Independent Investigation

into the

Care and Treatment Provided to Mr Y

by the

Cornwall Partnership NHS Foundation Trust,
Cornwall Council
and
Avon and Wiltshire Mental Health Partnership NHS Trust,

Commissioned by
NHS South West
Strategic Health Authority

Report prepared by the Health and Social Care Advisory Service
Authored by:
Helen Waldock
Len Rowland
Androulla Johnstone
Ian Allured

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1. Investigation Team Preface

1.1 The Independent Investigation into the care and treatment of Mr Y was commissioned by NHS South West pursuant to *HSG (94)27*[1].

1.2 This Investigation was asked to examine a set of circumstances associated with the death of Mr M.

1.3 Mr Y received care and treatment for his mental health condition from the Cornwall Partnership Mental Health Trust (Cornwall Partnership NHS Foundation Trust) and Avon and Wiltshire Mental Health Partnership NHS Trust. It is the care and treatment that Mr. Y received from these organisations that is the subject of this Investigation.

1.4 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.

1.5 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. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Trusts' senior management who have granted access to facilities and individuals throughout this process. The Trusts' Senior Management Teams have acted at all times in an exceptionally professional and open manner during the course of this Investigation and have engaged fully with the root cause analysis ethos of this Investigation.

1.6 This has allowed the Investigation to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

[1] DoH Guidance EL (94)27, LASSL (94) 27

2. Condolences

2.1 The Independent Investigation Team would like to extend their condolences to the family and friends of Mr M. The Independent Investigation Team was aware of the distress caused to the parents of Mr M and to his young family and hopes sincerely that this report does not cause further distress.

2.2 A member of the Independent Investigation Team met with the mother of the victim, Mr M, who requested that the following statement be included in the Report.

Statement from Mr M's Mother

2.3 Mr M was the child who most took after me and due to this we had some difficult teenage years. Later Mr M and I had become close again and I saw him not just as my son but also as my friend. Whilst he could be forthright he was also compassionate and had a natural empathy for those less able than himself. Indeed, he was even looking out for Mr. Y – making sure he was safe and was eating. He adored his beautiful daughter, and it still hits me really hard every time she reaches a new milestone, as her Dad is not there to share the experience.

2.4 After the homicide initially I coped reasonably well, but that was only through keeping busy. It finally hit me really hard nearly three years ago and since then I have been on anti-depressants, and I have not been able to work: and I can't see this changing. It affects you in so many ways.

2.5 I've had difficulty establishing new friendships, and indeed lost some old ones because I don't want to see the pity in people's eyes when they know what has happened. Every so often reminders of the awful events come flooding back and I am incapable of doing anything.

2.6 I have lost a son, my daughter in law lost a husband and my grand-daughter has lost a father. Life will never be the same again for us.

3. Incident Description and Consequences

3.1 Mr Y reported that he woke at approximately 10 am on the morning of 8 May 2007 when he took 3 gm of speed and four ecstasy tablets, after which he listened to music and went out. [2]

3.2 At some point during the day Mr Y attended Newquay Resource Centre where he met three of his friends including Mr M. They left together and went to an off license where they purchased beer.[3] They also stopped at a chemist shop and purchased some syringes. They then went to the flat of one of the group.[4]

3.3 The men spent the time taking drugs, (ecstasy, Valium and speed) watching television and drinking alcohol.

3.4 Mr Y was in conversation with one of the men whilst the other two were *"lazing on the bed"*. A comment was made about Mr Y not having any children and he took offence. Mr Y assaulted Mr M whilst he was lying on the bed. Mr M immediately jumped from the bed and the two men grappled in the middle of the room. The two witnesses reported that Mr Y grabbed Mr M around the back of the head with one hand and lunged at Mr M as though punching him.[5]

3.5 One of the witnesses punched Mr Y in the face and held him down to stop the fight. It was then realised that Mr Y had a knife in his hand and he tried to swipe this at the man restraining him, grazing his upper arm.[6]

3.6 Mr Y attempted to leave the flat but was restrained by the two men. They called an ambulance, whose crew notified the police. The call was logged by ambulance control at 21.25 hours.[7]

3.7 Mr M died of his injuries at the scene. He was pronounced life extinct at 21.56 hours by the attending paramedics who noted that Mr M had been stabbed 13 times, receiving six wounds to his back, four to his face and three to his chest.[8]

[2] Forensic records p. 7 police records pg 102
[3] Police records p. 100
[4] Police records p. 101
[5] Police records p. 111
[6] Police records p. 113
[7] Police records p. 65

3.8 Mr Y was charged with murder contrary to common law and remanded to Exeter Prison on 10 May 2007 where he was kept on the health care unit. [9]

3.9 The independent medical report completed in June 2007 noted that whilst Mr Y had been detained in custody he "*did not exhibit major symptoms of psychosis*". [10] The psychiatric report for the Court dated 17 November 2007 noted "*that there were no psychotic symptoms evident*".[11] It was concluded that Mr Y was not psychotic at the time he committed the offence.

