Independent Investigation

into the

Care and Treatment Provided to Mr. W

by the

Mersey Care NHS Trust

Commissioned by

NHS North West

Strategic Health Authority

Executive Summary

Independent Investigation: Health and Social Care Advisory Service

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1. Brief Background and Incident Description and Consequences

Background for the Care and Treatment of Mr. W

Mr. W was born in Manchester. He reported that his childhood was unhappy. He was in care from around age of 11 years.

Mr. W served a number of prison sentences although the full extent of his forensic history was never known to those providing care and treatment to him as Mr. W was reluctant to discuss this aspect of his life. He reported that he had attempted to kill himself in 2002 and 2003. At least one of these attempts occurred while he was serving a prison sentence and he subsequently received some psychiatric input.

Mr. W was in contact with the substance misuse services in Liverpool from around September 2004 and also under the care of the Lighthouse substance misuse project based in Knowsley/ Newton-Le-Willows from at least 2006. It appears that he was also in contact with the Five Boroughs NHS Trust Mental Health Services at some point between July 2005 and July 2006.

Mr. W first came to the attention of mental health services in Liverpool when his GP referred him with *"chronic depression"* and suicidal thoughts in July 2006. In September 2006 Mr. W was assessed under the Mental Health Act (1983) but was not found to be detainable. However following a further suicide attempt he was admitted to hospital as an informal patient. At beginning of October 2006 Mr. W was transferred, as an in-patient, from Broadoak to Windsor House, at least in part, because his therapeutic relationship with the ward staff had broken down.

Although Mr. W was assessed as being at continued risk of impulsively harming himself and attempting suicide no evidence of on-going depression or any symptoms of psychosis were identified during his admission. Diagnoses of depression and adjustment disorder were considered, however, Mr. W was discharged with a diagnosis of Emotionally Unstable Personality Disorder. It was concluded that his impulsive self harming behaviour was exacerbated by his social circumstances and probably by his continued drug misuse. Mr. W's girlfriend reported that both she and Mr. W had been threatened and Mr. W had been attacked on at least one occasion. Mr. W reported that he had debts of around £30,000.

Following his discharge from hospital Mr. W attended only one follow up appointments. He failed to respond to a letter asking him to make contact with the mental health service and was subsequently discharged.

In mid December 2006 Mr. W was convicted of driving whilst disqualified. At his hearing he informed the Court that he was engaged with the mental health services, was being prescribed anti-depressant medication and was attending weekly psychotherapy. None of this was true.

Incident Description and Consequences

The body of a colleague of Mr. W's girlfriend was found in her house on 6 January 2007. The Pathologist concluded that she had been killed on or around 29 December 2006. It was alleged that between these two dates Mr. W had withdrawn money from the victim's account and returned to her house on several occasions and taken goods which he sold.

Mr. W was convicted of murder at Liverpool Crown Court on 4 July 2007 and sentenced to 26 years imprisonment on 25 July 2007.

Mr. W was found hanged in his prison cell on 21 August 2009.

2. Terms of Reference

The Terms of Reference for this Independent Investigation were set by the NHS North West. The Independent Investigation was asked:

1. **To examine:**

- the care and treatment provided to the service user, at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate);

- the suitability of that care and treatment in view of the service user's history and assessed health and social care needs;

- the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;

- the adequacy of risk assessments to support care planning and use of the care programme approach in practice;

- the exercise of professional judgement and clinical decision making;

- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical needs;

- the extent of services' engagement with carers; use of carer's assessments and the impact of this upon the incident in question;

- the quality of the internal investigation and review conducted by the Trust.

2. **To identify:**

- learning points for improving systems and services;

- development in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

3. **To make:**

- realistic recommendations for action to address the learning points to improve systems and services.

4. **To report:**

- findings and recommendations to the NHS North West Strategic Health Authority Board as required by the SHA.

3. Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of Mersey Care 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 and Chair

Dr. Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service. Chair, Nurse Member and Co-Report Author

Investigation Team Members

Dr. Len Rowland	Director of Research HASCAS Health and Social Care Advisory Service. Psychologist Member of the Team and Co-Report Author
Dr. David Somekh	Forensic Consultant Psychiatrist Member of the Team

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Mrs. Fiona Shipley	Stenography Services

4. Findings of the Independent Investigation

No causal or contributory factors were found by the Independent Investigation Team. Four services were identified in the interests of learning lessons.

