Independent Investigation

into the

Care and Treatment Provided to Mr. Y

by the

Avon and Wiltshire Mental Health Partnership NHS Trust

Commissioned by

NHS South West
Strategic Health Authority

Independent Investigation: HASCAS Health and Social Care Advisory Service

Report Author: Dr. Len Rowland

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1. Preface to the Independent Investigation Report

The Independent Investigation into the care and treatment of Mr. Y was commissioned by NHS South West (the SHA) pursuant to *HSG (94)27*[1]. The Investigation was asked to examine the circumstances associated with the death of Mr. H on the 7 May 2008.

Mr. Y received care and treatment for his mental health condition from the Avon and Wiltshire Mental Health Partnership NHS Trust (the Trust) between October 2001 and May 2008. It is the care and treatment that Mr. Y received from this organisation that is the subject of this Investigation.

Investigations of this sort aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations.

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

We would like to thank the widow of Mr. H for meeting with the Independent Investigation Team and for her co-operation. We acknowledge her distress and that of her family.

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

The SHA wrote to the family of Mr. Y inviting them to contribute to the Independent Investigation. However at the time of writing the Independent Investigation has not had contact with Mr. Y's family.

2. Condolences to the Family and Friends of Mr. H

The Independent Investigation Team would like to extend its condolences to the widow, family and friends of Mr. H.

3. Incident Description and Consequences

Mr. Y was referred to the North Somerset Specialist Drug and Alcohol Service (NSSDAS) by his GP in October 2001. However at this time Mr. Y was reluctant to address his drug misuse problem. As a result of this reluctance, the Specialist Drug and Alcohol Service's (SDAS) lengthy waiting lists, Mr. Y's chaotic lifestyle and periods of imprisonment, he had little contact with the Drug and Alcohol Services until 2004. Following his assessment in September 2004 Mr. Y was placed on a Methadone substitute prescribing programme and from this time on he engaged well with the service and his drug-misuse problems were stabilised.

At the end of 2004 Mr. Y moved to Bristol as a result of threats being made towards him by other drug users in the Weston-super-Mare area. His care was passed to the Bristol Drug and Alcohol Service (BSDS). Mr. Y remained well engaged with the service and stable on the substitute prescribing programme; by late 2005 Mr. Y was reporting that he was no longer using illicit drugs.

Early in 2008 Mr. Y move back to Weston-super-Mare and his care was again taken up by the North Somerset SDAS; he re-engaged well with the service and his drug use remained stable.

From early in 2002 Mr. Y reported psychotic-like symptoms, in particular auditory hallucinations which he ascribed to his contact with an occult group some time before. At times he described feeling "paranoid" and suspicious. During the time he was in contact with the SDAS he was assessed by a number of psychiatrists in North Somerset, Bristol and in prison. On most occasions the reviewing psychiatrist concluded that Mr. Y's abnormal experiences were pseudo-hallucinations resulting from his drug misuse. When he was assessed by the psychiatrist in Bristol in 2005 she felt that a diagnosis of a psychotic disorder could not be discounted and gave as her differential diagnosis: mental disorder due to use of hallucinogens/stimulants, Schizotypal disorder and Schizophrenia. However despite the fact that the consensus opinion was that Mr. Y's abnormal experiences were related to his drug misuse from mid-2004 he was offered a trial of anti-psychotic medication. He initially

refused this but in 2005 he accepted and appears to have taken the medication for several months. Around December 2005 Mr. Y discontinued the medication without consulting his GP or the SDAS staff. On at least one occasion during this period Mr. Y reported that he felt he was benefiting from the medication, however his more consistent belief was that it was the Diazepam, which was prescribed as part of his drug management regimen, that was of benefit to him. In 2006, when he was re-assessed by the Bristol psychiatrist, Mr. Y reported that his mental state was stable and when he returned to Weston-super-Mare the North Somerset team, who had known him in 2004, felt that his mental state was much improved.

Mr. Y had an offending history predating his referral to the SDAS. Whilst under the care of that service, in addition to one short prison sentence, he was charged with an assault on an ex-girlfriend and an assault on his mother, he also assaulted an aunt and was involved in several fights with fellow residents at the hostels in which he was staying. A risk assessment in August 2005 concluded that Mr. Y presented a risk to women, particularly family members and that it would be preferable if he was seen by male members of staff.

Following Mr. Y's return to Weston-super-Mare in 2008 he was regularly reviewed by the Consultant Psychiatrist in the SDAS. During this time Mr. Y's drug misuse was well controlled and there did not appear to be any exacerbation of his mental health symptomatology. However, it was noted that he was drinking heavily. He did not, however, regard this as a problem.

In February 2008 Mr. Y's son came to live with him as Mr. Y's mother, with whom the child normally lived, was in hospital. It was noted that as Mr. Y's benefits had not been adjusted to take account of the fact that he now had his son living with him and Mr. Y was experiencing financial difficulties. There was no contact at this time between the SDAS and Children's Social Services regarding the suitability of placing Mr. Y's son with him or of his son's well-being.

On 7 May 2008 the SDAS team were informed that Mr. Y had been arrested for assault and detained in prison. On 27 May the team were informed that the victim of Mr. Y's assault had died and Mr. Y was to be charged with murder.

When Mr. Y was assessed by the prison psychiatrist she concluded that there was no evidence that Mr. Y was suffering from a serious mental illness.

Mr. Y was convicted of murder at Bristol Crown Court on 24 July 2009 and sentenced to life imprisonment with a recommendation that he serve a minimum of 3,899 days.

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

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South West, the Strategic Health Authority (SHA) to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 4, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:
"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

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

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

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

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

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient, in order to establish the lessons to be learnt, to minimise the possibility of the reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

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

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

5. Terms of reference for the Independent Investigation

The Terms of Reference for the Independent Investigation were set by NHS South West (the SHA). They are as follows:

1. The overall objectives of the Independent Investigation of the Case of Mr. Y:

- to evaluate the mental health care and treatment including risk assessment and risk management;
- to identify key issues, lessons learnt, recommendations and actions by all directly involoved in health services;
- assess progress made on the delivery of action plans following the Internal investigation;
- identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies.

2. Terms of Reference

- Review the assessment, treatment and care that Mr. Y received from the Avon & Wiltshire Mental health Partnership NHS Trust;
- Review the care planning and risk assessment policy and procedures;
- Review the communication between agaencies, services, friends and family including the transfer of relevant information to inform risk assessment;
- Review the documenation and recording of key information;
- Review communication, case management and care delivery;
- Review the Trust's Internal Investigation of the incident to include timeliness and methodology to identify:
    - whether all key issues and lessons have been identified;
    - whether recommendations are appropriate and comprehensive and flow from the lessons learnt;
    - review progress made against the action plan;
    - review processes in place to embed any lessons learnt;
    - Review any communication and work with families of victim and perpetrato;

- Establish appropriate contacts and communications with family/carers to ensure:
- appropriate engagement with the Internal Investigation process;

3. Outcomes

- A comprehensive report of this investigation which contains the lessons learnt and recommendations based on evidence arising from the Investigation.

6. The Independent Investigation Team

Selection of the Investigation Team

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

Investigation Team Leader and Chair

Dr. L.A. Rowland	Director of Research, HASCAS Health and Social Care Advisory Service. Clinical Psychologist Member

Investigation Team Members

Dr. A. Johnstone	Chief Executive Officer, HASCAS Health and Social Care Advisory Service. Nurse Member
Mr. I. Allured	Director of Adult Mental Health, HASCAS Health and Social Care Advisory Service. Social Worker Member

Support to the Investigation Team

Mr. C. Welton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Fiona Shipley Transcriptions Ltd	Stenography Services
Independent Legal Advice	Kennedy Solicitors

7. Investigation Methodology

7.1 Classification of Independent Investigations

Classification of Independent investigation

Three types of Independent Investigation are commonly commissioned, these are:

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

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

A Type C review is principally a documentary analysis review which utilises:

- clinical records;
- Trust policies and procedures;
- the Trust Internal Investigation report;
- the Trust Internal Investigation archive.

A Type C review does not seek to reinvestigate a case from the beginning if it can be ascertained that the internal review was robust. In a Type C review the Independent Investigation is charged with building upon any investigative work that has already taken place.

7.2 Communication and Liaison

7.2.1 Consent

On 10 March 2011 Mr. Y was visited in HM Prison Garth by a representative of the SHA and a member of the Independent Investigation Team. They explained to Mr. Y the purpose of the

Independent Investigation and sought his consent for the release of his clinical records. It was explained to Mr. Y that should he choose to withhold his consent, permission to release these, in the public interest, would be sought from the relevant Caldicott Guardians.

Mr. Y wrote to the SHA on 14 March 2011 indicating that he was not willing to give consent for the disclosure of his clinical records. The SHA wrote to the Caldicott Guardian at the Avon and Wiltshire Mental Health Partnership NHS Trust seeking permission to have Mr. Y's records released in the public interest. This permission was given by the Caldicott Guardian on 22 March 2011. The SHA requested permission from the Caldicott Guardian for NHS Bristol to have Mr. Y's Primary Care records released in the public interest. This permission was given on 4 April 2011.

7.2.2 Communication with the Family of the Victim

Two members of the Independent Investigation Team met Mr. H's widow on 8 November 2011 at her home.

7.2.3 Communications with the Avon and Wiltshire Mental Health Partnership NHS Trust

NHS South West wrote to the Avon and Wiltshire Mental Health Partnership NHS Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. Y.

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

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished;
- On the 23 November 2010 the Chief Executive of the HASCAS Health and Social Care Advisory Service and the Chair of Independent Investigation met the nominated Trust liaison person, and representatives of the SHA, the Local Authority, the Primary

Care Trust and the police. The purpose of the meeting was to clarify the arrangements for the forthcoming Independent Investigation;

- A workshop for witnesses to the Independent Investigation was held on 6 May 2011. The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible;
- On 14, 15, and 16 June 2011 interviews were held at the Avon and Wiltshire Mental Health Partnership NHS Trust Headquarters in Chippenham, Wiltshire. The Investigation Team were afforded the opportunity to interview witnesses and meet the Trust Corporate Team;
- On 9 November 2011 a meeting was held between the Chair of the Independent Investigation, CEO of the HASCAS Health and Social Care Advisory Service and the Trust Corporate Team in order to discuss the findings and to invite the Trust to contribute to the recommendation development.

7.2.4 Communications with other Stakeholder

- On 8 November 2011 the Independent Investigation Team met representatives of NHS North Somerset and of NHS Bristol.
- On 9 November 2011 two members of the Independent Investigation Team met the Independent Chair of the Bristol Children's Safeguarding Board.

7.3 Witnesses called by the Independent Investigation

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

Table 1: Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
14 June 2011	**Trust** • Executive Director: Nursing, Compliance, Assurance & Standards;	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist;

	• Clinical Director: Adult acute Inpatient Services; • Clinical Director: Specialist Drug and Alcohol Services; • Clinical Director: Service Redesign.	• Investigation Team, Nurse; • Investigation Team, Social Worker; • In attendance: Stenographer.
15 June 2011	**Trust** • Consultant Psychiatrist, NSSDAS; • Service Manger NSSDAS.	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist; • Investigation Team, Nurse; • Investigation Team Social Worker; • In attendance: Stenographer.
15 June 2011	**Trust** • Author 1 of the Internal Investigation Report; • Author 2 of the Internal Investigation Report.	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist; • Investigation Team, Nurse; • Investigation Team, Social Worker; • In attendance: Stenographer.
15 June 2011	Medical Director.	• Investigation Team Chair, Clinical Psychologist; • Investigation Team, Nurse; • Investigation Team, Social Worker; In attendance: Stenographer.

7.4 Salmon Compliant Procedures

The Investigation Team adopted Salmon compliant procedures during the course of their work. These are set out below:

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

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

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

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

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

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

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

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

(h) that they will be able to access copies of the clinical records both before and during their interviews to refresh their memory.

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

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

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

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

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

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

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

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

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

7.5 Independent Investigation Team

7.5.1 Initial Team Processes

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of

experience that was needed. During the Investigation the Team worked both in a 'virtual' manner and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview the general questions that they could expect to be asked. The Clinical Records were sent to the HASCAS Health and Social Care Advisory Service during the first week in October 2010 and the Internal Investigation archive was sent during November 2010.

7.5.2 The Team met on the following occasions:

31 May 2011. On this occasion the Team met in order to plan the interviews with the Trust Senior management team and clinical witness.

26 July and 28 September 2011. On these occasions the Team met to work through a root cause analysis process and to discuss findings of the Investigation.

7.5.3 Other Meetings and Communications

Other communications were maintained via email and telephone in order to complete the Investigation report and to develop recommendations.

7.6 Root Cause Analysis (RCA)

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

RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this, causal factors or critical issues can be identified.
3. **Root Cause Identification.** The National Patient Safety Agency (NPSA) advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Decision Tree and the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

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

7.7 Anonymity

All staff of the Avon and Wiltshire Mental Health Partnership NHS Trust have been referred to in this Investigation report by reference to their role titles, to preserve their anonymity.

The individual whose care and treatment is the subject of this report has been referred to throughout as Mr. Y. The victim has been referred to throughout this report as Mr. H.

8. Information and Evidence Gathered (Documents)

During the course of this investigation the following documents were actively used by the Independent Investigation to collect evidence and to formulate conclusions.

1. Mr. Y's Avon and Wiltshire Mental Health Partnership NHS Trust clinical records.
2. The Avon and Wiltshire Mental Health Partnership NHS Trust Internal Investigation Report.
3. Avon and Wiltshire Mental Health Partnership NHS Trust action plans.
4. Secondary literature review of media documentation reporting the death of Mr. H.
5. Avon and Wiltshire Mental Health Partnership NHS Trust Clinical Risk Clinical Policies, past and present.
6. Avon and Wiltshire Mental Health Partnership NHS Trust Incident Reporting Policies.
7. Avon and Wiltshire Mental Health Partnership NHS Trust *Being Open* Policy.
8. Avon and Wiltshire Mental Health Partnership NHS Trust Operational Policies.
9. Healthcare Commission/Care Quality Commission Reports for Avon and Wilt
10. shire Mental Health Partnership NHS Trust services.
11. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006.
12. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005.

9. Profile of the Avon and Wiltshire Mental Health Partnership NHS Trust

9.1 The Avon and Wiltshire Mental Health Partnership NHS Trust

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

The Trust operates across a geographical span of 2,200 square miles, encompassing a population of 1.6m people and covering six primary care trusts. Services are centred upon 11 main in-patient sites, 97 community bases and 4 community mental health houses. The Trust has an operating budget of £194 million per year and employs in excess of 3,500 staff.

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

Specialist Drug and Alcohol Service SBU;
Adults of Working Age SBU;
Liaison and Later Life SBU;
Specialised and Secure Services SBU.

The Trust's strategic objectives are to:

1. be the organisation of choice for service users, staff and commissioners providing a comprehensive range of services in primary, secondary and tertiary care settings, across the geographical area.

2. provide person-centred services that intervene early, are highly accessible, focused on recovery, are of high quality and leading edge.

3. be a Trust which is financially sustainable through robust financial management, use of innovative technologies efficiency and increased productivity.

Specialist Drug and Alcohol Service (SDAS), North Somerset

North Somerset Unitary Authority covers an area of approximately 145 square miles and has a population of 212,200.[1, 2]

There are four main urban centres of population in North Somerset: Weston-super-Mare with a population in excess of 70,000, Clevedon, Portishead, and Nailsea, all with populations around 20,000, with a number of smaller urban and semi-rural centres and villages.

Whilst both men and women in North Somerset have a higher average life expectancy than the national average, some areas of North Somerset are among the most deprived nationally. The gap in life expectancy between the most affluent and most deprived areas of North Somerset is the widest in the South West region and bigger than the national average. This has a particular impact on a number of groups which include the homeless and those with mental health conditions. The prevalence of mental health problems has been estimated to be significantly higher than the national average.[3]

North Somerset's coastal and rural environment may have contributed to the high concentration of residential treatment and 'dry house' services for people with drug and alcohol problems which has developed over the years. It has been suggested that this concentration of services may attract significant numbers of 'out of area' clients to North Somerset, some of whom stay in the area. North Somerset has a slightly higher rate of opiate and crack users, and injecting drug users, than the South West averages, with a higher proportion of older drug users in the 35-44 age group than elsewhere.[4]

[1] Office of National Statistics: Mid-year estimate 2010.
[2] The mid-year estimate for 2008 was 207,000
[3] Director of Public Health: *Annual Report 2010*
[4] North Somerset Drug Action Team Treatment Plan 2010-11

The Specialist Drug and Alcohol Service for North Somerset (SDAS) provides drug treatment services to North Somerset as part of the integrated Drug Treatment system, commissioned from a range of providers by North Somerset Drug Action Team.

In 2008 North Somerset SDAS provided services which included community-based treatment for both drug and alcohol problems, and one in-patient bed, located in a mental heath acute ward, for in-patient drug or alcohol detoxification treatment. The services provided included: assessment, including medical assessment, key work, care co-ordination and a range of pharmacological and associated psychosocial interventions for people with a range of drug and / or alcohol problems.

GPs in North Somerset have for some time provided a significant proportion of the available substitute prescribing treatment for those drug users who are opiate dependent, in shared care arrangements with key working, care co-ordination, advice and support from the specialist service. Prescribing treatment for service users with more complex needs would be managed directly by the specialist service. Where complex needs include mental health problems, the involvement of local mental health services would be sought as and when appropriate.

In 2008 the service was managed by a full time Service Manager, with a Consultant Psychiatrist employed in the service for seven sessions per week. The multi-disciplinary team included a number of nurses and drug / alcohol workers but at that time did not include social work staff nor a clinical psychologist. Doctors in training provided valuable additional medical input to the service.

In 2010-11 and 2011-12 alcohol and drug treatment services in North Somerset have been re-commissioned separately, by the Primary Care Trust and the Drug Action Team respectively. As a result, the Specialist Drug and Alcohol Service in North Somerset is no longer directly commissioned to provide alcohol services, although a number of community alcohol detoxification treatments continue to be provided.

Commissioning of in-patient treatment services for drug and alcohol detoxification from the Avon and Wiltshire Partnership NHS Trust also ended from the start of 2010-11. North

Somerset SDAS therefore now provides community based drug treatment services, as described above, to people with a range of primary drug problems and complex needs.

As a result of changes in national drug strategy, and commissioner requirements in response to these changes, the service has undergone significant changes and is continuing to do so. In summary, the service now has a clear emphasis on recovery-focused drug treatment and provides a wider range of structured psychosocial treatment in addition to pharmacological treatment and psychosocial services to support this.

The service now employs a Clinical Psychologist and a Recovery Support Worker, in addition to a revised mix of nurses and drug / alcohol workers in the multi-disciplinary team. Doctors in training continue to contribute to the medical staffing of the service.

The Service has a Team Manager who reports to the Service Manager for North Somerset, Bristol and South Gloucestershire. The Consultant Psychiatrist for the service is employed for six sessions per week in North Somerset SDAS but also now works for one session per week in a local Adult Community Mental Heath Team.

10. Chronology of Events

10.1 RCA First Stage

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

10.2 Chronology

On **11 October 2001** Mr. Y was referred to the North Somerset Specialist Drug and Alcohol Service (NSSDAS) by his General Practitioner (GP) in Weston-super-Mare[5]. Mr. Y had only recently been registered at the practice and the GP had met him for the first time on the previous day. The GP reported that Mr. Y had been misusing drugs for around eight years. At this time he was using amphetamines, cocaine, Dihydrocodeine and Nitrazepam which he was buying illicitly.

Mr. Y informed the GP that he had been in prison seven or eight years earlier for "joy riding" and was on bail at the current time for criminal damage to a car.

The GP also reported that Mr. Y had custody of his young son, though he was currently living with Mr. Y's mother. Mr. Y had no contact at that time with the child's mother who was a heroin addict. Mr. Y's son was not registered with this GP. Mr. Y had accepted the referral to the Drug and Alcohol services *"after quite a lot of discussion"*.[6]

On **16 October 2001** the referral of Mr. Y by his GP was received by the NSSDAS.[7]

[5] Case notes 1.257ff
[6] Case notes 2. 259
[7] Case notes 1.23

On **19 October 2001** NSSADS wrote to Mr. Y to inform him that he been placed on their waiting list. This letter encouraged Mr. Y to use the drop-in service while he was waiting to be assessed.

On **26 October 2001** NSSDAS wrote to Mr. Y's GP acknowledging the referral. In this letter it is noted that Mr. Y had custody of his son who was living with his Grandmother. The letter advised the GP that *"if the son was living with [Mr. Y] this would change the category to which he has been allocated"* and asked the GP to *"keep us updated if there are any changes in childcare arrangements"*.[8]

On **9 January 2002** Mr. Y was referred to NSSDAS by the Drug Arrest Team in Weston-super-Mare. It was noted that the police doctor who examined Mr. Y was concerned about his physical and mental health.[9] It is recorded in the assessment that Mr. Y was having thoughts of harming or killing himself. It was also noted that Mr. Y had a young son who lived with Mr. Y's mother.[10]

On **11 January 2002** NSSDAS wrote to Mr. Y acknowledging that he was having a *"difficult time"* and confirming that he was still on their waiting list. Mr. Y was advised that if he had concerns about his physical or mental health he should contact his GP.[11]

On **22 January 2002** NSSDAS wrote to Mr. Y's GP informing him that they had been contacted by the Drug Arrest Team who had been concerned about Mr. Y's physical and mental heath when he had been detained in the police cells. The letter also informed the GP that when Mr. Y had attended the drop-in service on 11 January 2002 an ambulance was called as Mr. Y had been complaining of abdominal pain. The letter encouraged the GP not to prescribe for Mr. Y, suggested that he encourage Mr. Y to make contact with the drop-in service and advised that if he had concerns about Mr. Y's mental health to refer him to the Community Mental Health Team (CMHT).[12]

On **7 March 2002** Mr. Y was referred to NSSDAS by GP 2 in Nailsea, Bristol. The referral letter notes that Mr. Y was using Dihydrocodeine and Diazepam and had used heroin in the past. GP 2's referral letter notes that Mr. Y had a flat in Weston-super-Mare but was living

[8] Case notes 1.253
[9] Case notes 1.233
[10] Case notes 1.233
[11] Case notes 1.229
[12] Case notes 1.225

with his mother in Nailsea. The letter notes that Mr. Y's mother looked after Mr. Y's son most of the time.[13]

On **10 July 2002 Mr. Y** attended an assessment appointment at NSSDAS. At this time he reported that he was moving between his mother's home, where his son lived, and his grandmother's home. A risk screening form was completed as part of this assessment. No risk was identified under any category. [14] The care plan section of the assessment was not completed.

Mr. Y failed to attend his appointments on **17and 24 July 2002.**[15] He was discussed at the team meeting on **18 July 2002** where it was agreed that Mr. Y was suitable for the service but that his current level of drug use needed to be clarified. [16]

On **9 August 2002** Mr. Y was discharged as he had failed to engage or make contact with the service.[17]

On **29 January 2003** Mr. Y was again referred to NSSDAS by his GP in Weston-super-Mare. In his referral letter the GP explained that Mr. Y had been in and out of prison. The GP reported that a social worker had contacted him in November 2001 to report that despite Mr. Y being in a detoxification unit while in prison he continued to report hearing voices. The voices provided a commentary on his life but were not directing him. He found the experience *"wearing"*. The letter notes that Mr. Y had a son with whom he remained in contact and that Mr. Y was in a new relationship. Mr. Y was smoking between £10 and £15 of heroin a day.[18]

Mr. Y was offered an assessment appointment for **24 February 2003** but failed to attend this and was subsequently discharged.[19]

On **23 October 2003** Mr. Y's GP in Nailsea referred him to the Woodspring Community Mental Health Team.[20]

[13] Case notes 1.223
[14] Case notes 1.40
[15] Case notes 1.49
[16] Case notes 1.49
[17] Case notes 1.213
[18] Case notes 1.21, 1.209
[19] Case notes 1.51,1.201,1.205
[20] Case notes 1.3

On **28 October 2003** there was a telephone discussion between the CMHT and NSSDAS regarding the possibility of a joint assessment. On **12 November 2003** it was agreed that Mr. Y would be offered a joint assessment on **1 December 2003.**[21]

On **24 November 2003** the CMHT received a telephone call from a hostel for homeless people in Bristol informing them at Mr. Y had moved there. The hostel staff were arranging for Mr. Y to be registered with a local GP and to access services in the Bristol area. Mr. Y was discharged by NSSADS.[22]

On **24 December 2003** a referral was made to the Bristol Specialist Drug Service (BSDS) by a GP in Bristol.[23] In the referral letter it was noted that Mr. Y had recently been discharged from prison. He was reported to be using crack cocaine and heroin regularly and to be dependent on benzodiazepines. He had had a withdrawal fit a week earlier and had been admitted to the Bristol Royal Infirmary. The GP's letter noted that Mr. Y's main concern at the time was his "auditory hallucinations" which had started approximately 18 months earlier *"after he became involved for one day with a Satanic group"*. Mr. Y reported that he found the voices intrusive *"but less so since he was given a prescription for Diazepam."* Mr. Y was also reporting anxiety and depression which he said he had experienced for a considerable time. According to the GP's letter Mr. Y was not interested in the Methadone programme at that time. [24]

On **24 December 2003** Mr. Y's GP in Weston-super-Mare wrote to NSSDAS reporting that Mr. Y had returned to Weston-super-Mare, had re-registered with him and was requesting that he be reinstated on NSSDAS's waiting list.[25]

On **8 January 2004** Mr. Y's referral was discussed at the NSSDAS team meeting. The team contacted the GP to clarify that the referral related to Mr. Y's drug use and contacted BSDS, to whom the case was still open, for an update on their involvement.[26]

On **12 January 2004** BSDS confirmed that Mr. Y was not receiving treatment from them and discharged him.[27]

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[21] Case notes 1.53, 1.187,1.189
[2222] Case notes 1.51,1.53, 1.185
[23] Case notes 1.7
[24] Case notes 2.373
[25] Case notes 1.183
[26] Case notes 1.55
[27] Case notes 1.55

On **16 January 2004** NSSDAS wrote to Mr. Y's GP in Nailsea recording Mr. Y.s referrals over the previous year:

> 29 January 2003: referred by GP in Weston-super-Mare;
>
> 21 October 2003: referred by GP in Nailsea requesting a mental health assessment. A joint CMHT and Drug and Alcohol team assessment was arranged for 1 December 2003. This appointment was cancelled as Mr. Y had moved to Bristol and was receiving treatment there.
>
> 24 December 2003: the current referral was from GP in Nailsea but it was discovered that Mr. Y was an active referral to the Bristol team.
>
> Mr. Y was placed on the waiting list for NSSADS on 8 January 2004.

The letter notes that Mr. Y "*seems to move around frequently and as a result never really engages with services. Hopefully he will stay in one place long enough now to receive some help from services."*[28]

On **16 January 2004** NSSDAS wrote to Mr. Y informing him that he had been placed on their waiting list and advised him of the availability of the drop-in facilities which he might use while waiting for his assessment.[29]

On **22 January 2004** Mr. Y's GP wrote to NSSDAS reporting that he had seen Mr. Y on 19 and 24 December 2003. At that time Mr. Y was concerned with his "*overall mental health and well as his drug problem."* However the GP reported that Mr. Y appeared *"quite well from the mental health point of view"*. He suggested that Mr. Y be placed only on the NSSDAS waiting list and his mental health assessed as part of his assessment by NSSDAS and, if necessary, a further referral to the CMHT, made at that time.[30]

However on **18 February 2004** Mr. Y's GP referred him to the CMHT. The GP reported that Mr. Y was *"expressing a strong desire to be assessed by the Psychiatric Services*." Mr. Y was reporting that he frequently heard voices and suffered from paranoia. He had informed the GP that the main reason he took drugs was to suppress the voices. However the GP was

[28] Case notes 1.179
[29] Case notes 1.177
[30] Case notes 1.175

unsure whether the voices were a result of Mr. Y misusing drugs or the drug use a mechanism for escaping from the voices.[31]

On **27 February 2004** the CMHT contacted NSSDAS to arrange a joint assessment appointment.[32] This was arranged for **21 April 2004.**[33]

However on **5 March 2004** the CMHT telephone NSSDAS to say that they did not think an initial joint assessment was appropriate. NSSDAS agreed to undertake the initial assessment and to refer to the CMHT if necessary.[34] An assessment appointment was made for Mr. Y for 22 April 2004.

On **10 March 2004** NSSDAS wrote to Mr. Y's GP to inform him that his referral to the CMHT had been passed to them, that they would undertake the initial assessment and subsequently refer Mr. Y to the CMHT if they felt this to be necessary.[35]

On **16 April 2004** NSSDAS were telephoned by Mr. Y's solicitor to inform them that Mr. Y had been arrested for forging a prescription.[36]

On **22 April 2004** Mr. Y did not attend his assessment appointment with NSSDAS. A letter was sent to him asking him to contact NSSDAS. As he failed to respond to this letter he was discharged on **27 April 2004.** [37]

On **10 May 2004** Mr. Y's GP wrote to NSSDAS explaining that at the time of his assessment appointment Mr. Y had been in the "Ryecroft" probation and bail hostel in Gloucestershire. He reported that he had spoken to Mr. Y who had been keen to attend the appointment but was unsure whether he would be allowed to travel. The GP apologised as there may have been a misunderstanding with Mr. Y expecting him, (the GP), to cancel the appointment. The GP was unsure as to Mr. Y's current whereabouts but as he was no longer in Weston-super-

[31] Case notes 1.171,2.315
[32] Case notes 1.169
[33] Case notes 1.56
[34] Case notes 1.57
[35] Case notes 1.167
[36] Case notes 1.57
[37] Case notes 1.9, 1.57, 1.163

Mare he felt that there was little point in NSSDAS offering Mr. Y further appointment at that time.[38]

On **12 May 2004** Mr. Y was assessed in Bristol Prison by the visiting Consultant Psychiatrist. He reported hearing muffled voices from both inside and outside the cell, talking mostly about God. He did not know if the voice(s) was male or female. Mr. Y also reported seeing things moving on the walls and floor. He had earlier told the dual diagnosis nurse that he had started hearing voices in May 2002.

Mr. Y denied thoughts of harm to self or others.

The Consultant Psychiatrist's opinion was that the "*Primary problem is drug dependence, heroin and crack. No definite evidence of psychotic illness, query auditory pseudo hallucinations*". She offered Mr. Y Promazine liquid (an antipsychotic medication) which he declined.

The Consultant Psychiatrist recorded the following forensic history:

- aged 12/13: vandalism (caution);
- aged 16: burglary, taking a vehicle without consent – 10 week sentence in a young offender institution;
- Mr. Y had served nine short prison sentences since July 2002 which he reported as being "*due to heroin use*".[39]

A core assessment was completed by the in-reach nurse on the same day. Mr. Y reported that he was used to the voices but was distressed by being "made" to think derogatory thoughts about people he cared about. The nurse concluded that Mr. Y was "*a religious man – lots of delusions seem to relate to the spirit world but he is extremely guarded in this regard."*

Mr. Y told the nurse that the drugs relieved his symptoms but acknowledged that his drug use pre-dated mental health symptoms. He said that he sometimes committed offences in order to be sent to prison to obtain help with detoxification.

[38] Case notes 1.161
[39] Case notes 2.95, 2. 383ff, 2.93ff

Mr. Y reported that he had tried a friend's Chlorpromazine and had disliked it. He was, therefore, unwilling to accept antipsychotic medication.[40]

On **14 May 2004** the Mental Health Support Team at Bristol Prison wrote to a GP in Gloucester informing him that Mr. Y was due for release from prison on 21 May 2004. He was described as "*quite psychotic, including delusional beliefs regarding religion*". The letter noted that Mr. Y was guarded about his mental state. The letter informed the GP that Mr. Y had been due to see a psychiatrist but due to his imprisonment had not been assessed. It was suggested that he should arrange for Mr. Y to be seen by local CMHT.[41]

On the same day the Prison In-Reach Team wrote to a GP in Taunton informing him that Mr. Y was due for release from prison on 21 May 2004 and his release address would be St. Martin's, Taunton. The letter informed the GP that Mr. Y was guarded about his symptoms but had disclosed that he heard voices and at times experienced hallucinations; at times Mr. Y felt that his thoughts were being controlled. "*He conceded that his drug misuse pre-dated these symptoms and while they never go away completely they are more manageable when he is drug free*."

This letter noted that Mr. Y had tried anti-psychotic medication in the past "*when his symptoms have been extremely troublesome"* but did not find them beneficial. He was resistant to being prescribed anti-psychotic medication.

Mr. Y used Diazepam, prescribed and illicit, and reported that he found this helpful. Mr. Y had also reported that he had once had a fit after being without Diazepam for some weeks and, in consequence, was convinced that even with supervised reduction he would experience further fits.

Mr. Y had indicated that he was keen to tackle his drug problem at St. Martin's. The letter concluded that it was difficult to know if Mr. Y needed secondary mental health services until he was free of illicit drugs.[42]

[40] Case notes 2.93
[41] Case notes 2.241
[42] Case notes 2.235

On **3 June 2004** Mr. Y was discharged from NSSDAS as he had not been in contact with them.[43]

On **31 July 2004** Mr. Y was referred to NSSDAS by the Advice and Counselling on Drugs voluntary service (ACAD). It was again noted that Mr. Y was asking to be seen by a psychiatrist.[44]

On **2 August 2004** Mr. Y was referred to NSSDAS by a further Weston-super-Mare GP.
The GP reported that Mr. Y had recently been in the House of St. Martin in Taunton where he had received help with his drug misuse problems. Mr. Y had reported to the GP that he had "mental health issues" but did not wish to discuss these. The GP noted that Mr. Y did not appear depressed, agitated or aggressive.[45]

The GP had obtained confirmation that Mr. Y had been prescribed Diazepam by his GP while in Taunton. He was also using heroin and Dihydrocodeine. Mr. Y had made arrangements to see ACAD.

