INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT PROVIDED TO MR X

Key Findings and Recommendations from the HASCAS Health and Social Care Advisory Service Investigation Report

Background

The Independent Investigation into the care and treatment of Mr X 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 Y who died on 26 September 2013 after being stabbed to death by Mr X.

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.

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr Y. Neither NHS England nor the Independent Investigation Team were able to make meaningful contact with the family during the investigation process for a variety of reasons.

Background for Mr X

Mr X is a Caucasian man who first came to the attention of Devon based mental health services in 2001 when he presented with drug and alcohol problems. At this time his mother was worried about his behaviour and the possibility that he was suffering from depression. Over the ensuing years Mr X received several diagnoses. Paranoid Schizophrenia is recorded in his clinical record from 2003 (and established firmly in 2007) together with Amphetamine Induced Acute Psychosis and Alcohol Residual Psychosis; he also had an opiate dependence of some eight-years standing.

Mr X received his care and treatment over time (from 2002) from both the Exeter and North Devon Addiction Service and from the East Devon Access and Wellbeing Team; however in the two years prior to the homicide Mr X's only regular secondary care contact was with addiction services.

Mr X was discharged from secondary care addictions services in August 2013 – the plan was for his case to remain open for monthly telephone recovery check-ups for a month or so. At this stage Mr X had successfully completed a Methadone reduction programme and was no longer receiving a prescription; in the event Mr X did not engage with the recovery follow up process that was offered to him. During this period, it is evident that Mr X's recovery was fragile; he was no longer being prescribed antipsychotic medication and he was not managing well with the Methadone reduction/cessation programme; he was anxious, agitated, and unable to cope.

Incident Description and Consequences

On 26 September 2013 Mr X was arrested on murder charges after a man was stabbed to death in the Black Horse Hotel in Sidmouth. Mr X had bought a rifle bayonet at an antique shop; it was supposedly from the First World War. He paid £80.00 for it and took it because he could not get a gun. Mr X has claimed not to remember the events surrounding the death of Mr Y however CCTV footage exists that clearly shows him to be the person responsible for the killing.

The Court heard that Mr X had been maintained in the community on Olanzapine but that he had not been on antipsychotic medication for over six months prior to the killing of Mr Y. Although Mr X did not appear to be overtly psychotic in the few weeks directly after the homicide (he was adept at masking his symptoms) the forensic report for the Court stated that Mr X was suffering from an abnormality of mind "*stemming from this recognised medical condition namely Paranoid Schizophrenia".* Mr X was found guilty of manslaughter and detained in a secure NHS facility.

IDENTIFICATION OF THE THEMATIC ISSUES

The Independent Investigation Team identified 11 investigation issues that arose directly from analysing the care and treatment that Mr X received from the Devon Partnership NHS Trust. These issues are set out below.

1. Diagnosis

Mr X had an established diagnosis of Paranoid Schizophrenia concurrent with significant substance misuse. However, Mr X's Schizophrenia was not acknowledged appropriately by the Trust's Drug Service which provided the majority of Mr X's care and treatment. Over the years Mr X's Schizophrenia went largely unmonitored, unmanaged and untreated as his care and treatment was not delivered by an appropriate community-based secondary care mental health team.

2. Medication and Treatment

Mr X did not receive care and treatment in keeping with either NICE Schizophrenia guidance or the Devon Partnership NHS Trust's Dual Diagnosis protocol. Mr X was not provided with a holistic approach to his wellbeing and recovery even though it was understood he struggled to find employment and deal with the outside world. Whilst the Drug Service provided psychosocial interventions – these were not necessarily appropriate for a person with a severe and enduring mental illness such as Schizophrenia. In the six months prior to the homicide of Mr Y the prescribing of Mr X's antipsychotic medication ceased. The failure to manage Mr X appropriately played a significant part in the relapse of his mental state, which the Court concluded, led directly to the homicide of Mr Y. The relapse of Mr X's mental health was due in large part to the lack of the care and treatment he received for his Paranoid Schizophrenia which fell below the standard required from both primary and secondary care services.

3. Mental Health Act (1983 & 2007)

No issues were found in relation to the Mental Health Act.

