Independent Investigation

into the

Care and Treatment Provided to Mr. Z

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

Contents

1. Preface to the Independent Investigation Report

The Independent Investigation into the care and treatment of Mr. Z 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. A on 24 May 2008.

Mr. Z received care and treatment for his mental health condition from the Avon and Wiltshire Mental Health Partnership NHS Trust (the Trust) between September 2002 and May 2008. It is the care and treatment that Mr. Z 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, 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.

The Independent Investigation Team is grateful to the family of Mr. Z for meeting with the Investigation Team and sharing their reflections on the care and treatment received by Mr. Z.

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

2. Condolences to the Family and friends of Mr. A

The Independent Investigation Team would like to extend its condolences to the widow, family and friends of Mr. A for the loss of their family member and friend.

3. Incident Description and Consequences

Mr. Z was referred to the Child and Adolescent Mental Health Service (CAMHS) by his General Practitioner in 2002 when he was 14 years old. Shortly after this referral was made Mr. Z was admitted to hospital under the Mental Health Act (1983) and diagnosed as suffering from a transient psychotic disorder. He was re-admitted to hospital in 2003 when he appeared to be relapsing following his failing to take his medication.

In 2005 Mr. Z was referred to the Adult Mental Health services and was formally transferred in 2006. He was accepted by the newly established Early Intervention in Psychosis Service in 2007. During late 2006 and early 2007 Mr. Z made a number of serious attempts to harm himself and was admitted to hospital under the Mental Health Act in April 2007. He discharged himself against medical advice at the end of April when his Section lapsed. From this time on his contact with the Mental Health Services was increasingly sporadic. Because of the risks associated with Mr. Z restrictions were placed on when and where he could be seen by staff and this contributed to the difficulty in engaging him. He appeared to increasingly disengage from the service as his mis-use of illicit drugs increased and as he had increasing contact with the Criminal Justice System.

The formulation of the clinical team caring for Mr. Z was that he was a young man who experienced episodes of psychosis related to a troubled upbringing, with his use of drugs contributing to his mental health problems. The plan was to admit him to hospital, if possible, so that he could be assessed in a stable and drug free environment. With this in mind he was assessed on a number of occasions following him being detained by the police. However the consistent conclusion was that he was not displaying the symptoms of a serious mental illness and could not be detained under the Mental Health Act.

Mr. Z's last planned contact with the Early Intervention Team was on 30 January 2008. He subsequently missed a number of appointments. In early 2008 two Care Programme Approach meetings to review Mr. Z's needs and plan his care were arranged but Mr. Z failed to attend these.

On 23 May 2008 Mr. Z was arrested on suspicion of being involved in two burglaries. He was assessed by the Court Assessment and Referral Service (CARS) and reported that he was depressed and hearing voices. His mother said that she believed he was unwell and should be admitted to hospital. The conclusion of the assessment was that Mr. Z was not displaying any overt signs of mental illness, however the CARS Nurse arranged a joint assessment with Mr. Z's care co-ordinator. During this later assessment Mr. Z reported that he had been feeling low for the previous two weeks and that he had been hearing voices. Mr. Z disclosed that he was continuing to misuse illicit drugs. The conclusion of the assessment was, again, that Mr. Z was not showing any overt signs of mental illness and was not detainable under the Mental Health Act. His Care Co-ordinator decided that as he had been detained on a number of occasions in recent months his case should be re-referred for a Multi-Agency Public Protection Arrangements (MAPPA) meeting.

Mr. Z was bailed to his mother's address with an overnight curfew from 20.00 to 07.00.

On 26 May 2008 Mr. Z was arrested on suspicion of murder. Following his arrest Mr. Z was assessed and the psychiatrist concluded that Mr. Z was fit to be interviewed with an Appropriate Adult present. On 29 May 2008 the prison psychiatrist reported that Mr. Z was not displaying signs of a mental disorder.

On 14 April 2009 Mr. Z was found guilty of manslaughter at Bristol Crown Court and sentenced to 11 years imprisonment.

4. Background and Context to the Investigation (Purpose of 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 review thoroughly the care and treatment received by the patient, in order to establish the lessons to be learnt, to minimize the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what 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 into the Care and Treatment of Mr. Z are:

- 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 involved in health services;
- to assess progress made on the delivery of action plans following the Internal Investigation;
- to identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies.

2. Terms of Reference

These are to:

- review the assessment, treatment and care that Mr. Z received from the Avon & Wiltshire Mental Health Partnership NHS Trust;
- review the care planning and risk assessment policy and procedures;
- review the communication between agencies, 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 the families of the victim and the perpetrator;
- establish appropriate contacts and communications with family/carers to ensure their appropriate engagement with the Internal Investigation process.

3. Outcomes

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

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team comprised 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 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 Solicitors

7. Investigation Methodology

7.1. Classification of Independent Investigations

Classification of Independent Investigations

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 (the Strategic Health Authority) as a Type C Independent Investigation.

A 'C' type Independent Investigation 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 'C' type Independent Investigation does not seek to reinvestigate a case from the beginning if it can be ascertained that the Internal Investigation was robust. In a 'C' type 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 Communication with the Family of the Victim

The SHA attempted, on number of occasions, both directly and via the Victim's Liaison Service to invite the widow of Mr. Z's victim to contribute to this Investigation. No response had been received from the victim's widow at the time of writing this report.

7.2.2 Communications with the Avon and Wiltshire Mental Health Partnership NHS Trust (the 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. Z.

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 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 and 15 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 with the Trust Corporate Team.

- On 09 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 development of recommendations.

7.2.3 Communications with the Commissioners

On 08 November 2011 the Chair of the Independent Investigation Team and the CEO of HASCAS met with representatives of NHS North Somerset and NHS Bristol, the commissioners of Mental Health Services from the Avon and Wiltshire Partnership NHS Trust for their respective localities. The meeting reviewed the reorganisation of Primary Care Trusts and commissioning arrangements locally. It also addressed the perceptions of the commissioners of services provided by the Trust and their plans for future commissioning. The PCTs described their governance arrangements and the role they played in monitoring investigations into serious untoward incidents and in agreeing and monitoring the subsequent action plans.

The Independent Investigation Team requested copies of relevant policy documents.

7.3. Witnesses called by the Independent Investigation

Each witness called by the Independent 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; • Clinical Director: Adult Acute Inpatient Services; • Clinical Director: Specialist Drug and Alcohol Services; • Clinical Director: Service Redesign. • Consultant Psychiatrist 2	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist; • Investigation Team, Nurse; • Investigation Team, Social Worker; • In attendance: Stenographer.
15 June 2011	**Trust** • CPN 2 • Manager of Early Intervention Team • Manager of Court Assessment and Referral Service	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist; • Investigation Team, Nurse; • Investigation Team, Social Worker; • In attendance: Stenographer.
	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	**<u>Trust</u>** • Trust Medical Director.	**<u>Investigation Team</u>** • Investigation Team Chair, Clinical Psychologist; • Investigation Team, Nurse; • Investigation Team, Social Worker; • In attendance: Stenographer.
7 February 2012	• Consultant Psychiatrist 1	**<u>Investigation Team</u>** • Investigation Team Chair, Clinical Psychologist; • Investigations Manger

In addition the Investigation Team received written statements from ASW 1, ASW2 and Mr. Z's GP.

7.4 Salmon Compliant Procedures

The Independent 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 Independent 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 Meetings and Communication

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 Terms of Reference for the Independent Investigation. Once the specific requirements of the Independent Investigation were understood the Independent 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. Each Team Member identified potential clinical witnesses and general questions that needed to be asked. Each witness was aware, in advance of their interview, of 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 Independent Investigation Team met on the following occasions:

31 May 2011. On this occasion the Independent Investigation Team met in order to plan the interviews with the Avon and Wiltshire Mental Health Partnership NHS Trust Senior Management Team and clinical witnesses.

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

7.5.3 Other Meetings and Communications

Other communications were maintained via email and telephone in order to complete the Independent 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 Independent 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 Independent Investigation Report by 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. Z. The victim has been referred to throughout this Report as Mr. A.

8. Information and Evidence Gathering

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

1. Mr. Z's Avon and Wiltshire Mental Health Partnership NHS Trust clinical records.
2. Mr. Z's GP records.
3. The Avon and Wiltshire Mental Health Partnership NHS Trust Internal Investigation Report.
4. Avon and Wiltshire Mental Health Partnership NHS Trust action plans.
5. Secondary literature review of media documentation reporting the death of Mr. A.
6. Avon and Wiltshire Mental Health Partnership NHS Trust Clinical Risk Clinical Policies, past and present.
7. Avon and Wiltshire Mental Health Partnership NHS Trust Incident Reporting Policies.
8. Avon and Wiltshire Mental Health Partnership NHS Trust *Being Open* Policy.
9. Avon and Wiltshire Mental Health Partnership NHS Trust Operational Policies.
10. Healthcare Commission/Care Quality Commission Reports for Avon and Wiltshire 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

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

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

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

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

1. the organisation of choice for service users, staff and commissioners, providing a comprehensive range of services in primary, secondary and tertiary care settings, across our existing geographical area.
2. providing person-centred services that intervene early, are highly accessible, focused on recovery and are high quality and leading edge.
3. a financially sustainable Trust through robust financial management, use of innovative technologies efficiency and increased productivity.

The City of Bristol has a population of 420,000.
There are high levels of morbidity within the Inner City area.
Avon and Wiltshire Mental Health Partnership NHS Trust's Mental Health Services work in close partnership with the Primary Care Trust, Bristol City Council and the Voluntary Sector.

Currently staff within the City Council that provide services to people with mental health conditions are integrated into the Mental Health Teams as described below.

Bristol is divided into three Community Sectors, North, South and Central. Each Sector is managed by a Community Services Manager with an Area Manager for all the Adult Community Services and Adult Acute Admission Wards.

The community teams in each sector comprise:

- Assertive Outreach Team;
- Assessment Team;
- Recovery Team.

The Assessment Teams provide the Integrated Single Point of Entry into Secondary Mental Health Services for each Sector. These Teams also provide shorter term work with service users. The teams work extended hours up to 19.00 on weekdays and from 09.00 to 17.00 at weekends.

The Recovery Teams work with service users who have more complex mental health conditions. The majority of people however will have time-limited conditions and will be referred back to their GP's when their condition has improved.

A substantial minority of people with more complex and enduring needs will remain with the Recovery Teams for ongoing specialist care and monitoring for a longer period of time.

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

Bristol has an Early Intervention Service. This Service works with individuals aged from 14 to 35 years of age who are experiencing a first episode of psychosis. The service aims to reduce the stigma associated with psychosis and raise awareness of the symptoms of psychosis and the need for early assessment in order to reduce the length of time young people remain undiagnosed and untreated. Providing a user centred service it is focused on meaningful engagement and promotion of recovery during the early phase of illness. The Early Intervention Teams provide a service for young people in the first three years following a first episode of psychosis. They offer intensive evidence based psychosocial interventions, including Cognitive Behavioural Therapy (CBT) and family work for psychosis.

The Trust's Assertive Outreach Teams provide ongoing treatment and support, mainly in the community, to people with severe and enduring mental health problems who may have found it difficult to engage with services in the past. The Service is for adults aged 18-65 years. The Service accepts referrals from all the other community teams.

The Teams work flexibly but quite intensively with service users and will see people at weekends and evenings. This is usually in the service users own preferred environment where they feel most comfortable and at ease.

10. Chronology of Events

10.1 Root Cause Analysis (RCA) First Stage

The chronology of events forms part of the RCA 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 had an impact on the life of Mr. Z and on his care and treatment from Mental Health Services.

10.2. Chronology

Mr. Z was born on **29 May 1988**
In **September 2002** he was referred by his GP to the Child and Adolescent Mental Health Services (CAMHS) with symptoms of anxiety, poor sleep and paranoid ideation.[1]

During September Mr. Z was described as becoming increasingly paranoid. On **11 September 2002** he was found with a ligature around his neck and was admitted to the in-patient Unit on Section 2 of the Mental Health Act (1983).[2]

Mr. Z was discharged from hospital on **November 2002** after an eleven-week admission**.** He was recorded to have responded well to pharmacological treatment. His diagnosis at discharge was: acute and transient psychotic disorder.[3]

On **10 April 2003** the CAMHS Consultant Psychiatrist wrote to Mr. Z's GP reporting an out-patient appointment on 09 April. She reported that Mr. Z's mother was concerned that he appeared to be depressed, withdrawn and irritable. He had recently been attacked by group of boys. The Consultant Psychiatrist felt that an "open mind" should be kept with respect to Mr. Z's diagnosis. She felt he might be becoming depressed, was displaying negative symptoms

1 Clinical Notes 1-1 803
2 Clinical notes 1-1 542
3 Clinical notes 1-1 803

of schizophrenia, or lacking motivation because he found life boring, was limited by his physical disabilities and was receiving no schooling. She noted that the Education Services were being "*tardy*" in addressing Mr. Z's educational needs.[4]

On **18 April 2003** Mr. Z was re-admitted as an in-patient with acute psychotic symptoms.[5] These included: persecutory delusions, third person auditory hallucinations and ideas of reference. It was noted that he displayed fewer behavioural problems and less aggression than on his previous admission and it was felt that he had more insight into his mental health problems. A drug screen was negative. Mr. Z's medication was changed from Quetiapine to Risperidone. He responded well to this and within a month became a day patient. However, as his discharge approached he became irritable, restless and preoccupied. Mr. Z's discharge was delayed and his medication was increased to Risperidone 2mg two times a day. The clinical team concluded that family difficulties were contributing to Mr. Z's problems. A plan was put in place for Mr. Z to attend school three mornings a week. However his attendance was erratic and he did not appear interested in using the resources of the Unit.[6]

Mr. Z was discharged from the in-patient unit on **30 May 2003** to the care of the CAMHS Community Team. It was noted in the discharge letter to Mr. Z's GP that it would be important for Social Services to be involved: *"which would include looking at the domestic environment*, *schooling, benefits etc*."[7]

In an undated assessment by an on call Specialist Registrar (SpR), when Mr. Z was 15 years old, it was noted that he had not felt well for the previous week. He reported that his sleep was poor and described thought interference, passivity phenomena and ideas of reference. Mr. Z said that he did not feel that people were talking about him but worried that this might start soon. He reported that he heard his brother's voice saying *"Don't hurt me [Mr. Z]."* He was frightened that he might hit someone in the street.

Mr. Z lived at home with his mother, younger brother and sister and an uncle's two-week old baby. He had been staying with his father to escape from his older brother who misused

4 Clinical notes 1-1 p.816
5 Clinical Notes 1-1 807
6 IBID
7 IBID

drugs. Mr. Z had had a row with his father, had returned to his mother's house, got a souvenir knife and said he wanted to stab his father.

It was noted that there was a strong family history of mental ill health.

Mr. Z felt he needed to be in hospital. However there were no beds available. His risk was recorded as: *"no signs of aggression in the home environment. Has been aggressive when psychotic."* The plan was for the CAMHS Community Psychiatric Nurse (CPN) to visit him the next day and he was prescribed Lorazapam 2mg, to reduce his anxiety, in addition to his current medication which was Risperidone 2 mg two times a day.[8]

A neurophysiology report dated **12 May 2003** concluded that Mr. Z was not displaying any epileptiform abnormality.[9]

On **12 August 2005** Mr. Z's CAMHS CPN wrote to the Adult Mental Health Services referring Mr. Z. He was 17 years of age and not in full time education and no longer met the eligibility criteria for receiving services from CAMHS. The CAMHS CPN, who had been involved with Mr. Z since his initial referral to the service, reported that Mr. Z had been well engaged since his last in-patient admission and had remained well on his medication. She noted that *"he continues to take his medication and he shows insight and is extremely mindful of keeping himself well.*"[10] He had failed to take his medication on only one occasion, for a period of a week. His mother had reported that he became irritable. Mr. Z had maintained a social network and went to the gym but was not engaged in education.[11]

On **24 August 2005** the Manager of the Petherton Resource Centre Team acknowledged the referral letter from CAMHS. He informed the CAMHS CPN that the referral had been accepted and that he would ensure that there was liaison to arrange a care package. However he added: *"Due to unusual service demands and staff vacancies, I am afraid that it will be difficult for us to commit to transfer before October.*"[12]

8 Clinical notes 1-1 p. 584
9 Clinical notes 1-1 p. 816
10 Clinical notes 1-1 803
11 Ibid
12 Clinical notes 1-1 802

On **02 February 2006** the Crisis Team completed the Trust's "New Referrals Risk Screening" form which identifies a number of areas of potential risk and on which the presence or absence of risk, in each area, is recorded. It was noted that Mr. Z was still being seen regularly by the CAMHS.