Mr. Y reported that he had recently sustained a whip-lash injury. The GP refused Mr. Y's request for Dihydrocodeine and recommended that he contacted ACAD.[46]

On **5 August 2004** Mr. Y was discussed at the NSSDAS team meeting and placed on the waiting list.[47]

On **9 August 2004** Mr. Y was again referred to NSSDAS by the GP in Nailsea who had originally referred him in October 2003. He suggested that he should be contacted immediately prior to Mr. Y's appointment so that he could confirm that Mr. Y was still in Nailsea and able to attend the appointment.[48]

[43] Case notes 1.57, 1.159
[44] Case notes 1.157
[45] Case notes 1.155
[46] Case notes 1.155
[47] Case notes 1.59
[48] Case notes 1.151, 2.311

On **10 August 2004** NSSDAS identified that Mr. Y had been referred by two GP surgeries and had received prescriptions from both. Both surgeries were alerted and the clinical manager was informed.[49]

On **17 August 2004** NSSDAS received a telephone call from the CMHT suggesting that the two services undertook a joint assessment.[50]

On **19 August 2004** NSSDAS wrote to Mr. Y's GP in Nailsea informing him that Mr. Y had been placed on the waiting list**.** The letter informed the GP that the team had been contacted by the CMHT suggesting a joint assessment but the decision had been taken that Mr. Y was to be assessed initially by NSSDAS and if there were any concerns about his mental health they would then contact the CMHT.[51]

On **24 August 2004** NSSDAS wrote to Mr. Y informing him that he had been placed on the waiting list and encouraging him to use the drop-in facilities that were available while he was waiting.[52]

On **3 September 2004** Mr. Y was seen at the drop-in service when it was noted that he remained on the waiting list, he had mental health issues and he had a young son who was cared for by Mr. Y's mother.[53]

On **6 September 2004** Mr. Y was again seen at the drop-in service. It was noted that Mr. Y had a son who lived with Mr. Y's mother. Mr. Y saw his son two to three times a week and sometimes looked after him when his mother was at work. Mr. Y also, very occasionally, looked after his young nieces.[54]

On **9 September 2004** Mr. Y was referred to NSSDAS by the Criminal Justice Intervention Team. He had been charged with theft. It was noted that he had parental responsibilities.[55]

[49] Case notes 1.59
[50] Case notes 1.59
[51] Case notes 1.149
[52] Case notes 1.147
[53] Case notes 1.61
[54] Case notes 1. 63
[55] Case notes 1.143

On **10 September 2004** Mr. Y attended the drop-in asking for an update on his referral. He was informed that he had an assessment appointment on **13 September 2004.** Mr. Y was advised that if his mental health problems worsened he should attend the local Accident and Emergency Department.[56]

On **13 September 2004** Mr. Y was assessed by a specialist nurse practitioner from NSSDAS.

Mr. Y reported that he was using £30 of heroin intravenously per day, as well as Dihydrocodeine and Diazepam. He reported that he had been released from prison in May 2004 and had been free from illicit drugs until he had been involved in a road traffic accident eight weeks prior to the assessment. He had suffered a whiplash injury and had been prescribed Dihydrocodeine. Since that time his use of illicit drugs had increased.

Mr. Y reported that he heard voices all the time and "saw things" when he had not slept for a few days. He said that the voices related to his involvement with the occult some years earlier and that he had felt traumatised since that time. It was noted that Mr. Y's mental health problem: "*appears to be of a PTSD [Post Traumatic Syndrome Disorder] type disorder."*[57]

With respect to Mr. Y's forensic history it was noted that he had numerous brief periods in prison for theft, shoplifting and car theft.

It was noted that Mr. Y looked after his son and occasionally looked after an infant nephew and his two young nieces.

No risk screen was completed nor was a care plan completed at this assessment. However it is recorded that the assessment was discussed with the NSSDAS Consultant Psychiatrist. An appointment was arranged for a medical review and to commence Methadone substitution.[58]

On **15 September 2004** Mr. Y was assessed by the NSSDAS Consultant Psychiatrist. Mr. Y reported that he was injecting 1 - 2 bags of heroin daily, taking 16 x 30 mg tablets of Dihydrocodeine and 70 mg of Diazepam daily. He also had a bingeing pattern of alcohol use.

[56] Case notes 1.69, 1.71
[57] Case notes 1.76ff
[58] Case notes 1.76ff

Mr. Y described his mood as "*OK"* and was positive about the future. He described an extensive history of overdosing and deliberate self harm. Mr. Y reported experiencing auditory hallucinations, describing these as muffled voices which he heard outside his head. He explained that he believed that he was surrounded by spirits. Mr. Y denied any first rank symptoms of Schizophrenia. He said that in the past he had been involved with the occult.

The Consultant Psychiatrist concluded that: *"it is probable that [Mr. Y] had a conduct disorder in his early teens",* and *"the impression is of a man who has a long history of drug abuse that has arisen within the context of a personality disorder and he exhibits traits of emotional instability. Although he described some quasi-psychotic symptoms I did not think he was suffering with a psychotic illness, and though his symptoms may relate to his abuse of stimulants it may also relate to his interest in the occult and other spiritual experiences".* [59]

In his letter to Mr. Y's GP the Consultant Psychiatrist diagnosed Mr. Y as suffering from: opiate dependence syndrome, benzodiazepine dependence and emotional unstable personality disorder.

The Consultant Psychiatrist also noted that Mr. Y had moved away from Weston-super-Mare to stay with his grandmother in Bristol because of threats from other drug users in the Weston-super-Mare area. The Consultant Psychiatrist noted that Mr. Y would have to register with a GP in Bristol but NSSDAS would continue prescribing for him for the next month.[60] Following this assessment Mr. Y was stabilised on Methadone with the dose being titrated up to 70mg with supervised consumption. In addition he was prescribed Diazepam 25mg a day.

On **21 September 2004** Mr. Y was offered additional support by the Advice and Counselling on Drugs voluntary service (ACAD).[61]

On **23 September 2004** Mr. Y failed to attend his appointment at NSSDAS.[62]

On the **28 September 2004** Mr. Y's GP wrote to NSSDAS to inform them that Mr. Y had presented at the surgery reporting that he had been assaulted and hit over the head with a

[59] Case notes 1.97ff, 1.35, 1.127
[60] Case notes 1.127
[61] Case notes 1.133
[62] Case notes 1.106

bottle. He report that he was in excruciating pain and was experiencing panic attacks. Mr. Y had doubled his Diazepam. The GP had agreed to an increase in Diazepam from 5mg to 6 mg three times a day.[63]

At his appointment at NSSDAS on **5 October 2004** Mr. Y reported that he had moved his accommodation because of problems with his landlord.[64]

When he was seen on **7 October 2004** Mr. Y reported that he had been threatened by the brother of another service user and a dealer. He was planning to go to Bristol to live with his grandmother as soon as possible. Prescription cover was agreed to allow him to go to Bristol. It is recorded in Mr. Y's clinical notes that as he was leaving his appointment Mr. Y was asked by another client if he wanted to "*finish what he started*".[65]

On **14 October 2004** the NSSDAS Consultant Psychiatrist wrote to Mr. Y's new GP in Bristol: "*When I first met [Mr. Y] I was concerned about some quite bizarre, quasi-psychotic symptoms which he described, but I suspect that this is a reflection of his underlying belief system rather than evidence of schizophrenia, and I think his mental difficulties arise through an emotionally unstable personality.*

In my brief acquaintance with [Mr. Y] he has always been polite and pleasant and there has never been any sense of hostility from him."[66]

The plan was to transfer Mr. Y's care to the services in Bristol.

On **26 October 2004** NSSDAS wrote to the Specialist Drug and Alcohol Service in Bristol (BSDS). This letter noted that *"[Mr. Y] has a history of overdosing and self harm and describes a number of bizarre quasi psychotic beliefs. However I do not think that he is suffering with schizophrenia and consider that his difficulties reside in an emotionally unstable personality disorder."*

[63] Case notes 1.131
[64] Case notes 1.109
[65] Case notes 1.109
[66] Case notes 1.129

Mr. Y's GP in Bristol was unable to prescribe for him and the NSSDAS Consultant Psychiatrist indicated that NSSDAS was willing to continue to prescribing for Mr. Y in the short term but requested that BSDS took over Mr. Y's care as soon as possible.[67]

Mr. Y continued to attend appointments with NSSDAS travelling from Bristol. On at least one occasion it is recorded that a staff member drove him back to the train station as he was felt to be under threat from other service users in Weston-super-Mare.

At his appointment on **27 October 2004** Mr. Y reported that he had had a fight with his ex-girlfriend and he was being charged with assault.

He also reported at this interview that his Bristol GP had stopped his Diazepam and he was concerned that he would have a fit.

Mr. Y reported that he was looking after his son and his grandmother.[68]

On **15 November 2004** the NSSDAS Consultant Psychiatrist wrote to Mr. Y's Bristol GP reporting that Mr. Y was stable on prescribed medication but he had requested to see a psychiatrist *"to talk about a number of frightening episodes from the past…he is quite preoccupied by what amounts to delusional beliefs, involving spirits and so forth. Although [Mr. Y] has a problem with emotional instability I do wonder whether he would benefit from a trial of an antipsychotic. I discussed this with him and he declined any such treatment. However I suggested that he thinks about it and I will discuss it with him when he next attends in two weeks time."*[69]

At this time Mr. Y's diagnosis was recorded as: Opiate dependence syndrome, Benzodiazepine dependence and emotionally unstable personality.

On **23 November 2004** the NSSDAS Consultant Psychiatrist wrote to the BSDS confirming that Mr. Y had an assessment appointment with BSDS on 24 November 2004 and that DSDS

[67] Case notes 1.125
[68] Case notes 1. 110
[69] Case notes 1.123,2.309

would take over prescribing for Mr. Y from the 1 December. He included a copy of the NSSDAS assessment summary with this letter.[70]

On **24 November 2004** Mr. Y attended late for his assessment appointment with BSDS. He said that he wanted to be drug free within twelve months but wanted an immediate increase in his Diazepam.[71]

On **1 December 2004** a BSDS Specialist Drugs Worker wrote confirming that BSDS had taken responsibility for Mr. Y's care and treatment from that date. The plan was that Mr. Y would attend the service fortnightly for support and counselling and BSDS would assume responsibility for prescribing his medication.[72]

On **3 December 2004** BSDS telephoned NSSDAS to confirm that they had taken over prescribing for Mr. Y and he had been discharged from NSSDAS.[73] This was confirmed in writing in a letter between the two services on 7 December 2004.[74]

On **8 December 2004** Mr. Y's assessment was completed by BSDS. He reported that he suffered from severe anxiety and psychotic symptoms, hallucinations and hearing voices. Mr. Y reported that he had used heroin prior to the assessment session as he, wrongly, believed that his prescription was not at the pharmacy. The Specialist Drug Worker noted that he would discuss Mr. Y's need for a mental health assessment with the team psychiatrist.[75]

On **5 January 2005 Mr. Y** discussed *"his situation with his grandmother and about their differences. It became apparent that both use passive aggressive ways of dealing with anger and this presents problems. We worked on [Mr. Y] being more assertive"*. Mr. Y reported that he felt less desperate and less paranoid. He attributed his improvement to his decreased drug intake.[76]

[70] Case notes 1.121
[71] Case notes 2.405
[72] Case notes 2.345
[73] Case notes 1.113
[74] Case notes 1.119
[75] Case notes 2.406
[76] Case notes 2.406

On **19 January 2005** Mr. Y arrived late for his appointment with the Specialist Drug Worker. He disclosed that he had used heroin and cocaine following an argument with his mother and grandmother.[77]

On **3 March 2005** Mr. Y discussed, with his Specialist Drug Worker, his unease about his forthcoming assessment by a female doctor and being dismissed by her. It was pointed out that he had had some positive experiences with female doctors and some bad experiences with male doctors.

Mr. Y discussed a recent episode when he had used cocaine powder. This had presented problems for him in the way he managed his voices. He reported that he was hearing voices all the time but usually managed them well. He disclosed information which he had previously been guarded about: "*a distressing episode of bad mental health which clearly still has a huge effect on his current thinking"*[78]

On **(?) 7 March 2005** Mr. Y contacted his Specialist Drug Worker by telephone. He reported that he was having increasing problems with his grandmother. He asked if his Key Worker could make a home visit to help his grandmother understand his situation better.

Mr. Y cancelled his appointments on **14 and 19 March 2005.**[79]

On **21 March 2005** Mr. Y was assessed by the Staff Grade Psychiatrist at BSDS at the request of his Specialist Drug Worker after Mr. Y had reported "psychotic sounding experiences". Mr. Y reported that he had been living with his maternal grandmother for eight to nine months at this time.

He reported that at that time he was being prescribed Methadone 70mgs daily and Diazepam 25mg daily but he was continuing to inject heroin and was using crack cocaine intermittently. He was also drinking alcohol regularly.

[77] Case notes 2.411
[78] Case notes 2.412
[79] Case notes 2.413

With respect to his psychiatric symptomatology Mr. Y reported that he was experiencing anxiety mainly when interacting with others. It was noted that this appeared to be related to a "*degree of general paranoia." "As such he feels constantly on edge and, at times, hostile towards others if he feels that they are talking about him"*.

Mr. Y complained that he was continuing to hear voices in the form of third person auditory hallucinations, either speaking his thoughts aloud or commenting on his actions. He believed the voices belonged to spirits, whose form he believed he could at times see. Mr. Y reported that he had lived with these experiences for almost three years, since 2 May 2002, and he related this to his traumatic experiences with the occult.

Mr. Y acknowledged the adverse effect cocaine had on his experiences.

Mr. Y reported that he believed that his ex-girlfriend had intentionally crashed a car, in which he was a passenger, so that she could obtain the insurance money for her own use.

It was noted that Mr. Y had a young son with whom he had regular contact. He reported that his son lived with his, Mr. Y's, mother, at this time.

The Staff Grade Psychiatrist concluded "*My impression of [Mr. Y's] presentation is that a formal diagnosis of psychotic disorder cannot be excluded at this time. He does describe several first rank symptoms including thought echo, auditory hallucination, a form of a running commentary and delusional beliefs relating to his spiritual experiences… He does not present with associated motor, behavioural or negative manifestations and I am not clear how significant the impact of his symptoms are on his daily functioning. The main relevant aetiological factor is that of his drug use, particularly his past use of stimulants and hallucinogens and I did wonder to what extent his current methadone prescription is providing him with some antipsychotic cover. My differential diagnosis in relation to psychotic disorder include – mental disorder due to use of hallucinogens/stimulants, Schizotypal disorder and Schizophrenia… In view of the above I did recommend to [Mr. Y] that he embarks on an empirical trial of antipsychotic medication (e.g. olanzapine or amisulpiride) but he was reluctant to consider this at this stage. Instead he requested his diazepam dose to be increased to 25mgs BD, saying then that he might consider antipsychotic medication at a later stage…."*

Mr. Y was concerned that a mental illness diagnosis would stigmatise him and jeopardise his future.[80]

On **2 May 2005** BSDS received a telephone call from Bristol Prison to inform them that Mr. Y had been arrested for taking a car. He was due to appear in Court on **16 May 2005.**[81] This Court appearance was later moved to **1 June 2005.**

On **12 May 2005** in Mr. Y's prison medical notes it is recorded that Mr. Y suffered from chronic anxiety and *"He seems to have a schizotypical disorder."*[82]

On **22 June 2005** Mr. Y was assessed by BSDS. It is recorded that Mr. Y had been released from prison on the previous day following a six-week prison sentence. The aim of this interview was to re-commence prescribing Mr. Y's medication. It was recorded that Mr. Y had been using crack cocaine. It was reported that he was paranoid but experiencing fewer auditory hallucinations. Mr. Y reported that he was not using cannabis as he felt it made him paranoid.

Mr. Y reported that he had experienced a fit when benzodiazepines had been withdrawn. It was noted however that he had been deprived of benzodiazepines for three weeks before he experienced the fit. It was also noted that Mr. Y did not like taking antipsychotic medication but saw Methadone and Diazepam as treatment.

He was identified as suffering with: anxiety/panic attacks, psychosis and possibly depression.[83]

On **23 June 2005** the Nurse Specialist with the Criminal Justice Team in Bristol wrote to Mr. Y's GP in Bristol informing him that Mr. Y was subject to a Drug Rehabilitation Requirement Order and the Criminal Justice Team was the identified treatment provider.[84]

[80] Case notes 2.419
[81] Case notes 2.414
[82] Case notes 2.213
[83] Case notes 2.55
[84] Case notes 2.277

On **27 June 2005** Mr. Y was assessed by the Nurse Specialist in the Criminal Justice Team. She noted that it was difficult to complete her assessment as Mr. Y was preoccupied with Lucifer/Satan and the occult. He was describing "manifestations", which he said were not hallucinations, and was experiencing auditory hallucinations although he would not discuss the content of the voices. [85]

On **1 July 2005** Mr. Y agreed to a one-month trail of the antipsychotic medication Olanzapine.[86]

On **(?) 6 July 2005** it was noted by the Nurse Specialist in the Criminal Justice Team that Mr. Y wanted to change the pharmacy where his Methadone was dispensed because he felt that the pharmacist had been rude to him. It was also noted that the date for the revocation of Mr. Y's Drug Rehabilitation Requirement Order (DRR Order) was on 28 July 2005.[87]

On **13 July 2005** it was noted that Mr. Y had been prescribed an extra 5mg Diazepam by his GP.[88] On **18 July 2005** the Consultant Psychiatrist e-mailed the Nurse Specialist to inform her that he had contacted the GP who had informed him that he had given Mr. Y the extra Diazepam because he had been complaining that he was not sleeping due to anxiety.[89]

On **1 August 2005** Mr. Y reported to the Nurse Specialist that he noticed the benefits of the Olanzapine he had been prescribed.[90]

On **8 August 2005** Mr. Y was asked to leave Bridge House, the hostel in which he had been staying, as he had provided two urine samples which were positive for illicit drugs. A referral was made to Stonebridge Park.[91]

As part of this referral a risk assessment was completed by the Nurse Specialist. Mr. Y was rated as posing no risk of violence and low risk of self harm. Although later in the same referral form it is noted that Mr. Y did have a conviction for *"One assault on partner".*[92]

[85] Case notes 2.415
[86] Case notes 2.175, 2.416
[87] Case notes 2.416
[88] Case notes 2.301
[89] Case notes 2.230
[90] Case notes 2.417
[91] Case notes 2.417
[92] Case notes2.291ff

Mr. Y was accepted by Stonebridge Park and moved in on **10 August 2005.**[93]

On **15 August 2005** Mr. Y attended BSDS in an agitated state. He had stayed at his grandmother's home the previous evening where he had an argument with his aunt. Mr. Y claimed that this aunt had treated him badly when he was a child. He reported that she had slapped him and he had retaliated *"by beating her around the kitchen"*. It was noted that Mr. Y did not regret his actions and felt he was within his rights to behave in this way. He reported, however, that he was concerned that his aunt was in the Mafia and the Mafia would now be looking for him. The Nurse Specialist discussed police involvement with Mr. Y but he said that he was sure they would not be involved.

The Nurse Specialist noted that Mr. Y's hands were swollen and he had minor cuts on his left hand. She advised him to have his hand X-rayed because of the swelling and the pain he was experiencing.

The Nurse Specialist telephoned Mr. Y's grandmother who described the incident as *"a bit of a ruckus"* and, according to the clinical note, did not seem overly concerned.

The Nurse Specialist noted *"? Some psychotic or paranoid thoughts from [Mr. Y]"*.[94]

In a risk assessment completed on the same day it was noted that "[*Mr. Y] states that he doesn't really like women. He feels that his auntie deserved to get beaten as she abused him as a child. No obvious signs of remorse."*

Mr. Y's risk was rated as follows:

	Past	Current
Suicide /Self harm	Yes	No
Risk from others	Blank	No
Risk to others	Blank	Yes
Risk to Children	Blank	No

and

[93] Case notes 2.417
[94] Case notes 2.418

	Current	Future
Self harm	Moderate	Low
Suicide	Low	Low
Risk from others	Moderate	Moderate
Risk to others	Substantial	Substantial
Risk to Children	Low	Low

The risk assessment also recorded a charge of assault on by Mr. Y on his girlfriend in 2004. It is noted that *"[Mr. Y] feels that the assault was justified as she crashed the car on purpose"*

It was noted that *"[Mr. Y] presents a risk to women especially family members also paranoid and? delusions?"*
Under the section of the risk assessment headed "Summary and (Interim) management plan the following was recorded:

- *"Mr. Y needs to be seen regularly preferably by male staff;*
- *he has a history of previous violent offences and recent violent attacks on family members;*
- *the Nurse Specialist did not feel threatened during assessment;*
- *Mr. Y had improved while on anti-psychotic medication but was still displaying some paranoia;*
- *possible risk of violence towards women and family members*."[95]

On **16 August 2005** the Nurse Specialist received a telephone call from the Stonebridge Hostel to inform her that Mr. Y had had an argument with the staff there about the use of the telephone. They were advised to provide him with a list of rules.[96]

On **22 August 2005** the Nurse Specialist wrote to Mr. Y's GP in Bristol asking him to continue the prescribing of Mr. Y's anti-psychotic medication, Olanzapine, as BSDS, as a specialist drug service, did not usually prescribe this.[97]

[95] Case notes 2.111ff
[96] Case notes 2.418
[97] Case notes 2.281

On **22 August 2005** Mr. Y attended BSDS in an agitated state because the Court Bailiffs had visited his grandmother's house. He was advised to attend the Fines Court the next day.[98] It was also noted in the clinical entry that Mr. Y was due to attend Court on 25 August 2005 *"for the revocation of order so transfer to community team can be completed."*[99]

A risk assessment was completed for Mr. Y on **22 August 2005**.

	Past	Current
Suicide /Self harm	Yes	No
Risk from others	Yes	No
Risk to others	Yes	Yes (Including poor anger control)
Risk to Children	No	No

It was also identified that further assessment is required.[100]

Mr. Y's Probation Officer informed the BSDS that on **25 August** 2005 Mr. Y's DRR Order was revoked by the Court and a Community Rehabilitation Order (CRO) "with a mental health requirement" was put in place.[101] There does not appear to be any official paper work conveying this information in Mr. Y's notes.

On **6 September 2005** Mr. Y's care was taken over by the community team and he was given a new Key Worker. It was anticipated that he would remain in the probation hostel for a further five months.[102]

On **30 September 2005** Mr. Y reported to his new Key Worker that he continued to hear voices of "the spirits". He told the Key Worker about his experiences with the occult and *"This in turn leading to his inability now to contain his experiences without medication."* Mr. Y reported that he was receiving no psychiatric support and felt unsupported and vulnerable. He also reported that he wanted to move from his current accommodation.[103]

[98] Case notes 2.418
[99] Case notes 2.249
[100] Case notes 2.109
[101] Case notes 2.249
[102] Case notes 2.249
[103] Case notes 2.251

On (?) **27 October 2005** Mr. Y told his Key Worker that he had been asked to leave Stonebridge Park but no reason for this move was given. At this point Mr. Y was identified as being of No Fixed Abode.[104]

On **7 November 2005** Mr. Y was seen by his Key Worker who recorded that Mr. Y had been "kicked out" of Stonebridge Park after he had been involved in a fight. He was living in a hostel in Staple Hill. Mr. Y reported that he was buying large amounts of Nitrazepam and was requesting an increase in his Diazepam prescription to substitute for this. However Mr. Y's GP had told him that he would liaise with the BSDS before prescribing any medication. The Key Worker noted that Mr. Y "*Clearly does not like to be told 'No'*".[105]

On **11 November 2005** the BSDS received a telephone call from the Probation Service to inform them that Mr. Y had presented to them requesting input from a psychiatrist. The Key Worker noted that he would explore this at his next appointment with Mr. Y.[106]

On **9 December 2005** Mr. Y's GP in Bristol wrote to the Staff Grade Psychiatrist in the BSDS requesting a review of Mr. Y's mental health. Mr. Y had presented to his GP requesting a psychiatric referral with the aim of getting help in controlling his auditory hallucinations. The GP recorded that Mr. Y had been taking Olanzapine 10mg for several months. He increased the dose to 20mg. Although Mr. Y had been registered with the GP since August 2005 he had only recently received Mr. Y's notes.[107]

On **15 December 2005** it was recorded that Mr. Y had moved to the Salvation Army Hostel.[108]

On **16 January 2006** Mr. Y was reviewed by the Staff Grade Psychiatrist of the BSDS in response to the request of the GP on 5 December.

The Staff Grade Psychiatrist recorded that Mr. Y reported no intensification of his psychotic symptoms. He had told the Staff Grade Psychiatrist that he believed that the GP had mis-

[104] Case notes 2.252
[105] Case notes 2.254
[106] Case notes 2.254
[107] Case notes 2.33
[108] Case notes 2.31

interpreted his information about hearing voices in the past as current phenomena. She recorded "*[Mr. Y] himself feels his mental health has improved over the last 2 months. This is despite him discontinuing his olanzapine without supervision about 2 months ago. Of note this coincides more or less with an increase in his methadone dose to 90 mgs daily. He has remained on diazepam liquid at a dose of 30 mgs daily. He considers the diazepam to be of most benefit to his mental health, and reported that he has not been distressed by any perceptual disturbance for many months. Certainly at interview he presented in a more relaxed and less guarded manner, compared to when I saw him last year and I could not elicit any overt psychotic symptoms from him. This is obviously slightly at odds to how he presented to you only a month or so ago, but he was adamant that he did not wish to restart antipsychotic medication. In terms of his drug treatment [Mr. Y] appears to be more stable currently and acknowledged this as beneficial to his mental health… For the time being therefore [Mr. Y] and I agreed that he should remain off antipsychotic medication… but I did advise him that as the dose (of Methadone) comes down then we may need to reconsider this decision.…"*[109]

Mr. Y identified his mother as his main source of stress. He said that he was keen to have more structure in his life and was due to attend the Bristol Day Care induction programme later the same month.

On **23 January 2006** Mr. Y reported that his grandmother had died. During his meeting with his Key Worker he also noted that it had been useful to see the Staff Grade Psychiatrist as the review had showed him how much better he was than he had been a year earlier.[110]

On **30 January 2006** Mr. Y's Key Worker partially completed a risk assessment. Mr. Y's risk was rated as follows:

	Past	Current
Suicide /Self harm	Yes	No
Risk from others	Blank	No
Risk to others	Blank	Yes
Risk to Children	Blank	No

[109] Case notes 2.267
[110] Case notes 2.257

It is noted on the risk assessment form that Mr. Y had a son.[111]

On **23 February 2006** Mr. Y reported to his Key Worker: *"…2 weeks (ago) [Mr. Y] got into a row with his mother which led to his mother being thrown to the ground sustaining injury to her head. Police were called. [Mr. Y] was arrested. He is now on Police bail. [Mr. Y] distressed by all this. No use of illicit drugs…Unresolved situation c/o [Mr. Y's] son…being pulled in two directions."*[112]

On **23 February 2006** the Bristol Day Care service wrote to Mr. Y inviting him to *"a 1:1 ending session"* as his attendance at the programme had been erratic.

On (?) **20 May 2006** Mr. Y's Key Worker recorded that Mr. Y had reported that he was spending most of his time in Weston-Super-Mare helping his mother and grandmother. He was also helping to care for his son.[113]

On **22 May 2006** Mr. Y's Key Worker wrote to his GP informing him that Mr. Y had been illicit-drug free for approximately six months. BSDS was continuing to prescribe Methadone 90 mg daily and Diazepam 30mg daily. Mr. Y was being seen every two weeks for counselling.

On the same day Mr. Y's key Worker recorded in his clinical notes that the Crown Prosecution Service might press charges against Mr. Y.

He also noted that a "*problematic heroin user had moved into the Salvation Army hostel. He was causing problems for Mr. Y by borrowing money and pestering him.*"[114]

On **6 June 2006** Mr. Y's Key Worker recorded in his clinical notes: *"[Mr. Y] arrived on time. Court case adjourned, his mum was sick. [Mr. Y] very disappointed. Picking himself up. Angry at mum – childhood issues. Doesn't feel he did anything wrong. Also discussed a*

[111] Case notes 2.127
[112] Case notes 2.258
[113] Case notes 2.265
[114] Case notes 2.262

fight at Salvation Army "I was protecting self". Opponent has been kicked out. Trouble seems to follow me about." [115]

On **8 August 2006** Mr. Y's Key Worker noted: *"Commenced session by discussing his anxiety about this charge of carrying a knife as the knife was less than 2 inches long. Worry making him ill…"*
Mr. Y reported that he "*still had 'domestics' to sort out*."[116]

On **13 September 2006** Mr. Y telephoned his Key Worker to inform him that he was not going to be imprisoned.[117] He had been given a conditional discharge for carrying the knife. For the assault on his mother he was given an 18 month Probation Order.

On **28 September 2006** Mr. Y reported to his Key Worker that he felt that the staff at the Salvation Army hostel were deliberately making life difficult for him.[118]

On **30 September 2006** an "Initial" care plan was drawn up for Mr. Y by his Key Worker. The care plan identified the following goals:

- *"stopped taking illicit drugs;*
- *by 30 be and behave like an adult;*
- *Methadone provides the relief from my psychotic symptoms;*
- *to find relief from emotional distress".*[119]

The care plan is not signed and it is unclear what input Mr. Y had into it.

On **20 October 2006** Mr. Y attended his appointment with his Key Worker in an intoxicated state. He said that he had been attacked by a group of youths.[120]

On **7 November 2006** he complained that people were constantly trying to borrow money and cigarettes from him.[121]

[115] Case notes 2.262
[116] Case notes 2.264
[117] Case notes 2.267
[118] Case notes 2.267
[119] Case notes 2.101
[120] Case notes 2.268

There were no entries in Mr. Y's clinical notes between **21 November 2006** and **30 July 2007.**

On 16 August 2007 Mr. Y discussed the possibility of moving from the Salvation Army Hostel with his Key Worker. They discussed his anxiety and concern that he would be lonely after being settled at the hostel for so long.[122]

On **10 October 2007** Mr. Y reported that he was having difficulties with his mother. "*She's doing my head in*." Mr. Y observed that "*some of his mum's responses [to Mr. Y's son] remind him of how she was with him."* The Key Worker tried to discuss whether Mr. Y played a part in the many fights with his mother. Mr. Y agreed that he played a part but did not want to continue this discussion. He did however disclose that he had been recording some conversations with his mother

The Key Worker discussed Mr. Y's potential move to a new flat. He recorded that Mr. Y was unsure about the move and felt "institutionalised" in the Salvation Army Hostel.[123]

On **23 October 2007** Mr. Y complained to his Key Worker that he was finding his probation officer's youth and style of working a problem.[124]

On **13 November 2007** Mr. Y again reported that he was having difficulties with his probation officer. It was noted that Mr. Y was having to do a "Think First" course but he was concerned that he would lose focus on his drug use. He reported to his Key Worker that his probation officer was pressing him to leave the Salvation Army Hostel which he was not keen to do at that stage.[125]

On **(?) 20 November 2007** Mr. Y told his Key Worker that he had been given a new worker at the Probation Service. Mr. Y felt that she was too young and did not understand what he was saying.[126]

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[121] Case notes 2.273
[122] Case notes 2.274
[123] Case notes 2.275
[124] Case notes 2.276
[125] Case Notes 2.276
[126] Case notes 2.277

On **11 December 2007** Mr. Y again discussed his difficulties with his probation officer with his Key Worker. It is also noted that he had two Court cases pending. [127]

On **13 December 2007** Mr. Y's Key Worker completed a "revised care plan". His goals included remaining drug free as he had been for over a year; his concern about sweating whilst on Methadone; looking for alternative accommodation, although Mr. Y was concerned about this as he felt settled at the Salvation Army hostel. It was noted that Mr. Y was considering moving back to Somerset.[128]

On Mr. Y's Key Worker noted that Mr. Y was anxious about having to move from the Salvation Army Hostel after two years. "*Feels he has done well but has become institutionalized".*[129]

Mr. Y's Key Worker at the Salvation Army Hostel reported to the Internal Investigation that Mr. Y had been stable and complied with all that was expected of him while at the hostel. He said that there had been difficulties with another resident and that Mr. Y had reported that people picked on him. Mr. Y had reported that he felt that when he walked into a room people looked at him from the corner of their eye. Mr. Y had one or two fights outside the hostel with a fellow resident who was a known bully. Mr. Y had reported that this man was trying to take his money so he fought him.

