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

Executive Summary

Independent Investigation: HASCAS Health and Social Care Advisory Service

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Contents

Brief overview of Mr. Y's contact with the Avon and Wilshire Mental Health Partnership NHS Trust

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-girl friend 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.

Terms of Reference for the Independent Investigation

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

1. Review the assessment, treatment and care that Mr. Y received from the Avon & Wiltshire Mental Health Partnership NHS Trust.
2. Review the care planning and risk assessment policy and procedures
3. Review the communication between agaencies, services, friends and family including the transfer of relevant information to inform risk assessment.
4. Review the documenation and recording of key information.
5. Review communication, case management and care delivery.
6. 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.

8. Review any communication and work with families of victim and perpetrator.
9. Establish appropriate contacts and communications with family/carers to ensure appropriate engagement with the Internal Investigation process.

3. Outcomes

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

The Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of the Avon and Wiltshire Mental Health Partnership NHS Trust. 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. Christopher Welton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Fiona Shipley Transcriptions Ltd	Stenography Services
Independent Legal Advice	Kennedy's Solicitors

Findings of the Investigation

The main findings of the Investigation are summarised below under broad thematic headings.

Access to Services

Mr. Y was referred to the Specialist Drug and Alcohol services on a number of occasions between October 2001 and July 2004. Most of those referring Mr. Y noted that he had both substance misuse and mental health problems. The delays in assessing Mr. Y and engaging him in services did not reflect best practice and resulted in his 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 impacted upon the events of May 2008.

Assessment

Mr. Y's needs were not assessed in a comprehensive manner and assessments were not undertaken on a planned basis as the Best Practice guidance recommends.

Mr. Y's care plans did not provide a clear formulation on the basis of which his behaviour could be understood and a strategy put in place to address the identified needs and risks. 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 on the events of May 2008.

Risk Assessment and Management

Best Practice guidance recommends that risk assessment should be undertaken on a 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 was a lack of a regular, planned risk assessment and a failure to adhere to a clear protocol identifying when risk assessment should be undertaken. This was a weakness in the care Mr. Y received.

Various risk behaviours were identified in Mr. Y's clinical notes but these were not brought together in a single, easily identifiable place, and the cumulative information was not used as the basis of a formulation which would enable those providing care and treatment to Mr. Y to respond to the identified risks in in a coherent fashion.

Although significant risks were identified, appropriate risk management plans were not put in place and those that were recorded were not of the standard that would be expected by the Best Practice guidance. 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 on the events of May 2008.

Diagnosis

Mr. Y consistently reported abnormal experiences. He 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. The relationship between Mr. Y's presenting symptomatology and his drug use was considered and the consensus opinion was that the main aetiological factor contributing to his reported symptoms was his drug misuse.

Mr. Y was also diagnosed as having an "emotionally unstable personality". However this diagnosis and how to respond to it does not appear to have been explored.

Treatment: Substance Misuse

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

Treatment: Medication

Although the consensus opinion was that the psychotic-like symptoms Mr. Y was reporting were a consequence of his drug misuse, he was offered a trial of anti-psychotic medication on a number of occasions. This was appropriate.

Mr. Y was fully involved in all decisions regarding medication. His decisions were respected by those offering him care and treatment. This was good practice.

Treatment: Psychological Therapies

The National Treatment Agency's Model of Care (2006) identified a number of evidence based psychological interventions that should be available to individuals with moderate to severe drug misuse problems. Similarly the National Institute for Health and Clinical Excellence (NICE) guidance on both Schizophrenia and Depression recommends that psychological interventions, particularly Cognitive Behaviour Therapy, should be available to individuals experiencing these problems. There is no evidence that evidence-based psychological interventions were offered to Mr. Y. This was a weakness in the care offered to him.

Safeguarding

It was known from the time that Mr. Y was first referred to the Specialist Drug and Alcohol Services that he had a young son. There is no evidence that the staff this service sought advice within the Trust or contacted Children's Social Services to discuss Mr. Y's situation, to share information or to make a formal referral.