He was identified as having persecutory beliefs or hallucinations, being at risk of self neglect and having tried to hang himself in the past. At that time he was not identified as a risk to others, to children or a suicide risk.[13]

On **04 May 2006** CPN 1 from the Adult Mental Health Team wrote to the CAMHS CPN confirming that the Adult Service would assume responsibility for the care of Mr. Z. A joint assessment appointment was arranged for 12 May 2006. There was some confusion about the time of this appointment, however, and it was rescheduled for **0**7 June 2006. CPN 1 requested copies of risk and core assessment from the CAMHS CPN for inclusion in Mr. Z's clinical notes. [14]

On **19 May 2006** the CAMHS CPN wrote to Mr. Z's GP informing him that Mr. Z was to be transferred to the Adult Mental Health Services.

On **01 August 2006** the CAMHS CPN and CPN 1 met Mr. Z and his mother. Mr. Z was formally transferred to the Ault Mental Health Services.[15]

On **09 August 2006** Mr. Z was sent a Standard Care Programme Approach (CPA) Care Plan which provided the contact details of CPN 1 and identified that Mr. Z might need extra support if he experienced anxiety or paranoia.[16] The review date for Mr. Z's Care Plan was recorded as December 2006.

On **10 August 2006** the CMHT CPN wrote to Mr. Z's GP informing him that Mr. Z had been transferred to the Adult Mental Health Services.[17]

13 Clinical notes 1-1 550
14 Clinical notes 1-1 800
15 Clinical notes 1-1 797
16 Clinical notes 1-1 708
17 Clinical notes 1-1 797

On **21 August 2006** Mr. Z was referred to Consultant Psychiatrist 1 by the Mental Health Team.[18]

On **05 October 2006** Mr. Z and his mother were seen by Staff Grade Psychiatrist 1 and CPN 1. This was his first psychiatric appointment in Adult Mental Health Services. Mr. Z's mother was concerned about his poor sleep, his mental restlessness, his poor concentration and his sense of paranoia. Mr. Z reported that he was not hearing voices or experiencing any hallucinations at that time.

Depression, Attention Deficit Hyperactivity Disorder (ADHD) and anxiety secondary to a psychotic process were considered as possible diagnoses at this point.

Mr. Z's medication, Risperidone, remained unchanged although the dosage was changed from 2 mg two times a day to 1 mg in the morning and 3 mg at night. The possibility of giving Mr. Z a short course of an antidepressant medication was considered but the decision was deferred until the next review. CPN 1 was to provide Mr. Z with sleep hygiene information.[19]

On **04 December 2006** Mr. Z was referred, at midnight, to the Crisis Team by the Out of Hours GP Service. He had not been seen, at that time, by the GP but Mr. Z's mother was requesting admission. The Crisis Team telephoned Mr. Z's mother. She was concerned that her son would commit suicide. She reported that his mood was changeable and she had removed a knife from his bedroom. Mr. Z's mother also disclosed that he had been taking crack cocaine.

When the Crisis Team spoke to Mr. Z he denied that he had any problems or suicide plans. However, he said that if the Crisis Team visited he would stab them. The team informed Mr. Z's mother that they would not visit to assess Mr. Z at home because of the threat he had made and the risk that this represented. The Crisis Team contacted the out of hours GP service. They, in turn, asked Mr. Z to attend their centre. Mr. Z refused. A GP went out to assess Mr. Z. He concluded that Mr. Z was acutely psychotic and prescribed 10 mg of Diazepam and requested that Mr. Z was seen and assessed the same day.

18 Clinical notes 1-1 502
19 Clinical notes 1-2 215, 1-1 793

The Crisis Team informed CPN 1 what had happened overnight. Mr. Z and his mother were offered an urgent appointment for **05 December.** They wanted CPN 1 and a doctor to visit Mr. Z at home but were informed that this was not possible because of the risk he posed.[20]

On **05 December 2006** Mr. Z and his mother attended an out-patient appointment with the Staff Grade Psychiatrist. Mr. Z's mother recounted the events of the previous few days. She reported that Mr. Z had been feeling suicidal and hearing voices, though Mr. Z was unclear whether the voices were speaking in the first or second person. He had been feeling paranoid and was carrying a knife to protect himself. Mr. Z denied that he had been using illicit drugs.

Mr. Z's mother reported that she had called the GP Service on the previous Friday and Monday nights. She was upset that the Crisis Team would not help her and her son. She said that she did not want to see CPN 1 again. Mr. Z was given leaflets about schizophrenia, anxiety and depression, and about sleep hygiene. His medication was increased to Rispiridone 3 mg two times a day. Mr. Z had been given Diazepam by the GP and had found this helpful. He was prescribed a further supply of this medication to take as he felt he needed it. He was also given Procylidine to take when he felt that he needed it.

The Risk Plan recorded at this time was that if Mr. Z felt suicidal he or his mother should call the Crisis Team, and his appointment with the Staff Grade Psychiatrist or Consultant Psychiatrist 1 would be brought forward.[21]

On **08 December 2006** the Staff Grade Psychiatrist wrote to Mr. Z's GP reporting his review of Mr. Z on 05 December 2006 and the events of the preceding week-end. He noted in this letter that Mr. Z had been allocated a new CPN (CPN 2). He also reported that he had tried to telephone Mr. Z following the interview, as he had promised, but that Mr. Z was not available. He noted that Mr. Z's psychosis appeared to be more than transient and concluded that he was suffering from a schizophrenic illness with some hebephrenic features. Mr. Z was reporting mainly negative symptoms although he did report some positive symptoms.[22]

20 Clinical notes 1-1 702 ff
21 Clinical notes 1-1 790, V1-2 217
22 Clinical notes 1-1n791

On **03 January 2007** Mr. Z was assessed by the Out of Hours GP Service. He was reporting suicidal thoughts and requesting admission to hospital. The GP was concerned because he found Mr. Z surprisingly calm. Mr. Z was subsequently seen by the Crisis Team. His mother, who was present during these assessments, provided most of the information. She reported that Mr. Z's mood had been volatile for several days; he had been hearing voices and had smashed up his bedroom, which he shared with his younger brother, on New Year's Day. He had been threatening to his family and the Police had been called at around 2 a.m. Mr. Z had wanted to be admitted to hospital and was taken to the in-patient unit, where he had previously been admitted. However as he was no longer under the care of the CAMHS he was not admitted.

Mr. Z's mother reported that after returning home he appeared calmer and had gone shopping with her for a birthday present for a relative. However later he had visited an aunt's house where, Mr. Z reported, he had searched for a rope to hang himself. He is reported to have said that he would hang himself if he was not admitted to hospital.

Mr. Z's mother reported that she had been told that Mr. Z had schizophrenia, he, however had not been told this. He denied that he had been drinking or using illicit drugs. Mr. Z's uncle had been staying at the family home for the previous ten days.

Both Mr. Z and his mother were requesting a hospital admission however they decided to delay admission as there was a family 21st birthday party. The plan to be put in place was that the Crisis Team would offer increased support, in addition to the support provided by his Care Co-ordinator. Mr. Z was also prescribed Diazepam to address his anxiety.[23]

The Crisis Team CPN carried out a risk assessment in which Mr. Z was rated as presenting a risk of self harm/suicide, and a risk to others. He was not rated as a risk to children; risk from others was not rated.[24]

On **04 January 2007** Mr. Z was visited at home and it was reported that his uncle had taken a knife from him.[25]

23 Clinical notes p. 1-1 535, 575, 680
24 Clinical notes p. 1-1 564
25 Clinical notes p. 1-1 694

On **05 January 2007** the Crisis Team discussed Mr. Z's presentation with his Care Co-ordinator, CPN 2, who advised that visits should only be undertaken by two members of staff together.

On **05 January 2007** Mr. Z called the Crisis Team asking to see a doctor. A home visit was arranged. Mr. Z reported that he was constantly hearing laughing voices. He felt unable to cope. He felt suicidal and had planned how he would commit suicide.

His mother reported that Mr. Z had taken £20 worth of cocaine the previous evening. She was concerned because he had written a suicide note. She was also concerned that Mr. Z might pose a risk to her other children.

It was recorded that admission the day before had not been accepted by Mr Z and his mother due to a family party. Mr. Z's mother was informed that there were no beds available in Bristol. She was angry at this information and indicated that she no longer wanted input from the Crisis Team. She was advised to contact the Emergency Duty Team if she had concerns. She said that she intended to call the police if Mr. Z *"kicked off."*

The Crisis Team continued to try to find a bed in Bristol. They were unable to contact the on-call manager,[26] however Consultant Psychiatrist 1 authorised employing agency staff (for the ward). At 21.32 hours the Crisis Team informed Mr. Z's mother that a bed was available on Lime Ward and Mr. Z was admitted to hospital.[27]

After Mr. Z's mother had left him Mr. Z took his bag and tried, on two occasions, to leave the ward. The ward had many disturbed patients at this time and Mr. Z was transferred to Hazel Ward, which provided a more secure environment, on Section 5(2) of the Mental Health Act (1983).[28] [29]

On **06 January 2007** Mr. Z's mother telephoned the ward and informed the ward staff that Mr. Z was saying the voices were the worst they have been for some years. They were telling him that he must kill himself or hurt someone else. He felt compelled to act on them. She

26 Clinical notes p. 1-1686, 698
27 Clinical notes p.1-1 695
28 Clinical notes p. 1-1 503, v1-2 159, v1-2 165 ff
29 Clinical notes p.v1-2 171

reported that when her son was unwell he became suspicious and his behaviour became unpredictable. She believed that her son's use of drugs and alcohol contributed to the deterioration in his mental health.[30]

On **07 January 2007** Mr. Z was assessed under the Mental Health Act but was not found to be detainable and was discharged home.[31]

On **08 January 2007** the Crisis Team completed a core assessment. It was recorded that Mr. Z kept a vegetable knife under his pillow. He had threatened his mother with this. It was also recorded that that Mr. Z's mood changed rapidly when he was unwell and he could become violent and nasty towards his mother.

Mr. Z's views were recorded. He said that he wanted support, wanted to move from his mother's home, wanted to reduce his drug use and wanted to have more structure in his life. The Care Plan was that Mr. Z's mental state would be monitored by the Crisis Team and consideration would be given to increasing his Risperidone. This Care Plan was not signed by Mr. Z.[32]

A Risk Assessment was completed on **08 January 2007.** Risks were identified associated with: violence and aggression, substance abuse, persecutory beliefs/hallucinations, suicide and self harm. Whether Mr. Z posed a risk to children was identified as 'unknown'.[33]

On **09 January 2007** Mr. Z was visited at home by the Crisis Team. It was reported that Mr. Z's voices had stopped on the previous Saturday night. He acknowledged, at this interview, that cocaine and cannabis were detrimental to his mental health.

Mr. Z reported that he had been swimming and going to the gym. It was noted that his uncle was continuing to sleep on the sofa in the living room.

Mr. Z's Care Plan was for him to have 6 mg of Risperidone at night and 2 mg of Diazepam when he felt that he needed it. The Crisis Team was to continue to visit him.[34]

30 Clinical notes. 1-1 534, V1-2 161
31 Clinical notes p. 1-1 528 570
32 Clinical notes: p.1-1 528, 570
33 Clinical Notes p. 1-1 664

On **10 January 2007** the Crisis Team visited Mr. Z at home. He appeared settled and denied hearing any voices. He was reluctant to engage with the Crisis Team staff as he wanted to go out with his uncle. Mr. Z's mother was angry with him. She said that he had been pacing both day and night.[35]

Mr. Z was visited again by the Crisis Team on **11 January 2007.** He again denied that he was hearing voices. The staff of the Crisis Team discussed the relationship between Mr. Z's substance misuse and his mental health.

Mr. Z requested help in finding a council flat. His uncle was asleep on the sofa during the interview. It was planned to discharge Mr. Z from the care of the Crisis Team on the following Monday after he had been seen by his Care Co-ordinator.[36]

Mr. Z was seen at home on **15 January 2007.** He reported that his mental state had improved and that his main concern was with his accommodation; he was sharing a room with his younger brother and his uncle was sleeping on the sofa in the living room. He confirmed that he was happy to be discharged from the care of the Crisis Team and was looking forward to working with CPN 2.[37]

On **29 January 2007** CPN 2 visited Mr. Z together with a Community Care Worker. Mr. Z reported that he had been vomiting blood the previous week but had not consulted his GP. He said that he did not feel ready to undertake a college course. He was feeling increasingly *"paranoid"*, to the degree where he was going out of the house only for short periods. He was agitated at night and his concentration was poor. Mr. Z's mother speculated that his brain was not maturing.

Mr. Z said that he had not used illicit drugs since before his last hospital admission and was continuing to take his medication as prescribed. He was due to be reviewed by Consultant Psychiatrist 1 on **06 February 2007**.

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34 Clinical notes p.1-1 675
35 Clinical notes p. 1-1 675
36 Clinical Notes p. 1-1 676
37 Clinical notes p.1-1 677

On **06 February 2007** an Integrated Care Programme Approach (ICPA) Review Meeting was held. Present were Consultant Psychiatrist 1, CPN 2, Mr. Z's mother and Mr. Z. Mr. Z was recorded as suffering from a Paranoid Disorder and an Organic Disorder, possibly the effect of a head injury.

The formulation was that Mr. Z had a four year history of irritability, suspiciousness, low mood and suicide attempts with his mental health being adversely affected by his use of illicit drugs. The formulation was shared with Mr. Z and it was recorded that he agreed with it.

The Care Plan was to support Mr. Z in moving to more independent accommodation; to help him engage in structured activities, such as joining a gym and to explore the possibility of him taking a college course when he was ready. Mr. Z reported that he found it difficult to talk to people about his inner experiences and preferred to go to the gym to release frustration. It was noted that psychological therapies had been considered but there is no discussion in the clinical notes as to what was considered.

It was noted that Mr. Z experienced headaches before he began to hear voices. He agreed to speak to his mother to obtain reassurance when he experienced a headache.

Mr. Z's Risk Management Plan was to inform his mother, his Care Co-ordinator, Consultant Psychiatrist 1, or the Crisis Team if he felt that his mental state was deteriorating.

As Mr. Z had been treated with Risperidone for four years, but still heard voices and experienced distressing thoughts, his medication was changed to Olanzapine 20 mg daily and Zopiclone 15 mg at night. Mr. Z was also referred for neuropsychological testing.

He was identified as posing a risk to himself, by committing suicide; a risk to others, when distressed or angry, and a risk to his siblings in that he could frighten, especially, his younger brother with whom he shared a room.[38]

38 Clinical notes p.1-1 512, 1-2 214

On **14 February 2007** the Community Care Worker (CCW) 1, visited Mr. Z at home. He helped Mr. Z complete a Housing Application Form but noted that Mr. Z was not interested in receiving any other help.[39]

On **02 March 2007** CPN 2 and CCW 1 visited Mr. Z. It was recorded that he was brighter in mood and more talkative. He had been going out on his bicycle with his brother. A further Housing Application Form was completed.[40]

On **20 March 2007** CPN 2 visited Mr. Z. He was on his way out when she arrived and did not want to engage with her.[41]

On **22 March 2007** Mr. Z attempted to hang himself. He had presented at the Accident and Emergency Department of the local hospital and had been referred to the Crisis Team. Mr. Z's mother reported that he had stolen £200 from her and £10 from his brother. When she had confronted him about this he had packed a bag and left home for a friend's house. Mr. Z had climbed on to the roof of the house but was persuaded to come down. His friend said that Mr. Z had taken crack cocaine. Later Mr. Z's younger brother heard a noise and found Mr. Z hanging from the attic hatch handles by a sheet. He had kicked away a chest of drawers. His mother called the Police who cut him down. Mr. Z was attended by paramedics who found him unconscious and fitting. He was seen by a Liaison Psychiatrist and discharged as he was not considered to be psychotic.

Mr. Z's mother found a knife in his room. He told her that he wished that he had died and wanted to cut his throat. It was arranged that the Crisis Team would visit Mr. Z at home as the risk of him committing suicide was high.[42]

On **23 March 2007** Mr. Z was visited by the Crisis Team. He said that he no longer felt suicidal. No evidence of psychosis or of clinical depression was detected. It was concluded that the risk of Mr. Z committing suicide was extremely high in the medium term. Mr. Z was looking forward to a holiday with his brother the following week and it was felt that a hospital admission would increase his feelings of helplessness and reduce family support. It

39 Clinical notes p. 1-2 216
40 Ibid
41 Ibid
42 Clinical notes p.1-2 216

was decided that there was no continuing role for the Crisis Team. It was noted that risk reduction needed to form part of Mr. Z's ongoing Care Plan.[43]

CCW 1 called on Mr. Z on **23 March 2007**. He read a letter with Mr. Z from the Housing Department indicating that he was a low priority for housing. He gave Mr. Z a leaflet from the Bristol Drug project on crack cocaine. Mr. Z's mother said that drug dealers in the local area knew that they should not sell drugs to Mr. Z because of his health problems "*and because they fear retribution from his brothers and herself."*[44]

On **27 March 2007** Mr. Z had an urgent out patient appointment with Consultant Psychiatrist 1 and CPN 2. It was concluded that Mr. Z was experiencing rapidly cycling and non-mood congruent hallucinations. The plan was for Mr. Z to continue to take the anti-psychotic, Olanzapine, and the hypnotic Zopiclone 15 mg. The anti-psychotic Clozaril was also to be considered as was the mood stabiliser, Lithium. It was planned that Mr. Z would be referred to the psychology service for an assessment for Attention Deficit Disorder (ADD).[45]

On **29 March 2007** CCW 1 called at Mr. Z's home to take him to the Bristol Drug Project but Mr. Z was in bed and did not want to attend.[46]

On **02 April 2007** Mr. Z was detained on Section 136 of the Mental Health Act (1983). His mother had called the police after he had gone out into a field to hang himself from a tree. It was recorded that Mr. Z showed no regret. A Mental Health Act assessment was conducted at the police station. Mr. Z reported that he heard voices comment on him and telling him to kill himself. He said that the voices were present regardless of whether or not he took drugs. It was concluded that he continued to present a suicide risk.