The Salvation Army Key Worker confirmed that Mr. Y had been keen to move to Somerset but that he, the Key Worker, had concerns about the level of support that would be available to Mr. Y. He did not think that Mr. Y was emotionally ready to live on his own. He believed that Mr. Y did not cope well with pressure because he was *"hugely paranoid"*. In Bristol Mr. Y had a great deal of support: from the hostel, from BSDS and from the church he attended. He was concerned that there would be less support available in Weston-super-Mare.[130]

[127] Case notes 2. 277
[128] Case notes 2.103
[129] Case notes 2. 278
[130] Internal Investigation 7.19

On **16 January 2008** Mr. Y informed his Key Worker that he had been offered accommodation in Weston-super-Mare nearer to his family. It was noted that he was "*generally pleased but anxious*".[131]

On **17 January 2008** Mr. Y's Key Worker wrote a letter of referral to NSSDAS informing them that: Mr. Y had moved from the Salvation Army hostel in Bristol to Weston-super-Mare; he had been on a prescription of Methadone and Diazepam for 3 years; "*He also has a history of mental breakdown although his mental state has been stable since engagement with our team. His problems were I believe associated with drug use. He strongly feels that his prescription is enabling him to remain mentally healthy and [Mr. Y] becomes very anxious when talk of reduction arises".*

The letter also informed the NSSDAS team that Mr. Y saw the probation service every two weeks: *"This is due to domestic difficulties with his mother who cares for his son."*[132]

In the accompanying referral form it is noted that Mr. Y has a "*history of domestic violence involving his mother*", and that Mr. Y had a son who was cared for by his mother.[133]

On **29 January 2008** a risk assessment was completed by a student nurse at NSSDAS. The risk Mr. Y posed was rated as follows;

	Past	Current
Suicide/self harm	Yes	No
Risk to others	Yes	No
Risk from others	Yes	No
Risk to children	No	No
Serious mental Health problems	Yes	No.[134]

In his letter to Mr. Y's GP dated **20 February 2008** reporting this assessment the Student Nurse reported that Mr. Y had said that he suffered from severe anxiety and *"experiences*

[131] Case notes 2.279
[132] Case notes 3.63
[133] Case notes 3.67
[134] Case notes 3.9

voices in his head but does not report delusions." Mr. Y was also reporting depression and OCD (Obsessive Compulsive Disorder).

He commented "*during the course of the assessment I got the distinct impression that [Mr. Y's] thought processes were chaotic, as he kept going off on tangents rather than sticking to the subject in hand and it was very difficult to stick to the themes of the assessment*".

The letter noted that Mr. Y had a son who lived with Mr. Y's mother "*under some kind of residential order*" and Mr. Y had complained that his son's clothes were too small and that the house was rarely tidy.[135]

On **13 February 2008** Mr. Y was reviewed by the NSSDAS Consultant Psychiatrist. He reported in a letter to Mr. Y's GP in Weston-super-Mare that Mr. Y was stable on Methadone and Diazepam; he denied any illicit drug use but was drinking up to 48 units of alcohol per week. At this time Mr. Y described his mental health as being *"all right"*.

He was hearing voices which he described as a *"room full of spirits"*. He denied any delusions, ideas of reference or thought alienation. The Consultant Psychiatrist concluded that Mr. Y was not suffering with any first rank symptoms of Schizophrenia. Mr. Y was not distressed and declined any antipsychotic medication.[136]

On **18 February 2008** Mr. Y telephoned NSSDAS and spoke to the Student Nurse who recorded that Mr. Y was "*Requesting a box of Dihydrocodeine for a wisdom tooth. However it sounded as if he was being instructed by someone else at his end of the line*."[137]

On **26 February 2008** Mr. Y was reviewed in the Transitional Prescribing Clinic. It was noted that he was stable on Methadone and Diazepam but had used cannabis on one occasion. He was drinking every day but did not see this as a problem.

It was noted that Mr. Y's son was living with him as Mr. Y's mother was having a heart operation. The clinical notes record that Social Services were aware of this and the name of a

[135] Case notes 3.53
[136] Case notes 3.59
[137] Case notes 3.77

social worker is recorded in the notes. It was also recorded that Mr. Y was having difficulties in claiming benefit.[138]

On **6 March 2008** Mr. Y complained that his Methadone was being watered down and tasted of *"white spirit"*. He was not able to say why he thought this was the case and was not experiencing any withdrawal effects.[139]

On **12 March 2008** Mr. Y was reviewed by the NSSDAS Consultant Psychiatrist. In his letter to Mr. Y's GP in Weston-super-Mare he reported that Mr. Y's son *"had recently moved to live with him living with him and Social services are aware of this."*
It was also recorded that Mr. Y was a heavy drinker consuming at that time around 60 units of alcohol per week.[140]

On **14 April 2008** Mr. Y attended his appointment with the NSSDAS Consultant Psychiatrist together with his son who was living with him. The Psychiatrist observed in his letter to Mr. Y's GP: "*There was evident warmth between father and son and his son appeared relaxed and well cared for.*" Mr. Y, however, reported that he was having financial difficulties as he had to care for his son and had not received an increase in his benefits.

It was noted, on this occasion, that Mr. Y was consuming up to 42 units of alcohol per week.[141]

On **23 April 2008** Mr. Y was reviewed by the NSSDAS Consultant Psychiatrist. Mr. Y reported that he was not using any top up illicit drugs. He complained that the Methadone had "*stopped working*". Mr. Y denied any physical withdrawal, but said that he was not sleeping and the Methadone was not keeping his "*head straight*", and it was not reducing his anxiety. However, he declined an increase in his dose. He was continuing to drink heavily.

Mr. Y also complained that he was having financial problems because his benefits did not allow for him looking after his son.[142]

[138] Case notes 3.75
[139] Case notes 3.80
[140] Case notes 3. 51
[141] Case notes 3.49
[142] Case notes 3.83

On **24 April 2008** NSSDAS wrote to Mr. Y informing him that he had been seen by the Consultant Psychiatrist in the Transitional Prescribing clinic until a full treatment package of care could be offered. Mr. Y's request for a male worker was acknowledged however he was informed that this was not possible and he had been allocated a female Key Worker. He was given an appointment for 6 May 2008.[143]

On **6 May 2008** Mr. Y arrived too late to be seen for his first appointment with his new Key Worker. However she spoke to him briefly in the waiting room and noted that he was clean, kempt, and calm and composed. A new appointment for 13 May 2008 was agreed.[144]

On **7 May 2008** Mr. Y's Key Worker received a telephone call to inform her that a Police Officer had collected Mr. Y's medication as he was in Police custody. She telephoned the custody suite to confirm that this was the case.[145]

On **9 May 2008** Mr. Y's mother telephoned NSSDAS. She reported that Mr. Y was in Horfield Prison charged with Grievous Bodily Harm (GBH) and that the victim was in intensive care in Frenchay Hospital. A Senior Specialist Nurse telephoned the prison and confirmed this information. Mr. Y's medication and record of health care needs were sent to the Prison who confirmed that Mr. Y's prescriptions were being continued.[146]

On **27 May 2008** the Police informed NSSDAS that the victim of assault had died and Mr. Y was to be charged with manslaughter/murder.[147]

[143] Case notes 3.43
[144] Case notes 3.41
[145] Case notes 3.84
[146] Case notes 3.85
[147] Case notes 3.85

11. Timeline and Identification of the Thematic Issues

11.1 Thematic Issues

The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Mr. Y received from the Avon and Wiltshire Mental Health Partnership NHS Trust. These thematic issues are set out below.

11.2 Assessment and Care Planning

11.2.1 Access to Services

11.2.1.1 Mr. Y's contact with the Specialist Drug and Alcohol Services provided by the Avon and Wiltshire Partnership NHS Trust between October 2001 and September 2004 was neither prompt nor assertive.

11.2.1.2 Mr. Y was referred to NSSDAS five times between October 2001 and July 2004. This resulted in only one assessment. On one occasion there was a gap of nine months between referral and assessment appointment and, on another occasion, four months. While it has to be acknowledged that some responsibility must be placed on the individual to attend appointments, the fact that Mr. Y was repeatedly referred to the service, by a number of referrers most of whom identified that Mr. Y had both substance misuse and mental health problems, suggests that the service should have been more proactive in attempting to assess and engage him prior to September 2004.

11.2.1.3 Contributory Factor 1

Mr. Y was referred to the Specialist Drug and Alcohol services on a number of occasions, by several referrers, most of whom identified that Mr. Y had both substance misuse and mental health problems between October 2001 and July 2004. The delays in assessing Mr. Y and employing a strategy to engage him in services did not reflect best practice nor did it address Mr. Y's needs in the most effective manner. However it cannot be concluded that a

more timely response by services between 2001 and 2004 would have impacted upon the events of May 2008

11.2.2 Assessment

11.2.2.1 Comprehensive Assessment: Mr. Y's assessments did not reflect the comprehensiveness that national guidance, best practice and local policy recommend.

11.2.2.2 Multi-Disciplinary Assessment: at the time that Mr. Y was under the care of the SDAS the team was made up of individuals with a nursing background and psychiatrists. As far as the resources of the teams allowed there were examples of good multi-disciplinary working. However for multi-disciplinary assessments to be effective there must be a process which brings together the various strands of the assessment into a single, common formulation shared by all those working with the service user. Such a mechanism was not evident in Mr. Y's clinical notes. There is mention of discussions during team meeting in Mr. Y's notes but if these discussions were used to bring together the threads of the assessment they are not recorded in the notes and the insights and understanding of Mr. Y's problems and needs were lost

11.2.2.3 Frequency of assessments: regular, planned systematic and comprehensive assessment undertaken, as far as possible, on a multi-disciplinary basis appears to have been lacking in the provision of Mr. Y's care. This should not be read to imply that no assessment took place. Mr. Y was seen regularly by his Key Workers and, when he returned to Weston-super-Mare in January 2008, he was reviewed on a regular basis by the NSSDAS Consultant Psychiatrist.

11.2.2.4 Care plans: Mr. Y's drug prescribing regimen was clearly planned and the plan shared appropriately. However a care plan should encompass more than this. There were few care plans recorded in Mr. Y's notes and these were somewhat cursory and not signed by Mr. Y.

11.2.2.5 Contributory Factor 2

Mr. Y's needs and the risks he posed were not assessed with the regularity and responsiveness that best practice would recommend; care plans did not provide a clear formulation on the basis of which Mr. Y's behaviour could be understood and a strategy

put in place to address the identified needs; there was no multi-agency involvement in either assessment or care planning and no mechanisms in place to facilitate this taking place. Had this been done it is probable that Mr. Y would have received more comprehensive care. However it would not be reasonable to conclude that this had a direct effect (causal relationship) with the events of May 2008.

11.3 Risk Assessment and Management

11.3.1 The risk Mr. Y posed to himself and to others was not assessed with the regularity and responsiveness that best practice would recommend, the risk management plans did not provide a clear formulation on the basis of which Mr. Y's behaviour could be understood and a strategy put in place to address the risks Mr. Y posed nor did they set out a clear plan of action as best practice guidance recommends. Had this been done it is probable that Mr. Y would have received more comprehensive care. However it would not be reasonable to conclude that this had a direct effect (causal relationship) with the events of May 2008.

11.3.2 Contributory Factor 2

The risk Mr. Y posed to himself and to others was not assessed with the regularity and responsiveness that best practice would recommend; risk management plans did not provide a clear formulation on the basis of which Mr. Y's behaviour could be understood and a strategy put in place to address the risks Mr. Y posed; risk management plans did not set out a clear plan of action as the guidance recommends. Had this been done it is probable that Mr. Y would have received more comprehensive care. However it would not be reasonable to conclude that this had a direct effect (causal relationship) with the events of May 2008.

11.4 Diagnosis

11.4.1 Mr. Y consistently reported hearing voices and at times reported being paranoid and behaved in a suspicious manner; Mr. Y's GPs and members of the SDAS service noted these symptoms and requested psychiatric assessments. This was an appropriate response to the

symptoms that Mr. Y was reporting. In response to these requests and as part of various assessment processes Mr. Y was reviewed on a number of occasions by several psychiatrists. They all noted and recorded his symptomatology and all considered whether Mr. Y was suffering from a psychotic disorder. All the psychiatrists who assessed Mr. Y concluded that main aetiological factor contributing to his reported symptoms was his drug misuse. The relationship between Mr. Y's presenting symptomatology and his drug use was considered and the consensus opinion appears to have been that Mr. Y's drug misuse precipitated his symptomatology. On only one occasion did a Psychiatrist consider it appropriate to give Mr. Y a diagnosis of a psychotic disorder.

11.4.2 In addition to giving consideration as to the possibility of Mr. Y having a psychotic-type disorder he was also diagnosed as having an "emotionally unstable personality". However this diagnosis and how to respond to it does not appear, from Mr. Y's clinical notes, to have been further explored. It would have been good practice to consider how this affected his behaviour and how this problem might be addressed especially as the NICE (2009)[148] guidance makes it clear that personality disorder is not only a treatable disorder but that it is the responsibility of the mental health services to institute appropriate interventions.

11.5 Treatment

11.5.1 Substance Misuse

Although Mr. Y was referred to the NSSDAS services in Oct 2001 he was not committed to addressing his drug misuse problem at that time. He appears to have determined to address this problem only in May 2004. His illicit drug use appears to have decreased from the time he was placed on a Methadone substitute programme in September 2004 and from around December 2005 he appears to have been largely illicit-drug free. When Mr. Y was willing to address his drug misuse problem the SDAS teams in North Somerset and Bristol appear to have treated this both appropriately and successfully.

[148] [148] NICE (2009) Borderline Personality Disorder: Treatment and Management

11.5.2 Medication

11.5.2.1 Although the consensus opinion was that Mr. Y was not suffering from a psychotic disorder but that the psychotic symptoms he was reporting were a consequence of his drug misuse, the option of prescribing anti-psychotic medication was discussed with Mr. Y. Initially Mr. Y declined this offer. Then between July 2005 and December 2005 he agreed to a trial of Olanzapine. On at least one occasion he reported that he found this to be beneficial. However by January 2006 he had stopped taking this medication without discussing this with either his GP or the staff at BSDS.

11.5.2.2 Mr. Y was offered a trial of anti-psychotic medication in response to his reported psychotic-like symptoms on a number of occasions. This was a reasonable course of action. When Mr. Y's GP understood Mr. Y to be complaining that his symptoms were worsening he increased his anti-psychotic medication and asked the BSDS psychiatrist to review his mental state. This again was a reasonable course of action.

11.5.2.3 The BSDS Psychiatrist noted that Mr. Y had discontinued the anti-psychotic medication and discussed the implications of this with him. Mr. Y was fully involved in all decisions regarding medication, indeed at least with respect to the anti-psychotic medication he chose a course of action contrary to the medical advice he was being offered. This decision was respected by those offering care and treatment to Mr. Y. This was good practice.

11.5 3 Psychological Therapies

11.5.3.1 The NTA's 2006 Model of care identified a number of evidence based psychological interventions that should be available to an individual with moderate to severe drug misuse problems. Similarly NICE guidance on both schizophrenia and depression recommend that psychological interventions, Cognitive Behaviour Therapy- based interventions in particular, should be available to individuals experiencing these problems.

11.5.3.2 While Mr. Y was seen on a regular basis by his Key Worker there is no evidence either that systematic, evidence based psychological interventions were undertaken or considered. This was a weakness in the care offered to Mr. Y.

11.5.3.3 Service Issue 1

Best practice in relation to the treatment of those with moderate to severe drug misuse problems, those with depression and individuals suffering with schizophrenia all indicate that psychological therapies should be made available to these individuals. Such interventions were not made available to Mr. Y and in this sense his needs and problems were not addressed in accordance with best practice. However it would not be reasonable to conclude that the absence of such interventions had any direct causal relationship with the events of 2008.

11.6 Safeguarding

11.6.1

That Mr. Y had a young son was noted at the time of his initial referral to the Specialist Drug and Alcohol Services. There is no evidence in Mr. Y's clinical notes, however, that the staff of NSSDAS sought advice within the Trust or contacted Children's Social Services to discuss Mr. Y's situation or to share information, or made a formal referral.

11.6.2 Risk assessment

11.6.2.1 Although a number of incidents of domestic violence are recorded in Mr. Y's notes none of these episodes triggered an assessment of the risk Mr. Y's behaviour posed to the wellbeing of his son or a referral to Children's Social Services.

11.6.2.2 One of the areas identified in the risk checklist employed by the SDAS is the risk posed by the service user to children. The risk screening tool in use in 2007 states: *"AWP **'Safeguarding Children Assessment Screen'** & SDAS **'Parenting Risk screen'** are both to be completed for **all** **SDAS Service Users** who have **responsibility** for **child care** or **significant contact** with a child."* There is no record in Mr. Y's clinical notes of these devices having been employed to assess Mr. Y's risk to children or to his parenting abilities.

11.6.3 Change of living situation and increased parental responsibility

11.6.3.1 From February 2008 Mr. Y's son was living with him. It was noted that Mr. Y was drinking heavily and, because his benefit entitlement had not been revised he was having

financial difficulties. Whilst it was recorded that Social Services were aware of this situation there is no record of any liaison between the SDAS and Social Services.

11.6.3.2 The *Working Together* guidance emphasises that there is a shared responsibility for ensuring that risks to the wellbeing of children are assessed and appropriately addressed. However the joint working and sharing of information which the guidance identifies as of central importance to ensuring the safeguarding of children was not evident.

11.6.3.3 There were a number of occasions when information should have been shared by the SDAS with Children's Social Services, there were occasions when information was available to the SDAS that should have triggered a formal referral to Children's Social Services to assess any risk posed to the wellbeing of Mr. Y's son, and Mr. Y's ability to carry out his parenting responsibilities should have been formally assessed.

116.3.4 Service Issue 2

Best Practice, local Safeguarding policies and statute require that there is co-operation and sharing of relevant information between health service providers and Children's Social Services to ensure that children and young people are protected from harm and their wellbeing is promoted. In this case, although appropriate policies were in place to realise these goals, the policies were not followed. The task of the Trust and other relevant partners is now to establish why these policies and the best practice guidance were not followed and to address these issues.

11.7 Service User Involvement

The Independent Investigation Team concluded that Mr. Y was fully involved in identifying his needs and in planning how these might be met. It would, however, have been better practice to have had a more regular and planned approach to assessing Mr. Y's needs and the risk he posed, to have had care plans which could be monitored and to have had a formal record of Mr. Y's agreement to these.

11.8 Family Involvement

11.8.1 While the Specialist Drug and Alcohol Service did not employ the Care Programme Approach at the time Mr. Y was under its care, the National Treatment Agency's Model of Care does recommend that assessment of need should be comprehensive. To achieve this comprehensiveness input from those who know the individual well is invaluable. The family of the service user can provide information to enable needs to be accurately identified and the most effective care plans to be put in place. It is good practice to obtain corroborative information when assessing risk; in Mr. Y's case this included risk to himself, violence towards others and risks relating to his son.

While it is perhaps less common for Specialist Drug and Alcohol Services to involve the families of those to whom they are providing treatment, best practice indicated that it would have been beneficial to have involved his family in assessing his needs and planning his care. It was noted that Mr. Y posed a risk to women and in particular to his mother. It would have been appropriate to discuss this identified risk with her and used this discussion to inform subsequent risk management plans.

11.8.2 Service Issue 3

Despite the important role Mr. Y's family, particularly his mother, played in his life and the fact that a risk assessment in 2005 had identified that he posed a particular risk to women, Mr. Y's family were not involved in identifying his needs, the risks he posed or in planning his care. Had this been done it is possible that the difficulties he experienced in relation to his family might have been better managed. However it would not be reasonable to conclude that the absence of such involvement had any direct causal relationship with the events of May 2008.

11.9 Communication

11.9.1 Within Mental Health Services the CPA process provides the mechanism to enable individuals, teams and agencies to communicate on a regular and planned basis, to engage in

joint assessment of the individual's needs, to jointly plan the individual's care and to deliver the agreed care and support plan in a co-ordinated manner. Within the CPA process it is the responsibility of the CPA Care Co-ordinator to ensure that CPA meetings are held with appropriate frequency, that the relevant players are appropriately involved and that the delivery of the individual's care is co-ordinated. As the Specialist Drug and Alcohol Services did not employ the CPA procedures at the time Mr. Y was under the care of the Trust this mechanism was not available and no alternative mechanism was put in its place. Similarly the role of the key worker in the SDAS teams does not appear to have been that of the Care Co-ordinator as described within the CPA process.

11.9.2 The focus of the Specialist Drug and Alcohol Services was on drug misuse and addressing this problem. Their communications relating, especially, to the prescribing of substitute medication was appropriate, timely and accurate. However communication with and the co-ordination of care with other agencies was much less robust. There was no mechanism in place at the time, as noted above, to ensure that such communication took place. Of particular concern was the lack of liaison between the Children's Social Services and the SDAS teams. It has to be noted that neither party took the initiative to contact the other. One would have expected this to have taken place at least when Mr. Y's son was returned to his care in 2008.

11.9.3 Service Issue 4

While communication relating to the treatment of Mr. Y's drug misuse was timely and appropriate, more comprehensive information relating to his mental state, the risks he posed to himself and others and information relating to the safeguarding of children was variable, at times of poor quality or incomplete and, on important occasions, absent.

There were no mechanisms in place to ensure that there was regular and effective communication between those providing care and support to Mr. Y and no mechanism to ensure that care and support was delivered in a coherent manner.

While it is reasonable to assume that better-informed care planning and better co-ordination of the delivery of care would have provided Mr. Y with a more efficient, and probably more effective, service, it would not be reasonable to conclude that the absence of this contributed directly to the events of May 2008.

11.10 Joint Working: Specialist Drug and Alcohol and Mental Health Services

11.10.1 Mr. Y's psychotic-like symptoms were noted by the staff of the SDAS, he was assessed on a number of occasions by psychiatrists and he was offered anti-psychotic medication to address his reported problems. Prior to his engagement with NSSDAS in September 2004 there had been discussions between that service and the mental health service on conducting a joint assessment. However after Mr. Y's engagement with NSSDAS there appears to have been no further consideration of joint working. Joint assessment and, possibly, joint working with the CMHT staff might have proved beneficial to Mr. Y's care.

11.10.2 Service Issue 5

After Mr. Y engaged with the Specialist Drug and Alcohol Services in 2004 no further consideration appears to have been given to working collaboratively with the mental health services to address his reported mental health problems. Although Mr. Y's mental state was competently assessed on a number of occasions, best practice would have suggested that as Mr. Y continued to complain of mental health problems collaborative working with the mental health services should have been considered. Had such a collaborative approach to Mr. Y's problems been undertaken it is probable that alternative and beneficial approaches to Mr. Y's mental health problems would have been identified. However it would not be reasonable to conclude that the absence of such collaborative working had a direct causal relationship with the events of May 2008.

11.11 Adherence to Local and National Policy and Procedure, and Clinical Guidelines

The Trust had in place relevant clinical policies and procedures. These were informed by best practice guidance, updated during the period that Mr. Y was under the care of the Trust and were fit for purpose. However Trust staff did not implement these in a consistent manner.

11.12 Clinical Governance and Performance

11.12.1The Trust has a fit for purpose set of governance arrangements which are overseen by the Trust Board. However failures to adhere to Trust policies do not appear to have been identified and addressed by the governance structures in place during the time Mr. Y was under the care of the Trust.

11.12.2 Service Issue 6

While Mr. Y was under the care of the Trust although appropriate policies and procedures were in place which reflected Best Practice guidance these were not always followed and there was no mechanism available to identify and address this lack of adherence to Trust policies.

11.13 Internal Investigation

The internal investigation was prepared to a good standard; it produced a relevant set of recommendations which the Trust has responded to appropriately. The Independent Investigation Team concurs with the findings of the internal investigation.

12. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

12.1 RCA Third Stage

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

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

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

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 relationship with the events of May 2008. 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 received 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 Mr. Y's mental health and/or wellbeing (or of those around him) 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 May 2008, need

to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

12.2 Assessing Needs and Planning Care

12.2.1 Access to Services

12.2.1.1 National Context

The National Treatment Agency for Substance Misuse (NTA) was established in 2001 as a Special Health Authority to improve the availability, capacity and effectiveness of drug treatment in England. Its remit was to improve the commissioning of drug treatment services, promote evidence-based and co-ordinated practice, and to improve the performance of drug treatment commissioners and practitioners

The NTA was given responsibility for realising the government's treatment targets:

- to increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and 100% by 2008 (against a baseline set in 1998);
- to increase the proportion of users successfully sustaining or completing treatment programmes year on year.

The NTA was monitored against four main criteria:

- improving access to treatment - double the number of individuals accessing structured treatment between 1998 and 2008;
- increasing capacity - recruit an additional 3,000 practitioners to the drug treatment workforce ;
- improving efficiency - increase efficiency of treatment services as indicated by reduced waiting times;
- improving effectiveness - increase the proportion of people completing or appropriately continuing treatment.

The Department of Health reported the following statistics for problem drug misusers in England in 2002/2003: [149]

Table 2 Problem Drug Misusers in Treatment in 2002/2003

Presenting for treatment	82,400
In treatment during the year	140,900
Retained in treatment	55,700
Leaving treatment during the year	85,200
Successfully completing treatment	25,000
Unsuccessfully completing treatment (e.g. dropped out, prison etc.)	57,200
Reason for completing treatment unknown	3,000
Retained in treatment or successfully completing treatment	80,600

In 2002 the NTA published "*Models of Care for the Treatment of Drug Misusers"*[150] in which it recommended a four-tiered approach to the provision of treatment for individuals with drug misuse problems. The document was revised in 2006 but the four tier model was retained. The four tiers were:

"Tier 1 interventions include provision of drug-related information and advice, screening and referral to specialised drug treatment…..

Tier 2 interventions include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare…...

Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care planned treatment and drug specialist liaison….

Tier 3 interventions that should be commissioned in each local area include:

- *Comprehensive drug misuse assessment;*

[149] Department of Health (2003) *PROVISIONAL STATISTICS FROM THE NATIONAL DRUG TREATMENT MONITORING SYSTEM IN ENGLAND, 2001/02 AND 2002/03*
[150] National Treatment Agency (2002), "*Models of Care for the Treatment of Drug Misusers"*

- *Care planning, co-ordination and review for all in structured treatment, often with; regular keyworking sessions as standard practice;*
- *Community care assessment and case management for drug misusers;*
- *Harm reduction activities as integral to care-planned treatment;*
- *A range of prescribing interventions, in the context of a package of care and in line; with Drug Misuse and Dependence – Guidelines on Clinical Management, known as; "the clinical guidelines". This will be updated alongside the relevant forthcoming National Institute for Clinical Excellence (NICE) guidelines and technology appraisals, and in line with other evidence-based clinical standards with specific interventions, including:*
    - *prescribing for stabilisation and oral opioid maintenance prescribing;*
    - *community based detoxification;*
    - *injectable maintenance prescribing; and*
    - *a range of prescribing interventions to prevent relapse and ameliorate drug and alcohol-related conditions.*
- *A range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour;*
- *Structured day programmes and care-planned day care (e.g. interventions targeting specific groups);*
- *Liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health and hepatitis services);*
- *Liaison services for social care services (e.g. social services (child protection and community care teams), housing, homelessness ;)*
- *A range of the above interventions for drug-misusing offenders.*

Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care coordinated to ensure continuity of care and aftercare."[151]

Amongst the standards identified in the 2006 document relating to the provision of high quality services are:

"Improving clients' journeys through treatment waiting times.

[151] National Treatment Agency (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*. p.20

Since April 2006, the expectation will be that service users voluntarily seeking treatment will be able to access treatment within three weeks, with faster access for priority groups. Partnerships will review any wait of six weeks or longer…

The treatment system needs to be able to engage people rapidly and retain them once they have entered treatment. Two issues important to improving treatment engagement are timely access to treatment and a focus on supporting retention for at least three months in structured treatment for adults with dependent drug misuse… (24)

Treatment delivery

All clients in structured treatment should have an identifiable written care plan, which tracks their progress and is regularly reviewed with them. (p.24)

Improvements in community integration

Whether clients wish to be maintained in the community on substitute opioid medication or wish to be drug-free, drug treatment systems should be well integrated with other systems of care and social support, to provide opportunities for drug users to receive appropriate housing, social support, education and employment to maximise treatment gains and enable reintegration into local communities. (p.25)

Assessment

Comprehensive assessment can be seen as an ongoing process rather than a single event. Comprehensive assessment will be carried out when a client may:

- *Require structured and/or intensive intervention;*
- *Have significant psychiatric and/or physical co-morbidity;*
- *Have significant level of risk of harm to self or others;*
- *Be in contact with multiple service providers;*
- *Have a history of disengagement from drug treatment services;*
- *Be pregnant or have children "at risk".*

Comprehensive assessment provides information that will contribute to the development of a care plan for a client. (p. 26)

The care plan

A care plan is an agreement on a plan of action between the client and service provider. It should be a paper document which is available to the client and kept on the client's file. Care plans should document and enable routine review of client needs, subsequent goals and progress across four key domains:

- *Drug and alcohol misuse;*
- *Health (physical and psychological);*
- *Offending;*
- *Social functioning (including housing; employment and*
- *Relationships." (p. 28)*[152]

In December 2010 the incoming Coalition Government introduced its new drug strategy: *"Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life".*

The Government described this as *"a major change to Government policy"* which set out a fundamentally different approach to preventing drug use and in supporting recovery from drug and alcohol dependence.

This strategy places an emphasis on recovery. It:

- puts more responsibility on individuals to seek help and overcome dependency;
- places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing;
- aims to reduce demand;
- takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad;
- puts power and accountability in the hands of local communities to tackle drugs and the harm they cause.

Paralleling the developments in substance misuse services, in 2002 the Department of Health published its guidance on services for people with a dual diagnosis of mental health problems and substance misuse: *Dual Diagnosis Good Practice Guide.*[153] This guidance notes that:

[152] National Treatment Agency (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*

"The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex. Possible mechanisms include:

- *a primary psychiatric illness precipitating or leading to substance misuse;*
- *substance misuse worsening or altering the course of a psychiatric illness;*
- *intoxication and/or substance dependence leading to psychological symptoms;*
- *substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses."*[154]

NICE updated this guidance in *Psychosis with Coexisting Substance Misuse (*2011*)*[155] where it emphasised the heterogeneous nature of those with drug and mental health problems:

"People with psychosis and coexisting substance misuse may have multiple (rather than two as implied by 'dual') diagnoses both in relation to mental illness (for example, schizophrenia and anxiety, depression, personality disorder) and substance misuse (for example, alcohol dependence, and harmful use of another substance(s))"[156].

The 2002 guidance noted:

"It is hard to assess the exact levels of substance misuse both in the general population and in those with mental health problems. UK data from one national survey and from local studies generally show that:

- *increased rates of substance misuse are found in individuals with mental health problems affecting around a third to a half of people with severe mental health problems;*
- *alcohol misuse is the most common form of substance misuse;*
- *where drug misuse occurs it often co-exists with alcohol misuse;*
- *homelessness is frequently associated with substance misuse problems;*
- *CMHTs typically report that 8-15% of their clients have dual diagnosis problems although higher rates may be found in inner cities;*

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[153] Department of Health (2002) Dual Diagnosis Good Practice Guide
[154] Department of Health (2002) Dual Diagnosis Good Practice Guide, p.7
[155] NICE (2011) *Psychosis with coexisting substance misuse.* CG120
[156] NICE (2011) *Psychosis with coexisting substance misuse.* CG1, p. 28

- *Prisons have a high prevalence of drug dependency and dual diagnosis."*[157]

This guidance emphasised that the co-existence of these two sets of problems has significant implications for both the well-being of the individual and for society in general.

"Substance misuse among individuals with psychiatric disorders has been associated with significantly poorer outcomes including:

- *Worsening psychiatric symptoms;*
- *Increased use of institutional services;*
- *Poor medication adherence;*
- *Homelessness;*
- *Increased risk of HIV infection;*
- *Poor social outcomes including impact on carers and family;*
- *Contact with the criminal justice system.*

Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide."[158]

The guidance concluded:

"Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focused and integrated care. ***This should be delivered within mental health services.***

This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely. "Mainstreaming" will not reduce the role of drug and alcohol services which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively."[159]

The 2011 guidance is more explicit in identifying the role and skills that are required of substance misuse services and the staff who work in them.

157 Department of Health (2002) Dual Diagnosis Good Practice Guide, p.7

158 Department of Health (2002) Dual Diagnosis Good Practice Guide, p.8

159 Department of Health (2002) *Dual Diagnosis Good Practice Guide*, p.4

"Substance misuse services

Competence

Healthcare professionals in substance misuse services should be competent to:

- *recognise the signs and symptoms of psychosis;*
- *undertake a mental health needs and risk assessment sufficient to know how and when to refer to secondary care mental health services.*

Assessment

Offer adults and young people with psychosis and coexisting substance misuse attending substance misuse services a comprehensive, multidisciplinary mental health assessment in addition to an assessment of their substance misuse.

Joint working

- *Healthcare professionals in substance misuse services should be present at Care Programme Approach meetings for adults and young people with psychosis and coexisting substance misuse within their service who are also receiving treatment and support in other health services;*
- *Specialist substance misuse services should provide advice, consultation and training for healthcare professionals in adult mental health services and CAMHS;*
- *Specialist substance misuse services should work closely with secondary care mental health services to develop local protocols derived from this guideline. The agreed local protocols should set out responsibilities and processes for assessment, referral, treatment and shared care across the whole care pathway."*[160]

12.2.1.2 Local Context

In 2008 the Avon and Wiltshire Partnership NHS Trust approved a new Dual Diagnosis strategy. This strategy document reviewed the relevant national policy and good practice guidance. In its executive summary it states:

"The provision of high quality services for individuals with a dual diagnosis and associated complex needs is one of the greatest challenges facing mental health services today. This strategy promotes 4 key approaches and a range of interventions to support their delivery.

The 4 key approaches are to ensure that AWP:

[160] NICE (2011) *Psychosis with coexisting substance misuse.* CG120, Quick Reference Guide p. 13

- *Delivers alcohol and drug treatment as a core part of day to day practice within all mental services, that they are 'mainstreamed' into services;*
- *Provides these services simultaneously, within an integrated treatment approach;*
- *Views alcohol and drug treatment within the recovery approach;*
- *Promotes entry criteria to secondary mental health care based on individual 'needs' and 'risk management', and not just on a diagnosis of severe and enduring mental illness, to ensure those in highest need receive the treatment they require from our services."* [161]

The strategy document describes how the Trust aims to realise an integrated and "mainstreaming" approach as follows:
"This strategy will also promote an integrated treatment approach for individuals with a dual diagnosis.

