered her mother. She succeeded eventually in getting Rachel a place in a `special' school (Crowdy Hill in Swindon) which she attended between the ages of 12 and 15. Rachel improved at this time.

Rachel became pregnant at age 16 and was only able to look after her daughter born with a number of health issues and severe learning disabilities for about a year. At the time, Rachel was in a relationship with a man who had introduced her to drugs and who encouraged her to shop lift. Her partner was imprisoned for violence towards her. Rachel also got into trouble with the Police and, unable to cope, she asked her mother to look after S for a couple of weeks. Rachel's mother has cared for S since then and has been S's legal guardian since 2005. She lives in the north of England.

Rachel stayed in Swindon when her mother moved north, supported by a homeless charity and/or local social services. However, her domestic circumstances remained troubled. For example, she was evicted from Mirreller House (accommodation provided by Threshold, a homeless charity) in July 2007 for having a male visitor and for being abusive to staff. She was also subsequently evicted from supported accommodation at Calvert Road in 2010 when, after removing the fridge and the oven, she was found to be using illicit drugs, alcohol and associating with known drug dealers.

Rachel has also never had a regular job and, supported by Disability Living Allowance, her plans at various stages to go to College (e.g., in 2008 and in 2014) never came to fruition owing to her high level of anxiety and chaotic lifestyle. By the end of 2012, Rachel was considered to be in immediate danger from her partner who was threatening to kill her daughter and mother if she did not obey him; this included having sex with clients for payment from which he benefitted. The local Borough Council took steps to register Rachel

as a `vulnerable adult' in 2010[15] when Police suspected that her flat was also being used for drug dealing.

CONTACT WITH SERVICES

Local Authority services and Substance misuse services

Rachel had contact with `Inclusion Drug Service' (now called the Crime Reduction Initiative or CRI at the time of this investigation) for a number of years prior to the index offence. She started using cocaine at age 15 but she did not start using Crack Cocaine regularly until the age of 19 (around 2002/3) and, at this time, she started using heroin as well. From approximately 2009 (age 25), Rachel was using intravenous heroin (8-9 bags per day of which 50% was injected and 50% was smoked); this was funded through shoplifting and sex work. She started on a Methadone withdrawal programme in 2010, although she continued to use Crack Cocaine, her main drug of choice. Her relationship with C, a known drug-user and local drug-dealing gang member, was abusive and Rachel also had contact with ISIS, a Swindon and Wiltshire team commissioned by Wiltshire Probation Trust focused on working with vulnerable women offenders working on the streets. Rachel was also supported when she was homeless in a range of local authority and charitable trusts providing supported accommodation (see below).

Police and Probation

After initially being arrested for shoplifting as a teenager, Rachel has had a number of contacts with Police. For example, she reported to Trust staff in 2007 that she had stabbed a girl prior to her involvement in mental health services, and she had also been cautioned by Police for beating up her next door neighbour. Rachel was also later charged with assault for hitting a girl with a brick, although the charges were dropped. In April 2011 she was arrested and charged with Theft, Criminal Damage, and Possession with Intent to Supply although she did not go to prison. She was given a conditional discharge.

In 2012 she was arrested for stabbing a woman in the leg – this was the mother of a friend, who it was subsequently alleged had a learning disability and was being bullied by Rachel and her boyfriend. Rachel was probably under the influence of drugs at the time as she admitted using crack cocaine and heroin. Rachel was remanded to HMP Eastwood for 5 months and then charged in 2013. Her sentence was 2 year' probation on licence. She was still on probation at the time of the index offence and she had, in fact, seen her Probation officer on the morning of the day the offence took place although there were no indications of what was to follow.

Mental health and psychiatric services

2006 Rachel was first referred by her GP to the Trust's adult mental health services at age 22 in February for assessment of the `black cloud thing' which she said had been present since she was a young teenager. However, she did not keep the appointment that was offered. She was referred again in July complaining of hearing voice(s) that were preventing her sleeping.

