Independent Investigation

into the

Care and Treatment Provided to Ms X

by the

Avon and Wiltshire Mental Health Partnership NHS Trust

Commissioned by NHS South West

Report Prepared by: HASCAS Health and Social Care Advisory Service

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1. Investigation Team Preface

The Independent Investigation into the care and treatment of Ms X was commissioned by NHS South West pursuant to *HSG (94)27*.[1] It should be noted that NHS South West is now replaced by NHS South of England, and this will be the name used throughout the rest of this Report. This Investigation was asked to examine a set of circumstances associated with the death of Mr Y who was found dead in his flat on **7 October 2010**.

Ms X received care and treatment for her mental health condition from the Avon and Wiltshire Mental Health Partnership NHS Trust. Ms X was convicted of the manslaughter of Mr Y and her boyfriend Mr Z was found guilty of murder. It is the care and treatment that Ms X received from this organisation that is the main subject of this Investigation. The care and treatment of Mr Y, who was also a service user with the Trust, is also reviewed as part of this Investigation. Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this 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.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's Senior Management Team which has granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has acted at all times in an exceptionally professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

Ms X was not found guilty of murder by the jury at the Crown Court in Bristol but of the lesser charge of manslaughter. The Independent Investigation Team was asked to include an overview of the care and treatment provided to the victim, Mr Y, and this is included in Section 10.2.

1 Health Service Guidance (94) 27

2. Condolences to the Family and Friends of Mr Y

The Independent Investigation Team would like to express its sincere condolences to the family and friends of Mr Y. In his summing up of the Crown Court Trial of Mr Z the judge commented that he had to *"take into account the victim impact statement of the mother of Mr Y who says that his killing had absolutely devastated her. She had been struggling already from the death of her sister and husband in 2010 and this was yet another supreme tragedy for her as a mother".*[2]

It is understood that the family of Mr Y was unable to be involved in the Avon and Wiltshire Partnership NHS Trust Internal Investigation due to the Police concerns about potential witnesses being asked about issues which might call their evidence in court into question.

It is hoped that this Report addresses hitherto unanswered questions the friends and family of Mr Y may have.

At the time of writing this report the Chair of the Independent Investigation Team and the Commissioner of the Investigation were making arrangements to meet the family of Mr Y to discuss the Independent Investigation Findings and Conclusions.

2 Crown Court Transcription Bristol Crown Court Summing Up: Indictment Number T20107487/8 03082011

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

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

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

This Guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery

of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

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

4. Terms of Reference

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

1. *"To draft a chronology relevant to the issues and circumstances. This should include reference to information available following the conclusion of Crown Court proceedings in order to determine the circumstances leading up to the homicide.*

2. *The quality of healthcare provided by the Trust, to include whether it complied with statutory guidance, statutory obligations, relevant Department of Health guidance and Trust policies.*

3. *The appropriateness and delivery of treatment and medication, this should include consideration of the appropriateness of discharge under the Mental Health Act on 5th July 2010, the after care plan and the actions then taking place to include a professionals' meeting held on 20th August 2010.*

4. *Inter-agency information sharing/communication and coordination of services.*

5. *The assessments of risk to include the recording and actions taken.*

6. *Documentation, including recording of clear plans/assessments and meetings, decisions on frequency of contact and visits and actions taken by all services.*

7. *The internal investigation, its definitions and findings, methodology, recommendations and actions subsequently taken.*

8. *To identify learning points for improving systems of care, together with practical recommendations for implementation.*

9. *Report findings and recommendations to NHS South".*

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

5. The Independent Investigation Team

Selection of the Investigation Team

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

Independent Investigation Team Leader

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

Investigation Team Members

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

Support to the Investigation Team

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

Independent Advice to the Investigation Team

Ashley Irons	Capsticks Solicitors

6. Investigation Methodology

Classification of Independent Investigations

Three types of Independent Investigation are commonly commissioned. These are:

- **Type A** – a wide-ranging investigation carried out by a panel examining a single case;
- **Type B** – a narrowly focused investigation by a panel examining a single case or a group of themed cases;
- **Type C** – a single investigator with a peer reviewer examining a single case as a desk top review.

Each of these categories has its own strengths which make it best suited to examining certain cases. This Investigation was commissioned by NHS South West Strategic Health Authority as a Type B Independent Investigation.

Communications with the Family of Ms X

NHS South West commissioned this Independent Investigation and attempted to make contact with the mother of Ms X by letter explaining that the Independent Investigation had been commissioned. No contact from her has been received.

Communications with the Family of Mr Y

At the time of writing this report it had not been possible for the Strategic Health Authority to make contact with the family of Mr Y.

Communications with Trust Services

The SHA wrote to the Avon and Wiltshire Mental Health Partnership NHS Trust Chief Executive in the autumn of 2011. This letter served to notify the Trust that an Independent Investigation under the auspices of *HSG (94)27* had been commissioned to examine the care and treatment of Ms X. As HASCAS had undertaken several investigations in the Avon and Wiltshire Mental Health Partnership NHS Trust over the past 18 months the Trust Senior Management knew the procedure for such Investigations and decided a meeting to explain the process and how HASCAS worked would be unnecessary.

The Independent Investigation Team worked with the Trust liaison person to ensure:

- that all clinical records were identified and dispatched appropriately;
- that each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished;
- that a workshop for witnesses to the Independent Investigation was held on 24 July 2012. The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible;
- that interviews on 3 October and 4 October 2012 were held at the Avon and Wiltshire Mental Health Partnership NHS Trust Headquarters in Chippenham, Wiltshire. The Investigation Team were afforded the opportunity to interview witnesses and meet with the Trust Corporate Team;
- that a transcribed telephone interview was held on 5 November 2012 with one witness from the Trust who had been unable to attend for interview in October;
- that on 3 December 2012 a meeting was held between the Chair of the Independent Investigation, the CEO of the HASCAS Health and Social Care Advisory Service and the Trust Corporate Team, in order to discuss the findings and to invite the Trust to contribute to the development of recommendations.

Communication with Bristol Primary Care Trust (PCT)

When the Independent Investigation Team had drafted its Report a meeting with the Bristol PCT was arranged to provide them with an overview of the findings of the Investigation and the areas for recommendations.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon compliant processes.

Table One

Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
3 October 2012	Doctor 2 Consultant Psychiatrist Manager 1 Psychologist 1 Internal Investigation Member 1 Internal Investigation Member 2 Internal Investigation Member 3 Senior Manager Trust 1 Senior Manager Trust 2	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
4 October 2012	Care Coordinator 3 Ward Manager 1 Modern Matron 1 Care Coordinator 2	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer
5 November 2012	GP 2 (A telephone conference call)	Investigation Team Chair Investigation Team Psychiatrist Investigation Team Nurse In attendance: Stenographer

Scott and Salmon Compliant Procedures

The Independent Investigation Team adopted Scott and Salmon compliant procedures during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be given the opportunity to review clinical records prior to and during the interview;

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Investigation Team Meetings and Communication

The Independent Panel met on three occasions and also had contact *via* email and telephone conversations.

The Investigation Team Met on the Following Occasions:

First Team Meeting 17 September 2012

The Team examined and discussed the Chronological Timeline which had been produced following the receipt of the full clinical records. The Team decided which staff they would wish to interview and agreed questions they would ask. The list of documents required was made which consisted of various Trust Policies and Operational Policies together with information about the Trust.

Second Team Meeting 4 October 2012

There was a gap in the interviewing schedule which allowed the Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the running of the various teams which had contact with Ms X and also on management and governance issues.

Third Team Meeting 5 November 2012

The Panel had received the transcriptions and were therefore able to add to the Chronological Timeline to reflect the additional information received *via* the interviews. There were also additional policies and procedures from the Trust which were examined.

The main activity was to consider the evidence collected and to start looking at the Root Cause Analysis of the information and thereby to identify key issues and potential contributory factors as well as good practice. The contribution of each Team Member to the Investigation Report was also agreed.

Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

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

RCA is a four-stage process.

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.

2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

7. Information and Evidence Gathered (Documents)

During the course of this Investigation the following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions:

1. Trust Clinical Records of Ms X from the Avon and Wiltshire Partnership NHS Trust (AWP);
2. GP Records of Ms X;
3. Trust Clinical Records of Mr Y;
4. AWP Policy to Safeguard Adults 2008;
5. AWP Policy to Safeguard Children 2008;
6. Policy to Manage Care Pathways and Risk 2006/2008; Prevention and Management of Violence and Aggression (PMVA) 2007/2009;
7. Safe Management of Patients in Hospital Policy 1998/January 2009;
8. Early Intervention in Psychosis Team Operational Policy November 2009;
9. AWP Policy for Interim Standard Operating Procedures for Acute Inpatient Wards:
   The Open Ward;
   The High Dependency Unit;
10. The Open Ward Staffing Rotas;
11. Staff Supervision Policy 2008/2011;
12. AWP Care Programme Approach and Risk Policy 2006/2011;
13. AWP Board Strategy for Quality Improvement 2010/2015;
14. First Action Plan for the Ms X Internal Investigation;
15. Second Action Plan for the Ms X Internal Investigation;
16. AWP Dual Diagnosis Strategy – Co-existing Mental Health and Alcohol and Drug Use Problems 2007/2008;
17. Care Programme Approach Dual Diagnosis Procedure 2007/2010;
18. Being Open Policy 2008;
19. AWP Clinical Governance Framework;
20. Risk Management Strategy 2010;
21. Policy for Reporting, Managing and the Investigation of Adverse Incidents (including Serious Untoward Incidents) also known as The Incident Policy;
22. Specialist Drug and Alcohol Service (SDAS) Substance Misuse Risk Assessment 2009.

8. Profile of Trust Services

The Avon and Wiltshire Mental Health Partnership NHS Trust's (The Trust) description of its services is reported below.

The Trust exists to provide high quality mental health and social care services to people of all ages, and to those with needs relating to drug or alcohol misuse. The Trust promotes health and wellbeing through the Recovery Model, supporting individuals to reach their potential and to live fulfilling lives. As one of the largest providers of Mental Health Services in the country, the Trust continuously works hard to ensure those in our communities receive help when they need it.

The Trust operates across a geographical span of 2,200 square miles, encompassing a population of 1.6m people and covering six Primary Care Trusts (PCTs). Services are centred upon 11 main in-patient sites, 97 community bases and four community mental health houses. The Trust has an operating budget of £194m per year and employs in excess of 3,500 staff.

The Trust is overseen by a Board of Directors with joint responsibility for the governance, leadership and strategic direction of the Trust. The Chief Executive is responsible for the day-to-day management of the Trust. The Chief Executive is supported by five Executive Directors, each of whom manages a Directorate with responsibility for an area of the Trust's operations and performance. The Operations Directorate leads the delivery of services across the Operational Business Units.

Until early 2013 these Business Units were managed as single entities across the Trust, covering Specialist Drug and Alcohol Services, Adults of Working Age, Liaison and Later Life Services, and Specialised and Secure Services. In early 2013, the Trust is moving to a system of locally managed services, starting in Bristol in January 2013 where all local services have moved under a single management system, which will be headed up by a local Clinical Director.

The Trust's Strategic Objectives are:

- A Sustainable Value for Money Business;
- Excellent Service User Access and Experience;

- Excellent Partnership Working with Other Organisations;
- Effective Staff Engagement and Improvement in Staff Satisfaction.

The City of Bristol has a population of 420,000. There are high levels of morbidity within the Inner City area. The Avon and Wiltshire Mental Health Partnership NHS Trust's mental health services work in close partnership with the Primary Care Trust, Bristol City Council and the Voluntary Sector. Staff within the City Council that provide services to people with mental health conditions are managed separately from the local NHS Mental Health Teams.

Bristol is divided into three Community Sectors, North, South and Central, with an Area Manager for all the Adult Community Services. Each Sector is served by a local Support and Recovery Team providing community mental health interventions in close collaboration with primary care. Access into the services is currently managed through a Primary Care Liaison Service which receives, triages and transfers on all GP and other referrals.

The Recovery Teams work with service users who have more complex mental health conditions. The majority of people however will have time-limited conditions and will be referred back to their GP's when their condition has improved. A substantial minority of people with more complex and enduring needs will remain with the Recovery Teams for ongoing specialist care and monitoring for a longer period of time.

There is also a city wide Intensive Team which provides around the clock crisis support across the city. The Service works with individuals with an acute psychiatric crisis of such severity that without their involvement hospitalisation would be necessary. The Team acts as a 'gate keeper' to Acute In-patient Services and for those individuals for whom Home Treatment would be appropriate, and provides immediate multi-disciplinary, community based treatment 24 hours a day, seven days a week. Where hospitalisation is necessary the Team is actively involved in discharge planning and provides intensive short term care at home to enable people to leave hospital at the earliest possible opportunity.

Bristol has an Early Intervention Service. This Service works with individuals aged from 14 to 35 years of age who are experiencing a first episode of psychosis. The service aims to reduce the stigma associated with psychosis and raise awareness of the symptoms of

psychosis and the need for early assessment in order to reduce the length of time young people remain undiagnosed and untreated. Providing a user centred service it is focused on meaningful engagement and promotion of recovery during the early phase of illness. The Early Intervention Teams provide a service for young people in the first three years following a first episode of psychosis. They offer intensive evidence based psychosocial interventions, including Cognitive Behavioural Therapy (CBT) and family work for psychosis.

9. Chronology of Events

This Forms Part of the RCA First Stage

The Chronology of Events forms part of the Root Cause Analysis first stage. The purpose of the Chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Ms X and on her care and treatment from mental health services.

Background Information

Birth to October 2007

Ms X had had a very difficult childhood having never known her father who left her mother to return to Morocco just after she was born. It was known to services that she had a problematic childhood.

Ms X started to experience panic attacks at the age of 12 and had problems with bullying at school. After a change of school Ms X became school-phobic and was transferred to another school which arranged to take her to school. At the age of 13 Ms X attempted suicide by taking an overdose, and later started to self-harm by cutting herself.[3]

In 1997 Ms X was admitted to the local hospital, with an overdose and again in **September 1999** following an overdose of Migraleve. In the same year her family underwent some sort of family therapy. In **November 2000** Ms X became pregnant but this was terminated due to the foetus being diagnosed as having anencephaly. This is the absence of a large part of the brain and skull making survival extremely unlikely and is extremely traumatic for the mother if the pregnancy is allowed to go to delivery.[4]

In 2001 Ms X took another overdose and was seen by a psychiatrist in the Accident and Emergency Department. At this time she was not living with her family but was reported to be living with a carer although this is not clarified further in the GP Records. In **August 2001** her mother telephoned the GP to report that Ms X had tried to drown herself in the sink

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4 Transcript 1 Page 2

because she had received news that her father had killed himself. She was referred to the psychiatric service in **September 2001** and was visited at her home. She made another suicide attempt later the same month and was again seen at home. In **October 2001** there were more self-harming incidents.[5]

In September 2002 Ms X took a deliberate overdose of Paracetamol. In **May 2003** Ms X reported to her GP that she had experienced abuse by a female in her family, and had slashed her wrists. Ms X had been attending counselling at 'Off The Record', which is the Young People's Counselling Service in the Bristol area.

In **July 2003** the GP records show that Ms X had a place at a college. At this time she was also attending CRUSE for bereavement support. In **September 2003** the GP recorded that there was some evidence of paranoia in her presentation at the surgery. In **February 2004** Ms X told her GP that she had stopped a dance course because it was *"all too much".*

Ms X had an unplanned pregnancy in **March 2004** and during this time she was seen by a psychiatrist who looked after patients with mental health problems during pregnancy. It was noted at the time that Ms X was using cannabis. She had a normal delivery in **November 2004**, after which the Prozac that she had been taking during her pregnancy was increased. She had a negative drug screen during the pregnancy for amphetamines, opiates, benzodiazepine and methadone.

In **December 2004** Ms X was referred to Psychiatric Services, and in **June 2005** sexual abuse counselling was discussed with her and she was referred for family therapy. In **December 2005** she had a termination of pregnancy and a coil was fitted.

In **April 2006** Ms X was referred to ACAD, a Drug and Alcohol Service. In **August 2006** Ms **X** was still attending ACAD and also the SWAN Project, a counselling and advice service in Bristol. In **September 2006** she was reported to be living in a Women's Refuge in Newcastle-under-Lyme and there was also mention of her living in another Women's Refuge in Birmingham. By **October 2006** she had moved back into Bristol and was living in a flat.

5 Transcript 1 Page 2

She had started attending the Freedom Programme which was a specific service for women who were experiencing domestic violence.[6]

In **January 2007** Ms X became pregnant again, with her son, and was attending the alcohol service, ACAD. **On 12 June 2007** Ms X attended the Bristol START Alcohol Service having been referred there by her GP. She told staff that her son was due to be born on **24 September 2007**. She claimed to be drinking just one pint of alcohol weekly and smoking cannabis three times a day and snorting cocaine once at weekends. Ms X reported that she had an alcohol problem and some psychological issues and that her aim was to stop drinking and to reduce her cannabis use.[7]

On **17 October 2007** Ms X was offered an appointment at the Bristol Specialist Drug and Alcohol Service which had been requested by her GP. She did not attend and a letter was sent to her GP on **20 December 2007** advising him that she had failed to attend the service.[8]

Clinical History with the Avon and Wiltshire Partnership NHS Trust Mental Health Services

On **24 May 2009** Ms X left her two children at her sister's house unattended without having informed her sister who was told by her neighbours that there were two young children in her garden. Her sister telephoned the Police and as a result Ms X was cautioned by them and the Bristol Children and Young People's Services became involved. The two children aged four years and 22 months, were assessed as being 'Children in Need' and Ms X was warned that if any further concerns about the children were raised, or the overall situation worsened then Child Protection Procedures were likely to be invoked.

At this time Ms X was living with her mother as she had been made homeless due to not paying her rent for the flat she had in Bristol. Her finances were muddled and she had refused to claim the benefits to which she was entitled. The living conditions were extremely

6 Transcript 1 Page 3
7 Clinical Records Volume 6 Pages 2262/2263
8 Clinical Records Volume 6 Page 2260

crowded with nine people sharing the accommodation which had four bedrooms. There were four adults, two teenagers and three children aged six years or less. The residents were:

- Mrs W (Ms X's mother);
- Ms X aged 25;
- a half-sister to Ms X aged 23;
- a half-brother to Ms X aged 22;
- another half-sister to Ms X aged 16;
- another half-brother to Ms X aged 15;
- another half-sister aged six years;
- Ms X's daughter aged four years;
- Ms X's son aged 22 months.[9]

Five days later on **29 May 2009** Ms X was referred to the Citywide Home Intervention Team but their promised support did not arrive so she and her mother rang the Mental Health Services. Her GP (GP 1) had referred her as she thought Ms X was psychotic. Ms X did not know why she was being assessed and only wanted to find a home for herself and her two children. A Core Assessment was undertaken as Ms X had appeared to be very agitated and distressed. Doctor 1 said that Ms X needed to accept the treatment offered or it would have repercussions for relationships with her family, her children and her own wellbeing.[10]

On **2 June 2009** a member of staff from the North Bristol Middle Team telephoned Ms X but spoke to her mother who said her daughter had only taken one tablet prescribed by Doctor 1 saying that her daughter said *"she did not need to take medication".* The same worker later spoke to Ms X who denied that she was ill and said she was taking medication but did not need it. She said she was *"fine"* but agreed to attend an Out Patient Review later in the week. It was noted that Social Worker 1 was arranging extra day nursery time for Ms X's children.

On **4 June 2009** Ms X went to see Doctor 1 for the Out Patient Review accompanied by her mother. It was noted that Ms X had recently left her two children with her sister and *"took off"* and her sister had contacted the Police. Ms X had been arrested and cautioned and the two children had now been assigned Ms X's mother as their main carer and lived with her

9 Clinical Records Volume 6 Pages 2274-2276
10 Clinical Records Volume 6 Pages 2056-2066

and Ms X. Ms X was presenting as paranoid, chaotic and unpredictable. She had believed that songs played on the radio had been written by her. The following plan was put into place:

- Ms X would start Risperidone at 1mg daily and then have it increased to 2mg;
- the Core Assessment would be sent to the local Community Mental Health Team;
- psychiatric services would liaise with Social Services due to concerns regarding Ms X's illness and the effect of this on her children;
- the mental health service would work with both Ms X and her mother.

The next day, **5 June 2009** Ms X was assessed by CPN 1 and Student Nurse 1 from the Crisis Resolution and Home Treatment Team (CRHTT) at her home. She was calm but suspicious and paranoid about their visit. Ms X had told them she thought she was pregnant, but this was said to be unlikely according to her mother and her GP. Ms X wanted her own home with her two children. She had bizarre ideas and had tried to leave the house naked through a window and thought her mother and others were trying to remove her children. Her dietary pattern and sleep pattern were both erratic.[11]

CPN 1 drew up the Acute Enhanced Integrated Care Programme Approach Review Multi-professional Care Plan with Ms X on **8 June 2009**. The aim was to support Ms X at home and to allow her the opportunity to discuss her beliefs and coping mechanisms as a way of being more able to support herself. It was also agreed that her mother needed support as she was her primary carer. This was to be achieved by daily visits and allowing Ms X to express her feelings and for staff to observe her for paranoid ideas and bizarre beliefs and delusional thoughts.[12] The next day, **9 June 2009** two home visits to Ms X were made. She was weeping, appeared muddled and refused to take her Olanzapine. She had little insight into her illness and the plan was for her to be admitted to hospital.[13]

On **10 June 2009** Ms X was admitted to hospital. She found it difficult to settle but eventually accepted Lorazepam 1mg and Zopiclone 3.75mg which helped her to sleep from midnight onwards.[14]

11 Clinical Records Volume 6 Page 2119
12 Clinical Records Volume 1 File 2 Page 340
13 Clinical Records Volume 1 File 2 Page 348
14 Clinical Records Volume 6 Pages 2120-2135

The next day, **11 June 2009,** another patient reported that Ms X had been trying to climb over the back garden fence in an attempt to leave the ward and the Hospital. Staff investigated and found her hiding in the hedge. Earlier in the day Ms X had run out of the ward when the door was open to let someone in. She was held under Section 5(4) of the Mental Health Act 2007. She continued to stand near the door and attempted to leave on several occasions. She was later detained under Section 5(2) of the Mental Health Act (2007).[15]

Ms X had telephoned for a taxi to collect her from the ward to take her home on **12 June 2009**. She was worried that her mother was at risk. She was assessed under the Mental Health Act (2007) and placed on Section 2.[16] The next day Ms X refused her medication and when told the importance of taking the tablets she said *"I feel tired. I'll go to sleep, how's that for a compromise"*?[17]

Ms X went absent without leave soon after a former service user had visited her on **14 June 2009**. Mrs W telephoned the ward and said she would try to get her daughter into the car and bring her back to the ward. Ms X was returned. She remained distracted and preoccupied but denied experiencing any voices. She appeared to be thought-disordered. She later climbed onto the roof of the High Dependency Unit attached to the ward. It was decided that she be transferred to the High Dependency Unit which had a higher staff to patient ratio to prevent her absconding so easily from the Hospital.[18]

On **15 June 2009** Ms X had a physical examination by a Senior House Officer (SHO) and was found to have a submandibular lump on the left side of her neck which was very tender. She also had an Electro-Cardiogram (ECG).[19]

Ms X was discharged from the ward on **17 June 2009** and was referred back to the CRHTT following a Ward Meeting which Ms X and her mother attended. She was asked to return to the ward on **22 June 2009** for a Care Planning Meeting. Mrs W considered that her daughter was still ill. The Section 2 of the Mental Health Act was rescinded.[20]

15 Clinical Records Volume 1 File 2 Pages 354-356
16 Clinical Records Volume 1 File 2 Page 356
17 Clinical Records Volume 1 File 2 Page 357
18 Clinical Records Volume 1 File 2 Pages 358-360
19 Clinical Records Volume 1 File 2 Pages 378-384
20 Clinical Records Volume 1 File 2 Pages 384

The Care Planning Meeting was held on **22 June 2009** and was attended by Doctor 2 and two junior psychiatrists. Ms X said she was taking her medication but Mrs W was not as certain as she had not seen much difference in her daughter's behaviour since she had been at home, although her appetite had been better. Ms X displayed some hostility towards her mother and stated that what she wanted was to:

- have her house back;
- get back into music;
- look after people;
- feel that people were listening to her as she currently had the opinion that they were not paying her attention.

It was agreed that Ms X would be treated by the Early Intervention Service Team and would continue to have Risperidone and Fluoxetine but would stop the Diazepam when the current supply was finished.[21]

On **23 June 2009** Student Nurse 1 and Psychologist 1 met Ms X at her home. She was agitated and claimed that she was taking her medication but her mother mentioned that she had not taken any of the medication since she was discharged home.[22]

On **29 June 2009** Mrs W explained that her daughter had been depressed for the past five years, but that in the last seven months she had been behaving bizarrely and had been struggling to look after herself and her two children. She had dismantled electrical goods, had taken an overdose in **March 2009** and had threatened suicide. In the past she had regularly harmed herself. Her previous rented accommodation had been sold, she had not made plans to move and so she had moved in with her mother. Mrs W also stated that she was finding life hard having so many people in her house, and that she was recovering from a serious illness and was tired and found it hard to cope with her daughter. Ideally Mrs W would have liked to be able to go out on her own and for her daughter, Ms X, to have some sort of supported accommodation. Mrs W also stated that the recent bereavement of several family members had meant that she did not get as much family support as previously. Care Coordinator 1 had undertaken a Carer's Needs Assessment with Mrs W and had provided her with her landline and mobile telephone numbers, plus the telephone numbers for the Citywide Home

21 Clinical Records Volume 1 File 2 Pages 284-386
22 Clinical Records Volume 6 Page 2172

Intervention Service and the Children's and Young People's Services. Mrs W had been advised that if she felt threatened by Ms X she could contact the Police.[23]

Ms X did not engage with the Mental Health Services while she was in the community and living with her mother from the time she was discharged on **17 June 2009**. On **21 July 2009** Mrs W reported that Ms X went out without shoes and stood on the pavement staring into space for 20 minutes. She was crying a great deal and was barely interacting with her children. She was not able to support herself due to self neglect. In response to this description of how poorly Ms X had been functioning a Mental Health Act Assessment was undertaken and Ms X was detained under Section 2 of the 2007 Mental Health Act on **22 July 2009**.[24]

The same day Ms X was admitted to hospital and she said she had not taken any medication while she had been at home. She was agitated on the ward and although she refused oral prn medication it was given intramuscularly by a Control and Restraint Team because she was looking for ways to leave the ward and abscond. She was placed on 10 minutes observations.

On **23 July 2009** Ms X had tried repeatedly to leave the ward and had to be restrained by the Control and Restraint Team and was given Lorazepam 2mg and Haloperidol 5mg intramuscularly.[25] On **25 July 2009** Ms X had an acute dystonic reaction from the Haloperidol.[26]

A First-tier Tribunal was held on **7 August 2009**. The responsible Clinician, Doctor 2, was unsure whether Ms X was psychotic or whether she had an affective disorder or a personality disorder. He considered that he required more time to further assess her symptoms. She had been unable to keep to any of the agreements made for leave and community assessment. Her concern was primarily for her own health rather than for the safety of her children. Doctor 2 had planned to take her off medication for a week and see how she responded. Doctor 2 felt that Ms X needed to talk and to open up about her problems as otherwise her mental state would deteriorate and this would mean that she would risk losing her children.

23 Clinical Records Volume 6 Pages 2274 – 2276
24 Clinical Records Volume 6 Page 2053 and Pages 2185 – 2187
25 Clinical Records Volume 1 File 2 Pages 387 - 388
26 Clinical Records Volume 3 File 2 Page 1301

It was noted in the Tribunal Report that Ms X had generally been non-compliant and unable to engage in any meaningful conversation with Ward Staff. She had made repeated attempts to leave hospital. Doctor 2 had tried giving her leave so she could engage with Care Coordinator 1, but this did not work as Ms X would not engage and was not taking her medication. During this admission which started on **22 July 2009** Ms X had moved from an open ward to the High Dependency Unit on **29 July 2009** until **4 August 2009.** She had home leave until **7 August 2009** when she returned to the ward but after only five minutes (sic) she was transferred to the High Dependency Unit again from where she was discharged 10 days later on **17 August 2009**.

On **9 August 2009** Ms X reported that she had had thoughts she described as *"friends"* and had *"heard religious things".* She was unable to elaborate further on this when asked by staff. She stated that she thought she was psychic and could see into people's minds.[27]

Ms X was discharged from Hospital on **17 August 2009.** A Personal Recovery Plan was prepared by Care Coordinator 1. Ms X's children had to remain with her mother but the house was crowded and she felt stressed there. The Children's and Young People's Service was to assess Ms X's parenting ability before her children would be allowed to live with her away from her mother's support. The Plan was that Ms X would:

- engage with the Early Intervention Service weekly;
- continue to have Prozac;
- be reviewed by Doctor 1 in three weeks.

Ms X agreed to return to the ward that afternoon to collect her medication.[28]

On **28 September 2009** after six weeks in the community during which Ms X had been receiving support from the Early Intervention Service in addition to the Community Mental Health Team, she was reported by her mother to have used alcohol and, she feared, crack cocaine. During this period Ms X had removed her daughter from school and had assaulted her sister. She had been taken to the Police Station and was subsequently detained under

27 Clinical Records Volume 6 Pages 2203 – 2204 and Volume 1 File 2 Pages 483 - 485
28 Clinical Records Volume 6 Pages 2092 - 2093

Section 2 of the Mental Health Act (2007) and was admitted to hospital the following day, **29 September 2009**.[29]

Ms X acknowledged to staff on the ward on **30 September 2009** that she had used cannabis the previous week when they asked for a urine test. She appeared settled and engaged with ward staff during this admission but again refused to engage with the Early Intervention Service on discharge.[30]

There was a Care Plan Meeting on the ward on **5 October 2009** when it was agreed Ms X would be discharged from the Early Intervention Service and Mental Health Services in general. This decision was based on the observation that there had been no evidence of mental illness. It was agreed that if in the future Ms X required further mental health assessment this would be undertaken by Doctor 2 in the North Sector Assessment Service. The Early Intervention Service would become involved again should Ms X display clear evidence of any psychosis due to the complex nature of her presentation.[31]

On **6 January 2010** the Police were called to a domestic incident where Ms X was fighting with her sister and was attempting to take her children away. The Children's and Young People's Service had forbidden Ms X to see her children on her own and had placed her mother as their main carer.

On **2 March 2010** Ms X was admitted to hospital under Section 2 of the Mental Health Act 2007. She felt that she had been 'set up' by her family. She was living with her mother but had started seeing a boyfriend during the last few weeks. She reported that her younger sister had talked about her mental health issues to her boyfriend on Facebook.

The initial impression given by the ward staff was that Ms X had psycho-social issues, a difficult family situation and did not display psychosis on the ward.[32]

The ward staff made contact with Social Worker 2 who explained that Ms X was not able to care for her children and that she was the aggressor in the home situation. She had been asked

29 Clinical Records Volume 6 Pages 2220 - 2221
30 Clinical Records Volume 6 Page 2198
31 Clinical Records Volume 6 Pages 2220-2221
32 Clinical Records Volume 3 File 2 Page 1121

to move out of her mother's home and find somewhere else to live. Ms X had been in denial and had torn up all official letters regarding her children and finding accommodation. Ms X was being prosecuted for not letting her five-year old daughter go to school for the past six months. Ms X had not claimed the State Benefits to which she was entitled and had been accused by her mother of having taken £1,000 from her bank account. When faced with these facts Ms X became violent and had to be forcibly restrained and was transferred to the High Dependency Unit where she was given Lorazepam 2mg, Haloperidol 5mg and Procyclidine 5mg by the Control and Restraint Team.[33]

The following day, **3 March 2010,** Ms X claimed that the Lorazepam, Haloperidol and Procyclidine given by the Control and Restraint Team the previous day would cause her to have an abortion. She said that she had two or three *"spliffs"* of cannabis a week and that she had been drinking. Ms X then left the ward for 35 minutes and returned on her own.[34]

As Ms X was homeless she was interviewed by a member of staff from Link House on **4 March 2010** and was offered a placement there. Link House works with women who have experienced mental illness. As a result Ms X was discharged from the Section 2 of the Mental Health Act (2007) into the care of Link House. On the journey to Link House Ms X asked to be dropped off to see a friend. She left the car and went looking at several houses and asked one householder if she could use the toilet in his house as she was pregnant. Once inside the house she refused to leave the property. The Police were called and Ms X was removed from the house and was placed on a Section 136 of the Mental Health Act 2007 and was held overnight in the Police cells.[35]

Ms X had threatened to commit suicide if she was separated from her children. She was not allowed to live with her mother who had care of her children as the Children's and Young People's Service had obtained an Exclusion Order to prevent her living in the same accommodation as her children. Ms X was deemed to be of No Fixed Abode and as there were no viable community alternatives for her she was again admitted to hospital on **5 March 2010** but was quickly transferred to the High Dependency Unit. She was commenced

33 Clinical Records Volume 3 File 2 Pages 1124 - 1125
34 Clinical Records Volume 3 File 2 Pages 1125 and 1134
35 Clinical Records Volume 5 Page 1965

on Risperidone 1mg twice a day but it was omitted later due to her poor physical health condition.[36]

On **6 March 2010** Mrs W (Ms X's Mother) visited Ms X with her children. The visit was reported to have gone well at first but then Ms X started shouting at her mother in front of the children. She wanted her daughter to stay with her and refused to give her back to her mother and spat at her.[37]

Ms X was thought to have a *"water works infection"* and that if not treated she could become very unwell. It was difficult to assess her mental capacity. The Duty Psychiatrist assessed her as not having mental capacity on **7 March 2010**. The staff on the ward were against her going to Medical Ward C as she was an absconding risk. It was agreed she would be treated on the current ward and this was done under Common Law as the Mental Health Act (1983 and 2007) were not applicable in situations such as this.[38]

On **8 March 2010** Ms X saw Doctor 2 who wanted her to have Risperidone depot and continue oral Risperidone twice daily, which she refused. Doctor 2 said that if she remained agitated she should be given Clopixol 50mg intramuscularly. A USC renal/abdomen was ordered to help inform the Urinary Tract Infection treatment. It was not clear whether Ms X would comply with either treatment.[39]

Ms X completed the Acute Recovery Review Form Section about her concerns regarding her treatment on **10 March 2010**. She stated that she would like to work with the patients on the ward as a member of staff. She complained that:

- she was not heard when she talked about the abuse she suffered at home;
- diaries, clothes and music belonging to her had been stolen;
- she was not allowed to send her children to a school in Bath or to another school in Bristol;
- she had been bullied at school and that she wanted to spare her children suffering this.