4.1. Referral and Discharge Procedures

Mr. W was appropriately referred to both mental health services and substance misuse services by his GP on a number of occasions. The services responded to these referrals but, for a variety of reasons, usually failed to engage Mr. W. When he was admitted to hospital in September 2006 the records suggest that Mr. W was not fully engaged in addressing his problems and no evidence of depression or psychosis was detected. He was discharged with a diagnosis of Emotionally Unstable Personality Disorder. At the point of discharge a plan was put in place which offered continuity of care, regular out-patient appointments and referral to the Rotunda Personality Disorder Psychotherapy Service. Mr. W did not avail himself of these opportunities. The clinical team caring for Mr. W considered referring him to the Community Mental Health Services but given his lack of engagement and commitment to addressing his problems it was decided to take an approach which required less commitment on his part with the opportunity to revise this decision should Mr. W show more commitment. At the point of Mr. W's discharge from hospital the clinical team considered the options open to them and the Independent Investigation Team concluded that the team made a reasonable decision about his on-going care.

4.2. Diagnosis

From the first recorded contact with health services Mr. W's presentation was characterised by the misuse of illicit substances and impulsive acts of self harm and attempted suicide. His first contact with services provided by the Mersey Care NHS Trust was in September 2004 when he was assessed for a community detoxification programme. In July 2006 Mr. W was referred to the mental health services by his GP who described him as suffering from chronic depression with suicidal ideation.

Mr. W was assessed as an in-patient over a four week period in September/October 2006 when the clinicians looking after him considered the diagnosis of depression as an explanation of his self harming and suicidal behaviour and his frequent reports that he felt *"fed up"*. However it was concluded that: *"During the in-patient admission it became clear*

that there were few consistent signs of depression and the main factors were the chaotic elements of [Mr. W's] life style such as the outstanding debts and his up and down relationship with his girlfriend".[1] They reached the conclusion that Emotionally Unstable Personality Disorder was a more appropriate diagnosis and better explained Mr. W's behaviour.

The Independent Investigation concluded that the clinical teams looking after Mr. W considered the relevant diagnostic categories and arrived at a reasonable conclusion that the most appropriate diagnosis was that Mr. W was suffering from a personality disorder, his impulsive behaviour being exacerbated by his social circumstances and his, probable, continued misuse of illicit substances.

4.3. Medication and Treatment

Substance Misuse

In October 2004 Mr. W was admitted to an in-patient detoxification programme but discharged himself before this was completed. Up to this point Mr. W had irregular contact with the Substance Misuse Services where a number of approaches to helping him with his use of illicit drugs had been considered but they had all failed to deliver the desired outcomes as Mr. W was unable or unwilling to adhere to the programmes suggested. However in May 2005 he was given a test dose of Naltrexone and as he displayed no adverse affects he was prescribed this drug throughout May, June and July 2005.

The 2007 NICE guidance on prescribing Naltrexone states that: *"It should only be given to people who have been told about the problems associated with treatment, and with proper supervision. Treatment with naltrexone should be given as part of a support programme to help the person manage their opioid dependence.*
Healthcare professionals should regularly review how well Naltrexone is working to help people stay off opioids".[2]

The Guidance also recommends that psychosocial and behavioural therapies should be made available. This echoes the advice of the National Treatment Agency for Substance Misuse (NTA, 2002). However as Mr. W was out of the country for much of the time that he was prescribed Naltrexone it is improbable that he availed himself of any intensive or structured support. His contacts with the service were infrequent and at times there was only telephone

1 Clinical notes Vol. 1 p 32, GP records Vol. 2 p 20
2 NICE (January 2007) TA 115: *Naltrexone for the Management of Opioid Dependence*

contact. So supervision would appear to have been at best infrequent and cursory. There is no record in Mr. W's clinical notes as to why the substance misuse team decided to prescribe Naltrexone even though they knew that he would be abroad for prolonged periods. There appears to have been a discrepancy between the NICE and NTA guidance and practice in the case of Mr. W.