- *The evidence-base regarding which treatment models and interventions are most effective when working with this group is limited (Cleary et al, 2008), however, research and national guidance provide some indicators of the required components (Drake et al, 2004, DH, 2002);*
- *The following principles have found to improve outcomes. An integrated approach, a stage wise approach (engagement, building motivation to change, active treatment and relapse prevention), an assertive approach, a harm reduction approach that reduces the negative consequences of alcohol and drug use, stabilisation of mental health symptomology with optimum pharmacological interventions, family involvement, consider housing and meaningful occupation, the importance of maintaining a long term perspective and therapeutic optimism;*
- *To deliver the knowledge and skills necessary for staff to deliver an integrated treatment approach;*
- *For mental health and substance misuse problems to be given equal prominence when assessing, and to treat both at the same time, ideally by the same individual or team. For staff working in mental health settings to be able to provide support*

[161] Avon and Wiltshire Partnership NHS Trust (2008) Dual Diagnosis Strategy - Co-existing Mental Health and Alcohol and Drug Use Problems. P. 4

and treatment (harm reduction, brief interventions and building motivation to change) for individuals with low/medium substance misuse problems;

- *For those individuals with severe mental health and substance misuse problems a collaborative treatment plan will be agreed between mental health and the substance misuse services, informed by the needs of the client, under ICPA documentation;*
- *To promote the active engagement of individuals who historically have been difficult to engage in services, either because they are too chaotic, homeless or do not feel that AWP has been able to address their needs. They carry a high risk and are often in contact with other agencies/organisations whose staff have less expertise;*
- *To have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with regard to smoking, alcohol and substance misuse;*
- *To engage with carers and families in treatment provision;*
- *To support staff from third sector organisations managing mild/moderate mental health needs which do not meet the entry criteria for AWP services;*
- *Due to the finite capacity in secondary mental health services entry criteria need to be fair and consistent, based on 'needs' and 'risk' rather than diagnosis;*
- *To prioritise dual diagnosis and complex needs provision within the strategic planning process of the Trust."*[162] *(p.9)*

In the Trust's CPA Dual Diagnosis Procedure document (2010) the care pathway for those with a dual diagnosis is identified as follows:

"Care Pathway framework

If mental health needs are identified within AWP substance misuse services, the substance misuse service will identify a temporary care coordinator. If the individual meets the entry criteria for secondary mental health services, they will allocate a care coordinator as per the CPA Policy.

It is important to assess the severity of needs for both mental health and substance misuse, and to ensure the most appropriate service coordinates the CPA treatment package."[163]

[162] Avon and Wiltshire Partnership NHS Trust (2008) Dual Diagnosis Strategy - Co-existing Mental Health and Alcohol and Drug Use Problems. P. 9

The document continues:

"The following approaches have been found to improve and strengthen the care pathway and communication across services in the Trust, and have been incorporated in the Trust Dual Diagnosis Strategy and Action Plan:

- *joint assessments;*
- *attending CPAs;*
- *attending other services' clinical meetings if appropriate;*
- *allocating link workers;*
- *sharing knowledge;*
- *requesting support;*
- *teaching sessions."*[164]

However while aiming at an integrated "mainstreaming" approach to the provision of services for those with dual mental health and substance misuse problems the policy notes:

"Care Pathways

Inappropriate referrals are time consuming and frustrating for both the service user and the service itself. Referral should only be considered when the referrer is confident they have identified the correct service for the individual at the right time.

> *Ensure effective screening and detection of dual diagnosis needs is in place.*
>
> *If mild needs are identified, or the person is not ready to engage with the other service, the worker should continue to monitor, assess risk, offer harm reduction advice, use motivational approaches and maintain optimism for future change."*[165] *(P.10)*

[163] Avon and Wiltshire Partnership NHS Trust *CPA Dual Diagnosis Procedure.* p.6
[164] Avon and Wiltshire Partnership NHS Trust *CPA Dual Diagnosis Procedure.* p.7
[165] Avon and Wiltshire Partnership NHS Trust *CPA Dual Diagnosis Procedure.* p. 10

12.2.1.3 Findings of the Internal Investigation

The Internal Investigation identified the following contributory factor: *"Lack of assertive approach to failure to attend appointments or regular moves between areas."* [166]

The Internal investigation report commented:

"10.3.1 Between 2001 and 2004 there were multiple referrals of [Mr. Y] to the drug and alcohol services but on several occasions due to lengthy waiting lists [Mr. Y] had often moved area or was in custody necessitating a new referral and leading to lengthy delay in assessment or commencing treatment."

"10.3.2 When this was discussed with the drug and alcohol teams they stated that waiting times are now much improved and subject to close balanced scorecard monitoring. Additionally they would take a more assertive approach to following up clients who do not attend appointments. North Somerset also maintains a transitional prescribing clinic to ensure continuity of care if delays occur in allocating a keyworker."

"10.3.3 At no point was a formal Mental Health Act assessment considered appropriate. SDAS staff were confident that had there been an indication for mental health involvement, this could have been organised."[167]

12.2.1.4 Findings of the Independent Investigation

It might be most appropriate to view Mr. Y's contact with the Avon and Wiltshire Specialist Drug and Alcohol services as two distinct episodes: between October 2001 and September 2004 and after September 2004.

Mr. Y was initially referred to the North Somerset Specialist Drug and Alcohol Services (NSSDAS) in October 2001 but was not assessed until the following July, a gap of nine months. He then failed to attend two appointments, did not respond to a letter and was discharged.

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[166] Avon and Wiltshire Mental Health Partnership NHS Trust (2008) *ROOT CAUSE ANALYSIS REPORT ALLEGED HOMICIDE [Mr. Y]*

[167] Avon and Wiltshire Mental Health Partnership NHS Trust (2008) *ROOT CAUSE ANALYSIS REPORT ALLEGED HOMICIDE [Mr. Y]*

There was then a gap of six months, during which time it appears that Mr. Y spent at least some time in prison before his next referral in January 2003. On this occasion Mr. Y was offered an assessment appointment within a month. However he failed to attend this appointment.

The third time Mr. Y was referred to the NSSDAS was in October 2003, eight months after the previous failed assessment appointment. On this occasion he was offered an appointment within five weeks but a week before his scheduled appointment, four weeks after he had been referred for the third time, the service was informed that he had moved to Bristol and would be accessing services there.

However within the month he was referred to the North Somerset services for the fourth time and to the Bristol services. On this occasion Mr. Y was not offered an assessment appointment for four months during which time he had been imprisoned and been placed in a probation hostel in Gloucestershire.

After a period in a rehabilitation hostel in Taunton Mr. Y was referred to NSSDAS for the fifth time. During July, August and September 2004 Mr. Y was referred by two GPs, a drug counselling service (ACAD) and the Criminal Justice Intervention Team. He was offered an assessment appointment five weeks after the initial referral, which he attended. He was assessed by a Specialist Nurse Practitioner and, some days later, by the NSSDAS Consultant Psychiatrist. From this point until events of May 2008 Mr. Y appeared to be well engaged with the Specialist Drug and Alcohol services although his life appears to have been no less disordered.

In October 2004 Mr. Y moved to Bristol but travelled to Weston-super-Mare to attend appointments with NSSDAS. In November 2004 he was transferred to the Bristol Specialist Services (BSDS). There was a smooth transition of care with good liaison between the two teams. In May 2005 Mr. Y received a six-week custodial sentence but was seen by BSDS the day after he was released from prison and his care resumed. Despite him moving around the Bristol area, Mr. Y remained in contact with BSDS until he moved back to Weston-super Mare in January 2008.

Again on this occasion there was good liaison between the two Specialist Drug and Alcohol Teams. Mr. Y was assessed by the NSSADS in January and reviewed on a regular basis by the NSSDAS consultant in the Transitional Prescribing Clinic until he was allocated a Key Worker and offered a "full care" package in May 2008.

12.2.1 5 Conclusion

Mr. Y was referred to NSSDAS five times between October 2001 and July 2004. This resulted in only one assessment. On a number of occasions Mr. Y missed his appointments because of circumstances over which he had no direct control: he was in prison or placed in a probation hostel out of the immediate area. On one occasion there was a gap of nine months between referral and the assessment appointment and, on another occasion, four months. While it has to be acknowledged that some responsibility must be placed on the individual to attend appointments, or make contact with services when they cannot, the fact that Mr. Y was repeatedly referred to the service, by a number of referrers most of whom identified that Mr. Y had both substance misuse and mental health problems suggests that the service should have been more proactive in attempting to assess and engage Mr. Y prior to September 2004.

One of the key findings in the Co-morbid Mental Health and Substance Misuse in Scotland (2006) was:

"The need for responsiveness and continuity: Providers and users alike reported that when service users asked for help they needed it immediately. They did not want to be placed on a waiting list and told to come back later. Equally, throughout the research project, it was generally felt that service users were often isolated and cut off from appropriate services after formal treatment had ended."[168]

As noted above, the NTA's Model of Care (2006) acknowledged this need for a prompt response when a need is identifies and a client requests help. The guidance states:

"Waiting times. Since April 2006, the expectation will be that service users voluntarily seeking treatment will be able to access treatment within three weeks, with faster access for priority groups…

[168] Scottish Executive Social Research Substance Misuse Research Programme (2006) *Co-morbid Mental Health and Substance Misuse in Scotland*

The treatment system needs to be able to engage people rapidly and retain them once they have entered treatment. Two issues important to improving treatment engagement are timely access to treatment and a focus on supporting retention for at least three months in structured treatment for adults with dependent drug misuse……" (p. 24)

The Trust's Dual Diagnosis strategy echoes the importance of a prompt response, engagement and retention:

- *"The following principles have found to improve outcomes. An integrated approach, a stage wise approach (engagement, building motivation to change, active treatment and relapse prevention), an assertive approach, a harm reduction approach that reduces the negative consequences of alcohol and drug use, stabilisation of mental health symptomology with optimum pharmacological interventions, family involvement, consider housing and meaningful occupation, the importance of maintaining a long term perspective and therapeutic optimism.*
- *To promote the active engagement of individuals who historically have been difficult to engage in services, either because they are too chaotic, homeless or do not feel that AWP has been able to address their needs. They carry a high risk and are often in contact with other agencies/organisations whose staff have less expertise."*

This prompt response, engagement and retention did not characterise Mr. Y's initial contact with the Specialist Drug and Alcohol Services provided by the Avon and Wiltshire Partnership NHS Trust. The three-week standard for responding to referrals was introduced by the NTA in 2006, several years after Mr. Y was initially referred to the Specialist Drug and Alcohol services. However, even at this time best practice indicated that a rapid response to referral and a strategy for engaging and retaining them in services is of critical importance if services are to be effectively delivered and intervention are to be successful.

Had the initial referral been responded to in a more timely manner, given the stability he later attained, it is likely that this would have contributed to Mr. Y's well being at that time. However it would not be reasonable to conclude that a more timely response by services between 2001 and 2004 would have affected the events of May 2008.

Contributory Factor 1

Mr. Y was referred to the Specialist Drug and Alcohol services on a number of occasions, by several referrers, most of whom identified that Mr. Y had both substance misuse and mental health problems between October 2001 and July 2004. The delays in assessing Mr. Y and employing a strategy to engage him in services did not reflect best practice nor did it address Mr. Y's needs in the most effective manner. However it cannot be concluded that a more timely response by services between 2001 and 2004 would have affected the outcome of the events of May 2008

12.2.2 Assessment

12.2.2.1 National Context

Sound assessment provides a basis for the identification of an individual's needs, a formulation and understanding of the individual's problems and the information on which a diagnosis can be made; these, in turn inform the interventions and the goals which the interventions strive to attain. Without sound assessment interventions are not based on a solid foundation and whether they prove to be beneficial becomes a matter of luck. This is unfair to the individual and wasteful of scarce resources.

Within the mainstream of mental health services comprehensive assessment is enshrined within the Care Programme Approach process. The guidance for specialist drug and alcohol services and for dual diagnosis services also emphasises the importance of sound, comprehensive and competently conducted assessment.

The Department of Health's Dual Diagnosis Good Practice Guide (2002) states:
"Specialised assessments are undertaken to determine the nature and severity of substance misuse and mental health problems, and to identify corresponding need. The more comprehensive and focused the assessment the better the understanding will be of the relationship between the two disorders.

Since substance misuse can itself generate psychological and psychiatric symptoms, assessment of this relationship should be longitudinal and open to revision."[169]

[169] Department of Health (2002) *Dual Diagnosis Good Practice Guide*. p.17

The 2011 Guidance on psychosis and coexistent substance misuse elaborates on this point:

"Assessment and recognition"

The possible coexistence of a psychosis among people who come to specialist substance misuse services is often underestimated at least in part as a result of the complex clinical picture often presented when substance misuse is severe, involves the use of multiple substances and in people with evidence of personality disorder or other mental health problems. This is further complicated by that fact that substances may well be used to combat particular psychiatric symptoms or experiences such as anxiety, depression, intrusive thoughts, difficulties sleeping or more severe and troublesome experiences such as hallucinations. Moreover, significant life events, such as bereavement, divorce and trauma, are frequently associated with the emergence of mental health problems, including relapse for people with psychosis, and are commonly also triggers for the beginning of, or a significant increase in substance misuse. Furthermore, substance misuse may alter the presentation of symptoms, improving some and worsening others; this is especially so when a person is either intoxicated or experiencing withdrawal. For these, and many other reasons, assessment of mental state for people with substance misuse problems can prove to be difficult and recognition of a coexisting psychosis delayed.

It is important that the assessment of people with a substance misuse problem is comprehensive, and may need to take place over several meetings over an extended period. It is also important to obtain additional information and history from friends, carers, chosen supporters or indeed advocates, where this is permitted and feasible. Ideally assessment will cover not only all the information needed for a substance misuse assessment and that needed for a mental health assessment, but it should also aim to examine how the individuals' behaviour, mental state and experiences co-vary (or not) with changing patterns of substance misuse; and how patterns of substance misuse may co-vary (or not) with changes in mental state; and how both substance misuse and mental state change in the light of different life events.

Understanding changes in mental state when someone misusing substances becomes either relatively or completely abstinent can be crucial in making the right diagnostic formulation,

not least because communicative and cognitive functions can be greatly improved at these times."[170]

The NTA 2006 Model of Care echoes the message:

"Comprehensive assessment

Comprehensive assessment is targeted at drug misusers with more complex needs and those who will require structured drug treatment interventions. The assessment aims to determine the exact nature of the client's drug and alcohol problems, and coexisting problems in the other domains of health (mental and physical), social functioning and offending. A full risk assessment should also be conducted. Comprehensive assessment may be conducted by more than one member of a multidisciplinary team, because different competences may be necessary to assess different areas of client need (e.g. a doctor needs to assess clients for prescribing interventions involving controlled drugs – a supplementary prescriber may also be involved; or a psychologist may need to carry out psychometric assessment).

Comprehensive assessment can be seen as an ongoing process rather than a single event. Comprehensive assessment will be carried out when a client may:

- *Require structured and/or intensive intervention;*
- *Have significant psychiatric and/or physical co-morbidity;*
- *Have significant level of risk of harm to self or others;*
- *Be in contact with multiple service providers;*
- *Have a history of disengagement from drug treatment services;*
- *Be pregnant or have children "at risk".*

Comprehensive assessment provides information that will contribute to the development of a care plan for a client."[171]

This guidance goes on to emphasize that if an assessment is to be reliable it has to be undertaken by individuals who are competent to undertake the task. In many instances this will mean that the assessment will be an ongoing and multi-disciplinary undertaking.

[170] NICE (2011) *Psychosis with coexisting substance misuse: full guideline*. P.142
[171] National Treatment Agency for Substance Misuse (2006) *Models of Care for treatment of Adult Drug Misusers.*p.26

The NICE 2011 guidelines, reiterates the advice on assessment provided in the 2002 guidance. It identifies the following components of an adequate assessment of an individual with mental health and substance misuse problems:

*"Adults and young people with psychosis and coexisting substance misuse attending secondary care mental health services should be offered a comprehensive, multidisciplinary assessment, including assessment of **all** of the following:*

- *personal history;*
- *mental, physical and sexual health;*
- *social, family and economic situation;*
- *accommodation, including history of homelessness; and*
- *stability of current living arrangements;*
- *current and past substance misuse and its impact upon their;*
- *life, health and response to treatment;*
- *criminal justice history and current status;*
- *personal strengths and weaknesses and readiness to change;*
- *their substance use and other aspects of their lives.*

The assessment may need to take place over several meetings to gain a full understanding of the person and the range of problems they experience, and to promote engagement."[172]

As noted above, assessment is not an end in itself but a means to ensuring that the individual receives appropriate care and treatment and that his/her needs are effectively and efficiently met. The most obvious and tangible outcome of an assessment should be a care plan. The NTA 2006 guidance provides the following advice:

"A care plan is an agreement on a plan of action between the client and service provider. It should be a paper document which is available to the client and kept on the client's file. Care plans should document and enable routine review of client needs, subsequent goals and progress across four key domains:

- *Drug and alcohol misuse;*
- *Health (physical and psychological);*
- *Offending;*
- *Social functioning (including housing, employment and relationships."*[173]

172 NICE (2011) *Psychosis with coexisting substance misuse: full guideline*. P.152

173 National Treatment Agency for Substance Misuse (2006) *Models of Care for treatment of Adult Drug Misusers*.p.28

12.2.2.2 Local Context

Avon and Wiltshire Mental Health Partnership NHS Trust *CPA Dual Diagnosis Procedure (2010)* post dates the period in which Mr. Y was receiving care and treatment from the Trust, however based as it is on existing good practice guidance, much of what it prescribes with respect to assessment would have been considered good practice at the time of Mr. Y's involvement with the Trust.

"Assessment
Co-existing alcohol and drug misuse is common in service users presenting with mental health problems.

> *Assessment of current and recent substance use should be an integral component of mental health assessment….*
>
> *In addiction services mental health risks must be assessed as part of the initial risk assessment. Mental health assessment should be integral to comprehensive assessment and where concerns are identified a formal psychiatric assessment should be undertaken in line with CPA."*[174]

12.2.2.3 Findings of the Independent Investigation

Comprehensive Assessment: Use of Trust assessment form.

Mr. Y was referred to the Specialist Substance Misuse services and not, at least initially, to the secondary mental health services. Given this route of referral it is not inappropriate that the emphasis during his assessment was on his substance misuse. However, two factors need to be noted: from the time of his first referral Mr. Y was reporting mental health problems; the available best practice guidance at the time emphasised the importance of assessments being comprehensive in nature, the NTA Model of Care talks of the importance of taking a holistic approach to the client's needs.

In support of this holistic approach, the North Somerset Specialist Drug and Alcohol Service had in place an assessment form which identified the areas that might be beneficially covered during an assessment. However this assessment form was used on only three occasions and was not fully completed on any of these. At the time of Mr. Y's first assessment in July 2004 most sections of the form were left blank. It is possible that this is because the assessment

[174] Avon and Wiltshire Mental Health Partnership NHS Trust (2010) *CPA Dual Diagnosis Procedure.* p.8

was incomplete and Mr. Y did not engage with the service on this occasion. However this is speculation as there is no record in Mr. Y's notes as to why the assessment form was not completed.

When Mr. Y was re-referred and assessed in September 2004 the form was more fully completed though the section entitled *"Client motivation, aims, objectives and goals"* was left blank. As the involvement of the client is central to conducting a sound assessment this is a significant weakness. However from the contemporaneous clinical notes it is evident that Mr. Y was able to express his options and articulate what he perceived to be his needs. Nevertheless they were not recorded on the assessment form.

On the final occasion when the form was employed in January 2008 the assessment form appears to have been used as an *aide memoire,* as most of the entries are in note form and some are indecipherable. Following Mr. Y's release from prison in June 2005 a *"Medical Assessment Form for starting substitute medication opiate use."* was completed. This is the only time a structured approach to conducting a comprehensive assessment is recorded during the time Mr. Y was under the care of BSDS from December 2004 to January 2008.

Multi disciplinary Assessment

As noted above the best practice guidance and the NTA Model of Care note that those undertaking assessments should be competent to do so. Often, in the case of a comprehensive assessment, this will mean a multidisciplinary assessment. At the time Mr. Y was under the care of the NSSADS and BSDS the teams were primarily composed of staff with a nursing background with medical input from psychiatrists. When Mr. Y was assessed in September 2004 the NSSDAS Consultant Psychiatrist undertook a thorough psychiatric review of Mr. Y including a mental state examination. In March 2006 the Staff Grade Psychiatrist in BSDS completed a similar psychiatric review at the request of Mr. Y's Key Worker.

As far as the resources of the teams allowed these were examples of good multi-disciplinary working. However these assessments did not reflect the comprehensiveness identified in the guidance, nor can they be described as holistic.

For clinicians with differing expertise to undertake distinct elements of the comprehensive assessment is good practice. However for such multi-disciplinary assessments to be useful

there must be a mechanism or process which brings together the various strands of the assessment into a single, common formulation shared by all those working with the service user. Such a mechanism was not evident in Mr. Y's clinical notes. There is mention of discussions during team meetings in Mr. Y's notes but if these discussions were used to bring together the threads of the assessment they are not recorded in the notes and the insights and understanding of Mr. Y's problems and needs were lost

Frequency of assessments

Good practice suggests that a review date should be set to assess an individual's progress and the benefits of any interventions that have been put in place. However there is no evidence of review dates being put in place to review Mr. Y's needs and progress.

Similarly good practice suggests that a client's problems and needs should be assessed when significant events occur in his/her life or when his/her circumstances change significantly. There were a number of instances when Mr. Y's life circumstances changed, his mental state appeared to be changing or significant events occurred. These changes in circumstances did not trigger a comprehensive, structured assessment.

This should not be read to imply that no assessment took place or that Mr. Y's progress and mental state were not monitored. There is evidence that Mr. Y was seen regularly by his Key Workers and, when he returned to Weston-super-Mare in January 2008, he was reviewed on a regular basis by the NSSDAS Consultant Psychiatrist who reported his observations to Mr. Y's GP. Mr. Y was also seen regularly by his GP and episodically by the Visiting Prison Psychiatrist, by the Criminal Justice Intervention Team and by the Prison in-reach team. What appears to have been lacking in the provision of Mr. Y's care was regular, planned systematic and comprehensive assessment undertaken, as far as possible, on a multi-disciplinary basis.

Care plans

As has already been noted assessment is not an end in itself but a means of identifying an individual's needs and monitoring his/her progress. The most tangible manifestation of this process is the care plan. Mr. Y's drug prescribing regimen was clearly planned and the plan shared appropriately. However a care plan should encompass more than this.

"A care plan is an agreement on a plan of action between the client and service provider. It should be a paper document which is available to the client and kept on the client's file. Care plans should document and enable routine review of client needs, subsequent goals and progress across four key domains:

- *Drug and alcohol misuse;*
- *Health (physical and psychological);*
- *Offending;*
- *Social functioning (including housing, employment; and*
- *Relationships."*[175]

The care plan then should document a client's needs and be used to monitor his/her progress. Mr. Y was transferred to BSDS in December 2004 and yet the first formal care plan recorded in his notes is an "Initial Care Plan" dated 30 September 2006. This had goals identified under three headings: "Substance use", "Health" and "Social". A "revised care plan" was recorded in Mr. Y's notes December.[176] As with the earlier care plan goals were identified in the areas of "Substance use", "Health" and "Social". However no explicit reference is made to the goals in the earlier plan in assessing Mr. Y's progress.

The guidance suggests that the care plan is a written agreement between the client and the service provider. However the care plans noted above are the only formal care plans, recorded on Trust forms, in Mr. Y's notes. They are somewhat cursory and they are not signed by Mr. Y. They do not chronicle a systematic and agreed response to a comprehensive assessment of Mr. Y's needs and as such do not reflect the available guidance.

12.2.2.4 Conclusion

Assessment and care planning are the cornerstones of the delivery of effective and efficient care and treatment. Detailed guidance is available as to what should be included in the assessment of those individuals who have substance misuse and mental health problems and on the form and content of the resulting care plan. The Avon and Wiltshire Mental Health Partnership NHS Trust Specialist Drug and Alcohol Services had put in place a structured format to support robust assessment and care planning. However the assessment of Mr. Y's

175 National Treatment Agency for Substance Misuse (2006) *Models of Care for treatment of Adult Drug Misusers.*p.28
176 Case notes 2.103

needs while he was under the care of the Specialist Drug and Alcohol Services was not characterised by the systematic, comprehensive and holistic assessment.

Best practice recommends that assessments should be undertaken at planned intervals and, also, in responses to significant changes in the service user's circumstances. While there is evidence of on-going, regular contact with Mr. Y, neither regular planned assessment, to monitor his progress against identified goals, nor more responsive assessments, to understand his needs at times of change or crisis, are evident in Mr. Y's clinical records.

The available guidance recommends that a comprehensive assessment should be characterised by multi-disciplinary input and co-operation. Within the limited resources of the Specialist Drug and Alcohol Teams there was evidence of multi-disciplinary working however there was no recorded evidence of a mechanism being in place to bring together the various insights and understanding of Mr. Y's problems, enabling the team to arrive at a common understanding of his needs and how these might be best met.

Best practice guidance suggests that the care plan is a written agreement detailing the care and treatment an individual will receive to meet identified needs. There are few formal care plans recorded in Mr. Y's clinical records. They do not chronicle a systematic and agreed response to a comprehensive assessment of Mr. Y's needs and as such do not reflect the available guidance.

Contributory Factor 2

Mr. Y's needs and the risks he posed were not assessed with the regularity and responsiveness that best practice would recommend; care plans did not provide a clear formulation on the basis of which Mr. Y's behaviour could be understood and a strategy put in place to address the identified needs; there was no multi-agency involvement in either assessment or care planning and no mechanisms in place to facilitate this taking place. Had this been done it is probable that Mr. Y would have received more comprehensive care. However it would not be reasonable to conclude that this had a direct effect (causal relationship) upon the events of May 2008.

12.3 Risk Assessment and Management

12.3.1 National Context

Risk assessment and planning should not be seen as free standing activities. They are integral elements in meeting a service user's health and social care needs. In his forward to *Best Practice in Managing Risk (2007*) Louis Appleby commented:

"*Safety is at the centre of all good healthcare. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk.*"[177]

The guidance goes on to list 16 principles which should characterise the assessment and management of risk. These are listed below:

"*Best practice*

1. *Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience and clinical judgement.*

Fundamentals

2. *Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.*

3. *Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.*

4. *Risk management must be built on recognition of the service user's strengths and should emphasise recovery.*

5. *Risk management requires an organisational strategy as well as efforts by the individual practitioner.*

Basic ideas in risk management

6. *Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.*

7. *Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.*

[177] DoH (2007), *Best Practice in Managing Risk*

8. *Knowledge and understanding of mental health legislation is an important component of risk management.*

9. *The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.*

10. *Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.*

11. *Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.*

Working with service users and carers

12. *All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.*

13. *Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and recognition that each service user requires a consistent and individualised approach.*

Individual practice and team working

14. *Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.*

15. *All staff involved in risk management should receive relevant training, which should be updated at least every three years.*

16. *A risk management plan is only as good as the time and effort put into communicating its findings to others".*[178]

Focusing on the importance of risk assessment for those individuals with substance misuse problems the NTA (2006) advised:

"Comprehensive assessment is targeted at drug misusers with more complex needs and those who will require structured drug treatment interventions. The assessment aims to determine the exact nature of the client's drug and alcohol problems and coexisting problems in the other domains of health (mental and physical), social functioning and offending. A full risk assessment should also be conducted. Comprehensive assessment may be conducted by more

[178] DoH (2007), *Best Practice in Managing Risk p.5-6*

than one member of a multidisciplinary team, because different competences may be necessary to assess different areas of client need (e.g. a doctor needs to assess clients for prescribing interventions involving controlled drugs – a supplementary prescriber may also be involved; or a psychologist may need to carry out psychometric assessment).

Comprehensive assessment can be seen as an ongoing process rather than a single event. Comprehensive assessment will be carried out when a client may:

- *Require structured and/or intensive intervention;*
- *Have significant psychiatric and/or physical co-morbidity;*
- *Have significant level of risk of harm to self or others;*
- *Be in contact with multiple service providers;*
- *Have a history of disengagement from drug treatment services;*
- *Be pregnant or have children "at risk".*

Comprehensive assessment provides information that will contribute to the development of a care plan for a client.

4.5 Risk assessment

It is best practice to carry out risk assessment as part of screening, triage and comprehensive assessment. Risk assessment aims to identify whether the individual has, or has had at some point in the past, certain experiences or displayed certain behaviours that might lead to harm to self or others. The main areas of risk requiring assessment are:

- *Risk of suicide or self-harm;*
- *Risks associated with substance use (such as overdose ;)*
- *Risk of harm to others (including harm to treatment staff, harm to children and domestic violence);*
- *Risk of harm from others (including domestic violence);*
- *Risk of self-neglect.*

If risks are identified, risk management plans need to be developed and actioned to mitigate immediate risk. If a service has concerns about the needs and safety of children of drug misusers, local protocols should be followed, for example if there are concerns about risk of significant harms, social services would normally be involved in further assessment of risk. As with comprehensive assessment, risk assessment is an ongoing process and requires integration into care planning. Issues of risk highlight the need for appropriate information

sharing across services and therefore the need for cross-agency policies and plans, and for clarity with a client around the limits of confidentiality".[179]

12.3.2 Local Context

The Trust's current risk management strategy echoes many of the values set out in national guidance and best practice. It states:

"The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety is at the centre of all good health-care and that ***positive risk management****, conducted in the spirit of collaboration with service users and carers, is essential. In order to deliver* ***safe, quality*** *services, the Trust will encourage staff to work in collaborative partnership with each other and service users to* ***minimise*** *risk to the greatest extent possible and promote patient well-being. Additionally, the Trust seeks to* ***minimise*** *the harm to service users arising from their own actions and harm to others arising from the actions of service users."* [180]

It is also clear that these best practices principles apply to all service users who come under the care of the Trust:

"Whether CPA or Non CPA is agreed, the principles and values underpinning CPA will apply; these comprise assessment, planning, intervention and review with a named practitioner responsible." [181]

Although not in place at the time Mr. Y was under the care of the Avon and Wiltshire Mental Health Partnership NHS Trust, the Trust's current Care Programme Approach Procedure policy advises:
"In addiction services mental health risks must be assessed as part of the initial risk assessment. Mental health assessment should be integral to comprehensive assessment and where concerns are identified a formal psychiatric assessment should be undertaken in line with CPA." [182] This would have been best practice at the time Mr. Y was under the care of the Trust.

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[179] National treatment Agency for Substance Misuse (2006), *Models of care for treatment of adult drug misusers: update 2006*. P. 26-27
[180] Avon and Wiltshire Mental Health Partnership Trust (2010) *Risk Management Strategy* p.3
[181] Ibid p.6
[182] Avon and Wiltshire Mental Health Partnership Trust (2010) *Care Programme Approach Procedures.* P. 8)

For those with a substance misuse problem the Trust risk assessment procedure identifies the areas that should be reviewed:

"Risk assessment should include:

- *Assessing the potential impact of different types of substance on violence, self harm, suicide, self-neglect, abuse and exploitation, and accidental injury;*
- *Assess risks specifically associated with substance use such as withdrawal seizures, delirium tremens, dangerous injecting practices, blood borne viruses, risks associated with mixing substances, accidental overdose, sexual health;*
- *The potential risks associated with the interaction of prescribed medication and non-prescribed and/or illicit drugs, and/or alcohol, should be considered.*

  This may increase overdose risk, increase non-concordance with prescribed medication or reduce the effectiveness of prescribed medication.

  The risk to children with whom the service user is in contact must also be assessed.

  Specific age-related risks, e.g. exacerbated effects of alcohol on younger people, leading to increased risk of sexual assault or alcohol poisoning (overdose); exacerbation of the risk of falls by elderly people who are intoxicated;
- *Specific gender-related risks, such as; women often experience higher levels of interpersonal violence and a history of sexual assault;*
- *Risk assessment must identify the risks associated with Mental Health, substance use and the interaction of the two, and include risks posed to service users, their family and carers, children, staff (both on Trust premises and in users homes) and others in the wider community."* [183]

12.3.3 Findings of the Internal Investigation

10.4 "Failure to follow Trust policy regarding risk screening, assessment and management and failure to maintain risk records that adequately captured and communicated all known risk factors

[183] Avon and Wiltshire Mental Health Partnership Trust (2010) *Care Programme Approach Dual Diagnosis Procedure*

10.4.1 *The Risk assessment completed at [Mr. Y's] initial assessment stated that there were no risks known at this time. However [Mr. Y] already had a known long offending history by that time which should have been considered as part of his ongoing risk. It is unclear whether this was omitted as the assessor did not have the relevant information or did not question [Mr. Y] regarding this.*

10.4.2 *No risk screen/assessment was completed as part of the initial assessment and acceptance into the Bristol SDAS services.*

10.4.3 *No risk management plan was completed following charges of assault on his ex-girlfriend and no contact with other services re possible risks linked to him caring for his son in the context of known domestic violence. The specific SDAS parental risk screen was not completed. If this had been completed when [Mr. Y's] son was placed in his care it would have led to more formal liaison between the SDAS service and the children's services.*

10.4.4 *On transfer from the court linked keyworker to the community keyworker the risk assessment did not transfer all risk information from the previous assessment and no risk management plan was completed.*

10.4.5 *Risk assessment was not updated with information regarding his arrest for assault on his mother leading to head injury or incidents with other residents at the Salvation Army Hostel and there was no risk management plan.*

10.4.6 *Potential risk to mum was not picked up during discussions of his concerns regarding her during keyworking sessions. This appears to be a combination of lack of previous risk information and some lack of understanding of risk specifically linked to psychosis.*

10.4.7 *On transfer from the Bristol SDAS team to the N Somerset SDAS team risk history information was only partly passed on and the team taking over his care were not fully aware of the history or circumstances of previous violent offending behaviour. This also meant that the previous concerns regarding possible risk to female staff members could not be taken into consideration when he requested a male keyworker.*

10.4.8 *There is no risk history compiled to provide an overview of the risk history for all risks and no evidence that the risk management process had been tracked and formed part of care co-ordination. In terms of [Mr. Y's] presentation and history, he was generally seen as someone who did not present a high risk to others".*[184]

12.3.4 Findings of the Independent Investigation

Frequency and Responsiveness of Risk Assessment.