Mr. Z was ambivalent about being admitted to hospital and said that he would only remain in hospital for a few days. He later said that he would stay longer if necessary.[47]

A Risk Assessment was completed and it was concluded that Mr. Z presented a significant risk to himself; but currently did not present a risk to others.[48]

43 Clinical notes p. 1-2 219
44 Clinical notes p. 1-2 222
45 Clinical notes 1-2 223
46 Clinical notes p.1-2 224
47 Clinical notes p. 1-1 621, V1-2 224ff

He was admitted to hospital on Section 2 of the Mental Health Act (1983).[49]

On **03 April 2007** Mr. Z was reviewed by the In-Patient Consultant, Consultant Psychiatrist 2. Mr. Z appeared pleasant and co-operative and denied any hallucinations or delusions. Mr. Z's mother reported that she was concerned that her son would kill himself. Consultant Psychiatrist 2 initiated a referral for a neuropsychological assessment to assess any cognitive deficits Mr. Z might have sustained.[50]

When first admitted to hospital Mr. Z was agitated. On **04 April 2007** the nursing notes recorded that Mr. Z had attempted to break down a door and smash light fittings. He was placed in seclusion and given Haloperidol and Lorazepam to help calm him.[51]

On **05 April 2007** Mr. Z was prescribed the mood stabiliser Sodium Valporate. On the same day he absconded from the garden attached to the ward. He was later found and returned to the ward. However he continued to try to leave the ward and picked up a chair to throw at a member of staff. He was restrained and again given medication (Haloperidol and Lorazepam) to help calm him. [52]

Over the next two weeks it was recorded in the nursing notes that Mr. Z continued to abscond or attempt to abscond from the ward. He was recorded as absconded or absent without leave on 06, 10,11,12,14 April 2007. On at least some of these occasions he took cocaine when he was absent from the ward.[53]

On **16 April 2007** a Nursing Report for a Mental Health Review Tribunal noted that Mr. Z had made no attempts at suicide after the first few days of his hospital admission. The Report noted that Mr. Z lost his temper very quickly if his "*needs are not met*". He could be aggressive and throw furniture at staff. It was felt that this behaviour would make him vulnerable in the community. It was also noted that he was sometimes anxious while on leave.

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48 Clinical notes p.1-1 V1-2 225
49 Clinical notes p. 1-1 520
50 Clinical notes p. v1-2 228
51 Clinical notes p. 1-2 151, 16
52 Clinical notes p. 1-1 19
53 Clinical notes p. V1-2 19ff

The Report concluded that Mr. Z had not expressed psychotic symptoms to staff for several weeks; his mood was changeable, low at times but not suicidal; he continued to use crack cocaine which negatively impacted on his mental health and increased his unpredictability. The Report concluded that Mr. Z did *"not appear to be suffering from a mental illness to an extent that really warrants a Section at present.*"[54]

A Social Circumstances Report prepared by CPN 2 on **17 April 2007** noted that Mr. Z had been found, following a suicide attempt, by his mother and 12 year old brother. Mr. Z shared a bedroom with his younger brother who had asthma. Mr. Z smoked in the room and had smashed it up when disturbed. This had frightened his brother. Mr. Z found his brother to be noisy and this upset him. This resulted in friction and arguments between the two brothers.

The report commented that Mr. Z's mother did not believe that Mr. Z was ready for discharge from his Section. She believed that he was still at risk of harming himself, he was continuing to use illicit drugs, was hearing voices, his mood changed quickly and he could be irritable and aggressive. She had reported that she was afraid of him when he had a knife.

Mr. Z wanted to be discharged from his section. He said that he did not feel he would make another attempt on his life and would remain in hospital, voluntarily, but only for a day or two.

CPN 2 recommended that Mr. Z's Section should be continued.[55]

On **18 April 2007** the Mental Health Tribunal upheld Mr. Z's detention under Section 2 of the Mental Health Act (1983).[56]

On **20 April 2007** a Risk Assessment was conducted. Mr. Z was rated as follows:

	Past	Present
Suicide/self harm:	Yes	Yes
From others	Blank	Blank

54 Clinical notes p.1-1 607
55 Clinical notes p.1-1 615
56 Clinical notes p. V1-2 45

To others	Yes	Yes
To Children	No	No.[57]

On **21 April 2007** Mr. Z's mother contacted the ward. She was very upset that Mr. Z was able, repeatedly, to abscond from the ward. She threatened to take legal action and demanded to speak to Mr. Z's Consultant Psychiatrist, Consultant Psychiatrist 2.[58]

On **23 April 2007** Consultant Psychiatrist 2 contacted Mr. Z's mother who agreed that an application to detain Mr. Z under Section 3 of the Mental Health Act (1983) be made.[59]

On **25 April 2007** Consultant Psychiatrist 2 requested a Mental Health Act Assessment as she believed that as Mr. Z had not been able to comply with assessment and treatment while in hospital. She believed that a further period of assessment was required. [60]

On **25 April 2007** Approved Social Worker (ASW) 1 consulted CPN 2. CPN 2 felt that Mr. Z needed a significant period in hospital before community care could be successful. She felt that Mr. Z's suicide attempts were rooted in mental illness not drug use, though his illicit drug use exacerbated the risk of him harming himself. It was noted that the Community Team had tried to care for Mr. Z after a previous suicide attempt, he had agreed to the Plan that had been put in place. However despite this he again attempted to commit suicide.[61]

ASW 1 interviewed Mr. Z with Mr. Z's GP. Mr. Z reported that his mental health had improved since he had been in hospital, "*he felt that he had been able to co-operate fully*" though he acknowledged that he had at times absconded. Mr. Z said the suicide attempts had been driven by being "*a bit low*".

Mr. Z agreed to remain in hospital, informally, "*until Wednesday"* but not for four weeks as recommended by Consultant Psychiatrist 2. ASW 1 and the GP noted no signs of psychosis or depression during the interview.

57 Clinical notes p.1-1 557
58 Clinical notes p. 1-2 51
59 Clinical notes p.V1-2 56
60 Clinical notes p.1-1 605
61 Clinical notes p.1-1 603

"[Mr. Z's] GP felt unable to make an application. This was on the grounds that Mr. Z had been able to work effectively with staff and act appropriately over the previous few days. He felt that he was clearly consenting to treatment and was willing to be informal until at least a week. His RMO felt detention was warranted on the grounds that treatment to stabilise would take 3-4 weeks extra and he had been non-co-operative for the first week of admission."

ASW 1 recorded that he discussed the situation with Consultant Psychiatrist 2. She had indicated that she would request a further Mental Health Act Assessment with a new assessing team and use the provisions of Section 5 of the Mental Health Act if there were major changes in Mr. Z's mental health presentation.

ASW 1 recorded: *"I advised that nursing staff should monitor mental state. If there is deterioration or Mr. Z is not keeping to the informal care he agreed to then the staff should consider a S 5(2) or 5(4) and request a further MHA assessment*."[62]

On the same day Consultant Psychiatrist 2 recorded her concern that a recommendation had not been made to detain Mr. Z under Section 3 of the Mental Health Act (1983). She noted that Mr. Z's Section 2 expired at midnight on Sunday 29 April 2007 and felt that staff would be placed in a difficult position. She recorded that she planned to request a second Mental Health Act Assessment with a Section 12 Approved Doctor.[63]

On **26 April 2007** a Community Care Worker took Mr. Z to the Drug Service drop-in where he saw a drugs advisor. Mr. Z agreed to attend a further session on the following Wednesday.[64]

On **27 April 2007** Consultant Psychiatrist 2 recorded in Mr. Z's clinical notes that she had had a telephone conversation with the Duty ASW who was unwilling to undertake a further Mental Health Act Assessment as Mr. Z had improved significantly. Consultant Psychiatrist 2 recorded that she had been advised to use Section 5 (4) of the Mental Health Act (1983). She had explained that Mr. Z's leave had been rescinded because of his absconding and his risk taking behaviour and, in consequence, he had not had the opportunity to deteriorate as he had

62 Ibid
63 Clinical notes p.V1-2 59
64 Clinical notes p. V1-2 229

been detained on a High Dependency Unit (HDU). She noted that it is poor practice to plan to use a Section 5 (4) or Section 5 (2).[65]

It was reported that the Duty ASW sent an e-mail to all ASWs on duty that day and the following Monday. She copied ASW1 and Consultant Psychiatrist 2 into the e-mail.
"Thought I had better let you know what has happened to this request for a MHA Assessment today. Given [Duty ASW 2] full information to me and a long telephone conversation with [Consultant Psychiatrist 2], I have agreed that I will not be convening a MHA Assessment at this stage. It seems as if [Mr. Z] has made some significant improvements since last Friday in engaging with ward staff and his treatment programme and we should continue to see if he is able to continue as an informal patient. I realise that the timing of his s.2 expiring at midnight on Sunday 29th is not ideal but a s. 5.2 or s.2.4 [5.4 sic] can be implemented if necessary and there do not seem to be grounds at the moment to look at s.3 as [Mr. Z] is complying and there are no signs of deterioration…."[66]

On **27 April 2007** Mr. Z absconded from the ward but retuned in the evening.[67]

Around midnight on **28 April 2007** Mr. Z became very agitated because he believed that his Section had lapsed and he was free to leave the hospital. He could not be convinced that his Section lapsed the next day, 29 April. The Control and Restraint Team was called to help deal with the situation.[68]

Around 16.00 on **29 April 2007** Mr. Z climbed over the fence of the ward garden and absconded.[69]

On **30 April 2007** Mr. Z visited the ward to collect his belongings but could not be persuaded to stay. He left without medication.[70]

An Interim Discharge letter to Mr. Z's GP reported that Mr. Z had discharged himself on 30 April 2007. His diagnosis was recorded as paranoid psychosis. His medication on discharge

65 Clinical notes p. V1-2 63
66 Witness Factual Accuracy statement
67 Clinical notes p. V1-2 64
68 Clinical notes p. V1-2 69
69 Clinical notes p. V1-2 71
70 Clinical notes p. V1-2 72

was Olanzapine 20 mg, once a day and Zopiclone 15 mg once a day. [71] An urgent out-patient appointment was made by CPN 2 for **03 May 2007**. [72]

On **03 May 2007** CPN 2 telephoned Mr. Z to arrange for him to attend his out-patient appointment. Mr. Z's mother informed her that a nephew had hanged himself the day before.[73] When CPN 2 spoke to Mr. Z later in the day he said that he did not feel able to attend his appointment and wanted to spend some time with his family. The appointment was rearranged for the following week.

On **03 May 2007** a Risk Assessment was completed by CPN 2. Mr. Z's risk was rated as follows**:**

	Present	Future
Self harm	Moderate	Moderate
Suicide	Substantial	Critical
From others	Low	Low
To others	Moderate	Substantial
To Children	Moderate	Moderate
Self neglect	Low	Low

It was noted that Mr. Z's mother was at particular risk.

It was noted that Mr. Z had a strong family history of mental health problems; an uncle had committed suicide and a cousin committed suicide in May 2007. In addition a close friend had committed suicide in January 2007.

The Risk Management Plan identified that:

- Mr. Z's engagement in his Care Plan would be facilitated;
- Mr. Z's mother would be supported;
- risk would be discussed with Mr. Z's mother;
- Mr. Z's Risk Management Plan would be revised as the risks he presented changed;
- Consultant Psychiatrist 1 would provide cover for the Care Co-ordinator when she was absent;

71 Clinical notes V1-1 715
72 Clinical notes V1-2 231
73 Clinical notes V1-2 231

- it was not possible to contain Mr. Z's rapidly fluctuating mood by using the Mental Health Act for prolonged periods;
- a review date was set for **05 July 2007**.

It was decided not to share the plan with Mr. Z immediately as he found it difficult to discuss past traumatic events. CPN 2 was to discuss the plan with Mr. Z after consultation with the clinical team.[74]

Mr. Z failed to attend his outpatient appointments on **10 May, 17 May** and **29 May 2007.**[75]

On **29 May 2007** Mr. Z's mother contacted the Crisis Team as she was concerned about her son's safety. His mother reported that he had been taking illicit substances, was not taking his medication and had been aggressive towards her. The Crisis Team contacted CPN 2.

Mr. Z's mother told CPN 2 that her son had been upset by the suicide of his cousin and had said at the funeral *"I'll be with you next week."* [76] She reported that he was taking crack and carrying a knife. She also reported that Mr. Z had hit a woman and she had stabbed him. No charges were being brought. Also a car had been set alight on the drive of the family's house. She believed that this had something to do with a burglary. She said that she had hit her son with a metal bar and kicked him because of his drug use.[77]

The possibility of a home visit to assess Mr. Z was discussed but Consultant Psychiatrist 1 felt that this was too dangerous. Instead he sent Mr. Z an urgent appointment.[78] He also asked the Police for a MAPPA (Multi-Agency Public Protection Arrangement) Level 2 Meeting.[79]

On **7 June 2007** Mr. Z's family requested a Mental Health Act Assessment. However later in the day when Mr. Z returned home and was not in a state of distress the family decided that they no longer wanted an Assessment.[80]

74 Clinical notes p. 1-1 545
75 Clinical notes p. V1-2 232, 1-1 542
76 Clinical notes p. V1-2 233
77 Ibid
78 Clinical notes p. 1-1 599
79 Clinical notes p. V1-2 278
80 Clinical notes p.V1-2 239

On the same day Consultant Psychiatrist 1 wrote to Mr. Z's GP. He noted that he was hoping to return Mr. Z to hospital under Section 3 of the Mental Health Act (1983). *"I would like to push for a Section 3 and a prolonged period of treatment of complex disorder which I believe is a dual diagnosis and some form of fairly significant psychotic disorder. The exact diagnosis of which we are very unclear. He is also very adept at hiding his symptomatology and hates being in hospital, which is of course a problem."*[81]

On **08 June 2007** the Community Support Worker wrote to Mr. Z informing him that as he was not able to visit him at home he was no longer able to offer him community support and, in consequence, was discharging him.[82]

On **14 June 2007** Mr. Z was discussed at a MAPPA meeting**.** Present at the meeting were the Police, Probation, Children and Young People's Services, Consultant Psychiatrist 1 and CPN 2. It was noted that Mr. Z suffered from a psychotic illness and was only partially compliant with treatment. It was recorded that he used crack cocaine and at times carried a knife. The clinical team had not visited for six weeks due to the risk associated with visiting Mr. Z at home. He was not attending his out-patient appointments. It was recorded that he had threatened his mother and she was concerned for her safety, although she did not believe that her other children were at risk from Mr. Z.

Consultant Psychiatrist 1 was of the opinion that Mr. Z suffered from a drug induced psychosis and detaining him in hospital would serve no useful purpose.

It was agreed at this meeting that the Police intelligence would be updated and a Mental Health Assessment sought if Mr. Z were arrested and that a Section 47 (of the Children Act 2005) referral would be made to the Children and Young People's Social Services because of the concern that Mr. Z posed a risk to the safety and well-being of his younger siblings.[83]

On **15 June 2007** CPN 2 telephoned the Child Care Duty Worker at Children's Social Services to make the referral as agreed at the MAPPA meeting. She provided the Duty

81 Clinical notes p. 1-1 751
82 Clinical notes p.1-1 742
83 Clinical notes p. V1-2 268

Worker with details of Mr. Z situation and recorded that she was informed that *"Case not loaded up on the system until I have spoken to [Mr. Z's mother] on Tuesday (19th)."*[84]

On **18 June 2007** it was recorded that Mr. Z had been picked up by the Police over the previous week-end but had not been detained. His mother was concerned as he was not taking his medication.[85]

On **19 June 2007** CPN 2 contacted Mr. Z's mother to inform her about the referral to Children's Social Services. Mr. Z's mother was not happy about this. She said that if Children's Social Services contacted her she would *"put the phone down on them."*[86]

CPN 2 then left a message at Children's Social Services for the case to "*go live*".[87]

On 19 June 2007 Mr. Z was seen by Consultant Psychiatrist 1. He reported that he had not used crack cocaine for four days, though his mother said that he was using drugs all the time. Mr. Z denied any abnormal experiences.[88]

On **20 June 2007** Consultant Psychiatrist 1 wrote to Mr. Z's GP informing him that Mr. Z was misusing crack cocaine, that he had been referred to MAPPA and that a Section 47 Referral had been made to Children's Social Services. The letter noted that Mr. Z's mother had been informed of the Referral and, as a result, wanted nothing more to do with Mental Health Services, instead she wanted Mr. Z to get his medication from his GP in future.[89]

On **21 June 2007** CPN 2 received a telephone call from a Child Care Social Worker who said that she would discuss Mr. Z's referral with her Manager.[90]

On **05 July 2007** Mr. Z failed to attend his out-patient appointment with Consultant Psychiatrist 1 and CPN 2 despite several phone calls to remind him of the appointment. His

84 Clinical notes p. V1-2 272
85 Clinical notes V1-3 242
86 Clinical notes p. V1-2 272
87 Ibid
88 Clinical notes p. V1-2 243
89 Clinical notes p. 1-1 748
90 Clinical notes p. V1-2 273

family informed the clinical team that Mr. Z was missing, he was carrying a knife, he was not speaking to people, he was not eating properly and he was using crack cocaine.[91]

On **09 July 2007** Mr. Z was detained by the Police on a Section 136 of the Mental Health Act (1983). He was noted as being anxious and hallucinating.[92]

On **02 August 2007** CPN 2 received an e-mail message from the Crisis Team. Mr. Z's mother had contacted the team. Mr. Z had been taking drugs, not taking his prescribed medication and was behaving in chaotic manner. He was not willing to speak to the Crisis Team.