When Mr. W was admitted to hospital in August 2006 he informed the Specialist Registrar (SpR) that he was being prescribed Subutex (Buprenorphine) by the St Helens substance misuse services. He was reluctant to discus his use of illicit drugs. His care plan was to continue to prescribe Buprenorphine with the longer term aim of abstinence. However, there is no record of any attempt to involve the Substance Misuse Services in Mr. W's care during the in-patient admission. In her letter to Mr. W's GP dated 16 October 2006 the Specialist Registrar (SpR) reported that Mr. W had informed her that the Newton-Le-Willows Community Drug Team had prescribed Subutex following his discharge and was happy to continue to do so. There is no formal confirmation of this in the notes and no record of any contact between the Mental Health Team and the Newton-le-Willows/St Helens/Knowsley Substance Misuse Team.

Mental Health

In July 2006 Mr. W was referred by his GP to the CMHT, on a number of occasions in August and September 2006 Mr. W presented to the Accident & Emergency Department in crisis and on 19 September 2006 he was admitted to hospital following an attempt to hang himself.

This admission was the only real opportunity for therapeutic intervention. However given the circumstances of the admission the primary focus was on managing the risk Mr. W presented to himself and on managing his substance misuse. This required that Mr. W was closely monitored. He was not comfortable with this and this placed a strain on his relationship with the nursing staff.

The clinical team concluded that Mr. W's impulsive, self harming behaviour was a manifestation of an Emotionally Unstable Personality Disorder. Given this diagnosis the treating team, appropriately, refrained from prescribing additional psychotropic medication. They concluded that although he continued to present a significant risk to himself a continued in-patient admission would not be beneficial. This again appears to have been a reasonable

decision. It was also suggested that Mr. W might be referred to a Personality Disorder Psychotherapy Service. Mr. W did not avail himself of the opportunity and he disengaged from the service before a referral was made.

Mr. W attended only one follow up appointment after leaving hospital and was discharged from the mental health services on 9 January 2007 without any further input, although he did present at the A&E Department on a number of occasions.

From his first contact with Mental Health Services it was evident that Mr. W's misuse of illicit drugs played a significant part in his presentation, however, in line with Best Practice guidance the clinical team offered him a service from within mainstream adult mental health services. Having concluded that Mr. W's problems could be viewed as a manifestation of his personality disorder, exacerbated by drug misuse and social stressors it was appropriate that his in-patient admission was not continued indefinitely. However prior to discharge it would have been politic to have sought the advice of the substance misuse service and those with expertise in personality disorders. Mr. W was given a follow up out-patient appointment and referral to a psychotherapeutic programme was discussed with him but Mr. W had a history of failing to engage with services and not adhering to programmes of intervention. His preferred mode of contact was to present at times of crisis. This is not unusual for people with a diagnosis of personality disorder.

The Best Practice guidance on personality disorder is clear that this is a treatable disorder and should be addressed within mainstream adult mental health services. However the guidance points out that if competent services are to be delivered then staff need to have appropriate training and expert advice, consultation and supervision need to be available. The Independent Investigation was informed that neither was available to Mr. W's treating team at that time.

However, given Mr. W's long established pattern of behaviour even had a co-ordinated plan informed by and shared with Substance Misuse Services and Personality Disorder Services been put in place at this time it could not be concluded with any degree of confidence that this would have significantly altered Mr. W's behaviour in the short term.

4.4. Use of the Mental Health Act (1983)

The clinicians looking after Mr. W considered using the Mental Health Act, assessed him and found him not to meet the criteria for detention. They offered him on-going assessment and

treatment on a voluntary basis. As they became more familiar with Mr. W's presentation and developed a clearer formulation of his problems they identified that Mr. W presented an on going risk to himself but concluded that he did not meet the criteria for detention under the Act. The Independent Investigation Team concluded that appropriate use was made of the Mental Health Act (1983).

4.5. The Care Programme Approach

There was on-going assessment of Mr. W's mental state, particular by the SpR, and much of the information one would have expected to be available was collected. However, this was not organised or recorded within the notes in a manner that reflected the comprehensive and multi-disciplinary approach which characterises CPA.

Six care plans are recorded in Mr. W's mental health clinical notes. That six care plans were drawn up in the space of a little over a month show a degree of conscientiousness, however none of the plans display the typical structure of a CPA care plan characterised by: identification of need, identification of goals that would meet the need, identification of actions to attain the goal, evaluation of progress and revising of the goal. Perhaps this is because the plans were not recorded on Trust CPA forms. The plans are not comprehensive and multidisciplinary, rather they deal, predominantly, with the immediate issues of providing care and maintain the safety of Mr. W.