3.10 However, prison staff became increasingly concerned about the mental health of Mr Y. He was socially withdrawn, behaving in a bizarre manner, refusing to eat and losing weight. Two medical recommendations were made for an urgent transfer to a psychiatric hospital. A transfer direction was issued by the Ministry of Justice.[12] Mr Y was transferred to the Butler Unit at the Langdon Hospital on 24 December 2007 under Section 48/49 of the Mental Health Act.[13]

3.11 On 30 August 2008 Mr Y was convicted of manslaughter and placed on a Hospital Order Sections 37/41 of the Mental Health Act (07) without limit of time.

4. Background to the Independent Investigation

4.1 The HASCAS Health and Social Care Advisory Service was commissioned by NHS South West to conduct this Investigation under the auspices of Department of Health Guidance (94)27.

4.2 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.

[8] Police records p. 70
[9] Police records p. 1
[10] Forensic medical assessment p. 14
[11] Forensic medical assessment p. 26
[12] Clinical records Volume 5 p.176
[13] Clinical records Volume 4 p. 193

5. Terms of Reference

5.1 The Terms of Reference for the Independent Investigation were set by NHS South West. The Cornwall Partnership NHS Foundation Trust and Cornwall and the Isles of Scilly Primary Care Trust were consulted with regard to the content of the Terms of Reference and did not wish to make any amendments. The Avon and Wiltshire Mental Health Partnership NHS Trust was not consulted due to the fact that their involvement with Mr Y was not known until after the Investigation had begun.

5.2 Terms of Reference:

1. Review the quality of the health and, where relevant, the social care provided by the Trust and establish whether this adhered to Trust policy and procedure.
2. To identify whether the Care Programme Approach (CPA) had been followed by the Trust.
3. To identify whether any risk assessments were timely, appropriate and followed by appropriate action.
4. To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records.
5. Review the Mental Health Act assessment process, where applicable.
6. To examine the adequacy of collaboration and effectiveness of communication with any other agencies who may have been involved in the care and treatment.
7. To review the Internal Investigation into the care of Mr Y already undertaken by Cornwall Partnership NHS Foundation Trust and any action plans that may have been formulated, including any immediate remedial action taken at the time of the incident, or action taken as a result of the Internal Investigation.
8. To consider any other matters that arise during the course of the investigation which are relevant to the occurrence of the incident or might prevent a reoccurrence the public interest may require.
9. To prepare an Independent Report for Cornwall Partnership NHS Foundation Trust, NHS South West and any other relevant bodies.

6. The Investigation Team

Investigation Team Leader and Chair

Ms Helen Waldock	Director of Nursing, HASCAS Health and Social Care Advisory Service.

Investigation Team Members

Dr Liz Gethins	Consultant Psychiatrist.
Dr Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service, Nurse Member.
Mr Ian Allured	Director of Mental Health, HASCAS Health and Social Care Advisory Service, Social Work Member.
Dr. Len Rowland	Director Research and Development HASCAS Health and Social Care Advisory Service, Clinical Psychologist Member.

Support to the Investigation Team

Mrs Louise Chenery	Stenographer, HASCAS Health and Social Care Advisory Service.

Independent Advice to Panel

Mr Ashley Irons	Solicitor, Capsticks.
Ms Natasha Finlayson	Chief Executive Officer, Who Cares Trust.
Mrs Tina Coldham	Service User Representative, HASCAS

7. Findings

7.1 When conducting Investigations of this nature, careful consideration is given to the notion of causality. Causality is the relationship between a series of events. In the case of HSG (94) 27 the care and treatment a service user received is examined to determine whether any acts of omission or commission provided the circumstances in which the serious untoward incident (the homicide), was likely to occur. Causality determines whether one event (the homicide) was a direct consequence of another series of events (the care and treatment received).

7.2 This report defines causality and contributory factors in the following way:

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal bearing upon the events of 8 May 2007. 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 care and treatment that a service user receives and any subsequent homicide perpetrated by them.

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 the mental health of Mr Y and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 8 May 2007, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

7.3 Independent Investigations conducted under the auspices of HSG (94) 27 are frequently critical of services and how they were delivered to an individual. On these occasions it would be relatively easy to say that the services failed and that this failure caused the homicide. However in mental health and other areas of health and social care it is not always so straightforward as

there are many variables to consider not least of which is the changing presentation of an individual.

7.4 Service users cannot be compelled to do things they do not wish to do unless detained under the Mental Health Act. Mr Y was an independent person living in the community at the time of the homicide. He was not subject to the provisions of the Mental Health Act (83) and was free to make his own lifestyle choices regardless of what others perceived as being in his best interests. In the case of Mr Y, although the Trust could have done things differently, the Independent Investigation Team found no direct causal factors which connected the care and treatment Mr Y received and the events of 8 May 2007.

Findings:

7.5 Mr Y was known to statutory services for a twenty-year period prior to the death of Mr M. Throughout this time Mr Y presented as a troubled and disadvantaged child who grew up to be a highly disturbed and challenging young man. The care and treatment Mr Y received chronicles the many policy changes that occurred within statutory agencies during the 1990s and early 2000s. It also chronicles the challenges that individuals such as Mr Y present to services.