As noted in the guidance quoted above, risk assessment should be an integrated part of an individual's assessment. Good practice suggests that assessments, including risk assessments should be undertaken on a regular and planned basis, in response to significant changes in the individual's circumstances and when there are changes in the individual's behaviour or mental state. There are, however, only four formal risk assessments employing Trust approved tools recorded in Mr. Y's clinical records.

One would expect a risk assessment to be undertaken whenever an individual is taken into a new service or transferred between services. Mr. Y was accepted into the specialist drug and alcohol services and his care transferred within the service on at least six occasions during the time he was under the care of the Avon and Wiltshire Mental Health Partnership NHS Trust:

- in July 2002 Mr. Y was assessed by the specialist drug service following his referral by his GP;
- in September 2004 he was again assessed following his re-referral to the service;
- in December 2004 Mr. Y's care was transferred to the Bristol specialist drug and alcohol services (BSDS);
- in June 2005 he was re-assessed following his release from prison;
- in September 2005 Mr. Y was transferred from the Criminal Justice Team to the Community Team;
- in January 2008 Mr. Y's care was transferred from the Bristol services to the North Somerset services following his move to Weston-super-Mare.

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Although various risk factors were recorded in the assessments that took place at these points of transition, formal risk assessments utilising Trust approved screening tools were recorded on only two occasions: when he was first assessed by NSSDAS and when Mr. Y's care was again transferred to NSSDAS in 2008.

There were also a number of other occasions when one might have expected a formal risk assessment to have been triggered:

- in September 2004 when Mr. Y reported that he was being threatened by other drug users and was, on at least one occasion, assaulted;
- in October 2004 when he reported that he was being charged for assault following a fight with an ex-girlfriend;
- in January 2005 when Mr. Y reported conflict and arguments with his grandmother;
- in August 2005 when he reported that he had beaten his aunt "*around the kitchen"* and believed that this was not unreasonable behaviour;
- in August and November 2005 when he was required to vacate his accommodation;
- in January/February 2006 when Mr. Y was arrested following an argument during which his mother was thrown to the ground;
- in August 2006 when he was arrested and charged with carrying a knife;
- in October 2007 when he again reported that he was having difficulties with his mother.

Only one of these incidents - the altercation with his aunt in August 2005 appears to have triggered a formal risk assessment.

There were also a number of occasions when it was recorded in Mr. Y's clinical notes that he was "paranoid" or suspicious about the behaviour of others or, as in the case of his probation officer in 2007, that he was not getting along with people, when a risk assessment might have been triggered but was not.

This lack of a regular, planned risk assessment and failure to adhere to a clear protocol indentifying when risk assessment should be undertaken did not conform to best practice or Trust policy. It was a weakness in the care Mr. Y received.

Quality of Risk Assessment

Regular and responsive risk assessment is, of course, in itself not sufficient, effective risk management requires that the risk assessment is of a good quality.

The Internal Investigation found that:

- no risks were identified when Mr. Y was first assessed by NSSDAS in September 2004 although he had a long offending history, he had been referred by the Drug Arrest Team in January 2002 and by the Criminal Justice Intervention Team in September 2004;
- when Mr. Y was transferred from the court- linked key worker to the community key worker the risk assessment did not transfer all risk information from the previous assessment;
- Mr. Y's risk profile was not updated with information regarding his arrest for assault on his mother in February 2006 or incidents with other residents at the Salvation Army Hostel;
- the potential risk to Mr. Y's mother was not identified. *"This appears to be a combination of lack of previous risk information and some lack of understanding of risk specifically linked to psychosis";*
- *"On transfer from the Bristol SDAS team to the N Somerset SDAS team risk history information was only partly passed on and the team taking over his care were not fully aware of the history or circumstances of previous violent offending behaviour. This also meant that the previous concerns regarding possible risk to female staff members could not be taken into consideration when he requested a male key worker."*[185]

The Independent Investigation Team agrees with these findings.

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The NTA (2006) Model of Care observes that "*Comprehensive assessment can be seen as an ongoing process rather than a single event."*

The Best Practice Guidance notes: "*The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis."*

However the Internal Investigation found that: *"There is no risk history compiled to provide an overview of the risk history for all risks and no evidence that the risk management process had been tracked and formed part of care co-ordination."*

The Independent Investigation Team agrees with this finding. In Mr. Y's clinical notes various of his risk behaviours are identified and his risk behaviours and forensic history are recorded, however these are not brought together in a single easily identifiable place in Mr. Y's notes, and the cumulative information is not employed as a basis of a formulation which would enable those providing care and treatment to Mr. Y to respond to his behaviours and needs in a coherent fashion as best practice recommends.

Risk assessment is not, of course, an end in itself but a step in planning the care of an individual. The Best Practice Guidance quote above notes:
"Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused." The NTA model of care advises: "*If risks are identified, risk management plans need to be developed and actioned to mitigate immediate risk."*

There were a number of occasions recorded in Mr. Y's notes when he was involved in violent altercations: with other drug users and drug dealers, with fellow hostel residents, with an ex-girlfriend, with his mother and with an aunt. Several of these incidents resulted in Mr. Y being arrested.

On at least three occasions Mr. Y was identified as a risk to others during a risk assessment. In the risk assessment conducted in August 2005 following Mr. Y's altercation with his aunt in which it was reported that he *"beat her around the kitchen"* it was noted that: "[*Mr. Y] states that he doesn't really like women. He feels that his auntie deserved to get beaten as she*

abused him as a child. No obvious signs of remorse." And *"[Mr. Y] feels that the assault [on his ex-girlfriend] was justified as she crashed the car on purpose."*

The assessor concluded that *"[Mr. Y] presents a risk to women especially family members also paranoid and? delusions?"*

Under the section entitled: "Summary and (Interim) management plan" the following was recorded:

- Mr. Y needed to be seen regularly, preferably by male staff;
- Mr. Y had a history of previous violent offences and recent violent attacks on family members;
- The Nurse Specialist did not feel threatened during assessment;
- Mr. Y had improved while on anti-psychotic medication but was still displaying some paranoia;
- There was a possible risk of violence towards women and family members.[186]

Although significant risks had been identified, this management plan did not realise the goal of providing *"flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused"*.

The Independent Investigation is in agreement with the Internal Investigation that appropriate risk management plans were not put in place as best practice would recommend and those that were recorded were not of the standard that would be expected by the Best Practice Guidance.

The fact that Mr. Y was under the care of specialist drug and alcohol services, not secondary mental health services, must not be overlooked. It is not unreasonable for the focus and scope of assessment, including risk assessment to be somewhat different in these two services. Nevertheless the NTA Model of Care is clear that: "*The assessment aims to determine the exact nature of the client's drug and alcohol problems, and coexisting problems in the other domains of health (mental and physical), social functioning and offending."* This

[186] Case notes 2.111ff

comprehensiveness was not evident in the assessment of the risk Mr. Y posed to himself or others.

While it is the responsibility of the individual practitioner to be familiar with Best Practice Guidance it is the responsibility of the institution to ensure that clinical staff receive appropriate training and supervision to realise the standards identified in the guidance, and to ensure that an appropriate multidisciplinary skill mix is available. The NTA Model of care advised:

Competences required to conduct assessments

The Drug and Alcohol National Occupational Standards (DANOS) outline the basic competences for professionals to undertake different levels of drug and alcohol assessment. Comprehensive assessment is intended to be a multidisciplinary process to ensure a holistic approach to client need." (p.27)

In this context the Internal Investigation observed:

"Psychiatric advice and assessment is available within the specialist drug and alcohol teams but it is unclear whether other team members have had sufficient training in risk assessment and management linked to psychosis as well as illicit substance use."

12.3.5 Conclusion

The risk Mr. Y posed to himself and to others was not assessed with the regularity and responsiveness that best practice would recommend. Although the risks that Mr. Y posed were noted in his clinical records these identified risks were not brought together in an appropriate manner. There is no evidence that risk assessment was undertaken as an on-going and accretitive process facilitating an understanding of the risks Mr. Y posed and how these might be most effectively addressed as best practice guidance recommends. The risk management plans did not provide a clear formulation on the basis of which Mr. Y's behaviour could be understood and a strategy put in place to address the risks he posed, nor did they set out a clear plan of action as the guidance recommends. Had this been done it is probable that Mr. Y would have received more comprehensive care. However it would not be reasonable to conclude that this had a direct effect (causal relationship) with the events of May 2008.

Contributory Factor 2

The risk Mr. Y posed to himself and to others was not assessed with the regularity and responsiveness that best practice would recommend; risk management plans did not provide a clear formulation on the basis of which Mr. Y's behaviour could be understood and a strategy put in place to address the risks Mr. Y posed; risk management plans did not set out a clear plan of action as the guidance recommends. Had this been done it is probable that Mr. Y would have received more comprehensive care. However it would not be reasonable to conclude that this had a direct effect (causal relationship) upon the events of May 2008.

12.4 Diagnosis

12.4.1 National Context

An often critical element in the planning of an individual's care is the diagnostic process. There is an on-going debate in the academic literature about the reliability and utility of categorical diagnostic schemas and what is sometimes, imprecisely, referred to as the medical model. What is not in debate, however, is that if an individual is to receive effective and efficient treatment there has to be a clear formulation of his/her difficulties, which informs a plan determining how the individual might be helped to achieve identified goals. This formulation should be based on a robust and comprehensive assessment and best practice suggests that the formulations should be multi-disciplinary with all members of the treating team being guided by a common understanding of the individual's problems.

12.4.2 Findings of the Independent Investigation

From at least January 2002 concerns regarding Mr. Y's mental health were being identified. At this time Mr. Y was expressing suicidal thoughts. A little later in January 2002 he reported hearing voices, a symptom which he continued to report during his contact with SDAS. By December 2003 it was being reported that Mr. Y had been experiencing anxiety and depression for a considerable period of time and by February 2004 he was describing paranoia. This was a significant array of symptoms, consistent with mental ill-health. However at his first formal psychiatric assessment in Bristol Prison in May 2004 the Visiting Consultant Psychiatrist's opinion was that the "*Primary problem is drug dependence, heroin and crack. No definite evidence of psychotic illness, query auditory pseudo*

hallucinations".[187] Despite this formulation Mr. Y was being described in correspondence as "*quite psychotic, including delusional beliefs regarding religion*".[188]

To add further complexity to the picture following his assessment by NSSDAS in September 2004 Mr. Y's mental health problem were described as: "… *of a PTSD type disorder."*[189]
When Mr. Y was assessed by the NSSDAS Consultant Psychiatrist in September 2004 he reported "*the impression is of a man who has a long history of drug abuse that has arisen within the context of a personality disorder and he exhibits traits of emotional instability. Although he described some quasi-psychotic symptoms I did not think he was suffering with a psychotic illness…".* [190]

When Mr. Y was referred to the Bristol services in November 2004 he was diagnosed as suffering from: Opiate dependence syndrome, Benzodiazepine dependence and emotionally unstable personality.[191]

Mr. Y continued to report the same symptoms when he was seen by the Bristol services and was assessed in March 2005. On this occasion the Psychiatrist concluded "…*a formal diagnosis of psychotic disorder cannot be excluded at this time. He does describe several first rank symptoms….. The main relevant aetiological factor is that of his drug use…. I did wonder to what extent his current Methadone prescription is providing him with some antipsychotic cover. My differential diagnosis in relation to psychotic disorder include – mental disorder due to use of hallucinogens/stimulants, Schizotypal disorder and Schizophrenia."*[192]

The same Psychiatrist assessed Mr. Y again in January 2006 at the request of his GP. She recorded "*[Mr. Y] himself feels his mental health has improved over the last 2 months…. at interview he presented in a more relaxed and less guarded manner, compared to when I saw him last year and I could not elicit any overt psychotic symptoms from him."*[193]

[187] Case notes 2.95, 2. 383ff, 2.93ff
[188] Case notes 2.241
[189] Case notes 1.76ff
[190] Case notes 1.97ff, 1.35, 1.127
[191] Case notes 1.123,2.309
[192] Case notes 2.419
[193] Case notes 2.267

When Mr. Y returned to the North Somerset DAS in February 2008 the Student Nurse who assessed him commented "*during the course of the assessment I got the distinct impression that [Mr. Y's] thought processes were chaotic, as he kept going off on tangents rather than sticking to the subject in hand and it was very difficult to stick to the themes of the assessment*".[194]

However when he was assessed by the NSSDAS Consultant Psychiatrist, he concluded that Mr. Y was not suffering with any first rank symptoms of Schizophrenia.[195]

Following his imprisonment in 2008 Mr. Y's mental state was reviewed by a Consultant Psychiatrist who concluded ". *During my meetings with [Mr. Y] I have found no evidence of serious mental illness, but have continued to monitor him with regards to his opiate and benzodiazepine dependence. I have spoken with his former key-worker at Bristol Specialist Drug and Alcohol Service and there appears to have been little change in his presentation since he last saw them." [196]*

Mr. Y consistently reported hearing voices and at times reported being paranoid and behaved in a suspicious manner; Mr. Y's GPs and members of the SDAS service noted these symptoms and requested psychiatric assessments. This was an appropriate response to the symptoms Mr. Y was reporting. In response to these requests and as part of various assessment processes Mr. Y was reviewed on a number of occasions by several psychiatrists. They all noted and recorded his symptomatology and all considered whether Mr. Y was suffering from a psychotic disorder. All the psychiatrists who assessed Mr. Y concluded that the main aetiological factor contributing to his reported symptoms was his drug misuse. The relationship between Mr. Y's presenting symptomatology and his drug use was considered and the consensus opinion appears to have been that while Mr. Y's drug misuse probably precipitated his symptomatology, particularly when his drug usage was stabilised this provided some amelioration of the symptoms. On only one occasion did a psychiatrist consider it appropriate to give Mr. Y a diagnosis of a psychotic disorder.

[194] Case notes 3.53
[195] Case notes 3.59
[196] Internal Investigation p.55 (90)

On a number of occasions Mr. Y requested to see a psychiatrist so that his mental health problems might be addressed and he complained that he was not receiving the psychiatric support that he wanted and, in consequence, he felt vulnerable. We will discuss elsewhere in this report the relationship between the specialist substance misuse services and the mental health services, however the Independent Investigation team has concluded that Mr. Y's mental health needs were noted and appropriately assessed on a number of occasions by several psychiatrists who came to a similar view of Mr. Y's problem.

In addition to giving consideration as to the possibility of Mr. Y having a psychotic-type disorder he was also diagnosed as having an "emotionally unstable personality". However this diagnosis and how to respond to it does not appear to have been further explored in Mr. Y's clinical notes.

Personality disorder problems are not uncommon in the population served by mental health and substance misuse services. In *New Horizons*[197] the Department of Health noted:
"Personality disorders are common conditions. Estimates of prevalence rate vary between 5 and 13 per cent of adults in the community. Among community mental health patients this rises to between 30 and 40 per cent, and 40 to 50 per cent of mental health inpatients."
(p. 72).

The document observes that: "*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." (p.72)*

As noted above the diagnostic process is part of the process of understanding an individual's problems and needs, with the intention of responding to these in the most effective, efficient and clinically beneficial manner. Given that Mr. Y was given a diagnosis of "emotionally unstable personality" it would have been good practice to consider how this affected his behaviour and how this problem might be addressed especially as the NICE (2009)[198]

[197] DoH (2009) *New Horizons: Towards a shared vision for mental health*
[198] [198] NICE (2009) Borderline Personality Disorder: Treatment and Management

guidance makes it clear that personality disorder is not only a treatable disorder, but that it is the responsibility of the mental health services to institute appropriate interventions.

The Internal Investigation commented:
***"11.6.1** Psychiatric advice and assessment is available within the specialist drug and alcohol teams but it is unclear whether other team members have had sufficient training in risk assessment and management linked to psychosis as well as illicit substance use."*[199]

The staff of the SDAS noted the symptoms Mr. Y was reporting and appropriately requested a mental state assessment. However, the Independent Investigation Team observed that terms such as PTSD, OCD, paranoia and depression were used at times without any explicit reference to agreed diagnostic schema such as ICD - 10 or DSM IV. The level of training and skill mix of the staff of the SDAS will be determined by a number of factors including the services it is contracted to deliver and how closely it works with and receives support and consultation from other functional teams. However as a significant proportion of those with substance misuse problems also have a range of mental health problems it is important that the staff of the SDAS have the skills to assess the needs of these individuals and either respond to these needs or refer these individuals, in a timely manner, to other, appropriate services.

While it is the responsibility of clinicians to ensure that they are competent to carry out the tasks required of them, it is the responsibility of the organisation to ensure that clinicians are not given responsibilities beyond their competencies and are provided with appropriate on-going training and supervision.

12.4.3 Conclusion

Mr. Y's symptomatology was noted by those caring for him. He was reviewed on a number of occasions by several psychiatrists all of whom considered whether Mr. Y was suffering from a psychotic disorder. They all concluded that the main aetiological factor contributing to his symptoms was his drug misuse. The consensus opinion was that while Mr. Y's drug misuse precipitated his symptomatology, when his drug usage was stabilised this provided

[199] Avon and Wiltshire Mental Health Partnership NHS Trust (2008) *ROOT CAUSE ANALYSIS REPORT ALLEGED HOMICIDE [Mr. Y]*

some amelioration of those symptoms. The Independent Investigation team has concluded that Mr. Y's mental health needs were noted and appropriately assessed on a number of occasions by several psychiatrists who came to a similar view of Mr. Y's problem.

In addition to giving consideration as to the possibility that Mr. Y suffered from a psychotic-type disorder he was also diagnosed as having an "emotionally unstable personality". However there is no evidence in Mr. Y's clinical records that this diagnosis and how to respond to it was explored. It would have been good practice to consider how this personality disorder affected his behaviour and how this problem might be addressed in line with best practice guidance.

As a significant proportion of those with substance misuse problems also have a range of mental health problems it is important that the staff of the SDAS have the skills to assess the needs of these individuals and respond to these needs in a timely manner.

12.5 Treatment

12.5.1 Context

The treatment of any major mental health problem is normally multi-faceted employing a combination of treatments: psychological (e.g. cognitive behaviour therapy, supportive counselling, and family therapy), psychosocial (problem solving, mental health awareness, psycho education, social skills training, family interventions), pharmacological (medication), community support, vocational rehabilitation and inpatient care. The treatment of any individual should be based on a sound assessment leading to an understanding of his/her problems and needs. Treatment should be delivered as part of a unique care/treatment plan drawn up in collaboration with the service user.

12.5.2 Substance misuse

12.5.2.1 Context

In describing the four tier model of service delivery that was being advocated in its "*Models of Care for the Treatment of Drug Misusers" (2002)* the NTA the guidance says.[200]

Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care planned treatment and drug specialist liaison….

Tier 3 interventions that should be commissioned in each local area include…

- *Community care assessment and case management for drug misusers;*
- *Harm reduction activities as integral to care-planned treatment;*
- *A range of prescribing interventions, in the context of a package of care and in line with Drug Misuse and Dependence – Guidelines on Clinical Management, known as "the clinical guidelines". This will be updated alongside the relevant forthcoming National Institute for Clinical Excellence (NICE) guidelines and technology appraisals, and in line with other evidence-based clinical standards with specific interventions, including:*
    - *prescribing for stabilisation and oral opioid maintenance prescribing;*
    - *community based detoxification;*
    - *injectable maintenance prescribing; and*
    - *a range of prescribing interventions to prevent relapse and ameliorate drug and alcohol-related conditions;*
- *A range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour;*
- *Structured day programmes and care-planned day care (e.g. interventions targeting specific groups ;)*
- *Liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health and hepatitis services);*
- *Liaison services for social care services (e.g. social services (child protection and community care teams), housing, homelessness ;)*
- *A range of the above interventions for drug-misusing offenders."*

[200] National Treatment Agency (2002), "*Models of Care for the Treatment of Drug Misusers"*

The evidence-based psychosocial interventions identified in the NTA's 2006 Model of care guidance include:

• Cognitive behaviour therapy (CBT);
• Coping skills training;
• Relapse prevention therapy;
• Motivational interventions;
• Contingency management;
• Community reinforcement approaches;
• Some family approaches.

As noted above in December 2010 the incoming Coalition Government introduced its new drug strategy: *"Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life"*.

This strategy places an emphasis on recovery. It:

- puts more responsibility on individuals to seek help and overcome dependency;
- places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing;
- aims to reduce demand;
- takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad;
- puts power and accountability in the hands of local communities to tackle drugs and the harms they cause.

12.5.2.2 Findings of the Independent Investigation

Mr. Y was referred to the North Somerset Specialist Drug and Alcohol Team (NSSDAS) by his GP in October 2001. His GP reported that at that time Mr. Y had had a drug misuse problem for approximately eight years but was reluctant to tackle this problem. This pattern of identifying that Mr. Y had a drug misuse problem but that he was reluctant to address it continued throughout 2002 and 2003. It was not until he was released from prison in May 2004 that there is any indication in Mr. Y's notes that he was interested in tackling his drug misuse problem. At this point he was referred to a specialist hostel in Taunton.

When Mr. Y was assessed by NSSDAS in September 2004 he was using heroin, Dihydrocodeine and Diazepam. Following this assessment Mr. Y was placed on the drug substitution programme and prescribed Methadone, as a substitute for heroin, and Diazepam. Despite receiving this regular prescription there is evidence that Mr. Y continued to "top up" until at least August 2005. In May 2006, however, it was reported that Mr. Y had been illicit-drug free for six months and he appears to have been successfully stabilised on prescribed medication from this point on.

12.5.2.3 Conclusion

Although Mr. Y was referred to the NSSDAS services in Oct 2001 he was not committed to addressing his drug misuse problem at that time. He appears to have determined to address this problem only in May 2004. His illicit drug use appears to have decreased from the time he was placed on a Methadone substitution programme in September 2004 and from around December 2005 appears to have been largely illicit-drug free.

When Mr. Y was willing to address his drug misuse problem the SDAS teams in North Somerset and Bristol appear to have treated this both appropriately and successfully.

12.5.3 Medication

12.5.3.1 Context

Psychotropic medications (medication capable of affecting cognitions, emotions and behaviour) fall into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers. Antipsychotic medication can be given orally (in tablet or liquid form) or by intramuscular injection (depot) at prescribed intervals e.g. weekly / monthly. Depot medication can be particularly useful for those individuals who, for whatever reason, fail to take their medication in a consistent manner and as prescribed.

All prescribed medication should be regularly monitored for effectiveness and unwanted side effects. The most common side effects described for antipsychotic medications are 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and electrocardiographic changes. Side effects can be managed by

changing the dosage, changing to a different type of antipsychotic medication or by prescribing specific medication to address the side effects.

Wherever practical it is good practice to seek the patient's consent to treatment. Consent is defined as '*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent*'[201]

12.5.3.2 Findings of the Independent Investigation

When Mr. Y was seen by the Visiting Consultant Psychiatrist in Bristol Prison in May 2004 she concluded that there was "*No definite evidence of psychotic illness, query auditory pseudo hallucinations*". However given that Mr. Y was reporting some symptoms which were compatible with a psychotic illness she offered a trial of an anti-psychotic medication, Promazine. Given Mr. Y's presentation this was a reasonable course of action. Mr. Y, however, declined the medication.

When Mr. Y was reviewed by the NSSDAS Consultant Psychiatrist in November 2004 he noted that Mr. Y *"….is quite preoccupied by what amounts to delusional beliefs, involving spirits and so forth. Although [Mr. Y] has a problem with emotional instability I do wonder whether he would benefit from a trial of an antipsychotic. I discussed this with him and he declined any such treatment. However I suggested that he thinks about it and I will discuss it with him when he next attends in two weeks time."*[202]

However in July 2005 following his move to Bristol and having been stabilised on prescribed medication for his drug misuse problem Mr. Y agreed to a one month trail of the antipsychotic medication Olanzapine.[203] In August 2005 BSDS asked Mr. Y's GP to take over the prescribing of this medication as BSDS, as a specialist drug service, did not usually prescribe this.[204]

In December 2005 Mr. Y's GP increased Mr. Y's Olanzapine 10mg to 20 mg a day and asked the Staff Grade Psychiatrist in the BSDS to review Mr. Y's mental health. When the Staff

[201] Department of Health (2008): *Code of Practice, Mental Health Act 1983*
[202] Case notes 1.123,2.309
[203] Case notes 2.175, 2.416
[204] Case notes 2.281

grade Psychiatrist reviewed Mr. Y in January 2006 she identified no intensification of his psychotic-like symptom. "*This is despite him discontinuing his olanzapine without supervision about 2 months ago. Of note this coincides more or less with an increase in his methadone dose to 90mgs daily. He has remained on diazepam liquid at a dose of 30mgs daily….. he was adamant that he did not wish to restart antipsychotic medication. In terms of his drug treatment [Mr. Y] appears to be more stable currently and acknowledged this as beneficial to his mental health… For the time being therefore [Mr. Y] and I agreed that he should remain off antipsychotic medication… but I did advise him that as the dose (of methadone) comes down then we may need to reconsider this decision…."*[205]

When Mr. Y returned to Weston-super-Mare in January 2008 the referral letter informed the NSSDAS team "*He also has a history of mental breakdown although his mental state has been stable since engagement with our team. His problems were I believe associated with drug use. He strongly feels that his prescription is enabling him to remain mentally healthy and [Mr. Y] becomes very anxious when talk of reduction arises".*[206]

The NSSDAS Consultant Psychiatrist reviewed Mr. Y in February 2008. He concluded that Mr. Y was not suffering with any first rank symptoms of Schizophrenia but again offered to prescribe anti-psychotic medication for Mr. Y. Mr. Y again declined this offer.[207]

12.5.3.3 Conclusion

Although the consensus opinion for much of the time Mr. Y was under that care of the SDAS teams was that he was not suffering from a psychotic disorder but that the psychotic symptoms he was reporting were a consequence of his drug misuse, the option of prescribing anti-psychotic medication was discussed with Mr. Y frequently, on most occasions when he was reviewed by a psychiatrist. Initially Mr. Y declined this offer. Then between July 2005 and December 2005 he agreed to a trial of Olanzapine. On at least one occasion he reported that he found this to be beneficial. However by January 2006 he had stopped taking medication without discussing this with either his GP who was prescribing at that time or the staff at BSDS.

[205] Case notes 2.267
[206] Case notes 3.63
[207] Case notes 3.59

It was recorded in Mr. Y's notes on a number of occasions that he believed that the medication he was being prescribed in relation to his drug misuse problem, particularly Diazepam, best addressed his mental health problems.

Mr. Y was offered a trial of anti-psychotic medication in response to his reported psychotic like symptoms on a number of occasions. This was a reasonable course of action. When Mr. Y's GP understood Mr. Y to be complaining that his symptoms were worsening he increased his anti-psychotic medication and asked the BSDS Psychiatrist to review his mental state. This again was a reasonable course of action.

The BSDS Psychiatrist noted that Mr. Y had discontinued the anti-psychotic medication and discussed the implications of this with him. She also discussed with Mr. Y the fact that the decision to stop the anti-psychotic medication should be reviewed when any decision to reduce his Methadone or Diazepam was made. Again this was an appropriate and responsible course of action. She also informed the GP of the situation.

Finally Mr. Y was fully involved in all decisions regarding medication, indeed at least with respect to the anti-psychotic medication he chose a course of action contrary to the medical advice he was being offered. This decision was respected by those offering care and treatment to Mr. Y. This was good practice.

12.5.4 Psychological Therapies

12.5.4.1 Context.

The NICE Clinical Guidelines on the treatment of Schizophrenia comments:

"Psychological therapies and psychosocial interventions in the treatment of schizophrenia have gained momentum over the past 3 decades. This can be attributed to at least two main factors. First, there has been growing recognition of the importance of psychological processes in psychosis, both as contributors to onset and persistence, and in terms of the negative psychological impact of a diagnosis of schizophrenia on the individual's well-being, psychosocial functioning and life opportunities. Psychological and psychosocial interventions for psychosis have been developed to address these needs. Second, although pharmacological interventions have been the mainstay of treatment since their introduction in the 1950s, they have a number of limitations. These include limited response of some people to antipsychotic medication, high incidence of disabling side effects and poor adherence to treatment. Recognition of these limitations has paved the way for acceptance of

a more broadly-based approach, combining different treatment options tailored to the needs of individual service users and their families. Such treatment options include psychological therapies and psychosocial interventions."[208]

The Guidance goes on to recommend:
"8.4.10.1 Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase or later, including in inpatient settings."[209]

The NICE Clinical Guidelines on the treatment of depression comments:
"A range of psychological and psychosocial interventions for depression have been shown to relieve the symptoms of the condition and there is growing evidence that psychosocial and psychological therapies can help people recover from depression in the longer-term (NICE, 2004a).....People with depression typically prefer psychological and psychosocial treatments to medication (Prins et al., 2008) and value outcomes beyond symptom reduction that include positive mental health and a return to usual functioning (Zimmerman et al., 2006)".[210] *(p.157)*

The guidance recommends:
"8.11.3.2 For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT)
8.11.3.3 The choice of intervention should be influenced by the:

- *duration of the episode of depression and the trajectory of symptoms;*
- *previous course of depression and response to treatment;*
- *likelihood of adherence to treatment and any potential adverse effects;*
- *person's treatment preference and priorities".*[211]

12.5.4.2 Findings of the Independent Investigation

The NTA's 2006 Model of Care Guidance identified a number of evidence-based psychological interventions that should be available to individuals with moderate to severe drug misuse problems. Similarly as noted above, NICE guidance on both Schizophrenia and

[208] NICE (2009) Schizophrenia: *Core interventions in the treatment and management of Schizophrenia in adults in primary and secondary care.* CG82 p. 244
[209] Ibid p. 274
[210] NICE (2009) *Depression; Treatment and management of depression in adults, including adults with chronic pain.* CG 90 p. 157
[211] Ibid p.298

depression recommend that psychological interventions, CBT based interventions in particular, should be available to individuals experiencing these problems.

Whilst Mr. Y was seen on a regular basis by his Key Worker there was no evidence in his clinical notes to suggest that systematic, evidence-based psychological interventions were undertaken or considered. This was a weakness in the care offered to Mr. Y.

Since the time Mr. Y was under the care of Avon and Wiltshire Mental Health Partnership NHS Trust there have been a number of changes to national drug strategy. In line with these changes the Trust's Specialist Drug Services now emphasise recovery-focused interventions and provide a wider range of structured psychosocial treatments in addition to pharmacological treatment. The service now employs a Clinical Psychologist and a Recovery Support Worker, in addition to a revised mix of nurses and drug / alcohol workers in the multi-disciplinary team.

12.5.4.3 Conclusion

Despite the fact that Mr. Y was identified as: having a drug misuse problem, possibly suffering from a psychotic-type disorder for which he was offered anti-psychotic medication and, on a number of occasions, he complained of being low in mood, there is no evidence in Mr. Y's records that systematic, evidence based psychological interventions were considered to address his needs as best practice guidance recommended. This was a weakness in the care and treatment provided to Mr. Y. However since the time Mr. Y was under the care of the Specialist Drug and Alcohol Teams of the Avon and Wiltshire Mental Health Partnership NHS Trust the model of service delivery employed has changed in line with national policy and best practice guidance. Services now emphasise recovery-focused interventions and routinely provide a range of evidence based psychosocial interventions.

Service Issue 1

Best practice in relation to the treatment of those with moderate to severe drug misuse problems, those with depression, and individuals suffering with schizophrenia all indicate that psychological therapies should be made available to these individuals. Such interventions were not made available to Mr. Y and in this sense his needs and problems were not addressed in accordance with best practice. However it would not be

reasonable to conclude that the absence of such interventions had any direct causal relationship with the events of May 2008.

12.6 Safeguarding

12.6.1 National Context

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

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

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

- Laming (2003, Climbié Report): providing safeguarding recommendations and influencing the future developments in safeguarding guidance and policy;
- Every Child Matters (2003): which responded to the Laming Report and outlined the five key improvement outcomes – be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing;
- National Service Framework for Children: which including a recommendation for Care Programme Approach meetings to take account of children's needs and any risks of harm to them;
- Children Act (2004): which stated that all organisations have a responsibility to prioritise safeguarding and to ensure that effective arrangements are in place;

- Working Together (2006): provided the benchmark for all organisations to ensure that safeguarding arrangements are in line with national requirements.

The 2010 guidance[212] comments:
"1.11 Effective measures to safeguard children are those that also promote their welfare. They should not be seen in isolation from the wider range of support and services already provided and available to meet the needs of children and families."

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

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

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

2.2 …….it is important to emphasise that we all share a responsibility for safeguarding and promoting the welfare of children and young people. All members of the community can help to safeguard and promote the welfare of children and young people, if they are mindful of

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

children's needs and are willing and able to act if they have concerns about a child's welfare…."

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

With respect to mental illness the 2010 guidance observes:
"9.28 …..Mental ill health in a parent or carer does not necessarily have an adverse impact on a child's development. Just as there is a range in severity of illness, so there is a range of potential impact on families…. It is essential to assess the implications of parental ill health for each child in the family. This would include assessment of the impact on the family members of the social, physical ill heath or substance use difficulties that a parent with mental illness may also be experiencing. After assessment appropriate additional support should be provided where needed.