In the context of the Care Programme Approach it would have been good practice to have held a multidisciplinary meeting, involving the substance misuse team and perhaps a representative from the Personality Disorder Service, when Mr. W's discharge was being planned to draw up a co-ordinated plan agreed with Mr. W and his girlfriend. This plan should have been comprehensive enough to address the issues identified by the clinical team.

The Independent Investigation took note of the observation that given Mr. W's poor motivation to engage with services and his history of poor collaboration with the services offered to him it was felt that it would be most appropriate to put in place a relatively undemanding programme of interventions. If Mr. W then appeared to be motivated to address his problems a more comprehensive range of services and interventions could have been introduced. The Independent Investigation concluded that this was not an unreasonable approach. Nevertheless, a more comprehensive CPA review meeting might have provided an opportunity to integrate the delivery of mental health and substance misuse services and to

explore how services might have been best delivered to an individual identified as having personality and substance misuse problems.

4.6. Risk Assessment and Management

Although it was known that Mr. W had served a number of prison sentences the nature of his offences was not known to those caring for him. With the benefit of hindsight one might argue that those assessing the risk Mr. W posed might have sought information on his offending history especially as it was noted that he was reluctant to provide this. However, it has to be noted that Mr. W was effectively only under the care of the mental health services for a little over a month. He presented in crisis and the immediate risk which the clinical team had to deal with was Mr. W's attempt to harm himself. When he was assessed at the time of his admission to hospital the risk of him harming others was perceived as being low. During his in-patient admission the SpR met Mr. W's girlfriend and she, like the clinical team, perceived the major risk to be Mr. W attempting to harm himself.

Rather than posing a risk to others Mr. W was perceived as being at risk from others because of his drug habit and the social context in which he moved. He claimed, on two occasions, that he had been abducted by drug dealers.

Adequacy of risk assessment

When Mr. W was initially in contact with the Substance Misuse Services in Liverpool they employed their own assessment protocols which focused, not unreasonably, on Mr. W's history of drug misuse. In the notes available to the Independent Investigation there is no record of a more comprehensive risk assessment being conducted.

When Mr. W was assessed in September 2006 prior to him being admitted to hospital the Trust's Effective Care Co-ordination Risk Assessment form was employed and when he was assessed on the 20 October 2006 a Threshold Assessment Grid (PRISM) form was employed. While no risk assessment device is ideal for all situations and while it is acknowledged that risk assessment has to be both on-going and dynamic it would have been helpful to those assessing and monitoring Mr. W if some common device had been used across services and across time.

As time past a familiar pattern emerged in Mr. W presentation. He tended to present to emergency services, mainly the A&E Department, at times of crisis, however when he was assessed he would report that the crisis had passed and he no longer felt suicidal. Indeed on

some occasions he did not wait to be assessed. This was the pattern when he presented to the A&E Department in September 2006; he was admitted to hospital and within two days he was reporting that his mood had improved and he wanted to go on leave from the ward. The clinical staff were appropriately cautious about such a rapid recovery and considered detaining him under the Mental Health Act as they considered him to be at risk of harming himself. However after observing Mr. W for some time the clinical team came to the conclusion that while he did continue to present an on-going risk of impulsive self harm this was a manifestation not of depression but of a personality disorder and it would not be in his best interests for him to remain in hospital indefinitely. It was concluded that the risk Mr. W posed would be best dealt with by addressing his personality difficulties.

Contingency planning

Given Mr. W's known propensity to harm himself impulsively, before granting him unescorted leave from the ward it would have been good practice to have identified the antecedents for this behaviour and agreed with Mr. W, and with his agreement, with his girlfriend, a contingency plan to address these. It is a moot point as to whether Mr. W would have complied with any plan once it was agreed but this might have been taken into account in the plan itself and been an early step in addressing his impulsivity and personality difficulties.

4.7. Service User Involvement in Care Planning

It is common practice to ask the service user to sign his/her care plan as a method of recording that s/he has been involved in the assessment of needs and the drawing up of the care plan. However there are no care plans recorded on Trust forms in the clinical notes made available to the Independent Investigation and so no formal record of Mr. W's involvement in the assessment of his needs or his care planning. However it is evident from the clinical notes that, to a significant degree, Mr. W controlled the care he received. When he presented himself to the Substance Misuse Services and the Crisis Service and he was clear what he wanted from these services. In September 2006 he presented at the A&E Department asking to be admitted to hospital. Soon after he was admitted to hospital he was vocal in asking for leave and, it appears, he left the ward on a number of occasions without informing the staff. Following his discharge from hospital Mr. W attended only one follow up appointment and, by his own admission, this was at the insistence of his girlfriend and so again Mr. W effectively controlled the care and support that was provided to him.