4. Care Programme Approach (CPA)

Mr X was not in receipt of CPA even though he was eligible for it. He met the criteria for prolonged periods of time and would have benefitted from Care Coordination during his Methadone detoxification programme and beyond to reinforce his recovery and to identify an appropriate care and treatment framework for the future. It would appear that Mr X fell through the safety net of care due to a combination of service pressures and non-adherence to either Trust (or national) policy, procedure and guidance – the failure to implement the Trust's Dual Diagnosis Pathway being of particular note.

5. Risk Assessment

Based upon what was known, and should have been known, about Mr X it is not possible to determine with certainty whether better risk assessment could have either predicted or prevented the death of

Mr Y. However, it is evident that Mr X was not subject to specialist, comprehensive mental state examination and risk assessment on a regular basis. Had this been achieved it would be reasonable to have expected Mr X's inner world to have been understood better and his hallucinations and delusions to have been assessed in relation to risk. It would also be reasonable to have expected better management plans to have been put into place to maintain his recovery and wellbeing.

6. Referral and Discharge Planning

The care and treatment offered to Mr X in relation to referral and discharge practice was of a poor standard. It is evident that in the absence of any dual diagnoses pathway implementation Mr X's needs were not addressed in a comprehensive and seamless manner. Each service only addressed the core components of Mr X's needs that were within their gift to provide. In the absence of a planned strategy for Mr X referral and discharge practice appears to have taken place in a manner that was not holistic leaving Mr X with significant areas of unmet need.

7. Service User Involvement in Care Planning and Treatment

Devon-based services did not ever really get to know Mr X properly and this impacted over the years upon his quality of life, health, safety and wellbeing.

8. Carer and Family Concerns

Following Mr X's return from Scotland in January 2011 there appears to have been no contact made by Trust services with his family, either before or after the homicide of Mr Y. Whilst limited (or a complete absence of) family contact can be explained to some extent prior to the homicide of Mr Y, it was poor practice for the Trust not to offer any support or information to Mr X's family during the internal investigation procedure and directly after.

9. Documentation and Professional Communication

The care and treatment that Mr X received was silo-based in that there was no holistic plan or ongoing professional management strategy across the disparate services that provided care and treatment to him. Professional communication failed to ensure Mr X was managed appropriately in accordance with his known diagnoses and ongoing presentation. The failure of services to maintain an appropriate level of professional communication represents a significant contributory factor in relation to the relapse of Mr X's mental health in the spring and summer of 2013 and the inability to manage it. The Independent Investigation Team also found that the current clinical record management system (across both primary and secondary care) in relation to Mr X's case notes is of a poor standard. This is totally unacceptable in the case of a living patient whose ongoing health, safety and wellbeing can be compromised by a failure to be able to either access and/or share significant information when required.

10. Adherence to Local and National Policy and Procedure

Clinical Guidelines Policies and care pathways were robust and evidence based. However, there was a significant lack of adherence to policy and procedure and this made a significant contribution to the relapse of Mr X's mental health and the subsequent death of Mr Y. There was a significant gap between what the Devon Partnership Trust NHS Trust believed to be happening on the ground and what was actually happening on the ground and clinical governance systems and process did not appear to be robust enough to assure policy adherence.

11. Clinical Governance and Performance

In December 2016 the Trust had a focused re-inspection visit from the Care Quality Commission (CQC); the subsequent report was published on 14 March 2017. The report makes many positive comments about the continuing improvement nature of current governance processes that pertain to the findings and conclusions in this report. There is ample evidence to suggest that the governance issues that made a contribution to the poor standard of care and treatment that Mr X received have now improved significantly and have withstood a high degree of recent external independent review.

SUMMARY

Mr X was understood poorly in the light of his psychiatric history. This problem was compounded by an ongoing lack of professional communication and a silo-based care and treatment provision which did not place Mr X on an evidence-based pathway. Whilst it was not predictable that Mr X would kill Mr Y it was entirely predictable that his mental health would break down. The relapse of Mr X's mental health was largely preventable had reasonable interventions been carried out by both primary and mental health services. An examination of the case highlights a series of missed opportunities on the part of disparate health professionals and Exeter And North Devon Addiction Service (ENDAS) workers. However, underpinning these missed opportunities is the constant factor of poorly performing systems, care pathways and evidence-based practice.