9.30 The majority of parents with a history of mental ill health present no risk to their children. However, in rare cases a child may sustain severe injury, profound neglect, or even die….."

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

services within their area. Consultation, supervision and training resources should be available and accessible in each service.

2.93 To safeguard children of patients, mental health practitioners should routinely record details of patients' responsibilities in relation to children, and consider the support needs of patients who are parents and of their children, in all aspects of their work, using the Care Programme Approach....

2.94 Close collaboration and liaison between adult mental health services and children's social services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm."

Mental Health Issues

Research indicates that the children of parents with mental health problems are more likely to require services and support, are more likely to experience health problems or developmental delay, and may require alternative care. In a few, exceptional, cases mentally ill parents will not be able to care safely for their children and the children may be exposed to abuse if appropriate protection is not available. Falkov's[213] study of 100 child deaths identified parental psychiatric disorder in one third of cases.

The Laming Form

Following the Climbié Report NHS Mental Health Trusts were required to record whether users of mental health services had regular contact with children. The requirement applied to:

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

The form covers a wide range of potential triggers including:

  - drug/alcohol abuse;
  - domestic violence;

[213] Falkov A: Fatal Child Abuse and Parental Psychiatric Disorder. DoH 1996

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

Substance Misuse Issues *Hidden Harm* the report of an inquiry by the Advisory Council on the Misuse of Drugs, was published in 2003. The six key messages from the inquiry were:

- it was estimated there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user;
- parental problem drug use can and does cause serious harm to children at every age from conception to adulthood;
- reducing the harm to children from parental problem drug use should become a main objective of policy and practice;
- effective treatment of the parent can have major benefits for the child;
- by working together, services can take many practical steps to protect and improve the health and well-being of affected children;
- the number of affected children is only likely to decrease when the number of problem drug users decreases."

With respect to drug and alcohol misuse services the 2010 guidance states:

9.39 "To understand how problem drug use can affect parents' capacity to meet the developmental needs of their children is far from simple and it is important not to generalise or make assumptions about the impact on children of parental drug misuse. Consideration needs to be given to both the type of drug used and its effects on the individual; the same drug may affect different people in different ways…….

9.40 Parental problem drug misuse is generally associated with some degree of child neglect and emotional abuse. It can result in parents or carers experiencing difficulty in organising their own and their children's lives, being unable to meet children's needs for safety and basic care, being emotionally unavailable and having difficulty in controlling and disciplining their children….

9.41 Such negative scenarios are not inevitable. A significant proportion of children who live with parents who are problem drug users will show no long term behavioural or emotional disturbance. Some problem drug users ensure their children are looked after, clean and fed, have all their needs met and that drugs are stored safely.
A caring partner, spouse or relative who does not use drugs can provide essential support and continuity of care for the child. Other protective factors include drug treatment, wider family and primary health care services providing support, the child's attendance at nursery or day care, sufficient income and good physical standards in the home."

The 2006 guidance notes
2.96"….. It is important that arrangements are in place to enable child protection services and substance misuse (including alcohol) services referrals to be made in relevant cases. Where children may be suffering significant harm because of their own substance misuse, or where parental substance misuse may be causing such harm, referrals need to be made by Drug Action Teams or alcohol services, in accordance with LSCB procedures. Where children are not suffering significant harm, referral arrangements also need to be in place to enable children's broader needs to be assessed and responded to."

In order to realise the goals of promoting the wellbeing and safety of children and young people the Children Act lays specific responsibilities on the Local Authority.
"Section 10 [of the Children Act] requires each local authority to make arrangements to promote co-operation between the authority, each of the authority's relevant partners…..and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section of the Children Act 2004 is the legislative basis for children's trust arrangements."[214]

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

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

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

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

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

Section 47(1) of the Children Act 1989 states that:
Where a local authority:
a. are informed that a child who lives, or is found, in their area (i) is the subject of an emergency protection order, or (ii) is in police protection, or (iii) has contravened a ban imposed by a curfew notice imposed within the meaning of Chapter I of Part I of the Crime and Disorder Act 1998; or
b. have reasonable cause to suspect that a child who lives, or is found, in their
area is suffering, or is likely to suffer, significant harm:
The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare….."[215]

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

The NTA (2006) Model of Care advises:

"If a service has concerns about the needs and safety of children of drug misusers, local protocols should be followed, for example if there are concerns about risk of significant harms, social services would normally be involved in further assessment of risk. As with comprehensive assessment, risk assessment is an ongoing process and requires integration into care planning. Issues of risk highlight the need for appropriate information."[216]

12.6.2 Local Context

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

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

2.2 *An assessment, using the Trust's ICPA and risk assessment tool, should be made of the impact of the parental mental health difficulties on the adult's ability to protect their children and to parent. In some cases, a joint assessment might be needed with the local Social Services Children and Families Team. If, as a result of the assessment, a child is thought to be vulnerable or at risk of harm, the clinician must discuss the concerns with their Line Manager or Supervisor and the relevant Safeguarding Children Lead. When appropriate, a referral should be made to the relevant Children and Families team (Social Services) and the local LSCB Child Protection Procedures followed."*[217]

[216] National treatment Agency for Substance Misuse (2006), *Models of care for treatment of adult drug misusers: update 2006*. P. 26-27

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

The Trust's Dual Diagnosis Strategy specifically identifies the importance of including the assessment of risk to children when conducting a risk assessment of those with a substance misuse problem:

"Risk assessment should include:…….The risk to children with whom the service user is in contact must also be assessed." [218]

12.6.3 Findings of the Internal Investigation

"10.6 Failure to follow correct child protection procedures

10.6.1 *In addition to the failure to complete the safeguarding children assessment screen there were a number of clear trigger points in the pathway which should have led to a safeguarding children response. In March 2008 when the team were aware that [Mr. Y's] son had moved in with him there was a duty to contact children's services, inform them of the concerns, discuss risk and make a formal referral under S47 (child protection) and S17 (child in need). In April when [Mr. Y] was reporting to the team that he was distressed regarding financial concerns and that he was struggling regarding food there was a clear duty to make a formal referral to children's services again under S47 and S17. In May 2008 when the team was informed that [Mr. Y] was in custody there is no record that they checked on the welfare of the child.*

At each of these points it may be that there was an assumption that other agencies were already involved and that there was no need for further communication, however the national recommendations following the Climbie inquiry were clear on the need for each agency/practitioner to check and act rather than assume that others had done so." [219]

12.6.4 Findings of the Independent Investigation

That Mr. Y had a young son was identified at the time of his initial referral to the Specialist Drug and Alcohol Services. NSSDAS noted Mr. Y's parental responsibilities in its response to this referral commenting: *"if the son was living with [Mr. Y] this would change the category to which he has been allocated*" and asked the GP to *"keep us updated if there are any changes in child care arrangements.*[220] In September 2004 it was noted that Mr. Y, occasionally, looked after his young nephew and nieces.

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[218] Avon and Wiltshire Mental Health Partnership Trust (2010) *Care Programme Approach Dual Diagnosis Procedure*

[219] Avon and Wiltshire Mental Health Partnership NHS Trust (2008) *ROOT CAUSE ANALYSIS REPORT ALLEGED HOMICIDE [Mr. Y]*

[220] Case notes 1.253

There is no evidence in Mr. Y's clinical notes, however, that the staff of NSSDAS sought advice within the Trust or contacted Children's Social Services to discuss Mr. Y's situation and that of his son or to share information, or made a formal referral.

Risk assessment

One of the areas identified in the risk checklist employed by the SDAS is the risk posed by the service user to children. The risk Mr. Y posed was formally assessed, using this Trust's approved checklist, on only three occasions. On each of these occasions he was assessed as presenting a low risk to children although no information is supplied indicating how this conclusion was arrived at. The risk screening tool in use in 2007 stated:

*"AWP **'Safeguarding Children Assessment Screen'** & SDAS **'Parenting Risk screen'** are both to be completed for **all SDAS Service Users** who have **responsibility** for **child care** or **significant contact** with a child."* There is no record in Mr. Y's clinical notes of these devices having been employed to assess Mr. Y's risk to children or his parenting abilities.

In February 2006 it was recorded that Mr. Y had thrown his mother to the ground resulting in her sustaining a head injury. On this occasion Mr. Y's clinical notes record: "*Unresolved situation c/o [Mr. Y's] son…being pulled in two directions"*[221]. In October 2007 Mr. Y reported that his mother's "*responses [to Mr. Y's son] remind him of how she was with him."*[222] In February 2008 Mr. Y complained that his son's clothes were too small and his mother's house, where his son lived, was rarely tidy.[223]

None of these episodes, nor other episodes of domestic violence recorded in Mr. Y's clinical notes, triggered either a more detailed assessment of the risk Mr. Y's behaviour posed to the wellbeing of his son or a referral to Children's Social Services.

Change of living situation and increased parental responsibility

From February 2008 it was noted that Mr. Y's son was living with him as Mr. Y's mother had been admitted to hospital. It was noted that Mr. Y was drinking heavily and, because his benefits had not been adjusted to take into account the fact that his son was living with him,

[221] Case notes 2.258
[222] Case notes 2.275
[223] Case notes 3.53

he was having financial difficulties. Whilst it was recorded on several occasions that Social Services were aware of this situation there is no record of any liaison between the SDAS and Social Services.

12.6.5 Conclusion

From the time of his initial referral to the SDAS it was known that Mr. Y had a young son, that he had parental responsibilities towards him, that he had frequent contact with him and that he, occasionally, looked after his young nephew and nieces.

It was also known that from February 2008 Mr. Y's son was living with him, that Mr. Y was drinking heavily and that he was in strained financial circumstances. In addition there are a number of episodes recorded in Mr. Y's clinical notes relating to domestic violence as well as observations made by Mr. Y that he was concerned for the well-being of his son while he was in the care of his mother. Best practice guidance indicated that this information should have been shared with Children's Social Services and that a formal referral should have been made to them. That this was not done was poor practice.

The Trust had in place clear policies relating to the assessment of risk to the well-being of children and the sharing of information with Children's Social Services. These policies and their associated procedures were not followed in the current case. This was poor practice.

It is often the case that those working in adult services focus their attention on their own clients and are less sensitive to the needs of and their responsibilities toward the children of those clients. In the current case it was noted when Mr. Y's son came to live with him, in February 2008, that Social Services were aware of the situation. However the joint working and sharing of information which the guidance identifies as of central importance to ensuring the safeguarding of children was not evident.

The guidance provided in *Working Together*, in all its versions, emphasises that there is a shared responsibility for ensuring that risks to the wellbeing of children are assessed and appropriately addressed. Amongst other things Section 11 of the Children Act (2004) "*places duties on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children"*.

The Internal Investigation Team commented, when it discussed this issue with the Independent Investigation Team, that the Trust policies at the time clearly indicated that there should be a sharing of information with Children's Social Services and it concluded that if the Trust policy on Safeguarding had been adhered to there were a number of occasions on which a formal referral to Children's Social Services should have been made. The Internal Investigation Team speculated that because staff knew that Social Services were involved with Mr. Y's son they, SDAS, felt that they did not have to take any action. The Internal Investigation Team was clear, however, that the Trust's policy at that time did require a formal referral to be made.

The SDAS staff providing care and treatment for Mr. Y acknowledged that they were aware, when Mr. Y's son came to live with him, that a social worker was involved. However they agreed that there should have been a parenting assessment and a sharing of information.
To give appropriate credit to the clinical staff of the SDAS they have identified this was a weak point in their practice on this occasion and they informed the Independent Investigation Team that they have tried to address this issue and are now more proactive in similar situations.[224]

Lord Laming in his review into the death of Victoria Climbié identified the themes of *"poor co-ordination; a failure to share information; the absence of anyone with a strong sense of accountability."*[225] Similar issues appear to have arisen in the present case. The Independent Investigation Team concurs with the analysis and conclusions of the Internal Investigation: there were a number of occasions when information should have been shared by the SDAS with Children's Social Services, there were occasions when information was available to the SDAS that should have triggered a formal referral to Children's Social Services to assess any risk posed to the well-being of Mr. Y's son, and Mr. Y's ability to carry out his parenting responsibilities should have been formally assessed.

Service Issue 2

Best Practice, local Safeguarding policies and statute require that there is co-operation and sharing of relevant information between health service providers and Children's

[224] Independent Investigation Interview p. 8-9
[225] Cm 5730 (2003). *The Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming*. London: The Stationery Office.Website:www.victoria-climbie inquiry.org.uk/finreport/finreport.htm p.5

Social Services to ensure that children and young people are protected from harm and their wellbeing is promoted. In this case, although appropriate policies were in place to realise these goals, the policies were not followed. The task of the Trust and other relevant partners is now to establish why these policies and the best practice guidance were not followed and to address these issues.

12.7 Service User Involvement in Care Planning

12.7.1. Context

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

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

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

It should be noted that Mr. Y was under the care of the Specialist Drug and Alcohol services not of the Mental Health Services, nevertheless the principles of engaging and individual in identifying his/her needs and planning his/her care hold good and represent good practice for these services also.

12.7.2. Findings of the Independent Investigation Team

User Involvement

The frequency and comprehensiveness of Mr. Y's assessments and care planning has been commented on elsewhere in this report and will not be discussed again here.

With respect to the identification of Mr. Y's problems and needs, two main areas were identified while he was under the care of the Avon and Wiltshire Mental Health Partnership NHS Trust: his misuse of drugs and his psychotic-like symptoms.

Mr. Y himself brought these to the notice of his GP in the first instance and continued to discuss what he perceived to be his needs while under the care of the SDAS. Mr. Y's clinical notes indicate that he was articulate and competent at identifying his needs and discussing these with those providing care.

With respect to addressing Mr. Y's needs, again Mr. Y's clinical records provide evidence that he was able to identify his preferred interventions to address his drug misuse problems and was able to make his views know to those caring for him. Similarly, although throughout much of the time Mr. Y was under the care of the SDAS when he complained of what appeared to be auditory hallucinations, he was fully involved in the discussions about the prescription of anti-psychotic medication, initially declining this when it was offered, later accepting this for a trial period and later discontinuing it of his own volition. The clinicians dealing with Mr. Y respected his decisions relating to anti-psychotic medication and there is no evidence that he was treated in a discriminatory manner when he declined to accept the medical advice he was offered.

12.7.3. Conclusions

The Independent Investigation Team concluded that Mr. Y was fully involved in identifying his needs and in planning how these might be met. It would, however, have been better practice to have had a more regular and planned approach to assessing Mr. Y's needs and the risk he posed, to have had care plans which could be monitored and to have had a formal record of Mr. Y's agreement to these.

12.8 Family Involvement

12.8.1. The National Context

It has long been accepted as good practice that the family and carers of service users should be involved in the assessment and planning of care of those they care for.

In its most recent guidance on the CPA the Department of Health notes:
"To make sure that service users and their carers are partners in the planning, development and delivery of their care, they need to be fully involved in the process from the start. Processes should be transparent, consistent and flexible enough to meet expectations of service users and carers, without over promising or under delivering. Service users will only be engaged if the care planning process is meaningful to them, and their input is genuinely recognised, so that their choices are respected."[226]
Later in the same document it is noted that:
"Trust and honesty should underpin the engagement process to allow for an equitable partnership between services users, carers and providers of services." [227]

The guidance points out that the family and carers should be involved in the assessment and care planning process because they provide a privileged source of information and the implementation of the care plans often requires their co-operations. It continues:
"Mental illness can have a major impact on carers, families and friends as well as on the person with the illness. It may cause social and financial disruption and restrict educational and employment opportunities for both the carer and the person being supported. The demands of caring can also affect the physical and emotional health of the carer……..Their needs can be overlooked by adult services.

Carers… should be identified at the service user's assessment and information provided to them about their right to request an assessment of their own needs. Services should ensure co-ordination of users' and carers' assessments, care and support plans and the exchange of information where agreement has been received to do this. A service user's own caring

[226] DoH (2008) Refocusing the Care Programme Approach *p. 8*
[227] Ibid p.18

responsibilities should also be explored and appropriate support, contingency and crisis plans put in place for the service user as a carer and for the person they care for."[228]

However a review by the King's Fund and The Sainsbury Centre for Mental Health[229] into how well the guidance had been implemented concluded:
"Carers were frustrated and disillusioned with the care their loved ones are given. They felt that professionals did not listen to them and gave little information. They felt that they were not regarded as part of the service users' care; rather they were treated like part of the problem. Their main support came from voluntary organisations." [230]

12.8.2 Findings of the Independent Investigation

Family Involvement

In Mr. Y's clinical notes there is only one record of contact being made with his family. This was in August 2005 when he reported that he had had an argument with his aunt and had beaten her around the kitchen. On this occasion Mr. Y's Key Worker contacted Mr. Y's grandmother, at whose home the argument had taken place. She is reported to have said that the fight was a "*bit of a ruckus*" and she "*did not seem overly concerned*".

In early 2006 Mr. Y was charged with the assault of his mother and, frequently, throughout 2006 and 2007, he complained of having problems with her, that she was causing him stress and distress and at times he indicated that he felt that she was not looking after his son appropriately. However, there is no record that any contact was made with Mr. Y's mother despite the important role she played in his life and the fact that these issues were raised on a number of occasions. Nor is there any record that Mr. Y's permission was sought to approach his family.

12.8.3 Conclusion

While the SDAS did not employ the Care Programme Approach at the time Mr. Y was under its care, as has already been discussed the NTA model of care does advocate that assessment of need should be comprehensive. Input from those who know the individual can provide

[228] DoH (2008) Refocusing the Care Programme Approach p. 25
[229] Warner, L., Mariathasan, J., Lawton-Smith, S., Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health.
[230] Warner, L., Mariathasan, J., Lawton-Smith, S, Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health p.80

invaluable information to enable needs to be accurately identified and the most effective care plans to be put in place.

In particular it is considered good practice to obtain corroborative information when assessing risk; in Mr. Y's case this included risk to himself, violence towards others and risks relating to his son.

While it is perhaps less common for Specialist Drug and Alcohol Services to involve the families of those to whom they are providing treatment than it is for secondary Mental Health services, best practice would have indicated that it would have been beneficial to have involved Mr. Y's family in assessing his needs and planning his care. It was noted on at least one occasion that Mr. Y posed a risk to women and in particular to his mother. It would have been appropriate to discuss this identified risk with her and used this discussion to inform subsequent risk management plans.

Service Issue 3

Despite the important role Mr. Y's family, particularly his mother, played in his life and the fact that a risk assessment in 2005 had identified that he posed a particular risk to women, Mr. Y's family were not involved in identifying his needs, the risks he posed, or in planning his care. Had this been done it is possible that the difficulties he experienced in relation to his family might have been better managed. However it would not be reasonable to conclude that the absence of such involvement had any direct causal relationship with the events of May 2008.

12.9 Communication

12.9.1. Communication

"Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion."[231]

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours cannot be met by one agency alone[232]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticises agencies for not sharing information and not liaising effectively.[233] In 1996 the Department of Health set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required, in its guidance *Building Bridges* (1996).

Within Mental Health Services the Care Programme Approach (CPA) pays a central role in ensuring that service users receive a co-ordinated service, with all those having input into the individual's care sharing an understanding of his/her problems and working to a common set of goals. Communication is key to the CPA and to effective and efficient multidisciplinary and inter-agency team working in general. While good communication is not a guarantor of good clinical care, without good communication between those caring for an individual it is difficult, if not impossible, to achieve efficient and effective clinical care.

12.9.2. Findings of the Internal Investigation

"10.5 Lack of comprehensive communication between agencies

10.5.1 *[Mr. Y] had contact with drug and alcohol services, probation services, children's social services and the voluntary sector through the Salvation Army Hostel. Although there was evidence of informal links between the drug and alcohol services and probation and the voluntary sector there was no evidence of any formal multiagency communication or care planning. At interview the Salvation Army worker [SAW1] was clear that [Mr. Y's] behaviour showed regular underlying paranoid traits. This was not formally discussed with*

[231] Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy,* (2002) Pg.121

[232] Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999). P.144.

[233] Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

the SDAS services as there was no joint care planning. There was no evidence of any communication at any time with the relevant children's services and it was clear from the telephone interview with [SW1] that children's services in Weston were only aware of [Mr. Y's] historic links with drug and alcohol services not that there was ongoing care.

***10.5.2** Although the North Somerset social services were aware that [Mr. Y] had had historic contact with the drug and alcohol services they were not aware that he was a current client of the service at the time that the decision was made that his son would move to live with him in 2008."*[234]

12.9.3. Findings of the Independent Investigation

12.9.3.1. Communication relating to Mr. Y's substance misuse

There are numerous examples within Mr. Y's clinical notes of timely and accurate communication about Mr. Y's drug misuse and the medication being prescribed to address this problem. This included communication between SDAS and Mr. Y's GP(s) and between North Somerset and Bristol Specialist drug and alcohol services.

12.9.3.2. Communication within the SDAS

When Mr. Y moved from Weston-Super-Mare to Bristol in December 2004 there was a full referral letter from the NSSDAS Consultant Psychiatrist to the BSDS. There were also a number of communications between the teams ensuing that Mr. Y's prescribed medication was uninterrupted or that it was not doubly prescribed. However we were not able to identify whether the NSSDAS notes were transferred to BSDS in timely manner.

When Mr. Y was transferred from BSDS to NSSDAS in January 2008 again there was a referral letter briefly outlining Mr. Y's history and his involvement with the probation service. The referral letter notes that Mr. Y "*Has engaged with Probation who he sees every two weeks. This is due to domestic difficulties with his mother who cares for his son.*"[235] A NSSDAS referral form was also completed [236] where under "special risks" it is recorded: "*has a history of domestic violence involving mother."* However it appears that Mr. Y's full

[234] Avon and Wiltshire Mental Health Partnership NHS Trust (2008) *ROOT CAUSE ANALYSIS REPORT ALLEGED HOMICIDE [Mr. Y]*
[235] Case notes 3.63
[236] Case notes 3.67

clinical record was not transferred at this time nor a full background history of the risks Mr. Y presented.

12.8.3.3. Communication with Primary Care

NSSDAS communicated with Mr. Y's, various, GPs on a regular basis. They wrote to them following most consultations and reviews with psychiatrists. These communications usually identified Mr. Y's current medication, his diagnosis, often provided an update on his mental state and current important changes in Mr. Y's living circumstances. BDSD also communicated with Mr. Y's GP while he was living in Bristol but with less frequency and often in response to contact being made by the GP.

12.9.3.4. Inter-agency Communication.

Under the section on Safeguarding we have noted that were a number of occasions on which good practice would have indicated that there should have been liaison between SDAS and Children's Social Services.

Similarly in late 2007 on a number of occasions Mr. Y complained that he was finding it difficult to work with his new female Probation Officer. There was no evidence in Mr. Y's clinical records that there was any contact between BSDS and the Probation Service to discuss this nor the identified risk Mr. Y posed to women and his difficulties in working with them.

More generally, although both BSDS and the Probation Service were working with and seeing Mr. Y on a regular and frequent basis, no mechanism appears to have been established to ensure that important and relevant information was shared and a common plan of intervention was agreed.

Similarly although Mr. Y had been living at the Salvation Army Hostel in Bristol from December 2005 until he moved back to Bristol in January 2008, there is no record of regular planned contact with those who provided him with support at the hostel.

12.9.4 Conclusion

Within mental health services the CPA process, including CPA meetings, provides the mechanism to enable individuals, teams and agencies to communicate with each other on a

regular and planned basis, to engage in joint assessment of the individual's needs, to jointly plan the individual's care and to deliver the agreed care and support plan in a co-ordinated manner. Within the CPA process it is the responsibility of the CPA care co-ordinator to ensure that CPA meetings are held with appropriate frequency, that the relevant players are appropriately involved and that the delivery of the individual's care is co-ordinated. As the Specialist Drug and Alcohol Services did not employ the CPA procedures at the time Mr. Y was under the care of the Trust this mechanism was not available and no alternative mechanism was put in its place. Similarly the role of the key worker in the SDAS teams does not appear to have been that of the care co-ordinator as described within the CPA process.

The focus of the Specialist Drug and Alcohol Services was on drug misuse and addressing this problem. Their communications relating, especially, to the prescribing of substitute medication were appropriate, timely and accurate. However communication with and the co-ordination of care with other agencies was much less robust. There was no mechanism in place at the time, as noted above, to ensure that such communication took place. Of particular concern was the lack of liaison between the Children's Social Services and the SDAS teams. It has to be noted that neither party took the initiative to contact the other. One would have expected this to have taken place at least when Mr. Y's son was returned to his care in 2008.

Clinical Records

Mr. Y's clinical records are of a very variable quality. The recording of needs and risk assessments has been discussed above as has communications with Mr. Y's GP, both about his drug replacement regimen and his mental health. While he was under the care of NSSDAS his clinical notes were well maintained however for a period of around eight months, between November 2006 and July 2007, while Mr. Y was under the care of BSDAS, no entries were recorded in the clinical notes available to the Independent Investigation. This does not reflect good practice.

Service Issue 4

While communication relating to the treatment of Mr. Y's drug misuse was timely and appropriate more comprehensive information relating to his mental state, the risks his posed to himself and others and information relating to the safeguarding of children was variable, at times of poor quality or incomplete and, on important occasions, absent.

There were no mechanisms in place to ensure that there was regular and effective communication between those providing care and support to Mr. Y and no mechanism to ensure that care and support was delivered in a coherent manner. Whilst it is reasonable to assume that better informed care planning and better co-ordination of the delivery of care would have provided Mr. Y with a more efficient, and probably more effective, service it would not be reasonable to conclude that the absence of this contributed directly to the events of May 2008.

12.10 Joint Working: Specialist Drug and Alcohol and Mental Health Services

12.10.1 Local Context

In 2008 the Avon and Wiltshire Mental Health Partnership NHS Trust approved a new Dual Diagnosis strategy. This strategy document reviewed the relevant national policy and good practice guidance and describes how the Trust aims to realise an integrated and "mainstreaming" approach for the treatment of dug misuse.[237]

In the Trust's CPA Dual Diagnosis Procedure document (2010) the care pathway for those with a dual diagnosis is identified as follows:

"Care Pathway framework

"It is important to assess the severity of needs for both mental health and substance misuse, and to ensure the most appropriate service coordinates the CPA treatment package."[238]

The document continues:

"The following approaches have been found to improve and strengthen the care pathway and communication across services in the Trust, and have been incorporated in the Trust Dual Diagnosis Strategy and Action Plan:

- *joint assessments;*
- *attending CPA's;*
- *attending other services' clinical meetings if appropriate;*
- *allocating link workers;*
- *sharing knowledge;*

[237] Avon and Wiltshire Partnership NHS Trust (2008) Dual Diagnosis Strategy - Co-existing Mental Health and Alcohol and Drug Use Problems. p. 4

[238] Avon and Wiltshire Partnership NHS Trust *CPA Dual Diagnosis Procedure.* p.6

- *requesting support;*
- *teaching sessions."*[239]

However while aiming at an integrated "mainstreaming" approach to the provision of services for those with dual mental health and substance misuse problems the policy notes: *"Inappropriate referrals are time consuming and frustrating for both the service user and the service itself. Referral should only be considered when the referrer is confident they have identified the correct service for the individual at the right time.*

Ensure effective screening and detection of dual diagnosis needs is in place.

If mild needs are identified, or the person is not ready to engage with the other service, the worker should continue to monitor, assess risk, offer harm reduction advice, use motivational approaches and maintain optimism for future change."[240] *(P.10)*

12.10.2 Findings of the Internal Investigation

"10.7 Lack of dual diagnosis working

10.7.1 *There was no joint working between the drug and alcohol teams and the adult community mental health services. A clear awareness of the ongoing mental health issues is described by both the Bristol and North Somerset teams. They did not believe that [Mr. Y] would be willing to see additional workers regarding his mental health and psychiatric assessment and prescribing of medication was arranged within the specialist drug and alcohol service. Both teams were clear that if they had felt that it was necessary or if they had needed to consider mental health act intervention that they would have been able to access appropriate input and support from the adult mental health service. Numerous psychiatric assessments were carried out by medical staff employed within SDAS. Whilst this provided a good core layer of assessment there could have been an advantage in accessing more specialist expertise around psychosis.*

In both teams assumptions were made regarding the appropriateness of his religious beliefs and the link to his psychotic symptoms and the associated risk that might have benefited from more mental health input. A more pro-active joint mental health and drug and alcohol

239 Avon and Wiltshire Partnership NHS Trust *CPA Dual Diagnosis Procedure.* p.7
240 Avon and Wiltshire Partnership NHS Trust *CPA Dual Diagnosis Procedure.* p. 10

approach could have assisted in a clearer understanding, monitoring and possibly treatment of his mental health condition." [241]

12.10.3 Findings of the Independent Investigation.

From at least January 2002 it was noted that Mr. Y was reporting mental health problems in addition to his drug misuse problems. As Mr. Y was unknown to either the SDAS teams or the mental health services at this stage, the relationship between his drug misuse and his reported mental health problems was also unknown. On three occasions prior to Mr. Y engaging with the Specialist Drug and Alcohol Services in September 2004 there was discussion between NSSDAS and the local CMHT about conducting a joint assessment. On the first occasion, October 2003, Mr. Y moved to Bristol before the assessment was undertaken. On the other two occasions, January-March 2004 and August-September 2004, after discussion between the two services it was decided that the SDAS would undertake the initial assessment.

12.10.4 Conclusion

That there was liaison between the two services and that a joint assessment was considered was good practice. When the services had more information about Mr. Y by 2004 the decision that the drug and alcohol services should undertake the initial assessment was not inappropriate.

As discussed elsewhere in this report Mr. Y's psychotic-like symptoms were noted by the staff of the SDAS, he was assessed on a number of occasions by psychiatrists in response to concerns about his mental health and he was offered anti-psychotic medication to address his reported problems. At interview with both the Internal and Independent Investigation teams the SDAS staff reported that if they had felt it necessary they could have accessed appropriate help and support from the mental health services. The Internal Investigation concluded, however: "*A more pro-active joint mental health and drug and alcohol approach could have assisted in a clearer understanding, monitoring and possibly treatment of his mental health condition."* The Independent Investigation Team agrees with this conclusion. After his engagement with NSSDAS, in September 2004, there appears to have been no further

[241] Avon and Wiltshire Mental Health Partnership NHS Trust (2008) *ROOT CAUSE ANALYSIS REPORT ALLEGED HOMICIDE [Mr. Y]*

consideration of joint working with the mental health services. Mr. Y continued, throughout the time he was in contact with the SDAS, to complain of mental health problems but other than being offered psychotropic medication no alternative interventions to deal with these problems appear to have been considered. Joint assessment and, possibly, joint working with the CMHT staff who have more familiarity with mental health problems and their manifestations might have proved beneficial to Mr. Y's care.

Service Issue 5

After Mr. Y engaged with the Specialist Drug and Alcohol Services in 2004 no further consideration appears to have been given to working collaboratively with the mental health services to address his reported mental health problems. Although Mr. Y's mental state was competently assessed on a number of occasions, best practice would have suggested that as Mr. Y continued to complain of mental health problems collaborative working with the mental health services should have been considered. Had such a collaborative approach to Mr. Y's problems been undertaken it is probable that alternative and beneficial approaches to Mr. Y's mental health problems would have been identified.

However it would not be reasonable to conclude that the absence of such collaborative working had a direct causal relationship with the events of May 2008.

12.11 The Management of Mr. Y's Care

12.11.1 Context

If a service is to function effectively, each of its component parts must have a clear remit as to its responsibilities, the functions it is to undertake, the services it is to provide, and the client group it is to serve. These parameters need to be set by the organisation in clear and relevant polices.

The Department of Health published *New Ways of Working* in 2007[242]. This required a change to the established team working practice. A successful implementation of *New Ways of Working* required clear multi-disciplinary team management and clinical leadership. These roles were no longer identified with particular disciplines. The purpose of introducing this new policy was to promote patient-centred care and to ensure that the available resources were employed most efficiently and effectively for the benefit of service users. In this sense *New Ways of Working* supported the central role given to the care co-ordinators.

12.11.2. Findings and conclusion

There was a significant delay in assessing Mr. Y and a lack of assertive service delivery in engaging him following his referral to the Specialist Drug and Alcohol Services in 2001. However following his assessment by SDAS in 2004 Mr. Y was well engaged with the service and his drug misuse problems were appropriately and effectively addressed.

A broader, more comprehensive assessment of Mr. Y's needs was absent, however, and, in consequence, the care plans which were put in place for Mr. Y were limited in their scope and quality.

At the time Mr. Y was under the care of the Trust's SDAS this service did not employ the Care Programme Approach and there was no mechanism in place to ensure that assessments, including risk assessments, were comprehensive, undertaken on a planned basis and involved relevant individuals and agencies; nor was there a mechanism to ensure that information was gathered in a single readily accessible place to facilitate a sound understanding of Mr. Y's needs and the risks he posed and monitor the progress he was making.

Similarly there was no mechanism in place to ensure that there was timely and effective communication between individuals and agencies involved in Mr. Y's care and support, or to ensure that important information such as risk information and information relating to safeguarding was communicated efficiently and joint or co-ordinated planning and service delivery could take place.

[242] DoH (2007) Mental Health: *New Ways of Working for Everyone*

Prior to the events of May 2008 Mr. Y was involved in at least three acts of violence. On at least two of these occasions Mr. Y was arrested and charged. These must be regarded as "near misses". However no comprehensive or multi-agency risk management plan was put in place. This was poor practice.

While there was no comprehensive formulation of Mr. Y's needs, as noted, his drug misuse problem was appropriately and beneficially addressed. Similarly his reported psychotic-like symptoms were noted, his mental state was assessed on a number of occasions by several psychiatrists and consideration was given as to the possibility of his suffering from a psychotic disorder. Although the consensus opinion was that Mr. Y's psychotic symptoms were the result of his drug misuse he was offered a trial of anti-psychotic medication. This was appropriate.