4.8. Carer Involvement and Carer Assessment

Mr. W's girlfriend appears to have been a stabilising influence on him during the time he was in contact with the mental health services. She was at times his advocate and was forceful in putting forward her views and making known her concerns about the risk Mr. W posed to himself.

While Mr. W was an in-patient the SpR saw Mr. W's girlfriend on at least two occasions and she was present at the ward round immediately prior to him being discharged and so was party to the planning of his on-going care. It would appear then that, at least during the period when he was an in-patient, Mr. W's girlfriend was appropriately involved in his care.

Despite her intimate involvement in Mr. W's care his girlfriend was not offered her own carer's assessment. However, as has been noted, he was under the care of the mental health services for only a very brief period and once he was discharged from hospital he rapidly disengaged from the services with the result that contact with his girlfriend was also lost. Given this situation it is not surprising that she was not offered her own carer's assessment.

4.9. Documentation and Professional Communication

Although Mr. W was in contact with services only erratically and for a short space of time he was in contact with a substantial number of services. This is not, however, an unusual presentation for an individual who has a drug misuse problems and has been given a diagnosis of personality disorder. The lives of these individuals are often chaotic and characterised by both crises and impulsive behaviour.

Communications between Mersey Care NHS Trust teams was found to be generally appropriate. Communication by all the Mersey Care teams with Mr. W's GP appears to have been both regular and timely. The one area in which communication appears to have failed was with the Community Drug Service based in Newton-le-Willows. It was this service that was prescribing Mr. W's medication prior to his in-patient admission and which resumed this role when he was discharged from hospital. There are no communications with this service recorded in the either the Mersey Care clinical notes or Mr. W's GP clinical notes made available to the Independent Investigation. This is in contrast to the regular and timely information the Kevin White Unit provided to the GP when Mr. W was under the care of that service.

The Newton-le-Willows Community Drugs Service was provided by a non-statutory agency which has since been replaced. The Independent Investigation did not have access to the policies of this organisation and so is not in a position to comment on whether this lack of communication was an organisational failure or poor clinical practice.

It has already been noted that Mr. W had a substantial forensic history. There was no contact however between the mental health service and the Police. Had Mr. W engaged with the service over a longer period of time it would have been good practice to have established a collaborative approach with the Police and Criminal Justice Service. However given his presentation, his reluctance to disclose information, the lack of any information available to those assessing him that he might prove to be a threat to others and the short time he was involved with the service it would be unrealistic to have expected the clinical team to put such a liaison in place.

4.10. Clinical Governance

At the time Mr. W was under the care of Mersey Care NHS Trust the Trust had in place a number of appropriate policies and procedures informed by best practice guidance and national policy. However the protocols put in place by the Trust were not always followed. It has to be noted, however, that Mr. W was only under the care of the Trust's mental health services for a little over a month and since that time there has been a significant re-organisation of Trust services and revision of its protocols.

5. Lessons Learned

Mr. W was only episodically involved with services delivered by Mersey Care NHS Trust. He was initially in contact with the Substance Misuse Service, though he failed to engage with this service for any prolonged period so that his problems might be addressed in a consistent manner. Later he presented himself to the crisis service via the A&E Department on a number of occasions and between 19 September and 11 October 2006 he was an in-patient in the mental health service. Following his discharge from this admission Mr. W attended only one follow up appointment. With such a pattern of unplanned presentations and an apparent lack of commitment on the part of Mr. W to engage in services and address his problems managing his care in a coherent manner was a significant challenge however a number of lessons which might be learnt can be identified.

Comprehensive Assessment

Mr. W was under the care of the mental health services for a little over a month. He presented in a time of crisis, as he had done on a number of previous occasions, and the focus of his care at this time was on containing the risk he posed to himself. He was assessed on a number of occasions and his drug misuse problems, his chaotic life style and his relationship difficulties were identified as factors exacerbating his distress and acting as triggers to his impulsive self harming. It was concluded that Mr. W was suffering from a personality disorder and whilst he remained at risk of impulsively harming himself a prolonged in-patient admission was not deemed to be in his best interest nor was this what Mr. W wanted.