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[15] Swindon Local Adults Safeguarding Board oversees local authority Borough Council teams who work with Police and probation services to support people they identify as vulnerable adults. A vulnerable adult is someone who is 18 years or over, in receipt of or who may need of community care services by reason of mental or other disability, age or illness who may be unable to take care of themselves, or protect themselves from significant harm or exploitation. Victims of physical or sexual abuse are examples of potentially vulnerable adults.

2007 in January 2007, age 23, Rachel reported tidying and checking rituals and seeing a dark shadowy man; she heard his voice telling her to do bad things, including self-harm, or to hurt other people, and not accept help. At night she described the voice as coming from outside; she had cut, hit and bitten herself to make it stop. The voice would ask her to clean and tidy; it would ask her what she'd eaten; repeat back the information; and it would recede if she went through ritual checks of her bags. There was some evidence at this time that Rachel had tried amphetamine and cocaine but she was not dependent.

Following a worsening of these symptoms, a possible overdose in May, and an admission for a definite overdose in July of 2007 following the death of her boyfriend from a heart attack Rachel was prescribed Quetiapine (an antipsychotic) and Fluoxetine (used to treat depression and OCD). Investigations were also undertaken at this time to establish the potential cause of an epileptiform fit which was thought to be due to Quetiapine (Rachel's mother also has epilepsy). However, this was not confirmed.

2008 In January 2008 (age 24), Rachel was admitted to hospital (Sandalwood Court) for just over two weeks in an extremely anxious state. Mrs M and the assessment team reported Rachel to have been sitting within a square of candles, rocking. She told her mother `he's going to make me kill you.' Initially, it proved very difficult to find a bed for Rachel and Mrs. M felt let down by services as a consequence; this was a very worrying time. When Rachel was admitted, she was treated with Aripiprazole (an anti-psychotic) and she was given a diagnosis of schizophrenia. The voice which she had earlier complained about was present, but quieter. However, Rachel still reported thoughts of suicide by drinking bleach. Her medication chart indicates a warning not to prescriber Quetiapine.

After Rachel's discharge, with initial support from the Crisis Team, she was then followed up by a CPN and she moved to her own flat – into which a drug-using boyfriend then moved as well. An exacerbation of her auditory hallucinations led to another overdose in April. She had also self-harmed by cutting. Her Aripiprazole was increased to 15mg daily. Over this period, which also involved some changes in the CPN staff team, Rachel moved back into Albion Street (supported accommodation) in August.

In September, an increase in the presence of an auditory and visual hallucination (the shadowy figure) appeared to be associated with a dispute with another resident at Albion Street and in October Rachel took another overdose which she described as a `cry for help'. Her antidepressant medication was changed to Venlafaxine 150mg.

2009 In 2009 (and it may be important to note that Rachel's Crack Cocaine use was increasing, as was her used of heroin) Rachel changed her GP and a new CPN refers to a `diagnosis of Borderline Personality Disorder and also possibly schizophrenia'. Rachel's pattern of contact with Trust services was intermittent; she missed a number of appointments and there are reports in the notes of her failing to take her prescribed medication owing to the fact it caused her to put on weight. Support was provided by the Crisis Team at this time.

By October, Rachel reported having stopped taking her medication altogether. She had also been using heroin quite heavily for about eight months and her psychotic symptoms returned. In discussion with Dr. S, the consultant psychiatrist, Rachel agreed to go back to taking an anti-psychotic as long as it was not Olanzepine, so he prescribed Aripiprazole 20mg which was increased by the end of that year to 30mg.

2010. Rachel had moved into supported accommodation at Calvert Road but, complaining that her Aripiprazole wasn't working, she stopped taking it. An argument with a fellow resident over an alleged theft was also provoking stress. Once re-started on the anti-psychotic, Rachel remained relatively stable for the next six months but then she handed in her notice, saying she'd decided to move to the north of England. It was also at this time that

Police identified Rachel as a vulnerable adult owing to her association with drug dealers and she was also arrested. Her attendance at appointments at the Trust was very poor at this time.