7.6 Mr Y was known to services from the age of three years. He was born in 1986 and raised in Bristol until the age of eleven when his family moved to Cornwall. Mr Y moved between Bristol and Cornwall as he grew up and received his care and treatment from two mental health Trusts. The findings are set out below under the headings of 'Bristol' and 'Cornwall'.

Bristol (16 February - 13 September 2004)

Transfer process

7.7 The transfer process in February 2004 was handled poorly by the Bristol services. No needs assessment or care plan was put in place to support Mr Y and the supported housing scheme prior to his discharge from the Roycroft Unit. There could and should have been a forensic CPN allocated to advise on the case, act as a point of contact, ensure that Mr Y had a care package in place in a timely manner and facilitate his handover to a Community Mental Health Team (CMHT). The delay and lack of urgency attributed to the referral of the Forensic Consultant to the CMHT compounded the issues. The fact that Mr Y was not seen by any mental health service until six weeks after his discharge from a secure in-patient service into the community is

not acceptable. This delay, lack of acceptance and involvement and planning by Bristol mental health services prior to, and immediately after, the discharge of Mr Y from the Roycroft Unit contributed directly to his medication and coping ability not being monitored or supported and contributed to a deterioration in his mental health.

Care Programme Approach and Section 117 Aftercare (MHA1983)

7.8 Mr Y was known to the CMHT services for approximately four months in 2004. During this time he had an assessment and a care plan was in place that met his basic mental health needs. The care plan cannot be described as comprehensive in that it was not holistic nor did it include the recommendations suggested by the Roycroft Unit regarding vocational training. The view of the Independent Investigation Team was that it was adequate for the immediate needs of Mr Y around maintaining some form of stability in relation to his mental heath. There were indications of multi disciplinary working within the CMHT and clear lines of management.

7.9 However what cannot be explained is the lack of adherence to Section 117 in 2004. The Independent Investigation Team therefore concluded that Bristol Mental Health Services failed to meet their statutory duties under Section 117 of the Mental Health Act (1983) and this contributed to a deterioration in the mental health and social well being of Mr Y. The opportunity to support and enable him to reintegrate into the community and manage his mental illness was lost. It is a fact that Mr Y was homeless and staying in a night shelter at the time of his discharge from Section 117.

Risk Assessment and Management

7.10 Mr Y presented as a complex individual and raised the concerns of those that he had direct contact with through his risk taking behaviour. A comprehensive and timely risk assessment and subsequent management plan was not developed by any of the services that Mr Y had contact with.

Diagnosis and Medication

7.11 Mr Y had been diagnosed with paranoid schizophrenia whilst at the Roycroft Unit with the advice that he continue to take anti psychotic medication. Mr Y was admitted to hospital in Bristol with psychotic symptoms and prescribed Olanzapine. At the point of discharge in August 2004, the psychosis Mr Y suffered from had abated and he was discharged without medication.

The conclusion of the Independent Investigation Team was that Mr Y should have been prescribed antipsychotic medication at the point of discharge. Failure to do this in the light of his diagnosed psychotic illness and the recommendations of the Roycroft Unit resulted in the mental illness of Mr Y not being treated and the deterioration in his mental state and well being.

Management of the Clinical Care and Treatment

7.12 Mr Y was a complex individual with multiple needs and diagnosis. The Independent Investigation Team acknowledged that Mr Y presented as a challenging individual. There were opportunities to review the presentation and treatment plan of Mr Y in a comprehensive manner, but full advantage was not taken of these opportunities. Rather the over-riding opinion was that it was the conduct disorder that Mr Y had that motivated his behaviour. The Independent Investigation Team agreed that his conduct disorder did influence his behaviour. However that should not have detracted from the facts that:

- Mr Y had a diagnosis of paranoid schizophrenia and conduct disorder;
- Mr Y was known to use alcohol and drugs;
- Mr Y was homeless;
- Mr Y was not prescribed any anti psychotic medication.

Findings: Cornwall

Care and Support of Mr Y during his Childhood and Adolescence (1997-May 2003).

7.13 Mr Y presented with a complex set of issues from a young age. There was clear evidence that his behaviour was challenging to manage. He was noted to be out of parental control as early as 1998. He was absenting himself, not engaging with education, assaulting staff and using alcohol and drugs. Although social services tried to support the family within their home this ultimately failed and Mr Y was placed on a Care Order in secure accommodation. There were a number of opportunities that were missed where Social Services should have intervened more assertively. There were grounds for Child Protection proceedings and a Care Order to be implemented at a much earlier stage of Social Services' involvement.

7.14 It was the conclusion of the Independent Investigation Team that Cornwall Social Services should have more assertively managed the case and that their failure to do so contributed to deterioration in the mental health and social well being of Mr Y.

Leaving care

7.15 Mr Y did not receive a coherent assessment or plan, as was his right under the Leaving Care Act. This made a contribution to the lack of organisation that occurred regarding his accommodation and case management between January 2002 and January 2003.