CPN 2 contacted Mr. Z's mother who reported that her son was using crack cocaine and possibly heroin. He had been to Court the previous day for stealing and had been given a conditional discharge and fined £200. She reported that Mr. Z was not eating and was aggressive.

Mr. Z's mother was about to go on holiday and believed that her son should be in hospital. She was offered the opportunity to attend a carer's support group but rejected this.

CPN 2 then contacted the Bristol Specialist Drug Service and after discussion with the Staff Grade Psychiatrist it was agreed that Mr. Z should be referred to the Drugs Service.

She also arranged a joint assessment visit with an ASW at Mr. Z's home on **Monday 06 August**. Mr. Z's mother was informed of this.[93]

On **05 August 2007** Mr. Z's mother contacted the Emergency Duty Service asking for a Mental Health Act Assessment. Mr. Z had left the family home on Thursday and was missing for 24 hours. His mother had contacted police. Mr. Z returned home on **Friday 03 August** but went missing again on 04 **August**, returning the following day. Mr. Z's mother felt that Mr. Z was a risk to himself and needed to be in hospital.

91 Clinical notes V1-2 236
92 Clinical notes p. 1-1 741
93 Clinical notes p.V1-2 246

A risk screening was recorded. It was noted that Mr. Z was at risk of harming himself and of committing suicide and his behaviour frightened his siblings.[94]

On **06 August 2007** CPN 2 visited Mr. Z at home with an ASW as planned. When they arrived Mr. Z was in bed and was reluctant to come downstairs. No symptoms of psychosis or suicidal ideas were elicited. Mr. Z said that he did not want anything to do with the Mental Health Team as they had contacted Children's Social Services.

Mr. Z's mother reported that people were coming to the house and threatening Mr. Z. Mr. Z's desire for more independent accommodation was again discussed as was his becoming involved in structured activities and reducing his drug intake. Mr. Z said he believed that he did not need help to stop taking drugs and was reluctant to access any formal help.[95]

On 23 August 2007 Consultant Psychiatrist 1 wrote to CPN 2 informing her that Mr. Z had been assessed at the police station**.** He commented *"This young man appears to be caught up in drug misuse related crime, possibly driven by crack cocaine misuse. He is not currently mentally disordered and we cannot use Mental Health Act to enforce safety and treatment".*[96]

On **23 August 2007** a MAPPA meeting was held. Present were the Police, Probation, Children and Young People's Social Services and Consultant Psychiatrist 1. It was reported that Mr. Z was continuing to use crack cocaine and was stealing to fund his drug misuse habit. He had been convicted earlier in the month for stealing money from a betting shop.

It was also noted that Mr. Z's mother was worried that Mr. Z might stab someone if a victim of his stealing caught up with him.

Mr. Z was not taking medication regularly but he was not showing signs of mental illness.
The Crisis Team were continuing with their policy of not seeing Mr. Z at home due to the risks he posed to staff.

It was agreed that a marker would be put on the Police National Computer (PNC) so that contact would be made with Mental Health Services if Mr. Z were detained. It was also

94 Clinical notes p. 1-1 592
95 Clinical notes p.V1-2 248
96 Clinical notes p. 1-1 745

agreed that Mr. Z would be moved from MAPPA Level 2 to Level 1 (Single agency management).[97]

On the same day Consultant Psychiatrist 1 wrote to CPN 2 informing her of the outcome of the MAPPA meeting. He noted that allegations were being made that Mr. Z was being chased around the area and that guns being pointed out of cars. He noted that while Mr. Z's MAPPA status had been changed everyone accepted that risks remained. He wrote that the opinion of the meeting was that everyone was doing all they could do to work safely, but the risk remained high. There was nothing more the Police, Probation or Child Protection could do. He commented: *"I am sure we are not far away from a tragedy."* He was of the opinion that when appropriate Mr. Z should have a Mental Health Act Assessment.[98]

On **29 August 2007** Mr. Z was arrested for handling stolen goods. He was assessed by Consultant Psychiatrist 1 but found not to be mentally unwell. It was recommended that he was dealt with by the Criminal Justice System.[99]

On **21 September 2007** Mr. Z was arrested for allegedly demanding money at knife point. He was assessed by Consultant Psychiatrist 1, CPN 2 and an ASW. He was found not to be detainable under the Mental Health Act and was processed through Criminal Justice System. Mr. Z was offered an urgent appointment with Consultant Psychiatrist 1 and CPN 2.[100]

On **28 September 2007** Mr. Z's mother contacted CPN 2. Mr. Z had *"collapsed"* and an ambulance had been called. He was assessed by CPN 2 and a Specialist Registrar. Mr. Z reported that his mood was labile and he felt that he was becoming unwell but he did not want to go into hospital immediately. He denied hearing voices or having thoughts of self harm but admitted that he had some paranoid thoughts. Mr. Z had run out of medication and this was re-prescribed.[101]

Mr. Z did not attend his appointment on **09 October 2007.** [102]

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[97] Clinical notes V1-2 262
[98] Clinical notes p. 1-1 746
99 Clinical notes p. 1-1 544, V1-2 251
100 Clinical notes p.1-1 544, 589, V1-2 251,
101 Clinical notes p.V1-2 252
102 Clinical notes p. V1-2 254

On **18 October 2007** Consultant Psychiatrist 1 wrote to Mr. Z's GP informing him that he was about to retire. He expressed concerns about Mr. Z's ongoing mental health problems which he described as a drug induced psychosis and periods of depression secondary to drug misuse. He noted that Mr. Z had recently been assessed while in Police custody but no evidence of mental health problems was identified. He concluded: *"At the present time, in view of the fact that he does not have a primary psychotic illness and knows full well that illicit drugs cause him significant difficulties, we do not feel we can move forward to secure the situation with a Mental Health Act [Assessment]."*[103]

On **22 October 2007** Mr. Z's mother reported that he had been missing since the previous Saturday. He had asked her for money and she had refused. Mr. Z had threatened to kill his mother and younger siblings and burn down the house. Mr. Z's mother wanted her son to be detained under the Mental Health Act. The plan was for Mr. Z to have a Mental Health Act (1983) Assessment if he was detained by the Police. CPN 2 was to maintain contact with Mr. Z's mother.[104]

Mr. Z was arrested on **30 October 2007.** The Court Liaison Team arranged a joint assessment with CPN 2. Mr. Z complained that his mother and brother had been urging him to stop using illicit drugs. He had wanted to hit his mother but instead had kicked the door. His mother had to call the Police.

Mr. Z's older brother was staying at the family home and had taken over Mr. Z's room. He was now sleeping on sofa in the living room.

No evidence of mental illness was detected.[105]

Mr. Z failed to attend his out-patient appointment on **02 November 2007.**[106]

On **05 November 2007** CPN 2 took Mr. Z to the Housing Department where he was given a list of Supported Housing Schemes.[107]

103 Clinical notes p.1-1 722
104 Clinical notes p. V1-2 225
105 Clinical notes p. V1-2 259
106 Clinical notes p. V1-2 260
107 Clinical notes p. V1-2 260

On **19 December 2007** Mr. Z again failed to attend an appointment.[108]

On **10 January 2008** Mr. Z was detained by the Police after he was removed from scaffolding after trying to hang himself. His mother reported that he had also tried to jump out of a bedroom window. She reported that he had a vegetable knife under his pillow which he had threatened to use. No trigger for this episode was identified other than Mr. Z was sleeping poorly and his older brother had taken over his room. Mr. Z said that he had last heard voices around two weeks previously. The differential diagnosis at this time was: substance mis-use, acute psychosis, underlying schizo-affective disorder.

Mr. Z was admitted to hospital under Section 2 of the Mental Health Act (1983).[109]

Mr. Z was discharged from hospital on **15 January 2008,** following a CPA Review. His Care Co-ordinator was not listed as being present at this meeting.[110]

On **15 January 2008** Mr. Z's mother contacted the Crisis Team. She had found her son in the house of a drug dealer. He had sold his jacket for drugs. He was abusive to his mother. She hit him and told him he could not return home that night. Mr. Z's mother was advised to contact Police but was reluctant to do this.[111]

On **17 January 2008** Mr. Z was reviewed by representatives of the Early Intervention Team and the Crisis Team. He said that he felt *"OK"*. His mother reported that his mood changed very quickly. She also reported that she had found the Crisis Team unhelpful as they would not visit. Mr. Z initially declined the offer of support by the Crisis Team but later agreed to be seen every other day and telephoned on alternate days.[112]

On **18 January 2008** Mr. Z was reviewed by a locum Consultant Psychiatrist. He complained of sleeping poorly but would not discuss any abnormal experiences, though the Psychiatrist concluded that he did not appear to be experiencing delusions. Mr. Z said that he was willing to take medication and denied using illicit drugs.[113]

108 Clinical notes p. V1-2 260
109 Clinical notes p. V2 351ff, 375ff
110 Clinical notes p. V2 365
111 Clinical notes p. V2 386
112 Clinical notes p. V2 387
113 Clinical notes p. V2 443

Over the following days the Crisis Team made a number of attempts to contact Mr. Z by telephone without success. They finally made contact with him on **21 January**, when he said that he did not want to see them that day.[114]

On **25 January 2008** Mr. Z failed to attend his appointment with CPN 2 and the Crisis Team. CPN 2 telephoned his mother who informed her that Mr. Z had been questioned the previous night by the Police in connection with a burglary.[115]

On **30 January 2008** Mr. Z was discharged from the care of the Crisis Team. His mother attended the discharge meeting with her son. Mr. Z had been seen on only one occasion by the Crisis Team. Appointments were made to see him at places which were deemed to be safe but Mr. Z consistently failed to attend. [116]

Mr. Z's mother wanted to know how to access help with Mr. Z's drug misuse but did not believe that talking was helpful.[117]

On **05 February 2008** Mr. Z failed to attend his appointment with CPN 2 despite her making a number of telephone calls to encourage him to attend.[118]

On **14 February 2008** Mr. Z failed to attend an appointment at the Fairbridge Project, a Project aimed at developing confidence and motivation in young people, and helping them move into work or education. He had previously indicated that he was keen to attend this Project.[119]

On **27 February 2008** Mr. Z failed to attend a psychiatric review appointment with the Locum Consultant Psychiatrist.[120]

On **6 March 2008** Mr. Z again failed to attend a meeting at the Fairbridge Project.[121]

114 Clinical notes P. V2 388
115 Clinical notes p. V2 399
116 Clinical notes p. V2 437
117 Clinical notes p. V2 400
118 Clinical notes p. V2 410
119 Clinical notes p. V2 402
120 Clinical notes p.V2 403
121 Clinical notes p. V2 403

Mr. Z failed to attend an Enhanced Care Programme Approach Review Meeting on **13 March 2008.** The meeting went ahead in his absence. Mr. Z's GP was recorded as being present at this review. Mr. Z was diagnosed as suffering from a paranoid disorder and possibly from organic brain damage following a head injury when he was a child.

Although the Care Plan acknowledged that Mr. Z was not present at the Review Meeting no strategy was identified to address his disengagement form clinical services. It was noted that he had chosen not to take up the assessment offered by the Specialist Drugs Service.

The risks Mr. Z posed were rated as follows:

	Current	Future
Self harm:	Moderate	Moderate
Suicide:	Serious	Critical
To others:	Moderate	Serious
To children:	Moderate	Moderate

The Risk Management Plan was to offer support to Mr. Z's mother and discuss risk with her; and to change the plan rapidly as risks changed. The review date was identified as **03 September 2008**.[122].

A further risk assessment was recorded on **17 March 2008** in which the risks Mr. Z posed were rated as follows:

	Past	Present
Suicide:	Yes	Yes
From Others:	No	No
To Others:	Yes	Yes
To Children:	Yes	Yes

122 Clinical notes p. V2 345, 403

	Current	Future
Self harm:	Moderate	Moderate
Suicide:	Serious	Critical
To others:	Moderate	Serious
To children:	Moderate	Moderate.[123]

An Enhanced CPA meeting was held on **30 April 2008**. Mr. Z did not attend this meeting.[124] It was noted that: *"It appears that Mr. Z is disengaging from the support of his care team. However it is likely that his mother will contact the team if he is in crisis."*[125]

A further CPA Review Form was completed dated **08 May 2008** this contained the same information as the earlier CPA Reviews.[126] A Risk Assessment was recorded for **09 May 2008**.[127]

On **23 May 2008** Mr. Z was arrested on suspicion of being involved in two burglaries. He was assessed by the Court Assessment and Referral Service (CARS). Mr. Z reported that he was depressed and hearing voices. His mother said that she believed he was unwell and should be admitted to hospital. The conclusion of the assessment was that Mr. Z was not displaying any overt signs of mental illness. However The CARS Nurse arranged a joint assessment with CPN 2, Mr. Z's Care Co-ordinator.

During this later assessment Mr. Z reported that he had been feeling low for the previous two weeks and that he had been hearing voices, though not during the interview. Mr. Z disclosed that he was continuing to misuse illicit drugs. The conclusion of the assessment was, again, that Mr. Z was not showing any overt signs of mental illness.

Mr. Z was bailed to his mother's address with a night curfew from 20.00 to 07.00. [128]

123 Clinical notes p. V2 298
124 Clinical notes p. V2 335
125 Clinical notes p. V2 295
126 Clinical notes V2 4996
127 Clinical notes p. V2 496
128 Clinical notes p. V2 404ff, 457ff

On **26 May 2008** Mr. Z was arrested on suspicion of murder. Following his arrest Mr. Z was assessed to determine whether he was fit to be interviewed by the Police. Mr. Z was found to be oriented in place, person and time; he denied any abnormal experiences and said that he had not heard voices for the previous month. The assessing Psychiatrist concluded that Mr. Z was fit to be interviewed with an Appropriate Adult present.[129]

On **29 May 2008** the Prison Psychiatrist reported that she had seen Mr. Z and he was displaying no signs of a mental disorder. He was refusing to go to the hospital wing of the prison preferring to go on to an open wing of the prison.[130]

On **13 June 2008** it was recorded that Mr. Z had been moved to an open wing of the prison and was doing well.[131]

On **14 April 2009** Mr. Z was found guilty of manslaughter and sentenced to 11 years imprisonment.

129 Clinical notes p. 433
130 Clinical notes p. V2 411
131 Clinical notes p. V2 411

11. Identification of Causal and Contributory Factors and Service Issues.

11.1. 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 national and/or local policy expectation;
2. key causal and contributory factors and service issues.

In the interests of clarity each theme 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 repeatedly redirected to reference material elsewhere in the report. The terms 'causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

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 relationship with the events of 24 May February 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. Z's mental health and/or the failure to manage it effectively.

Service Issue

The term is used in this Report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectations. Identified service issues in this Report whilst having no direct bearing on the events of 24 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.

11.2. The Care Programme Approach

11.2.1. Context.

The Care Programme Approach (CPA) became the main vehicle for delivering high quality Mental Health Care following the NHS and Community Care Act (1990). From April 1991 Health Authorities, in collaboration with Social Services Departments, were required to put in place CPA arrangements for the care and treatment of people with mental health problems.
In *Building Bridges (1995)*[132] the Department of Health identified the four main elements of the CPA:

- a comprehensive assessment of health and social needs;
- a (CPA) Care Plan which addresses the identified needs;
- a care co-ordinator whose responsibility it is to maintain close contact with the service user, to ensure that the care plan is delivered and to monitor the service user's need for care; and
- regular reviews of the individual's needs for care and support with appropriate revisions of the CPA Care Plan.