Given Mr. W's complex presentation it would have been good practice to have followed more explicitly the protocol of the Care Programme Approach, ensuring that there was a comprehensive assessment involving the services that were involved in Mr. W's care and employing a multi-disciplinary approach. The identified needs should have informed Mr. W's care plan and a system should have been put in place to review his progress and revise his care plan on a planned basis. This would have been facilitated had a Trust protocol been employed.

One of the key elements of the Care Programme Approach is that it provides a mechanism to bring together all those involved in providing care for an individual to ensure that care is co-ordinated. The responsibility for ensuring that care is delivered in a co-ordinated manner and care plans are reviewed and revised in a timely manner is assigned to the care co-ordinator.

Although it was noted that Mr. W had substance misuse as well as mental health problems no co-ordinated plan, involving both services, was drawn up. When Mr. W was identified as suffering from a personality disorder it was identified that he might be referred to the Rotunda psychotherapy service. This would have been an appropriate intervention. However given that it was known that Mr. W had a poor history of engagement and compliance and that both these traits are not uncommon in the populations serviced by Substance Misuse and Personality Disorder Services it would have been appropriate to have capitalised on the expertise of these services when drawing up Mr. W's care plan to ensure that a coherent and co-ordinated approach was adopted and increase the likelihood that he might engage in services.

Risk, Contingency Planning and Responding to Crises

A number of triggers associated with increased risks related to Mr. W were identified by the clinical team looking after him however no crisis or contingency plans appear to have been put in place, for example, when Mr. W was on leave from the ward during his in-patient admission. The purpose of assessment is to provide information on the basis of which a formulation is drawn up which provides a shared understanding of the individual's behaviour and informs the interventions of the clinical team. Having identified the triggers associated with increased risk related to Mr. W it would have been good practice to have agreed a crisis plan with Mr. W and, with his agreement, with his girlfriend.

Mr. W's preferred method of dealing with crises was impulsively to self harm and then to present to the crisis services. While presenting to crisis services and them dealing with the immediate situation might be an appropriate method of managing infrequent crises, when self harming and threats of suicide become more common dealing with only the immediate crisis is likely to prove to be a less effective strategy. When Mr. W presented to the crisis service following his discharge the crisis team contacted the Consultant Psychiatrist caring for him and suggested that a management plan for dealing with such presentations should be put in place. This was good practice.

Repeated crisis presentations, particularly following episodes of self harm, are not unusual in people with a diagnosis of personality disorder. This suggests that while it is good practice to have crisis management plans in place and, where appropriate, shared with the crisis service for those already under the care of the mental health services it would be good practice for

crisis services also to have in place a mechanism to recognise those who present in crisis repeatedly and engaging them in services in a constructive manner.

As noted above the Department of Health in *New Horizons*[3] noted:

"People with complex problems make frequent and often chaotic use of inpatient mental health, primary care, A&E, social care, and criminal justice and other services. Emerging evidence from the new personality disorder services demonstrates that this can be reduced, and people with this diagnosis can engage in training and work if they receive appropriate support to address their problems. Outcomes from the new services demonstrate the benefits of multi-agency, cross-sector commissioning and collaborative working". (p.72)

This suggests that it would be beneficial to link the strategy for providing services for people with diagnosis of personality disorder and the mechanism for identifying and engaging those who present repeatedly in crisis. This integrating strategy might also be linked to the Dual Diagnosis, Substance Misuse – Mental Health Strategy.

[3] DoH (2009) *New Horizons: Towards a shared vision for mental health*

6. Recommendations

Each recommendation is set out below in combination with the relevant service issue and has taken into account the progress that the Trust is already making in the area.

The Executive Directors of the Mersey Care NHS Trust had the opportunity to review the findings of this Investigation and contributed to the recommendations both at the preliminary feedback stage and during the factual accuracy checking stage. The Trust should be given recognition for the work that it has put into this process and the progress that it has already put into place. It was noted by the Independent Investigation Team that due to the passage of time between the killing of Ms. Y and the completion of this Investigation process the Trust had completed an extensive service redesign and had also completed all of the recommendations developed by the internal investigation process. Therefore few recommendations are set out below.