7.16 The Leaving Care Act is clear that bed and breakfast accommodation should be used only in an emergency. Mr Y had approximately 20 such placements over a period of 15 months. His frequent moving between Cornwall and Bristol was an established pattern of behaviour and therefore predictable. An alternative plan should have been considered as a matter of urgency to try to prevent the social situation and the mental health of Mr Y from deteriorating.

7.17 Whilst the Independent Investigation Team acknowledged that Mr Y was a complex and challenging young adult who confounded most of the attempts to help him, it concluded that basic processes were not adhered to, and that the care that was offered to Mr Y was not in accordance with either local procedure or national policy expectation.

Care and support of Mr Y (February 2005 - 8 May 2007)

Care Programme Approach (CPA)

7.18 The CPA process is the main vehicle by which effective mental health services are planned and delivered. The Trust CPA policy was clear in that CPA meetings should have been held every three months or more frequently if the individual had recently been discharged from hospital or was deemed to be a high risk. The Forensic Team held only two meetings identified as CPA meetings between February 2005 and May 2006.

7.19 Mr Y received considerable input from both health and social care services and there was evidence that there was an ongoing review of his behaviour and mental health state. In a case such as this CPA has a definite role to play in providing a clear 'route map' to both service users and professionals. The risk and behaviour of Mr Y was managed by other frameworks such as the Multi Agency Public Protection Arrangements (MAPPA). As a consequence his risk to other people became the lens through which he was reviewed. As a result the care and treatment planned for Mr Y was not patient centered (focusing on the needs of Mr Y), but risk centered (focusing on the risk he presented to other people).

7.20 The behaviour of Mr Y and his lifestyle was such that by 2007 a serious untoward incident of some kind was foreseeable. The CPA process could have made a significant contribution to the development of a long term care and treatment strategy that had meaning for Mr Y.

Risk Assessment and Management

7.21 Mr Y presented with a complex pattern of risk and managing this proved challenging. It was concluded by those caring for Mr Y that his risk behaviours were associated with his conduct disorder and drug and alcohol misuse rather than his psychotic illness.

7.22 The overall risk profile of Mr Y did not change throughout the time that he was under the care of Cornwall Partnership NHS Foundation Trust. Consequently his risk management plan did not change. It was predictable that Mr Y would continue to present in a violent and threatening manner and that he would continue to commit criminal offences whilst under the influence of illicit substances. What was not predictable was what the next offence would be or when this would occur. The evidence suggests that the risk management strategies employed, namely ensuring that medication was given, that the risks were communicated, and when appropriate Mr Y was admitted to hospital under the Mental Health Act (1983) were the best practicable options available to the team.

7.23 At the time of the incident Mr Y was under the influence of alcohol and drugs. Mental health services can advise people regarding their drug and alcohol use and, if they are amenable, support them in addressing these problems. This option had been offered to Mr Y but it was not a course of action he was ready to pursue. The Independent Investigation Team found that the risk assessments and plans were appropriate.

Diagnosis and Medication

7.24 At various times Mr Y was diagnosed as suffering from a dissocial personality disorder, from a drug related psychosis and from schizophrenia. The absence of a clear, agreed, diagnosis made it difficult for the teams treating Mr Y to arrive at a clear formulation to guide their interventions.

7.25 In spite of the complexity of the presentation of Mr Y, the teams endeavoured to provide Mr Y with a consistent approach to the management of his psychotic symptoms through the

prescription of anti psychotic medication. The care and treatment of Mr Y would have benefitted from a more comprehensive approach, reflecting the guidance contained in the national guidelines for the treatment of schizophrenia, personality disorder and substance misuse. Had CPA been in place in a more effective manner his problems would have been addressed as part of a coherent approach. This was not done and it was to the detriment of his long-term care and treatment outcomes.

7.26 The diagnoses of schizophrenia, personality disorder and substance misuse have a dynamic relationship with each other making it difficult to address any one of them in isolation. The mental health problems of Mr Y needed to be addressed in an integrated manner for there to be any real prospect of improvement. Given the reluctance of Mr Y to address his substance misuse problems and the difficulty his chaotic life style posed in addressing his psychological problems, Mr. Y did not receive the intervention that might have best met his needs. This contributed to his continued mental illness and distress.

Interagency Communication - Multi Agency Public Protection Arrangements (MAPPA)

7.27 The Independent Investigation Team found that the MAPPA process exercised its authority in an appropriate manner, bringing together all relevant agencies and professionals on a regular basis.

7.28 There are, however, two issues that need to be highlighted:

1) Clear routes and circumstances for return to the MAPPA process should have been identified at the point of de-registration.

2) A Care Programme Approach meeting should have been organised at the point of deregistration to ensure the continued inter agency care plan.

Mental Health Act 1983

7.29 The application of the Mental Health Act (1983) was appropriate where inpatient treatment was required. However the application of Section 117 discharge planning was not used as a means of engaging Mr Y with services. It might have been appropriate to use Section 117 to enable Mr Y to pursue more constructive activities.

7.30 The Independent Investigation Team concluded that this was an omission on the part of the Forensic Mental Health Team and an opportunity to provide support for and engage Mr Y

was missed. Whilst this did not contribute to deterioration in his mental health the support and engagement provided may well have acted as a protective factors for Mr Y.