Prior to 2008, when the Department of Health issued its revised guidance on the CPA,[133] there were two levels of CPA identified: Standard CPA and Enhanced CPA. This, at times, led to a lack of clarity as to the level of service an individual was entitled to. The 2008 guidance sought to clarify the situation:
"All individuals receiving treatment, care and support from secondary mental health services are entitled to receive high quality care based on an individual assessment of the range of

132 Dept of Health (1995) *Building Bridges: A guide to arrangements for inter–agency working for the care and protection of severely mentally ill people*.
133 Dept of Health (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*

their needs and choices. The needs and involvement of people receiving services (service users) and their carers should be central to service delivery." [134]

"It is clear that all service users should have access to high quality, evidence-based mental health services. For those requiring standard CPA it has never been the intention that complicated systems of support should surround this as they are unnecessary. The rights that service users have to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be good practice for all."[135]

11.2.2 Transition between and Access to Services:

11.2.2.1 Local Context

In discussing the transfer of service users from CAMHS to Adult Mental Health Services the Avon and Wiltshire Mental Health Partnership NHS Trust's (the Trust) Integrated Care Programme Approach Policy (2007) notes that:

"Transitional arrangements must provide a 'joined up' approach when service users transfer between services, based on the following principles:

- *a flexibility of approach based on a service user's identified needs and not on age alone;*
- *an appropriate handover period;*
- *joint review and identification of who is responsible for actions;*
- *support from the previous services as required during the transition period."*[136]

The Trust *Framework for Transition from Child to Adult Mental Health Services* (2004) identified 13 standards which set out good practice in considerably more detail.

"Standard 1

The needs of the service user and not the service should be paramount.

Standard 2

Preparation for a smooth transition should ideally begin at least 6 months before the young person is due to leave the Child Service. CAMHS is responsible for initiating this through discussion with the young person and their parents or carers….and by approaching AMHS with a written referral summarising the case and reasons for transfer of care.

134 Ibid p. 2
135 Ibid p. 11
136 Avon and Wiltshire Mental Health Partnership NHS Trust (2007) ICPA and the Assessment and Management of Risk: Policy, Procedure and Guidance p.33

Standard 3

Where it is agreed that the young person has needs that are likely to be met in a specialist service within AMH, the CAMHS clinician initiating the transfer will approach the specialist service ….

Standard 4

Within 2 weeks of receipt of the referral the AMHS must decide whether the young person meets the entry criteria for their service. If they do a named Care Co-ordinator must be identified and CAMHS informed who this is to be.

Standard 5

Where the young person is deemed not to meet the entry criteria for AMHS this must be communicated within two weeks of receipt of referral to the referring CAMHS clinician…

Standard 6

Within 8 weeks of receiving the name of the AMHS Care Co-ordinator, the CAMHS clinician(s) involved should convene a meeting involving the young person, their parents or carers (where appropriate) and the Care Co-ordinator. Other relevant agencies (e.g., SSD) should also be involved. The purpose of this meeting is to

a) reach agreement on what services will be needed … The young person and their carer must be given written information about the services to which they will be entitled.

b) draw up a Care Plan with a clearly defined exit from CAMHS / entry to AMHS strategy.

Standard 7

At the Care Planning meeting the doctor with Medical Responsibility must be identified….

Standard 8

All agencies involved in a young person's care will be informed in advance of the transition and a date for transfer of care be clearly stated.

Standard 9

Preparation for the transfer to AMHS will involve discussion with the young person and their carers in understanding the need for the young person to become responsible for attendance at services and compliance with treatments offered. These discussions should be documented in the notes and any difficulties encountered must be communicated in writing to the AMHS Care Co-ordinator.

Standard 10

At initial appointments with AMHS a CAMHS worker known to the young person should be present in order to provide support and ensure attendance. In some cases initial

appointments with AMHS might be better held at the young person's familiar CAMHS service.

Standard 11

A period of joint care may be beneficial to the young person. When this does occur there must be a clear agreement between both services, including consultation with the young person and their family, about the details of care to be provided, how long the arrangement will continue and how it will be reviewed. The issue of medical responsibility must be clearly defined to all involved.

Standard 12

Transfer of Care must take place generally at a time when the young person is not acutely unwell.

Standard 13

To smooth the transfer of information from CAMHS to AMHS it is the responsibility of CAMHS clinicians to ensure that the case notes are comprehensively summarised. CAMHS will retain the case notes as they often contain information pertaining to parents and siblings, which will be inappropriate to transfer."[137]

11.2.2.2 Findings of the Internal Investigation

The findings of the Internal Investigation with respect to the transfer of Mr. Z from CAHMS to Adult Mental Health Services are reported below.

"Transition process from CAMHS to Adult Services

Although CAMHS made the initial approach to Adult Services in a timely way in August 2005 when [Mr. Z] was 17 years and 3 months, and although the letter was acknowledged within two weeks, no care co-ordinator was identified at this stage. In the acknowledgement letter, the team manager says that it will be unlikely that they will be able to commit to a transfer before October, due to service demands and staff vacancies. In fact it was not until June 2006 that [Mr. Z] formally transferred to adult services, although he was offered an appointment in May 2006. His main contact with adult services then seems to have been through outpatient appointments with the staff grade psychiatrist, offered on a monthly basis, although he did not attend one until early October.

137 Avon and Wiltshire Mental Health Partnership Trust (2004) Framework *for Transition from Child to Adult Mental Health Service*.

Given he had had two previous admissions to the [In-patient] Unit when he was 15 years of age and had been given a diagnosis at that stage of paranoid psychosis a much tighter transfer to adult services, with more frequent efforts to engage with him, probably in an 'assertive outreach' way, was indicated. The referral letter to adult services refers to [Mr. Y] being 'well engaged… shows insight and is extremely mindful of keeping himself well'. The gap between his contact with CAMHS and intensive efforts to engage him in adult services may have decreased the likelihood of successful engagement.

At the time of first contact with Adult Services, the services in Bristol were in a state of transition from Community Mental Health Teams to more functionally based teams. This may partly explain why there was a delay of ten months before it was possible to identify a care co-ordinator and to effect a transfer from Child and Adolescent Services to Adult Services.

Additionally, the Bristol Early Intervention Team, which specifically provides a service for young people in the first three years following a first episode of psychosis, did not become operational until February 2007…. This team has established good working links with both the [In-patient] Adolescent Unit and local CAMH services, and would have worked with CAMHS to actively engage with [Mr. Z] from the age of 16 years. The Early Intervention philosophy would have suggested a much greater frequency of contact with [Mr. Z] and his family, particularly in the early stage of his contact with the service."[138]

11.2.2.3 Findings of the Independent Investigation

Mr. Z was first referred to Mental Health services in September 2002 with symptoms of anxiety, poor sleep and paranoid ideation. [139] Later the same month he was admitted to hospital on Section 2 of the Mental Health Act (1983) having been found with a ligature around his neck.[140] He was re-admitted to hospital in April 2003 with acute psychotic symptoms.[141]

In August 2005 Mr. Z referred to Adult Mental Health Services by the CAHM Service. The referral letter noted that Mr. Z had been well engaged since his last in-patient admission and

[138] Avon and Wiltshire Mental Health Partnership NHS Trust: ROOT CAUSE ANALYSIS REPORT: On the alleged fatal stabbing of [Mr. A] by [Mr. Y]
[139] Clinical Notes 1-1 803
[140] Clinical notes 1-1 542
[141] Clinical Notes 1-1 807

had remained well on his mediation. The referral letter noted that "[Mr. Z] *continues to take his medication and he shows insight and is extremely mindful of keeping himself well.*"[142]

The Adult Mental Health Team responded to the referral within two weeks but noted that "*Due to unusual service demands and staff vacancies, I am afraid that it will be difficult for us to commit to transfer before October.*"[143] It was not until May 2006 that a joint assessment appointment was arranged and Mr. Z was not formally transferred until August 2006.[144]

11.2.2.4 Conclusion

The Independent Investigation Team agrees with the conclusions of the Internal Investigation. While the CAHM Service referred Mr. Z in a timely manner and the response of the CMHT was within the two weeks specified by Trust policy, Mr. Z was not formally transferred to Adult Services until August 2006, almost a year later. This delay might not, in itself, have been a problem had this period of time been used to support the smooth transfer of care from one service to the other. However, having noted that there were *"unusual service demands and staff vacancies"* no planning relating to the transfer of Mr. Z appears to have taken place until May 2006, nine months after the referral. The Independent Investigation Team was informed that this was a period when services were being reconfigured and the letter acknowledging Mr. Z's referral noted that there were staff vacancies at that time. However re-organisation and staff vacancies within the health services are not unusual occurrences. The Trust policy highlights some of the dangers associated with the transfer from CAMHS to adult services. Knowing that there was likely to be a delay in transferring Mr. Z to adult services, good practice would have indicated that this period should have been used, in a planned fashion, to increase the likelihood that Mr. Z's transition was successful and that he was successfully engaged in Adult Services. This is particularly the case as Mr. Z had been admitted to hospital on two occasions, once under a Section of the Mental Health Act; he had made serious attempts on his life and had been diagnosed as suffering from a psychosis.

Mr. Z was assessed by the Crisis Team in February 2006. This was a particular opportunity to review how services might be best delivered to Mr. Z.

[142] Clinical notes 1-1 803
143 Clinical notes 1-1 802
144 Clinical notes 1-1 797

An Early Intervention in Psychosis Service came into being in February 2007 and Mr. Z was one of its first clients. The Independent Investigation Team was informed that since the inception of this team there are much closer relationships between CAMHS and Adult Services and transfers between the two services now reflect best practice.

11.2 3 Level of CPA and engagement of Mr. Z in Adult Services.

11.2.3.1 The Trust's Integrated Care Programme Approach (ICPA) in force at the time Mr. Z was transferred to Adult Services in August 2005 in line with the national guidance at the time identified two levels of CPA: Standard and Enhanced.

"National guidance describes two levels of ICPA: Standard and Enhanced. The service user's ICPA level is determined by the level of identified risk and the complexity of the plan of care.

It is expected that service users on the ICPA Register may move between standard and enhanced levels of ICPA as their needs change….

2.1 Enhanced Level

Enhanced ICPA reflects an increased necessity for monitoring and co-ordination of the care package. This level indicates a higher level of risk, crisis and contingency planning and attention to detail in communication, co-operation, and planning for staff absences. This is particularly relevant at times of change, during transfer of care, or when there are disagreements regarding assessment of need or care planning.

Enhanced ICPA requires a level of responsiveness from the care co-ordinator that must be reflected in the profile of the care co-ordinator's caseload. General guidance indicates that service users on Enhanced Level ICPA are likely to have some of the following characteristics:

- *they have multiple care needs, including housing and employment which, require inter-agency co-ordination;*
- *they are only willing to co-operate with one professional or agency, but they have multiple care needs;*
- *they are, or have been detained under a Section of the Mental Health Act;*

- *they may be in contact with a number of agencies (including the Criminal Justice System);*
- *they are likely to require more frequent and intensive interventions, perhaps with medication management;*
- *they are more likely to have mental health problems co-existing with other problems such as substance misuse;*
- *they are more likely to be at risk of harming themselves or others;*
- *they are more likely to disengage from services;*
- *the carer is at high/moderate risk of abuse/assault from the service user.*

Within AWP, Enhanced Level ICPA applies to the majority of service users accepted for care and treatment by Secondary Mental Health Services, and always to all service users in the following groups:

- *Inpatients;*
- *Crisis and Home Treatment service users;*
- *Assertive Outreach service users;*
- *Forensic Services;*
- *Service users under a Section of the Mental Health Act 1983, or subject to S117 aftercare arrangements.*

2.2 Standard Level

General guidance indicates that the characteristics of service users on ICPA Standard Level will include some of the following:

- *they require the support or intervention of one mental health professional;*
- *they require only low key support from their GP;*
- *they are more able to self-manage their mental health problems;*
- *they have an active informal support network;*
- *they pose little danger to themselves or others;*
- *they are more likely to maintain appropriate contact with services.*

Service users remaining on Standard Level ICPA for an extended period should be considered for return to the care of Primary Care Services.

Within AWP, Standard Level will apply only when the service user requires the input of one professional only on an outpatient basis ***and*** *the service user does not meet the threshold for Enhanced Level ICPA (this decision must be clearly recorded in the service user's health and social care record)."*[145]

11.2.3.2 Findings of the Internal Investigation.

"Inappropriate Level of ICPA initially

On 09 August 2006, [Mr. Z] was given a standard level ICPA care plan. This was based on [CPN 1's] perception that [Mr. Z's] suicide risk was reduced, his mental health was well maintained, and that he was not aware of any drug use at that time. Given what was known about [Mr. Z's] family and social circumstances, his history of self harm, together with his age, previous involvement with CAMHS, and history of acute psychotic symptomatology, it would have been more appropriate for him to be placed on enhanced ICPA. One goal was mentioned, namely that [CPN 1] and [Mr. Z] would meet in two weeks to begin to establish a therapeutic relationship.

4. Initial ICPA plans inadequately addressing [Mr. Z's] needs.

On 06 October 2006 the care plan (which appears to be on a standard level care plan letter format) mentions medication and the provision of information on sleep hygiene.

On 08 December 2006, the care plan letter mentions medication, advice to contact the CWHIS if mental state deteriorates, and a pointer towards discussing involvement with community groups with [CPN 2].

On 04 January 2007, the care plan letter indicates difficulties in engaging with [CPN 2] and mentions medication, seeing [CPN 2], permission for [CPN 2] to discuss things with [Mr. Z's] mother, and [CPN 2} to look into longer term support for [Mr. Z] and his mother.

It is not until 06 February 2007 that we see the first enhanced level care plan with a detailed and comprehensive care plan which appears to address the range of [Mr. Z's] difficulties.

It is difficult to know if the initial ICPA plans reflect the level of care offered to [Mr. Z] during this initial period of care prior to his being taken onto the Early Intervention Team caseload, but if so, the lack of a sufficiently comprehensive care plan focusing on [Mr. Z's] needs may have contributed to his poor engagement with the service. When [CPN 2} picked

145 Avon and Wiltshire Mental Health Partnership NHS Trust (2007) ICPA and the Assessment and Management of Risk: Policy, Procedure and Guidance p.10ff

up the case in December 2006, her attempts to develop a more comprehensive plan were initially thwarted by the family asking for contact to be postponed until the New Year, and subsequently by the need to deal with [Mr. Z's} crisis in early January."[146]

11.2.3.3 Findings of the Independent Investigation

When he was accepted into the Adult Mental Health Services on 09 August 2006 Mr. Z was placed on the Standard level of CPA and was sent a Standard CPA Care Plan which provided the contact details of CPN 1 and identified that Mr. Z might need extra support if he experienced anxiety or paranoia.[147] The review date for Mr. Z's care plan was recorded as December 2006.

In October 2006 Mr. Z's mother reported her concerns about her son's poor sleep, his mental restlessness, his poor concentration and his sense of paranoia.[148] By December 2006 she was requesting that her son be admitted to hospital because she believed that he might try to kill himself[149] and in January 2007 Mr. Z was briefly admitted to hospital[150] and subsequently received input from the Crisis Team.[151]

On 06 February 2007 an ICPA Review was held and Mr. Z was recorded as being on the Enhanced Level of CPA. [152]

11.2.3.4 Conclusions

Given that Mr. Z was transferred from CAMH Services, and that he had attempted to kill himself, had been detained under the Mental Health Act, had received a diagnosis of acute psychosis and had been assessed by the Crisis Team while awaiting transfer to Adult Mental Health Services, it would have at least been prudent to consider whether Mr. Z's needs would have been best met if he had been placed on the Enhanced Level of CPA. As noted above all those referred to Mental Health Services should have appropriate assessment resulting in a care plan. When an individual is placed on an Enhanced Level of CPA the assessment is more clearly structured and more explicitly comprehensive. Given the fluctuating nature of

146 Avon and Wiltshire Mental Health Partnership NHS Trust: ROOT CAUSE ANALYSIS REPORT: On the alleged fatal stabbing of [Mr. A] by [Mr. Y]
147 Clinical notes 1-1 708
148 Clinical notes 1-2 215, 1-1 793
149 Clinical notes 1-1 702 ff
150 Clinical notes p.1-1 695
151 Clinical notes p.1-1 677
152 Clinical notes p. 1-1 512, 1-2 214

Mr. Z's presentation, his use of illicit drugs and the dynamics of his family, it is reasonable to assume that such a comprehensive assessment and Care Plan would have enhanced the care he received and possibly improved his engagement with Adult Mental Health Services.

Given that Mr. Z had been in contact with Mental Health Services since September 2002 the content of Mr. Z's first Care Plan can be regarded as rather limited. It identified that Mr. Z might need extra support if he experienced anxiety or paranoia and a goal was set for CPN 1 to meet Mr. Z, two weeks after the care plan was recorded, to *"establish a therapeutic relationship."*[153] The purpose of Mr. Z's involvement with Mental Health Services is not identified and no clear, agreed outcomes are identified.

By 05 October 2006, when Mr. Mr. Z was reviewed by the Staff Grade Psychiatrist, his mother had made it clear that she felt that his mental health was poor and she was concerned about the risk he posed to himself. Mr. Z's medication was reviewed at this time and he was provided with information on sleep hygiene. Again there does not appear to have been any consideration that a more comprehensive assessment and Care Plan should be undertaken or that Mr. Z's CPA status should be changed from Standard to Enhanced.