Although a number of incidents of domestic violence are recorded in Mr. Y's notes these did not trigger an assessment of the risk that Mr. Y's behaviour posed to the wellbeing of his son, or trigger a referral to Children's Social Services. The Trust's safeguarding policy was not followed in this instance.

From February 2008 Mr. Y's son was living with him. It was noted that Mr. Y was drinking heavily and was having financial difficulties. However no contact was made by the Specialist Drug and Alcohol Service with Children's Social Services.

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 that 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 to establish why these policies and the best practice guidance were not followed and to address these issues.

Service User Involvement

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.

Family Involvement

The Specialist Drug and Alcohol Service did not employ the Care Programme Approach at the time Mr. Y was under its care, however the Model of Care promoted by the National Treatment Agency for Substance Misuse 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 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.

Despite the important role Mr. Y's family 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.

Communication

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 pace 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.

Joint Working: Specialist Drug and Alcohol and Mental Health Services

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.

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.

Clinical Governance and Performance.

The 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.

Internal Investigation.

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

Conclusion

When Mr. Y was initially referred to the Specialist Drug and Alcohol Service 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 times are now 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 whose focus is to address the drug misuse problems of its clients. Once engaged with this service Mr. Y's drug use was stabilised and he became illicit-drug free relatively quickly. He received an effective service to address his drug-misuse problems.

Like many people presenting to Specialist Drug and Alcohol Services Mr. Y reported a range of difficulties beyond his substance misuse, however there was a lack of comprehensiveness in assessing and then addressing these problems.

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. The consensus of opinion was that Mr. Y's abnormal experiences were the result of his drug misuse, however, he claimed that he used drugs to help him cope with the abnormal experiences. There is no record in Mr. Y's clinical notes that his explanation as to why he misused drugs was explored to any significant degree.

Although Mr. Y continued to complain of mental health problems after he was engaged with the Specialist Drug and Alcohol Service in 2004 no further consideration appears to have been given to working jointly with the Mental Health Team. The advantage of multi-disciplinary working and working with other teams is that different professions and teams have different expertise. They have different ways of construing the problem, different views

as to what is of importance and different ways of addressing problems. 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.

Mr. Y was involved in three assaults and a number of fights while he was under the care of the Specialist Drug and Alcohol Service. He was charged on at least two occasions. With the benefit of hindsight these must be regarded as near misses While the Specialist Drug and Alcohol Service 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 was evident with regard to safeguarding. It was known that Mr. Y was in regular contact with his son, he informed the Specialist Drug and Alcohol Service when his son came to live with him in 2008 and the Specialist Drug and Alcohol Service were aware that Children's Social Services were involved with Mr. Y's son. However, no contact was made with Children's Social Services despite the fact that the local Safeguarding Policy indicated that contact should have been made.

The formal assessments of Mr. Y's needs were not comprehensive, though the staff of the Specialist Drug and Alcohol Service were aware that Mr. Y's had problems in a number of areas of his life. There was no system in place, however, which facilitated translating these observations into comprehensive care plans or which supported joint working with other services such as Mental Health Services, the Probation Service and Children's Social Services.

If lessons are to be learned then it is important that the services reflect not so much on what was done but rather on why things were done in the way they were. In the present case it would appear that there was not a culture of co-working, no mechanism was in place to support comprehensive assessment and care and risk planning and there was no mechanism which supported the joint delivery of services and care plans.

Recommendations

Recommendation 1: Access to Services

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: Commissioning Alcohol Services

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[1]

Recommendation 3: Assessment and Formulation

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:

[1] 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*

- 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.

Recommendation 4: Treatment

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 his/her care.

Recommendation 5: Safeguarding

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.

Recommendation 6: Family Involvement

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.

Recommendation 7: Communication

Given the improvements that the Trust has put in place in Specialist Drug and Alcohol Service 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.

Recommendation 8: Joint Working: Specialist Drug and Alcohol and Mental Health Services

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 individuals 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.

Recommendation: 9: Commissioning

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 exercises, including audits, to assure themselves that their policies are being implemented in a consistent and effective manner.