However despite his on-going complaints about experiencing auditory hallucinations and some paranoid features there is no evidence that joint working with the mental health services was considered and Mr. Y was not offered any psychological interventions to help address his mental health problems.

From the time of his initial referral to the SDAS it was noted that Mr. Y had a young son with whom he had regular contact. However despite the fact that there were several instances of domestic violence while Mr. Y was under the care of the Trust, the fact that his son came to live with him in 2008 and that the Trust policy indicated that those who have significant contact with a child should be assessed in line with the local Child Safeguarding policy, these assessments were not undertaken and there was no contact with or referral to Children's Social Services. This was a significant failure.

From Mr. Y's clinical notes it would appear that he was fully involved in identifying his needs and planning his care however there is no formal record of Mr. Y's involvement and agreement. Good practice indicates that this should have been done. Mr. Y's family were not, however, involved in the assessment of his need or the planning of his care. This was not good practice.

12.12 Clinical Governance and Performance

12.12.1 Context

'*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*'[243]

NHS Trusts clinical governance systems aim to ensure that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

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

During the time that Mr. Y was receiving his care and treatment the Avon and Wiltshire Mental Health Partnership NHS Trust would have been subject to two main kinds of independent review from the NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation.

The Avon and Wiltshire Mental Health Partnership NHS Trust was registered without condition by the CQC in April 2010. Subsequently the 18 locations from which the Trust delivers its services were reviewed against the CQC's 21 essential care standards. It would be inappropriate to report the details of these reviews here and the reader is asked to consult the Care Quality Commission website for more information. The CQC employs a four-point scale to evaluate the care provided by Trusts: compliant, minor concerns, moderate concerns and major concerns. It was the judgement of the CQC that the Trust was compliant in most of its sites on most of the standards. In its overall review of the Trust the CQC noted minor concerns in relation to three standards: supporting workers, assessing and monitoring the

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

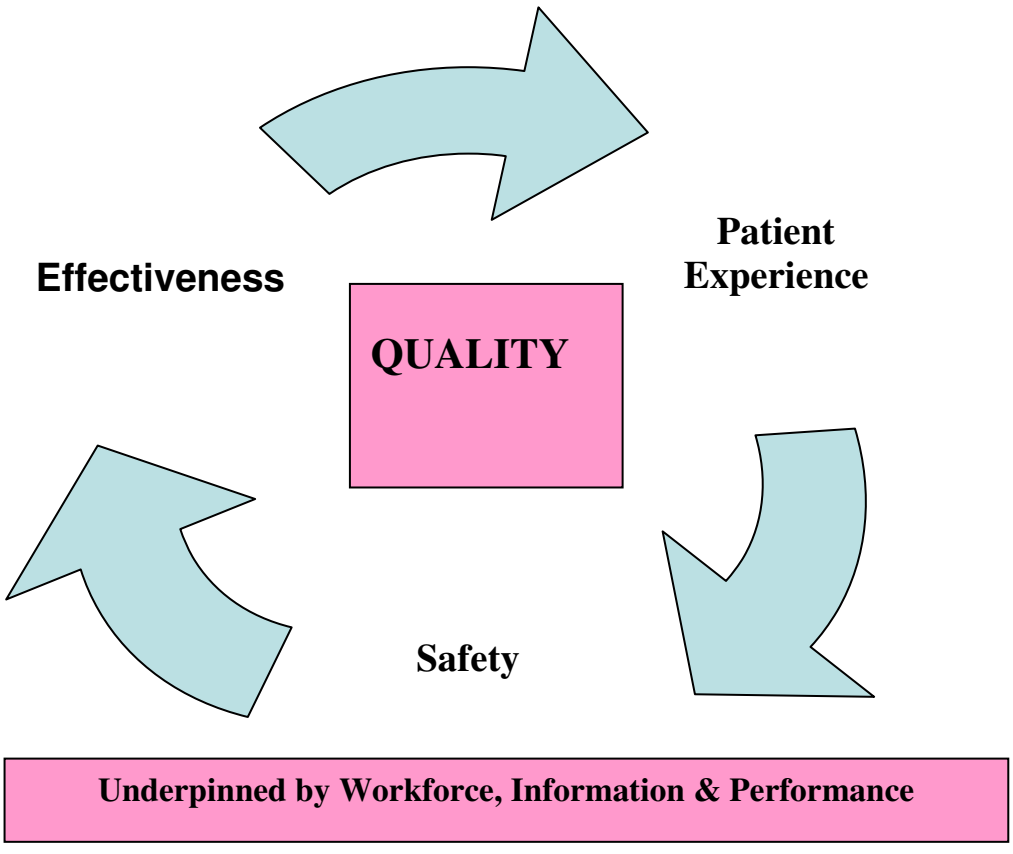
quality of the service provided and record keeping. A moderate concern was identified against the standard: care and welfare of the people who use the service.

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr. H. The issues that have been set out below are those which have relevance to the care and treatment that Mr. Y received.

12.12.2 Findings

12.12.2.1. Clinical Governance Systems and Performance

In 2010 the Avon and Wiltshire Mental Health Partnership NHS Trust put in place a five-year strategy for improving clinical quality. This is based on the integration of three core areas of quality improvement: patient experience, effectiveness and safety. Quality improvement is defined in this strategy document as the combined and continuous process of making the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning). The relationship between these elements is illustrated in the diagram below.



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

- quality metrics that will enable the measurement of quality across the whole spectrum of care;
- the implementation of best practice;
- regular clinical auditing and performance monitoring against national and local standards;
- the identification of ways for service users and cares to receive more personalised care;
- the provision of information on the accessibility and quality of services;
- the delivery of services in a safe environment;
- improving feedback from services users and carers and using that feedback to drive quality improvement;
- staffing, training, support and appraisal and continuous professional development.

The Quality improvement strategy is complemented and supported by a number of other strategies and policies including:

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

The strategy recognises the importance of clinicians and practitioners in improving the quality of clinical care. It recognises that clinicians and practitioners should:

- fully engage with the Trust clinical governance arrangements;
- influence service modernisation and redesign;
- be able to reflect on their practice and actively contribute to quality improvement;

- have access to a full range of educational, training and continuous personal and professional development opportunities.

Engagement with clinical governance arrangements
Each Strategic Business Unit (SBU) has an Integrated Governance Group led by the Clinical Director. Clinicians are involved in local integrated-governance activities and reviews.

The Trust Professional Council, Trust Medical Advisory Group and Trust Nursing Advisory Group are fora that enable clinicians and practitioners to provide professional scrutiny and advice on best practice, clinical effectiveness and service improvement. They also provide support to clinicians.

Service modernisation and redesign:
To ensure clinical involvement and influence in service redesign, the Trust has established Clinical Reference Groups and the Practitioners for Change Forum. These groups enable structured and timely engagement and influence in the modernisation and service redesign process.

Reflecting on practice and contributing to quality improvement:
The Trust approach to quality improvement has led to a number of initiatives:

- the productive ward/team programme enables nurses and practitioners to spend more time on clinical engagement and patient care;
- the Manchester Patient Safety Framework (MapSaF) is being used to help the Trust assess its safety culture;
- an annual programme of Chief Executive and Executive Director led Patient Safety Visits has been established.

Education, training and continuous personal and professional development:
The Trust Learning and Development Policy aims to:

- improve the quality of the service as experienced by users and carers;
- ensure that learning needs are identified in a systematic way linked to service development and organisational priorities;

- promote a philosophy of continuous personal development;
- ensure that the Trust delivers modern and effective services through enabling staff to develop their skills in line with changing national priorities, policy guidance and service development.

Supervision and appraisal processes are identified as important in helping to ensure that staff take appropriate advantage of development options.

Governance and assurance processes and structure

The Trust Board leads and directs clinical quality and its governance. Lead responsibility for scrutinising and assuring clinical quality, safety and performance is delegated to the Quality and Healthcare Governance Committee. The Committee is composed of three Non Executive Directors, the Chief Executive, the Executive Director for People and the Executive Director of Nursing, Compliance, Assurance and Standards. The Committee is also attended by the Trust SBU clinical directors and two representatives from the Professional Council. The Chair of the Committee reports formally to the Board.

The Trust Mental Health Legislation Committee plays a key role in clinical governance. This Committee is composed of two Non Executive Directors and meetings are attended by the Executive Director of Nursing, Compliance, Assurance and Standards, the Mental Health Act Lead, SBU managers, a Social Work Representative, the Mental Health Act and Mental Capacity Act Manager and a Consultant Psychiatrist. The Chair of the Committee reports formally to the Board.

To support continuous clinical quality improvement the Trust has established a number of management groups chaired by Executive Directors which report to the Performance Executive Management Team. The management groups:

- scrutinise and review compliance with core quality and safety standards and outcomes;
- peer review draft policy, guidance, protocol and strategy;
- manage and co-ordinate engagement of Strategic Business Units and relevant corporate leads.

The Strategic Business Units contribute to the clinical governance system by attending the Trust management groups and Board Committees, disseminating good practice, implementing quality improvement plans, coordinating operational activity against set standards, and providing an evidence base of delivery against clinical quality standards.

The Trust has identified the importance of ensuring that it has processes in place that enable the early identification of potential failings in patient care. The Trust's ability to spot the early signs of failings is strengthened by:

- the provision and understanding of regular information on key clinical indicators;
- staff being empowered to engage in management processes, raise concerns and be involved in quality improvement processes;
- service users and carers voices and experiences being heard and shared from Ward to Board.

12.12.3. Adherence to Local and National Policy and Procedure

12.12.3.1 Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[244] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility.

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

[244] Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p. 328

regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance.

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

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

12.12.4 Findings

Quality of Local Policies and Procedures

The Trust has an appropriate set of clinical policies and strategic documents which are informed by both best practice guidance and national guidelines. It is also noteworthy that the Trust's clinical policies are informed by the learning accrued from previous events and investigations.

However at the time Mr. Y was under the care of the Trust, the Specialist Drug and Alcohol Services did not employ the Care Programme Approach process and there was no alternative mechanism in place to ensure that assessment and care planning took place on a regular and planned basis and in response to events in the individual's life; nor was there a mechanism in place to ensure that there was efficient communication between agencies and co-ordinated delivery of care. Similarly while the SDAS did employ a Key Worker system the role of this member of staff appears to have been primarily to meet with the service user and to deliver care, rather than take on the co-ordination function identified for the care co-ordinator in the Care Programme Approach process.

Implementation of Trust Policies

As has been noted elsewhere in this report Trust policies were not always adhered to. In particular the local Safeguarding Policy was not adhered to and as a result there was no contact between the SDAS and Children's Social Services. Similarly although the Trust risk

screening tool required that where an individual had significant contact with children a risk assessment should be undertaken employing *"AWP **'Safeguarding Children Assessment Screen'** & SDAS **'Parenting Risk screen'"***. Although it was known from the time of his initial referral to the service that Mr. Y had regular contact with his son and that his son had come to live with him in 2008 there is no evidence in Mr. Y's clinical records that these devices were ever used.

Again, we have noted elsewhere in this report that communication and the transfer of information was not consistent. Information relating to the treatment of Mr. Y's drug misuse was communicated efficiently but other information, particularly information relating to risk, was not always communicated in a timely manner. It also appears that Mr. Y's clinical records were not always transferred when his care was transferred between teams.

12.12.5 Conclusion

The Trust now has in place an appropriate set of clinical policies informed by Best Practice guidance. At the time Mr. Y was under the care of the Trust, Trust policies were not always implemented in a consistent manner. Although Mr. Y was under the care of the Trust for approximately four years there did not appear to be a mechanism in place to identify and address these lapses.

Service Issue 6

While Mr. Y was under the care of the Trust although appropriate policies and procedures were in place which reflected Best Practice guidance these were not always followed and there was no mechanism available to identify and address this lack of adherence to Trust policies.

13. Findings and Conclusions

13.1 Root Cause Analysis

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

1. **Key Causal Factor.** The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team has concluded had a direct causal bearing upon the homicide that occurred on 6 May 2008. In the realm of mental health service provision it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

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

3. **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 6 May 2008, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

13.2 Key Causal Factors

The Independent Investigation identified no direct causal factors connecting the care and treatment of Mr. Y by the Avon and Wiltshire Mental Health Partnership NHS Trust and the events of 6 May 2008.

The main findings of the Independent Investigation are reported below.

13.3 Conclusion of the Independent Investigation into the Care and Treatment of Mr. Y

The primary aim of an investigation undertaken under the auspices of HSG 94 (27) is to ensure that learning takes place which promotes the development of safer and higher quality services.

When Mr. Y was initially referred to the SDAS he was placed on a lengthy waiting list and it was some time before he was offered an assessment. Perhaps because of this wait, perhaps because of his own ambivalence about addressing his problems and perhaps because of his disorganised life style Mr. Y did not engage with the Drug and Alcohol Service at this stage. The Independent Investigation Team was informed that the service recognised this weakness and has been re-organised with the result that waiting lists are significantly shorter and assessments are undertaken at a much earlier stage in the individual's contact with the service.

Mr. Y was referred to a Specialist Drug and Alcohol Service the focus of which was, appropriately, on addressing the drug misuse problems of its clients. Once engaged with this service Mr. Y's drug use was stabilised and relatively quickly he became illicit-drug free. Mr. Y received an effective service to address his drug misuse problems.

However Mr. Y, like many people presenting to Specialist Drug and Alcohol Services, was reporting a range of difficulties. The weaknesses in the care Mr. Y received can be viewed as a lack of comprehensiveness in both assessing and then addressing these problems. A

mechanism that promoted co-working to address problems that are not the core focus of the services was absent.

Mr. Y consistently reported problems with his mental health. In response he was offered, and on one occasion accepted, a trial of anti-psychotic medication. However other approaches to addressing these difficulties were not explored. While the consensus of opinion was that Mr. Y's abnormal experiences were the result of his drug misuse, his explanation that he used drugs to help him cope with the abnormal experiences was not explored to any significant degree. The strength of multi-disciplinary working and co-working with other teams is that they have a different expertise. One is exposed not just to different ways of addressing problems but also different ways of construing the problem and different views as to what is of importance. Mr. Y's mental health and psychological problems might have been better addressed if a more collaborative approach involving the mental health services had been employed.

Similarly those caring for Mr. Y noted the risks he posed. However this information was not shared in an effective manner. Mr. Y was in contact with the Probation Service and the risks he posed and how these might be addressed would certainly fall within its remit, but again there does not appear to have been a culture of joint working in the SDAS at that time. It is noteworthy that Mr. Y was involved in three assaults while he was under the care of the SDAS as well as a number of fights, with the benefit of hindsight these must be regarded as "near misses". Mr. Y was charged on at least two occasions, so while SDAS might not have been primarily responsible for addressing the risks Mr. Y posed, as they were in regular contact with him, it would have been good practice to have engaged in joint working with the Probation service to attempt to understand this problem and agree how it should be addressed.

A similar lack of joint working appears to have been the case with regard to safeguarding. It was known that Mr. Y was in regular contact with his son, he informed the SDAS when his son came to live with him in 2008 and the SDAS were aware that Children's Social Services were involved with Mr. Y's son. No contact was made with Children's Social Services, despite the fact that the local Safeguarding policy indicated that contact should have been made. Again a culture of joint working was not evident.

The NTA model of care talks about the importance of comprehensiveness. The formal assessments of Mr. Y's needs were not comprehensive, however, the staff of the SDAS were aware of Mr. Y's needs. There was no system in place, however, which facilitated translating these observations into comprehensive care plans and supported joint working with other services such as: Mental Health Services, Probation and Children's Social Services.

If lessons are to be learned, then it is important that the service reflects not so much on what went wrong but rather why it went wrong. In the present case it would appear that there was not a culture of co-working and no mechanism in place to support comprehensive assessment and care planning and no mechanism which supported the joint delivery of services and care plans.

14. Response of Avon and Wiltshire Mental Health Partnership NHS Trust to the Incident and the Internal Investigation

The following section sets out the response of Avon and Wiltshire Mental Health Partnership NHS Trust to the events of 6 May 2008.

14.1 The Trust Serious Untoward Incident Process

At the time of the incident the Trust had in place a clear Serious Adverse Incident Policy and Procedure. This set out the actions to be taken following a serious incident, who should be involved, the time scales, the methodologies to be employed and guidance on contacting and supporting families. The policy required a Management Investigation to be completed by the Locality Manager/Speciality Manager within 72 hours. A template for completing this report was provided.

As required by the Trust policy a Management Investigation report was completed. The report identified that as both the NSSDAS Consultant and the Service Manager were on leave at the time of the incident there was a lack of awareness amongst staff on the procedures to be followed. However, on his return from leave the Consultant Psychiatrist initiated the appropriate response. The relevant officers within the Trust were informed of the incident on 3 June 2008 and the 72 hour report was completed on 6 June 2008. It contained a record of the actions of Trust staff up to and including 6 June 2008. The report also noted that a plan had been put in place to raise the awareness of the staff as to how they should respond when a serious untoward incident occurred. This was good practice and an example of reflective practice and learning.

The incident report contains an excellent time line, which is all the more impressive given the short time the author had to construct it. It also contains a succinct history of Mr. Y.

The Trust's Serious Adverse incident policy advises that the service user and, where appropriate, his/her family should be contacted following a serious untoward incident. Where appropriate an apology should be given. The service user and his/her relatives should be

informed that an investigation will be undertaken and an explanation provided as to how this will be conducted. Agreement should be reached with the service user and his/her relatives as to what continued support and information will be provided.

It is noted in the management report that Mr. Y's mother had contacted the service on 9 June 2008 to inform them that Mr. Y had been detained and was in prison. However there is no record within the report of further contact being made or planned as the Trust policy required.

14.2 The Trust Internal Investigation (Structured Investigation Report)

14.2.2 Terms of reference for the Internal Investigation

The Internal Investigation report did not record the terms of reference for the Investigation, instead it reported the aims of an Investigation employing the Root Cause Analysis (RCA) methodology as follows:

"4.1 Root Cause Analysis (RCA) is one method for objectively determining the underlying, as well as the immediate, causes of patient incidents, so enabling staff and management to learn from and avoid similar incidents in the future

4.2 It seeks to do the following in sequence

- *Scope the incident gaining as much information as possible;*
- *Generate hypotheses about why the incident happened (the immediate cause);*
- *Investigate hypotheses;*
- *Determine if there were any Care Delivery Problems (CDP's) including any missing or inadequate safeguards;*
- *Determine if there were any Service Delivery Problems (SDP's) including any missing or inadequate safeguards;*
- *Identify the factors contributing to the identified CDP's and SDP's;*
- *Analyse the contributory factors to determine if the event would have happened if the factor had not been present. Any factors where the answer is "no" are considered to be root causes;*

- *Make recommendations aimed at ensuring the identified root cause(s) cannot become root causes for another incident. The recommendations will aim to improve or implement safeguards."*[245]

When discussing this issue with the Internal Investigation Team they reported that at the time this investigation was undertaken it was the custom to use generic terms of reference informed by the RCA methodology. While the RCA methodology is a widely accepted and employed methodology, it is a methodology for collecting and analysing data and does not, itself, identify the questions to be addressed by an investigation. It is better practice to draw up the terms of reference for each investigation in such a way that specific and relevant questions, pertinent to the situation under investigation, are identified and stated clearly.

14.2.3 Investigation Team

The Internal Investigation Team had originally been made up of three senior members of the Avon and Wiltshire Mental Health Partnership NHS Trust staff however before the investigation got under way one member of the team had to withdraw. Both of the remaining members of the Investigation team were experienced senior clinicians who had been trained in the use of the RCA methodology and had experience of conducting investigations into a serious incident.

The Investigation Team had experience of both Mental Health Services and Specialist Drug and Alcohol Services and as such were well equipped to undertake the investigation.

14.2.4 Methodology

As noted above, the Internal Investigation Team employed the RCA methodology. They identified a number of hypotheses which they tested as part of the investigation, although they did not feel that they could reach a definitive conclusion at that time as Mr. Y's trial had not taken place and the team were unaware of the information that would be presented and the decision that Court would arrive at. They independently identified the themes which needed to be explored and arrived at a consensus position.

[245] Internal Investigation Report

The Investigation Team interviewed relevant clinical Trust staff, Mr. Y's Key Worker from the hostel in Bristol and a Social Worker from the Social Services' Children and Families Department. This was good practice. They had intended to interview Mr. Y's Probation Officer however this did not prove to be possible.

The Internal Investigation Team had intended to speak to Mr. Y's family and involve them in the investigation but they reported that no contact details for Mr. Y's mother were available and so they were unable to speak to her. We have commented elsewhere in this report about the lack of contact between those providing care and support to Mr. Y and his family.

Similarly the Internal Investigation Team reported that they were unable to obtain contact details for the victim's family.

The Internal Investigation Team reported that no resources e.g. time or administrative support, were allocated to the team when undertaking this investigation. Perhaps in part because of this no archive of the Investigation was created for future reference.

14.2.5 Conclusion

The Internal Investigation was very competently conducted employing an accepted methodology and adopting a client centred approach. The families of the victim and of Mr. Y were not involved in the investigation. The Internal Investigation Team were aware that it was good practice to involve the families but were unable to do this because of a lack of contact details. In part, this reflected the lack of family involvement by the clinical teams caring for Mr. Y and in part, perhaps, a lack of co-operative working with the police in the spirit of the Memorandum of Understanding (2006).[246]

No resources were allocated to support the Internal Investigation Team and no Investigation archive was created. The Trust may wish to review this situation.

[246] Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006.

14.2.6 Findings of the Internal Investigation

The Internal Investigation Team identified seven contributory factors and two service issues:

- *"Lack of assertive approach to failure to attend appointments or regular moves between areas;*
- *Failure to follow trust policy regarding risk screening, assessment and management and failure to maintain risk records that adequately captured and communicated all known risk factors;*
- *Lack of comprehensive communication between agencies;*
- *Failure to follow correct child protection procedures;*
- *Lack of dual diagnosis working;*
- *Failure to follow trust policy regarding transfer of patient records;*
- *Failure to record details of next of kin in the care records…;*
- *Failure to maintain adequate service capacity to ensure that service users are seen and assessed rapidly;*
- *Lack of appropriate crisis services for worsening mental health issues."* [247]

14.2.7 Recommendations of the Internal Investigation

The Internal Investigation Team made the following recommendations:

"14.1 Risk assessment

14.1.1 *The trust policy on risk assessment contained within the ICPA and risk assessment policy is very comprehensive. All staff should adhere to this policy. It already provides clarification of its application for SDAS service users who are not subject to ICPA.*

14.1.2 *Risk assessment needs to be informed by a good understanding of the substance use, history and any adverse or potentially serious incidents and information from carers and others. Risk chronologies should be regularly updated and used in risk assessments.*

14.1.3 *Risk management plans should be completed with specific interventions in the care plan targeted at all identified risks.*

14.1.4 *The parental risk assessment to be completed by teams when appropriate as described in the SDAS clinical governance guidance.*

247 [247] Internal Investigation 3.7

14.2 Interagency communication

14.2.1 *If multiple agencies are involved there should be formal and documented multiagency meetings and care plans. Changes in risk or other circumstances should be communicated to all agencies involved.*

14.3 Child Protection

14.3.1 *All teams to review staff attendance at statutory child protection training.*

14.3.2 *Guidance to be reissued regarding existing joint working protocols with children's services.*

14.4 Dual diagnosis working

14.4.1 *The Trust has committed to a wide ranging dual diagnosis strategy. This should be implemented as rapidly as possible.*

14.4.2 *When SDAS teams are working with clients with long histories of psychological and psychiatric symptoms there should be ongoing discussion of these cases with mental health services even if the client is perceived as not willing to engage with these services.*

14.5 Transfer of patient records

14.5.1 *Trust policy directing that the full records transfer within five days when a service user transfers teams should be implemented and audited."* [248]

These recommendations were appropriately drawn from the evidence the Internal Investigation reviewed and the findings it arrived at.

Conclusion

The Independent Investigation Team is in agreement with the findings of the Internal Investigation and has concluded that these are soundly based. Given that Mr. Y had not been tried at the time that the Internal Investigation took place and the Internal Investigation team

[248] Avon and Wiltshire Mental Health Partnership NHS Trust (2008) *ROOT CAUSE ANALYSIS REPORT ALLEGED HOMICIDE [Mr. Y]*

did not have any detailed information relating to the offence they did not feel it appropriate to reach a conclusion as to whether there was a root cause, in the sense that this term is used in RCA. However they did identify a number of contributory factors with which the Independent Investigation Team agree.

Similarly the Independent Investigation Team concluded that the recommendations made by the Internal Investigation team were appropriate and soundly based on the findings of the Internal Investigation.

14.2.8 The Trust's Response to the Internal Investigation's Recommendations.

In response to the recommendations of the Internal Investigation the Trust drew up an action plan. This action plan was informed by the recommendations of the Internal Investigation into the care and treatment of Mr. Y and also by the recommendations of other investigations which had taken place around that time, so that a thematic and co-ordinated approach to service improvement could be adopted. This was an appropriate response.

The actions identified by the Trust and the progress made towards realising these are set out in the table below.

Recommendations	**Agreed Action**	**Work Completed**	**Actions Outstanding**
If multiple agencies are involved there should be formal and documented multiagency meetings and care plans. Changes in risk or other circumstances should be communicated to all agencies involved.	Check that Trust policies and multi-agency safeguarding procedures are consistent with this recommendation.	The ICPA Policy has been further developed to reference and deliver these recommendations within the new policy to manage care pathways and risk and the relevant PDG's. Information sharing protocols are in place across a wide range of safeguarding processes.	None.

Recommendations	Agreed Action	Work Completed	Actions Outstanding
Risk assessment needs to be informed by a good understanding of the substance use, history and any adverse or potentially serious incidents and information from carers and others. Risk chronologies should be regularly updated, collating an accurate and comprehensive chronology in respect of all relevant aspects of risk. Up to date risk chronologies and risk information from previous episodes of treatment should be incorporated in current assessment of risk.	Suggested revision to recommendation from SDAS Governance 22 Jan 2009. Review ICPA Policy to incorporate this recommendation.	The new templates for the policy to manage care pathways and risk meet this recommendation, and are included in the assessment and specialist assessment templates and relevant PDG's (32).	Implementation of the new policy to manage care pathways and risk and templates now complete.
Risk management plans should be completed with specific interventions in the care plan targeted at all identified risks.	Review ICPA Policy to incorporate this recommendation.	The ICPA Policy has been further developed to reference, re-enforce and deliver these recommendations within the new policy to manage care pathways and risk and the relevant PDG's.	Implementation of the new policy to manage care pathways and risk now complete.

Recommendations	Agreed Action	Work Completed	Actions Outstanding
The parental risk assessment to be completed by teams when appropriate as described in the SDAS clinical governance guidance.	Draft report reviewed at SDAS Governance Safety meeting on 22nd January 2009. A number of suggested changes were proposed to the draft report recommendations. This included an additional recommendation in respect of safeguarding: "14.3.3 A revised 'SDAS Safeguarding children assessment' should be developed, which accords with national guidance and best practice and combines the existing 'AWP Safeguarding children risk assessment' with the existing 'SDAS Parenting Risk screen'." SDAS should ensure that staff have access to appropriate training, advice and supervision in respect of safeguarding issues, and the impact of substance misuse on parenting.	SDAS have revised the safeguarding risk assessment as recommended. This is currently being piloted and will be reviewed in 3 months time. The revised "SDAS Safeguarding children assessment" incorporates detailed guidance to staff regarding safeguarding children procedures, and where to seek further guidance when necessary. An SDAS Governance Seminar on Safeguarding Children was held in Feb 2009. All the documentation has been developed and training held in April 2009 for managers with practitioner training completing by autumn 2009.	None.

Recommendations	Agreed Action	Work Completed	Actions Outstanding
Teams need adequate administrative resources to ensure that records are kept properly and information and communication flows are maintained efficiently. Administrative responsibilities need to be allocated differently to ensure adequate monitoring so that if risk screens, assessments etc are not completed there is a method for flagging this which does not rely on a (sole) practitioner. The Trust needs to develop models for the competencies and skills it requires in different types of teams. These should include skills in the assessment and management of dual diagnosis, formulation skills and motivational enhancement techniques are appropriate.	Capable Team approach and care process approach which is being lead by the Director of New Ways of working is examining all acute adult care processes and enabling Teams to better understand their administrative and other skills and competencies.	No outstanding work as all of these areas as now included in redesign.	
Trust policy directing that the full records transfer within five days when a service user transfers teams should be implemented and audited.	Rather than audit, SDAS and other SBUs work with AWP Records Management service to establish systems which both ensure this happens and monitors compliance on an ongoing basis.		Discuss at CIOG on 16th February, and follow up as appropriate at Operations Directorate Meeting or Joint Operations Group

Recommendations	Agreed Action	Work Completed	Actions Outstanding
Details of the next of kin, or a specific refusal to share these details should be documented in the care record.	Amend documentation pro formas as necessary to prompt practitioners to request and record this, or to record refusal to share this information (and possibly, reason given).		Discuss at CIOG on 16th February, and follow up as appropriate.
The trust has committed to a wide ranging dual diagnosis strategy. This should be implemented as rapidly as possible.	To be taken forward through Dual Diagnosis Steering Group.	This strand of work is picked up in other recommendations.	None.
When SDAS teams are working with clients with long histories of psychological and psychiatric symptoms there should be ongoing discussion of these cases with mental health services even if the client is perceived as not willing to engage with these services.	Substantial detail to be added to this recommendation suggested by SDAS Governance 22 Jan 2009. To be reviewed by CIOG 16 Feb '09. This strand of work is picked up in implementation of Dual Diagnosis Strategy Action Plan through Dual Diagnosis Steering Group, highlighted in other recommendations.	This strand of work is picked up in other recommendations.	None.

Recommendations	Agreed Action	Work Completed	Actions Outstanding
All teams to review staff attendance at statutory child protection training.	Managers to monitor staff completion of mandatory CP training, review competence through supervision and appraisal and agree learning opportunities to meet competence development requirements.	AWP staff training matrices have been reviewed and are published on AWP intranet. Appropriate training is available to staff as required Systems are in place which enable managers and supervisors to monitor uptake of training, and staff training requirements and gaps, via Managed Learning Environment on an ongoing basis.	None.
A revised 'SDAS Safeguarding children assessment' to be developed, which will combine the existing AWP Safeguarding Children risk assessment with the existing "SDAS Parenting Risk screen" in line with national guidance and best practice.	Agreed actions appear under earlier recommendation.		None.

Conclusion

The recommendations made by the Internal Investigation are addressed in the Trust action plan. The emphasis in the action plan is on revising policies and providing training for staff. While this is an important response to the recommendations, the Trust might make explicit how it assures itself that the proposed actions realise the desired improvements in patient care and clinical services which prompted the recommendations.

14.2.9 Notable Practice Identified by the Internal Investigation

- *"[Mr. Y] was well supported and maintained in treatment by SDAS for several years leading to marked improvements in his mental health and abstinence from top up drug use. Good working relationships were maintained with the client by several key workers and psychiatrists.*
- *Good assessment documentation and care plans were maintained by both teams during this period.*
- *Good handover of care and prescribing in moves from North Somerset/Bristol – both ways despite at times extremely precipitous moves by [Mr. Y].*
- *Thorough forensic assessments and forensic history were undertaken by Prison Mental Health Services."*[249]

14.3 Dissemination and Staff Involvement

Both the Internal Investigation Team and staff of the Specialist Drug and Alcohol Service interviewed by the Independent Investigation reported that following the Internal Investigation the findings were fed back to the clinical teams who had the opportunity to discuss these with the Investigating team. The clinical staff had the opportunity to reflect on the findings of the investigation and instituted a number of changes in practice ahead of an action plan being developed. Such reflective practice is commendable. It is important, if services are to improve, that the clinical staff own the changes and feel that they effectively address any weakness that have been identified in an investigation. The process adopted in this case appears to meet these requirements.

The recommendations of the Internal Investigation were passed to the Specialist Business Unit (SBU) and were combined with the findings of other investigations to produce a comprehensive action plan. The clinical staff interviewed were not aware of any actions or changes that took place as a direct consequence of this Internal Investigation but were aware of a number of changes that have taken place, some as a result of the recommendations of

249 [249] Internal Investigation 12.1

Internal Investigations and some as a result of changes in the commissioning of drug and alcohol services.

14.4 Staff Support

15.4.1Context

The Trust's Serious Adverse Incident policy [250] recognises that members of staff can be detrimentally affected by adverse incidents.

"11.2 The Trust recognises that staff can be deeply affected by adverse events and may require debriefing either as part of a team or personally. The level of support staff required will vary between individuals. Managers should be proactive in supporting staff."

14.4.2 Staff support during the Independent Investigation

The Trust worked with the Independent Investigation Team to support staff in practical ways to ensure that:

1. information was sent, and received, to advise each witness what was expected of them;
2. information was sent, and received, regarding the purpose of the investigation;
3. support was given if required in the writing of a witness statement;
4. witnesses received support during the day of their interviews and had the offer of a debriefing session afterwards;
5. witnesses received the opportunity to attend a findings workshop at the end of the process.

14.4.3 Conclusion

The staff interviewed by the Independent Investigation did not comment on the support they had received either following the incident in May 2008 or during the Internal Investigation. However they were positive about the opportunity they had been afforded to discuss the findings of the Internal Investigation and found this a constructive experience.

[250] Avon and Wiltshire Mental Health Partnership Trust (2006) *Serious Adverse Incident Policy and Procedure*

14.5 Being Open

14.5.1 Context

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006[131]. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who have been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done[132].