The independent Investigation Team concludes that whilst each individual health professional and ENDAS worker could and should take responsibility for the poor quality of care and treatment afforded to Mr X, the underlying system, particularly in relation to the Dual Diagnosis pathway failed and that this was a key responsibility of the Devon Partnership NHS Trust. On balance the Independent Investigation Team found the mental health relapse Mr X experienced to be both predictable and preventable. The Court at Mr X's trial found Mr X's diminished mental capacity (by virtue of his untreated Paranoid Schizophrenia) to be directly responsible for his actions that led to the death of Mr Y. The Independent Investigation Team therefore concludes that there was a direct causal link between the significant omissions in the care and treatment provided to Mr X, his relapsed mental state and the killing of Mr Y.

LESSONS FOR LEARNING

Policy and Procedure Adherence

It is essential that individuals, clinical teams and Boards of NHS Trusts adhere to evidence-based guidelines and policy documentation. There are three main issues to highlight when care and treatment provision sits outside of formal, agreed structures and process:

1. Service users cannot be guaranteed an evidence-based and safe delivery of service.
2. Professional communication and the continuity of care and treatment delivery between NHS services and partner agencies can become compromised leading to the service user 'falling through the safety net of care'.
3. Service users and their families can find it more difficult to self advocate successfully to ensure that they navigate their way through complex care and treatment programmes.

All policies and procedures mandated by a Trust Board should be audited for both compliance and the quality of implementation; appropriate action should be taken if evidence of non-compliance or poor quality implementation is identified. Whilst the Independent Investigation Team appreciates that on occasions treating teams might need to depart from guidance – these decisions should never be

undertaken lightly and clear rationales should be set out in the clinical records as to why such departures were deemed to be necessary.

RECOMMENDATIONS

The Independent Investigation Team worked with the Devon Partnership NHS Trust to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress, development and good practice have 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. These recommendations have been set after the completion of the Independent Investigation process and take into account the progress the Trust has made against key findings and conclusions.

Recommendation 1: Diagnosis and Dual Diagnosis Care Pathway

It is evident from the work the Trust has undertaken recently in relation to the Dual Diagnosis care pathway that a great deal has been achieved since 2012 and the completion of this Independent Investigation. The Trust will therefore complete all outstanding actions and audit all of its existing arrangements within six months of this report to ascertain ongoing effectiveness. This audit should be overseen by the commissioners of the service. However it should be noted that commissioners have an additional responsibility to ensure GP services and the independent/third sector also comply with best practice guidance and work should be done in partnership with the NHS Trust to ensure any audit recognises the complexity of service provision and that the audit is managed in an integrated manner. The audit should play particular attention to:

1. Dual Diagnosis care pathways shared between the Trust, GP services and the independent/third sector.
2. Professional communication and record keeping.
3. Diagnostic formulation and risk assessment.
4. The quality of CPA to include specifically the development of holistic assessment of need, crisis and contingency planning, and care plans in keeping with a recovery and wellbeing ethos.

Recommendation 2: Internal Investigation Process and Being Open

In light of the significant progress made the recommendation is that the Trust audits its current process within six months of the Independent Investigation report. This audit will be overseen by the commissioners of service and will specifically address:

1. The levels of family and service user uptake of the offer of full inclusion and their satisfaction with the process.
2. Quality assurance processes and feedback from commissioners.
3. Evidence of improved levels of safety and service improvement as a result of learning from investigations.
4. Evidence that learning influences the clinical governance engender (such as policy re view, clinical audit and training)

End.

APPENDIX 1

TERMS OF REFERENCE

a) Review the engagement, assessment, treatment and care that Mr X received from Devon Partnership NHS Trust from his first contact with services in October 2011 up to the time of the incident on 26 September 2013.
b) Review the contact between the drugs and alcohol team, Recovery and Independent Living team, the GP and Devon Partnership NHS Trust services and assess if Mr X's risks (to self and others) were fully understood and addressed (especially the two overdoses in July 2013 and paranoid activity in February 2012).
c) Review the communication between agencies and services, especially between the GP, drugs service and Recovery and Independent Living team and other services within Devon Partnership NHS Trust.
d) To consider the number of contacts that Mr X had with the police and whether further multi - agency working may have assisted in assessing the risk of Mr X to others.
e) Review the documentation and record keeping of key information by the Devon Partnership NHS Trust against best practice and national standards and if record keeping is an issue within the Trust.
f) 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
g) Having assessed the above, to consider if this incident was predictable or preventable and comment on relevant issues that may warrant further investigation.
h) 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