From the beginning of December 2006 there were suggestions that Mr. Z's mental state was beginning to deteriorate culminating in him being admitted to hospital on 05 January 2007. However when Mr. Z was reviewed on 05 December 2006 his Care Plan consisted of increasing his medication and providing him with information about schizophrenia, anxiety, depression and sleep hygiene. Again no consideration appears to have been given to his CPA status or to undertake a more comprehensive assessment.

In preparation for the establishment of the Early Intervention in Psychosis Service Mr. Z was transferred to the care of CPN 2, who was to be one of the members of staff of the new service. CPN 2 tried to initiate contact with Mr. Z in December 2006 but he and his mother wanted to defer this until after the Christmas period. However by that time a crisis had occurred and Mr. Z was being seen by the Crisis Team.

153 Clinical notes 1-1 708

CPN 2 did undertake a more comprehensive assessment and convened an Enhanced ICPA Review on 06 February 2007. This was six months after his care had been transferred to Adult Mental Health Services, after he had been admitted to hospital and assessed under the Mental Health Act and been under the care of the Crisis Team.

The Trust Care Programme Approach Policy states:
"Enhanced ICPA reflects an increased necessity for monitoring and co-ordination of the care package. This level indicates a higher level of risk, crisis and contingency planning and attention to detail in communication, co-operation, and planning for staff absences. This is particularly relevant at times of change, during transfer of care, or when there are disagreements regarding assessment of need or care planning."

Best practice, as set out in Trust policies, was not followed in transferring Mr. Z from CAMH Services to Adult Mental Health Services. Following his transfer to Adult Services he was placed on the Standard Level of CPA when Trust Policy and good clinical practice would have suggested that consideration should have been given to placing an individual with a prolonged contact with Mental Health Services and identified vulnerabilities on the Enhanced Level of CPA, with its more explicitly comprehensive assessment and care plans.

It was reported by the CAMHS CPN that Mr. Z was well engaged with that service, his engagement with Adult Services was much poorer. It is impossible to know, however, whether a better transfer of care and more robust and comprehensive care planning would have resulted in better engagement by Mr. Z in adult services. However it is reasonable to conclude that this would have been more likely to be beneficial than detrimental to his mental health and well-being.

11.2.4 Care Planning

11.2.4.1 Findings of the Independent Investigation

The essence of the Care Programme Approach is to ensure that the service user receives a comprehensive assessment of his/her needs and that a Care Plan, agreed with the service user, is developed to address these identified needs.

Between Mr. Z being transferred to the Adult Mental Health Services in August 2006 and him being admitted to hospital in January 2007 four Standard CPA Care Plans are recorded in

his clinical notes. Three of these Care Plans contain Risk Management Plans. Being Standard Care Plans they are brief and address only Mr. Z's medication regimen, his sleep and what he might do if his mental state deteriorated.

Following his discharge from hospital CPN2 organised Mr. Z's first, more comprehensive Enhanced CPA review in February 2007.

Employing the Trust's CPA paperwork, the CPA Assessment and Care Plan covered a number of areas of Mr. Z's life including: his desire for alternative accommodation, the need for structured activities and education, how he might address his anxieties, paranoia and sense of frustration and his use of illicit drugs. His medication was reviewed and it was noted that psychological therapies were considered, although other than noting that Mr. Z found it difficult to talk about his inner experiences there is no discussion in the clinical record as to what was considered. The risks Mr. Z posed to himself and others were also recorded.[154] This Review and Care Plan was comprehensive in its scope as it followed the Trust's Template.

Mr. Z's Care Plan was due to be reviewed on 05 July 2007. However by that time Mr. Z had spent a month in hospital on Section 2 of the Mental Health Act (1983) and been under the care of the Crisis Team. Good practice dictates that a CPA review is held before a service user is discharged from hospital. However Mr. Z left hospital against the advice of those caring for him as soon as his Section lapsed and he could not be persuaded to remain in hospital while an appropriate plan of care and support was put in place.

Mr. Z was given an urgent appointment with Consultant Psychiatrist 1 and CPN 2 following him leaving hospital but he felt unable to attend this as his cousin had recently committed suicide. In his absence a Management Plan was put in place which noted the need to engage Mr. Z in his Care Plan, to offer his mother support and the need for Mr. Z's Risk Management Plan to be responsive to his changing mental state. No strategy as to how Mr. Z might be engaged is recorded, however; nor was any strategy recorded as to how the factors, which had precipitated the deterioration of Mr. Z's mental health in December 2006 and January 2007, might be addressed.

154 Clinical notes p.1-1 512, 1-2 214

Over the following months Mr. Z was reviewed at two MAPPA meetings and assessed on a number of occasions following him being detained by the Police. However it was not until 13 March 2008 that Mr. Z's next formal CPA Review took place. Mr. Z failed to attend this. A further CPA Review took place on 30 April 2008. Again Mr. Z failed to attend this meeting. It was noted *"It appears that Mr. Z is disengaging from the support of his Care Team. However it is likely that his mother will contact the Team if he is in crisis."*[155]

11.2.4.2 Conclusion

Once Mr. Z's care was transferred to CPN 2 she ensured that he was placed on the Enhanced Level of CPA and a comprehensive assessment of his needs took place. A date was identified to review the Care Plan but this was overtaken by fluctuations in Mr. Z's mental state and the responses of the service to this. By the time a further review was organised Mr. Z had, to a very considerable degree disengaged from the service. He had, however, been assessed on a number of occasions when it was concluded that there were no obvious signs of a serious mental illness. The assessments that took place over this period tended to be in response to specific incidents or crises. They were focused assessments addressing Mr. Z's mental state or put in place plans to address the immediate crisis. They were not the comprehensive Assessments and Care Plans envisaged by the Care Programme Approach. A Management Plan was drawn up on 03 May 2007 following Mr. Z discharging himself from hospital. While it was good practice to put in place a Risk Management Plan at this time, it would have been both good practice and prudent to have held a CPA Review to ensure that there was a clear formulation of Mr. Z's needs, to plan his care in a comprehensive manner and to address the identified difficulties with engagement.

11.2.5 Engagement

11.2.5.1 Findings of the Internal Investigation

"5. Limited strategies for tackling [Mr. Z's] lack of engagement with care plans

> *Although the Early Intervention Team had put together a good and comprehensive care plan … [Mr. Z's] limited engagement meant that it was not possible to implement most aspects of the plan. …… Although it may appear that when the original plan was not working, the team took a 'wait and see' attitude, rather than look to see what alternatives there were, this followed a good deal of reflection and*

[155] Clinical notes p. V2 295

discussion within supervision and team meetings. The Team had received some training in motivational interviewing..... The Team did not seek additional consultation from other parts of the service as they felt that they understood why [Mr. Z] was not engaging, and that they had an appropriate plan of action……

11.5.1 Establishing meaningful engagement

By the time [Mr. Z] was transferred to [CPN 2]…it proved difficult to develop an effective engagement. This did not relate to a poor relationship between [CPN 2] and [Mr. Z], as [Mr. Z] was always warm towards [CPN 2] but to [Mr. Z's] view that what the team had to offer was largely irrelevant to him. The Mental Health Policy Implementation Guidance suggests that 'focusing on the strength and the interests of the service user and the benefits that the contact with the service can bring' can help increase engagement. [CPN 2] reports that the Team did attempt to do this…. but that whilst [Mr. Z] was happy to agree in theory to particular goals or activities, he would usually not co-operate with the follow through of these plans.

[CCW 1] was introduced to [Mr. Z] as a community care worker to support him in accessing appropriate social, educational and health related activities. [CCW 1] found [Mr. Z] to be lacking in motivation to follow through agreed plans. ….. [CCW 1] …..had limited experience and training in how to manage situations like this, although he did receive support and supervision from [CPN 2] in relation to his input. It is possible that with more experience he may have been able to be more assertive or persuasive with [Mr. Z]."[156]

11.2.5.2 Findings of the Independent Investigation

The Independent Investigation Team concurs with the analysis and conclusion of the Internal Investigation.

In August 2006, when Mr. Z was referred to the Adult Mental Health services, it was reported that he was well engaged with the CAMH service. Following his transfer Mr. Z appears to have been offered a low intensity service, nevertheless he did attend at least three out-patient appointments between August and December 2006. However from December 2006 Mr. Z's presentation began to change. Around this time Mr. Z's mother began to

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contact the service at times of crisis and Mr. Z was admitted to hospital, briefly, in January 2007 and then for a more prolonged period in April 2007. As noted above a Care Plan was drawn up in February 2007, however much of the contact the service had with Mr. Z between this time and his admission to hospital in April was in response to his mother's requests for help in crisis or dealing with the consequences of crises.

This pattern of non-engagement on the part of Mr. Z continued following his discharge from hospital. Mr. Z failed to attend most of his appointments. Contact was maintained primarily through his mother, who contacted the service at times of crisis. He was seen on an increasingly frequent basis when detained by the police, either because he had made an attempt to harm himself or in relation to alleged criminal activity.

In June 2007 the Service's relationship with Mr. Z reached a low point following the decision to refer his case to Children's Social Services. Both Mr. Z and his mother were unhappy about this referral.

The degree of Mr. Z's disengagement from the Mental Heath Services is illustrated by the fact that although he was under the care of the Crisis Team from 15 to 30 January 2008, following an in-patient admission and a serious attempt to harm himself, he was seen on only one occasion.

A number of factors coalesced to make engaging Mr. Z difficult: he was not motivated to engage with the Mental Health Services as they did not address his perceived needs; often, when he was assessed, it was determined that he was not displaying any symptoms of a serious mental illness; his abnormal experiences were identified as being the result of his use of illicit drugs and he showed no evidence of wanting to address this issue.

The situation was exacerbated by the restrictions placed on meeting Mr. Z. As early as December 2006 the Crisis Team refused to visit Mr. Z at home because he had threatened to stab any member of staff who visited. It appears that the Crisis Team did visit Mr. Z at his home in January 2007. However by August 2007 it was deemed too dangerous to visit him at home and the plan was to see him only at venues which were deemed to be safe. Mr. Z, however, frequently failed to attend these meetings. Mr. Z's mother complained that she found the Crisis Team unsupportive because they would not see her son at home.

In May 2007 Mr. Z's mother contacted the Mental Health services with concerns about the safety of her son. Although a home visit to assess Mr. Z was considered it was decided that this was too dangerous and Mr. Z was, instead, given an urgent out-patient appointment.

Similarly in June 2007 the Community Care Worker discharged Mr. Z as he was unable to see him at home and felt that there were no activities he could support Mr. Z in pursuing.

CPN 2 attempted to deliver a planned service. She visited Mr. Z at home on a number of occasions and attempted to maintain contact with him by telephone. She maintained contact, by telephone with Mr. Z's mother. However Mr. Z consistently failed to attend his appointments with her, with Consultant Psychiatrist 1 and with other services which CPN 2 had arranged for Mr. Z to have contact with. Contact with Mr. Z was increasingly determined by the crises in which he found himself. Between August 2007 and May 2008 he was assessed on at least six occasions following him being detained by the Police.

The meeting to discharge Mr. Z from the care of the Crisis Team, on 30 January 2008, appears to have been the last planned direct contact with Mr. Z.

11.2.5.3 Conclusion

It would appear that because of the difficulties identified above Mr. Z, although identified as being under the care of the Early Intervention Team and on Enhanced CPA, was *de facto* not receiving a planned service to meet his identified needs, which is the essence of the Care Programme Approach.

It was not within the gift of the Early Intervention Team to ensure that Mr. Z was more co-operative with the services offered or to ensure that his lifestyle was less chaotic. It would have been irresponsible and inappropriate to ignore the risk that had been identified. However Services do have a duty to ensure that they do all that is reasonable to deliver services which meet the needs of those under their care.

The Internal Investigation commented:

"Although it may appear that when the original plan was not working, the team took a 'wait and see' attitude, rather than look to see what alternatives there were, this followed a good deal of reflection and discussion within supervision and team meetings. The team had

received some training in motivational interviewing…The team did not seek additional consultation from other parts of the service as they felt that they understood why [Mr. Z] was not engaging, and that they had an appropriate plan of action"[157]

The clinical witnesses to the Independent Investigation were able to articulate, clearly, their approach to their provision of services to Mr. Z. They informed the Independent Investigation Team that there was a clear conceptualisation of Mr. Z's mental health problems. Mr. Z had psychotic episodes related to a troubled upbringing and he had been using illicit drugs since the age of 11 which contributed to his presentation. In response to this formulation, Mr. Z was receiving medication to address his psychotic symptomatology and the Early Intervention Team were trying to engage Mr. Z in age appropriate Recovery work which they saw as providing a longer term perspective, even when it was unclear what was happening in the short term.

Adopting an approach informed by the Recovery Model to Mr. Z's difficulties was appropriate and reflected relevant guidance. However, it has to be noted that throughout 2007 and 2008, and particularly following him leaving hospital at the end of April 2007, his life became increasingly chaotic, he failed to attend appointments and was disengaging from the service, and his involvement with the Criminal Justice System increased. The aspiration to involve Mr. Z in age-appropriate recovery work was not being realised and his response to medication could not be monitored effectively. Mr. Z was not receiving a planned service.

Good practice would suggest that following his non-attendance at several appointments a review should have been held to identify how a service might be delivered to Mr. Z. Similarly CPA reviews should have been held when it was noted that his involvement with the Criminal Justice System was increasing and when Consultant Psychiatrist 1 retired. The Internal Investigation concluded that the Team adopted a *"wait and see"* approach after a good deal of reflection and discussion. However there is no record, in the multi-disciplinary team notes, of this decision being made at a CPA Review. This would have been the appropriate forum for such a decision to be made. The CPA Review is intended to be a place where those clinicians directly involved in the care of a service user, together with others who

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have relevant expertise and other relevant teams or agencies and, where possible, the individual and his/her family, come together to reflect on the individual's needs and identify how these can be best met. There is no evidence in Mr. Z's clinical notes that such a multi-disciplinary multi-team/agency meeting took place or that the reflection such a meeting is intended to promote took place. The MAPPA meeting, although it is a multi-agency meeting, is not, and is not intended to be, a substitute for the CPA Review.

There is, of course, no guarantee that had CPA Reviews been held in a timely manner that any more constructive strategies would have been identified. What it is reasonable to conclude is that if CPA reviews had been conducted in a timely manner Mr. Z's care would have had greater focus, a strategy put in place to address his non-attendance and achievable goals identified which would have been shared with Mr. Z and his mother.

Having said this, the Clinical Team caring for Mr. Z did have and were able to articulate a strategy for delivering a service to Mr. Z. The Team was of the view that Mr. Z's involvement with illicit drugs and related criminal activity adversely affected both his mental health and the dangers he posed to himself and others. The aspiration of the Team was to assess Mr. Z in a drug free environment and, hopefully determining the relationship between his mental state, behaviour and his use of illicit drugs. In this context the Team proactively took the decision to see Mr. Z only in venues where safety could reasonably be assured but to respond to every opportunity to assess him with a view to admitting him to hospital under the Mental Health Act (1983) where his needs and difficulties might be more comprehensively explored and an intervention strategy established. However although Mr. Z was assessed on a number of occasions he was almost always found not to be displaying the symptoms of a serious mental illness and not to be detainable under the Mental Health Act. As a result the strategy of assessing him in a drug free environment was never realised.

Contributory factor 1.

Mr. Z became increasingly disengaged from the Early Intervention Team and the services that it was offering him. Contact with Mr. Z was increasingly at times of crisis and frequently at the instigation of either Mr. Z's mother or the Police. Mr. Z's agreed CPA Care Plan could not be delivered. Despite this CPA Reviews were not held in a timely manner. No strategy to address Mr. Z non-attendance at appointments, increased disengagement and increasingly chaotic behaviour was recorded. While it cannot be

certain that holding a CPA Review would have resulted in improved strategies for engaging Mr. Z, it is reasonable to conclude is that if CPA Reviews had been conducted in a timely manner Mr. Z's care would have had greater focus and achievable goals identified which would have been shared with Mr. Z and his mother.

Failure to hold such a meeting was a missed opportunity to establish a strategy to address Mr. Z's needs in the most effective manner. The inability to deliver, assertively, a service to Mr. Z possibly contributed to his disengagement which in turn may have affected his mental health and behaviour. It cannot be reasonably concluded, however, that this contributed directly to the events of 24 May 2008

11.3. Risk Assessment and Management

11.3.1 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.*"[158]

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.*

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

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.*

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".*[159]

11.3.2 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."* [160]

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

- *"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;……
- *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*

159 DoH (2007), *Best Practice in Managing Risk p.5-6*
160 Avon and Wiltshire Mental Health Partnership Trust (2010) *Risk Management Strategy* p.3

and carers, children, staff (both on Trust premises and in users homes) and others in the wider community." [161]

11.3.3 Findings of the Internal Investigation

"10.1.2 Management of Risk

A good chronological risk history was maintained, and several risk assessments and risk management plans were completed. The Team were very aware of the high risks associated with [Mr. Z], though were more concerned about the risk of suicide…..