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers the guidance is entirely transferable when considering any harm that may have occurred to members of the public, in particular the families of the victims, resulting from a potential healthcare failure.

144 5.4 Findings

The Trust had in place a *Being Open* policy which reflected the national guidance.

Following the events of May 2008 the Trust reported that it was unable to contact Mr. Y's mother as her contact details had not been recorded in Mr. Y's clinical notes.

The Trust's current *Being Open* policy acknowledges that "*The needs of those adversely affected by the actions of someone with a serious mental health problem – 'victims' in the widest sense of the term – also need to be taken into account in the* Being Open *process.*"[251] Although the policy in operation in 2008 did not explicitly identify this responsibility those undertaking the Internal Investigation were aware that it was good practice to contact the families of the victim and the perpetrator of the homicide they were unable to access the contact details of either.

The wife of Mr. Y's victim spoke to the Independent Investigation team. She described the effect of her husband's killing on her and her family. She feels that the consequences of her husband's death should be acknowledged as part of the Investigation. Mr. H's wife was a witness to her husband's killing. She experienced very considerable emotional distress and has, at times, felt that life was no-longer worth living. She has had to move her home, as she could no longer live in the place where her husband was killed. This has caused significant disruption to her life, and has resulted in significant distress, practical difficulties and financial hardship.

Initially Mr. H's wife received support only from the Police. Following Mr. Y's conviction she received support from the Victim's Liaison Service. However up to the time of preparing this report the only care and support she had received from the NHS was a referral by her GP to a Primary Care Counsellor. She found that this did not meet her needs and, because of its limited scope and the relative infrequency of her appointments, served to increase her distress.

15.5.4 Conclusion

In 2008 the Trust had in place a *Being Open* policy which reflected national guidance. This policy did not explicitly identify the duty of care that the Trust owed to those affected by the actions of those under its care. This responsibility is identified in the current policy although the requirement to provide or facilitate the provision of care or support is not made explicit.

Those conducting the Internal Investigation were aware that it was good practice to contact and, as far as was appropriate, to involve the families of both the victim and the perpetrator.

[251] Avon and Wiltshire Mental Health Partnership NHS Trust (2010) *Being Open* p .23

They were unable to do this because the details of Mr. Y's mother had not been recorded in his clinical notes and, as Mr. Y's victim was not a service user the Trust had no contact details for his family.

The degree of distress and hardship experienced by Mr. H's wife have not to date been acknowledged and addressed by the NHS.

There are several points of learning to be identified here.
Contact details of the service user's next of kin and/or family should be recorded in the individual's clinical notes.

Where a serious incident occurs it would be appropriate for the Trust to liaise with the police, in the spirit of the Memorandum of Understanding. The police might facilitate communication with the victim's family. The Trust could then acknowledge the distress that the family is experiencing, in line with the *Being Open* policy, and offer to provide or facilitate the provision of care and support and involve them, appropriately, in any ongoing investigations.

15. Commissioning

15.1 Structure of Commissioning

Prior to October 2011 three Primary Care Trusts (PCTs): Bristol PCT, North Somerset PCT and South Gloucestershire PCT commissioned mental health services from the Avon and Wiltshire Mental Health Partnership NHS Trust. South Gloucestershire PCT acted as lead commissioner for mental health services. In October 2011 a new commissioning cluster, made up of these three former PCTs, was brought into being. This is now responsible for commissioning mental health services for this geographical area.

The commissioners in North Somerset reported that they had a good relationship with the Trust staff. There were regular meetings between commissioners and the Trust, particularly with the local managers. One result of this has been the development of local services which address local needs.

NHS Bristol has expressed concern that that there is poor co-ordination between Trust services and other services in Bristol, with whom they interface. Two reasons were suggested why this might be the case:

Services for many statutory agencies in Bristol are organised on a three-layer model: the City, areas, neighbourhoods. The Trust's services are not organised on this model with the result that there is a lack of co-terminosity. It was speculated that this inhibits the joint development of services and the development of relationships which foster collaboration, information sharing and continuity of care.

It was also observed that those outside the Trust found its management structure difficult to understand and because the Trust has its base in Chippenham it is experienced as being remote and difficult to engage with.

In October 2011 NHS Bristol, North Somerset and South Gloucestershire published the results of an engagement exercise.[252] This document noted that concern had been expressed about the quality of mental health services in Bristol. Amongst other things the consultation exercise identified that service users and referrers wanted more a locally integrated service with easier access.

In November 2011 a paper was presented to the Board of Bristol PCT, North Somerset PCT and South Gloucestershire PCT entitled "*Modernising Mental Health Services in Bristol*". This noted that: "*Whilst Avon & Wiltshire Partnership NHS Trust (AWP) has demonstrated some areas of good performance, the analysis of the Quarterly Performance reports and the Care Quality Commission ratings appear to corroborate many of the concerns raised in the stakeholder Engagement Process*." Amongst the concerns identified were the performance of the Crisis Teams, waiting times, staff issues and referrals and the Care Plan Approach.

The paper commented: "*In building the model [of mental health service provision], we will not be taking current services and trying to fit them into a new model but instead we will define what is required to meet the needs of service users in each pathway. The details of the service model will be worked out as part of the project's next phase, with commissioners from both health and social care, clinicians, GPs and service users*."

The identified aim of the paper was to: "*ask for the Board's approval of the option to re-commission the majority of services of secondary care mental health services in Bristol, which are provided by Avon & Wiltshire Partnership NHS Trust."* It concluded with the recommendation: "*To Tender (or accredit providers) for locally accountable provision of citywide care pathways, delivered in three GP localities, flexibly responding to each individual and locality's distinct needs*."

15.2 Governance

Commissioners are responsible for monitoring that the services which they have commissioned are delivered and for assuring the quality of those services. As has been noted above a major review of the provision of mental health service is taking place in Bristol and, amongst other things, this review place emphasises the importance of collaborative working.

[252] NHS Bristol, North Somerset and South Gloucestershire (October 2011) *Engagement Exercise into Mental Health Services*

This review will no doubt impact of the way services are delivered by the Avon and Wiltshire Mental Health Partnership NHS Trust in other localities and the paper presented to the Board notes the importance of liaison and co-operation between commissioners. To comment on this review and the proposed remodelling of services in Bristol is beyond the scope of this Independent Investigation and we will limit our comments to one particular aspect of governance that is pertinent to the current case.

Following a serious adverse incident, as part of their governance and assurance role, commissioners of services should ensure that investigations take place in a timely manner, that these are of an acceptable quality, that they result in action plans which ensure that services are safe, fit for purpose and meet identified quality standards and current best practice guidance. The commissioners also have a role to play in ensuring that the action plans are implemented and monitored.

When the Independent Investigation Team spoke to representatives of NHS Bristol and NHS North Somerset the policies and protocols relating to the monitoring of investigations were not available, due to changes of personnel and reorganisations of the commissioning body, and to date the Independent Investigation has not been able to review these.

16. Notable Practice

It is perhaps the nature of an Investigation that its emphasis is on things that can be improved and, in consequence, the reports of such Investigations can appear somewhat unbalanced and overly critical. Although the current report, too, focuses on what might be improved this is not to be read as indicating that good practice was not also present. The Independent Investigation Team noted a substantial amount of good practice and commitment by those involved in the care and support of Mr. Y.

16.1 The interventions Mr. Y received relating to his drug misuse were effective. Communication relating to Mr. Y's prescribed medication was consistently timely and accurate and staff worked in a flexible manner to ensure that Mr. Y received his medication.

16.2 Although all information was not communicated in a timely manner when Mr. Y was transferred between the North Somerset and Bristol teams there was good liaison between the teams ensuring that there were no gaps in the service provided to Mr. Y.

16.3 There was generally good communication between the Specialist Drug and Alcohol Services (SDAS) and Mr. Y's GPs. There are a number of examples in Mr. Y's clinical notes of timely and responsive communication between the SADS and Mr. Y's GPs.

16. Lessons Learned

There is a tension in the delivery of health care. While each functional team must have a clearly defined and commissioned set of services it is required to deliver, it must also be patient centred, and its assessment and the care it delivers should strive to be comprehensive.

In the current case, Mr. Y was referred to a Specialist Drug and Alcohol Service and this service delivered its core service efficiently and effectively. Mr. Y however, like many who are served by such services, had a collection of need that went beyond the core remit of the service. The Trust, in its Dual Diagnosis strategy, observed that it is a waste of resources to constantly refer service users between services. The challenge for those in both mental health services and specialist drug and alcohol services is that the boundaries between mental health and substance misuse problems are not fixed and the relationships between these two sets of problems is often dynamic.

What is the solution? Robust comprehensive assessment is the foundation for the provision of a good service. After this the essential requirement is a culture of co-operation and flexibility. A culture which promotes the timely sharing of appropriate information and collaborative working ranging from consultation though joint assessments to the joint delivery of services.

It is unlikely that exhortation to realise this way of working will be enough. Most clinicians would want to work in this way but the demands made on their time make it difficult. A process or mechanism which underpins this way of working is required. In mental health services the Care Programme Approach (CPA), when it is properly implemented, fulfils this role. In services that do not employ CPA it is important that a similar mechanism is put in place. Its efficacy needs to be regularly monitored. Staff need to be provided with training and supervision to ensure that they use the mechanism to realise the goals of high quality, collaborative and comprehensive care. In the absence of such a mechanism the dangers are: clinical staff will try to address issues that are not properly the remit of the service in which they work and become overstretched; or, because some area of the individual's life is not their responsibility, staff will ignore it and assume that someone else will deal with it. These

approaches will lead either to the individual's care being fragmented or his/her needs not being addressed at all.

18. Recommendations

18.1 Assessment and Care Planning

Access to Services

Contributory Factor 1

Mr. Y was referred to the Specialist Drug and Alcohol services on a number of occasions, by several referrers, most of whom identified that Mr. Y had both substance misuse and mental health problems, between October 2001 and July 2004.

The delays in assessing Mr. Y and in employing a strategy to engage him in services did not reflect best practice. These delays resulted in Mr. Y's needs not being addressed in the most effective manner. However it cannot be concluded that a more timely response by services between 2001 and 2004 would have affected the events of May 2008

The Trust provided the following update:

The Specialist Drug and Alcohol Service (SDAS) has substantially reduced waiting times for services across all services and teams, including North Somerset, since this homicide occurred.

North Somerset is working toward commencing treatment for service users within five days of referral and has established processes to enable this to happen in the majority of cases. However, the service does not have a reliable method of reporting against this goal.
The national standard applicable to drug treatment is for treatment to commence within three weeks of referral. Since 01 January 2010, North Somerset SDAS has commenced treatment for over 90% of service users within three weeks of referral, except for a brief period over the summer of 2010. Since 1 January 2011 all service users in North Somerset have commenced treatment within 3 weeks of referral.

The picture is similar across all SDAS Teams, with 99% of service users commencing drug treatment within 3 weeks of referral over the first 6 months of this financial year, 2011/2012.

The picture, however, is less positive with regard to service users with alcohol problems. Where this service provision is still commissioned from AWP SDAS, differential funding is apportioned to alcohol treatment and service capacity is directed as a priority toward service users with drug problems (although service users who have serious physical health problems or complex needs associated with alcohol dependence would still be offered treatment as a priority). This situation is a consequence of the different national strategies in place to address drug and alcohol problems, and the differences in commissioning that result. The Avon and Wiltshire Mental Health Partnership Trust (AWP) SDAS is no longer commissioned to provide alcohol services in North Somerset.

Recommendation 1

Given the changes in access to Specialist Drug and Alcohol Services the Trust should put in place mechanisms to demonstrate and monitor this improvement.

- **The Trust should develop a reliable and valid methodology for monitoring:**
    - **access to the service;**
    - **commencement of treatment.**

  In the first instance this methodology might collect performance activity in relation to identified goals on an episodic basis. This should be done as a matter of some urgency. The Trust should then look at how it might develop the monitoring of access to and treatment by this service on a more continuous basis.

Recommendation 2

Commissioners should ensure that they are commissioning services in a manner that is consonant with the latest NICE Guidance on the commissioning of alcohol services[253]

[253] NICE (2011) *Services for the Identification and Treatment of Hazardous Drinking, Harmful Drinking and Alcohol Dependence in Children, Young People and Adults: Commissioning Guidance, Implementing NICE Guidance*

Assessment

Contributory Factor 2

Mr. Y's needs and the risks he posed were not assessed with the regularity and responsiveness that best practice would recommend; care plans did not provide a clear formulation on the basis of which Mr. Y's behaviour could be understood and a strategy put in place to address the identified needs; there was no multi-agency involvement in either assessment or care planning and no mechanisms in place to facilitate this taking place. Had this been done it is probable that Mr. Y would have received more comprehensive care. However it would not be reasonable to conclude that this had a direct effect (causal relationship) with the events of May 2008.

The Trust provided the following update:

At the time of Mr. Y's involvement with the Specialist Drug and Alcohol Service, treatment was structured to allow capacity within the treatment system. An initial assessment would be made and treatment commenced. Service users would then be held in a Transition Prescribing Clinic (TPC) whilst awaiting allocation of a keyworker. Whilst being held in TPC, appointments would be limited to one 20 minute medical review (usually with the consultant psychiatrist) and one appointment with a clinic worker per month. Once assigned a keyworker, a more comprehensive review of care would be undertaken, which was designed to identify wider needs and other agencies who should be involved in care planning.

The National Treatment Agency target pertaining to waiting times from receipt of referral to commencement in treatment nationally is three weeks. SDAS has a local target for commencing treatment within five days. The National target is consistently met and the local target is achieved in majority of cases. This is clearly a significant improvement on the situation at the time of Mr. Y's engagement with services, particularly in the earlier episodes.

Since January 2010 the treatment system has been restructured to allow a more responsive and comprehensive service earlier in the treatment episode. The current model in operation allocates service users a keyworker at the outset of treatment, with full responsibility to complete any initial assessments pertaining to risk and safeguarding, tracking involvement with other agencies and formulating a plan of multi agency care early in the treatment episode.

This assessment has been further enhanced by SDAS having developed a standardised set of forms for identifying and recording issues of safeguarding, including full information on all children the service user has contact with as a parent or carer. Additionally the risk documentation has been standardised, both in identifying risks specific to substance misuse, and the use of the RiO risk assessment documentation for wider risk behaviour. This suite of risk related tools are central to an SDAS wide care and risk management training programme, which provided training and skills development in using the tool kit. This also sets out the expectations and requirements for staff in completing the assessment processes.

Care planning has also been restructured to include an International Treatment Effectiveness Project (ITEP) based element which identifies service user priorities, and an electronic element (managed via RiO care plan libraries) that record issues of risk and risk management, and the relevant technologies utilised in evidence based drug treatment. SDAS has developed and delivered Mind Mapping and Birmingham Treatment Effectiveness Initiative (BTEI) training for all clinical staff to enable them to deliver these methods of care planning and delivery to a consistent standard.

The North Somerset treatment services have been undergoing a tendering process: as part of the service reconfiguration in anticipation of the needs of a recovery based service model, SDAS has commissioned a clinical psychology post within the team. Not only does this post allow the service to directly address the needs of complex service users, it also provides training and supervision to enhance the skills of the clinical team in delivering a wider range of psychosocial interventions to a wider group of service users.

Recommendation 3

Given the initiatives and service improvements that have been put in place in the Specialist Drug and Alcohol Services the Trust should put in place mechanisms to assure itself and its commissioners that:

- **all relevant staff undergo appropriate training which is updated on a regular basis;**
- **staff receive appropriate support and regular supervision to enable them to implement their newly acquired skills in a consistent manner.**

The Trust should put in place regular monitoring, including regular audits, to assure itself and its commissioners that:

- **assessments are undertaken and care and risk management plans are reviewed both on a regular pre-determined basis and in response to changes in the services user's life;**
- **care plans include a clear formulation:**
  - **enabling those providing care and treatment for the service user to have a common understanding of his/her needs;**
  - **which provides the basis for treatment interventions;**
- **there is appropriate multi-agency involvement in assessment and care and risk management planning;**
- **care and risk plans are disseminated in a timely manner.**

18.2 Risk Assessment and Management

Contributory Factor 2:

The risk Mr. Y posed to himself and to others was not assessed with the regularity and responsiveness that best practice would recommend; risk management plans did not provide a clear formulation on the basis of which Mr. Y's behaviour could be understood and a strategy put in place to address the risks Mr. Y posed; risk management plans did not set out a clear plan of action as the guidance recommends. Had this been done it is probable that Mr. Y would have received more comprehensive care. However it would not be reasonable to conclude that this had a direct effect (causal relationship) with the events of May 2008.

The Trust provided the following update:

The current model in operation allocates service users a keyworker at the outset of treatment, with full responsibility to complete any initial assessments pertaining to risk and safeguarding, tracking involvement with other agencies and formulating a plan of multi agency care early in the treatment episode.

This assessment has been further enhanced by SDAS having developed a standardised set of forms for identifying and recording issues of safeguarding, including full information on all children the service user has contact with as a parent or carer. Additionally the risk documentation has been standardised, both in identifying risks specific to substance misuse, and the use of the RiO risk assessment documentation for wider risk behaviour. This suite of risk related tools are central to an SDAS wide care and risk management training programme, which provided training and skills development in using the tool kit. This also sets out the expectations and requirements for staff in completing the assessment processes.

Recommendation 3

(NB This is the same recommendation as made above in section 18.1: Assessment and Care Planning)

Given the initiatives and service improvements that have been put in place in the Specialist Drug and Alcohol Services the Trust should put in place mechanisms to assure itself and its commissioners that:

- **all relevant staff undergo appropriate training which is updated on a regular basis;**
- **staff receive appropriate support and regular supervision to enable them to implement their newly acquired skills in a consistent manner.**

The Trust should put in place regular monitoring, including regular audits, to assure itself and its commissioners that:

- **assessments are undertaken and care and risk management plans are reviewed both on a regular pre-determined basis and in response to changes in the services user's life;**
- **care plans include a clear formulation:**
  - **enabling those providing care and treatment for the service user to have a common understanding of his/her needs;**
  - **which provides the basis for treatment interventions;**
- **there is appropriate multi-agency involvement in assessment and care and risk management planning;**
- **care and risk plans are disseminated in a timely manner.**

18.3 Treatment

Psychological Therapies

The NTA's 2006 Model of care identified a number of evidence based psychological interventions that should be available to individual with moderate to severe drug misuse problems. Similarly NICE guidance on both schizophrenia and depression recommend that psychological interventions, CBT based interventions in particular, should be available to individuals experiencing these problems.

While Mr. Y was seen on a regular basis by his Key Worker there is no evidence that systematic, evidence based psychological interventions were undertaken or considered. This was a weakness in the care offered to Mr. Y.

Service Issue 1

Best practice in relation to the treatment of those with moderate to severe drug misuse problems, those with depression and individuals suffering with schizophrenia all indicate that psychological therapies should be made available to these individuals. Such interventions were not made available to Mr. Y and in this sense his needs and problems were not addressed in accordance with best practice.

However it would not be reasonable to conclude that the absence of such interventions had any direct causal relationship with the events of May 2008.

The Trust provided the following update:

The North Somerset Specialist Drug and Alcohol Services have been undergoing a tendering process: as part of the service reconfiguration, in anticipation of the needs of a recovery based service model, SDAS has commissioned a clinical psychology post within the team. Not only does this post allow the service to directly address the needs of complex service users, it also provides training and supervision to enhance the skills of the clinical team in delivering a wider range of psychosocial interventions to a wider group of service users.

Psychological interventions addressing substance misuse issues:

All keyworkers are now trained in the use of Mind Mapping. The BTEI version of mapping allows for structured topic based discussions around:

Building motivation;

User friendly goal setting and recovery planning (Goal Planner);

Reviewing and exiting treatment.

Use of Mind Mapping and psychological interventions arising from these are delivered under the supervision of the team clinical psychologist. These include the use of motivational interviewing, relapse prevention etc.

Psychological interventions for mental health problems:

All keyworkers are currently undergoing training to deliver Cognitive Behavioural Therapy (CBT) guided self help for anxiety and depression. Those individuals who require a higher intensity CBT will either receive this from the team clinical psychologist or other suitably trained staff, who are also able to deliver other high intensity psychological interventions such as Eye Movement Desensitisation and Reprocessing (EMDR), Dialectical Behaviour Therapy (DBT), etc.

Clients with co-morbid substance misuse and severe mental health problems would normally be managed jointly by substance misuse and mental health services. CBT for psychosis would normally be delivered by secondary mental health services.

Recommendation 4

The Specialist Drug and Alcohol services have put in place a number of initiatives relating to the availability and quality of psychological interventions. The Trust should put in place mechanisms, including regular audit, to assure itself and its commissioners that:

- **all relevant staff receive appropriate training to deliver these interventions and that this training is updated on a regular basis;**
- **all staff receive regular supervision at an identified minimum frequency;**

- **the psychological interventions delivered are of a consistent and acceptable quality;**
- **the need for psychological intervention is assessed for each individual on a regular basis and that delivery of this is included in an agreed care plan;**
- **where a service user has need of psychological assessment or intervention which is beyond the skills of the care worker or clinical team this need is met by ensuring that the individual is referred to appropriate services for this aspect of their care.**

18.4 Safeguarding

Service issue 2

Best Practice, local Safeguarding policies and statute require that there is co-operation and sharing of relevant information between health service providers and Children's Social Services to ensure that children and young people are protected from harm and their wellbeing is promoted. In this case, although appropriate policies were in place to realise these goals, the policies were not followed. The task of the Trust and other relevant partners is now to establish why these policies and the best practice guidance were not followed and to address these issues.

The Trust provided the following update:

SDAS has developed a standardised set of forms for identifying and recording issues of safeguarding, including full information on all children the service user has contact with as a parent or carer. The SDAS Safeguarding Children Assessment pro forma includes four pages of guidance to practitioners and responses to 'Frequently Asked Questions'.

SDAS have also developed guidance to practitioners regarding practice expectations (including record-keeping) in respect of assessment, risk assessment and management, care planning and review.

The Safeguarding guidance to practitioners sets out clear expectations regarding inter-agency communication, and incorporation of safeguarding issues in care planning.

The Trust has developed training resources to be used in supervision. SDAS and Trust guidance to managers has set out clear expectations regarding monitoring of practice and record-keeping, and addressing safeguarding competence and practice issues, through supervision.

Recommendation 5

The Trust, in conjunction with its partner agencies and commissioners, should ensure that the local Children's Safeguarding policies and procedures are being implemented in a consistent manner.

It should ensure that:

- **assessments and risk assessments routinely identify contact with and concerns regarding children;**
- **this information is communicated to relevant agencies in an agreed and timely manner.**

The assurance mechanism should look at both the quality of the assessments and any related plans and not merely that these are being undertaken.

18.5 Family Involvement

Service Issue 3

Despite the important role Mr. Y's family, particularly his mother, played in his life and the fact that a risk assessment in 2005 had identified that he posed a particular risk to women, Mr. Y's family were not involved in identifying his needs, the risks he posed or in planning his care. Had this been done it is possible that the difficulties he experienced in relation to his family might have been better managed. However it would not be reasonable to conclude that the absence of such involvement had any direct causal relationship with the events of May 2008.

The Trust provided the following update:

AWP and SDAS have taken a number of steps to promote greater engagement and involvement of family members and significant others in the care and treatment of service users, including contributions to risk assessment.

SDAS have incorporated improvements in this respect in their Quality Improvement Plan for 2011-14. As steps toward improving the experience of Carers, SDAS aims to:

- *Invite all service users to bring a carer or significant other to their initial assessment;*
- *Identify carers or significant others for all Service Users at assessment;*
- *Follow up or establish initial contact with carer / significant other to encourage input into clients care and/or to assess carers needs;*
- *Follow up this contact with a letter*
  - *outlining the content of any discussion;*
  - *signposting to carers support services and local partner agencies;*
  - *providing emergency and routine contact details.*

SDAS is committed to promoting the involvement of Carers and significant others in the provision of care for its service users by engaging with commissioners in providing an established pathway of care within the locally commissioned treatment systems.

Recommendation 6

The Specialist Drug and Alcohol Service has put in place a number of initiatives to improve the likelihood that carers and significant others are involved in the assessment of the service user's needs and the planning of his/her care.

The Trust should put in place clear deadlines and reporting and monitoring mechanisms to assure itself that the Specialist Drug and Alcohol Services Quality Improvement programme is being realised in a timely manner.

While the Quality Improvement programme is being implemented the Trust should establish priorities to ensure that, for example, carers and families are informed of relevant aspects of

the risk management plan and have up to date information on how to access the Specialist Drug and Alcohol Service, or other relevant services, in times of crisis.

It would be good practice to involve families and carers in the reviewing and monitoring of their involvement in risk assessment, risk and crisis management planning and access to relevant information.

8.6 Communication

Service Issue 4

While communication relating to the treatment of Mr. Y's drug misuse was timely and appropriate, more comprehensive information relating to his mental state, the risks his posed to himself and others and information relating to the safeguarding of children was variable, at times of poor quality or incomplete and, on important occasions, absent.

There were no mechanisms in place to ensure that there was regular and effective communication between those providing care and support to Mr. Y and no mechanism to ensure that care and support were delivered in a coherent manner.

While it is reasonable to assume that better informed care planning and better co-ordination of the delivery of care would have provided Mr. Y with a more efficient, and probably more effective, service it would not be reasonable to conclude that the absence of this contributed directly to the events of May 2008.

The Trust provided the following update:

It has been acknowledged that this was an indentified shortcoming of the delivery of care, particularly with reference to safeguarding.

However, in part in response to AWP's internal review of this case, the standards of and mechanisms to deliver care have been reviewed.

SDAS has developed a standardised set of forms for identifying and recording issues of safeguarding, including full information on all children the service user has contact with as a parent or carer. The SDAS Safeguarding Children Assessment pro forma includes four pages of guidance to practitioners and responses to 'Frequently Asked Questions'.

SDAS have also developed guidance to practitioners regarding practice expectations (including record-keeping) in respect of assessment, risk assessment and management, care planning and review.

The Safeguarding guidance to practitioners sets out clear expectations regarding inter-agency communication, and incorporation of safeguarding issues in care planning.

The Trust has developed training resources to be used in supervision. SDAS and Trust guidance to managers has set out clear expectations regarding monitoring of practice and record-keeping, and addressing safeguarding competence and practice issues, through supervision.

Recommendation 7

Given the improvements that the Trust has put in place in SDAS it should now put in place mechanisms to assure itself that:

- **there is effective and timely communication between its clinical staff and other relevant agencies;**
- **other agencies and professionals who are, or ought to be, involved in the support, care and/or treatment of a service user are routinely identified as part of the service user's assessments;**
- **the other relevant agencies are routinely, appropriately, involved the assessment of the service user's needs and any risk s/he poses and in the planning of care;**
- **there are mechanisms in place which are being used in an effective manner to ensure that support, care and treatment are being delivered in a coherent and co-operative fashion.**

18.7 Joint Working: Specialist Drug and Alcohol Services and Mental Health Services

Service Issue 5

After Mr. Y engaged with the Specialist Drug and Alcohol Services in 2004 no further consideration appears to have been given to working collaboratively with the mental health services to address his reported mental health problems. Although Mr. Y's mental state was competently assessed on a number of occasions, best practice would have suggested that as Mr. Y continued to complain of mental health problems, collaborative working with the mental health services should have been considered. Had such a collaborative approach to Mr. Y's problems been undertaken it is probable that alternative and beneficial approaches to Mr. Y's mental health problems would have been identified.

However it would not be reasonable to conclude that the absence of such collaborative working had a direct causal relationship with the events of May 2008.

The Trust provided the following update:

Since the events this investigation relates to, the Trust has developed and implemented a Dual Diagnosis Strategy, which has recently been reviewed and refreshed.
The Dual Diagnosis Strategy Implementation Plan sets out clear indicators of service improvement in the key areas of Access; Assessment; Addressing identified substance misuse needs in care planning; workforce competences and service user involvement.

Dual Diagnosis Link Workers have been established in Community Mental Health Teams, and in Specialist Drug and Alcohol Services, providing clear lines of communication and pathways for collaborative working.

As part of the implementation plan for the revised Dual Diagnosis Strategy, Community Mental Health Services will appoint to designated Dual Diagnosis practitioner roles within Community Mental Health Teams, to act as a resource in supporting colleagues to work with service users with dual diagnosis. SDAS will provide supervision to practitioners undertaking these roles.

Recommendation 8

The Trust should put in place mechanisms to ensure that its revised Dual Diagnosis policy is being implemented in a consistent manner;
it should conduct audits to ensure that the mental heath needs of those individual's under the care of the Specialist Drugs and Alcohol Services are being effectively identified and addressed in a timely and effective manner;

it should ensure that:

- **it is clear who, in the clinical team, is responsible for identifying that the service user's mental health needs are identified and met;**
- **a mechanism is in place to ensure that this function is carried out in an effective and consistent manner.**

18.8 Commissioning

Recommendation: 9
Bristol PCT and North Somerset PCT should ensure that they have in place policies and procedures which ensure that:

- **they are informed of any serious adverse incident in a timely manner;**
- **standards for the quality and time scale of investigations are in place;**
- **the role of Bristol PCT and North Somerset PCT in assuring that the recommendations of the investigation are translated into meaningful and effective action plans which are consonant with the quality standards identified for the commissioned services, is identified;**
- **the role of Bristol PCT and North Somerset PCT in assuring that the action plan is implemented in a timely manner, is identified;**
- **all relevant staff in Bristol PCT and North Somerset PCT are aware of the policy and protocol;**

- **information concerning serious adverse incidents is fed into the governance and quality and performance monitoring structures of the PCTs in such a way that they can assure themselves that local mental health services are safe and of an acceptable quality;**
- **they conduct regular assurance exercise, including audits, to assure themselves that their policies are being implemented in a consistent and effective manner.**

19. Glossary

Akathisia	Akathisia is a movement disorder characterised by: a feeling of inner restlessness and a compelling need to be in constant motion, actions such as rocking while standing or sitting, lifting the feet as if marching on the spot and crossing and uncrossing the legs while sitting. Akathisia is often a side effect of drugs such as anti-psychotics.
Care Coordinator	This person is usually a Health or Social Care Professional who co-ordinates the different elements of a service users' care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure that assessment and care planning occur in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom Government established in 2009 to regulate and inspect Health and Social Care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Chlorpromazine	Chlorpromazine is an anti-psychotic medication belonging to the phenothiazine group. It is used in the treatment of various psychiatric illnesses. Chlorpromazine works by blocking the receptors for the neurotransmitter dopamine in the brain.
Cognitive Behavioural Therapy (CBT)	Cognitive Behavioural Therapy (CBT) is a talking psychological therapy that aims to help people solve emotional, behavioural and cognitive problems. CBT employs behavioural and cognitive techniques. It is goal-oriented and uses a systematic, structured procedure.

Citalopram	Citalopram is an anti-depressant medication. It belongs to the class of anti-depressant known as Selective Serotonin Re-uptake Inhibitors (SSRIs). It works by increasing the amount of serotonin in the brain.
Diazepam	Diazepam belongs to a group of drugs called benzodiazepines. It is used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms. It is sometimes used with other medications to treat seizures.
Dihydrocodeine	Dihydrocodeine, also known as DF-118, is a semi-synthetic opioid analgesic. It is prescribed for pain. Dihydrocodeine has been used for some time to treat substance misusers. It is often preferred in situations where methadone is seen as hazardous, such as in police custody or prison.
Dystonia	Dystonia is a disorder characterised by involuntary muscle contractions that cause slow repetitive movements or abnormal postures. The movements may be painful and some individuals with dystonia may have a tremor or other neurological features. There are several different forms of dystonia some of which may affect only one group of muscles. Some forms of dystonia are genetic but others may be the side effect of medications such as anti-psychotic medication.
Fluoxetine	Fluoxetine is an anti-depressant medication of the Selective Serotonin Re-uptake Inhibitor (SSRI) type. It works by increasing the amount of serotonin in the brain.
Mental Health Act (1983)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition.
Methadone	Methadone is a long-acting synthetic painkiller that mimics the effects of heroin, but is less addictive. It is widely used as a substitute for patients who are attempting to combat addiction to heroin. Like heroin, it produces feelings of euphoria and sedation, but to

	a lesser degree. The drug is usually provided to substance misusers under the supervision of a specially trained pharmacist or healthcare professional.
NICE	The National Institute for Health and Clinical Excellence, known as NICE, is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
OCD	Obsessive Compulsive Disorder is a mental disorder characterised by recurrent obsessions or compulsions that are severe enough to cause distress or impairment and consume significant amounts of time. Obsessions are persistent ideas, thoughts or images. Compulsions are repetitive behaviours performed to escape or reduce anxiety
Olanzapine	Olanzapine is an anti-psychotic medication used to treat the symptoms of schizophrenia and other psychoses. It belongs to a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain.
Primary Care Trust	A NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Promazine	Promazine is an anti-psychotic medication belonging to the phenothiazine group. It is used to treat agitated or restless behaviour. Promazine works by blocking the receptors for the neurotransmitter dopamine.

	It produces a sedative and calming effect.
Psychosis	Psychosis refers to a mental state or mental illness characterised by a loss of contact with reality, usually including false ideas about what is taking place.
Quetiapine	Quetiapine is an anti-psychotic medication used to treat the symptoms of schizophrenia and other psychoses. It belongs to a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain.
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
Venlafaxine	Venlafaxine is an anti depressant drug which becomes effective within two to four weeks of commencement.
Valium	Valium, also known as Diazepam, belongs to a group of drugs called benzodiazepines. It is used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms. It is sometimes used with other medications to treat seizures.
Zispin	Zispin (Mirtazapine) is an anti-depressant medication. It works by increasing the availability of noradrenalin and serotonin in the brain.