Clinical Governance Processes

7.31 In 2003/4 the Cornwall Partnership NHS Trust was a two star Trust, it was performing well overall but had not quite reached consistently high standards.

3.5.4 Conclusion

7.32 The story of Mr Y's life and the care and treatment he received over a twenty-year period provides a detailed case study of a young man who came from a troubled family background and experienced an unsettled and difficult childhood. Mr Y was known to statutory services for a twenty-year period prior to the death of Mr M. Throughout this time Mr Y presented as a troubled and disadvantaged child who grew up to be a highly disturbed and challenging young man. The care and treatment Mr Y received chronicles the many policy changes that occurred within statutory agencies during the 1990s and early 2000s. It also chronicles the challenges that individuals such as Mr Y present to services.

7.33 During his adolescence and young adulthood there were many occasions when statuary agencies *did not* use the powers that they had within their gift to provide the structured care and treatment that Mr Y required. There were also many occasions when statutory agencies *could not* intervene to provide care and treatment to Mr Y due to either his lack of cooperation or a suitable legislative framework to work within. As a result Mr Y ricocheted around services in, what seemed at times, a chaotic and disorganised manner. This was exacerbated by diagnostic confusion, Mr Y's lack of familial and social security, and his wide range of anti-social behaviours.

7.34 The Independent Investigation Team explored the notions of predictability and preventability in relation to the death of Mr M. This was no straightforward task as Mr Y's history was challenging and complex to analyse. Taking a longitudinal view of Mr Y's life it could be seen that, with a snowball-like effect, everything that happened to him contributed to make him the troubled young man that he was. His family, statutory services and Mr Y himself all played significant roles in determining the care and treatment pathway that he undertook and the successes and failures that were encountered along the way.

7.35 It was the view of the Independent Investigation Team that whilst the death of Mr M was not predictable *per se*, Mr Y's history and behavioural profile being what it was, a serious untoward incident of some kind was most definitely foreseeable.

7.36 When exploring the notion of preventability Mr Y's case raises the ever-present difficulties faced by all statutory services, namely the degree to which the legislative and service frameworks in place can provide care and treatment to a person who does not want it and will not cooperate with it. By the time of the incident it was probably too late for any intervention to have had a significant impact on the way Mr Y had chosen to live his life.

7.37 His chaotic lifestyle, alcohol and substance misuse, unemployment and fragile social and family structures made for a worrying scenario. However at the time of Mr M's death Mr Y was not detainable under the Mental Health Act, and until he had committed another criminal offence, not subject to any Probation or MAPPA supervision. This meant that there were no formal processes that could have appropriately been used to manage Mr Y's mental health, aside from those that were in place. Those arrangements that were in place were unable to protect either Mr Y or those around him from his impulsive behaviour.

8. Contributory Factors, Service Issues and Recommendations

8.1 The Independent Investigation Team worked with the Cornwall Partnership NHS Foundation Trust and the Avon and Wiltshire Partnership NHS Trust in order to develop recommendations that took into account:

- the progress made against action plans derived from internal investigation processes;
- current standards of service delivery.

8.2 The recommendations are set out under separate headings for both Cornwall and Bristol Services. The contributory and service issues are set out in the chronological sequence that they occur in the main body of the report for each geographical location.

8.3 Cornwall Services

Contributory Factors, Service Issues and Recommendations relating to Cornwall (NHS and Local Authority Services)

8.3.1. Contributory Factor 1:

There was a lack of adherence to the CPA policy and process. This ensured that Mr Y did not have a long-term and proactive care and treatment strategy put into place and this made a contribution to his continued ill health and management problems.

Recommendation 1 (Cornwall Partnership NHS Foundation Trust):

An audit is conducted within the high risk/high needs services of the Trust including forensic, assertive outreach and eating disorders services; this should take place alongside the current dip sample audits carried out by the Care Process Redesign Group to ensure that:

- the CPA process is clearly delineated within the clinical record as to when a CPA review or CPA meeting has taken place;
- care plans are up to date;
- care plans do not contain information that is out of date;
- consideration has been given to meeting the needs of the individual in a holistic manner.
- The results of these audits should be reported to:

- the service line leads for actions/developments and areas of improvement;
- the Clinical Effectiveness Strategy Group which reports to the Risk, Quality and Standards Committee for the overall governance and monitoring.

8.3.2 Service Issue 1: **(Cornwall NHS Partnership Foundation Trust, Cornwall Council)**

The procedure for identifying and reviewing an unmet need was unclear.

Recommendation 2 (Cornwall Partnership NHS Foundation Trust, NHS Cornwall and Isles of Scilly, Cornwall Council)*:*

- there is a multi-agency review of the process for registering an unmet need and a clear policy as to how unmet needs are to be addressed;
- this review should include Cornwall Council and its relevant departments, in particular Social Services and Housing Departments, and other relevant agencies;
- this review should be placed within the context of local and National Social Inclusion initiatives;
- it should be informed by the recovery and well-being models of care and service provision.