Record of outcome from the MAPPA process

- *At the initial MAPPA meeting it was agreed that [Mr. Z] would be placed on Level 2. At a subsequent meeting it was agreed to change this to Level 1. However, apart from the record from the meeting there is no clear note in [Mr. Z's] records of when this change was made.*
- *Additionally, the change to level 1 is not referenced in the new set of clinical notes (Volume 2), which would have made it more difficult for staff to consider longitudinal risks.*

Contradiction in Risk Threshold

- *There is some contradiction in terms of risk threshold. The home situation was considered unsafe for staff to visit, but was presumably assessed as safe enough for the children in the household by the Children's Social Care Team….*

11.4 Individual risk factors

11.4.1 Medication compliance

From the information received, clinicians confirmed that to the best of their knowledge [Mr. Z] was compliant with medication during the time that he was under their care. His use of illicit drugs may have compromised the therapeutic benefits of his prescribed medication.

11.4.2 Illicit Drug misuse

Although he had a significant history of illicit drug use – particularly crack cocaine and cannabis, there is nothing to indicate that drug use or intoxication had a bearing on the events surrounding the alleged offence.

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

11.4.3 Suicidal behaviour

[Mr. Z] had a significant history of suicidal behaviour often associated with recent illicit drug use/intoxication. This had included serious and impulsive hanging attempts. No such behaviour was temporally related to the material time.

11.4.4 Use of weapons

[Mr. Z] had a history of carrying weapons – namely knives – for his own protection.

11.4.5 Criminal activity

He had a significant history of prior offending which includes burglary, robbery and possession of an offensive weapon. Much of his offending appears to have been in order to fund his illicit drug habit.

11.5.2 ICPA and Risk Assessment

…there were a large number of detailed risk assessments and ICPA care plans completed from the point where [Mr. Z] became engaged with the Crisis and Home Treatment Team in January 2007. Prior to that [Mr. Z] had been placed on a standard ICPA care plan at the point of entry to the service which would have been in line with the AWP ICPA policy as he was being seen as an outpatient following the initial acceptance to the service. However [Mr. Z] was transferred from CAMH services with some complex needs and two episodes of inpatient care at the [In-patient] Unit. Under normal circumstances this combined with the high risk of suicide should have triggered an enhanced ICPA care plan meeting. From January 2007 [Mr. Z's] level of risk clearly escalated with several serious suicide attempts resulting in a range of interventions including hospital admissions, intensive crisis and home treatment follow up and community management via the EI team. There is detailed documentation outlining the risks and associated care plans which covered a wide range of actions ranging from [Mr. Z's] need for supported accommodation, interventions to engage [Mr. Z] in his personal interests via the Fairbridge project, as well as trying to engage him in seeking solutions to effectively manage his illicit drug problems.

> *The area of concern with regards to [Mr. Z's] ICPA and risk management plans relate primarily to the Team's ability to engage him in the care planning process. Although the EI care plans were detailed and documented to a high professional standard there appears to be a fundamental problem with the EI team's ability to actually engage [Mr. Z] in the delivery of these plans. At times his attendance at these meetings was sporadic and from the end of January 08 he failed to physically attend any of the care planning meetings…This meant that for a period of almost four months….he did not have a face to face assessment with any of the mental health services. Risk assessments and ICPA care plans were amended in his absence. The Team appeared to have put an over-emphasis on the role of [Mr. Z's] mother with regard to maintaining contact via telephone conversations to relay third party information which then formed the basis of the revised plans. As a consequence of this process the Team may have missed several opportunities to directly reassess his mental health state with a view to amending his care plan. These reviews could have incorporated consideration for additional safeguards, such as detention under the Mental Health Act or a MAPPA review. The latter point may be significant as [Mr. Z] had had his MAPPA joint agency care plan downgraded from Level 2 to Level 1 in August 2007, but had continued to carry out a number of criminal offences without the knowledge of the EI Team…However it is important to note that [Mr. Z] was assessed on a number of occasions following his initial arrest on the 23 of May 08 and subsequent detention on a murder charge and on each occasion was not deemed to be suffering from a serious mental illness."*

11.3.4 Findings of the Independent Investigation

From almost his first contact with Mental Health Services in 2002 when he was 14 years old Mr. Z was identified as being at risk. Initially this was viewed as being a risk to himself. However as early as 2003 he reported that he felt *"paranoid"* and that he carried a knife for protection and he thought that he might harm someone. It was at this time that he said that he wanted to stab his father following an argument. In 2005 it was recorded that Mr. Z had head butted a patient while he was an in-patient. By 2006 his mother was reporting that his mood was labile and she associated this with his use of illicit drugs and an increased potential for violent behaviour towards himself and others. On almost his first contact with the Crisis

Team in 2006 he threatened to stab any member of the Team who called at his home; by January 2007 he was identified as posing a risk to both his mother and his siblings. From May 2007 Mr. Z's involvement in crime increased, and on at least one occasion he is reported to have threatened his victim with a knife. In August 2007 it was reported that people were coming to his home threatening him and a car was set alight on the drive of the family home.

This is not an exhaustive account of the dangers posed by Mr. Z and to which he was subject but it serves to illustrate the range of risks with which he was associated and that these were manifest soon after he came under the care of the Mental Health Services.

11.3.5 Conclusion

11.3.5.1 Assessments

From the time of his first contact with the Crisis Team in February 2006 until May 2008 there were at least eight risk assessments, employing a standard Trust format, recorded in Mr. Z's clinical notes. These were undertaken at times of crisis, following him discharging himself from hospital and as part of planned CPA Reviews. In addition Mr. Z was discussed at MAPPA meetings on two occasions. This provided an opportunity for information to be shared between agencies and for a multi-agency perspective to be taken on the risks Mr. Z posed to himself and others.

There is also evidence within Mr. Z's clinical notes that there was regular informal discussion within the Early Intervention Team, including discussions with Consultant Psychiatrist 1, and between the Early Intervention Team and the Crisis Team on the risks associated with Mr. Z.

At least to this extent it can be concluded that Mr. Z's risks were assessed on an on-going basis.

11.3.5.2 Adequacy of Risk Assessments

Whilst there are a number of Risk Assessments recorded in Mr. Z's clinical notes there is no regularly updated history associated with the risks he posed. This may have been because he was in contact with a few members of staff who knew him well; it may have been that the information about Mr. Z's risk behaviour was either second hand or not perceived to be immediately associated with his mental health problems. Nevertheless it would have been good practice to have maintained an up-to-date risk history. It might have helped to identify patterns in his behaviour and would certainly have assisted those who knew him less well.

The Trust Risk Assessment and Management Policy is clear that a comprehensive Risk Assessment should include an assessment of the individual's use of illicit drugs. Normally this would include identifying the type of drugs used, frequency, amount and method of drug use. The Risk Assessment should include an evaluation of the effects of drug use on the service user's mental state, on his/her behaviour and its association with increased risk.

That Mr. Z was using crack cocaine is recorded in his clinical notes. There is a suggestion that he was, at least at times, using heroin, though he denied this. Similarly there was a suggestion that Mr. Z used cannabis. Again, at least on occasions, he denied this. The amount and frequency of Mr. Z's drug use was not systematically explored and recorded in his clinical notes. This, however, was in the context of Mr. Z being unwilling to discuss his drug usage and him, usually, being clear that he did not want help in reducing his illicit drug usage.

The association between Mr. Z's drug use and his increased risk was identified in his clinical notes. It was noted that, especially after May 2007, he was increasingly involved in criminal activities to fund his drug use. At the same time he appears to have been at risk from drug dealers who threatened him with violence. Indeed in August 2007 Consultant Psychiatrist 1 wrote*, "This young man appears to be caught up in drug misuse related crime, possibly driven by crack cocaine misuse. He is not currently mentally disordered and we cannot use the Mental Health Act to enforce safety and treatment".*[162]

162 Clinical notes p. 1-1 745

It was also recorded that Mr. Z's mother identified an association between Mr. Z's use of drugs and his liability of mood and, on at least one occasion, he was identified as suffering from drug-induced psychosis.[163]

It would appear, then, that most of the areas relating to illicit drug misuse that one would expect to be considered in a Risk Assessment were recorded in Mr. Z's clinical notes. The weakness was that these were not gathered together in a single place, with an accompanying exploration of the risks associated with Mr. Z's illicit drug use, and a formulation, to help understand Mr. Z's behaviour, which would, in turn, inform a Risk Management Plan.

It is important to note, however, that as Mr. Z's drug use increased his contact with the Mental Health Services decreased. From around August 2007 Mr. Z was seen most frequently following him being arrested by the police, to determine whether he was detainable under the Mental Health Act (1983). This was not the appropriate situation in which to systematically explore his illicit drug use and the implications of this on the risks he posed.

11.3.5.3 Involvement of the family

It is regarded as good practice to involve the service user's family in both the assessment of risk and in planning how to address the risks identified. In Mr. Z's case his mother was consistently involved. It was she who raised concerns as to the danger that her son posed to himself. She identified an association between his use of illicit drugs and the lability of his mood, his risk taking behaviour, criminal activities and the risk of him both perpetrating violence and of being a victim of violence.

The Internal Investigation commented that there may have been an over reliance on Mr. Z's mother as a source of information. A balance has to be struck between appropriate corroboration and over-reliance on second-hand information. In Mr. Z's case, given that the Clinical Team found him difficult to engage, it was appropriate to attempt to maintain contact via his mother. However as far as can be determined, other than when he was detained by the Police or was an in-patient, Mr. Z was normally interviewed together with his mother. Given that Mr. Z's mother had made it known that she was strongly opposed to her son using illicit

163 Clinical notes p.1-1 722

drugs it would have been difficult for Mr. Z to discuss his drug use and how he might address this in her presence. However, when he was provided with the opportunity to discuss this problem in the absence of his mother he did not avail himself of the opportunity.

While it is important to gain corroboration one must always be aware of the context in which information is being given. On many of the occasions on which Mr. Z's mother contacted the Mental Health Services her intention was not to provide a balanced appraisal of his mental state and the risks he was subject to, but rather to persuade the services that her son was at risk and convince the service that he needed their input. Unfortunately because of Mr. Z's increasing disengagement from the services from May 2007 it was difficult to compare more objective observations of Mr. Z's behaviour, his self-reported mental state and his mother's account. In this situation the Clinical Team was forced to rely on Mr. Z's mother's account of events more than would be desirable.

11.3.5.4 Adequacy of Risk Management Plans

As noted above a significant range of risks were associated with Mr. Z: risk that he might harm himself and that he might place himself at risk of harm from others especially as a result of his criminal activities, risks associated with him to his mother, to his siblings and to others as a result of his illicit drug use and its associated criminal activities.

A number of Risk Management Plans were recorded in Mr. Z's notes designed to address these risks, however the same plan appears to have been repeated on a number of occasions, for example:

- Mr. Z's engagement in his Care Plan would be facilitated;
- Mr. Z's mother would be supported;
- risk would be discussed with Mr. Z's mother;
- Mr. Z's Risk Management Plan would be revised as the risks he presented changed;
- an identified member of the Team would provide cover for the care co-ordinator when she was absent;
- it was not considered possible to contain Mr. Z's rapidly fluctuating mood by using the Mental Health Act for prolonged periods;
- a review date was set.[164]

164 Clinical notes p. 1-1 545

This Risk Plan, like much of the planning around the care for Mr. Z was, to a significant extent, determined by the fact that Mr. Z was not engaged with the service. The first element of the plan: to engage Mr. Z in his Care Plan, was entirely appropriate. However without a clear formulation as to why he was not engaging with services and a strategy to address this, this element of his care plan was more of an aspiration than a plan. It was certainly not a plan explicitly designed to address identified risks.

Similarly while discussing the risks Mr. Z posed with his mother was entirely appropriate, the aim of such a discussion and how this might relate to the management of risk was left unclear in the risk management plan recorded in the notes.

That the use of the Mental Health Act was considered was appropriate and good practice but, again, it would have been useful if this had been explicitly related to the identified risk so that any clinician assessing Mr. Z had a clear context in which to assess Mr. Z and could place the use of the Mental Health Act within a comprehensive Risk Management Strategy.

Making explicit in the Care Plan who was to provide cover for the Care Co-ordinator when she was not available was good practice.

The Risk Management Plans recorded as part of Mr. Z's CPA reviews were not the only plans put in place to manage the risks he was identified as posing. At the MAPPA meetings it was agreed that Mr. Z's name would be put onto the Police National Computer (PNC) so that whenever he was detained by the Police the Mental Health Services could be alerted and, if appropriate, Mr. Z could be assessed under the Mental Health Act (1983). This plan appears to have worked well, and Mr. Z was assessed on a number of occasions when he was detained by the Police, though he was never considered to be detainable under the Mental Health Act.

It was also at a MAPPA meeting that, having identified the risk to Mr. Z's siblings, it was decided to refer Mr. Z's case to Children's Social Services.

Another significant element of risk management put into place, though not recorded with a rationale in Mr. Z's risk management plan, was that Mr. Z was not to be seen by a member of

the clinical team on his/her own and, for much of the time Mr. Z was under the care of the Mental Health Services, he was not seen at home. The Internal Investigation commented that: *There is some contradiction in terms of risk threshold. The home situation was considered unsafe for staff to visit, but was presumably assessed as safe enough for the children in the household by the Children's Social Care Team..."*

We have commented elsewhere in the report on the Safeguarding issues and on the difficulties in engaging Mr. Z. We will not repeat that discussion here. It is pertinent to note, however, that risk is not always generic and different individuals may be the subject of different levels or types of risk.

The Clinical Team providing care for Mr. Z, and the other agencies involved with Mr. Z, were aware of the serious risks he posed but they felt helpless to do anything that might significantly influence his behaviour and the associated risk. On 23 August 2007 following a MAPPA meeting, Consultant Psychiatrist 1 wrote that the opinion brought forth from the meeting was that everyone was doing all they could to promote Mr. Z's safety and those about him, but the risks associated with Mr. Z remained high. The meeting had concluded that there was nothing more the Police, Probation or Child Protection could do. He commented: *"I am sure we are not far away from a tragedy."*[165]

Service Issue 1

Although much of the information that one would expect to be considered in a comprehensive Risk Assessment was recorded in Mr. Z's clinical notes, no cumulative risk history was recorded and the information relating to risk was not gathered together in a single place with an accompanying exploration of the risks and a formulation, to help understand Mr. Z's behaviour, which would inform a Risk Management Plan. Perhaps as a result of this the risk action plans recorded in Mr. Z clinical notes are not explicitly grounded in a clear formulation and understanding of his behaviour and the actions identified in the plans are not explicitly related to the risks identified.

It would not be reasonable however to conclude that this had a direct causal relationship with the events of 24 May 2008.

165 Clinical notes p. 1-1 746

11.4. Diagnosis

11.4.1 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.

Arriving at a definitive diagnosis for a young person is a particularly contentious area and in providing its guidance for the implementation of the National Service Framework for Mental Health and establishing Early Intervention in Psychosis Teams, the Department of Health observed:

"All professionals need to understand the many and varied ways in which psychosis can develop and the spectrum of 'normal' mood and behavioural changes that can occur during adolescence and early adulthood….

Treatment needs to focus on management of symptoms and sufficient time needs to be allowed for symptoms to stabilise before a diagnosis is made.

Diagnosis can be difficult in the early phases of a psychotic illness. The services should be able to adopt a 'watch and wait' brief when the diagnosis is unclear".[166]

11.4.2 Findings of the Internal Investigation

2. Formulation / Diagnosis

166 Department of Health (2001) *The Mental Health Policy Implementation Guide, 5.3*

Coming to a firm diagnosis of [Mr. Z's] difficulties was complicated by the transient nature of his symptoms, the variability in his presentation, his drug use, chaotic home and social circumstances, and his 'adeptness at hiding symptomatology'….

The Early Intervention team tended to focus on the management of [Mr. Z's] symptoms rather than diagnosis, in line with the Mental Health Policy Implementation Guide (Department of Health, 2001) ….The team had a provisional formulation around the stressors within [Mr. Z's] home and social environment and how these impacted on his drug use and mental health..

It is interesting to consider whether [Mr. Z] being on the caseload of the Early Intervention Team limited consideration of other diagnoses, for example, conduct disorder or personality disorder, which could have had implications for his management…..

11.2.1. Diagnostic formulation

…..In summary, [Mr. Z] appears to have a genetic vulnerability to developing psychosis. This vulnerability occurring in an individual from a chaotic background characterised by violence and conflict. Although his early psychotic episodes do not appear to be related to illicit drug use, those in adulthood in contrast are significantly associated with contemporaneous significant drug use. In addition his home environment clearly acts as a stressor – overcrowding and high expressed emotion. His impulsivity and sporadic engagement and compliance with follow-up and medication act as perpetuating factors.