36 Clinical Records Volume 3 File 2 Page 1143
37 Clinical Records Volume 3 File 2 Page 1144
38 Clinical Records Volume 3 File 2 Page 1152
39 Clinical Records Volume 3 File 2 Page 1159

Ms X's current medication was Risperidone 1mg twice daily, Ciprofloxacin 500mg twice daily and Risperdal Consta depot.[40]

On **16 March 2010** Ms X went missing from the High Dependency Unit.[41]

The next day, **17 March 2010,** Ms X was escorted to Court by staff as the case about the care of her children and their residence was to be heard. Ms X absconded from the Court and was later returned to the High Dependency Unit intoxicated. The result of the Court Hearing was that the children were placed in the care of their maternal grandmother, Mrs W.[42]

On **27 March 2010** Ms X asked staff if she could be returned to the Open Ward as she wanted to be able to make her own coffee and have use of the kitchen which was not possible on the High Dependency Unit. It was agreed that a gradual move to the Open Ward could be arranged and she was transferred back on **30 March 2010**.[43]

At the Ward Round on **29 March 2010** Manager 1 from the Early Intervention Service attended and agreed that he would appoint a Care Coordinator for Ms X. Care Coordinator 2 was appointed and attended all the weekly Ward Rounds and met Ms X at least once weekly.[44] Two days later Ms X went missing from the ward for three days, being returned by the Police at 20.15 hours on **2 April 2010**.[45]

On her return to the ward on **2 April 2010** Ms X was considering making a complaint that she had lost her baby on the ward. She explained that at age 15 she had had an abortion because her mother and her boyfriend thought she could not look after a baby. (Elsewhere in the records this abortion was said to have been carried out due to the baby having anencephaly).[46]

Ms X continued to abscond from the ward and the Hospital. On **4 April 2010** she left the ward at 16.00 hours and went home, telling her mother that she had had a miscarriage at the

40 Clinical Records Volume 3 File 2 Pages 1172 - 1176
41 Clinical Records Volume 3 File 1 Page 865
42 Clinical Records Volume 3 File 2 Page 1203
43 Clinical Records Volume 3 File 2 Page 1237
44 Clinical Records Volume 3 File 2 Page 1227
45 Clinical Records Volume 3 File 1 Page 861
46 Clinical Records Volume 3 File 2 Page 1242

Bristol Royal Infirmary. The ward sent a taxi with a member of staff to her mother's house and she was returned to the hospital.[47]

On **8 April 2010** Ms X was listed as being of No Fixed Abode and reported to the Police as being a missing person. She had had escorted leave with two staff members to have a CAT scan. She had asked to use the toilet in the Hospital Canteen and had escaped through the toilet window. Later that day Ms X telephoned the ward from her mother's address in a distressed state and it was clear that she had been drinking. As before, she was returned to the ward by taxi accompanied by a member of staff.[48]

The next day, **9 April 2010** Ms X absconded from the ward and the Hospital by presenting herself at another ward and by pretending to be a relative she managed to escape from that ward. She returned from her mother's house in a taxi and had clearly consumed alcohol.[49] On **10 April 2010** Ms X informed staff that whilst away from the ward the day before she had taken 16 Paracetamol tablets and 16 Ibuprofen tablets together with three pints of beer.[50]

Ms X was listed again as being of No Fixed Abode and reported to be a missing person on **13 April 2010** when she absconded from the ward and returned just after midnight at 00.30 hours.[51]

On **18 April 2010** the AWP Comprehensive Assessment was completed with the Section on Dynamic Risks stating that these were:

- going absent without leave;
- being non-concordant with prescribed treatment, disengaging from Mental Health Services and the Community Mental Health Teams including the Early Intervention Service;
- having a history of self-harm, including in April 2010 an overdose of Paracetamol and Ibuprofen whilst absent without leave, and an earlier overdose of Paracetamol in March 2009;
- not managing her self-care which could deteriorate when she was unwell and her dietary needs were also neglected.

47 Clinical Records Volume 3 File 1 Page 858 and Volume 3 File 2 Page 1249
48 Clinical Records Volume 3 File 1 Page 853 and Volume 3 File 2 Page 1258
49 Clinical Records Volume 3 File 2 Page 1258
50 Clinical Records Volume 3 File 2 Page 1260
51 Clinical Records Volume 3 File 1 Page 845

The Risk Management Plan comprised the following components:

- Ms X was to be admitted to the High Dependency Unit (HDU) and all paperwork completed;
- Ms X was to be nursed on 60 minute observations, unless mood, mental state or risk should indicate otherwise;
- Ms X was to be advised of the treatment options to develop a good understanding of the current need for accepting prescribed treatment;
- A completion of a full and ongoing assessment of her mental state and associated risks was to be undertaken;
- Ms X was to be reviewed by the Medical Team regularly and to work closely with her community team and Care Coordinator 2 to ensure a safe, successful and good care package on discharge from Hospital, including accommodation;
- Ms X was to be transferred back to the Open Ward if she was able to avoid going absent without leave from the High Dependency Unit.[52]

The next day, **19 April 2010,** Ms X went out with two members of staff, her mother and her children and she made no attempt to abscond. The following day Ms X was out of the Hospital on escorted leave when she ran away from her escorts in a public place and went to her mother's house. She was returned to the High Dependency Unit by the Police at 13.30 hours. When she was questioned about any use of alcohol or drugs Ms X reported that she had taken 20 Paracetamol and 20 Ibuprofen. There was no evidence in her demeanour that she had taken this quantity of drugs and as she did not get a reaction to her statement she confessed that she had made up the comment.[53]

On 21 April 2010 Ms X requested a second opinion about her diagnosis and having to be in hospital. Doctor 3 agreed to do this. Care Coordinator 2 telephoned the ward to inform staff that there should be no unsupervised contact for Ms X with the children at her mother's house. Social Worker 2 had started to question the suitability of the current placement for the two children.[54]

52 Clinical Records Volume 3 File 2 Page 1301
53 Clinical Records Volume 3 File 1 Page 841 and Volume 3 File 2 Pages 1267 and 1275
54 Clinical Records Volume 3 File 2 Page 1288

At the Ward Round on **26 April 2010** ward staff were informed that they should liaise with Care Coordinator 2 from the Early Intervention Service regarding any housing issues and possible appropriate applications. It was also noted that Ms X had disclosed incidents of past mental, emotional and sexual abuse. Doctor 2 explained that his diagnosis comprised three differential diagnoses which were a complex Post Traumatic Stress Disorder, Borderline Personality Disorder and that she had a psychotic illness.[55]

The current medication for Ms X comprised Risperdal Consta depot 25mg every two weeks, Diazepam 5mg at 08.00 and 22.00 hours daily and Thiamine at 100mg at 08.00 and 18.00 hours daily. If she needed medication to help her sleep she was given one of Lorazepam, Haloperidol and Zopiclone at night.[56]

The following day, **27 April 2010,** Psychologist 1 from the Early Intervention Service visited Ms X on the ward and talked to her about trauma and asked her if she would welcome some sessions to address such issues.[57] Two days later Ms X talked to staff about a man who was the father of the baby who had been aborted and commented that she did not feel the same about him anymore.[58]

Doctor 3 saw Ms X for the second opinion she had requested on **21 April 2010**. He was unable to complete the assessment because Ms X terminated the session after 30 minutes. On the basis of what he had managed to glean from Ms X, Doctor 3 concluded that he thought it appeared to be a paranoid psychotic episode.[59] On **1 May 2010** Ms X asked one of the nurses about the boyfriend of another patient who she thought she used to go out with. She was concerned that the patient was telling this man *"things about her".* [60]

On **4 May 2010** Care Coordinator 2 visited Ms X on the ward and provided her with information about college courses. Ms X was tearful and hostile from the outset of the meeting and said she did not want to be referred to Molitor House but to go to a refuge. Ms X

55 Clinical Records Volume 4 Page 1516
56 Clinical Records Volume 4 Pages 1521 and 1532
57 Clinical Records Volume 4 Page 1534
58 Clinical Records Volume 4 Page 1541
59 Clinical Records Volume 4 Page 1543
60 Clinical Records Volume 4 Page 1546

also stated that she was taking neither the morning Diazepam nor the Thiamine, and added that she did not want any of the other medicines either.[61]

She then spoke quite candidly about the only time she had felt happy which was also when she had felt safe. This was when she was in a Women's Refuge in Birmingham which would have been in 2006 and early 2007.[62]

On **11 May 2010** Ms X went absent without leave when she went out to the gym with a nurse escort. She telephoned the ward the following day but refused to say where she was. Later on **12 May 2010** Ms X returned to the ward in a taxi and stated that she had been at her mother's house. She did not remember where she had been the night before but thought she had been drinking. Later Ms X added that she had been drinking and had also smoked 'weed' while she had been away from the ward.[63]

On **24 May 2010** Ms X had escorted leave but managed to evade her escort and returned to the ward by herself about five hours later.[64] During the week Ms X was seen to be settled and stable in mood with no indicators of mood disturbance or psychotic symptoms. She got tearful at times about her detention in hospital and was very angry with staff after her return from leave on **26 May 2010** which had been granted so that she could attend a court hearing about her children. She claimed to have taken Anadin and Ibuprofen whilst away from the ward but refused a physical examination and would not allow a blood test to be done. She requested PRN Zopiclone and Lorazepam most evenings to help her relax and sleep.[65]

On **7 June 2010** Ms X was warned about her behaviour on escorted leave. If she absconded whilst on leave she would be seen by the Duty Medical Officer to see if she had taken drugs or alcohol. If she did not return within the hours agreed in her Section 17 leave all her leave would be stopped.

Ms X continued to be unaware of her behaviour and to take no responsibility for any of the difficulties she had had in her life, always blaming other people or services. Ms X had visited

61 Clinical Records Volume 4 Page 1550
62 Transcript 2 Page 10
63 Clinical Records Volume 4 Page 1577
64 Clinical Records Volume 4 Page 1635
65 Clinical Records Volume 4 Page 1635

Molitor House to see about having housing but there was none available. She was thought to require supported living accommodation.[66]

On **9 June 2010** Ms X was given a one-hour period of leave with staff but she went absent and was the brought back to the High Dependency Unit the following morning. She had gone to her mother's house and when the Police arrived was being restrained by family members as she was attempting to cut her wrists. In the light of the warning about absconding she had been given a few days previously all her entitlement to leave was suspended.[67]

A Professionals' Meeting (to all intents and purposes like a Care Programme Approach Meeting but without the service user being present to allow the professionals to discuss care plans and treatment options) was held on **14 June 2010** which was attended by the Clinical Team, four representatives from the Bristol Child and Family Support Team and Psychologist 1 representing Care Coordinator 2 who was unable to attend. Doctor 2 confirmed that the diagnosis for Ms X's problems was now assessed as being a Borderline Personality Disorder. Mrs W was informed that her daughter could not be detained in hospital for this condition. Concerns were raised at the meeting about the possibility of Ms X making contact with her children and absconding with them once her Section 3 Mental Health Act (2007) was rescinded upon her discharge. Care Coordinator 2 was to be asked to produce a Recovery Plan for Ms X.[68]

On **18 June 2010** Care Coordinator 2 visited Ms X with a Community Psychiatric Nurse (CPN) who was to become Care Coordinator 3 as a CPN would be required to give Ms X her depot medication in the community. Ms X was not pleased to see them and as written in the Clinical Record *"tolerated 15 minutes"* before leaving the room saying she would not take any depot injections once she was discharged and would consider if she would engage with the Early Intervention Service.[69]

Ms X had her Care Programme Approach Meeting on the ward on **21 June 2010.** Ms X stated that she wished to come off all medication. The plan agreed at the Meeting was that:

- the Section 3 Mental Health Act 2007 would be rescinded that day;

66 Clinical Records Volume 4 Pages 1656 - 1659
67 Clinical Records Volume 4 Page 1679
68 Clinical Records Volume 4 Pages 1673 - 1675
69 Clinical Records Volume 4 Page 1704

- Ms X would move to an open ward from the High Dependency Unit;
- the Early Intervention Service would engage with Ms X and would discuss psychology and medication with her;
- Ms X was to comply with the Ward Rules until she was discharged;
- Ms X was to liaise with HUB (Housing for the Homeless) to discover her options for housing accommodation.

The risks surrounding Ms X were described as being:

- complete disengagement from all services;
- deliberate self-harm;
- readmission to hospital;
- losing contact with her children.

Ms X did not accept any of these risks and thought all would be well in the future. She said she would borrow other people's sofas and floors and all would be well. Ms X was transferred to the Open Ward.[70]

On **28 June 2010** Ms X absconded and was returned by the Police with a male service user with whom she wanted to have sexual intercourse and have a baby. She was drunk and was found kissing another male service user a little time later. The next day, **29 June 2010**, Ms X failed to return to the ward and was telephoned by a member of staff at 19.50 hours when she stated she would be back in an hour. In the event Ms X returned to the ward at 23.00 hours.

On **1 July 2010** a Discharge Plan was made for Ms X. It highlighted that she would have her depot that day and that if in the future she did not return within 12 hours of her expected return time she would be listed as absent without leave. In addition, should she return to the ward and behave badly or unmanageably she would be asked to leave and to return when she was stable and able to behave.

The accommodation for Ms X at the Housing Association became available on **6 July 2010**. The house was in Bedminster and Ms X was warned that there would be zero tolerance of her being drunk in the property. The Housing Association was a specialist supported housing facility for women who were vulnerable having had experiences of mental illness. It was an

70 Clinical Records Volume 4 Pages 1696 - 1711

all-women property with a female support worker. The rules were that no men were allowed to be in the accommodation and that drugs and alcohol were not allowed in the accommodation. Failure to comply with these conditions of tenancy could lead to the eviction of the tenant.

Ms X was discharged from hospital after an 18 week admission to live in the Housing Association Supported Housing facility. An appointment for the Housing Support Worker to visit her had been made for **8 July 2010** but when Senior Support Worker 1 went to her flat she was not at home, and consequently did not deal with important matters concerning her tenancy. A week later an arrangement had been made for Care Coordinator 3 to visit on **15 July 2010** to give Ms X her depot injection. It became known that Ms X had deliberately left her flat 20 minutes before the time of the appointment.

On **20 July 2010** Care Coordinator 3, Psychologist 1 and Senior Support Worker 1 all visited Ms X as she had been discharged for two weeks. She refused to have her depot and appeared to be well. She said she would like to enrol on a dance course when Care Coordinator 3 mentioned the possibility of this. Ms X also commented that she did not like the boundaries imposed on her by the Housing Association. The staff arranged a timetable for visiting Ms X which comprised her being seen five times a week. Care Coordinator 3 would visit her on Wednesdays and Senior Support Worker 1 would visit twice a week and there would be supervised visits to see her children on two days each week.

During the period from **28 July to 4 August 2010** Ms X complained about living in the Housing Association property because she did not like its boundaries and rules. Ms X stated she went out binge drinking two nights a week. Other residents at the Housing Association said that they had not seen her for four days. Despite this Ms X did agree to help develop a Relapse Management Plan.

On **11 August 2010** Ms X was not at home when Care Coordinator 3 visited her as arranged. Senior Support Worker 1 explained that Ms X was convinced that she would be successful in gaining a three-bedroomed property where she and her two children could live. She refused to acknowledge that she would be eligible only for a one-bedroomed property.

A Liaison Nurse from the Bristol Royal Infirmary telephoned Care Coordinator 3 on **16 August 2010** to inform her that Ms X had been detained overnight having taken an overdose of 32 Paracetamol tablets. She had been asking for Fluoxetine and refused Risperidone. She had been clear that she did not wish to meet any of the Clinical Team but would agree to see Care Coordinator 3 and would attend her Outpatient Appointment on **20 August 2010.**

On **17 August 2010** Care Coordinator 3 received a telephone call from Social Worker 3 who informed her that Ms X had been unreliable in keeping her supervised visits to see her children which was proving upsetting for them. Social Worker 3 was proposing to meet Ms X with Senior Support Worker 1 to explain that she would not be having her children back and that they would remain in the care of her mother.

A Professionals' Meeting was held on **20 August 2010** attended by Care Coordinator 3, Senior Support Worker 1, Manager 1 and a Trainee Psychiatrist. It was evident that Ms X no longer wanted to be in contact with Mental Health Services. She was in difficulty with Income Support as she had not informed them that she had moved to the Housing Association and was still claiming the same amount of money as when she had had the children with her. A plan was developed for Ms X which comprised:

- Care Coordinator 3 offering her weekly appointments;
- Senior Support Worker 1 offering her meetings twice a week;
- giving her the Housing Association Self Harm Worker's telephone number and that of the weekend support line;
- the Trainee Psychiatrist to speak with the Liaison Service to see the blood test results following the Paracetamol overdose;
- discussions about the letter from Ms X's solicitors asking if the Mental Health Services thought she had mental capacity.

On **30 September 2010** Ms X was evicted from the Housing Association Accommodation as she had taken a male into the house, had used drugs and alcohol with him and had damaged some of the property. The eviction took place on a Friday and the Early Intervention Service was not informed until the following Tuesday when Senior Support Worker 1 spoke to Care Coordinator 3.

On **7 October 2010** Social Worker 3 reported that Ms X had found a boyfriend and was living with him. She had made two allegations of domestic violence against him. These incidents were hitting her with a rolling pin and placing a hot iron on her arm and burning it. As a result Ms X was in a Women's Refuge in Bath. She had failed to attend seven out of nine arranged visits to see her two children, including her son's birthday. There was no evidence of mental ill health in her stated current behaviour and she was clearly saying that she did not wish to have contact with the mental health services.

Account of the Incident

The account of the homicide of Mr Y is taken from the Court Report and the media coverage at the time of the incident. The Mental Health Services were not actively involved with Ms X at the time of the homicide, but she had been receiving a service from them in the six months prior to it. This made her treatment and care relevant to the conditions of HSG (94) 27 which governs the commissioning of an Independent Investigation by the NHS.

Ms X had met Mr Z, who was also a service user of the Avon and Wiltshire Partnership NHS Trust, and quickly formed a relationship with him. Having been made homeless following her eviction from the Housing Association accommodation Ms X had not taken the advice of Senior Support Worker 1 to make contact with HUB. This Bristol City Council Advice Centre provides housing advice and information to people who are homeless. The services include advice on finding accommodation, accessing health services and benefits advice. Ms X decided she would rather stay with friends and sleep on spare sofas and floors.

Sometime around **3 October 2010** Ms X met Mr Y, a man she recognised as a friend of her father's who offered her a bed for the night. Ms X subsequently accused Mr Y of raping her and left his home and went to find Mr Z. He insisted that they both went back to where Mr Y lived and he remained hidden when Ms X rang the doorbell so it appeared she was alone. When Mr Y opened the door Ms X stood to one side and Mr Z charged in and violently attacked Mr Y with a knife causing 43 wounds.

The Judge at the Crown Court Trial of Ms X and Mr Z stated in his summing up that *"…sometime on 04 October 2010 you [Mr Z] were told by Ms… [X] that she had been raped*

by Mr…[Y]. It is quite clear that you and [Ms X] had decided that she would pretend that she was alone so the two of you could get access to his flat. You [Mr Z] knew he was a big man; one of the reasons why you had armed yourself…it was a chilling attack. He [Mr Y] stood no chance. You believed by that stage, it is clear to me, that he had raped [Ms X] who you had known for about six weeks. You say you loved her and she has said that she loved you. Equally, it is clear to me that you physically abused her on quite a regular basis. When she was arrested for shoplifting on that afternoon in Boots it did not take you long to go off with another girl and spend the night with her".

Ms X was not sentenced at the same time as Mr Z as the Judge stated, *"Your case is going to be adjourned for a pre-sentence report and for psychiatric reports from Dr… [X] who has already given evidence, and from Dr… [Y] who is in charge of [a medium secure unit for patients with psychiatric problems and who have usually committed serious offences.]*

When Ms X was sentenced on **4 November 2010** the Judge said that in his opinion Ms X was not dangerous but that a prison sentence was inevitable for her part in such an offence. He sentenced her to three-and-a-half years of which she would serve half in prison. Ms X had already spent 13 months in prison which would be taken into account. The Judge said: *"I hope that when you emerge from custody the various agencies will be able to give you some assistance on getting your life back on track".*

10. Exploration and Identification of Contributory Factors and Service Issues

RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. contributory (both influencing and causal) and service issue factors.

In the interests of clarity each thematic issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Contributory factors can be identified as either being 'influencing' or 'causal'.

Causal Factor. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide perpetrated by them. The term 'causal factor' is used to describe an act or omission that is concluded to have had a direct causal bearing upon the failure to manage a service user effectively and that this as a consequence impacted directly upon an incident occurring.

Contributory Factor. The term is used in this Report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Ms X's mental health and/or the failure to manage it effectively

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct

bearing upon the death of Mr Y need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

10.1. Avon and Wiltshire Mental Health Partnership NHS Trust Findings Relating to the Care and Treatment of Ms X

The findings in this Section analyse principally the care and treatment given to Ms X by the Avon and Wiltshire Mental Health Partnership NHS Trust.

10.1.1. Diagnosis

10.1.1.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, Mental State Examination and observation.

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

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

Background Information (ICD 10 definitions as relevant)

During the course of her psychiatric illness and while she was receiving her care and treatment from the Avon and Wiltshire Mental Health Partnership NHS Trust Ms X had two diagnoses, first that of an acute transitory psychotic episode and secondly an Emotionally Unstable Personality Disorder of a borderline type.

Acute Transitory Psychotic Episode

A heterogeneous group of disorders characterized by the acute onset of psychotic symptoms such as delusions, hallucinations, and perceptual disturbances, and by the severe disruption of ordinary behaviour. Acute onset is defined as a crescendo development of a clearly abnormal clinical picture in about two weeks or less. For these disorders there is no evidence of organic causation. Perplexity and puzzlement are often present but disorientation for time, place and person is not persistent or severe enough to justify a diagnosis of organically caused delirium (F05). Complete recovery usually occurs within a few months, often within a few weeks or even days. If the disorder persists, a change in classification will be necessary. The disorder may or may not be associated with acute stress, defined as usually stressful events preceding the onset by one to two weeks.

Emotionally Unstable Personality Disorder of a Borderline Type

The International Classification of Mental and Behavioural Disorders (ICD 10) (World Health Organisation 1992), defines a Personality Disorder as: *"a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption"*. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association 1994) is another internationally used classification system, often used in research. It defines a Personality Disorder as: *"an*

enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment".[71]

Personality Disorders are broadly categorised into three groups. In the interests of clarity and to assist lay readers the Independent Investigation Team has used the Royal College of Psychiatry Advice Leaflet to explain what these three groups or clusters consist of.

- ***"Cluster A 'Suspicious' (Ms X displayed some of these features)***

  Paranoid
  - *suspicious*
  - *feel that other people are being nasty (even when this is not true);*
  - *sensitive to rejection*
  - *tend to hold grudges*

  Schizoid
  - *emotionally 'cold'*
  - *does not like contact with other people*
  - *have a rich fantasy world*

  Schizotypal
  - *eccentric behaviour*
  - *odd ideas*
  - *difficulties with thinking*
  - *lack of emotion, or inappropriate emotional reactions*
  - *can see or hear strange things*
  - *related to schizophrenia*
- ***Cluster B 'Emotional and Impulsive' (the cluster most closely describing Ms X's symptoms.)***

  Antisocial or Dissocial
  - *does not care about the feelings of others*
  - *easily frustrated*
  - *tends to be aggressive*
  - *commits crimes*
  - *finds it difficult to make intimate relationships*

71 *Personality Disorder no Longer a Diagnosis of Exclusion* DH pages 9

- *impulsive*
- *does not feel guilty*
- *does not learn from experience*

Borderline

- *impulsive*
- *finds it hard to control emotions*
- *feels bad about self*
- *often self-harms*
- *can feel paranoid and depressed*
- *when stressed may hear noises or voices*

This cluster also includes Histrionic and Narcissistic Personality Disorders

- ***Cluster C 'Anxious' (set out as headings only as Ms X did not receive a diagnosis within this cluster)***

  Obsessive Compulsive

  Avoidant

  Dependent". [72]

ICD 10 defines Post Traumatic Stress disorder as follows:

"Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency

72 Personality Disorder Guidance Leaflet, Royal College of Psychiatry pages 3-4

period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0)".

10.1.1.2. Findings

Internal Investigation

The Avon and Wiltshire Mental Health Partnership NHS Trust Internal Investigation did not comment on the diagnosis but did highlight the lack of a dedicated consultant psychiatrist within the EIT which slowed down the access to assistance in formulating a diagnosis and the ability to quickly organise multi-disciplinary meetings and Care Programme Approach Reviews.[73] The Internal Investigation did highlight a communication factor relating to the EIS Team and the Inpatient Service not clarifying any previous mental health involvement with Ms X prior to her contact in **June 2009**.[74]

Independent Investigation Team

Ms X first developed mental health problems around the age of 12, and started self-harming and taking overdoses shortly after this time. This behaviour continued into her adult life, with regular attempts at self-harm through her teenage years and beyond. She had a very disturbed childhood and family background, witnessing domestic violence from an early age. Her GP described her childhood as *"extremely difficult, having lived with a number of different men being her mother's partners, some of whom were abusive to her".* She also began polysubstance abuse, including alcohol, cannabis, cocaine and crack cocaine at an early age.

On **29 May 2009** Ms X was referred to the Citywide Home Intervention Team but their promised support did not arrive so she and her mother contacted mental health services. Her GP (GP 1) had referred her to secondary mental health services as she thought Ms X was psychotic. Ms X did not know why she was being assessed and said that she only wanted help to find a home for herself and her two children. A Core Assessment was undertaken as Ms X appeared to be very agitated and distressed. Doctor 1 said that Ms X needed to accept the treatment offered or it would have repercussions for relationships with her family, her children and her own wellbeing.[75]

73 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 48
74 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 50
75 Clinical Records Volume 6 Pages 2056-2066

On **2 June 2009** a member of staff from the North Bristol Middle Team telephoned Ms X but spoke to her mother who said her daughter had only taken one tablet prescribed by Doctor 1 saying that *"she did not need to take medication".* The same worker later spoke to Ms X who denied that she was ill and said she was taking medication but did not need it. She said she was *"fine"* but agreed to attend an Out Patient Review later in the week. It was noted that Social Worker 1 was arranging extra day nursery time for her two children.

On **4 June 2009** Ms X went to see Doctor 1 for the Out Patient Review accompanied by her mother. It was noted that Ms X had recently left her two children with her sister and *"took off".* Her sister contacted the Police. Ms X had been arrested and cautioned. Ms X's mother was identified as the main carer of the two children who were required to live with her and Ms X. Ms X was presenting as paranoid, chaotic, and unpredictable and believed that songs played on the radio had been written by her. The following plan was put into place:

- Ms X would start Risperidone at 1mg daily and then have it increased to 2mg;
- the Core Assessment would be sent to the local Community Mental Health Team;
- Psychiatric Services would liaise with Social Services due to concerns about her being ill;
- the service would work with both Ms X and her mother;
- undated and unsigned Safeguarding Forms were partially completed.

The next day, **5 June 2009** Ms X was assessed by CPN 1 and Student Nurse 1 from the Crisis Resolution and Home Treatment Team (CRHTT) at her home. She was calm but suspicious and paranoid about their visit. Ms X had told them she thought she was pregnant, but this was said to be unlikely according to her mother and her GP. Ms X said that she only wanted help to find a home for herself and her two children. She had had bizarre ideas and had tried to leave the house naked through a window; she thought her mother and others were trying to remove her children. Her dietary pattern and sleep pattern were both erratic.[76]

CPN 1 drew up the Acute Enhanced Integrated Care Programme Approach Review Multi-professional Care Plan with Ms X on **8 June 2009**. The aim was to support Ms X at home and to allow her the opportunity to discuss her beliefs and coping mechanisms as a way of being more able to support herself. This was to be achieved by daily visiting and allowing Ms

76 Clinical Records Volume 6 Page 2119

X to express her feelings and for staff to observe her for paranoid ideas and bizarre beliefs and delusional thoughts.[77]

It was also agreed that her mother needed support as she was her prime carer. Care Coordinator 1 did later complete a Carer's Assessment with Mrs W. The next day, **9 June 2009** two home visits to Ms X were made. She was weeping, appeared muddled and refused to take her Olanzapine. She had little insight into her illness and the plan was for her to be admitted to hospital.[78] Ms X could not understand why she was being assessed by Mental Health Services and had been taken to the two assessments by her mother.

On **10 June 2009** Ms X was admitted to the Open Ward at the local Hospital. She found it difficult to settle but eventually accepted Lorazepam 1mg and Zopiclone 3.75mg which helped her to sleep from midnight onwards.[79] The day following her admission another patient reported that Ms X was trying to climb over the back garden fence of the ward. Staff found her hiding in the hedge. She had earlier in the day run out of the ward when the door was open to let someone in. She was held under Section 5(4) of the Mental Health Act (2007). She continued to stand near the door and attempted to go on several occasions and was later detained under Section 5(2) of the MHA.[80] A day later Ms X had telephoned from the ward for a taxi to take her back home as she thought her mother was at risk. It was decided that a Mental Health Act Assessment was required and she was placed under Section 2 of the Mental Health Act (2007).[81]

On this first admission Ms X was uncooperative, guarded and agitated and immediately made attempts to leave. Although Ms X appeared disorganised and muddled, having some bizarre behaviour and ideas, no specific first rank or psychotic phenomena were noted. A diagnosis of Acute and Transient Psychotic Disorder F23.0 (ICD 10, Classification of Mental and Behavioural Disorders, World Health Organisation 1992) was made. She was discharged one week later. At this time she was being treated with Risperidone and Fluoxetine and Diazepam PRN. Ms X was referred to the Early Intervention Service for follow-up. Ms X refused to

77 Clinical Records Volume 1 File 2 Page 340
78 Clinical Records Volume 1 File 2 Page 348
79 Clinical Records Volume 6 Pages 2120-2135
80 Clinical Records Volume 1 File 2 Pages 354-356
81 Clinical Records Volume 1 File 2 Page 356

take her medication and ignored the advice that the medication was important as it would help alleviate the symptoms of her mental illness.[82]

It is likely that she was not compliant with this medication in the community (she stated she was but her mother said that she was not). She then had four further admissions, presenting with self-neglect and bizarre behaviour, each admission being characterised by poor engagement, repeat absconding and indulging in substance misuse whilst absent without leave. During her final admission on **5 March 2010**, which was of three months' duration, she was treated with Risperdal Consta. Ms X made some improvement. However her oral Risperidone was stopped immediately and it is questionable how psychoactive the depot would have been during this admission as it is recommended to be used with oral medication initially due to reduced bio-availability.

Diagnosis

The Clinical Team came to the conclusion that Ms X's diagnosis was one of Emotionally Unstable Personality Disorder of a borderline type F60.31 (ICD 10, Classification of Mental and Behavioural Disorders, World Health Organisation 1992), and the Independent Investigation Team would concur with this. Ms X demonstrated characteristic features of Emotionally Unstable Personality Disorder which included the recurrent self-harm, chaotic lifestyle and substance misuse, affective instability and verbal hostility associated with poor engagement. Ms X was predisposed to this by her traumatic childhood experiences. She appeared to present at times with quasi-psychotic symptoms, but these always resolved quickly when she was admitted. There was no evidence of any sustained or ongoing psychotic symptoms.

Her Responsible Clinician (Doctor 2) considered a diagnosis of Complex Post Traumatic Stress Disorder (PTSD) and discussed this with Ms X. This is a disorder described in the literature but not formally recognised by diagnostic systems such as ICD 10, and remains controversial as a diagnosis distinct from PTSD. It was clear from his interview that Doctor 2 favoured a diagnosis of Borderline Personality Disorder, but instead used the term Complex Post Traumatic Stress Disorder as he felt that a diagnosis of Personality Disorder was often not received well by patients and their relatives. It was apparent from the GP records and

82 Clinical Records Volume 1 File 2 Pages 357

from some statements Ms X made in hospital that she had been abused in childhood physically, sexually and emotionally.[83]

Diagnostic Decision Processes

The Independent Investigation Team concluded that the diagnosis process was appropriate although it did take a considerable period to ascertain that there was little if any indication of psychosis. It was good practice to identify differential diagnoses of PTSD, some form of psychosis, drug induced psychosis and Personality Disorder. The final admission confirmed that Ms X did abuse both alcohol and drugs and therefore the probability of dual diagnosis increased significantly. Ms X did recover quickly when she was admitted to hospital with any initial evidence of psychosis reducing within a few days.

There was one issue connected with diagnosis which the Independent Investigation Team discussed at some length. This was the practice of Doctor 2 informing Ms X that he thought she had Complex Post Traumatic Stress Disorder in order to not 'alarm' her or her mother by stating that she had a Personality Disorder. Whilst this might have been 'kind' it made it difficult for the diagnosis to be altered at a later date. Ms X's diagnosis was confirmed/agreed at a Professionals' Meeting on **14 June 2010** when Doctor 2 informed the meeting that he had decided that Ms X suffered from a Borderline Personality Disorder. It is noted that Mrs W was informed that her daughter could not be detained in hospital for this condition.[84]

In some ways it was true that Ms X was a victim of her extremely difficult and abusive childhood. She was also determined to 'have her own way' and not to engage with services. Several of the staff interviewed by the Independent Investigation Team considered that she knew what she was doing, had Mental Capacity, and was in control of the way she was leading her life.

It would have been better practice for Doctor 2 and the Early Intervention Team to have been honest with Ms X and her mother and informed her of what they believed was the correct diagnosis. Ms X displayed the characteristics of Emotionally Unstable Personality Disorder which explained her erratic and impulsive behaviour. Such a diagnosis also took into account the recurrent self-harm, chaotic lifestyle and frequent substance misuse. In addition it also

83 Transcript 1
84 Clinical Records Volume 4 Pages 1673-1675

accounted for her affective instability and verbal hostility which was associated with her poor engagement with services.

Ms X's traumatic childhood experiences may have predisposed her to developing an Emotionally Unstable Personality Disorder. As a result she remained unable to make lasting and serious relationships. The period between **June 2009 and July 2010** exemplified this with her seeking short-lived relationships for casual sex in her quest to become pregnant. Whilst remaining steadfast in her assertion that all she cared about were her children, in fact she did not attend very many of the arranged supervised meetings with her children. In part this was because she had no insight into her condition.

10.1.1.3. Conclusions

The Independent Investigation Team concluded that the diagnosis of Emotionally Unstable Personality Disorder was appropriate and that it did take into account how Ms X behaved and presented.

The Avon and Wiltshire Mental Health Partnership NHS Trust 'Policy to Manage Care Pathways and Risk' states that:
"Robust and accurate diagnosis and formulation is central to the identification and delivery of evidence based interventions, and in provision of information to service users and carers, in order for them to be full partners in planning of care. This is particularly important where there are complex diagnoses and needs.

There is therefore a requirement for all service users to have an identified diagnosis or formulation, whether fully developed or a working construct. The diagnosis and formulation must be clearly recorded and discussed with the service user, carer and family (as appropriate)".[85]

- ***Service Issue 1: Medical Staff must always be open and clear with their service users and their relatives about the diagnosis agreed by the Multi-disciplinary Clinical Team. The Trust must ensure that service users understand the diagnosis and what it means, together with the Care Plan designed to help them.***

85 Policy to Manage Care Pathways and Risk : GOV_IGCE_03 Dated 17 December 2008

10.1.2. Medication and Treatment

10.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

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

Consent is defined as "*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent"* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act under a Treatment Order (Section 3 or 37), medication may be administered without the patient's consent for a period of up to three months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Appointed Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide

whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation, that is to say do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals, for example weekly or monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and/or who may be non-compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects, that is to say tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

10.1.2.2. Findings

Internal Investigation

The Trust Internal Investigation did not make comments about the Medication and Treatment received by Ms X except in relation to her relationship with the Mental Health Services possibly having been damaged by repeated admissions to hospital under the Mental Health Act (2007) and periods spent in the High Dependency Unit.[86]

Independent Investigation

Medication

Due to uncertainty about her diagnosis, Ms X was prescribed both antidepressants (Fluoxetine) and oral antipsychotics at low dose (Risperidone and Olanzapine) and depot antipsychotic medication (Risperdal Consta), along with Lorazepam and Haloperidol for rapid tranquilization. It is not unusual for individuals presenting with Borderline Personality

86 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 51

Disorder, and those presenting with affective instability and self-harm, to be prescribed antidepressants to attempt to improve their mood, although the evidence base to support this practice is limited.

Antipsychotics were prescribed due to the ongoing concerns that Ms X may have had psychotic symptoms. However she was rarely compliant with them so they were of minimal worth in treating her effectively. During the final admission which started on **5 March 2010** Risperdal Consta was prescribed. Ms X would not comply with oral Risperidone medication so this was discontinued and Risperdal Consta was used alone.[87] It is recommended that oral medication be used concurrently with Risperdal Consta for at least three weeks, due to reduced bioavailability for this time period, and anecdotal evidence suggests that it may take longer for Risperdal Consta to be effective.

It is unlikely that the depot medication would have been responsible for the improvement noted in the mental state of Ms X over such a short space of time. It is more likely that this improvement was due to the absence of alcohol and illicit drugs. It is probable therefore that antipsychotic medication was not a significant factor in Ms X's improvement during her last and longest admission.

In addition, Ms X stopped her Risperdal Consta as soon as she was discharged and took no antipsychotic medication, yet she appeared not to display any psychotic symptoms. The Independent Investigation Team heard evidence from one witness, Care Coordinator 3, that when seen in prison after the offence Ms X was not receiving medication, and she did not present with psychotic symptoms.[88] This provides further evidence that she did not have a diagnosis of a primary psychotic disorder.

Other Effective Evidence-Based Treatments

There is evidence from the GP records that Ms X first developed mental health problems from the age of 12, and started self-harming and taking overdoses shortly after this time. This behaviour continued into her adult life, with regular attempts at self-harm throughout her teenage years and beyond. Ms X had a very disturbed childhood and family background, witnessing domestic violence from an early age. She was referred to Child and Adolescent

87 Clinical Records Volume 3 File 2 Page 1143
88 Transcript 3

Mental Health Services (CAMHS) at this time and was seen once, but there is no record of her being diagnosed or engaging in treatment.