***8.3.3 Contributory Factor 2. (*Cornwall Partnership NHS Foundation Trust)**

A CPA planning meeting should have been arranged when Mr Y was discharged from the MAPPA process to ensure the ongoing coordination of his care.

Service Issue 2.

Clear criteria should have been in place for the re-referral of Mr Y to the MAPPA process.

Recommendation 3 (Cornwall Partnership NHS Foundation Trust):

The CPA policy and the Clinical Risk Policy are reviewed to ensure:

- CPA documentation is completed in parallel to the MAPPA process for service users subject to MAPPA;
- clear criteria are established on a case by case basis for re-referral into the MAPPA process and recorded within the CPA documentation;
- a CPA meeting is held within four weeks for all patients who have been deregistered from the MAPPA process;

- a CPA meeting should be held earlier than four week post deregistration:
    - when a patient is deregistered against the advice of his/her care co-ordinator;
    - where a pre-MAPPA, CPA and risk review did not occur;
    - where needs change rapidly after de-registration;
- prior to MAPPA meetings a structured assessment of risk and needs should be completed.

8.3.4 Service Issue 3: (Cornwall Partnership NHS Foundation Trust, Cornwall Council Social Services Department of Adult Care and Support)

Cornwall Mental Health Services did not adhere to the principles under pinning Section 117 aftercare nor did they implement the Section 117 aftercare processes. This limited the options that were considered in the care and treatment that were offered to Mr Y.

Recommendation 4 (Cornwall Partnership NHS Foundation Trust)

Cornwall Partnership NHS Foundation Trust should undertake a further review of its Section 117 policy and audit of practice to consider the issues raised in this case. This should be incorporated within the Trust's clinical governance and performance management arrangements. It should identify how awareness of these issues will be disseminated and how Section 117 awareness can be effectively included in CPA training.

Recommendation 5 (NHS South West Strategic Health Authority)

The Strategic Health Authority needs to assure itself that Cornwall Partnership NHS Foundation Trust and the Cornwall and Isles of Scilly PCT monitor that Section 117 is working for the patients under their care and that local services have mechanisms for:

- identifying patients subject to Section 117;
- hold CPA/Section 117 care planning meetings to develop care packages for patients covered by Section 117;
- hold similar meetings to review the progress and care and agree discharge plans for patients who no longer meet the criteria for Section 117.

Recommendation 6 (Cornwall Council):

Local Authorities are jointly responsible with PCTs for the provision of aftercare services under Section 117. Local Authorities therefore need to ensure that social workers, housing officers

and others as necessary are available and participate in CPA/Section 117 care planning meetings.

- Local Authorities need to ensure that any services identified as necessary for a particular patient on Section 117 are provided when the provision of those services are within its responsibilities;
- Housing Authorities need to take a proactive role in the provision of appropriate accommodation to people who are subject to Section 117.

Decisions to end the Section 117 status of a patient are joint Health and Social Service decisions. Local Authorities must therefore ensure that social workers and relevant others are available and participate in CPA/Section 117 meetings to review and if appropriate discharge patients.

8.3.5 Vulnerable Adults:

The possibility of Mr Y being registered as a 'vulnerable adult' was discussed by those providing his care, however it was decided that he did not meet the criteria as they were established at that time. The Independent Investigation Team were informed that the Adult Services Intake Team "only [had] workers for the elderly or those with Learning Disabilities".[14]

Recommendation 7 (Cornwall Social Services Department of Adult care and Support):

The Cornwall and Isles of Scilly Multi-agency Safeguarding Adults Policy is reviewed and audited to consider the interface for:

- young People who are leaving the care system and on a care order;
- young people with a diagnosed serious mental illness;
- people who present with self harm.

[14] Probation File d p. 19

8.4 Bristol Services

Contributory Factors, Service issues and Recommendations relating to Bristol (NHS and Local Authority Services)

8.4.1. Contributory Factor 3: (Bristol)

Social Services had the opportunity to intervene at several key points throughout Mr Y's childhood, but they did not and the interventions that might reasonably have been expected to improve his well-being and functioning were not employed.

Firmer action to safeguard Mr Y and to provide a degree of stability in his life should have been considered, and should have included receiving him into care. It is however too long ago to make valid recommendations for the 1990s as Child Care has altered significantly during the last 20 years.

8.4.2 Contributory Factor 4: (Bristol)

Mr Y's discharge from the Roycroft Unit was not co-ordinated well by Bristol services. The lack of a comprehensive care plan led to a serious delay in his follow up. This deprived Mr Y the opportunity to receive potentially beneficial services in a timely manner.