16.1. Medication and Treatment

Substance misuse

Service Issue 1

There appears to have been a discrepancy between the NICE and NTA guidance and the practice of the Substance Misuse Services in the case of Mr. W. The supervision, support and interventions recommended in the Best Practice guidance were not evident. Although it has to be acknowledged that Mr. W did not show any consistent commitment to addressing his substance misuse problems.

Recommendation 1

The commissioners of substance misuse services together with service providers should put in place mechanisms to ensure themselves that best practice guidance on the delivery of substance misuse services is being implemented.

Commissioners and providers of substance misuse should put in place mechanisms to ensure that information on the quality of services is reported in a timely manner and that this information is feedback to practitioners and teams in a meaningful fashion to ensure that the quality of services is maintained.

Service Issue 2

While Mr. W was an in-patient his prescription of Buprenorphine was continued. However, there is no record in Mr. W's clinical notes of any joint planning as how Mr. W's substance misuse and mental health problems might be addressed in a collaborative and co-ordinated manner by the two services.

Recommendation 2

The Trust and its commissioner should ensure that the Best Practice guidance on the co-ordinated treatment of individuals with a dual diagnosis of mental health problems and substance misuse problems is implemented.

The Trust should ensure that when an individual with a substance misuse problem is admitted to hospital for treatment of a mental health problem a collaborative care plan is put in place, where appropriate, with the substance misuse services to ensure that the individual's needs are addressed in a holistic and coherent manner.

The Trust should ensure that substance misuse problems are routinely addressed as part of the Care Programme Approach discharge plan when an individual is discharged from in-patient care.

16.2. Mental Health

Service Issue 3

The Best Practice guidance recommends that individuals with a diagnosis of Personality Disorder are treated in mainstream mental health services. To achieve this clinical staff in mental health services need to have appropriate training and have access to expert advice, consultation and supervision. These were not available to Mr. W's treating team at that time he was under its care.

Recommendation 3

The Trust should ensure that all clinical staff have relevant, regular training in assessing and treating individuals with a diagnosis of Personality Disorder.

The Trust should ensure that all clinical staff have access to advice, consultation and supervision on the assessment and treatment of individuals with a diagnosis of personality disorder.

The Trust should put in place mechanisms to assure itself that the Best Practice guidance on the treatment of individuals with a diagnosis of personality disorder is being implemented.

16.3. The Care Programme Approach

Service Issue 4

A more comprehensive CPA review meeting might have provided an opportunity to integrate the delivery of mental health and substance misuse services and to have explored how services might have been best delivered to an individual identified as having personality and substance misuse problems.

Recommendation 2 (repeated)

The Trust and its commissioner should ensure that the Best Practice guidance on the co-ordinated treatment of individuals with a dual diagnosis of mental health problems and substance misuse problems is implemented.

The Trust should ensure that when an individual with a substance misuse problem is admitted to hospital for treatment of a mental health problem a collaborative care plan is put in place, where appropriate, with the substance misuse services to ensure that individual's needs are addressed in a holistic manner.

The Trust should ensure that substance misuse problems are routinely addressed as part of the Care Programme Approach discharge plan when an individual is discharged from in-patient care.

16.4. Risk Assessment and Management

Although it was know that Mr. W had served a number of prison sentences the nature of his offences was not known to those caring for him. With the benefit of hindsight one might argue that those assessing the risk Mr. W posed might have sought information on his offending history especially as it was noted that he was reluctant to provide this.

Adequacy of risk assessment

While no risk assessment device is ideal for all situations and while it is acknowledged that risk assessment has to be both on-going and dynamic it would have been helpful to those assessing and monitoring Mr. W if some common device had been used across services and across time.

Contingency planning

Given Mr. W's known propensity to harm himself impulsively, before granting him unescorted leave from the ward it would have been good practice to have identified the

antecedents for this behaviour and agreed with Mr. W, and with his agreement, with his girlfriend, a contingency plan to address these.

Recommendation 4

The Trust should ensure the Best Practice Guidance on risk assessment and risk management is being implemented in a consistent manner throughout the Trust.

The Trust should ensure that appropriate corroborative information is sought when a risk assessment is being undertaken.

The Trust should ensure that a clear, explicit formulation is part all risk assessments and risk management planning. This formulation should provide an understanding of the risks that individual poses and is subject to and inform the risk management plan.