She also began polysubstance abuse, which included alcohol, cannabis, cocaine and crack cocaine at an early age, but there was no evidence of referral to substance misuse services until **April 2006** when she was referred to ACAD, a substance misuse service in Bristol. In **June 2007** Ms X had attended the Bristol START substance misuse service having been referred by her GP when she was pregnant with her son. During her attendance at the Bristol START Ms X reported that she had tried treatment for drugs and alcohol twice before, but had not been able to stay the course. She again attended ACAD in **August 2007**.

Ms X was referred to the psychiatric services at her local hospital in **October and December 2007**, and on the latter occasion admitted to using cannabis. There were no full notes of these referrals which were mentioned in the GP Records. It therefore appears she did not receive any significant treatment for her mental health problems as a child or as a teenager.[89]

On presentation in **2009**, Ms X was initially offered intensive home treatment, which was appropriate, but due to her lack of engagement and noncompliance with medication, she was then admitted, initially informally, to the Open Ward at the local hospital and then placed under Section 5(4) of the Mental Health Act 2007 followed by a Section 5(2) and then finally placed under Section 2. Due to her difficult behaviour and her refusal to take oral medication Ms X's early experience of Psychiatric Hospital Admission involved the use of Control and Restraint, and her being detained. This was unfortunate and did not foster an attitude of trust on Ms X's part. It was also an example of poor practice in that Section 2 is **not** a treatment section and medication should not have been forcibly given unless clinically indicated. No specific appropriate rationale was provided for this action in the clinical record.

The community care and follow-up for Ms X was provided by the Early Intervention Service (EIT), as it was thought she may have had a primary psychotic illness. This team followed her up assertively and she was offered a broad range of interventions, including medication, psychological interventions including Dialectical Behavioural Therapy (DBT) which is the evidence-based and NICE-recommended intervention for individuals with Borderline

89 Transcript 1

Personality Disorder, and social interventions. The quality of the Care Plan was good, but unfortunately Ms X would not engage with it. Once it was established that her diagnosis was that of Borderline Personality Disorder, and that she did not have a diagnosis of psychosis, she no longer met the criteria for the Early Intervention Service and it may have been expected that she would be discharged to a CMHT. However there was no evidence that remaining with the Early Intervention Service had an adverse effect on her care. By the time of the incident Ms X had disengaged from the Early Intervention Service and had made it clear that she did not want any further involvement with the Mental Health Services.

Multi-disciplinary Inputs

There were limited multi-disciplinary interventions because Ms X would not engage with the services offered. This was also the case when she was an inpatient. She rarely joined in with any group activities and only occasionally made use of the nursing staff to discuss matters or seek information.

The Early Intervention in Psychosis Services had a Trust-wide Operational Policy but divided into sections for the six individual teams so the Policy reflected the local characteristics of Bristol, Bath and North East Somerset (BANES), North Somerset, South Gloucestershire, Swindon and Wiltshire.[90] The purpose of the EIS Teams was described in the Operational Policy as:

"The Early Intervention Teams ensure individuals experiencing a potentially emerging or actual first episode of psychosis and their families receive effective help based on the following principles to;

- *engage with individuals and their families as soon as psychosis is suspected/identified. Provide evidence-based interventions and promote recovery during the first three years.*
- *reduce the duration of untreated psychosis of people referred to Mental Health services in the Trust.*
- *provide a service for those within the age range of 14 – 35 in line with Dept Health M.H.P.I.G guidelines (2001).*

90 AWP Policy : Early Intervention in Psychosis Team Operational Policy Final : November 2009

- *make effective links between child and adolescent mental health (CAMHS) and adult services to facilitate an effective service delivery for a team which straddles these traditionally separate services.*
- *increase stability in the lives of service users, facilitate development and opportunities for personal fulfilment.*
- *develop links with Primary Care Services and other key agencies, providing education and support with the aim of facilitating early identification of psychosis.*
- *develop links with key agencies e.g. Primary Health, Education, Social Services, Youth and other non-statutory services*
- *reduce the stigma associated with psychosis and improve professional and lay awareness of the symptoms of psychosis and the need for early assessment.*
- *at the end of the 3 year treatment period, ensure that the care is transferred thoughtfully and effectively*". [91]

The EIT were assertive in their approach to working with Ms X and tried to visit her regularly despite her attempts to avoid them. They used appropriately psycho-social approaches. Although the EIT had doubts that Ms X did have psychosis they retained responsibility for her as they thought that she would respond better to their assertive approach than if she had been passed to the local CMHT which was not so generously staffed. The team were good at trying to build a rapport with Ms X, and although she had three Care Coordinators during the 16 months she was receiving care and treatment from mental health services, the offer of help and support remained with named a Care Coordinator and Psychologist 1.

Psychologist 1 offered to provide Ms X with some individual therapy to address her traumatic childhood but she declined. He also suggested some Cognitive Behavioural Therapy but this was also refused. All three Care Coordinators offered help and support with practical activities and suggesting courses Ms X might wish to pursue at college once she felt better. Ms X maintained that her sole wish was to have a two- or three-bedroomed house in which to live with her two children. She was equally firm in refusing college courses as she said that she preferred to make the arrangements herself.

91 Early Intervention in Psychosis Team Operational Policy Final : November 2009 Pages 5-6

In the situation presented by Ms X who did not wish to engage in Mental Health Services the Operational Policy stated that:

"In a situation where a person is reluctant to have contact with the team either for assessment or ongoing treatment, the team will follow the following process:

- *As full a risk assessment as possible will be undertaken to determine if a Mental Health Act assessment is required for the safety of the person or others.*
- *If this is not felt to be necessary then plans will be made to monitor the situation with a view to engaging the person at a later stage. This could include keeping in touch by phone or text messages; offering practical support with such things as housing and finances; offering purely social contacts in non stigmatising settings and keeping in contact through carers whilst offering them information and support.*
- *If, after three months of attempts by the Team to assess a person with no previous history, no further contact or evidence of deterioration has occurred, the person will be discharged back to the referrer with a contingency plan for re-referral.*
- *If the person has had one or more episodes of psychosis, they will remain on the Team Caseload for up to 12 months before discharging back to Primary Care.*
- *If there is evidence that the person has moved to a different location or part of the country, attempts will be made to alert local services/transfer care wherever possible".* [92]

The Early Intervention in Psychosis Policy Implementation Guidance from the Department of Health stated that each Team should comprise:

- *"10 whole-time equivalent Care Coordinators with an appropriate mix of CPNs, ASWs, OTs and psychologists;*
- *0.5 whole-time equivalent consultant psychiatrist;*
- *1.00 whole-time equivalent non-career grade psychiatrist;*
- *Support workers and administrative staff as required".* [93]

As the Bristol EIT did not have its own psychiatrist there were limited opportunities for full assessments from Doctor 2, and little scope for any individual work. The National Policy Implementation Guidance for Early Intervention in Psychosis states clearly that each EIT

92 Early Intervention in Psychosis Team Operational Policy Final : November 2009 Pages 10-11
93 The Mental Health Policy Implementation Guide : Department of Health 2001 Page 62.

Team should have 0.5 whole-time equivalent Consultant Psychiatrist and also 1.00 whole-time equivalent non career grade psychiatrist.

The Early Intervention Service Operational Policy for the Bristol Team stated that:

"During the first phase of development there is no specific consultant psychiatrist input into most of the EI Teams within AWP. Sector teams will identify the consultant psychiatrist to be involved with the service user via their normal procedures. Dedicated Consultant Psychiatrist input is currently under discussion as at Oct 2009". [94]

The Independent Investigation Team concluded that the lack of having its own psychiatrist prevented the Bristol EIT being able to offer the full range of appropriate interventions to service users, as there was not a specialist EIT psychiatrist within the team. Doctor 2 informed the Independent Investigation Team that he had three roles. First, he was the Consultant Psychiatrist in a Community Mental Health Team; second, he was the Admission Ward Consultant Psychiatrist for the service users admitted to hospital from his CMHT; and third, he also took responsibility for those service users from his CMHT who were referred to the EIS Service and remained their consultant should they be admitted to hospital.

As the EIT did not have its own Consultant Psychiatrist it had to book appointments with the CMHT Consultant Psychiatrist and this could take some time. In the case of Ms X her Professionals' Meeting prior to her discharge from the Open Ward could not be held before she had been discharged due to Doctor 2 not being available.

The accommodation for Ms X at the Housing Association became available on **6 July 2010**. The house was in Bedminster and Ms X was warned that there would be zero tolerance of her being drunk in the property. The Housing Association was a specialist supported housing facility for women who were vulnerable having had experiences of domestic violence. It was an all-women property with a female support worker. The rules were that no men were allowed to be in the accommodation and that drugs and alcohol were not allowed in any of the flats. Failure to comply with these conditions of tenancy could lead to the eviction of the tenant.

94 Early Intervention in Psychosis Team Operational Policy Final : November 2009 Page 16

Ms X was discharged from the Open Ward after an 18 week admission to live in the Housing Association Supported Housing facility. An appointment for the Housing Support Worker to visit her had been made for **8 July 2010** but when Senior Support Worker 1 went to her flat she was not at home, and consequently did not deal with important matters concerning her tenancy. A week later an arrangement had been made for Care Coordinator 3 to visit on **15 July 2010** to give Ms X her depot injection. It became known that Ms X had deliberately left her flat 20 minutes before the time of the appointment.

A Professionals' Meeting was held on **20 August 2010** attended by Care Coordinator 3, Senior Support Worker 1, Manager 1 and a Trainee Psychiatrist. It was evident that Ms X no longer wanted to be in contact with Mental Health Services. She was in difficulty with Income Support as she had not informed them that she had moved to the Housing Association and was still claiming the same amount of money as when she had had the children with her. A plan was developed for Ms X which comprised:

- Care Coordinator 3 offering her weekly appointments;
- Senior Support Worker 1 offering her meetings twice a week;
- providing Ms X with the Housing Association Self Harm Worker's telephone number and that of the weekend support line;
- the Trainee Psychiatrist to speak with the Liaison Service to see the blood test results following the Paracetamol overdose;
- discussions about the letter from Ms X's solicitors asking if the Mental Health Services thought she had mental capacity.

Care Coordinator 3 mentioned that towards the middle of **September** the EIT was starting to consider whether it should continue to provide a service for Ms X as she clearly did not appear to have a psychotic condition and did not wish to receive a service from the EIS Team. The Team wanted to hold a Professionals' Meeting to discuss her discharge from the service, and to determine what her care pathway should be if she was discharged from the EIT. The issue about the future role for the EIS Team became more pressing when the Team learnt that on **30 September 2010** Ms X had been evicted from the Housing Association Accommodation as she had taken a male into the house, had used drugs and alcohol with him and had damaged some of the property. The eviction took place on a Friday and the Early

Intervention Service was not informed until the following Tuesday when Senior Support Worker 1 spoke to Care Coordinator 3.

An urgent Professionals' Meeting was required to plan for the future but Doctor 2 was unable to attend one until **21 October 2010**. The homicide of Mr Y had taken place on **4 October 2010**, and Ms X was arrested for the murder on **11 October 2010**.

On **7 October 2010** Social Worker 3 reported that Ms X had found a boyfriend and was living with him. She had made two allegations of domestic violence against him. These incidents were hitting her with a rolling pin and placing a hot iron on her arm and burning it. As a result Ms X was in a Women's Refuge in Bath. She had failed to attend seven out of nine arranged visits to see her two children, including her son's birthday.

The Mental Health Services did not have significant contact with Ms X after she was evicted from the Housing Association Accommodation as they did not know where she was living, and were unaware of the homicide. There was no proper Contingency Plan for what should be done should Ms X be evicted from her Housing Association flat, and no clarity as to whether she should be referred back to the EIS Team or transferred to a Community Mental Health Team.

10.1.2.3. Conclusion

The Independent Investigation Team concluded that Ms X did not take her medication once she was discharged from Hospital and her Section 3 Mental Health Act 2007 Order was rescinded.

The medication used was appropriate except for the use of the Risperdal Consta without the oral Risperidone. The EIT provided a good and appropriate range of interventions including Dialectic Behavioural Therapy as well as social interventions and support. The staff had been on the Thorn Training which is geared to provide interventions and therapeutic techniques for people with a psychotic condition.

A Treatment and Care Plan had been prepared on **20 August 2010** but became unworkable with Ms X not wanting contact with the EIT and not working with Senior Support Worker 1 at the Housing Association. When Ms X was made homeless due to her continued breaches

of the conditions of her tenancy and her not having completed any of the administrative requirements to trigger funding for her placement, she became 'lost' to the Mental Health Services. Ms X sought a bed or floor wherever she could find one and made herself vulnerable as a result. Mr Y offered her a bed for the night but she alleged that he raped her and this led directly to his murder. Such a circumstance could not have been predicted or prevented.

- ***Service Issue 2: Ms X was non-concordant with her medication. A medicines management plan should have been considered and it would appear that this aspect of good practice was not considered by the treating team.***

- ***Service Issue 3: the commencement of Risperdal Consta and the cessation of the oral Risperidone occurred at the same time. No consideration appears to have been taken as to the effects of this medication change as the new medication regimen would have taken several weeks to have become effective and this was understood poorly by staff.***

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

10.1.3.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing

medical intervention and have been assessed to be either a danger to themselves or to others.[95]

Sections of the Act to which Ms X was Subject

Section 136 of the Mental Health Act (1983 and 2007) allows a police officer to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital (often a special section 136 suite).
The Mental Health Act states [96]

"136. (1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an [approved mental health professional] and of making any necessary arrangements for his treatment or care.

(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.

(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection".

Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days. An application under Section 2 can be made by a relative or an Approved Mental Health Professional

95 Mental Health Act Commission 12th Biennial Report 2005-2007
96 Mental Health Act (1983, 2007) Code of Practice

(AMHP) and must be supported by two medical recommendations, one of which must be from an approved doctor under Section 12 of the Act, that is to say someone having special experience in the diagnosis or treatment of mental disorder - generally a consultant or senior registrar psychiatrist. The medical recommendations must agree that the detention is in the interests of the patient's own safety, or the safety of others, or the patient is suffering from mental disorder of a nature or degree which warrants detention for assessment, or assessment followed by treatment, at least for a limited period.

Section 5 (2) of the Act allows the compulsory detention of a patient already receiving inpatient treatment for a duration of up to 72 hours by the doctor in charge of the case. As for Section 2, the patient must be suffering from a mental disorder and be a potential danger to himself or to others. The detention is to allow time for an application for admission under Section 2 or 3 to be made.

Section 3 of the Mental Health Act (1983 and 2007) is an Admission for Treatment Order for a period of up to six months. Strict assessment criteria have to be used in order to detain someone. It has to be agreed that the person suffers from a mental disorder which requires assessment and treatment and that this needs to be given in hospital in the best interests of their own health and safety or that of other people.

Section 17 of the Mental Health Act (1983 and 2007) allows the Responsible Clinician (RC) to give a detained patient leave of absence from hospital, subject to conditions the RC deems necessary. These include a requirement to take medication whilst on leave and to reside at a particular address. Although the RC can require a patient to take medication while on Section 17 leave, treatment cannot be forced on the patient while they are in the community. There is no limit to the duration of Section 17 leave provided the original authority to detain remains in force.

10.1.3.2. Findings

Mental Health Act (1983 and 2007)

Internal Investigation

The Internal Investigation discussed the discharge to the Housing Association Supported Accommodation without there having been a period of trial leave. *"This would have had the advantage of demonstrating to all if the placement was going to succeed. It would appear that she [Ms X] was discharged straight to the Housing Association house without this occurring"*.[97] The Independent Investigation Team concur with this finding.

Independent Investigation

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

Following her first contact with Adult Mental Health Services Ms X was quickly admitted, initially informally, and then placed under Section 5(4) of the Mental Health Act 2007 followed by Section 5(2) and then a Section 2. This care pathway was unfortunate, and as mentioned above, appears to have had a detrimental effect on her future engagement.

Ms X was recognised as living a chaotic life style and given her history there was a significant likelihood that she would deteriorate once she left hospital. Given these circumstances it might have been more appropriate if her Section 3 had not been rescinded so early following her admission in **March 2010**. This would have allowed time for more adequate discharge care planning. It would also allowed the clinical team to employ a longer term Section 17 leave to test and monitor Ms X's community tenure. Where longer term Section 17 leave is being considered it is also good practice to consider employing a Community Treatment Order. However in Ms X's case, given her limited insight and her history of failing to engage with services, it is unlikely that this would have provided significant benefit in supporting her or ensuring that appropriate care was delivered.

97 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 46

Use of Control and Restraint

As has been clear from the Chronology Ms X had a disturbed and damaging childhood due to the abuse she suffered from family members and others. Despite this, up until the time of her first admission into the Open Ward on **10 June 2009** she had managed to live in the community with her two children, albeit in a somewhat chaotic and unplanned manner. Within 11 weeks of her informal first admission she had been subject to Sections 5(4) and 5(2) of the Mental Health Act (1983 and 2007) to prevent her leaving hospital and then being placed on a Section 2 of the Mental Health Act (1983 and 2007). Having experienced the coercive powers of the Mental Health Act she was then discharged back to her mother's home within a week of admission, on **17 June 2009**. As described below Ms X was also subjected to Control and Restraint Procedures and by **17 August** was not allowed to care for her two children without her mother being present and she had to reside with her mother if the children were with her.

At the Acute Enhanced ICPA Review Meeting held on the High Dependency Unit on **15 June 2009**, during her first admission to hospital the comments about Ms X stated:
"Moved to [High Dependency Unit] as repeatedly trying to escape. Climbed onto the roof of [High Dependency Unit]. Went AWOL on Saturday – brought back by family against her will.
Quiet on Ward, not floridly psychotic". [98]

Ms X was discharged two days later on **17 June 2009**. The description of her behaviour on the ward did not suggest the need for PMVA and the use of the Control and Restraint Team.

Four days later, on **21 June 2009**, Ms X was again placed on Section 2 of the Mental Health Act 2007 and admitted to the Open Ward again. On this occasion she was forced to receive medication by a Control and Restraint Team on four occasions as shown in the Table below:

98 Clinical Records Volume 1 File 1 Page 368

Table 2: Use of Control and Restraint (C&R)

Date	Event
22 July 2009	Restraint following Ms X refusing to take oral medication so C&R Team was called to forcibly inject medication.
23 July 2009	Restraint following many attempts to leave the ward with PRN administered intramuscularly by C&R Team
27 July 2009	Restraint following Ms X refusing to take oral medication so a C&R Team was called to forcibly inject medication.
29 July 2009	Restraint so that PRN could be administered by a C&R Team intramuscularly.

The Independent Investigation Team considered that this use of Control and Restraint Teams was unusual as it was known that Ms X did not take her medication when she was discharged and in the community, and it was not a matter of urgency that she should take her oral medication. Throughout the interviews with staff working with Ms X the description of her and how she behaved did not resonate with someone who would require four enforced medications in the space of eight days.

Ms X was described as being aggressive but in a verbal and postural way and staff did not feel afraid that they would be physically attacked by her. She would shout and use abusive language but always absented herself from the room without having resorted to physical assault. When discussing with ward staff how Ms X behaved on both the Open Ward and the High Dependency Unit it was made clear that she did not present many problems apart from her strong desire to abscond. The ward manager explained that Ms X was not brought to her attention by ward staff as being a service user they were concerned about.

The Avon and Wiltshire Mental Health Partnership NHS Trust Prevention and Management of Violence and Aggression Policy updated in March 2009 states that:

"PMVA techniques by their nature require physical interventions administered during challenging situations which could give rise to increased risk of injury if administered inappropriately or not in a measured way. The aims of this policy are therefore to ensure that PMVA techniques are applied in a professional and dignified manner that minimises risk to

the service user and staff involved and that suitable safeguards are placed within the PMVA techniques procedure.

For the purpose of this policy PMVA techniques are used in the following services:

- *Adults of Working Age Acute, HDU and PICU Inpatient Wards*
- *Secure Services Inpatient Wards*
- *Drug Rehabilitation Wards*

PMVA technique team working is a designated system of techniques, which employs a minimum of three persons during crisis interventions. It is of vital importance that all other possible interventions have been attempted and exhausted prior to the use of PMVA techniques which is designed for use only as a last resort". [99]

The Independent Investigation Team considered that for the Control and Restraint Teams to have been called to deal with Ms X four times in eight days was excessive when her stated needs on the ward did not warrant such action which was designed to be 'a last resort'. The PMVA Policy also states that:

"*The management of difficult and challenging behaviour is a human activity, requiring decency, honesty, humanity, and respect for the rights of the individual. Restraining any aggressive behaviour by physical means should be used where there seems to be a real possibility that harm would occur if the intervention is withheld.*

A planned response *i.e. there will be some circumstances whereby a patient requires compulsory care and treatment under provision(s) of the Mental Health Act 1983. The patient may be non-compliant with care and treatment but not pose an immediate threat to others. However, if intervention is withheld, it is likely that the patient's physical and/or mental health would deteriorate.*

An emergency response *i.e. there will be some circumstances whereby an individual's behaviour will necessitate immediate physical intervention in order to prevent harm occurring to themselves or others".* [100]

Ms X was known not to take her medication when she was at home and living in the community, and her diagnosis of psychosis was uncertain. It was not the case that Control

99 AWP Prevention and Management of Violence and Aggression Policy Updated 10 March 2009 Pages 3-4
100 AWP Prevention and Management of Violence and Aggression Policy Updated 10 March 2009 Page 9

and Restraint was necessary in order to prevent Ms X posing *"an immediate threat to others"* nor was it *"likely that [her] physical and/or mental health would deteriorate".*

10. 1.3.3. Conclusions

The Independent Investigation Team concluded that the care and treatment of Ms X was heavy handed and inappropriate based on the description of the behaviour she displayed whilst on the Open Ward or when on the High Dependency Unit due to her risk of absconding. It did not require the PMVA Policy to be invoked as there was no evidence that either she or other service users were in danger. It is of particular concern that Ms X was on a Section 2 of the Act which is an assessment Section and **not** a treatment Section.

The Avon and Wiltshire Mental Health Partnership NHS Trust should undertake an audit of the use of the Prevention and Management of Violence and Aggression Policy in general, and the use of Control and Restraint Teams in particular. In the situation the staff faced regarding Ms X during her second admission from **21 June to 17 August 2009** the Policy would appear to have been invoked without other less intrusive and potentially injurious techniques having been considered.

- ***Service Issue 4: control and restraint and prevention of violence techniques were used with Ms X and she was forcibly medicated without there being (i) a clear rationale for this contained in her clinical notes and (ii) without this being part of either a care plan or a risk and crisis management plan. Use of these techniques was inconsistent with Ms X's perceived level of risk, her identified need for medication and with the fact that she was discharged from hospital within days of this compulsion being used when it was known that she would not take medication. This was poor practice and not in accordance with either Trust local policy or national best practice guidance.***

- ***Contributory Factor 1: Ms X was discharged from the Open Ward to the Supported Flat provided by the Housing Association. This placement failed. The subsequent failure to use Section 117 to best effect contributed to her being made homeless and increasing her risks as a vulnerable adult.***

The question of the use of Section 117 when Ms X was discharged from hospital will be examined in Section 10.1.6 'Referral, Admission and Discharge Processes'.

10.1.4. The Care Programme Approach

10.1.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[101]. Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach.*[102]

"*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services"*[103] (Building Bridges; DoH 1995). This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

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

101 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990
102 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008
103 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH; 1995

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s). This should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient
  - to monitor that the agreed programme of care remains relevant and
  - to take immediate action if it is not;
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

The Avon and Wiltshire Mental Health Partnership NHS Trust Care Programme Approach Policy

The Policy to Manage Care Pathways and Risk sets out the ways in which effective mental health multi-disciplinary care and treatment is managed, co-ordinated and delivered in secondary mental health (Health and Social Care) Services.

The Care Programme Approach (CPA) is precisely that - an approach. The key values and principles of CPA are applicable to the management of all care pathways for those with mental illness. The only difference is the level of co-ordination and complexity of assessment and management planning to support those formally on CPA. The common key values and principles are:

- *"that the approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery;*
- *that it is respectful - building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties;*

- *that it recognises the individual as a person first and patient/service user second. Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including family, parenting, relationships, housing, employment, leisure, education, creativity, spirituality, self-management and self-nurture, with the aim of optimising mental and physical health and well-being;*
- *that self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care;*
- *that carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported;*
- *that services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care;*
- *that the quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success. Care planning is underpinned by effective engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies;*
- *that "Best practice in managing risk" DoH 2006 is incorporated in practice to ensure a partnership approach, working with all relevant agencies to the effective identification and management of risk and promotion of positive risk taking;*
- *that all service users receiving care and treatment from the Trust for mental illness are informed of the care pathway to be used, and allocated to a care co-ordinator or lead practitioner who is available and contactable;*
- *that there are effective arrangements to record and communicate all Care Pathway plans and arrangements that are accessible to services for each service user at all times;*
- *that care will be delivered in an effective way that minimises bureaucracy, demonstrates sound professional practice, and clarifies responsibilities;*

- *that all plans (personal recovery plans, care plans or care programmes) are reviewed with all members of the partnership on at least a yearly basis, or more often, as required to maintain a safe and effective partnership;*
- *that the Trust will set arrangements and standards to monitor, audit, and report on the delivery of care, to ensure effective quality management and assurance;*
- *that managing care is a shared responsibility, and has the full support and involvement of all partner agencies, including Social Services Departments, Primary Care, Commissioners and other multi agency partners;*
- *that, when CPA is applicable, it is the overarching framework to meet the needs, and define the care and treatment, of service users. The CPA plan (or programme) must incorporate, co-ordinate, and include all other plans relevant to the service user (e.g. professional or service specific plans, such as drug and alcohol plans, MAPPA or MARAC plans, advance planning, directives and statements, housing support plans, etc".*[104]

10.1.4.2. Findings

Internal Investigation

The Internal Investigation identified that a Care Programme Approach (CPA) Review was not convened in **July 2010**. It states that *"it was evident by the middle of July that the Discharge CPA which was a Section 117 Discharge Plan was breaking down, as [Ms X] was not accepting medication and was not complying with the tenancy contract of the Housing Association. This was a key point when an urgent Review CPA was indicated".*[105] The Independent Investigation concurs with this finding.

Independent Investigation

The Care Programme Approach (CPA) was followed by the EIT. There were two 'versions' of the Care Programme Approach with the required Case Review every six months but with a Professionals' Meeting as and when required. This was to provide an opportunity for the professionals to meet to discuss the service user's care and treatment and to plan for the future without the service user and their carer or family being present. This was particularly

104 Policy to Manage Care Pathways and Risk : GOV_IGCE_03 Dated 17 December 2008 Pages 5-6
105 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Pages 46-47

useful with a service user like Ms X who did not want to engage and when she did attend meetings was likely to be disruptive and to walk out before the end.

The staff on the Open Ward and the High Dependency Unit, in common with the other inpatient wards across the Avon and Wiltshire Mental Health Partnership NHS Trust had what they termed 'the ward care programme approach'. These were not always included in the formal CPA process. Every week there was a Ward Round and prior to this a summary of the previous week was prepared and placed in the Clinical Records. This then formed the 'agenda' for the Ward Round and ensured that the main issues from the previous week were discussed and plans for the coming week and beyond were made. In reality, this weekly summary was not part of the CPA, but it did serve to ensure that all staff were up to date with the current situation with every service user on the ward. The Care Coordinator from the EIS attended the weekly Ward Round and was able to see from the weekly summary how Ms X was progressing.

A selection of CPA Plans, Professionals' Meetings and Risk Assessments is set out below in order to discuss the Mental Health Services adherence to the CPA Policy. There is a brief discussion about each 'plan'.

Ms X was discharged from Hospital on **17 August 2009.** A Personal Recovery Plan was prepared by Care Coordinator 1. This was the first CPA Plan undertaken by the EIT. The care plan noted that Ms X's children were required to live with her mother, Mrs W. Mrs W's house was crowded and Ms X felt stressed there. The Children and Young People's Service was planning to assess Ms X's parenting ability before her children would be allowed to live with her away from her mother's support. The Plan was that Ms X would:

- engage with the EIS Team on a weekly basis;
- continue to take Prozac;
- be reviewed by Doctor 2 in three weeks.

Ms X agreed to return to the ward that afternoon to collect her medication.[106] This Plan was somewhat limited as it did not fully address the likelihood that Ms X would not take her medication nor fully engage with the EIT. The Plan was shared with Social Worker 2. The

106 Clinical Records Volume 6 Pages 2092 - 2093

Plan would have been stronger had it included a risk assessment about the risk Ms X presented to her children and whether the support and supervision of her mother was sufficient to obviate the risk of Ms X absconding with her children. The Plan relied heavily on Mrs W to ensure that her daughter did not harm the children or seek to take them away with her. It was known that there had been a difficult relationship between Ms X and her mother.

There was a Care Plan Meeting on the Open Ward on **5 October 2009** when it was agreed Ms X would be discharged from the Early Intervention Service and Mental Health Services in general. This decision was based on the observation that there had been no evidence of mental illness. If in the future Ms X required any further mental health assessment this would be undertaken by Doctor 2 in the appropriate Sector Assessment Service. The Early Intervention Service would become involved again should Ms X display clear evidence of any psychosis due to the complex nature of her presentation.[107]

This Plan was also appropriate in that it accepted that Ms X was not going to engage with Mental Health Services but the door was left open for her to return should her mental health deteriorate in the future. There had been no clear signs of psychosis during much of this admission.

Ms X completed the Acute Recovery Review Form Section about her concerns regarding her treatment on **10 March 2010**. She stated that she would like to work with the patients on the ward as a member of staff. She complained that:

- she was not heard when she talked about the abuse she suffered at home;
- diaries, clothes and music belonging to her had been stolen;
- she was not allowed to send her children to a school in Bath or the school of her choice in Bristol;
- she had been bullied at school and that she wanted to spare her children suffering this.

Ms X had a Care Programme Approach Meeting on the ward on **21 June 2010.** She stated that she wished to come off all medication. The plan agreed at the Meeting was that:

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- the Section 3 Mental Health Act 2007 would be rescinded that day;
- Ms X would move to the Open Ward from the High Dependency Unit;
- the Early Intervention Team would engage with Ms X and would discuss psychology and medication with her;
- Ms X was to comply with the Ward Rules until she was discharged;
- Ms X was to liaise with HUB (Housing for the Homeless) to discover her options for housing accommodation.

The risks surrounding Ms X were described as being:

- complete disengagement from all services;
- deliberate self-harm;
- readmission to hospital;
- losing contact with her children.

Ms X did not accept any of these risks and thought all would be well in the future. She said she would borrow other people's sofas and floors and all would be well. Ms X was transferred to the Open Ward.[108]

The Risk Management Plan should have explored the potential risk Ms X posed to her children who were being looked after by her mother. She had had a deep desire and conviction that she would be able to have a two- or three-bedroomed house where she and her children could live. The main emphasis of the Risk Management Plan was about minimising the risks she presented to herself and did not explore the risks she posed to her children should she decide to act impulsively and remove them from her mother's care.

A Professionals' Meeting was held on **20 August 2010** attended by Care Coordinator 3, Senior Support Worker 1, Manager 1 and a trainee psychiatrist. It was evident that Ms X no longer wanted to be in contact with Mental Health Services. She was in difficulty with Income Support as she had not informed them that she had moved to the Housing Association and was still claiming the same amount of money as when she had had her children with her.

108 Clinical Records Volume 4 Pages 1696 - 1711

A plan was developed for Ms X which comprised:

- Care Coordinator 3 offering her weekly appointments;
- Senior Support Worker 1 offering her meetings twice a week;
- giving her the Housing Association Self Harm Worker's telephone number and that of the weekend support line;
- the trainee psychiatrist to speak with the Liaison Service to see the blood test results following the Paracetamol overdose;
- discussions about the letter from Ms X's solicitors asking if the Mental Health Services thought she had mental capacity.

This Plan, as with so many of the plans and proposals made in connection with Ms X, relied entirely on Ms X engaging with the EIT and working with Senior Support Worker 1 from the Housing Association. As was evident from her previous behaviour when discharged from hospital Ms X did not engage with mental health services and when at the Housing Association flat she failed to work with Senior Support Worker 1 to secure the funding for her flat. She also broke the rules and was evicted from the Housing Association flat on **30 September 2010**. She thus became homeless and as she proposed to 'sofa surf' or beg a space on a floor, would be vulnerable given her wish to become pregnant. Following her eviction from the Housing Association property Ms X was difficult to contact and the EIT had no further contact with her until after the homicide.

The main issue for the Professionals' Meeting should have been to also devise a plan about how to deal with her likely disengagement with services and what practical steps could be taken to address this. The actual plan totally depended on Ms X working with the EIT and Senior Support Worker 1 from the Housing Association. It should have been clear to staff that Ms X would not engage with the mental health services and also that she would find it difficult to cope and comply with the strict terms of the tenancy of the flat.

The Avon and Wiltshire Mental Health Partnership NHS Trust Policy to Manage Care Pathways and Risk states that the Care Programme Approach should be applied in all cases where the following characteristics are present:

"Characteristics to consider when deciding if support of CPA is needed:

- *Severe mental disorder (including personality disorder) with high degree of `clinical complexity*
- *Current or potential risk(s), including:*
    - *Suicide, self harm, harm to others (including history of offending)*
    - *Relapse history requiring urgent response*
    - *Self neglect/non concordance with treatment plan*
    - *Vulnerable adult; adult protection, domestic violence, MAPPA*
    - *Exploitation e.g. financial/sexual*
    - *Financial difficulties related to mental illness*
    - *Disinhibition*
    - *Physical/emotional abuse*
    - *Cognitive impairment*
    - *Child protection issues*
- *Current or significant history of severe distress/instability or disengagement*
- *Presence of non-physical co-morbidity e.g. substance/alcohol/ prescription*
- *Drugs misuse, learning disability*
- *Multiple service provision from different agencies, including:*
    - *Housing*
    - *Physical care*
    - *Employment*
    - *Criminal justice*
    - *Voluntary agencies*
- *Currently/recently detained under Mental Health Act or referred to crisis/home treatment team*
- *Significant reliance on carer(s) or has own significant caring responsibilities*
- *Experiencing disadvantage or difficulty as a result of:*
    - *Parenting responsibilities*
    - *Physical health problems/disability*
    - *Unsettled accommodation/housing issues*
    - *Employment issues when mentally ill*
    - *Significant impairment of function due to mental illness*
    - *Sexuality or gender issues*

- *Ethnicity, e.g. immigration status, race/cultural issues, language difficulties, religious practices".*[109]

When looked at within the context of the Policy to Manage Care Pathways and Risk Ms X would qualify to be subject to the Care Programme Approach as she had attempted suicide and had self-harmed in the past. In addition she had a relapse history, did not engage with services and refused to take her medication. Ms X was a vulnerable adult as she placed herself in situations where she was at risk of being exploited sexually and subject to violence, which was an increased risk when she abused alcohol and drugs. At this time, from **July to September 2010**, she was likely to also have accommodation difficulties due to the terms of her tenancy with the Housing Association. As of **30 September** she was evicted from the Housing Association flat and was homeless. Ms X had been subject to Section 3 of the Mental Health Act (1983 and 2007) and had been admitted as an inpatient on five occasions, this alone should have led to a robust discharge CPA being conducted.

10.1.4.3. Conclusions

The Independent Investigation Team concluded that in some respects the Care Programme Approach had been implemented appropriately by the EIT. The assessment of need had been undertaken and those needs identified were listed. Staff had kept all relevant staff and agencies informed about how Ms X was, and liaised closely with the Children and Young People's Department regarding her children.

Assessment of Need

The EIT did undertake regular assessments of need and all three Care Coordinators reviewed the situation both in the community and when Ms X was in hospital. This aspect of the Care Programme Approach was well managed.

Adequacy of Care Plans

The Care Plans were not consistent with the list of risks highlighted in the assessment of needs. There was no statement about how engagement with mental health services was going to be attempted given her known reluctance to take her medication and attend regular meetings with the care coordinator and the Senior Support Worker from the Housing Association.

109 AWP Policy Manage Care Pathways and Risk Pages 14 -16

The Care Plans highlighted her vulnerability but did not consider referring her to the Local Authority as a vulnerable adult which the assessment of needs described. The Care Plans were not robust and could not be implemented as they were dependent on Ms X working with staff which was one of the main issues to be addressed.

Forum for Multi-disciplinary and Multi-agency Discussion

The CPA meetings and the Professionals' Meetings did include the Children and Young People's Service staff as well as the Senior Support Worker from the Housing Association. There was good liaison and communication between the services involved but the ability to address the needs identified was lacking.