Recommendation 8 (Avon and Wiltshire NHS Partnership Trust):

- in line with best practice and CPA guidance, and the requirements of Section 117 of the Mental Health Act (2007) there should be a clear care plan and risk assessment in place for each service user moving to the catchment area;
- the receiving team has a responsibility to ensure that an appropriate care plan is put in place;
- when there is a lack of clarity as to where the individual will be living or which team will provide his/her care the Avon and Wiltshire NHS Partnership Trust should put in place clear guidelines to identify who will take the lead in coordinating the individual care;
- when an individual is being transferred from a secure unit the Avon and Wiltshire Partnership NHS Trust Forensic Services should play a leading role to ensure that an appropriate care plan is in place and appropriate risk assessments have been carried out and risk management plans put in place;

- if a service user is transferred to the catchment area from an in-patient facility outside the catchment area the individual should be seen within seven days in line with best practice on discharge;
- protocol should be agreed with appropriate agencies to ensure that the individual receives a co-ordinated package of care. This is particularly the case for:
    - young people age between 16 and 21 years;
    - those being discharged from secure accommodation/services;
- the Avon and Wiltshire NHS Partnership Trust should ensure that it has in place appropriate audit and other monitoring mechanisms to ensure that these policies and protocols are being effectively implemented.

8.4.3 Contributory Factor 5: (Bristol)

Bristol Mental Health Services did not fully adhere to the principles underpinning Section 117 aftercare neither did they fully implement the Section 117 aftercare processes. This had a direct impact on Mr Y's mental health and social well being. The decision to discharge Mr Y from the Community Mental Health Team ensured that he was lost to follow-up.

Recommendation 9 (Avon and Wiltshire NHS Partnership Trust):

- the Avon and Wiltshire NHS Partnership Trust should review its Section 117 protocols and audit cases against the identified standards. This should be incorporated within the Trust's clinical governance and performance management arrangements;
- the Avon and Wiltshire Partnership NHS Trust should disseminate the revised protocol to all relevant Trust staff ensuring that they understand both the protocols and the principles underpinning these: "*Aftercare 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*";[15]
- the Avon and Wiltshire Partnership NHS Trust should undertake an audit to ensure that the revised protocols are being effectively implemented.

[15] Mental Health Act Code of Practice Chapter 27 p. 250

8.4.4 Contributory Factor 6: (Bristol)

Mr Y was not risk assessed in a comprehensive and timely manner. The risk assessments that were completed were poor and did not reflect the complexities of Mr Y's behaviour. Because Mr Y's risk assessments were of a poor standard they did not result in an adequate or appropriate management plan. This resulted in Mr Y being inappropriately discharged from services.

Recommendation 10: (Avon and Wiltshire NHS Partnership Trust)

The Trust to conduct a risk assessment audit of its Bristol-based Forensic services to ensure:

- clinical compliance to policy and procedure;
- that each service user has a dynamic plan based upon a current and comprehensive risk assessment;
- that each service user has a crisis and contingency plan;
- that all documentation is shared appropriately with the service users clinical network;
- to ensure that service users and carers are involved and communicated with as appropriate.

Recommendation 11: (Avon and Wiltshire NHS Partnership Trust)

The Avon and Wiltshire NHS Partnership Trust should undertake an audit of completed discharge plan to ensure that the identified standards are being met. The Trust should incorporate a discharge planning audit into its routine clinical governance and performance management arrangements.

8.4.5 Contributory Factor 7: (Bristol)

Mr Y had a diagnosis of paranoid schizophrenia and was not prescribed anti psychotic medication at the point of discharge from Bristol services which contributed to his mental illness being untreated.

Recommendation 12: (Avon and Wiltshire NHS Partnership Trust)

The Avon and Wiltshire NHS Partnership Trust should review and audit its prescribing practices, especially with respect to the prescribing of prophylactic and maintenance doses of medication and the regimen for withdrawing medication, to ensure that these comply with Best Practice Guidance

8.4.6 Contributory Factor 8: (Bristol)

Mr Y had several diagnoses and presented as a complex individual with both behavioural and psychotic disorders. Mr Y's care pathway was predominantly determined by his behaviour which was challenging to manage. As a consequence his psychotic disorder was not given the necessary and appropriate consideration resulting in him being untreated and lost to services.

Recommendation 13: (Avon and Wiltshire NHS Partnership Trust)

Service Users with complex diagnoses accompanied by challenging behaviours and personality disorders should be subject to a robust mental state examination and be in receipt of a coherent management plan in keeping with NICE guidance for personality disorder.

8.4.7 Supervision and Caseload Management

Clinical supervision, management supervision and caseload management should provide a safety net which ensures sound, evidence based clinical practice and compliance with Trust policies and protocols. Good supervision may have obviated some of the shortcomings identified in the care and treatment of Mr. Y.

Recommendation 14: (Avon and Wiltshire NHS Partnership Trust)

The Avon and Wiltshire Partnership NHS Trust should undertake regular and routine audits of both the frequency and the quality of supervision. This should be incorporated within the Trust's clinical governance and performance management arrangements.

9. Profile of Cornwall Partnership NHS Foundation Trust (past and present) and Avon and Wiltshire NHS Partnership Trust (Past and Present)

9.1 Profile of Cornwall Partnership NHS Foundation Trust (past and present)

Historical Context

9.1.1 Cornwall Partnership NHS Foundation Trust (CPFT) was approved by Monitor on 1 March 2010. Monitor is the governing body of all NHS Foundation Trusts.