The Care Plan contains a list of the facts, including that Rachel was at risk as a vulnerable adult, that she had poor impulse control, violent behaviour, and a criminal record although this is not outlined in detail. Rachel was given a list of things she needed to do or risk eviction and possible discharge from the psychiatric service. However, she did not comply and failed to attend a review. Evicted from Calvert Road, Rachel was then sleeping on friends' couches and she failed to respond to attempts to contact her. Her plans to move north were not realised, although there had been some communication between the Trust and psychiatric services in the north of England in preparation. She was then discharged from the Trust psychiatric service in November due to lack of engagement, failure to take medication, and continued drug use, according to a note made by the CARS team.

2011 In March and again in April, Rachel was re-referred to the Trust service, first by her key worker at the drugs service and secondly by the CARS[16] team. Rachel had been seen in Court charged with Theft, Possession with Intent to Supply and Criminal Damage. By now, Rachel was using a large volume of drugs and working as a sex worker under the control of her boyfriend. Although she had begun a Methadone/heroin withdrawal programme with support from her GP and CRI. Nevertheless, she was apparently struggling to cope and her mental health was deteriorating. Although the CARS team assessment noted no psychotic symptoms, it was clear that Rachel was distressed and chaotic. Police charged Rachel with Theft, Criminal Damage, and Possession with Intent to Supply. Rachel was not seen at this time by mental health staff other than at the CARS team and it does not appear that she was not taken on by secondary care mental health services. She had not apparently had any psychotropic medication since 2010 but was not keen to engage with mental health services either.

2012 In July Rachel was referred to the Trust mental health `Recovery' and `Primary Care Liaison' teams by the GP at the drugs service (Inclusion, now called CRI). The RiO note of the assessment expresses clearly that Rachel is at risk of deliberate self-harm (DSH), of neglect and risk to others due to domestic violence (sic). Rachel also described a recurrence of the male voice which, in the past, had told her to stab someone. The voice was also telling her to harm herself and Rachel said that she suspected someone was tampering with her food. The GP prescribed Olanzepine in a small dose and asked for CPN support.

A CPN (AD) from the `Early Intervention Service' agreed to see Rachel for a period of assessment and she was subsequently seen in September for psychiatric review by Dr. K, the locum consultant psychiatrist and a worker from `Inclusions' (now CRI). They concluded that Rachel did not suffer from schizophrenia. Rather, she was described as having difficulties including anxiety, poor self-esteem and obsessional phenomena, against a background of personality difficulties and poor coping. Various predisposing factors were described, including the trauma she had experienced in childhood and learning difficulties. They identified maintaining factors such as her drug use, her life with an abusive partner who was also forcing her into sex work, and an unhealthy life style. Her partner was also on remand at this time. It was recommended that Rachel re-engage with the drugs team and attend LIFT psychology services, but she did not.

In August and in November, the drugs worker (AW from `Inclusion') contacted the Trust concerned for Rachel's safety as she was being threatened by her abusive partner/pimp; she was saying she would kill herself, and there was a discussion about moving her to a safe house/refuge if she was not admitted to psychiatric care. AW liaised on Rachel's behalf

[16] This is a Court diversion and CJS liaison team, funded by the Trust working within the CJS to identify people coming before the Courts who have mental health problems.

with the domestic violence unit and Swindon's Drug Interventions Programme Sex Work Initiative. Rachel was anxous about being assessed fearing her partner would beat her up and she did not attend. Plans were apparently made for a Section 135 assessment and possible admission to a hospital outside Swindon but there is no documentation on Rio regarding any further action taken.