The Independent Investigation Team concluded that the Care Plans were not appropriate as they did not address the core issue of non-engagement and vulnerability. Instead the Care Plans were overly optimistic that Ms X would work with staff when all the evidence from the previous 18 months suggested the opposite.

The Avon and Wiltshire Policy to Manage Care Pathways and Risk identifies the key role of the Care Coordinator and the service user in being central to CPA working well. It was difficult for the three Care Coordinators who worked with Ms X as she did not wish to explore her illness and was throughout her two years in contact with Mental Health Services unable to engage. It was unfortunate that two of the female Care Coordinators became pregnant thus requiring three changes of Care Coordinator, although it was a conscious decision to provide Ms X with a female staff member due to her history of abuse in the hope that this would lead to trust and a strong relationship. This did not occur.

- ***Contributory Factor 2: the failure of the service to develop a plan at the point of her discharge from the inpatient unit that took into consideration Ms X's vulnerability and history of non engagement made a direct contribution to the failure to manage her continued health, safety and wellbeing in the manner to be expected for a service user who had been until recently detained under Section 3 of the Mental Health Act.***

- ***Contributory Factor 3: the Early Intervention Service did not fully comply with the Care Programme Approach Policy. The assessment of need was undertaken but the resultant Risk Management Plans and Care Plans did not specify actions to address the risks identified or to minimise their effect.***

10.1.5. Risk Assessment and Risk Management

10.1.5.1. Context

Risk Assessment and Risk Management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that *"positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed".*[110]

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multi-disciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

The Avon and Wiltshire Mental Health Partnership NHS Trust Policy for the Management of Care Pathways and Risk

This Policy states that the underpinning principles for effective risk assessment and management are:

- *"Systematic arrangements for **assessing** and recording the health and social care needs and risks in the care pathway and developing an appropriate diagnosis and formulation*

110 Best Practice in Managing Risk; DoH; 2007

- *Consistent identification of the appropriate effective care pathway and systematic mapping of, and engagement with. the service user, carers, family and community networks*
- *The formulation and recording of a **personal recovery (care programme) plan** which co-ordinates the involvement of health and social care providers, other statutory agencies, non statutory providers, carers, family, and community networks in maximising recovery and well being of the service user and managing any identified risks.*
- *The appointment of a **care co-ordinator** to keep an overview of the personal recovery (care programme) plan, record, monitor and co-ordinate care, and assess, manage and review needs and risks, and record all appropriate information".* [111]

10.1.5.2. Findings

Internal Investigation

The Internal Investigation identified difficulties with the Risk Screening Tool used by AWP. The Report stated that *"the risk screening tool in use during [2009/2010] made a distinction between past and current risk, with no timescales identified as to what constitutes 'current'. As a consequence, recent episodes of violence were not identified as presenting current risk and therefore the assessment failed to fully take into account the ongoing risks. The result of this was that there was no management plan…".* [112]

Independent Investigation

The staff from the EIT did identify risks and sought to prepare plans to manage them. All along they had difficulty in engaging Ms X which made it difficult to fully understand and monitor the situation without active participation from the service user. When Ms X was on the Open Ward or the High Dependency Unit she was involved in her risk assessments although she often walked out of meetings so was not fully involved or fully committed to the process of risk assessment and risk management. Risk assessment and risk management was discussed when the Care Coordinators met with Ms X, but there were many appointments where she was unavailable and others when she terminated them early.

111 Policy to Manage Care Pathways and Risk Page 9
112 Root Cause Analysis Report of the Homicide Page 44

Risk Assessment as Included in the AWP Comprehensive Assessment eCP1d+ Form

The instructions on Page Six of the 12 Page form state that for *"Core Risks – Please type Y for Yes, N for No and record U/K for unknown". The areas of risk covered by the forms are:*

1. *Suicide and Self Harm*
2. *Risk from Others*
3. *Risks to Others*
4. *Risks to Children*
5. *Driving*
6. *Self Neglect*
7. *History of Detention/Supervision*
8. *Additional Risk Factors (including alcohol abuse, use of illicit drugs, symptoms etc)*
9. *Risk of Loss of Contact*
10. *Social Risk Factors*
11. *There is then space for an 'Ongoing chronological record of risk history (including identified changes to risks)*
12. *Further assessment and management of risks".*

The AWP Trust also had a Risk Screen for new referrals to be seen in the community. It asked the question – *"Do any of the following categories present a risk?*

1. *Violence / Aggression:*
2. *Gender specific violence risk:*
3. *Substance abuse:*
4. *Persecutory beliefs / hallucinations:*
5. *Self-neglect:*
6. *Suicide:*
7. *Race specific harassment / violence:*
8. *Self-harm:*
9. *Risk to children:*
10. *Any other risk details:*

If you have identified a risk, what measures will you take to minimise this?
e.g. Joint visit with a colleague,
arrange positive reporting to colleagues,
arrange for patient to attend team base, hospital, clinic, etc.,

Other (refer to local policy on safe working in the community) Early assessment".

An example of a risk assessment was included in the Personal Recovery Plan (eCPA1e) dated **28 June 2010** at the time of Ms X's discharge to the Housing Association Accommodation which was planned and actually took place on **6 July 2010**. The risks to self were identified as:

Self-Harm: Ms X had done this previously and, during this admission to hospital, whilst absent without leave, had self-harmed and had taken overdoses of Paracetamol. She had described how she used this behaviour to display her level of frustration.

Risk of Relapse/disengagement: Ms X had been reluctant to take antipsychotic medication on discharge but wished to receive community follow-up although historically she had struggled to engage with the Bristol Early Intervention Service Team.
Child Protection: there was a risk of Ms X abducting her children but the Children and Young People's Service had procedures and measures in place to monitor and manage this risk. The nature of the procedures and measures were the fact that there was an Exclusion Order preventing Ms X going to her mother's home where her two children lived and she was only allowed one supervised visit to see them each week. Her mother was acting as their parent.

Risk to Others: there had been no physical aggression in hospital but Ms X had been verbally hostile and irritable.

Alcohol and Substance Misuse: there was a history of both and on return from her absences without leave Ms X had drunk alcohol.

Vulnerability: Ms X had expressed a desire to become pregnant again. This desire increased when she was under the influence of alcohol and drugs and she put herself in vulnerable positions where she could be exploited by males.

Self Neglect: there had been previous concerns regarding her not caring for herself but nothing of this nature had occurred during her current admission.

In general terms the assessed needs remained much the same throughout the time Ms X was receiving care and treatment from the Bristol Mental Health Services. It was also a constant issue that the Care Plans devised to manage the identified risks were not robust as they did not address key issues which constituted significant risk. These were her non-engagement with services and her vulnerability, especially when she was in the community, or absent without leave from the inpatient services, when she did misuse alcohol and drugs.

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

Table 3: Absconding by Ms X

Date	Event	Return
14/06/2009	Ms X absconded after a former service user had visited her.	Her mother brought her back later the same day.
03/03/2010	Ms X left the ward for 35 minutes.	Ms X returned herself.
04/03/2010*	Ms X left the car taking her to Link House. Admitted the next day. Not AWOL as Section 2 had been rescinded.	Was arrested by Police and admitted under Section 136 converted to Section 3.
16/03/2010	Ms X went AWOL from the hospital canteen.	Returned later that day.
17/03/2010	Ms X went AWOL from Court.	Returned later that day.
31/03/2010	Ms X went AWOL from ward.	Returned by Police in evening on 02/04/2010.
04/04/2010	AWOL from ward.	Returned.
08/04/2010	AWOL from toilet in hospital canteen.	Returned.
09/04/2010	AWOL via Oakwood Ward	Returned.
13/04/2010	AWOL	Returned.
20/04/2010	Evaded staff in busy public place – outside NATWEST bank in Gloucester Road.	Returned by Police 2.5 hours later.
11/05/2010	AWOL from hospital gym with escort.	Returned the next day.

24/05/2010	AWOL for five hours.	Returned by herself.
26/05/2010	AWOL from Court.	Returned.
09/06/2010	AWOL from leave	Returned by herself next day.
28/06/2010	Ms X went missing.	Returned by Police.
29/06/2010	Failed to return at end of leave at 17.00 hours.	Returned by herself at 23.00 hours.

*****Not technically absconding as Section 2 had been rescinded that afternoon on discharge.

The risk assessments and risk management plans mentioned that Ms X presented a high risk of absconding but this always appeared to be in the context of her leaving the ward. It was not viewed generally as Ms X placing herself in danger through the risks she took when seeking men to fulfil her wish to become pregnant.

Ms X was placed on the High Dependency Unit as it was felt the High Dependency Unit would help prevent her absconding, but as Table 3 above illustrates she was still able to escape from the High Dependency Unit, the hospital grounds and when out with a staff escort. The level of being able to abscond is alarming, especially as Ms X was under Section 3 of the Mental Health Act (1983 and 2007) during the time of the most absconding from the High Dependency Unit from **5 March 2010** until she was transferred back to the Open Ward on **21 June 2010**.[113]

There was little evidence of the ward staff taking firm action over her absconding and the only details of staff confronting her about her absconding was on **7 June 2010**. Ms X was warned about her behaviour on escorted leave and told that if she absconded she would be seen by the Duty Medical Officer to check whether she had taken drugs or alcohol. She was further warned that if she did not return within the hours of Section 17 leave agreed all her leave would be cancelled. Ms X was reported to be unaware of her behaviour and to take no responsibility for any of the difficulties she had had in her life, and always blamed other people or services.[114]

113 Clinical Records Volume 4 Pages 1696-1711
114 Clinical Records Volume 4 Pages 1656-1659

Two days later on **9 June 2010** Ms X was given one hour's leave with staff but absconded and was brought to the High Dependency Unit the next morning. She had gone to her mother's house and stayed overnight but an argument had broken out and the Police were called to the address. When the Police arrived Ms X was being restrained by family members as she was attempting to cut her wrists.[115] As a result Ms X's leave was suspended.

A few days later on **14 June 2010** a Professionals' Meeting was held which was attended by the Clinical Team, representatives from the Bristol Child and Family Support Team and Psychologist 1 representing Care Coordinator 2 who was unable to attend. Doctor 2 confirmed that the diagnosis for Ms X's problems was now Borderline Personality Disorder. Mrs W was informed that her daughter could not be detained in hospital for this condition. Concerns were raised at the meeting about the possibility of Ms X making contact with her children and absconding with them once her Section 3 Mental Health Act 2007 was rescinded upon her discharge. Care Coordinator 3 was to be asked to produce a Recovery Plan for Ms X.[116]

On **18 June 2010** Care Coordinator 2 visited Ms X on the High Dependency Unit with a Community Psychiatric Nurse (CPN) who was to become Care Coordinator 3 as a CPN would be required to give Ms X her depot medication in the community. Ms X was not pleased to see them and as written in the Clinical Record *"tolerated 15 minutes"* before leaving the room saying she would not take any depot injections once she was discharged and would consider if she would engage with the Early Intervention Service.[117]

Ms X had her Care Programme Approach Meeting on the ward on **21 June 2010**. Ms X stated that she wished to come off all medication.

The risks surrounding Ms X were described as being:

- complete disengagement from all services;
- deliberate self-harm;
- readmission to hospital;
- losing contact with her children.

115 Clinical Records Volume 4 Page 1679
116 Clinical Records Volume 4 Pages 1673 - 1675
117 Clinical Records Volume 4 Page 1704

Ms X did not accept any of these risks and thought all would be well in the future. She said she would borrow other people's sofas and floors and all would be well. Ms X was transferred to the Open Ward.[118]

10.1.5.3. Conclusions

The Independent Investigation Team concluded that the care and treatment of Ms X in hospital was poor. The level of Control and Restraint which was discussed in Section '10.1.3 The Mental Health Act' discussed the suspected over use of Control and Restraint and the Prevention and Management of Violence and Aggression Policy for someone who was described by all staff interviewed as difficult to engage with, but not as a violent person of whom they were afraid. Her anger was said to be postural and verbal but staff did not fear that she would attack them.

In contrast to the use of Control and Restraint for the purposes of ensuring Ms X was having her medication which she refused to take orally, it appeared from all the evidence in the Clinical Records that the use of Control and Restraint was hardly used to prevent Ms X absconding. The staff have a 'Duty of Care' to all their service users to prevent them from harm and to prevent them from harming others. The latter did not really apply to Ms X, except in regard to her children who were being cared for by her mother and she was under a Restraining Order not to visit the children at her mother's house for fear that she might try to take them away with her.

It was well known that Ms X was impulsive and did not 'think things through'. It was also known that she was very likely to abuse alcohol and drugs when she did abscond. It is reported that she wanted to become pregnant. Such behaviour inevitably placed her in danger.

"On 28 June 2010 Ms… [X] was returned by the Police to the Open Ward with a male service user from the Ward with whom she wanted to have sex and have a baby. She was drunk and was found later kissing another male service user a little while later".

Action should have been taken to strengthen the ability of the High Dependency Unit to prevent Ms X leaving. Similarly the granting of Section 17 leave should have been made

118 Clinical Records Volume 4 Pages 1696-1711

conditional on Ms X keeping to the times agreed and not just pleasing herself with no regard for the potential consequences. The suspension of leave following her absconding from staff when she was granted escorted leave for an hour on **9 June 2010** was too little too late. Within 12 days of Ms X having her leave suspended she was moved from the High Dependency Unit to the Open Ward with the Section 3 of the Mental Health Act 2007 rescinded.

It is unclear from the clinical records why there was no consideration of Ms X being placed in a low secure environment in order to prevent her absconding, or having an additional member of staff to observe her and seek to prevent her leaving the ward. She appeared to be using the ward as accommodation, which was the case as she was homeless until a vacancy became available in the Housing Association which had offered her a supported flat for people who had a history of domestic violence.

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

It was poor practice not to 'police' Ms X's stay on the ward to prevent her placing herself in danger. Knowing her past, and her behaviour during the 18 weeks she was at the local Hospital, better preparation and more consideration for her safety and wellbeing should have been taken. She was vulnerable, and her mental capacity to take decisions was in doubt, as the solicitor representing her in the legal proceedings regarding her custody of her two children asked Doctor 2 if he considered she had capacity to understand what the legal issues were. In addition the protection of the Mental Health Act had been removed.

- ***Contributory Factor 4: when a service user is vulnerable and impulsive the risk assessments and risk management plans must be robust and identify clearly how the risks are to be managed. The Trust should identify what actions could have been taken and use this situation with Ms X as a training example of what could and should have been done. The lessons from this incident must be learnt and converted into practical measures to better safeguard service users who cannot protect themselves due to their impulsivity. The failure of the service to mitigate***

against the risks posed by Ms X made a contribution to her continued vulnerability and this was detrimental to her health, safety and wellbeing.

10.1.6. Referral, Transfer and Discharge Planning

10.1.6.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies can be communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

The Avon and Wiltshire Mental Health Partnership NHS Trust Policy for Managing Care Pathways and Risk

"The Care Pathway Process

Referral

Each service operates a single point of entry for referrals, which ensures access to the range of resources of both health and social care through a single process.

On receipt, referrals are entered onto the MHIS, and then screened against service referral criteria by the team manager, and a decision is taken to:

- *Reject the referral, as does not meet the referral criteria (and discuss and/or feedback to referrer) or*
- *Allocate an assessor to undertake a core assessment (including risk).*[119]

Assessment

The purpose of the core assessment is to identify the person's health and social care needs, including risks, in order to devise a personal recovery plan (care programme), to determine if the person meets the criteria for the service, and to commence planning for discharge from

119 Policy for Managing Pathways and Risk December 2008 Page 19

the service. A core assessment, including assessment of risk is completed for all people when referred to the Trust who meet service referral criteria.

Following a core assessment, if the service user meets the criteria for access to secondary mental health services, the assessor then becomes the interim care co-ordinator, responsible for ensuring that an initial personal recovery plan (care programme) is agreed, and copied to the service user, carer (as appropriate) and GP, until a definitive care co-ordinator appointed.

The core assessment and related personal recovery plan should identify and manage the basic needs and risks of a service user, and may fully meet the needs for assessment and care planning for service users managed on Standard Care.

However, service users on CPA or those with more complex needs and/or higher levels of risk or where there is uncertainty of the type or level of needs and risks, will require a more comprehensive assessment of their needs and risks. Therefore a trust comprehensive assessment should be completed for these service users.

The comprehensive assessment should obtain information, which should be obtained from as wide a range of sources as possible, wherever possibly independently. All previous AWP and other health and social care records should always be sought and obtained and collateral information should always be sought from and obtained from carers and family members or significant others, including a comprehensive record of the relevant family history and current family networks and relationships. [120]

Transfer and Discharge

A key principle of personal recovery (care programme) planning is that discharge planning should start at the point of initial assessment and entry into services, and continue throughout each review within the care pathway.

120 Policy for Managing Pathways and Risk December 2008 Page 19-20

Everyone involved in the personal recovery (care programme) planning should be informed and included in decision-making, especially the service user, carers and GP, by the care coordinator.

If the service user is subject to Section 117 Aftercare arrangements, then the Section 117 must be discharged or transferred either prior to the review, or at the review, if discharge is to proceed.

People who have arrangements in place to contact the service and resume care when certain criteria are met will have a (rapid) re-entry to the service, they must not be 'held' or 'in limbo' in the meantime, but fully discharged.

A Personal recovery (care programme) plan should record the arrangements when discharging or transferring a person from a service (including crisis and contingency arrangements), and a copy of the plan must be sent to the service user, carer and family (as appropriate), the GP and identified others". [121]

10.1.6.2. Findings

Internal Investigation

As mentioned above the Internal Investigation considered that Ms X should have had a trial leave period prior to her discharge to the Housing Association Supported Housing Flat to test if she could meet the terms and conditions of the tenancy. She was discharged straight to the new accommodation without testing if she could meet their requirements when it entailed a fundamental change to her behaviour at the time. The Independent Investigation concurs with this finding.

Independent Investigation

The Bristol Mental Health Services

The position in 2009 was that Bristol was divided into three Sectors- North, Central and South, each of which had an Assessment Team which acted as a single point of entry to the Mental Health Services. The Assessment Team would undertake a core assessment and on the evidence they gained would decide whether a referral was required and if so which team

121 Policy for Managing Pathways and Risk December 2008 Page 24

should be involved. The referral could be passed to any of the following teams depending on the needs of the potential service user: the Citywide Home Intervention Team, the Crisis Resolution and Home Treatment Team, the Early Intervention Service [122] or a Community Mental Health Team.

Referral

GP 1 made an urgent referral to Mental Health Services on **28 May 2009** to the Citywide Home Intervention Team. A Core Assessment had been done and Ms X and her mother were told that the appropriate services would be alerted and would make contact with them the next day. No service had made contact on **29 May 2009** so Mrs W contacted the nearest service and Ms X was seen by Doctor 1 at the Crisis Resolution and Home Treatment Team (CRHTT) at the North Bristol Community Mental Health Team.[123]

It is unclear from the Clinical Records what happened to Ms X's referral. It is likely from the information in the Clinical Records, that the referral from GP 1 went to the Assessment Team where a Core Assessment Form was completed. It appears that following the Assessment it had been thought that the Citywide Home Intervention Team would be the appropriate service to become involved. This obviously had not occurred as Mrs W and her daughter made contact with the Crisis Resolution and Home Treatment Team (CRHTT) where Doctor 1 also completed an assessment and prescribed medication for Ms X. Ms X continued with the CRHTT until it became clear that she needed to be admitted to hospital.

Following Ms X's first admission to hospital she was referred back to the CRHTT on **17 June 2009**. After a Care Planning Meeting on **22 June 2009** where it was recorded that:

"[Ms X] was taking her medication but Mrs W was not so sure as she had not seen much difference in her behaviour since she had been at home although her appetite had been better. Ms… [X] displayed some hostility towards her mother and stated that what she wanted was to:

- *have her house back;*
- *get back into music;*
- *look after people;*

122 Mental Health Policy Implementation Guide: Department of Health 2001
123 Clinical Records Volume 6 Pages 2056-2066

- *feel that people are listening to her as she currently had the opinion that they were not paying her attention.*

It was agreed that Ms…[X] would be treated by the Early Intervention Service (EIS) Team and would continue to have Risperidone and Fluoxetine but would stop the Diazepam when the current supply was finished". [124]

The EIT had link workers who related to the Assessment Teams so that if they knew the referral was of someone presenting with a first onset of a psychotic illness they could do joint interviews and assessments with the Assessment Team which was said to have worked well, and ensured an easy handover. The link staff from the EIT did joint assessments of referrals from Primary Care and attended the Assessment Team Meetings to screen referrals with them.[125]

Transfer and Discharge

Everyone with mental health needs is entitled to a community care assessment to establish what services they might need. There are two important factors to be considered when a service user who has been under Section 3 of the Mental Health Act (1983 and 2007) (MHA) is due to be discharged from hospital. The first factor is Section 117 of the MHA which states that:

"Section 117 after-care

27.2 Section 117 of the Act requires primary care trusts (PCTs) and local social services authorities (LSSAs), in cooperation with voluntary agencies, to provide after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained. This includes patients granted leave of absence under section 17 and patients going onto supervised community treatment (SCT).

27.3 The duty to provide after-care services continues as long as the patient is in need of such services….

27.4 Services provided under section 117 can include services provided directly by PCTs or LSSAs as well as services they commission from other providers.

124 Clinical Records Volume 1 File 2 Pages 284-386
125 Transcript 4

27.5 After-care is a vital component in patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital.

27.6 Where eligible patients have remained in hospital informally after ceasing to be detained under the Act, they are still entitled to after-care under section 117 once they leave hospital. This also applies when patients are released from prison, having spent part of their sentence detained in hospital under a relevant section of the Act."

The second factor is the advice in the AWP Policy for Managing Pathways and Risk quoted above but repeated in part here:

"If the service user is subject to Section 117 Aftercare arrangements, then the Section 117 must be discharged or transferred either prior to the review, or at the review, if discharge is to proceed…

A Personal recovery (care programme) plan should record the arrangements when discharging or transferring a person from a service (including crisis and contingency arrangements), and a copy of the plan must be sent to the service user, carer and family (as appropriate), the GP and identified others". [126]

The discharge for Ms X when she finally left the Open Ward and the High Dependency Unit and moved to the Housing Association flat was 'optimistic' given all the EIS Team and the ward staff knew about Ms X.

The pattern of rescinding the Section of the MHA 2007 as soon as Ms X was to be discharged appeared unusual to the Independent Investigation Team, especially after the 18 week stay in the local Hospital under Section 3 of the MHA 2007. Maintaining the Section 3 in place would have provided the opportunity to recall Ms X to hospital if she appeared to be suffering a relapse. The decision to discharge Ms X to the Housing Association accommodation with no lifeline under Section 3 or Section 117 was extremely likely to fail.

126 Policy for Managing Pathways and Risk December 2008 Page 24

Within a few days it was clear that Ms X did not like living in her flat. She was discharged from hospital to the Housing Association link on **6 July 2010** and having left the ward she had minimal contact with the EIT Staff and Senior Support Worker 1 despite appointments having been made. On **20 July 2010** Care Coordinator 3, Psychologist 1 and Senior Support Worker 1 visited Ms X who refused to have her depot injection and told the staff that she did not like the boundaries imposed by the Housing Association.[127] She made the same comments on **28 July 2010** and **4 August 2010** saying she disliked the rules and boundaries and went out binge drinking twice a week. She wanted to move out.

In view of Ms X not wishing to engage with the EIS a Professionals' Meeting was held on **20 August 2010** which was attended by Care Coordinator 3, Senior Support Worker 1, Manager 1 and a trainee psychiatrist. There was no representative from the Children's and Young People's Service at this meeting which excluded discussion about the legal proceedings regarding the custody of Ms X's two children; this was to be discussed in a multi-disciplinary setting. It was evident that Ms X no longer wanted to be in contact with mental health services. She was in difficulty with Income Support as she had not informed them that she had moved to the Housing Association and was still claiming the same amount of money as when she had had the children with her. A plan was developed for Ms X which comprised:

- Care Coordinator 3 offering her weekly appointments;
- Senior Support Worker 1 offering her meetings twice a week;
- giving her the Housing Association Link Self Harm Worker's telephone number and that of the weekend support line;
- the Trainee Psychiatrist to speak with the Liaison Service to see the blood test results following Ms X's Paracetamol overdose on 16 August 2010;
- discussions about the letter from Ms X's solicitors asking if the Mental Health Services thought she had mental capacity.

On **30 September 2010** Ms X was evicted from the Housing Association for breaking the rules, not having arranged the necessary finance to pay the rent, and for causing damage to a glass door at the property. The Mental Health Services were not informed prior to the eviction so they were unable to intervene as Ms X had been made homeless and they did not know where she was.

127 Internal Investigation Page 139 and Clinical Records Volume 4 Page 1737

10.1.6.3. Conclusion

The Independent Investigation Team concluded that the care and treatment to Ms X could have been better from the time of her final admission to hospital on **5 March 2010** until her eviction from the Housing Association Accommodation.

The areas where better care could have been provided were:

- the lack of robust action to prevent Ms X absconding from the hospital;
- the rescinding of the Section 3 MHA;
- the lack of a clear and achievable crisis and contingency plan;
- no reference to the after-care provisions of Section 117 MHA 2007;
- the Care Plan which placed Ms X in a position where it was predictable that she would struggle to meet the requirements of the tenancy.

The conditions of the tenancy at the Housing Association property comprised all the things which Ms X had demonstrated over the previous months and years she was unable to manage. There was a ban on males being brought into the flats as the living accommodation was for women only and they had all experienced mental illness and were therefore vulnerable. No drugs or alcohol were allowed on the premises and residents had to work with Senior Support Worker 1 to obtain the necessary benefits to pay the rent.

The Care Plan produced by the Professionals' Meeting on **20 August 2010** was unlikely to be adhered to by Ms X as she was by this time determined not to stay at the Housing Association and also not to work with the mental health services. It is at this point that the Section 3 MHA 2007 could have been used to recall her to hospital had it been in force. It was also evident that her mental health was not deteriorating but it was equally evident that her accommodation was at risk and that she would be vulnerable as a homeless woman.

- ***Contributory Factors 1, 2, 3 and 4 described in this report are also applicable for this section.***

10.1.7 Service User Involvement in Care Planning

10.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes."

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

10.1.7.2. Findings

Internal Investigation

The Internal Investigation considered that the EIT had worked hard to try to engage Ms X. It did note that *"the discharge CPA in June 2010 was based on 2 optimistic premises, firstly that [Ms X] would be concordant with depot medication, and secondly that she would agree to be placed in supported accommodation, she had not yet seen. The care plan was probably not sustainable given her patterns of behaviour and history. Under these circumstances the CPA should have openly explored issues of her engagement and motivation around this plan, and should have set up a crisis plan and review arrangements to activate if the plan started to break down".* [128] The Independent Investigation Team concurs with this finding.

Independent Investigation

The Crisis and Resolution Home Treatment Team accepted the referral of Ms X and made sure that she and her mother were included in their assessment and the care planning.

The notes by Doctor 1 providing the details of his interview with Ms X and her mother were written very sensitively and provided much information which Ms X could check when she was less ill. The tone was friendly and was written in a style and language Ms X would be

128 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 46

able to relate to. Doctor 1 wrote in the Core Assessment *"this is the first opportunity we have had to meet and I know it was a difficult meeting for you. It does sound like you have had some quite longstanding difficulties over several years and how you feel about yourself, manifested by having low self-esteem and harming yourself. There also does however seem to be periods where you become very frightened and paranoid. The history from your mum was that this has got worse recently and you dream of frightening things about people were try [sic] to harm you. It does appear that this is having an effect on how you cope in your life and very importantly, how you are able to be with your children and your family. I think it is important that you do accept the treatment offered otherwise I think it is going to have repercussions for relationships with your family, your children and your own wellbeing".* [129]

Ms X was discharged from the Open Ward on **17 June 2009** and the plan was for staff from the CRHTT to visit her daily and to discuss her care with her. This did not happen. Ms X told the staff that she was taking her medication; her mother advised them that this was not the case. Ms X deteriorated and was admitted to the Open Ward under Section 2 of the Mental Health Act 1983 and 2007) on **22 July 2009**. Throughout her five admissions Ms X did not actively use the help and support available and on offer to her. She repeatedly asked to be allowed to go home and had no insight into her illness. At the First-tier Tribunal held on **7 August 2009** the responsible Clinician, Doctor 2 reported that Ms X had been unable to keep to any of the agreements made for leave and community assessment. Her concern was primarily for her own health rather than for the safety of her children.

It was noted in the Tribunal Report that Ms X had generally been non-compliant and unable to engage in any meaningful conversation with Ward Staff. She had made repeated attempts to leave hospital. Ms X was discharged from the Open Ward on **17 August 2009** and the Care Plan was that she should engage with the Early Intervention Team (EIT) weekly. Ms X received the support but did not make the best use of it and always cut short the period of time allocated for therapeutic or supportive sessions. Staff interviewed during the Independent Investigation stated that Ms X was only compliant and ready to work with staff if she thought they were helping her achieve her agenda which was to have her children back with her and secure a two- or three-bedroomed house in which to live with them. Otherwise,

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as soon as she realised this was not what the staff were working towards, she became aggressive verbally and would walk out of meetings or terminate interviews.

The same pattern of behaviour was apparent during her 18 week admission on the Open Ward and the High Dependency Unit between **5 March 2010** and **6 July 2010** during which she absconded 14 times.

During this admission Ms X had asked for a Second Opinion which was provided by Doctor 3. Doctor 3 made two attempts to complete his assessment but Ms X 'gave up' on the assessment as she believed the Doctor was not going to say what she wanted, which was to be given more leave and to go home without medication. He wrote the following recommendations:

1. *"I feel that you are suffering from a psychotic illness, which is of a paranoid nature.*
2. *You require an adequate course of anti-psychotic treatment, which will help you in controlling these paranoid symptoms.*
3. *It is in your best interest to stay on the ward and to work with the Mental Health Team to help you in your recovery and care.*
4. *I had read in your file that you had requested a change in consultant. I would suggest that if you stay with your current team, who know you in great detail, it will help in your recovery. If you continue taking the treatment as advised by them, it will be much better for you. In my opinion the change of consultant will not help you in your recovery, as the reasons cited by you were to go on leave and be discharged from the ward immediately. I do not think that a new consultant will be able to recommend your request as you require proper treatment and care.*

I understand that you may not be happy with my opinion, but in case you want to discuss any of the contents of my Second Opinion, then I will be happy to discuss this with you. Please contact my secretary about this and we can arrange a mutually agreeable time".[130]

On **20 July 2010** Care Coordinator 3, Psychologist 1 and Senior Support Worker 1 met with Ms X and agreed with her that Care Coordinator 3 would meet with her weekly on Wednesdays, she would have supervised visits to see her children twice a week and a meeting

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with the Support Worker from the Housing Association once a week. The vast majority of these meetings never took place because Ms X did not attend or cancelled them. Ms X remained adamant that she would not take medication and did not want help from the EIT.

10.1.7.3. Conclusions

The difficulty throughout the time Ms X was receiving her care and treatment from the mental health services in the Avon and Wiltshire Mental Health Partnership NHS Trust was that she did not want to engage with the services and once discharged from hospital refused to take her medication.

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

10.1.8. Documentation and Professional Communication

10.1.8.1. Context

Documentation

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

The GMC states that:

"Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off". [131]

Pullen and Loudon writing for the Royal College of Psychiatry state that:

131 http://www.medicalprotection.org/uk/factsheets/records

"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised".[132]

Professional Communication

"'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion".[133]

Jenkins *et al* (2002)

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

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone[134]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.[135] The Department of Health's *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

10.1.8.2. Findings

Documentation

Internal Investigation

The Internal Investigation identified that there were some missing case notes. It stated that: *"Volume One of the notes is not the actual AWP volume one, as [Ms X] had significant contact with the service prior to when these notes commenced. There has been an internal investigation undertaken and the missing notes have now been located".* [136]

132Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) PP 280-286
133 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P121
134 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999) P144.
135 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)
136 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 47

Independent Investigation

The standard of documentation was generally good both with the Community Mental Health Services and with the documentation used on the Open Ward and the High Dependency Unit. There were full discharge letters sent to GP 1 and GP 2 when Ms X was discharged, and good communication between Doctor 2 and the members of the EIT. The email trail was certainly working as staff worked to keep all those involved informed about the current situation.

The documentation was generally of a good standard, although sometimes the records were not in date order, but this could probably be explained by the Crisis and Home Treatment Team, the Early Intervention Team, the Consultant Psychiatrist and the local Hospital staff being in different locations which made consecutive entries difficult to maintain.

The Primary Care Records are in date order and provide a good overall picture of the health and welfare of Ms X prior to her contact with Mental Health Services in **May 2009**.

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

The notes by Doctor 1 providing the details of his interview with Ms X and her mother were written very sensitively and provided much information which Ms X could check when she was less ill. The tone was friendly and was written in a style and language Ms X would be able to relate to.[137] Similarly, the letter from Doctor 3 who at Ms X's request assessed her care and treatment to provide a second opinion as to her diagnosis and treatment was written in a clear and open style. The letter to her dated **5 May 2010** outlined the reason for the second opinion. Doctor 3 actually explained that it was Ms X's fault that the second opinion had not been more comprehensive. He wrote:

"I discussed with you at length regarding the current problems and difficulties that you are experiencing, when I met with you in the morning of 30th April. I wanted to complete the assessment during the afternoon, later that day, as you felt exhausted after speaking with me

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for about an hour. Later when I met with you in the afternoon, you felt there was no point in continuing the interview, as I wasn't going to deliver what you had been expecting from a 'Second Opinion' and you decided to end the interview. Therefore, my opinion will be based on the discussions we had together in the first meeting of 30th April". [138]

Another example of a good report was that of Care Coordinator 2 who wrote the Social Circumstances Report about Ms X on **7 May 2010**.[139] The Social Circumstances Report provided a good overview of the whole situation and the difficulties Ms X faced and also the difficulties her behaviour and attitude caused staff from all the agencies involved in her care.

Professional Communication

Internal Investigation

The Internal Investigation considered that the communication was generally good between the agencies. It did highlight two areas where this had not been of a satisfactory standard:
"[Social Worker 3] was not invited to the professionals' meeting (August 2010) – and therefore information that she had about [Ms X's] understanding of the court proceedings [Child Care] was not considered in a multidisciplinary forum".[140]

The second point made by the internal Investigation was that *"It is unclear exactly when the Mental Health Services were informed of [Ms X's] eviction [from the Housing Association property] as this was not clearly recorded. If the EIS Team were aware of this before the eviction they failed to respond in relation to reviewing her mental state, and in supporting her in finding suitable alternative accommodation. If they were unaware then this was a very significant failure of communication between the housing agency and the Mental Health Trust".* [141]

Ms X was evicted from the Housing Association accommodation on Friday 30 September 2010 and the Early Intervention Service was informed of this eviction on the following Tuesday when Senior Support Worker 1 spoke to Care Coordinator 3. With this clarification in mind the Independent Investigation Team concurs with this finding.

138 Clinical Records Volume 5 Pages 2025-2028
139 Clinical Records Volume 5 Pages 2020-2024
140 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 47
141 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 47

Independent Investigation

There was good liaison between the mental health services and the Children's and Young People's Service. At the initial interview with Doctor 1 it was evident that Ms X was having difficulties in coping with her children, and the involvement with the Police and the Children's and Young People's Service. Doctor 1 wrote in the Core Assessment form that the Care Coordinator should make contact with the social worker responsible for the safety of Ms X's children.

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

From the clinical records and the Internal Investigation it was clear that when Ms X was evicted from her flat, the liaison between the Housing Association and the Mental Health Services did not work as it should have done. As the Internal Investigation states:

"*Representatives from the Children and Young People's Service, mainly Social Worker 1, Social Worker 2, and Social Worker 3, the three EIS Team Care Coordinators and Senior Support Worker 1, were in regular contact to ensure that all knew the current situation with Ms… [X] and her two children. They also attended Professionals' Meetings and Discharge Meetings. The Children and Young People's Service was informed when Ms…[X] absconded as it was recognised that she sometimes went to her mother's and that in the interests of the children the social workers should know".*

10.1.8.3. Conclusions

Documentation

The Independent Investigation Team concluded that the documentation was generally of a good standard, although sometimes the records were not in date order but this was probably due to the various locations from which different teams and members of teams worked.