9.1.2 Its predecessor organisation, Cornwall Partnership NHS Trust (CPT) was established in April 2002 to provide specialist services for people with mental health problems, people with learning disabilities and people who misused drug and alcohol

9.1.3 Prior to this, the Trust operated as Cornwall Healthcare NHS Trust (CHT), which was formed in 1993. It merged with Trecare NHS Trust (formerly Cornwall and Isles of Scilly Learning Disabilities NHS Trust) in 1999.

9.1.4 In 2004, Cornwall Partnership NHS Trust was awarded the maximum performance rating (3 stars) by the government's independent regulator, the Healthcare Commission. In 2005, the Trust's performance rating was reduced to 2 stars.

9.1.5 A joint investigation, by the Healthcare Commission and the Commission for Social Care Inspection, into the provision of services for people with learning disabilities at Cornwall Partnership Trust was published in July 2006. The Trust was then placed on special measures (a system of additional supervision and monitoring) by the Secretary of State for Health. At this time, a new senior management team was appointed which included the current substantive Chief Executive.

9.1.6 In March 2008, the Secretary of State lifted the Trust out of special measures. This reflected the significant improvements in the quality of services.

Context

9.1.7 Cornwall Partnership NHS Foundation Trust is the primary provider of specialist mental health and learning disability services in Cornwall and the Isles of Scilly. The services provided are managed through five service lines:

- Hospital Care Services;

- Community Care Services (including Social Care in partnership with Cornwall Council (Section 75);
- Adult Learning Disability Services;
- Children's Services;
- Complex Care and Dementia.

9.1.8 In addition to the above, the Trust also provides estates management and financial services to other NHS partners and provides a variety of training and education programmes.

Population and Geography of Cornwall

9.1.9 Cornwall has a resident population of 544,000 (ONS: 2006). Each year at the height of the tourist season there are, on average, an extra 270,000 people in the County.

9.1.10 Being a rural county, population centres are scattered and there are substantial areas of sparse population. Public transport is limited and car ownership is higher than the national average.

Main Commissioners

9.1.11 NHS Cornwall and Isles of Scilly (NHS CIOS, the Primary Care Trust) is the only significant NHS commissioner. Cornwall Council, which is the unitary authority in Cornwall, has delegated the provision of social care for clients with mental health needs to the Trust. This is contracted through a Section 75 agreement (an agreement which is made under the provision of Section 75 of the National Health Services Act 2006 between a Local Authority and a Primary Care Trust). There are Joint Commissioning Boards in place to provide the governance and commissioning direction for both the adult mental health and social care services (under the Section 75 agreement) and for adult learning disability services.

Service Model

9.1.12 The general model of care operated by the Trust is community led with a relatively small (159) number of inpatient beds used to a high level of occupancy.

9.1.13 As a specialist provider of mental health and learning disability services, pathways and referral routes stem from primary care through to secondary care specialist services which are provided in both hospital and community settings. Whilst all inpatient services are non elective,

the vast majority of access to inpatient units is managed well. The philosophy being that wherever possible, clients should be treated and supported in the community, with hospitalisation only when absolutely necessary.

9.1.14 All inpatient services are provided from two units - Longreach House (Redruth) and Bodmin Hospital.

9.1.15 Community services are deployed on a team basis throughout the county, across all service lines. Teams typically have a 'base', usually in one of the local population centres where clinics and therapy can be provided. Many staff travel extensively to support clients at home, in surgeries, or other more local facilities, however much of the travel is to and from base, often to access files or use technology. Mobile technology and access to other NHS/primary care facilities will enable staff to travel less, but increase the quality of service.

9.1.16 Specialist mental health teams, e.g. home treatment teams, link community and hospital services and manage the flow of referrals and admissions. The Trust does not provide inpatient learning disability beds, although care is arranged under 'green light' principles. Likewise the Trust does not provide hospital care (Tier 4 services) for children; referrals are made to Plymouth, which is the centre for such Tier 4 services.

9.2 Avon and Wiltshire Partnership NHS Trust (Past and Present)

9.2.1 Avon and Wiltshire Mental Health Partnership NHS Trust provides mental health and social care services and specialist services for people with needs relating to drug or alcohol misuse. The Trust promotes health and wellbeing through the recovery model, aiming to support people to reach their potential.

9.2.2 The Trust is a significant provider of mental health services, operating across a geographical span of 2,200 square miles, encompassing a population of 1.6m people and covering six primary care trusts. Services are centred upon 11 main in-patient sites, 97 community bases and four community mental health team bases. The Trust has an operating budget of just over £200m per year and employs approximately 4,200 people.

9.2.3 The Trust's strategic objectives during the next five years are to:

- deliver patient-centred services that focus on recovery;
- develop its core business;
- achieve Foundation Trust status.

9.2.4 The Trust achieved a rating of 'good' for its quality of financial management and 'fair' for quality of services in the Care Quality Commission Annual Health Check for 2008/09.

9.2.5 The Trust provides a full range of mental health services in Bristol for adults of working age and older people, including Community Mental Health Teams, a Crisis Resolution and Home Treatment Team and inpatient services.