2013 In September, Rachel was assessed by the Mental Health Liaison Service at Great Western Hospital having been admitted after collapsing whilst in police custody. She had been arrested for attacking and stabbing a woman, the mother of a friend who Rachel said had been `winding her up' for some time. Following this, Rachel was assessed by the CARS (Court Liaison) team and the clinical picture was much as before; that is, Rachel reported a male voice which told her to attack and stab the victim; poor sleep; low mood; concerns about her food; rocking; and various checking and cleaning rituals. She was still taking Crack cocaine at this time (to a value of £200 per day), and Methadone (heroin substitute) and Subutex (for heroin withdrawal symptoms). Her boyfriend was in prison.

During 2013 whilst on remand for 6 months at HMP Eastwood Park, RACHEL was seen and assessed by the mental health in-reach team. Her behaviour remained disturbed and she was moved to a single cell to protect a cell-mate. The internal male voice telling her to harm herself and/or others continued to feature in Rachel's description, and she was prescribed Aripirazole with positive effect.

2014 On 17th January Rachel was released on license from prison where she had been remanded for 6 months. She was prescribed Aripiprazole (anti-psychotic) and Trazodone (anti-depressant and anxiolytic) and in February she was referred to the Swindon Primary Care Liaison Team (PCLS) by her GP. Not having had any medication for two weeks, Rachel reported that the derogatory voice was back. Rachel reported continuing to self-harm by punching and biting to alleviate the stress caused by this and said she had tried to kill herself on two separate occasions by taking an overdose and cutting her arms. The thorough and detailed assessment of Rachel's mental state describes Rachel's risk to herself as `medium' and the recommendation was that she should be referred to LIFT psychology services – a suggestion that, it would appear, Rachel was not keen to follow up, fearing that her then boyfriend would object.

In March, she was assessed by AD working in the EIS (Early Intervention Service) who agreed to maintain contact with Rachel in the community whilst completing an extended assessment and providing support and structure through activities (badminton, gym etc.). Risk summaries completed at this time for the records mention DSH and a risk of harm from others but no risk of harm to others. The record states that Probation services were involved and Rachel's MAPPA level was scored low. There was a crisis plan in the notes which lists triggers and contingencies associated with relapse containing a number for the EIS in the event of an emergency. There is also occasional mention in the notes of Rachel's physical health: for example, it is recorded that she had plastic surgery to re-build her jaw after being beaten up; that she has polycystic ovary syndrome, is deaf in one ear and was overweight.

In June 2014 Rachel decided that she wanted to live in the north of England to be near her mother and daughter. Her mother therefore found Rachel a place to live and arranged for it to be furnished. However, in less than two weeks, Rachel was reporting concerns that the neighbours there were looking at her in a suspicious way; she came back to Swindon. She was arrested in early August after Police raided her flat to look for drugs and found £2000 worth of cocaine.

By July of 2014 it had been decided that Rachel did not have a psychotic illness and plans were in place to discharge her. The team (AD and SK) concluded that Rachel's hallucinations were `pseudo-hallucinations' i.e. that they were more closely related to her personality disorder, anxiety and substance misuse rather than to schizophrenia or other

psychosis and that they were, essentially, a manifestation of her anxiety and lack of capability to formulate or think very clearly in the context of a very abusive background. By now, Rachel was back living with her abusive partner again, and she continued to take heroin periodically and crack cocaine. A referral to the MARAC[17] team was made by her Probation Officer and her DIP worker referred her to the Vulnerable Adults team. An appointment was arranged by the Trust (Dr K and AD) to review her care on 5th September. Rachel was aware that this was to discuss her discharge, something she was reluctant to consider and she did not attend.

Rachel was arrested on 11 September 2014 suspicion of murder following the death of Mr. Y in a house fire at his home the night before. The Court heard that Rachel and Mr.Y himself a vulnerable unemployed man with alcohol and other problems, had met a few weeks earlier. They had been heard to argue over money and, on the evening of the 10th, after arguing again, Rachel took his keys, set fire to a shirt which she then threw to the bottom of the stairs, locked the door and left. She disposed of the keys and Mr. Y's Post Office bank card in a drain in a nearby alleyway.

ENDS

[17] A Multi Agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focussed meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.