There were examples of good recording and of sensitive descriptions of interviews clinical staff had had with Ms X. The one weaker area was in the completion of the Risk Assessment and Risk Management Forms which listed the chronological risk but did not expand on this in completing the Risk Management pages. The risks were primarily about Ms X and her risk to herself and the loss of her children. The risk to the children through her absconding from hospital and abducting them from their grandmother's home were not fully explored.

The Community Mental Health Teams and the Ward Continuing Records were mainly of a good standard, although some of the Incident Forms for when Ms X absconded from the Open Ward and the High Dependency Unit whilst on ground leave and escorted community leave were sometimes not fully completed.

Professional Communication

Professional communication was of a good standard. The liaison between the various Mental Health Teams was good, as was that between them and other agencies involved in the overall care and treatment of Ms X. Letters were well written and there was excellent written communication with Ms X herself which explained why particular decisions were taken about having leave or not having leave. They acknowledged that some of the decisions taken about her treatment were not accepted by her, and there were good reasons offered for why they had had to be taken.

There was one example of poor liaison between agencies. This concerned the failure of the Housing Association to warn the Mental Health Services that Ms X was likely to be evicted should her observance of the tenancy agreement and her arranging payment of the rent remain neglected. The situation became more concerning when Ms X was given immediate notice to leave the flat when she was discovered with Mr Z in her flat, together with drugs and alcohol they had used there, and without having made any arrangements for the rent to be funded. The Mental Health Services were not informed until four days after this had occurred.

The Independent Investigation Team considered this to be a serious breakdown in communication between agencies. If the Housing Association had been able to let Mental Health Services know Ms X was about to be evicted the Care Coordinator or another member of staff could have visited Ms X to assess her mental state and to help her visit HUB for

appropriate accommodation. As it was Ms X was homeless and the Mental Health Services did not have contact with her until she had been arrested for the homicide of Mr Y.

It is known that the recommendation by the Internal Investigation Report about the need for the Housing Association to inform other agencies involved with their tenants so that they can access all available assistance has been fully implemented.

- ***Service Issue 5: Housing Services should have warned mental health services that Ms X was about to be evicted and preferably a meeting with mental health services should have been held prior to this decision being activated in order to ensure the continued health, safety and wellbeing of Ms X.***

10.1.9 Safeguarding Children Issues

10.1.9.1. Context

The aim of the Safeguarding of Children Policy is to ensure that children and young people are healthy, safe, enjoy life, achieve their potential, make a positive contribution to society and are well prepared to secure their economic well-being in future years. (Every Child Matters (2003); Section 11 of the Children Act 2004).

All local authorities are required to have a Local Safeguarding Children Board (LSCB), the prime objective of which is to coordinate and ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children. The Avon and Wiltshire Mental Health Partnership NHS Trust is an important member of the LSCB. It has the responsibility to assist the Local Authority in its work, to identify any children whose safety is considered to be at risk and to help assess and promote the safety of such children.

The national background to Safeguarding Policy has, since 2003, comprised the following documents and initiatives:

- Lord Laming's Report (2003, Climbié Report) provided safeguarding recommendations and influenced the subsequent developments in Safeguarding Guidance and Policy;

- *Every Child Matters* (2003), the Government's response to the Laming Report, outlined five key improvement outcomes – be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing;
- *National Service Framework for Children* (2004) included a recommendation for Care Programme Approach meetings to take account of children's needs and any risks of harm to them;
- Children Act (2004) stated that all organisations have a responsibility to prioritise safeguarding and to ensure that effective arrangements are in place;
- Working Together (2006) established a benchmark that all organisations should ensure that safeguarding arrangements are in line with national requirements.

The 2010 guidance[142] comments:
"1.11 Effective measures to safeguard children are those that also promote their welfare. They should not be seen in isolation from the wider range of support and services already provided and available to meet the needs of children and families".

The 2006 guidance, which was in force for the later part of the time Ms X was under the care of the Trust, comments:
"1.6 Shortcomings when working to safeguard and promote children's welfare were brought into the spotlight once again with the death of Victoria Climbié and the subsequent inquiry. The inquiry revealed themes identified by past inquiries that resulted in a failure to intervene early enough. These included:
poor co-ordination; a failure to share information; the absence of anyone with a strong sense of accountability; and frontline workers trying to cope with staff vacancies, poor management and a lack of effective training (Cm 5860, p.5)".

In addressing this problem the guidance emphasises the importance of shared responsibility and joint working:
"1.14 Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm – depends on effective joint working between agencies and professionals that have different roles and expertise…".

142HM Government, Department for Children, Schools, and Families (2010) *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children*

"2.1 An awareness and appreciation of the role of others is essential for effective collaboration between organisations and their practitioners…".

"2.2 …it is important to emphasise that we all share a responsibility for safeguarding and promoting the welfare of children and young people. All members of the community can help to safeguard and promote the welfare of children and young people, if they are mindful of children's needs and are willing and able to act if they have concerns about a child's welfare…".

The 2010 guidance elaborates on this:
"2.62 …Other health professionals who come into contact with children, parents and carers in the course of their work also need to be fully informed about their responsibility to safeguard and promote the welfare of children and young people. This is important as even though a health professional may not be working directly with a child, they may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child's safety and welfare…".

With respect to the responsibilities of Mental Health Services and mental health practitioners the 2006 guidance comments:
"2.92 Adult Mental Health Services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. These staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse. They should follow the child protection procedures laid down for their services within their area. Consultation, supervision and training resources should be available and accessible in each service…".

"2.94 Close collaboration and liaison between adult mental health services and children's social services are essential in the interests of children. This may require sharing information

to safeguard and promote the welfare of children or to protect a child from significant harm".

The Laming Form

Following the Climbié Report NHS Mental Health Trusts were required to record whether users of Mental Health Services had regular contact with children. This applied to:

- people on Enhanced Care Programme Approach (CPA);
- people on Standard CPA where assessment indicates a significant risk;
- anyone who is admitted to an inpatient unit;
- if a patient is regarded as a potential risk.

The form covers a wide range of potential triggers including:

  - drug/alcohol abuse;
  - domestic violence;
  - forensic history;
  - past history of severe mental illness;
  - past history of sexual/physical abuse;
  - serious self-harm attempts;
  - a child with a severe physical illness or learning disability in the family;
  - unsettled family circumstances;
  - any other circumstances where the assessing health or social care professional is concerned about the welfare of children in the family.

In order to realise the goals of promoting the wellbeing and safety of children and young people the Children Act lays specific responsibilities on the Local Authority.

"Section 10 [of the Children Act] requires each local authority to make arrangements to promote co-operation between the authority, each of the authority's relevant partners…and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section of the Children Act 2004 is the legislative basis for Children's Trust arrangements". [143]

143 HM Government, Dept for Children, Schools and Families (2006) *Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children*

"Section 11 of the Children Act 2004, section 175 of the Education Act 2002 and section 55 of the Borders, Citizens and Immigration Act 2009 places duties on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children".

"The Children Act 1989 places a duty on local authorities to promote and safeguard the welfare of children in need in their area. Section 17(1) of the Children Act 1989 states that: It shall be the general duty of every local authority:

- *to safeguard and promote the welfare of children within their area who are in need; and*
- *so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.*

Section 17(10) states that a child shall be taken to be in need if:
a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;
b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
c) he is disabled.

Section 47(1) of the Children Act 1989 states that:
Where a local authority:
a. are informed that a child who lives, or is found, in their area (i) is the subject of an emergency protection order, or (ii) is in police protection, or (iii) has contravened a ban imposed by a curfew notice imposed within the meaning of Chapter I of Part I of the Crime and Disorder Act 1998; or
b. have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm:

The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare…". [144]

Trust Safeguarding Policy

The Trust Safeguarding Children policy in force from 2006 echoed the national guidance. It states:

2.1 "Children of adults accessing Adult Psychiatric Services (including Locality, Forensic, and Specialist Drug & Alcohol Services) need to be routinely identified as part of the overall adult assessment and relevant information sought, using the relevant ICPA risk screen. This screen will include collection of information, which includes each child's name, address, age, the name of each child's primary carer, those with parental responsibility and each child's GP. For children of school age, the name of each child's school must be recorded; gaps in this information should be passed on to the relevant authority in accordance with local arrangements.

2.2 An assessment, using the Trust's ICPA and risk assessment tool, should be made of the impact of the parental mental health difficulties on the adult's ability to protect their children and to parent. In some cases, a joint assessment might be needed with the local Social Services Children and Families Team. If, as a result of the assessment, a child is thought to be vulnerable or at risk of harm, the clinician must discuss the concerns with their Line Manager or Supervisor and the relevant Safeguarding Children Lead. When appropriate, a referral should be made to the relevant Children and Families team (Social Services) and the local LSCB Child Protection Procedures followed". [145]

10.1.9.2 Findings

Internal Investigation

The Internal Investigation made no specific reference to the issue of Safeguarding Children other than the comment that the Social Worker 3 was not present at the Professionals' Meeting held on **20 August 2010**.[146]

144 HM Government, Dept for Children, Schools and Families (2006) *Working Together to safeguard Children: A guide to interagency working to safeguard and promote the welfare of children*

145 Avon and Wiltshire Mental Health Partnership NHS Trust (2006) *Safeguarding Children and Young People under 18 Years in Adult Mental Health Facilities.* Page *5*

146 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 47

Independent Investigation

The overall management of the care and treatment of Ms X did take into account the needs of her children, aged 4 and 22 months in **May 2009** when Ms X was referred to the Bristol Mental Health Services. The AWP Policy for Safeguarding Children made each Mental Health Service Team Leader the responsible member of staff for ensuring that any Safeguarding Children issues were discussed with the appropriate staff in the Bristol City Council.

When Ms X was first referred by her GP to the North Bristol Assessment Team and Doctor 1 was the Consultant, Mrs W approached them following failure of the arranged Mental Health Service to make a planned home visit on **29 May 2009**. Doctor 1 started to assess Ms X using the Trust Core Assessment Form (eCPAc+). The situation regarding Ms X's children was immediately recognised as Doctor 1 wrote on the form that at this assessment Ms X had explained to him that her only concern was to be able to find a home for herself and her two children and to look after them. He noted that Ms X did not appreciate why she was being assessed and stated that she did not think there was any need for her to be there. Mrs W thought that her daughter needed help if she was to be able to look after her children, but she herself was also ill and needed assistance to support her daughter. Ms X could not understand why her mother was worried about her.

Mrs W stated that on **24 May 2010** Ms X had left her two children at her sister's house unattended without having informed her sister they were there. Her sister was told by her neighbours that there were two young children in her garden. Her sister telephoned the Police and as a result Ms X was cautioned by them. The Bristol Children and Young People's Services also became involved. The two children were assessed as being 'Children in Need' and Ms X was warned that if any further concerns about the children were raised, or the overall situation worsened then Child Protection Procedures were likely to be invoked. Ms X and her mother had an appointment with the Bristol Children and Young People's Service to discuss the children on **1 June 2009**.

Mrs W mentioned that Ms X's son had a burn on his arm and that her daughter had said it had happened on her sister's house doorstep. Her mother had said she thought this was odd and

that Ms X had been finding it difficult to cope with her children in the recent past. Her mother had been offering considerable assistance. It was noted on the Risk Section of the eCPAc+ Form that Ms X had difficulty in controlling her temper at times and had been angry and aggressive. Doctor 1 noted on the Form that Ms X's condition could be worsened by the use of alcohol and that her symptoms of paranoia and her lack of insight into her condition meant she was not totally in control of situations without her mother's help.

The Form stated under 'Social Factors' that Ms X was homeless, had significant debts, had no employment and had conflict with her personal relationships. Doctor 1 noted that the Care Coordinator should make contact with the Children and Young People's Service and also with Mrs W.[147]

A Safeguarding Children Form CPe had been partially completed and under the Section on Parenting it had been noted that Ms X had a significant and prolonged deterioration in her ability to look after her children. It was noted that both she and another family member (her mother) had expressed concern about her ability to care for her children. It was evident that Care Coordinator 1 had contacted the Children and Young People's Service as Social Worker 1 was named on the form as were her contact details. A Children in Need Conference had been arranged for **8 July 2010** and Care Coordinator 1 was listed to attend.[148]

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

When Ms X was admitted to the Open Ward on **2 March 2010** under Section 2 of the Mental Health Act (1983 and 2007) the ward staff made contact with Social Worker 2 who explained that Ms X was not able to care for her children and that she was the aggressor in the home situation. She had been asked to move out of her mother's home and find somewhere else to live. Ms X had torn up all the official letters relating to her children and finding accommodation. Ms X was being prosecuted for not letting her five-year old daughter go to school for the previous six months. Ms X had not claimed the State Benefits to which she was

147 Clinical Records Volume 6 Pages 2056-2066
148 Clinical Records Volume 6 Pages 2069-2072

entitled and had been accused by her mother of having taken £1,000 from her bank account. When faced with these facts by staff Ms X became violent and had to be forcibly restrained and was transferred to the High Dependency Unit.[149] (This was the only record of violent behaviour by Ms X when an inpatient). Supervised visits by Ms X's children were held on the Open Ward when Ms X's mother brought them to see their mother. Ward staff and the Care Coordinator maintained communication with the Children and Young People's Service.[150]

The Professional Meeting on **14 June 2010** was attended by the Clinical Team, four representatives from the Bristol Child and Family Support Team and Psychologist 1 representing Care Coordinator 2 who was unable to attend. Doctor 2 confirmed that Ms X's diagnosis was Borderline Personality Disorder. Mrs W was informed that her daughter could not be detained in hospital for this condition. Concerns were raised at the meeting about the possibility of Ms X making contact with her children and absconding with them once her Section 3 Mental Health Act 2007 was rescinded. Care Coordinator 3 was to be asked to produce a Recovery Plan for Ms X.[151]

Care Coordinator 3 maintained close communication with Social Worker 3 from the Child and Family Support team during the period when Ms X was absconding frequently from hospital, as it was recognised that she often went to her mother's address where her children were. This was in breach of the arrangements Ms X had with the Children and Young People's Service as an Exclusion Order had been put in place.

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

149 Clinical Records Volume 3 File 2 Pages 1124 - 1125
150 Clinical Records Volume 3 File 2 Page 1144
151 Clinical Records Volume 4 Pages 1673 - 1675

10.1.9.3. Conclusions

The Independent Investigation Team concluded that on the whole the requirements of the Safeguarding Children Policy both nationally and locally were adhered to by the Avon and Wiltshire Mental Health Partnership NHS Trust. Mental Health staff acted appropriately and were in frequent contact with the Children and Young People's Service. The Senior Support Worker from the Housing Association also had contact with Social Worker 3 to confirm that Ms X was not making use of the support available at her flat, and that her accommodation was in jeopardy because she was breaking the rules and regulations of the tenancy and had also done nothing to secure funding to pay the rent.

However the two children were in danger of Ms X acting on impulse to go to her mother's home and abduct them. The Risk Management Plan did not rate this as a high risk. There was evidence that this could happen given the pattern of Ms X's absconding from the Open Ward and the High Dependency Unit prior to her discharge to the Housing Association property. Given the potential seriousness of this situation there should have been a clear contingency plan in place.

The agencies worked well together to try to provide Ms X with the support she and her children needed. Unfortunately Ms X did not acknowledge her need for support and avoided engaging with those agencies who were in a position to help her.

- ***Service Issue 6: when service users are difficult to engage and act in a highly impulsive manner there are often additional risks presented to the safety of children. In the case of Ms X these risks were not always highlighted as a priority and this represents a significant omission in the way child safeguarding was managed.***

10.1.10 Vulnerable Adult Processes

10.1.10.1. Context

National

Safeguarding Adults is a responsibility placed on social care through the *No Secrets* guidance which is issued under Section 7 of the Local Authority and Social Services Act 1970.

Through this legislation, statutory social care organisations have a duty of partnership to work with other statutory bodies to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice.

The *No Secrets* statutory guidance was developed in response to several serious incidents, and states that: [152]

"The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety". (Paragraph 1.2)

This document was supported by a further document produced by the Association of Directors of Social Services which describes a framework for good practice and outcomes in adult protection.[153]

By 2008, based on the content of both of these documents, Local Authorities would have been expected to have had a Safeguarding Board/Committee and a safeguarding framework/procedure in place. Social care staff would be expected to be trained in this area of work and to be familiar with adult safeguarding policies and procedures and should have been clear as to how to respond to issues as they arose.

There was a clear expectation from the Department of Health that *No Secrets* would apply to all statutory agencies, however this is statutory *guidance*; it therefore took some time before it was fully implemented in the NHS.

In October 2008, the Department of Health carried out a large national consultation on the *No Secrets* guidance.[154] The aim of this consultation was to understand how far *No Secrets* had progressed across agencies and to find out how it could be improved. Over 12,000 people

152. Department of Health (2000) No secrets: *Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse,* DH, London

153.Association of Directors of Social Services (2005) Safeguarding Adults *A National Framework of Standards for Good practice and outcomes in adult protection work,* ADSS, London

154. Department of Health (2008) *Safeguarding Adult', the review of the No secrets guidance,* DH, London

took part in the consultation including 3,000 citizens. There were around 500 responses in total but only 67 of these were from NHS organisations.

One of the key findings was the absence of adult safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns are considered in the wider safeguarding arena. In response, the Department of Health published a document which tied existing systems of Clinical Governance into adult safeguarding in order to clarify responsibilities and expectations of NHS staff in relation to this issue. [155]

The Department also funded an adult safeguarding campaign, run by the Nursing and Midwifery Council in 2010, to raise awareness of adult safeguarding amongst nurses and midwives.

It would therefore not have been common practice for health staff to have been fully aware of, and using, adult safeguarding procedures in 2008/09.

At the current time GPs are not yet engaged nationally with adult safeguarding. Recently, the British Medical Association published a toolkit to support Practices in dealing with this issue but, as yet, it has not been implemented in the majority of Practices.[156]

Safeguarding Process

When safeguarding is working effectively the following things are in place:

- all staff have a basic understanding of safeguarding and can make a prompt referral to the right place in order to elicit a response;
- staff who deal directly with safeguarding will pick up the referral and respond to it (within a short agreed timescale e.g. 24 hours) in order to ensure the safety of the individual;
- immediate action/referral to the Police if necessary should take place when a crime has been committed. The Police may well lead the process if this is required;
- a strategy planning meeting will be called involving all those who have knowledge of the case to agree what is known and what further investigation should happen (this

155. Department of Health (2010) Clinical Governance and Adult Safeguarding *An integrated approach* DH, London
156. British Medical Association (2011) Safeguarding Vulnerable Adults *A Toolkit for General Practitioners,* BMA London

would usually happen within seven days) and a protection plan should be put in place, after discussion with the individual;

- investigation should occur;
- Case Conferences will take place at specific intervals both to hear the outcomes of the investigation and to monitor the protection plan. Again the views of the individual should be sought throughout the process;
- the case should be closed once the issue had been resolved and ongoing safety assured.

The Avon and Wiltshire Mental Health Partnership NHS Trust Policy to Safeguard Adults

The Trust Policy to Safeguard Adults was ratified by the Trust Board on 26 November 2008 and follows the National Guidelines and states that the aim of the Policy is to:
"assist staff in effectively meeting their statutory duty to protect and safeguard adults (particularly those who are vulnerable) from the age of eighteen years old onwards.

It is intended to complement the local multi agency safeguarding adult policies and procedures throughout the Trust, by defining the Trusts internal arrangements for Safeguarding Adults, informing staff of the general principles to safeguard adults and effectively signposting staff into their local procedures to safeguard adults and to access local contacts and leads. The policy describes the support, advice, policies, and guidance available to staff, both internally and externally, in the effective safeguarding of children within their practice". [157]

The Trust Policy applies to all staff including volunteers and temporary staff and states that:
"the purpose of safeguarding adults is to prevent, detect and manage the risk of abuse or neglect of an adult, particularly where there is an increased level of vulnerability (either permanent or transitory".

"Abuse is a violation of an individual's human and civil rights by any other person or persons." ('No secrets' Department of Health 2000) Abuse can be a single act or repeated acts.

157 Trust Policy to Safeguard Adults Page 3

"Types of abuse include:
Physical *– including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.*

Sexual *– including rape, sexual assault, sexual acts carried out without the consent of the individual or where the individual was pressured into consenting.*

Psychological *– including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation, or withdrawal from services or supportive networks.*

Financial or material *– including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.*

Neglect and acts of omission *– including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, withholding of the necessities of life, such as medication, adequate nutrition and heating.*

Discriminatory abuse *– including racist, sexist, that based on a person's impairment, and other forms of harassment, slurs, or similar treatment.*

Institutional abuse *– can include any of the above and is characterised by repeated instances of poor care, sometimes intentional, but often unintentional and resulting from a lack of knowledge".*[158]

The Trust Policy continues to explain how Trust staff should seek advice and assistance and what should be reported and to whom. Team Managers are the designated staff members responsible for ensuring vulnerable adults are identified and are protected via the use of the Policy. It states:
"When an adult protection concern or issue is identified, staff or volunteers can contact the Trust Public Protection and Safeguarding Team to discuss their concern(s) and seek advice

158 Trust Policy to Protect Adults Page 4

on the protection of the person(s) concerned and/or on the need to make a referral under local Safeguarding Adults procedures. They can also seek advice and support within their general clinical, practice or supervision arrangements.

When staff make a referral, this must be reported to the Trust, by submitting an AWP PPS reporting form to the PPS Team and a copy of the referral. Any concern or referral should be recorded in the health and social care record, and flagged as a risk on MHIS.
All Trust staff, including medical staff, and volunteers must undertake the relevant statutory and/or mandatory Safeguarding Adult training and update training relevant for their post, as identified at induction and appraisal.

AWP Staff must recognise that many service users of secondary mental health services will have a significant level of vulnerability, which must be identified and managed within their Personal Recovery and plans. Where they discover or have information disclosed about alleged abuse and/or neglect, they must additionally contact/refer under the local multi-agency safeguarding adult procedures".[159]

10.1.10.2. Findings

Internal Investigation

The Internal Investigation considered that Ms X was a vulnerable adult and should have been referred to the appropriate local authority. The Internal Investigation stated that:
"… [Ms X] had a long history of sexual vulnerability and of moving quickly into sexual relationships, often with short term partners that physically, emotionally and possibly sexually abused her. She had been in a number of shelters due to domestic abuse from partners. There were a number of points on her care pathway where she would clearly have met the criteria for a referral into safeguarding adult procedures, on the grounds that:

- *she was a vulnerable adult, and in receipt of community care*
  And
- *she had been subject to abuse".* [160]

The Independent Investigation concurs with this finding and enlarges upon it in this Section of the Report.

159 Trust Policy to Protect Adults Page 6
160 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 46

Independent Investigation

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

Ms X had what can only be described as a very poor childhood having described herself as *"having never been happy"* during a meeting with the Child and Adolescent Mental Health Service (CAMHS) in 1998.[161] A list taken from her Primary Care (GP) file provides a graphic picture of her disturbed and disrupted childhood.

Table 4: List of Incidents Indicating Vulnerability

Date	Incident
02/11/1977	Para-suicide
07/11/1977	Para-suicide
07/01/1998	Referral to CAMHS as Ms X being bullied at school and in home neighbourhood so she hardly ever ventured out. Worried about her mother's new partner as they are constantly arguing. Told GP she felt like running away and he felt she was at *"some considerable risk of self harm."*
20/01/1998	School refusal for being bullied and molested by boys. When reported at school the same boys did it near her home on one of the local greens and Ms X was scared to go out alone. Presented as extremely unhappy and angry with her mother.
30/01/1998	Psychological problems. Entry states – "*[Ms X] flipped last night and became hysterical after subject of returning to school was brought up after [her return from] visit to her father in Cardiff. Has not attended [school] for few months due to bullying. Says [she is] very unhappy at home for last year since arrival of mum's new partner – frequent rows, also gets thrown around by him at times when he loses his temper on account of her behaviour, mum also slapped and pulled her hair during confrontations, wants to leave home but doesn't know where to go, tried living with dad for 6 weeks but [did] not work out.* *Reluctant to talk at first, kept shrugging her shoulders, lost temper again and walked out when mum came in to put her side of the story. Been offered family therapy on w/1.* *Ms X told the situation is not going to improve while she lives at home. She needs space and time to sort herself out. Advised her to contact SW re alternative accommodation and to keep appointment with the local Hospital".*

161 GP Records Page 86

Date	Incident
14/08/1998	Referred for Family Therapy. Had one family session and then five individual sessions with a therapist. The issues identified were: • her schooling; • having no confidence to go out on her own; • wants to know more about her Moroccan father; • relationships at home – arguments and rows; • being bullied and abused by boys on local green (same as those bullying her at school). This was mentioned to Social Services by the therapist.
05/09/1999	Para-suicide
30/11/2000	Termination of Pregnancy – due to anencephaly. This led to depression and grief therapy
11/05/2001	Parental concern about Ms X
29/07/2002	Senior Support 1 at the Housing Association wrote to GP about Ms X seeking information about her mental health issues.
08/01/2003	Depressive episode.
20/12/2004	Post-natal depression following the birth of her son – had been admitted to mental health unit at the local Hospital.
07/04/2005 03/05/2005 15/06/2005 24/06/2005	Worked with health visitor due to depression, stress and considered to be at risk of self-harm. ***Throughout 2005/2006 there were on-going concerns about child protection issues due to domestic violence in the family. The major incidents in the GP Records were:*** • domestic violence and a family support worker was provided; • multi-disciplinary Case Conference Child Protection; • Child Protection concerns over the level of domestic violence
14/12/2006	Ms X saw a GP in Newcastle-under-Lyme as she was depressed and was living in a Women's Refuge there. Also referred to the local Mental Health Services because of her depression.
20/03/2009	Overdose Paracetamol.

It is clear from the above Table 4 that Ms X had suffered a great deal during her childhood and adolescence. When she was referred to the Mental Health Services in **May 2009** she already had a long history of abuse, violent relationships, stormy relationships with her family and many moves and breakdowns in accommodation and in relationships with partners. She had been abused physically, sexually and emotionally both within the family

and in relationships outside the family. This vulnerability remained throughout the time she was with the Mental Health Services from **29 May 2009** to **7 October 2010**.

Safeguarding Adults

The Core Assessment undertaken by Doctor 1 was prophetic in that he had stated that *"It does sound like you have had some quite longstanding difficulties over several years and how you feel about yourself, manifested by having low self-esteem and harming yourself. There also does however seem to be periods where you become very frightened and paranoid. The history from your mum was that this has got worse recently and you dream of frightening things about people were try [sic] to harm you. It does appear that this is having an effect on how you cope in your life and very importantly, how you are able to be with your children and your family. I think it is important that you do accept the treatment offered otherwise I think it is going to have repercussions for relationships with your family, your children and your own wellbeing".* [162]

The period during which Ms X was in the care of the Avon and Wiltshire Mental Health Partnership NHS Trust will now be examined for evidence to determine whether Ms X was a vulnerable adult and as such should have been referred to the appropriate Local Authority, or to demonstrate that she did not meet this threshold.

Ms X was admitted to the Open Ward on **10 June 2009** and within less than 24 hours she had begged to be allowed home and had tried to abscond. She refused to take her prescribed medication and appeared to have no insight into her mental ill health.[163] She was discharged on **17 June 2009** and referred back to the CRHTT. A Care Planning Meeting was held on the Open Ward on **22 June 2009** which identified that she said she was taking her medication although her mother, Mrs W, was not sure as she had not seen much difference in Ms X's behaviour since she had been at home although her appetite had been better. Ms X displayed some hostility towards her mother and stated that what she wanted was to:

- have her house back;
- get back into music;
- look after people;

162 Clinical Records Volume 6 Pages 2058-2066
163 Clinical Records Volume 1 File 2 Pages 340-384

- feel that people were listening to her as she currently had the opinion that they were not paying her attention.

The accommodation Ms X and her two children had in her mother's four-bedroomed house was extremely cramped as there were nine people living there. The relationships within the house were tense and Ms X wanted to have a house of her own in which to bring up her children.

On **10 June 2009** Ms X was admitted to the Open Ward and was placed under Section 2 of the MHA on **12 June 2009**. She was quickly discharged without a comprehensive assessment having taken place. Ms X was returned to hospital on **21 July 2009** under Section 2 of the MHA. She had not taken her medication during her time in the community. Ms X had not used the opportunity to work with the ward staff during her stay on the Open Ward and the High Dependency Unit as she had generally been non-compliant with leave and had not engaged with ward staff in meaningful discussions. She was discharged on **17 August 2009**. She returned to the overcrowded accommodation with her mother.

Whilst in the community, support was provided by the EIT but Ms X had used alcohol and crack and had not engaged with the EIT. On **28 September 2009** Ms X removed her daughter from school and also assaulted her sister and was subsequently detained in the Open Ward under Section 2 of the MHA. She was discharged on **5 October 2009** with the Section 2 rescinded meaning another opportunity to fully assess her whilst under the Section 2 had been missed. On this occasion Ms X was discharged and did not have follow-up from the EIT as she was considered not to have displayed any symptoms of psychosis.

Ms X was again admitted to the local Hospital on **2 March 2010** under Section 2 of the Mental Health Act and felt that she had been set up by her family. She was living with her mother but had recently started seeing a boyfriend. She reported that her younger sister had talked about her mental health issues to her boyfriend on Facebook. The initial impression given was that Ms X had psycho-social issues, a difficult family situation and did not display psychosis on the ward.[164]

164 Clinical Records Volume 3 File 2 Page 1121

The ward staff made contact with Social Worker 2 who explained that Ms X was not able to care for her children and that she was the aggressor in the home situation. She had been asked to move out of her mother's home and find somewhere else to live. Ms X had torn up all the official letters regarding her children and finding accommodation. Ms X was being prosecuted for not letting her five year old daughter go to school for the past six months. Ms X had not claimed the State Benefits to which she was entitled and had been accused by her mother of having taken £1,000 from her bank account. When faced with these facts by staff Ms X became violent and had to be forcibly restrained and was transferred to the High Dependency Unit where she was given Lorazepam 2mg, Haloperidol 5mg and Procyclidine 5mg by the Control and Restraint Team.[165]

On **4 March 2010** Ms X was interviewed by a member of staff from Link House which provided accommodation for homeless people. Ms X was no longer able to live at the same address as her children with whom she could only have supervised access. Ms X was offered a place at Link House and was therefore discharged from the ward to Link House. On the way there she left the car and asked a stranger if she could use his toilet as she was pregnant and then refused to leave his house. The Police were called and arrested Ms X and she was returned to the Open Ward under a Section 136 of the MHA and later placed on Section 3 which allowed detention and treatment.

As described in the Chronology and in Section 5 'Risk Assessment' Ms X absconded from both the Open Ward, the High Dependency Unit and from leave no less than 16 times. During much of this period Ms X was determined to get pregnant by any male she could find. She took drugs and alcohol whilst on leave and whilst absent without leave and deliberately placed herself in dangerous and vulnerable situations, as the alleged rape by Mr Y demonstrated once she had been discharged.

Ms X was discharged from the Open Ward on **6 July 2010** and went to accommodation provided by a Housing Association for women with mental illness. The Section 3 MHA was rescinded when Ms X was discharged which had the effect of not being able to recall her back to hospital should she become unwell in the future. The discharge to the Housing Association accommodation was a positive move but the terms and conditions of the tenancy

165 Clinical Records Volume 3 File 2 Pages 1124 - 1125

made it apparent that Ms X would not manage to obey them for long. She would not be able to have males in her flat, not to have alcohol or drugs on the premises and had to make arrangements to fund the rent by working with Senior Support Worker 1.

Ms X made it clear as soon as she was discharged from the Open Ward that she would not take her medication and did not want to be involved with the Mental Health Services and missed most of the meetings which were arranged. On **1 October 2010** Ms X was evicted from her Housing Association flat after two warnings and being found with a man in her flat, evidence of drug use and a damaged glass panelled door. Unfortunately the Mental Health Services did not receive notice of this until four days later. On being evicted Ms X refused help with going to the HUB, and left most of her belongings in the flat. She therefore became homeless.

The Risk Assessment and Risk Management Section of the Care Programme Approach Plan made on **21 June 2010** stated that the risks surrounding Ms X were described as being:

- complete disengagement from all services;
- deliberate self-harm;
- readmission to hospital;
- losing contact with her children.

Ms X did not accept any of these risks and thought all would be well in the future. She said she would borrow other people's sofas and floors and all would be well. Ms X was transferred to the Open Ward.[166]

On **7 October 2010** Social Worker 3 told Care Coordinator 3 that Ms X had made two allegations against her boyfriend Mr Z, saying he had hit her with a rolling pin and had also burnt her arm with a hot iron. It was also reported that Ms X was in a Women's Refuge in Bath and that she had missed seven out of nine arranged supervised visits to see her children.

10.1.10.3. Conclusions

In the National Guidance and the Trust Policy to protect adults from abuse several different kinds of abuse are listed. The form is provided in Table 5 below.

166 Clinical Records Volume 4 Pages 1696 - 1711

Table 5: The Abuse Ms X Experienced

Form of Abuse	Details of the Abuse	Was Ms X Safeguarded?
Physical Abuse	• Allegation of abuse by Mr Z with rolling pin and hot iron • Having been resident in Women's Refuges in Birmingham, Newcastle-under-Lyme and Bath	No
Sexual Abuse	• The seeking of men. Whilst deliberate, Ms X may not have foreseen the risks	No
Psychological Abuse	None	
Financial/Material Abuse	• Did not apply for benefits to which she was entitled. • No attempt to fund her a placement with Homeless Accommodation via HUB	No – Section 117 No – Section 117
Neglect/Omission	Her own neglect to accept she had any mental health issues and her refusal to take medication and to work with staff to help her gain benefits	No
Discriminatory Abuse	None	
Institutional Abuse	None	

From Table 5 above it can be seen that had Ms X been regarded as a Vulnerable Adult some protection could have been offered to her. At the very least a referral could have been made and giving the items listed in the Table a strategic conference would in all probability have been called to examine her needs in full and decide how they could possibly be met.

Looking at the vulnerability Ms X exhibited the main issues were:

- she lacked insight and understanding of her illness and her apparent inability to 'think things through' before acting and not anticipating the likely outcome, for example disregarding all letters and forms regarding benefits, the care of her children and the funding of the Housing Association Flat;
- as she considered she did not have a mental illness Ms X did not want to take medication;
- her getting out of the car on the way to Link House where she would have had supported accommodation for people who had been a victim of domestic violence.

The Independent Investigation Team concluded that Ms X could have been offered a better service regarding her status as a Vulnerable Adult and that she should have been referred to the appropriate Local Authority for an assessment and a strategic conference to identify how she could be helped. Given her life experience to 2010 the reasons for her vulnerability were there for all to see.

The Independent Investigation Team considered Ms X to be a vulnerable adult. She had had a disturbed and disrupted childhood which may have predisposed her to have difficulties in her adult life. During her five stays in hospital she absconded 16 times; she often went out at night seeking a partner with whom to have casual sex in order to become pregnant; she did not believe that she had a mental illness; she did not recognise the risks the EIT identified; she was satisfied to 'seek floors or sofas' for the night; she had a history of entering into abusive relationships and she refused to accept help or support from any agency.

Ms X's impulsiveness and unpredictability together with her Borderline Personality Disorder (Emotionally Unstable Personality Disorder) made her extremely vulnerable and the AWP Policy should have been brought into action. This would almost certainly have triggered a Strategy Meeting where all agencies having contact or knowledge of Ms X would have met to reconsider her vulnerability and what actions they might together take to lessen the dangers she faced.

Contributory Factor 5: Ms X clearly met the local criteria to be identified as a Vulnerable Adult. While there was generally good communication between agencies the local adult safeguarding protocols were not called into play and as a result Ms X's vulnerability was not reviewed under the auspices of these protocols and no agreed multi-agency approach was put in place. This was a missed opportunity.

The Independent Investigation Team noted during the interviews with staff that the Trust now has a Public Protection Team with a lead for safeguarding children and a lead for safeguarding adults which staff can telephone to get advice and to discuss whether their situation warrants referral.

10.1.11. Clinical Supervision

10.1.11.1. Context

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations[167] which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.

The NHS Management Executive defined clinical supervision in 1993 as:
"…a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations"[168]

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990s.

Trust Clinical Supervision Policy

The Avon and Wiltshire Mental Health Partnership NHS Trust 'Staff Supervision Policy' has the purpose of maintaining and reinforcing effective management practice. It states that:
"AWP believes that management supervision and the other types of supervision described in this policy are integral to effective management practice, improved service user experiences and the delivery of a safe and high quality service that meets national, multi agency and Trust standards. The links between effective management practice and service user outcomes are well documented and as a result the Trust is committed to ensuring that all staff receive supervision as part of routine working practice".[169]

The Policy describes three forms of supervision, Management, Caseload and Clinical. The latter is described as being:

167 Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses
168 Nursing and Midwifery Council, Advice Sheet C. (2006)
169 AWP Policy for Staff Supervision Page 5

*"a) **A formative function** – that is the educational process of developing skills and abilities. It encourages reflection, self awareness, appreciation of one's own actions and examination of interventions and outcomes.*
*b) **A restorative function** – this is the supportive process of helping those who work with stress and distress.*
*c) **A normative function** – this is the quality control process which encourages awareness and identification of blind spots, prejudices, and areas of vulnerability.*

It is widely recognised that there may be a relationship between clinical supervision and managerial functions. These responsibilities may be vested in one person or they may be separated. Clinical supervision performs a different function from management supervision, and therefore should not be used for matters relating to such matters as terms and conditions, performance or achievement of objectives.

It is recommended that all staff should have the opportunity to select their supervisor, who may not necessarily be their line manager or from the same professional discipline. However, individual practitioners should discuss and agree their choice of supervisor with their line manager. For some disciplines there is a professional requirement for at least one form of supervision to be provided by someone of the same professional background. Where the supervisor is of a different professional discipline from the supervisee, the supervisor must ensure that they are familiar with and clearly understand the Professional Code that the supervisee must abide by".[170]

"Clinical supervision may be undertaken in a variety of ways including;
*a) **One to One Supervision.***
*b) **One to One Peer Supervision** – with a person of similar clinical competence and expertise.*
*c) **Group Supervision** – with people from within a multi-disciplinary team. This may be facilitated by an external supervisor or by the group itself.*
*d) **Peer Group Supervision**- with peers of similar clinical competence and expertise.*
*e) **External Supervision**- with a supervisor who is not employed within the organisation. This may be necessary in particular instances where the supervisee is carrying out very*

170 AWP Policy for Staff Supervision Page 7

specialised work, and there is not the relevant expertise within the organisation to provide appropriate supervision.

f) ***Internal Specialist Supervision*** *– relating to a particular client group or set of interventions, carried out with a relevant Trust expert".*[171]

10.1.11.2. Findings

Internal Investigation

The Internal Investigation did not specifically address this issue but it did highlight the lack of a Consultant Psychiatrist within the EIT.

Independent Investigation

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

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

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

171 AWP Policy for Staff Supervision Page 8

In situations where the wider needs of the service user involved housing or social care issues other specialist workers within the Team would meet with the service user and work with them within the overall agreed Care Plan.

The clinical risk assessment and management process was that as used within the CPA process. All clients had to have a 'risk screen' and also every service user would have a risk management plan, and any issues from those would be discussed in supervision or earlier if urgent. The Risk Screen in place in 2009/2010 was a two-step approach process which activated a more detailed risk assessment should there be positive risk factors. The system has since been replaced by the RiO Electronic Record.

Service users were graded with the 'traffic light' risk system whereby they were graded red, amber or green to indicated the level of risk they were assessed as presenting. Team Meetings discussed new referrals, assessments and those service users graded a 'red'. These would include people who had just come out of hospital and those who were in hospital. There were also fortnightly 'Cluster Meetings' which were broadly Bristol-based, at which staff would discuss those service users in the amber and green zones within a multi-disciplinary group to ensure there was a plan to achieve team ownership of the caseload. The aim was that the practitioners within the Team, the Care Coordinators and mental health workers, met to discuss the caseload of the team and make suggestions about the way forward with service users.

In addition there was a monthly Team Formulation Supervision which was run by Psychologist 1. This involved sharing ideas and contributing to formulating what a service user's needs were and how they could be best met. External supervision of a case was available in order to consider different approaches. There was also family work supervision with an external consultant nurse.

10.1.11.3. Conclusion

Clinical Supervision was being carried out in concordance with the Avon and Wiltshire Mental Health Partnership NHS Trust Policy. The staff had their regular monthly management supervision and also their clinical supervision from an appropriate clinician from their profession. There were in addition team supervision and discussion days, and

additional external or internally facilitated meetings to cover any specific issues affecting the Team.

10.1.12. Adherence to Local and National Policy and Procedure

10.1.12.1. Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[172] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

172 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) P 328

10.1.12.2. Findings

Internal Investigation

The Internal Investigation did not comment specifically on this.

Independent Investigation

Quality of Local Policies and Procedures

The quality of the Avon and Wiltshire Mental Health Partnership NHS Trust's policies and procedures was good. They followed a standard format, with an introduction which briefly described the history of the relevant National Policies and then incorporated these within the Trust Policy. The Policies were well written and easy to follow with easy to understand flow charts where appropriate in Safeguarding Children and the Safeguarding Vulnerable Adults Policies.

Non-Adherence Issues

Internal Investigation

The Internal Investigation commented on the lack of a Consultant Psychiatrist in the Bristol EIT. It stated that: *"The lack of a dedicated psychiatrist in the team had a number of effects on the Care Pathway for [Ms X]. EIS Team members found it difficult to schedule professionals' meetings, an example being that the meeting planned for early September was actually not going to happen until 21 October 2010, as the meeting was subject to supporting medical consultants' availability".* [173]

The Internal Investigation also made comments about Safeguarding Vulnerable Adults, the use of the Mental Health Act 2007, and the lack of a clear and achievable Crisis and Contingency Plan. These comments have been included in the relevant areas of this Section of the Report.

Independent Investigation

Dedicated Consultant Sessions in the six Early Intervention Service Teams in the Trust

There were some non-adherence issues relating to the EIT. The most serious being the lack of a dedicated 0.5 whole time equivalent Consultant Psychiatrist for the Early Intervention Service (EIT) in Bristol at the time of the incident as stipulated in the Policy Implementation

173 Internal Investigation (Root Cause Analysis Report; 01 February 2011) Page 48

Guidance for Early Intervention Teams.[174]. Following the Internal Investigation into the Care and Treatment of Ms X, Mr Z and Mr Y the Bristol EIT now has a 0.5 whole time equivalent dedicated Consultant Psychiatrist as does the Bath EIT. Two of the remaining four EITs have a very small allocation of consultant psychiatrist time and two have no dedicated time. This is a serious situation as the lack of such a dedicated resource was a contributory factor to the, at times, less than optimal management of Ms X's mental health.

Safeguarding Adults Policy (AWP Policy to Protect Adults)

The Policy contained the national overview and then gave a good local statement about the potential forms of abuse to which vulnerable adults might be susceptible. The Policy was appropriate and fit for purpose but unfortunately the staff working with Ms X did not really see her as a vulnerable adult, but tended to concentrate more on her risks to herself and to her children.

The Independent Investigation Team considered Ms X to be a vulnerable adult. She had experienced a disturbed and disrupted childhood which included emotional, physical and sexual abuse which could predispose her to be a vulnerable adult. During her five stays in hospital she absconded 16 times; she often went out at night seeking a partner with whom to have casual sex in order to become pregnant; she did not believe that she had a mental illness; did not recognise the risks the EIT identified; she was satisfied to 'seek floors or sofas' for the night; she had a history of entering into abusive relationships and she refused to accept help or support from any agency

Ms X's impulsiveness and unpredictability together with her Borderline Personality Disorder (Emotionally Unstable Personality Disorder) made her extremely vulnerable and the AWP Policy should have been activated by the EIT. This would almost certainly have triggered a Strategy Meeting where all agencies having contact or knowledge of Ms X would have met to examine and consider her vulnerability and what actions they might together take to lessen the dangers she faced. Staff knew of her history and that she had used several Women's Refuges in Bristol, Birmingham, Newcastle-under-Lyme and as recently as **7 October 2010** in Bath following two allegations of physical abuse against Mr Z. The Independent Investigation Team does accept that the EIT did not know where she was in **October 2010**

174 The Mental Health Policy Implementation Guide: Department of Health 2001 Page 46.

but they did know her very abused history as a child, by her family as an adolescent and alleged violence as an adult.

The lack of a clear and achievable Crisis and Contingency Plan

Ms X was evicted from the Housing Association Supported Flat. The Independent Investigation Team considered the Care Plan to be too optimistic for Ms X to comply with given the terms and conditions of her tenancy with the Housing Association: the no alcohol or drugs on the premises, the no male friends visiting and staying in the accommodation and the need to work with the Senior Support Worker to arrange finance for the rent all pointed to Ms X failing to comply and having to leave the accommodation.

The Discharge Policy says that everyone must have a Care Plan and a Crisis and Contingency Plan at the point of discharge. This should address identified needs and risks. Even if it is not stated it is assumed that the plan must be deliverable. The EIT did not meet the requirements of this Policy as they did not have a Crisis and Contingency Plan, and the Care Plan with which Ms X was required to comply with was optimistic given her history of non-engagement.

Adherence to National Best Practice Guidelines

The Care Programme Approach Policy, as included within the AWP Policy to Manage Pathways and Risk, was in line with the National Policy. The Risk Assessment was undertaken but tended to be a chronological list of previous risks without there being very much discussion of how these might realistically be avoided or managed. It was a good policy but was not adhered to by the EIT.

The Risk Management element of the Care Programme Approach was not in line with National Best Practice as it did not fully examine the risks, nor consistently look wider than the risks Ms X presented to herself. The risk of her absconding and abducting her two children from her mother's home was not fully considered, nor were, as stated above, the risks associated with being a vulnerable adult.

10.1.12.3. Conclusions

Local Policies and Procedures

Local Policies and Procedures were generally well adhered to and the Policies had a section which stipulated the National Policy and its requirements. There were a few exceptions which were discussed above, namely:

- dedicated Consultant Sessions in the six Early Intervention Service Teams in the Trust;
- the Safeguarding Adults Policy (AWP Policy to Protect Adults);
- the Mental Health Act (1983 and 2007) in that Section 117 was not used fully on discharge to afford Ms X additional safeguards *via* the Clinical Team being able to recall her to hospital and use funding to improve her discharge plan;
- the lack of a clear and achievable Crisis and Contingency Plan.

There was a lack of a robust Risk Management process where all the risks identified were discussed with a clear plan for their management. The examination of risk did not go far enough and tended not to include the risk of her absconding and then abducting her children.

Adherence to National Best Practice Guidelines

In all other respects from the evidence the Independent Investigation Team examined the overall adherence to National Practice and Guidelines was good.

10.1.13. Clinical Governance and Performance

10.1.13.1. Context

"Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish".[175]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and

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

compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

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

The Care Quality Commission (CQC) is the health and social care regulator for England. The vision of the Care Quality Commission is to *"... make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere".*

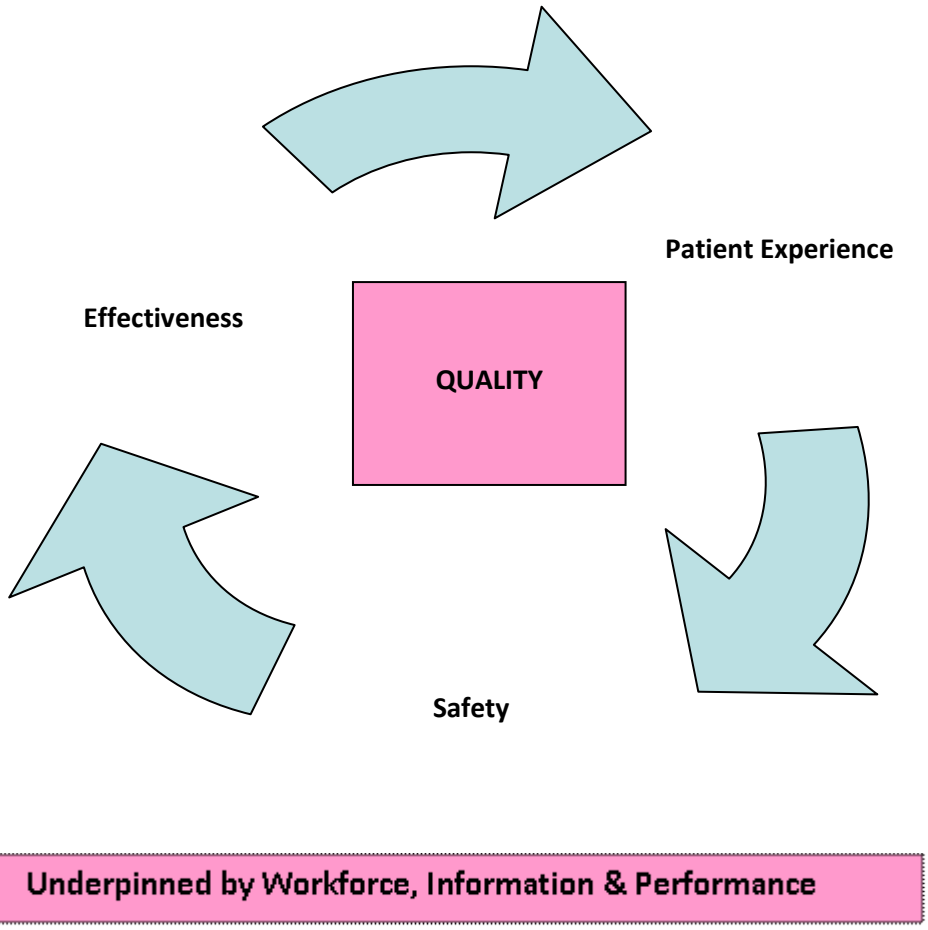
The Avon and Wiltshire Mental Health Partnership NHS Trust was registered without condition by the CQC in April 2010. Subsequently the 18 locations from which the Trust delivers its services were reviewed against the CQC's 21 essential care standards. It would be inappropriate to report the details of these reviews here and the reader is asked consult the Care Quality Commission website for more information. The CQC employs a four point scale to evaluate the care provided by Trusts: compliant, minor concerns, moderate concerns and major concerns. It was the judgement of the CQC that the Trust was compliant in most of its sites on most of the standards. In its overall review of the Trust the CQC noted minor concerns in relation to three standards: supporting workers, assessing and monitoring the quality of the service provided and record keeping. A moderate concern was identified against the standard: care and welfare of the people who use the service. It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr Y. The issues that have been set out below are those which have relevance to the care and treatment that Ms X received.

10.1.13.2 Findings

10.1.13.2.1. Clinical Governance Systems and Performance

In 2010 the Avon and Wiltshire Mental Health Partnership NHS Trust put in place a five-year strategy for improving clinical quality. This is based on the integration of three core areas of quality improvement: patient experience, effectiveness and safety. Quality improvement is defined in this strategy document as the combined and continuous process of making the

changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning). The relationship between these elements is illustrated in the diagram below.



The strategy identifies the following areas which underpin the quality improvement strategy:

- quality metrics that will enable the measurement of quality across the whole spectrum of care;
- the implementation of best practice;
- regular clinical auditing and performance monitoring against national and local standards;
- the identification of ways for service users and carers to receive more personalised care;
- the provision of information on the accessibility and quality of services;
- the delivery of services in a safe environment;

- improving feedback from service users and carers and using that feedback to drive quality improvement;
- staffing, training, support and appraisal and continuous professional development.

The Quality Improvement Strategy is complemented and supported by a number of other strategies and policies including:

- Clinical Audit Strategy;
- Risk Management Strategy;
- Community Engagement and Involvement Strategy;
- Strategic Framework for Improving the Patient Experience;
- Performance Management Framework;
- Financial Strategy;
- Information and Data Quality Management Strategy.

The strategy recognises the importance of clinicians and practitioners in improving the quality of clinical care. It recognises that clinicians and practitioners should:

- fully engage with the Trust Clinical Governance arrangements;
- influence service modernisation and redesign;
- be able to reflect on their practice and actively contribute to quality improvement;
- have access to a full range of educational, training and continuous personal and professional development opportunities.

Engagement with clinical governance arrangements:

Each Strategic Business Unit (SBU) has an Integrated Governance Group led by the Clinical Director and clinicians are involved in local integrated governance activities and reviews.

The Trust Professional Council, Trust Medical Advisory Group and Trust Nursing Advisory Group are forums that enable clinicians and practitioners to provide professional scrutiny and advice on best practice, clinical effectiveness and service improvement. They also provide support to clinicians.

Service modernisation and redesign:

To ensure clinical involvement and influence in service redesign the Trust has established Clinical Reference Groups and a Practitioners for Change Forum. These groups enable structured and timely engagement and influence in the modernisation and service redesign process.

Reflecting on practice and contributing to quality improvement:

The Trust approach to quality improvement has led to a number of initiatives:

- the Productive Ward/Team Programme enables nurses and practitioners to spend more time on clinical engagement and patient care;
- the Manchester Patient Safety Framework (MapSaF) is being used to help the Trust assess its safety culture;
- an annual programme of Chief Executive and Executive Director-led Patient Safety Visits has been established.

Education, training and continuous personal and professional development:

The Trust Learning and Development Policy aims to:

- improve the quality of the service as experienced by users and carers;
- ensure that learning needs are identified in a systematic way linked to service development and organisational priorities;
- promote a philosophy of continuous personal development;
- ensure that the Trust delivers modern and effective services through enabling staff to develop their skills in line with changing national priorities, policy guidance and service development.

Supervision and appraisal processes are identified as important in helping to ensure that staff take appropriate advantage of development options.

Governance and assurance processes and structure

The Trust Board leads and directs clinical quality and its governance. Lead responsibility for scrutinising and assuring clinical quality, safety and performance is delegated to the Quality and Healthcare Governance Committee. The Committee is composed of three Non Executive Directors, the Chief Executive, the Executive Director for People and the Executive Director

of Nursing, Compliance, Assurance and Standards. The Committee is also attended by the Trust SBU clinical directors and two representatives from the Professional Council. The Chair of the Committee reports formally to the Board.

The Trust Mental Health Legislation Committee plays a key role in clinical governance. This Committee is composed of two Non Executive Directors and meetings are attended by the Executive Director of Nursing, Compliance, Assurance and Standards, the Mental Health Act Lead, SBU managers, a social work representative, the Mental Health Act and Mental Capacity Act Manager and a consultant psychiatrist. The Chair of the Committee reports formally to the Board.

To support continuous clinical quality improvement the Trust has established a number of management groups chaired by Executive Directors which report to the Performance Executive Management Team. The management groups are expected to:

- scrutinise and review compliance with core quality and safety standards and outcomes;
- peer review draft policy, guidance, protocol and strategy;
- manage and co-ordinate engagement of Strategic Business Units and relevant corporate leads.

The Strategic Business Units contribute to the Clinical Governance system by attending the Trust Management Groups and Board Committees, disseminating good practice, implementing quality improvement plans, coordinating operational activity against set standards, and providing an evidence base of delivery against clinical quality standards.

The Trust has identified the importance of ensuring that it has processes in place that enable the early identification of potential failings in patient care. The Trust's ability to spot the early signs of failings is strengthened by:

- the provision and understanding of regular information on key clinical indicators;
- staff being empowered to engage in management processes, raise concerns and be involved in quality improvement processes;
- service users' and carers' voices and experiences being heard and shared from ward to Board.

10.1.13.3. Conclusions

The Independent Investigation Team conclusion is that the AWP Clinical Governance processes were fit for purpose. There was ample evidence to suggest that the Trust could demonstrate that it was a learning organisation and that the learning from previous incidents had been used to improve and develop services in a comprehensive and robust manner.

10.2. The Care and Treatment of Mr Y (The Victim)

This Independent Investigation was asked to examine the care and treatment Mr Y received. This has been set out below. However Mr Y's care and treatment has not been set out in detail as this is not required to understand the case and out of consideration to his family and friends.

The Independent Investigation Team reviewed Mr Y's clinical records to determine whether any aspects of the care and treatment he received could be viewed as contributing to his death. The Independent Investigation Team found no causal or contributory factors relating to the care and treatment that Mr Y received that contributed to his death.

10.2.1. Chronology

Background

Mr Y's parents emigrated from Jamaica to England in the mid 1950s and married in 1957. They had four children of whom Mr Y was the second. Mr Y's parents were described as conscientious and hard working. His father was described as a strict disciplinarian.

Mr Y's primary schooling was unremarkable. He passed the 11 plus examination and obtained a place at a local grammar school. However, Mr Y was expelled from this school in 1974 when he was 14, allegedly for fighting and bullying. In **November 1975** a Juvenile Court remanded Mr Y to the care of the Local Authority for 21 days. Later that month a report was presented to the Court recommending a Residential Care Order be put in place. He was given a two-year conditional discharge.

1975 to 1981. During this period Mr Y was charged and convicted of a number of offences including: various driving offences, Taking and Driving Away a Motor Vehicle (TAD),

grievous bodily harm (GBH), actual bodily harm (ABH), assaulting a Police officer, burglary, theft and handling stolen goods. It was also recorded that Mr Y was involved with 'pimping' prostitutes from around the age of 15. He later claimed that at one time he had up to 20 girls working for him.

Mental Health History

Mr Y's mental health appears to have deteriorated in his late teens. Signs of a psychotic illness were being recorded by **1980**. When he was detained in custody at the age of 20 he was described as presenting in a disturbed and deluded state. It is reported that it required four people to restrain him and he assaulted a Police Officer who sustained serious head injuries. Mr Y said that he had responded automatically to what he saw as a threat.

In **1981** while in Portland Borstal Mr Y exhibited bizarre behaviour. He was suspicious, grandiose, elated, talking to himself and aggressive. He was admitted to Glenside Hospital in the same year.

Following his discharge from hospital Mr Y failed to take his medication and was subsequently described as being elated and grandiose and required readmission to Glenside Hospital. During this admission he was described as being violent and he required care in the Psychiatric Intensive Care Unit (PICU). Following his discharge Mr Y was again non-compliant with follow-up and treatment and he appears to have remained out of contact with services until **October 1983** when he was readmitted to hospital under Section 37 of the Mental Health Act (1983). At this time he was described as withdrawn and neither eating nor sleeping; he was incoherent and thought disordered. He appears to have been discharged in the spring of **1984**.

It is recorded in Mr Y's notes that in **1985** he attempted to coerce a woman into prostitution by holding a knife to her child's neck. In the same year he met a woman at a party and subsequently acted as her pimp. It is unclear whether this was under duress. There are reports of him being violent towards her and her being afraid of him.

While Mr Y and his victim were staying in Southampton Mr Y's victim tried to escape from him. However he followed her to the railway station and was seen by a number of witnesses

abducting her. Mr Y took the victim to their accommodation where he attacked her violently. The Police broke into the accommodation and arrested Mr Y.

Mr Y was convicted of kidnapping, living off immoral earnings and causing grievous bodily harm with intent in **December 1985**. The Psychiatrist who assessed Mr Y in prison diagnosed him as suffering from Schizoaffective Disorder and a Psychopathic Personality Disorder. He concluded that Mr Y was ill at the time he committed the offence and recommended transfer to hospital.

Mr Y was transferred to Broadmoor hospital where he was described as: aroused, aggressive, grandiose and elated. During the early stages of his admission Mr Y was described as *"proudly aggressive".* He was elated and demanding. Mr Y was noted to have a poor opinion of women and in **1992** it was noted that while he was able to chat well with women, he later referred to them in a disparaging fashion.

By **1992** requests were being made that Mr Y be transferred to the local medium secure unit. By **1995** he had appeared to have made sufficient improvement on a medication regimen of Fluphenazine Decanoate (Modecate) 200mg monthly depot injections and lithium carbonate 800mg daily to warrant his transfer and in **November 1996** he was transferred to the local Medium Secure Unit. There are a number of reports of Mr Y expressing disparaging views of women, of inappropriate sexual behaviour and of him attempting to contact the victim of his offence during this period.

By **March 1999** Mr Y had manifested sufficient improvement to be given a Conditional Discharge under Section 37/41 by a Mental Health Review Tribunal. However it is recorded in Mr Y's notes that such were the difficulties in finding him appropriate accommodation that a judicial review was required to identify a suitable placement. In **June 2000** Mr Y left hospital and his care was passed to the Inner City CMHT with input from Forensic Services.

It is recorded that in **2001** and again in **2004** Mr Y's girlfriends of the time disappeared and that the Police viewed these incidents *"with extreme caution".* However on both occasions the women concerned re-emerged after a short time and no blame was attached to Mr Y for their disappearance.

In **May 2002** Mr Y moved into independent accommodation. In **August** of that year a risk assessment recorded that he had not been involved in any violent episodes since 1999; he had not used illicit drugs for many years; he was compliant with drug screens; and he remained reluctant to disclose personal information.

In **January 2003** a further risk assessment recorded that Mr Y had a partner who had children; she was happy with the way in which Mr Y interacted with her children. Mr Y continued to refrain from illicit drug use; he was compliant with his care plans and he "poses a minimal risk to those around him" at this time. It was recorded that his mental illness was in remission.

Mr Y's mental state appears to have remained stable and he remained compliant with his care plans until **May 2004** when his partner reported that she was concerned that he was not taking his lithium. He was using cannabis and drinking alcohol, his moods were more variable and he was at times verbally aggressive, he appeared to have lost interest in going to a day centre or college and he was involved with a local prostitute. However Mr Y's behaviour continued to be appropriate in the presence of the children.

In response to these concerns Mr Y was reviewed by the Forensic Consultant Psychiatrist. When questioned about his behaviour, Mr Y disagreed with the version of events reported by his partner. However it was decided that urine screens would be introduced and Mr Y was to be seen more frequently.

In **February 2005** the Forensic Psychiatrist caring for Mr Y reported to the Home Office that Mr Y's mental state and behaviour were stable and when Mr Y had achieved five years successful tenure in the community he would recommend an Absolute Discharge. At a CPA review in **June 2005** it was reported that Mr Y's mental state remained stable, he attended his appointments and accepted medication. Drug screens in **December and February** had been negative. The Consultant Forensic Psychiatrist therefore wrote to the Home Office recommending that Mr Y be given an Absolute Discharge.

In **September 2005** it was noted that Mr Y's partner was pregnant and she was to be spoken to about her needs. The Social Service Children and Young People's team was also contacted and informed of the situation. This team responded to the alert saying that it would not be

investigating but would inform the midwife at the hospital. Mr Y's partner had said that she did not want Social Services contacted. It was suggested at the CPA Review that Mr Y's partner should be invited to contact the Mental Health team to discuss her needs.

In his **December 2005** report to the Home Office the Forensic Psychiatrist recorded that Mr Y's partner was pregnant and that Social Services had been informed. He also again recommended that Mr Y be given an Absolute Discharge.

Mr Y's mental state remained stable throughout **2006**, he was seen regularly and his progress was monitored at regular Care Programme Approach Reviews.

In **May 2007** Mr Y's care was transferred to a Community Psychiatrist. In his transfer letter the Forensic Psychiatrist wrote *"In all the time I have known him (since the mid-90's) I have never seen any active signs of psychosis and he remains entirely well in good remission"*. He also reported that the Home Office had rejected his recommendation for Mr Y's Absolute Discharge from the Mental Health Act (1983) in **January 2007** on the basis that there were on-going concerns about Mr Y's cannabis and alcohol use. The Forensic Psychiatrist felt that there was no basis for this. Mr Y's diagnosis was recorded as schizoaffective psychosis. In **September 2007** Mr Y was discharged from the caseload of the Forensic Community Psychiatric Nurse. His care was now in the hands of the Community Mental Health Team. At this time it was recorded that Mr Y was compliant with the terms of his Conditional Discharge and compliant with his medication which was Fluphenazine Decanoate (Modecate) 200mg four weekly and Lithium Carbonate 600mg daily.

Mr Y was seen and reviewed regularly throughout the rest of **2007** and no concerns were identified. A CPA review was held on **14 January 2008** and Mr Y was seen at home by his Social Supervisor on **6 February**. No concerns were identified on either occasion. However on **15 February 2008** Mr Y was arrested for an alleged rape. He was remanded to prison. The CPN who saw him in prison did not identify any signs of mental illness but the Prison In-Reach team felt that he was irritable and grandiose. Mr Y told the nurse that he had not taken his Lithium or Procyclidine for about two months. His next depot injection was due on **3 March 2008.** Mr Y continued to refuse his medication while he was in prison and when he was visited on **29 February** he was described as elated.

Mr Y was interviewed by Forensic Psychiatrist 2 on **31 March 2008**. He was continuing to refuse medication and the Psychiatrist found it difficult to complete a formal assessment. However he found Mr Y to be grandiose, dismissive, hostile, irritable and threatening. In these circumstances Forensic Psychiatrist 2 concluded that Mr Y should be returned to hospital for a more thorough assessment. Mr Y was formally recalled to hospital on Section 37/41 of the Mental Health Act (1983 and 2007) on **2 April 2008** and transferred to the local medium secure unit. The charges against Mr Y were dropped due to lack of evidence.

On **10 April 2008** it was recorded that Mr Y had been hostile and dismissive when he was first admitted to the local Medium Secure Unit. However over the admission period he was co-operative. He was well kempt and established rapport. He appeared to have slowed verbal responses and cognition but it was concluded that this was not a symptom of psychosis. He was euthymic in mood and denied any abnormal experiences. There was no evidence of psychosis or thought disorder and Mr Y denied any illicit drug use.

Mr Y did not want his depot medication to be re-instated as he had not experienced any mental illness symptoms since the 1980s. It was put to him that he had been well in the community on depot medication; that he would need to be drug-free for at least six months and then there would need to be a further six months of close observation before a recommendation could reasonably be made that he should cease to have medication and be released into the community. As Mr Y's case was due to be heard at a Mental Health Review Tribunal he agreed to re-start his medication. He was prescribed a depot injection of Fluphenazine Decanoate 37.5mg every two weeks.

A risk assessment on **24 April 2008** identified no current risk of self-harm, current risk from others and a moderate risk to others, particularly women for whom he had low esteem, and no current risk to children. A further risk assessment on **18 May** rated Mr Y's risk of self-harm as low, harm to others as low and risk of non-compliance as low/moderate.

In **May 2008** it was concluded that having re-started Mr Y on medication and having had the opportunity to observe him in hospital there was no evidence of relapse of his mental illness.

On **13 June 2008** a Mental Health Review Tribunal deferred their decision on Mr Y's discharge and requested a second opinion on his mental state.

On **10 July 2008** a Multi-Agency Public Protection Arrangements (MAPPA) meeting was held in anticipation of Mr Y's discharge. The Police expressed concerns about Mr Y returning to his former accommodation. It was agreed that when a date for Mr Y's discharge was known the Police would show his photograph to the local street workers.

On **30 July 2008** the Second Opinion Psychiatric report concluded that Mr Y was not displaying any symptoms of psychosis.

Further MAPPA meetings were held in **August** and **September 2008** in preparation for Mr Y's discharge from hospital. It was decided at the **September** meeting that Mr Y's status would be changed to MAPPA Level 1 (single agency monitoring), and that the Police would share any information with the Mental Health Team and street workers would be made aware of Mr Y.

Mr Y was given escorted ground leave in **July**, unescorted ground leave in **August** and escorted community leave in **October 2008. On 7 November 2008** he was granted a Conditional Discharge by the Mental Health Review Tribunal.

The conditions of his discharge were that:

1. Mr Y would reside at a specified address;
2. Mr Y would comply with such treatment as may be directed by his Responsible Clinician (RC);
3. Mr Y should comply with home visits and out-patient appointments as this may be directed by his Community Psychiatric Nurse and Community Forensic Nurse;
4. Mr Y should comply with all necessary directions from his RC and Social Supervisor as to his supervision particularly in connection with his Care Programme;
5. Mr Y should submit himself for random drug tests as directed by his RC.

Mr Y's diagnosis on discharge was recorded as being Paranoid Schizophrenia, and his medication was Fluphenazine Decanoate 37.5mg every two weeks and Procyclidine 5mg daily.

Mr Y was visited at home a week after his discharge from hospital. It was recorded that he had adjusted well to returning to his flat; he was accepting medication; he had discussed

engaging in meaningful activities and he was spending time with his parents, daughter and friends. However it was also noted that he was occasionally using cannabis.

In **December 2008** Mr Y's partner contacted the mental health team to share her concerns. She said that he was smoking cannabis and drinking alcohol, and he was not visiting his mother's home regularly. She reported that he was becoming jealous and she wanted to separate from him.

Mr Y's partner also reported that when Mr Y had visited her house some weeks earlier he had asked to have a bath. She later found him undressing in her 19 year old daughter's bedroom. The daughter was asleep. When she confronted Mr Y he dismissed her concerns saying that the room was nearest to the bathroom. Mr Y's Social Supervisor asked if Mr Y had done anything like this before or since. Mr Y's partner said that he had not, and that he had always been fine with the children. She had never felt concerned. The Social Supervisor discussed this incident with the Psychiatrist who was reviewing Mr Y, with the Forensic CPN and Forensic Social Worker. The Ministry of Justice were informed of the incident. Mr Y was seen by the Community Psychiatrist to review his mental state, a Professionals' Meeting was arranged for **January 2009** and MAPPA was informed.

Mr Y was seen on **19 December 2008** by his Social Supervisor and his Responsible Clinician. He was described as being well presented. His concentration was good and he did not disclose any symptoms indicating deterioration in his mental state. He denied using illicit drugs. It was noted that Mr Y was convincing and that it was difficult to know if he was telling the truth.

Mr Y's Social Supervisor spoke to Mr Y's partner again on **24 December 2008** to discuss her situation, and to ask her whether she needed any help and whether she wanted the Police informed of her situation.

Mr Y was seen twice in **January 2009** prior to the Professionals' Meeting being held. He presented well on both occasions and his mental health was stable. No grounds for concern were identified during these meetings. The Professionals' Meeting was held on **26 January 2009.** Mr Y's partner was not able to be present but his Social Supervisor had spoken to her before the meeting. The meeting decided that as Mr Y wanted to continue to see his daughter

on a regular basis contact should be supervised and only at his parents' home. It was also decided that regular drug screening would not provide any clinical benefit. Mr Y's partner's address was put on the Police computer for an urgent response.

Mr Y accepted the restrictions placed on him in relation to seeing his daughter. He was seen regularly throughout the rest of **2009** by both his Psychiatrist and his Social Supervisor, at home and at the CMHT base. His mental state was consistently found to be stable, he was compliant with his medication and he was not identified as presenting a risk to himself or the public. This situation was reflected in the reports submitted to the Ministry of Justice every three months.

However in early **October 2009** Mr Y was accused of rape. He was arrested and interviewed by the Police but was not detained. The rape charge was not pursued due to lack of evidence; however Mr Y was bailed for being in possession of cannabis. No concerns about Mr Y's mental health were identified at the time of his arrest and 10 days later, when he was again reviewed, he was described as well presented, his concentration was good and he did not disclose any symptoms indicating a deterioration of mental state. Mr Y denied using illicit drugs.

On **20 October 2009** Mr Y's now former partner contacted his Social Supervisor. She reported that she was concerned about Mr Y coming to her house following the incident when he had undressed in her daughter's bedroom. She said that Mr Y was coming to the house when she was out and she did not trust him. She said that she was worried because he had been violent towards her in the past and she had asked the children not to let Mr Y in to the house when she was not present. She asked if someone from the Mental Health Service could tell Mr Y not to call at her house.

When asked if she felt Mr Y was a danger to the children and she said he was not. The Social Supervisor told Mr Y's (ex-) partner that the Children and Young People's Service would have to be informed. The following actions were taken:

- the Children and Young People's service was informed;

- the Police were contacted for advice. They informed the Domestic Violence unit of the situation and a uniformed Police Office called to see Mr Y's (ex-) partner and an 'Urgent' marker was placed on her file;
- the Ministry of Justice was informed of the situation. They asked whether Mr Y should be recalled to hospital but were advised that his mental state had recently been assessed and no signs of relapse had been identified and recall was not thought to be appropriate at this time.

When he was seen on **28 October 2009** Mr Y denied the rape allegation. He said that he was seeing his daughter regularly at his parents' home and he denied that he had been going to his (ex-) partner's house. It was noted that Mr Y had missed his depot medication through confusion about times and dates, and arrangements were made for him to have his injection.

Mr Y was seen and reviewed regularly over the next few months and no concerns were identified with respect to his mental health. There was on-going discussion about him seeing his daughter only at his parents' home and him not visiting his (ex-) partner's home.

In **February 2010** the Ministry of Justice insisted that Mr Y had regular drug screening tests although the Clinical Team did not feel that this would be clinically useful. Mr Y had a CPA Review in **February 2010**. No concerns were identified and no current risks were identified.

Mr Y's mental state remained stable throughout **March and April 2010** and his drug screens were negative in **March and May** although he admitted to his Social Supervisor that he occasionally smoked cannabis. As on previous occasions he was reminded of both the harm this could do to his mental health and the conditions of his discharge. In **May 2010** Mr Y's father died and he appeared to cope with this appropriately.

In **July 2010** Mr Y's urine drug screen test was positive and the Ministry of Justice was informed.

Throughout **July, August and September 2010** Mr Y was seen regularly and no concerns were identified about his mental state, which remained stable, nor over his compliance with medication or the risks he posed which were seen as low and unchanged. Mr Y was last seen

when he attended his appointment at the CMHT base on **21 September 2010**. No concerns were identified during this interview.

On 5 **October 2010** Mr Y was found dead in his flat.

10.2.2. Findings

Risk

The Internal Investigation noted that Mr Y's risk indicators were identified in the **February 2010** report to the Ministry of Justice as:

- *"Poor engagement with mental health services;*
- *Abuse of illicit drugs;*
- *Excessive alcohol use;*
- *Potential difficulties with relationships: either family, social or professional;*
- *Relapse of mental illness, including, insomnia, elation of mood, delusional thought contents;*
- *Difficulties with the Police".*

It goes on to note that this report "*does not refer to the specific risk to women or how this might be indicated, however the risk to women are outlined in the 23 February 2010 risk assessment incorporated in the AWP comprehensive assessment".*[176]

The Internal Investigation report went on to examine the risks associated with Mr Y under a number of headings:

- Alcohol and Drugs;
- risk to women;
- risk to [Mr Y's] ex-partner and his daughter and her other children;
- Violence and Aggression.

Alcohol and Drugs: the Internal Investigation noted that "*There were no concerns from professionals about [Mr Y's] use of alcohol or drugs at the time of his death*." The clinical team arrived at this position based on: Mr Y's self report- he acknowledged that he used both alcohol and cannabis socially and this was regularly discussed with him; the fact that from

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February 2010 his urine was regularly screened for drugs and when a drug screen was found to be positive this was reported to the Ministry of Justice, as in **August 2010**; and the fact that Mr Y's partner informed the clinical team when she was concerned about his mental state and/or behaviour and when she felt that this was related to his use of drugs or alcohol, as in **December 2008**.

The Independent Investigation concluded that the clinical team monitored Mr Y's use of drugs and alcohol appropriately, in the context of their regular monitoring of his mental health and behaviour, and came to a reasonable conclusion as to the effect these were having on him.

Risk to women: the Internal Investigation noted: "*[Mr Y] had a well documented history of violence and assaults to women over many years. He had been arrested on two occasions in recent years following allegations of rape"*. Mr Y's index offence was one of violence towards a woman and his low opinion of women was documented in his clinical notes. The clinical team caring for Mr Y had limited power over his behaviour. However he was conditionally discharged from hospital on a Section 37/41 which meant that the power to recall him to hospital, should there be significant concerns about the risk he was posing to women, was retained. It has to be acknowledged that in 2005 it was recommended that, as Mr Y had been symptom-free for some years and had successfully resettled in the community, his discharge should be made absolute. The Ministry of Justice did not accept this advice. However it was part of a reasonable debate about establishing a balance between caution and positive risk taking and, as such, was good practice.

As part of the planning to discharge Mr Y from the medium secure unit in 2008 three MAPPA meetings were held. These provided the opportunity for information to be shared with the Police and an action plan to be drawn up. This plan included agreeing that there should be on-going sharing of information between the Police and the Mental Health Services and that local street workers should be informed about Mr Y and the risks associated with him.

The clinical teams caring for Mr Y identified the risks associated with him and took reasonable and balanced actions to address these.

Risk to [Mr Y's] ex-partner and his daughter and her other children: the Internal Investigation commented: "*It was agreed….on the 27.1.2010 that [Mr Y's] contact with his daughter would be at [Mr Y's] mother's home and be supervised by her older sister. This was in response to [Mr Y's] ex-partner's concerns about [Mr Y's] behaviour hanging around her house when she was not there but her children were".*

There are two issues which need to be considered under this heading: Children's Safeguarding and responding appropriately to the risks to [Mr Y's] ex-partner.

Children's safeguarding: the clinical teams caring for Mr Y were aware of their responsibilities to protect the wellbeing of his daughter and other children with whom he was regularly in contact.

In **2003** when it was noted that Mr Y had a new partner, she was interviewed and asked about his interactions with her children and if he behaved appropriately in their presence. When Mr Y's partner reported her concerns about his mental state in **2004** again she was questioned about his behaviour with respect to her children. When the team was made aware that Mr Y's partner was pregnant in **2005** they immediately informed Children's Social Services.

In **April 2008** when Mr Y was recalled to hospital, Children's Social Services were contacted to ask whether they had any concerns about his daughter visiting him there.

In **December 2008** Mr Y's partner reported that she had found him undressing in her daughter's bedroom. The issue was discussed within the clinical team and advice was sought from the Forensic Service, the Ministry of Justice was informed, MAPPA was alerted, a professionals' meeting was arranged and Mr Y's partner was offered support. It was decided that Mr Y would see his daughter only at his parents' home in a supervised situation. However it is not clear that Children's Social Services were informed at this time.

In **October 2009** Mr Y's ex-partner expressed concern about him coming to her house when she was not there. Again Mr Y's mental state was reviewed; he was reminded that he was allowed to see his daughter only at his parents' home. Children's Social Services were informed of the situation.

The clinical teams caring for Mr Y demonstrated an awareness of their responsibility for the well-being of those children with whom he was regularly in contact. They responded promptly to concerns and shared information appropriately. Although the Mental Health Services did alert and consult Children's Social Services appropriately on several occasions it is not clear from the clinical notes whether this was done on all occasions.

Responding to the risks to Mr Y's ex-partner*:* The clinical team caring for Mr Y was in regular contact with his ex-(partner) from **2003**. From the information contained in the clinical notes it appears that she felt comfortable in sharing her concerns with the clinical team and even in asking them to set limits with Mr Y on her behalf. There are a number of recorded instances in the clinical records of those caring for Mr Y asking her what support she felt she needed.

In **October 2009** Mr Y's (ex) partner informed his Social Supervisor that she was concerned about Mr Y coming to her house following the incident when he had undressed in her daughter's bedroom. She was worried because he had been violent towards her in the past and she had asked the children not to let Mr Y in to the house when she was not present. She asked if someone from the Mental Health Service could tell Mr Y not to call at her house. The clinical team were supportive and responded by:

- informing the Children and Young People's Service about the situation;
- contacting the Police for advice. They informed the Domestic Violence unit of the situation and a uniformed Police Officer called to see Mr Y's (ex) partner and an 'Urgent' marker was placed on her file;
- informing the Ministry of Justice of the situation;
- seeing Mr Y and assessing his mental state and reminding him of the limitations on his access to his daughter.

There is no record that Mr Y's (ex) partner was offered a formal carer's assessment to address her own needs but the clinical team did consult her, offered her support and responded promptly when she expressed concern.

Violence and Aggression: the Internal Investigation commented: "*the professionals involved with [Mr Y] did not feel any threat from him towards them in relation to aggressive*

behaviour. [Mr Y] was co-operative with professionals and his treatment but it is likely given the stability of [Mr Y's] mental state and the routine nature of their contact with [Mr Y] that they would not have known about large areas of [Mr Y's] life. [Mr Y] had a significant history of previous violence and of holding a negative view of women. The aggression included exploitation and intimidation. The degree of association of these behaviours and mental illness is not clear".

The Independent Investigation agrees with these observations. While Mr Y was living independently in the community it was inevitable that there were aspects of his life that were unknown to those caring for him. They did, however, maintain a good relationship with Mr Y's (ex) partner and while they did not always actively seek corroboration from her, the records suggest that she was able to share any concerns she had with those caring for him.

Vulnerability

The Internal Investigation commented: *"[Mr Y's] risk assessment and risk indicators did not identify him as vulnerable. It is possible that the area where he lived had become less suitable for him over the years as his alleged offending against women continued and because the concerns about his behaviour had led to there being a disclosure about his offences and behaviour to local street workers. He also had periods of time in prison and hospital when he would have been absent from his community for periods of time. This perhaps increased the risks to him of being subject to a vigilante style attack".*

The Independent Investigation agrees with these observations of the Internal Investigation. As events proved, Mr Y was at risk. His life style prior to his admission to Broadmoor Hospital in **1986** would almost certainly have placed him at risk, however there is no evidence that he returned to this lifestyle following his conditional discharge from hospital in **2000**. The regular risk assessments from **2000** did not identify Mr Y as being at significant risk from others. Being vulnerable is, of course, more than being at risk and the local Adult Safeguarding policy identifies the criteria for classifying an individual as vulnerable. In Mr Y's case he had a mental illness and was in receipt of mental health services; however he had been symptom-free for a number of years. He had the capacity to make his own decisions and he was "street wise". Mr Y was physically healthy. He was not socially isolated but had both family and social networks. It would be difficult to reasonably conclude that Mr Y was vulnerable in the formal sense of that term.

There were examples of good communication between the mental health service and the Police when risks associated with Mr Y were identified. Given these factors it is difficult to conclude that formally identifying Mr Y as a Vulnerable Adult would have enhanced his care.

Diagnosis and treatment

In his late teens and early twenties Mr Y displayed the symptoms of a psychotic disorder and through the rest of his life he was diagnosed as suffering from either a Schizoaffective or Paranoid Schizophrenic Disorder. At the time of his index offence he was also given the diagnosis of Psychopathic Personality Disorder.

However it should be noted that in **May 2007** when Mr Y's care was transferred from the Forensic Psychiatrist to the Community Psychiatrist the former wrote *"In all the time I have known him (since the mid-90's) I have never seen any active signs of psychosis and he remains entirely well in good remission"*. In late **March 2008** Mr Y was accused of rape. When he was assessed he was described as being grandiose, dismissive, hostile, irritable and threatening. He had stopped taking his medication at this time. In these circumstances the assessing Psychiatrist concluded that Mr Y should be returned to hospital for a more thorough assessment. In **May 2008** it was concluded that having re-started Mr Y on medication and having had the opportunity to observe him in hospital there was no evidence of a relapse of his mental illness. The Mental Health Review Tribunal requested a second opinion on Mr Y's mental state. This report also concluded that Mr Y was not displaying any symptoms of psychosis.

Prior to his admission to Broadmoor Hospital Mr Y's compliance with medication was poor and relapses in his mental state were associated with him failing to have his medication. They may also have been associated with an increase in his use of illicit drugs.

From the time of his admission to Broadmoor Hospital he was prescribed the depot anti-psychotic medication Fluphenazine Decanoate. While he was on this medication he was symptom-free. Until **2008** he was also prescribed the mood stabiliser Lithium Carbonate. Both these prescriptions were appropriate for the symptoms Mr Y was observed to be experiencing. As Mr Y was symptom-free over such a long period of time it is impossible to say to what extent and over what period this medication altered the symptomatology of Mr Y,

or whether the episode of psychosis was self-limiting. However, given Mr Y's history and the seriousness of his index offence there was a reluctance to discontinue the medication without a prolonged period in hospital to establish that he would continue to be symptom-free when not taking medication. This was discussed with Mr Y and he chose to continue to take the medication.

Following his discharge from the medium secure unit in **2000** Mr Y was encouraged to engage in constructive activities. He never committed himself to these and there is no record of him engaging in any therapeutic activities. While it is good practice to offer individuals with a diagnosis of schizophrenia a range of therapeutic interventions, where that individual is symptom-free and disinclined to engage with services more than is required of him, a clinical team has no power to compel him to accept the offered interventions.

Mr Y's mental state and behaviour were monitored while he was in the community and the clinical team caring for him responded quickly when concerns were identified. They supported him to enable him to survive successfully in the community and encouraged him to engage in constructive activities but Mr Y was not committed to engaging in these.

Care Programme Approach and the Management of Mr Y's Case

The overall management of Mr Y's care and treatment was governed, to a very significant extent, by the fact that he was subject to the requirement of Section 37/41 of the Mental Health Act (1983 and 2007). Following his index offence in **1986** Mr Y was admitted to Broadmoor Hospital. He was transferred to the local medium secure facility in **1996**. Mr Y was conditionally discharged from hospital in **1999**, remaining on Section 37/41, though due to difficulties in identifying suitable accommodation he did not leave hospital until **June 2000**.

The conditions of Mr Y's discharge specified where he was to live, that he had to accept medication and that he had to see his Responsible Medical Officer and Social Supervisor on a regular basis so that his mental state could be reviewed. This is what happened. Mr Y was reviewed regularly and he accepted his medication. His Responsible Medical Officer and Social Supervisor saw Mr Y regularly and discussed his progress, often with other members of the multi-disciplinary team. They reported their observations to the Home Office on a three-monthly basis as was required of them. These reports record that Mr Y had settled into

the community, he was symptom free and he had established social and family networks. By **2005**, when Mr Y had been in the community for five years, the clinical team caring for him felt that he had made sufficient progress to recommend that he be granted an Absolute Discharge. The Home Office did not, however, accept this advice and the Section 37/41 was continued. Mr Y continued to be monitored in the same manner with regular CPA reviews and reports to the Home Office recording a largely stable presentation and no significant changes in the support given to him other than when concerns were raised by his partner.

During **2007** Mr Y was transferred to the care of the Community Psychiatrist and a little later in the same year the forensic CPN withdrew from Mr Y's care. In **February 2008** Mr Y was accused of rape and after being assessed by a Forensic Psychiatrist he was recalled to hospital under the continuing Section 37/41. Having restarted Mr Y on medication and having had time to observe him it was concluded that he was not displaying the symptoms of a serious mental illness and he was again conditionally discharged from hospital with conditions similar to those that had been put in place in **2000**.

Again Mr Y complied with the conditions of his discharge. He was seen approximately quarterly by his Responsible Clinician and monthly by his Social Supervisor. These two clinicians sometimes saw Mr Y together at his home and used these meetings as a CPA Review. Both clinicians appear to have been flexible and responded appropriately whenever concerns were raised about Mr Y's wellbeing.

Mr Y's mental state remained stable during this period and his CPA/Personal Recovery Plan focused on maintaining this, continuing his medication regimen, addressing his relationship with his (ex-)partner and their daughter, supporting Mr Y to function in the community and continuing to monitor his drug use.

His crisis plan during this period was to contact his Social Supervisor if a crisis occurred during the day and to contact the Crisis and Home Treatment Team if one occurred out of hours.

Mr Y's progress was reported to the Ministry of Justice on a regular three-monthly basis. Mr Y's reviews with his Responsible Clinician were routinely recorded in a letter to his GP and both these reviews and Mr Y's meetings with his Social Supervisor were recorded in Mr Y's

clinical notes. The CPA meetings were not always recorded on Trust CPA forms in the notes available to the Independent Investigation. However it is possible that these are recorded on the Trust's electronic record.

Mr Y's mental state was reviewed on a regular basis and reports were submitted to the Home Office/Ministry of Justice which covered many of the areas one would expect to see addressed in a CPA review. Given that Mr Y's presentation was largely stable over a prolonged period of time the care and support he was offered also remained largely unchanged. Mr Y's care plans focused mainly on what was required by the conditions of his discharge and the limited involvement of Mental Health Services he would accept. The clinical team did respond appropriately and promptly when concerns were brought to its notice and this was reflected both in the reports submitted to the Home Office/Ministry of Justice and in his care plans.

10.2.3. Conclusion

The fact that Mr Y was subject to the Mental Health Act (1983 and 2007) from **1986** until his death in **October 2010** provided structure and consistency to the care and treatment he received. It also provided a context for the understanding of his problems. For much of the time he was under the care of the Mental Health Services he was viewed as having a serious mental illness which was in remission or controlled by his antipsychotic medication. He had a substantial forensic history and was regarded as presenting a risk to others, particularly women, when he was unwell.

The risks Mr Y posed were regularly assessed and his risk factors were identified. These changed little over the time he was in the community and symptom-free. When concerns were drawn to the attention of the Mental Health Team caring for Mr Y they responded appropriately and informed the Home Office/Ministry of Justice of the concerns and the actions that had been taken.

Mr Y was required to accept medication under the terms of his Conditional Discharge from hospital and he did this. He was supported to settle and survive in the community. However beyond this he was reluctant to engage with the Mental Health Services.

The care and treatment Mr Y received from the Mental Health Services was appropriate to his presentation and was to some degree prescribed and overseen by the Home Office/ Ministry of Justice. Transfers between services were conducted in an appropriate manner and communication between professionals and agencies was generally appropriate. Given these circumstances it would not be reasonable to conclude that the care and treatment Mr Y received contributed to him being killed on 4 **October 2010**.

10.3. Analysis of the Connection Between Mr Y and Ms X

Mr Y

Ms X had known Mr Y when as a young girl he had been a friend of her stepfather. It is not known how frequently they had met, but Mr Y did not appear in any of the information contained in the AWP Trust Clinical Records.

Mr Y had been subject to the Mental Health Act (1983 and 2007) from **1986** until his death in **October 2010** which provided structure and consistency to the care and treatment he received. It also provided a context for the understanding of his problems. For much of the time he was under the care of the Mental Health Services he was viewed as having a serious mental illness which was in remission or controlled by his antipsychotic medication. He had a substantial forensic history and was regarded as presenting a risk to others, particularly women, when he was unwell. Despite some relatively minor relapses Mr Y was considered fit for a Conditional Discharge in **June 2000**.

Mr Y was not considered to be a Vulnerable Adult as he had been coping well in his local community since he left hospital. The Independent Investigation Team concluded that Ms X was a Vulnerable Adult due to her refusal to engage with Mental Health Services and her misuse of alcohol and drugs. At the time she met Mr Y in a street in Bristol Ms X was homeless having been evicted from some sheltered Housing Accommodation having refused to visit the HUB to seek appropriate accommodation.

At the time before his death Mr Y was considered to be well mentally and not to be a risk to other people. The care and treatment Mr Y received from the Mental Health Services was appropriate to his presentation.

Ms X

Ms X had been seeking overnight accommodation by seeking 'friends' with a sofa, a bed or a floor she could borrow. It was therefore quite rational for her to accept the offer of a bed for the night from someone she knew. Mr Y had been convicted of rape and actual bodily harm and had been a 'pimp' earlier in his life, but Ms X would probably not have known this.

The chance encounter led to Ms X accusing Mr Y of rape. She left his house the following morning and went to visit Mr Z and told him of her distress. Mr Z agreed to visit Mr Y with Ms X in order to 'teach him a lesson' which as described in this Report turned into a savage attack leading to his death. The three service users from the AWP Trust were brought together by pure coincidence and no one could have predicted the outcome.

Conclusion

Based on what was known and should have been known at the time of Mr Y's death the care and treatment that he was receiving from AWP was fit for purpose. The Independent Investigation Team concluded that his death was not the result of any act or omission on the part of the AWP Trust. The Independent Investigation Team noted with regret that individuals who live chaotic lifestyles place themselves in a position of vulnerability more often than not, but statutory services cannot always be expected to intervene when individuals place themselves in situations of increased risk by their voluntary actions which are not directly the result of their mental illness.

This Investigation found no causal link between any act or omission on the part of AWP Trust.

The staff of the Trust could not reasonably have been expected to prevent the homicide because they did not have the:

Knowledge: AWP did not have day-to-day knowledge of the three service users as they were living independently in the community at the time of the incident. Trust workers could not have known that Ms X was placing herself at risk by sleeping in Mr Y's accommodation and therefore could take no action to prevent harm coming to either Ms X or Mr Y.

Opportunity: Trust workers had no opportunity to intervene in such an incident. There were no warning signs, and whilst an incident of some kind may have been able to be predicted regarding Ms X's vulnerability, the imminent nature of this particular incident could not have been either predicted or prevented by the Trust.

Means: due to the fact that the Trust had no knowledge or opportunity to intervene it goes without saying that the means was also denied to them on this particular occasion.

11. Findings and Conclusions Regarding the Care and Treatment Ms X Received.

Overview of Care

Ms X became involved with the Bristol Mental Health Services in **May 2009** having left her two young children aged four and twenty-two months unattended at her sister's house without first having informed her sister or having checked that she was there. The Police and the Children and Young People's Service became involved. Ms X was cautioned by the Police and her two children were reported to be 'children in need'. Following this incident Ms X was seen by her GP and was referred to the Assessment Team who in turn thought she would be best served by the City-wide Home Intervention Team which assessed her and promised to provide some support which did not arrive as promised. Ms X's mother took her to the Crisis and Home Treatment Team (CRHTT) in order to get help as she was very concerned about her daughter's behaviour and mental health.

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

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

Ms X was a vulnerable adult and as she refused to follow any advice from the Mental Health Services she was discharged to some supported accommodation managed by a local Housing Association. The terms of the tenancy stated that no men were allowed on the premises and no drugs or alcohol were to be consumed on the property. Given her lifestyle and her wish to become pregnant and to use drugs and alcohol it appeared unlikely that the terms and conditions of residence at the Housing Association would be complied with. Ms X met Mr Z who she took back to her flat where they used drugs and alcohol and damaged the property. Therefore her tenancy was terminated and she was evicted on **1 October 2010** and thereby became homeless. The Housing Association had not informed the Mental Health Services that she was being evicted and they did not know until **4 October**.

Ms X met Mr Y who she recognised as a friend of her stepfather and accepted his offer of a bed for the night. She accused him of raping her and left his property and told Mr Z what had happened. She and Mr Z went to Mr Y's flat where Mr Z stabbed him to death.

Findings

The Independent Investigation Team did not find a root cause for the murder of Mr Y on 4 **October 2010**.

11.1.1. Diagnosis

On her first admission to the Open Ward at the local Hospital on **10 June 2009** Ms X was uncooperative, guarded, agitated and immediately made attempts to leave. Although Ms X appeared disorganised and muddled, having some bizarre behaviour and ideas, no specific first rank or psychotic phenomena were noted. A diagnosis of Acute and Transient Psychotic Disorder F23.0 (ICD 10, Classification of Mental and Behavioural Disorders, World Health Organisation 1992) was made, and she was discharged one week later to the care of the CRHTT.

Ms X was readmitted on **22 July 2009** when it was still considered that she did display some symptoms of psychosis. She was discharged on **17 August 2009** and received care and treatment from the ET. In the community Ms X did not engage and refused to take her medication. The validity of her psychotic symptoms was challenged as she very quickly

became calmer on admission. A diagnosis of Borderline Personality Disorder was made but Doctor 2 preferred the term Complex Post Traumatic Stress Disorder (PTSD). The Panel thought he should have been honest and have given her his true diagnosis, as it could have made it more difficult to say later that she did have a personality disorder. Eventually Doctor 2 did consider that Ms X had an Emotionally Unstable Personality Disorder of a Borderline type which explained her erratic and impulsive behaviour.

The EIT stayed with her even when it was decided she did not have a psychotic illness. They tried hard to engage her, but to no avail as she refused medication and avoided contact with members of the Team.

The Independent Investigation Team concluded that the diagnosis of Emotionally Unstable Personality Disorder was appropriate and that it did take into account how she behaved and presented.

Service Issue 1: Medical Staff must always be open and clear with their service users and their relatives about the diagnosis agreed by the Multi-disciplinary Clinical Team. The Trust must ensure that service users understand the diagnosis and what it means, together with the Care Plan designed to help them.

Conclusion

The Independent Investigation Team concluded that the giving of diagnoses by clinical staff was a communication factor as the truth should always be told to service users. It was a service issue and did not in any way contribute to the homicide.

11.1.2. Medication and Treatment

Ms X was prescribed antipsychotic medication due to the ongoing concerns that she might have had psychotic symptoms. She was very rarely compliant with taking her medication so the antipsychotics were of minimal worth in treating her effectively. During the final admission which started on **5 March 2010** under a Section 3 of the Mental Health Act (1983 and 2007) Risperidol Consta was prescribed, but she would not comply with oral medication so Consta was used alone. It is recommended that oral medication be used concurrently with

Consta for at least three weeks, due to reduced bio-availability for this time period, and anecdotal evidence suggests that it may take longer for Consta to be effective. In the treatment of Ms X her oral Risperidone was stopped immediately.

In the short term this medication would not have been effective, so the lack of alcohol and illicit drugs would have had more to do with the improvement in Ms X's condition. It is probable therefore that antipsychotic medication was not a significant factor in Ms X's improvement during her last and longest admission.

In addition, Ms X stopped her Risperdal Consta as soon as she was discharged and took no antipsychotic medication, and appeared not to display any psychotic symptoms. The Independent Investigation Team heard evidence from one witness, Care Coordinator 3, that when seen in prison after the offence Ms X was not receiving medication, and she did not present with psychotic symptoms. This provides further evidence that she did not have a diagnosis of a primary psychotic disorder.

The community care and follow-up for Ms X was provided by the Early Intervention Team (EIT), as it was thought she may have had a primary psychotic illness. The EIT followed-up Ms X assertively and she was offered a broad range of interventions, including medication, and psychological interventions including Dialectical Behavioural Therapy (DBT) which is the evidence-based and NICE-recommended intervention for individuals with Borderline Personality Disorder. She was also offered social interventions and the opportunity to learn new skills at a college. The quality of the proposed interventions was good, but unfortunately Ms X would not engage. Once it was established that her diagnosis was that of Borderline Personality Disorder, and that she did not have a diagnosis of psychosis, she would have no longer met the criteria for the Early Intervention Team and it may have been expected that she would be discharged to a Community Mental Health Team. This did not occur but there was no evidence that remaining with the Early Intervention Team had an adverse effect on her care, as it was evident that she would not engage with Mental Health Services. By the time of the incident Ms X had been discharged from the Early Intervention Team and had made it clear that she did not want any further involvement with the mental health services.

There were limited multi-disciplinary interventions because Ms X would not engage with the services offered. This was also the case when she was an inpatient as she very rarely joined in

with any group activities and only occasionally made use of the nursing staff to discuss matters or seek information.

As the Bristol EIT did not have its own psychiatrist there were limited opportunities for full assessments from Doctor 2, and little scope for any individual work. The National Policy Implementation Guidance for Early Intervention in Psychosis states clearly that each EI Team should have 0.5 whole time equivalent (wte) Consultant Psychiatrist and also 1.00 wte non career grade psychiatrist.

Conclusion

The Independent Investigation Team concluded that the medication prescribed for Ms X was appropriate. The discontinuation of the oral Risperidone and the continuation of the Risperidol Consta was a Task Factor and as such should be learned by the EIS Team. It was a service issue and did not of itself contribute to the homicide.

- ***Service Issue 2: Ms X was non-concordant with her medication. A medicines management plan should have been considered and it would appear that this aspect of good practice was not considered by the treating team.***

- ***Service Issue 3: the commencement of Risperdal Consta and the cessation of the oral Risperidone occurred at the same time. No consideration appears to have been taken as to the effects of this medication change as the new medication regimen would have taken several weeks to have become effective and this was understood poorly by staff.***

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

Control and Restraint

On **21 June 2009** Ms X was detained under Section 2 of the Mental Health Act 2007 and admitted to the Open Ward for her second admission. On this occasion she was forced to receive medication by a Control and Restraint (C & R) Team on four occasions as shown in the Table below:

DATE	EVENT
22 July 2009	Restraint following Ms X refusing to take oral medication so C&R Team was called to forcibly inject medication.
23 July 2009	Restraint following many attempts to leave the ward with PRN administered intramuscularly by C&R Team
27 July 2009	Restraint following Ms X refusing to take oral medication so a C&R Team was called to forcibly inject medication.
29 July 2009	Restraint so that PRN could be administered by a C&R Team intramuscularly.

The Independent Investigation Team considered that this use of Control and Restraint Teams was unusual as it was known that Ms X did not take her medication when she was discharged and in the community, and it was not a matter of urgency that she should take her oral medication. Throughout the interviews with staff working with Ms X the description of her and how she behaved did not resonate with someone who would require four enforced medications in the space of eight days.

Rescinding of the Section 2 and Section 3 of the Mental Health Act immediately Ms X was discharged

Each time Ms X was discharged from hospital the Section 2, and on the last discharge, the Section 3, was rescinded at the same time. Given how difficult Ms X was in relation to absconding it was surprising that this method enabling her to be recalled to hospital was not used. It was also unusual that the first admission on **10 June 2009**, which lasted for a week, was not extended to the full 28 days a Section 2 of the Mental Health Act 2007 would allow, especially as her diagnosis was not clear at this point. The full 28 days may have clarified the actual diagnosis which remained in doubt until **14 June 2010** when Doctor 2 decided that Ms X had a Borderline Personality Disorder.

Treatment of Borderline Personality Disorder

Doctor 2 commented at the Professionals' Meeting on **14 June 2010** that as Ms X had a Borderline Personality Disorder, she could not be admitted to hospital. This was not the case as the Mental Health Act (2001) explicitly states that people with a Personality Disorder can and should be admitted to hospital when treatment is indicated.

Use of Section 117

Ms X had been admitted to the Open Ward/High Dependency Unit under Section 3 of the Mental Health Act (2007) on **5 March 2010**. As mentioned above the Section 3 was rescinded at the same time as her discharge but having been under Section 3 Ms X should have had a discharge CPA, and the use of Section 117 to provide necessary assistance for the discharge should have been used. The use of a Section 117 would have proved useful in helping to sort out her accommodation, yet alone having the power to return her to hospital had the Section 3 been allowed to remain in force.

Conclusion

The Independent Investigation Team concluded that the use of the Mental Health Act 2007 was not in accordance with best practice. Ms X would not engage with the EIT and at the time of the homicide was homeless. The safeguards of Section 117 and the continuation of the Section 3 at the last discharge plus the lack of a trial period at the Housing Association Supported Accommodation prior to her discharge were all contributory factors to Ms X losing her accommodation and being rendered homeless.

- ***Service Issue 4: control and restraint and prevention of violence techniques were used with Ms X and she was forcibly medicated without there being (i) a clear rational for this contained in her clinical notes, and (ii) without this being part of either a care plan or a risk and crisis management plan. Use of these techniques was inconsistent with Ms X's perceived level of risk, her identified need for medication and with the fact that she was discharged from hospital within days of this compulsion being used when it was know that she would not take medication. This was poor practice and not in accordance with either Trust local policy or National best practice guidance.***

- ***Contributory Factor 1: Ms X was discharged from the Open Ward to the Supported Flat provided by the Housing Association. This placement failed. The subsequent failure to use Section 117 to best effect contributed to her being made homeless and increasing her risks as a vulnerable adult.***

11.1.4. Care Programme Approach (CPA)

On **18 April 2010** the Avon and Wiltshire Mental Health Partnership NHS Trust (The Trust) Comprehensive Assessment was completed with the Section on Dynamic Risks stating that these were:

- going absent without leave;
- being non-concordant with prescribed treatment, disengaging from Mental Health Services and the Community Mental Health Teams including the Early Intervention Service;
- having a history of self-harm, including in April 2010 an overdose of Paracetamol and Ibuprofen whilst absent without leave, and an earlier overdose of Paracetamol in March 2009;
- not managing her self-care which could deteriorate when she was unwell and her dietary needs were also neglected.

The Risk Management Plan should have explored the potential risk Ms X posed to her children who were being looked after by her mother. She had had a deep desire and conviction that she would be able to have a two- or three-bedroomed house where she and her children could live. The main emphasis of the Risk Management Plan was about minimising the risks she presented to herself and whilst identifying the risks she posed to her children should she decide to act impulsively and remove them from her mother's care, there was no actual plan to minimise this possibility.

On **20 August 2010** when Ms X was living at the Housing Association flat a Care Plan was made which as with so many of the plans and proposals made in connection with Ms X, relied entirely on her engaging with the EIT and working with Senior Support Worker 1 from the Housing Association. As is evident from the Chronology, Ms X did not engage with Mental Health Services and failed to work with Senior Support Worker 1 to secure the funding for her flat. She also broke the rules and was evicted from the Housing Association flat on **1 October 2010**.

The risks identified within the CPA Review papers did not fully cover the domestic violence she had experienced prior to living in Bristol and being referred to the Mental Health

Services. When she became attached to Mr Z he abused her by hitting her with a rolling pin and placing a hot iron on her arm and burning it, and as a result she was placed in a Women's Refuge in Bath. The level of domestic violence she had been subjected to throughout her life was never identified but she was not prepared to discuss such issues in any depth. The services were aware of her being in a Women's Refuge in Birmingham and another in Newcastle-under-Lyme.

It is understood that the Avon and Wiltshire Mental Health Partnership NHS Trust has addressed the issues about non-compliance with the Care Programme Approach and the poor quality of the Care Plans and Risk Management Plans following the recommendations of the Internal Investigation.

Conclusion

The Independent Investigation Team concluded that the Care Programme Approach was not fully adhered to by the EIS Team. The assessment of need was undertaken and the risks posed by Ms X to herself and others were listed. The resultant Care Plans and Risk Management Plans relied entirely on Ms X engaging with the EIT. When Ms X was discharged to the Housing Association Accommodation on **6 July 2010** the Care Plan was based on her working with the EIT and the Senior Support Worker 1 from the Housing Association. As was evident from her previous behaviour when discharged from hospital Ms X did not engage with Mental Health Services and when at the Housing Association flat she failed to work with Senior Support Worker 1 to secure the funding for her flat. She also broke the rules and was evicted from the Housing Association flat on **30 September 2010**. She was thus made homeless and as she proposed to 'sofa surf' or beg a space on a floor, would be vulnerable given her wish to become pregnant. Following her eviction from the Housing Association property Ms X had no further contact with the EIT until after the homicide.

The main issue for the Professionals' Meeting on **14 June 2010** should have been a plan about how to deal with Ms X's likely disengagement with services and what practical steps could be taken to address this. The Plan totally depended on working with the EIT and Senior Support Worker 1 from the Housing Association. It should have been clear to staff that Ms X would not engage with the Mental Health Services and also that she would find it difficult to cope and comply with the strict terms of the tenancy of the flat.

This was a Team and Social Factor as the EIT did not undertake the prescribed CPA Policy regarding the Management of Risk. This was a Contributory Factor to Ms X losing her accommodation and being rendered homeless but did not of itself lead to the homicide.

- ***Contributory Factor 2: the failure of the service to develop a plan at the point of her discharge from the inpatient unit that took into consideration Ms X's vulnerability and history of non-engagement made a direct contribution to the failure to manage her continued health, safety and wellbeing in the manner to be expected for a service user who had been until recently detained under Section 3 of the Mental Health Act.***

- ***Contributory Factor 3: the Early Intervention Service did not fully comply with the Care Programme Approach Policy. The assessment of need was undertaken but the resultant Risk Management Plans and Care Plans did not specify actions to address the risks identified or to minimise their effect.***

11.1.5. Risk and Clinical Assessment

The staff from the EIT did identify risks and sought to prepare plans to manage them. All along they had difficulty in engaging Ms X which made it difficult to fully understand and monitor the situation without active participation from the service user.

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

The Risk Assessments and Risk Management Plans mentioned that Ms X presented a high risk of absconding but this always appeared to be in the context of her leaving the ward. It was not also viewed as Ms X placing herself in danger through the risks she took when seeking men to fulfil her wish to become pregnant. The level of being able to abscond is alarming, especially as Ms X was under Section 3 of the Mental Health Act 2007 during the time of the most absconding from the High Dependency Unit from **5 March 2010** until she

was transferred back to the Open Ward on **21 June 2010**. Staff also had a Duty of Care to do what they could to ensure she was safe in their care.

Action should have been taken to strengthen the ability of the High Dependency Unit to prevent Ms X leaving. Similarly the granting of Section 17 leave should have been made conditional on Ms X keeping to the times agreed and not just pleasing herself with no regard for the potential consequences. The suspension of leave following her absconding from staff when she was granted escorted leave for an hour on **9 June 2010** was too little too late. Within 12 days of Ms X having her leave suspended she was moved from the High Dependency Unit to the Open Ward with the Section 3 of the Mental Health Act 2007 rescinded.

The Independent Investigation Team concluded that the poor level of Risk Management Plans was a Team and Social Factor within the EIT. The effect of the poor Risk Management Plans made it more likely that Ms X would lose contact with services and become vulnerable but did not directly lead to the homicide.

- ***Contributory Factor 4: when a service user is vulnerable and impulsive the risk assessments and risk management plans must be robust and identify clearly how the risks are to be managed. The Trust should identify what actions could have been taken and use this situation with Ms X as a training example of what could and should have been done. The lessons from this incident must be learnt and converted into practical measures to better safeguard service users who cannot protect themselves due to their impulsivity. The failure of the service to mitigate against the risks posed by Ms X made a contribution to her continued vulnerability and this was detrimental to her health, safety and wellbeing.***

11.1.6. Referral, Admission and Discharge Processes

The Independent Investigation Team concluded that the care and treatment of Ms X could have been better from the time of her final admission to hospital on **5 March 2010** until her eviction from the Supported Housing Accommodation.

In view of Ms X not wishing to engage with the EIT, a Professionals' Meeting was held on **20 August 2010** which was attended by Care Coordinator 3, Senior Support Worker 1, Manager 1 and a Trainee Psychiatrist. It was evident that Ms X no longer wanted to be in contact with Mental Health Services. She was in difficulty with Income Support as she had not informed them that she had moved to the Housing Association flat and was still claiming the same amount of money as when she had had the children with her. A plan was developed for Ms X which comprised:

- Care Coordinator 3 offering her weekly appointments;
- Senior Support Worker 1 offering her meetings twice a week;
- giving her the Housing Association Self Harm Worker's telephone number and that of the weekend support line;
- the Trainee Psychiatrist to speak with the Liaison Service to see the blood test results following Ms X's Paracetamol overdose on **16 August 2010**.

The areas where better care could have been provided were:

- the lack of robust action to prevent Ms X absconding from the hospital;
- the rescinding of the Section 3 of the Mental Health Act 2007;
- the lack of a clear and achievable crisis and contingency plan;
- no reference to the after-care provisions of Section 117 MHA 2007;
- the Care Plan which placed Ms X in a position where it was predictable that she would struggle to meet the requirements of the tenancy.

The Independent Investigation Team concluded that the less than optimal use of the Mental Health Act (2007) was an Organisational and Strategic Factor which indicated that the use of the Act was not being monitored within the Team during Team Meetings nor in individual supervision. This Service Issue did not directly have a bearing on the homicide. It did make it more likely that Ms X would be evicted from the Housing Association Flat.

- ***Contributory Factors 1, 2, 3 and 4 described above in this report are also applicable for this section.***

11.1.7. Service User Involvement in Care Planning and Treatment

The EIT staff worked hard to try to adhere to the Care Plans which were agreed with Ms X. They were concerned about her and wanted to help her cope better with her life and to gain secure accommodation. The Team did involve her and Care Coordinator 2 visited her weekly in hospital during the 18 week admission. The staff in the community and on the ward did what they said they would do but Ms X did not give them the opportunity to meet with her, or if they did meet she would not agree to participate. Some of the letters sent to Ms X were excellent in outlining the issues in a clear and sensitive manner. Ms X would not engage but the EIS Team kept trying.

The Independent Investigation Team concluded that the EIS Team did try to involve Ms X and her mother as fully as possible given Ms X's reluctance to engage with Mental Health Services and her refusal to accept that she had a mental illness. As identified in the Sections about the Care Programme Approach, Risk Assessment and Risk Management and the Mental Health Act (2007), the EIT and the Hospital Team could have been more assertive and proactive by utilising the powers invested in the Mental Health Act to ensure Ms X was regularly reviewed so that her overall situation and mental state could be checked.

This was considered to be a Task Factor as the powers were available and appropriate but were not utilised. It did not directly have any connection with the homicide.

11.1.8. Documentation and Professional Communication

The Independent Investigation Team concluded that the documentation was generally of a good standard, although sometimes the records were not in date order but this was probably due to the various locations from which different teams and members of teams worked.

There were examples of good recording and of sensitive descriptions of interviews clinical staff had had with Ms X. The one weaker area was in the completion of the Risk Assessment and Risk Management Forms which listed the chronological risk but did not expand on this in completing the Risk Management pages. The risks were primarily about Ms X and her risk to

herself and the loss of her children. The risks to the children through her absconding from hospital and abducting them from their grandmother's home were not fully explored.

The Community Mental Health Teams and the Ward Continuing Records were mainly of a good standard, although some of the Incident Forms for when Ms X absconded from the Open Ward and the High Dependency Unit whilst on ground leave and escorted community leave were sometimes not fully completed.

The Independent Investigation Team concluded that the overall recording was generally of a good standard. The exception was the way in which Risk Management was not fully addressed in that the Plans merely reiterated the risks without providing a full description of how they would be addressed.

Professional Communication

Professional communication was of a good standard. The liaison between the various Mental Health Teams was good, as was that between them and other agencies involved in the overall care and treatment of Ms X. Letters were well written and there was excellent written communication with Ms X herself which explained why particular decisions about having leave or not having leave had been made. They acknowledged that some of the decisions taken about her treatment were not accepted by her, and there were good reasons offered for why they had had to be taken.

There was one exception to the good professional communication. This was the failure of the Housing Association to provide Mental Health Services with advance notice that Ms X was likely to be evicted thereby providing an opportunity for advance plans to be considered. This was compounded by the immediate eviction of Ms X on **30 September 2010** with no contact being made with the EIT or other mental Health Services in Bristol until four days later.

Conclusion

The Independent Investigation Team concluded that the failure to notify Mental Health Services was a communication factor which contributed to the vulnerability of Ms X as the direct consequence was to make her homeless as she refused advice to visit the HUB to secure accommodation for homeless people.

It is understood that the recommendation about communication between Housing Associations and other Voluntary Sector Organisations and Mental Health Services made in the Internal Investigation Report has been implemented in full.

- ***Service Issue 4: Housing Services should have warned mental health services that Ms X was about to be evicted and preferably a meeting with mental health services should have been held prior to this decision being activated in order to ensure the continued health, safety and wellbeing of Ms X.***

11.1.9. Safeguarding Children Issues

The Independent Investigation Team concluded that the requirements of the Safeguarding Children Policy both nationally and locally were adhered to by the Avon and Wiltshire Mental Health Partnership NHS Trust. Mental Health staff had acted appropriately and were in frequent contact with the Children and Young People's Service. The Senior Support Worker from the Housing Association also had contact with Social Worker 3 to confirm that Ms X was not making use of the support available at her flat, and that her accommodation was in jeopardy because she was breaking the rules and regulations of the tenancy and had also done nothing to secure funding to pay the rent.

Ms X's two children were in danger of their mother suddenly acting on impulse to go to her mother's home and abduct them. The Risk Management Plan did not rate this as high a risk as it potentially was, but there should have been a clear contingency plan should this occur. There was plenty of warning that this could happen given the pattern of her absconding from the Open Ward and the High Dependency Unit prior to her discharge to the Housing Association property.

The agencies worked well together to try to provide Ms X with the support she and her children needed. Unfortunately Ms X did not wish to have any of her prescribed medication and also after moving to the Housing Association flat she had very little contact with the EIS Team due to apparently deliberately missing the appointments and plans they had made with her.

The Independent Investigation Team concluded that the Safeguarding Children arrangements were good in terms of active and regular communication between Mental Health Services, the Children's and Young People's Service and the Housing Association. The issue was a Patient Factor as Ms X was unwilling to engage with services and did not follow professional advice.

- ***Service Issue 5: when service users are difficult to engage and act in a highly impulsive manner there are often additional risks presented to the safety of children. In the case of Ms X these risks were not always highlighted as a priority and this represents a significant omission in the way child safeguarding was managed.***

11.1.10. Vulnerable Adult Process

In the National Guidance and the AWP Trust Policy to Protect Adults, various forms of abuse are listed. The Table below identifies the abuse Ms X had suffered using the National and Local categories of abuse.

Table 5: Abuse Ms X Experienced

Form of Abuse	Details of the Abuse	Was Ms X Safeguarded?
Physical Abuse	• Allegation of Abuse by Mr Z with rolling pin and hot iron • Having been resident in Women's Refuges in Birmingham, Newcastle-under-Lyme and Bath	No
Sexual Abuse	• The seeking of men. Whilst deliberate, Ms X may not have foreseen the risks	No
Psychological Abuse	None	
Financial/Material Abuse	• Did not apply for benefits to which she was entitled. • No attempt to fund her a placement with Homeless Accommodation via HUB	No – Section 117 No – Section 117
Neglect/Omission	Her own neglect to accept she had any mental health issues and her refusal to take medication and to work with staff to help her gain benefits	No
Discriminatory Abuse	None	

Institutional Abuse	None	

From Table 5 above it can be seen that had Ms X been regarded as a Vulnerable Adult some protection could have been offered to her. At the very least a referral could have been made and given the items listed in the Table a strategic conference would in all probability have been called to examine her needs in full and decide how they could possibly be met.

Looking at the vulnerability Ms X exhibited the main issues were:

- she lacked insight and understanding of her illness and of her apparent inability to 'think things through' before acting and not anticipating the likely outcome, for example disregarding all letters and forms regarding benefits, the Care of her Children and the funding of the Housing Association Flat;
- as she considered she did not have a mental illness Ms X did not want to take medication, nor to send her children to school;
- her getting out of the car on the way to Link House where she would have had supported accommodation for people who had been a victim of domestic violence.

The Independent Investigation Team concluded that Ms X could have been offered a better service regarding her status as a Vulnerable Adult and that she should have been referred to the appropriate Local Authority for an assessment.

The Independent Investigation Team concluded that the lack of a referral to the Local Authority Vulnerable Adult Department was a contributory factor in her remaining homeless and thereby being more vulnerable given her wish to become pregnant. Ms X's impulsiveness and unpredictability together with her Borderline Personality Disorder (Emotionally Unstable Personality Disorder) made her extremely vulnerable and the AWP Policy should have been brought into action. This would almost certainly have triggered a Strategy Meeting where all agencies having contact or knowledge of Ms X would have met to reconsider her vulnerability and what actions they might together take to lessen the dangers she faced.

The staff interviewed by the Independent Investigation Team stated that having help and advice available within the Trust was a welcome improvement which they had found useful in deciding if an issue should be formally referred or not.

- ***Contributory Factor 6: Ms X clearly met the local criteria to be identified as a Vulnerable Adult. While there was generally good communications between agencies the local adult safeguarding protocols were not called into play and as a result Ms X's vulnerability was not reviewed under the auspices of these protocols and no agreed multi-agency approach was put in place. This was a missed opportunity.***

11.1.11. Clinical Supervision

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

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

Clinical Supervision was being carried out in concordance with the Avon and Wiltshire Mental Health Partnership NHS Trust Policy. The staff had their regular monthly management supervision and also their clinical supervision from an appropriate clinician from their profession. There were in addition team supervision and discussion days, and additional external or internally facilitated meetings to cover any specific issues affecting the Team.

The Independent Investigation Team concluded that Clinical Supervision was being undertaken appropriately and in accordance with National and Local Policy.

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

Generally there was compliance with Local and National Policy. The areas where the Independent Investigation had some concerns were:

- the lack of a 0.5 whole time equivalent consultant psychiatrist for the Bristol EIT. It is understood that although the Bristol EIT now has this post filled, four of the other five EITs in the Trust do not have the consultant psychiatrist posts filled;
- the lack of adherence to the Safeguarding of Vulnerable Adults Policy;
- the early rescinding of section 2 and Section 3 of the Mental Health Act (2007) and the lack of use of Section 117;
- the confusion caused by the referral system in 2009 when the Assessment Teams acted as the single point of entry to the services and then referred on to the appropriate team;
- GPs having little faith in the mental health services;
- the lack of full risk management plans to consider all risks to the service user and others;
- the lack of Crisis and Contingency Plans.

The Independent Investigation Team concluded that apart from the seven areas listed above where Local and National policy was not being adhered to the AWP Trust was developing good policies and that generally these were being adhered to. This was an Organisational and Strategic Factor as not all parts of the Trust were adhering to all Local and National Policies.

In the context of the care and treatment of Ms X the areas where policy was not followed were important, and together contributed to her not having as proactive and assertive a Mental Health Service as required to better meet her needs.

11.1.13. Clinical Governance and Performance

The Trust has an appropriate set of clinical policies and strategic documents which are informed by both best practice guidance and national guidelines. It is also noteworthy that the

Trust's clinical policies are informed by the learning accrued from previous events and investigations.

The Independent Investigation Team concluded that the Clinical Governance and Performance of the AWP Trust was good. In the context of serious untoward incidents it is clear that lessons are being learned and the process for Internal Investigation Reports is robust and identifies the key issues and addresses them.

11.2. Conclusions

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

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

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

The Independent Investigation Team would like to highlight that the quality of the Avon and Wiltshire Mental Health Partnership NHS Trust Internal Review (The Root Cause Analysis Report) was of a high standard and many useful findings and conclusions were made and recommendations set. This is to be commended when taking into consideration the difficulties that the ongoing Police Investigation presented to the work of the Internal

Investigation process by denying access to important witnesses from the family of both the perpetrator and the victim.

The Independent Investigation Team whilst concluding that the death of Mr Y could not have been predicted or avoided has highlighted a number of service issues which the Trust needs to consider and address. It did not find any causal factors. The Trust has worked hard since the time of this incident to learn lessons and to ensure that processes and systems are in place and that services are being delivered in accordance with all the required policies and procedures at the present time. Whilst it cannot ever be stated with confidence that such an occurrence will never happen again, the Independent Investigation Team, during the course of the Investigation process, was able to identify significant service improvements pertinent to this case and could determine that the Trust is a learning organisation.

12. Avon and Wiltshire Mental Health Partnership NHS Trust Response to the Incident and the Internal Investigation

The following information has been taken from the Trust Internal Investigation and Post-Incident archive and from interviews with witnesses to the Independent Investigation including three of the Internal Investigation Panel. At the time of the incident the Trust had a comprehensive Serious Untoward Incident Policy entitled The Policy for the Reporting, Management and Investigation of Adverse Incidents (Including Untoward Incidents). The Internal Investigation Panel completed their report within the allotted timescale of 50 working days. This was a notable achievement as the homicide involved three service users known to the AWP Trust: Ms X and Mr Z who originally were jointly accused of the homicide; and Mr Y, the victim, who was also a service user under the care and treatment of the Inner City Support and Recovery Team and subject to Ministry of Justice supervision as he had been released from Broadmoor High Secure Hospital.

The Internal Investigation Panel handled the complexities of the three service users involved in the homicide extremely well and produced a clear and unambiguous Investigation Report.

12.1. The Trust Serious Untoward Incident Process

The initial reporting of the Incident was done through the line management arrangements to the Director of Nursing who later commissioned the Internal Investigation. An Incident Form was completed and was dated **14 October 2010** in relation to Ms X and Mr Z. There was also an Unexpected Death and Homicide Management Report dated **20 October 2010** which had been completed by Manager 1 and a Clinical Team Leader from the Bristol Specialist Drugs and Alcohol Services. Both reports were reviewed by the Director of Nursing.

12.2. The Trust Internal Investigation Team

The Internal Investigation The Avon and Wiltshire Partnership NHS Trust selected four members of staff to undertake the Internal Investigation (Root Cause Analysis Report

Alleged Homicide of [Mr Y] by [Mr Z] and [Ms X]) on or around **4 October 2010**. The staff were:

- a Registered Mental Nurse who had undertaken a number of unexpected death and critical incident audits;
- a second Registered Mental Nurse who had undertaken a number of unexpected death and critical incident audits;
- a Head of Psychology with the Bristol Specialist Drugs and Alcohol Services who had undertaken numerous unexpected death audits;
- a Consultant General Adult and Addiction Psychiatrist who had undertaken one Root Cause Analysis Homicide Investigation.

The Terms of Reference

The Terms of Reference for the Root Cause Analysis Investigation were:

"To undertake a Root Cause Analysis Investigation to examine the strengths and weaknesses of the provision and managements of the treatment and care provided to Mr Z and Ms X by and on behalf of Avon and Wiltshire Mental Health Partnership NHS Trust. The Root Cause Analysis Investigation will seek to do the following, in sequence:

- *Scope the incident, obtaining as much information as possible;*
- *Generate and consider hypotheses about why the incident happened (the immediate cause);*
- *Determine if there were any Care Delivery Problems (CDPs), including any missing or inadequate safeguards;*
- *Determine if there were any Service Delivery Problems (SDPs), including any missing or inadequate safeguards;*
- *Identify the factors contributing to the identified CDPs and SDPs.*

Analyse the contributory factors to determine if the event would have happened if the factor had not been present. Any factors where the answer is 'no' are considered to be root causes.

Make recommendations aimed at ensuring that the identified root cause(s) cannot become root causes for another incident. The recommendations will aim to improve or implement safeguards.

Review the facts of the events preceding the death of Mr Y, following his murder on 7 October 2010. This will involve:

- *Understanding the involvement of Mr Y with NHS Mental Health Services;*
- *Completing a chronology of involvement with NHS Mental Health Services for Mr Z and Ms X;*
- *Commenting as appropriate on the assessment, treatment and care provided to all parties by and on behalf of the NHS Trust and in association with the other agencies involved in care and/or as a result of any previous criminal activity.*

To examine the extent to which the care and treatment provided to all parties corresponded with statutory obligations, including identifying performance concerns.

To engage as far as is possible the involvement of the victim and perpetrators carers and families in the investigative process.

To prepare a report based on the findings and to make recommendations to the Director of Nursing, Compliance, Assurance and Standards".

Findings

The Internal Investigation concluded that the homicide of Mr Y could not have been predicted or prevented. The Internal Investigation Team made the following findings:

"A Care Delivery Problem (CDP) is a problem that arises in the process of care, usually actions or commissions by staff. (In Practice, 2009).

CDP 1 – Not considering [Ms X] as a vulnerable adult.

[Ms X] had a long history of sexual vulnerability and of moving quickly into sexual relationships, often with short term partners that physically, emotionally and possibly sexually abused her. She had been in a number of shelters due to domestic abuse from partners. There were a number of points on her care pathway where she would have clearly met the criteria for a referral into safeguarding adult procedures, on the grounds that:

- *She was a vulnerable adult, and in receipt of community care*
  And
- *She had been subject to abuse.*

Had a safeguarding adult referral been made, it could have identified her ongoing risk from predatory and/or abusive male partners, and put in place a multiagency (including Police) safeguarding plan, which may have ensured agencies noted the new relationship with [Mr Z] at an early stage, identified the risks he posed through multiagency checking and information sharing arrangements that are implicit in the safeguarding adult process. This may have enabled better risk management of [Ms X]

CDP 2 – Service user acceptance of the Care Plan

The discharge CPA in June 2010 was based on 2 optimistic premises, firstly that [Ms X] would be concordant with depot medication, and secondly that she would agree to be placed in supported accommodation, she had not yet seen. The Care plan was probably not sustainable given her patterns of behaviour and history.

Under these circumstances the CPA should have openly explored issues of her engagement and motivation around this plan, and should have set up a crisis plan and review arrangements to activate if the plan started to break down.

CDP 3 – Discharge to Supported Accommodation without trial leave

If [Ms X] has been offered a trial leave to the Housing Association house, this would have had the advantage of demonstrating to all if the placement was going to succeed. It would appear that she was discharged straight to the Housing Association house without this occurring.

CDP 4 – Not convening a Review CPA in July 2010

It was evident by the middle of July that the Discharge CPA which was a Section 117 Discharge Plan was breaking down, as [Ms X] was not accepting medication and was not complying with the tenancy contract of the Housing Association. This was a key point when an urgent Review CPA was indicated.

Although professionals were aware that the plan was breaking down this was not reviewed, and alternative contingency plans were not considered.

CPD 5 – Lack of face-to-face contact with the Early Intervention Team

There was no face-to-face contact between the Early Intervention Team staff and [Ms X] between 26 August 2010 and the time of the incident, with two appointments cancelled due to staff sickness. Alternative arrangements could have been made to see her, particularly given that the discharge care plan was breaking down.

CPD 6 – Child Care Social Worker not involved in professionals' meeting in August 2010

[Social Worker 3] was not invited to the professionals' meeting (August 2010) – and therefore information that she had about [Ms X's] understanding of the court proceedings was not considered in a multidisciplinary forum.

CPD 7 – Eviction from supported accommodation without involvement of Mental Health Services

It is unclear exactly when Mental Health Services were informed of [Ms X's] eviction, as this was not clearly recorded. If the [Early Intervention Team] were aware of this before the eviction they failed to respond in relation to reviewing her mental state, and in supporting her in finding suitable alternative accommodation. If they were unaware then this was a very significant failure of communication between the housing agency and the Mental Health Trust.

CPD 8 – Missing Case Notes

Volume one of the notes is not the actual AWP volume one, as [Ms X] had significant contact with the service prior to when these notes commenced. There has been an internal investigation undertaken and the missing notes have now been located.

Service Delivery Problems – Definition

A Service Delivery Problem (SDP) refers to acts or omissions that are identified during the analysis of the incident, which are not associated with the direct provision of care…
The Tabular Time Line identified 1 Service Delivery Problem in the care of [Ms X].

SDP 1 – Lack of a dedicated psychiatrist attached to the Bristol [Early intervention Team]

The lack of a dedicated psychiatrist in the team had a number of effects on the Care Pathway for [Ms X]. Early Intervention Team members found it difficult to schedule professionals' meetings, an example being that the meeting planned for early September was actually not

going to happen until 21 October 2010, as the meeting was subject to supporting medical consultants availability.

The Mental Health Policy Implementation Guide for Early Intervention Services specifies that Early Intervention Teams should have embedded medical staff as part of the core multidisciplinary team, including a Consultant Psychiatrist and supporting junior medical staff. The lack of dedicated medical staff in this case contributed to the difficulties experienced by the team following [Ms X's] discharge from hospital in June 2010".

The Internal Investigation made seven recommendations relating to the work of the AWP Trust in general and the Early Intervention Service Team in particular. The Table below shows the progress in the implementation of these seven recommendations. Five out of the seven recommendations have been implemented but the two outstanding ones were the provision of a dedicated consultant psychiatrist to each of the six EIS Teams as only two teams have the required half-time provision. The other outstanding recommendation was never started as the relatives of the families involved in the Ms X, Mr Z and Mr Y Internal Investigation were not contacted by the Trust although the Action Plan to implement the recommendations states that it is completed.

The Action Plan was clearly was not completed as the reason for the families not being contacted to discover whether they would welcome a meeting suggests that neither the Trust nor the Police knew the whereabouts of the family members. The addresses of relatives are in the Trust Clinical Notes. The Chair of the Ms X Independent Investigation and the lead commissioner from the NHS South of England will be writing to the family of Mr Y and Ms X to offer a meeting once the Independent Investigation Report is completed and ready for publication.

Table 6: Implementation Plan for the Ms X Internal Investigation

Recommendation	Action	Outcome	Done
AWP to develop joint protocols with housing providers generally, and Housing Association in particular, describing arrangements for partnership working; to include consideration of actions to be taken when someone is at risk of eviction and/or at point of eviction.	CPA arrangements already in place to manage crisis and contingency plans for vulnerable service users. Guidance on development of relapse plans has been improved on Rio Wiki and in CPA procedures. A housing protocol has been developed and is in place with Bristol City Council. The Housing Association is subject to the protocol and has close working relationships with BCC Housing and AWP services.	Protocol in place with Bristol City Council and in turn with the Housing Association	Yes on time by Sept 2012
AWP to address the appointment of a dedicated consultant psychiatrist to the E.I. Teams.	Bristol EI Team and BANES now have medical staffing. There is a 1.0 WTE medical post for Wiltshire which will be filled post July 2012 after the preference exercise is completed and medics are in substantive posts.	Bristol & BANES EIS Teams have medical input. Wiltshire, Swindon & N Somerset pending redesign. Of the current 6 teams only 2 have the required consultant hours.	NO
Personal Recovery Plans need to ensure that there are detailed contingency plans in place should care break down, in particular identifying what support vulnerable individuals faced with eviction from supported accommodation can expect.	CPA policy and procedures include this requirement	Policy, procedure and training in place.	YES by target date of July 2011
The Manager of the E.I. Team should conduct an audit of care plans to ensure adequate contingency plans are in place in their service.	A single stand alone audit would not have improved ongoing quality. Therefore, the existence of quality of crisis and contingency plans has been built into caseload profiling tools that are used in management supervision monthly.	All care coordinators are subject to monthly caseload profiling under which the existence and quality of contingency plans is checked.	YES by target date of June 2012
The E.I. Team Manager to ensure that plans are in place to provide continuity of service provision at times of staff absence and sickness.	The E.I. Quality Improvement Managers will discuss this action at the next E.I. Governance Meeting and will provide assurance that contingency plans are in place after further discussion with Team Managers.	E.I. teams have contingency plans in place Assurance provided	YES by target date of June 2012
The Medical Records Manager should review the health records governance issues raised by this investigation and instigate appropriate action both within health records departments and teams generally, to ensure that all volumes of records are correctly identified and that duplicates are avoided.	Check that the Rio policy duplicates the existing Records Management Policy to identify all existing records for a Service User and avoid duplicates.	The Health & Social Care Records Service has issued a Trust wide procedure to assist staff to avoid the duplication of health records on the Rio system. Further guidance has been produced to inform staff of the numbering process when historic volumes from other services are received.	YES by target date of July 2011
A meeting with the families of	The case concluded in November	The case concluded in	NO

the three individuals under the care of AWP should be arranged at the earliest possible opportunity with members of the RCA team to allow them to express their views about the care their family member received from the Trust. If there are further recommendations following these meetings, an addendum to this report will be made and circulated to all relevant parties.	2011.	November 2011.	was due to be done by Sept. 2011

The Internal Investigation was rigorous and highlighted all the key issues relating to the care and treatment of Ms X. The recommendations have largely been implemented although it is of concern that the key recommendation about the dedicated hours for a consultant psychiatrist in each of the Early Intervention Service Teams has only been achieved in two of the six teams. The Bristol and Bath and North East Somerset Teams have the required dedicated hours but North Somerset, South Gloucestershire, Swindon and Wiltshire do not. It is important that the lessons from the Ms X situation are learned and acted upon.

13. Notable Practice

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

13.1. Notable Practice from Individual Practitioners and Teams

The following notable practice was identified:

- the tenacity of the Early Intervention Team in trying to engage Ms X when it was evident she did not wish to accept help from mental health services. The EIT attempted to remain in contact with Ms X even though they realised that she was not taking her medication and was not keeping her appointments with her Care Coordinator or other members of the Team;
- the written notes of the assessments carried out by Doctor 1 in **May 2009**, and the Social Circumstances Report for the Mental Health Act Tribunal written by Care Coordinator 2 dated **7 May 2010**, both of which gave a clear and detailed account of how Ms X had presented and provided a good summary of the interview and the care and treatment being provided;
- the efforts to explain matters to Ms X even when she was not showing any wish to discuss the care of her children or other issues to do with her mental health and her need for accommodation;
- allowing Ms X to stay in hospital until supported accommodation had been identified and a date for moving in to the Housing Association property had been agreed;
- the good liaison between the EIT and the Children's and Young People's Services.

14. Lessons Learned

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

Louis Appleby (2007), the then National Director of Mental Health commented:
"Increasingly, services aim to go beyond traditional clinical care and help patients back into mainstream society, re-defining recovery to incorporate quality of life - a job, a decent place to live, friends and a social life". [177]

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

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

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

Corroboration and Sharing Information

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

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

Assessment and Care Planning

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

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

Discharge Planning

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

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

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

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

Reflective Practice

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

Governance

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

15. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Avon and Wiltshire Mental Health Partnership NHS Trust to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice has been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process. This Section is set out in two parts. The first addresses provider recommendations, the second addresses commissioner recommendations.

15.1. Recommendations for the Avon and Wiltshire Partnership NHS Trust

Each recommendation is set out below in accordance with the relevant progress that the Trust has already made since the time of the incident.

15.1.2. Diagnosis

- ***Service Issue 1: Medical Staff must always be open and clear with their service users and their relatives about the diagnosis agreed by the Multi-disciplinary Clinical Team. The Trust must ensure that service users understand the diagnosis and what it means, together with the Care Plan designed to help them.***

Progress Made by the Trust since the Time of the Incident:

All teams have undertaken team based training on care planning, including collaboration with and involvement of relatives. Each individual practitioner's approach to collaborative working is being reviewed through the caseload supervision process, using

the agreed profiling tool and monitored through line management route. The Trust now regularly audits the practice within teams.

Recommendation 1.

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

15.1.3. Medication and Treatment

- ***Service Issue 2: Ms X was non-concordant with her medication. A medicines management plan should have been considered and it would appear that this aspect of good practice was not considered by the treating team.***

- ***Service Issue 3: the commencement of Risperdal Consta and the cessation of the oral Risperidone occurred at the same time. No consideration appears to have been taken as to the effects of this medication change as the new medication regimen would have taken several weeks to have become effective and this was understood poorly understood by staff.***

Progress Made by the Trust since the Time of the Incident:

The Trust now undertakes more systematic audits and reviews of prescribing practice linked to The Prescribing Observatory for Mental Health (POMH-UK).

Recommendation 2

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

Recommendation 3

All prescribing staff should be familiar with the necessary steps to commence oral and depot antipsychotic medication safely, and this should include the risks associated with switching

between oral and intramuscular forms of medication. Prescribing staff should have completed mandatory training in medication prescribing.

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

- ***Service Issue 4: control and restraint and prevention of violence techniques were used with Ms X and she was forcibly medicated without there being (i) a clear rationale for this contained in her clinical notes, and (ii) without this being part of either a care plan or a risk and crisis management plan. Use of these techniques was inconsistent with Ms X's perceived level of risk, her identified need for medication and with the fact that she was discharged from hospital within days of this compulsion being used when it was know that she would not take medication. This was poor practice and not in accordance with either Trust local policy or National best practice guidance.***

- ***Contributory Factor 1: Ms X was discharged from the Open Ward to the Supported Flat provided by the Housing Association. This placement failed. The subsequent failure to use Section 117 to best effect contributed to her being made homeless and increasing her risks as a vulnerable adult.***

Progress Made by the Trust since the Time of the Incident:

All staff who use restraint, are trained in PMVA, which includes the use of de-escalation techniques to try and prevent the need for a restraint intervention. The current policy was updated in November 2012.

The Trust is currently undertaking an audit of physical interventions in line with NICE guideline 25 '*Short-term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient Settings'*, to review all incidents of violence and aggression that have resulted in a physical intervention team being convened (whether this resulted in restraint or not), and review whether the principles of the tertiary intervention policy and NICE guidance 25 are correctly and consistently applied. This audit is reviewing 12 months data and the findings will be present nationally.

Weekly bed management meetings are now held. These involving In-patient, Community and Crisis Team Managers with Local Authority representation in order to enable better communication regarding complex individuals and care pathways.

The Social Care Lead for the Trust is reviewing Section 117 agreements with Local Authority commissioners.

Recommendation 4

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

15.1.5. Care Programme Approach

- ***Contributory Factor 2: the failure of the service to develop a plan at the point of her discharge from the inpatient unit that took into consideration Ms X's vulnerability and history of non-engagement made a direct contribution to the failure to manage her continued health, safety and wellbeing in the manner to be expected for a service user who had been until recently detained under Section 3 of the Mental Health Act.***

- ***Contributory Factor 3: the Early Intervention Service did not fully comply with the Care Programme Approach Policy. The assessment of need was undertaken but the resultant Risk Management Plans and Care Plans did not specify actions to address the risks identified or to minimise their effect.***

Progress Made by the Trust since the Time of the Incident:

All service users now have a CPA meeting within 7 days of admission to hospital, to ensure that there is early identification of any issues that need addressing to support recovery and discharge in a timely manner. Intensive Support Teams have been reviewed, and further recruited to, to ensure that there is now regular input provided to all open acute wards to support discharge planning, work with and facilitate preparation for discharge, and provide ongoing involvement and support to service users in the community upon discharge from hospital.

As part of clinical supervision, team managers and senior practitioners are scrutinising a number of clinical patient records, using an agreed scrutiny template. This includes risk assessment and risk management plans. Outcomes are recorded as part of the supervision record including any actions required.

The revised CPA Policy was Highly Commended by the CPA Association in 2011. The revised Policy includes definition for 'ON CPA' and 'Non CPA'. The definition would ensure that any service user admitted and/or detained would be 'On CPA'

Recommendation 5

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

15.1.6. Risk Assessment and Management

- ***Contributory Factor 4: when a service user is vulnerable and impulsive the risk assessments and risk management plans must be robust and identify clearly how the risks are to be managed. The Trust should identify what actions could have been taken and use this situation with Ms X as a training example of what could and should have been done. The lessons from this incident must be learnt and converted into practical measures to better safeguard service users who cannot protect themselves due to their impulsivity. The failure of the service to mitigate against the risks posed by Ms X made a contribution to her continued vulnerability and this was detrimental to her health, safety and wellbeing.***

Progress Made by the Trust since the time of the Incident:

There is a review being undertaken of the CPA and Risk management training. Quality of care planning including risk management plans are being monitored through caseload supervision.

Discussions are underway to develop a 'risk panel' which will provide expert clinical advice to care co-ordinators where there are complex issues and concerns.

Additional work is being done to look at developing refresher training for all staff on clinical assessment and formulations. This will be linked to clinical supervision so that staff who have been identified as having deficits in this areas will be referred for updated skill training

Recommendation 6

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

15.1.7. Referral, Transfer and Discharge

- ***Contributory Factors 1, 2, 3 and 4 described above in this report are also applicable for this section.***

Progress Made by the Trust since the Time of the Incident:

All teams now have a Standard Operating Procedure in place which describes referral, transfer and discharge processes and sets standards for these. Maintaining Standards around CPA have been added as core objectives to all adult community team appraisals.

The CPA Policy and Procedures have been reviewed and address standards and practice for Referral, Transfer and Discharge.

Implementation of the electronic health record enables staff in different teams to have access to clinical information in real time.

15.1.8. Documentation and Professional Communication

- ***Service Issue 5: Housing Services should have warned mental health services that Ms X was about to be evicted and preferably a meeting with mental health services***

should have been held prior to this decision being activated in order to ensure the continued health, safety and wellbeing of Ms X.

Progress Made by the Trust since the Time of the Incident:

The Trust has now reorganised services in Bristol to come under local management. This significantly strengthens the potential for local partnership working with all statutory support services used by mental health users, including Housing. One of the first steps that the new Bristol Locality is taking is a detailed mapping of links with and barriers to Housing support for service users, particularly in the inner city.

15.1.9. Safeguarding Children

- ***Service Issue 6: when service users are difficult to engage and act in a highly impulsive manner there are often additional risks presented to the safety of children. In the case of Ms X these risks were not always highlighted as a priority and this represents a significant omission in the way child safeguarding was managed.***

Progress Made by the Trust since the Time of the Incident:

Every team has two staff members trained in safeguarding Level 3 to ensure that safeguarding issues are highlighted within the team.

In teams with higher numbers of parents in their caseloads this number will be extended following the conclusion of further work with commissioners to agree a final training matrix for Level 3 training in final quarter of 2012/2013.

15.1.10. Safeguarding Vulnerable Adults

- ***Contributory Factor 5: Ms X clearly met the local criteria to be identified as a Vulnerable Adult. While there was generally good communications between agencies the local adult safeguarding protocols were not called into play and as a result Ms X's vulnerability was not reviewed under the auspices of these protocols and no agreed multi-agency approach was put in place. This was a missed opportunity.***

Progress Made by the Trust since the Time of the Incident:

New Safeguarding procedures are in place in Bristol through joint working arrangements between mental health services and local authority partners

AWP has led the development of the Bristol Safeguarding Adult multi-agency policy, including providing clearer guidance to practitioners on the thresholds for making safeguarding adult alerts to the local authority

Every team has 2 staff members trained in safeguarding Level 3 to ensure that safeguarding issues are highlighted within the team. A joint protocol for safeguarding has been developed between AWP safeguarding leads and BCC.

Level 2 training is available to all practitioners, with an 80% attendance rate over a 2 year cycle. This training has been further developed, and a new enhanced training has been introduced from December 2012 for practitioners. The south west thresholds framework (and where relevant local thresholds guidance) issued in 2010/2011 has been incorporated into Trust policy, and is available to all practitioners on dedicated Safeguarding Adult pages on the Trust intranet. The numbers of alerts made by AWP staff has risen significantly since 2009, and alert rates are monitored and reported as part of AWP's internal governance and performance arrangements, as well through the relevant safeguarding adult Boards.

Recommendation 7

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

16. Glossary

Amphetamines	Medication prescribed in the 1960s for treating low blood pressure, asthma, sleep disorders, migraine and to aid slimming. They are now a Class B illegal drug (Class A if prepared for injection) with severe penalties for possession and sale.
Benzodiazepines	Benzodiazepines are a group of medicines that are sometimes used to treat anxiety, sleeping problems and other disorders. Two of the most common are Diazepam and Lorazepam
Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Mental Health Act (83 and 07)	The Mental Health Act 1983/2007 covers the assessment, treatment and rights of people with a mental health condition.
Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care.

National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk Assessment	An assessment that systematically details a person's risk to both themselves and to others.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
SHO (Senior House Officer)	A grade of junior doctor between House Officer and Specialist Registrar in the United Kingdom.

Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.