11.4.3 Findings of the Independent Investigation

Given the number of diagnostic labels applied to Mr. Z it might seem that those caring for him failed to arrive at a firm diagnosis. We have listed the main diagnoses/diagnostic labels applied to Mr. Z in chronological order:

- anxiety and paranoid ideation - September 2002;[167]
- acute and transient psychotic disorder - 11 September 2002;[168]
- differential diagnoses: depression, schizophrenia or lacking motivation because he found life boring - 10 April 2003; [169]
- acute psychotic symptoms - 18 April 2003; [170]

167 Clinical Notes 1-1 803
168 Clinical notes 1-1 803
169 Clinical notes 1-1 p.816
170 Clinical Notes 1-1 807

- differential diagnoses: depression, Attention Deficit Hyperactivity Disorder (ADHD) and anxiety secondary to a psychotic process - 5 October 2006;[171]
- acutely psychotic - 4 December 2006;[172]
- a schizophrenic illness with some hebephrenic features - 8 December 2006; [173]
- paranoid disorder and an organic disorder, possibly the effect of a head injury - 6 February 2007;[174]
- differential diagnoses: rapidly cycling and non-mood congruent hallucinations and/or Attention Deficit Disorder (ADD) - 27 March 2007;[175]
- paranoid psychosis, schizoaffective disorder - 17 April 2007;[176]
- *"complex disorder……a dual diagnosis and some form of fairly significant psychotic disorder. The exact diagnosis of which we are very unclear."* - 7 June 2007;[177]
- drug induced psychosis - 14 June 2007;[178]
- drug induced psychosis and period of depression secondary to drug misuse. - 18 October 2007;[179]
- differential diagnoses: substance mis-use, acute psychosis, underlying schizo-affective disorder - 10 January 2008;[180]
- paranoid disorder and, possibly, organic brain damage following a head injury - 13 March 2008.[181]

Despite the number of diagnostic labels used there does appear to be some consistency in the attempts to understand Mr. Z's problems. On almost all occasions on which he was given a diagnosis it was the opinion of the assessing clinicians that he was suffering from a psychotic disorder, one of the main features of which was paranoia and suspiciousness. A second diagnostic strand appears to have been the presence of an affective component in Mr. Z's presentation. This was variously identified as depression and as a manifestation of a schizoaffective disorder. The more negative features of Mr. Z's presentation were variously identified as the negative symptoms of psychosis, hebephrenia and depressive symptomatology.

171 Clinical notes 1-2 215, 1-1 793
172 Clinical notes 1-1 702 ff
173 Clinical notes 1-1n791
174 Clinical notes p.1-1 512, 1-2 214
175 Clinical notes 1-2 223
176 Clinical notes p.1-1 613
177 Clinical notes p. 1-1 751
178 Clinical notes p. V1-2 268
179 Clinical notes p.1-1 722
180 Clinical notes p. V2 351ff, 375ff
181 Clinical notes p. V2 345, 403

A third strand was the cycling and transient nature of Mr. Z's symptomatology

The fourth diagnostic strand was the identification of an underlying trait-like consistency in Mr. Z's behaviour which led clinicians to speculate about the possibility of him suffering from Attention Deficit Hyperactivity Disorder or possibly a deficit related to an earlier brain injury.

The aetiology, course and context of Mr. Z's symptomatology were also noted. Perhaps the main immediate aetiological factor in Mr. Z's presentation was his use of illicit drugs. Consultant Psychiatrist 2 noted that Mr. Z first presented with psychotic symptomatology before he started mis-using drugs. However Mr. Z later disclosed that he had been mis-using illicit drugs from the age of 11, pre-dating his first contact with Mental Health Services. This information on its own, of course, does not tell us whether these early episodes of psychosis were or were not drug induced. However by mid-2007, given Mr. Z's known and increasing use of illicit drugs, the transient nature of his symptomatology and the rapid remission of symptoms when he was know to be abstaining from drugs, those caring for him concluded that his psychotic symptomatology was drug induced. This conclusion was reinforced by the fact Mr. Z was assessed on a number of occasions at times of crisis, from mid-2007 onwards, and was found not to be displaying the symptoms of a serious mental health problem.

Mr. Z's strong family history of mental health problems and the fact that several close family members had committed suicide was noted and identified as a source of increased vulnerability in the context of family and social stressors. Consultant Psychiatrist 2 explicitly addressed this factor when she was considering the possibility that Mr. Z might be suffering from a Personality Disorder. She concluded that the Mr. Z's family history of mental ill-health supported a diagnosis of psychosis.

Finally although contextual factors are not, in themselves, diagnostic criteria they are pertinent to the interpretation of symptomatic phenomena and as such of central importance in making a diagnosis. The clinicians involved in Mr. Z's care noted the various potential stressors in Mr. Z's life: the high level of involvement of his mother, the high level of expressed emotion, social pressures and immediate cultural norms, overcrowding and a lack of privacy and limited scope for the development of independence.

11.4.4 Conclusion

It is not the role of an Independent Investigation to adjudicate on the 'true' diagnosis but rather to identify whether good practice was followed. The Independent Investigation Team agrees with the Internal Investigation that given the nature of Mr. Z's presentation and social circumstances a firm diagnosis was difficult to arrive at. Nevertheless, whilst a single diagnostic label was not agreed upon, there was some clarity about the features of Mr. Z's mental health problems, most reasonable diagnoses appear to have been considered at some time and contextual factors were taken into account. As has been noted the guidance to Early Intervention Teams was that they should be prepared to live with diagnostic uncertainty and rather focus on symptom management and adopt a Recovery approach to intervention.

Diagnosis is not an end in itself but rather an element in understanding an individual's problems and needs. This understanding should lead to focused, evidence based, effective interventions. This drawing together of disparate phenomena into a common framework is commonly known as a formulation. It is this common understanding that needs to be shared by all those providing care and treatment so that interventions are coherent and have the maximum chance of being effective.

As noted in an earlier section of this report this formulation is normally arrived at in a CPA Review. Mr. Z's first Enhanced CPA Review was held on 6 February 2007 and at that time a formulation was agreed. This was that Mr. Z had, at that time, a four-year history of irritability, suspiciousness, low mood and suicide attempts with his mental health being adversely affected by his use of illicit drugs. It was recorded that this formulation was shared with Mr. Z and that he agreed with it.[182] This formulation remained unchanged at later CPA Reviews.

When discussing this issue with clinical witnesses the Independent Investigation was provided with a similar formulation: a young man who experienced episodes of psychosis related to a troubled upbringing, with his use of drugs, from an early age, contributing to his mental health problems.

182 Clinical notes p.1-1 512, 1-2 214

That a formulation was arrived at that went beyond diagnostic labelling was good practice, as was the fact that the formulation was shared with Mr. Z and his opinion sought. However, particularly where services are seeking to promote normalisation, it is important that the formulation describes the relationships between observed phenomena, how these relationships determine the individual's needs and how this understanding can inform effective intervention. The formulation recorded in Mr. Z's clinical notes is a list of observed phenomena and a statement that these were affected by his use of illicit drugs. This provides little understanding of Mr. Z's behaviour and needs or how these might be most effectively addressed. The clinical witnesses were clear that they had not arrived at a definitive diagnosis and formulation. The nature of the relationship between Mr. Z's mental state, behaviour and his use of illicit drugs was unclear and the team felt that a period of observation and assessment in a drug-free environment was needed in order to clarify this relationship. However, although Mr. Z was assessed with a view to admitting him to hospital under the Mental Health Act, on a number of occasions he was never found to be detainable for long enough for such an assessment to be completed.

It would have been good practice to have recorded the Team's reflections, their conclusions that a period of assessment in a drug free environment was needed and their strategy to assess him with a view to employing the Mental Health Act (1983) to detain him in a drug free environment.

11.5. The Mental Health Act

11.5.1 Context

The Department of Health summarises the Mental Health Act as follows:
"1. The main purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

2. Part 2 of the Act sets out the civil procedures under which people can be detained in hospital for assessment or treatment of mental disorder. Detention under these procedures

normally requires a formal application by either an Approved Mental Health Professional (AMHP) [Formerly an Approved Social Worker, ASW] or the patient's nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies……

5. Part 3 of the Act concerns the criminal justice system. It provides powers for Crown or Magistrates' Courts to remand an accused person to hospital either for treatment or a report on their mental disorder. It also provides powers for a Court to make a hospital order……for the detention in hospital of a person convicted of an offence who requires treatment and care. The Court may also make a guardianship order. ……

Most patients who are detained in hospital under the Act can be given treatment for their mental disorder without their consent. Some types of treatment have to be approved first by an independent doctor - a Second Opinion Appointed Doctor (SOAD). ….

6. Most patients who are detained ……have the right to apply to a Tribunal for their discharge. The Tribunal is an independent, judicial body……Most detained patients …can also ask the managers of the relevant hospital to discharge them. Patients' responsible clinicians must also keep the appropriateness of continued compulsory measures under review."

The goal of the Act then is to ensure that people with a 'mental disorder' receive assessment and treatment. The Code of Practice to the Act provides some clarification as to what constitutes a 'mental disorder'. It comments:

"3.8 Section 1(3) of the Act states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act.

3.9 This means that there are no grounds under that Act for detaining a person in hospital …on the basis of alcohol or drug dependence….

3.10 Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. If the relevant criteria are met, it is

therefore possible (for example) to detain people who are suffering from mental disorder, even though they are also dependent on drugs. This is true even if the mental disorder in question results from the person's alcohol or drug dependence."[183]

Applications to detain a person in hospital to assess or treat their mental disorder are normally made under Section 2 or Section 3 of the Act. The Code of Practice provides the following guidance:

"4.26 Section 2 should be used if:

- *The full extent of the nature and degree of a patient's condition is unclear;*
- *There is a need to carry out an initial in-patient assessment in order to formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission; or*
- *There is a need to carry out a new in-patient assessment in order to re-formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis.*

4.27 Section 3 should be used if:

- *The patient is already detained under section 2 (detention under section 2 cannot be renewed by a new section 2 application); or*
- *The nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment on a voluntary basis are already established."*[184]

In addition a person can be detained under what are sometimes referred to as Emergency Sections: Sections 5(2) and 5(4) of the Act. The Code of Practice describes these as follows:

"Section 5(2)

12.2 The power can be used where the doctor or approved clinician in charge of the treatment of a hospital in-patient (or their nominated deputy) concluded that an application for detention under the Act should be made. It authorises the detention of the patient in the hospital for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made….

183 Department of Health (2008) *Code of Practice: Mental Health Act 1983*
184 Department of Health (2008) *Code of Practice: Mental Health Act 1983*

12.8 Section 5(2) should only be used if, at the time, it is not practicable or safe to take the necessary steps to make an application for detention without detaining the patient in the interim. Section 5(2) should not be used as an alternative to making an application, even if it is thought that the patient will only need to be detained for 72 hours or less……

Section 5(4)
12.21 Nurses of the "prescribed class" may invoke Section 5(4) of the Act in respect of a hospital in-patient who is already receiving treatment for a mental disorder.
12.22 This power may be used only where the nurse considers that:

- *The patient is suffering from mental disorder to such an extent that it is necessary for the patient to be immediately prevented form leaving the hospital either for the patient's health and safety or for the protection of other people; and*
- *It is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under Section 5(2)…….*

12.23 The use of the holding power permits that patient's detention for up to six hours or until a doctor or approved clinician with the power to use Section 5(2) arrives, whichever is the earlier. It cannot be renewed……

12.25 The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else."[185]

Under Section 136 of the Act the Police have the power to remove a person from a public place to a place of safety. The Code of Practice provides the following guidance:
"10.12 Section 136 allows for the removal to a place of safety of any person found in a place to which the public have access….who appear to the police officer to be suffering from a mental disorder and to be in immediate need of care or control.

10.13 Removal to a place of safety may take place if the police officer believes it is in the interests of that person, or the protection of others.

185 Department of Health (2008) *Code of Practice: Mental Health Act 1983*

10.14 The purpose of removing a person to a place of safety in these circumstances is only to enable the person to be examined by a doctor and interviewed by an AMPH, so that necessary arrangements can be made for the person's care and treatment. It is not a substitute for an application for detention under the Act, even if it is thought that the person will need to be detained in hospital for a short time……

13.15 The maximum period a person may be detained under section 136 is 72 hours. The imposition of consecutive periods of detention under section 136 is unlawful.

The Mental Health Act was substantially amended in 2007.

11.5.2 Findings of the Internal Investigation

"11.5.8 Application of the Mental Health Act

[Mr. Z] was detained under the provisions of section 2 of the Mental Health Act 1983 in early April 2007 and after a month long assessment he was assessed for a Treatment Order (section 3). Although there was a recommendation from the RMO the assessment was undertaken by his general practitioner…and an Approved Social Worker, but without the RMO. The decision not to detain was arrived at based on his settled mental state at the time of his assessment and the view of the assessors that he would comply with informal treatment. This was not a view shared by the RMO. The RMO sought to arrange a further assessment but was advised that this was not possible. Concerns raised by the RMO included the lack of consultation between the other two members of the assessment team and her, as well as the clinical assessment of the GP based on limited prior contact, knowledge and expertise.

Whether or not a more prolonged period of assessment (under the provisions of section 3) would have added anything to the overarching clinical view or long-term management plan is difficult to say. However, the fact that he was not placed on a section 3 meant that the opportunity for him to benefit from a significant period of treatment and stability, as well as engage in community resources from this stable base, was lost.

The team continued to try to take opportunities to assess [Mr. Z] within a safe setting with a view to 'moving forward with a MHA Assessment as soon as possible.' In a letter of 23.8.2007 [Consultant Psychiatrist 1] wrote 'although he may not be overtly mentally

disordered, in view of the fact of his recent three suicide attempts and the involvement with guns and knives in a highly unpredictable individual, I am sure we are not far from a tragedy. If there was an opportunity to stabilize him with a period of assessment and possible treatment on a formal basis, I am sure the restrictions to his personal liberty would be far outweighed by the advantages of an assessment, a period of detoxification and a re-examination of his mental state of formal mental illness.' However on the occasions when he was assessed under the MHA, [Mr. Z] was not found to be detainable."

11.5.3 Findings of the Independent Investigation

Soon after he was referred to the Mental Health Services in September 2002 Mr. Z was detained under Section 2 of the Mental Health Act (1983) following him attempting to kill himself. He was 14 years old at this time. He was assessed again in January 2007 following a further attempt to harm himself and although he was briefly admitted to hospital he was not found to be detainable on this occasion. However in April 2007 Mr. Z was detained in hospital under Section 2 of the Act.

During this admission Mr. Z repeatedly absconded from hospital. Consultant Psychiatrist 2, who was responsible for his care at this time, was of the opinion that he needed a prolonged stay in hospital, in a stable, drug free environment, to clarify his diagnosis and the role illicit drugs played in his presentation, to allow his mental state to stabilise and to institute appropriate interventions based on this longer period of assessment. Consultant Psychiatrist 1 and CPN 2 also favoured this course of action. With this strategy in mind she requested that Mr. Z be assessed with a view to instituting Section 3 of the Act.

However Mr. Z's GP, who provided the Second Medical Opinion, concluded that Mr. Z displayed no signs of psychosis when he interviewed Mr. Z. Mr. Z reported that his mental state had improved, that he intended to abstain from illicit drugs and that he would remain in hospital, for at least a few days, following his Section lapsing. Given this presentation Mr. Z's GP felt that he could not recommend that Mr. Z be detained under the Mental Health Act.

Consultant Psychiatrist 2 immediately sought a further Mental Health Act Assessment involving a Section 12 Approved Doctor but was informed by the duty Approved Social Worker that as Mr. Z's situation had not changed that this was not appropriate. She further

advised that should Mr. Z's condition change then consideration could be given to him being detained under Section 5(2) or 5(4) of the Act.

Mr. Z absconded from hospital and discharged himself against medical advice when his Section 2 lapsed at the end of April.

In June 2007 Consultant Psychiatrist 1 wrote to Mr. Z's GP *"I would like to push for a Section 3 and a prolonged period of treatment of complex disorder which I believe is a dual diagnosis and some form of fairly significant psychotic disorder. The exact diagnosis of which we are very unclear. He is also very adept at hiding his symptomatology and hates being in hospital, which is of course a problem."*[186]

It was decided to place Mr. Z's name on the Police National Computer so that the Mental Health Services could be informed whenever he was detained by the Police with a view to admitting him to hospital under the Mental Health Act. This strategy worked well in as far as Mr. Z was assessed on a number of occasions following him being detained by the Police. However he was consistently found not to be displaying symptoms which would justify detention under the Act.

Mr. Z's mother requested, on a number of occasions, that her son be admitted to hospital under the Mental Health Act but again he was consistently found not to be detainable when assessed.

Mr. Z was assessed under the Mental Health Act following his arrest on 24 May 2008 and was again found not to be detainable.

186 Clinical notes p. 1-1 751

11.5.4 Conclusion

11.5.4.1 Appropriate use of the Mental Health Act 1983 (The Act)

Mr. Z made a number of very serious attempts to harm himself and in response to these incidents the Mental Health Act was employed as part of a strategy to protect him and to initiate treatment.

CPN 2 and Consultant 1 with the other member of the Clinical Team had considered less restrictive options but as discussed elsewhere in this Report it proved difficult to deliver a service to Mr. Z in the community. The team felt that his use of illicit drugs and the general environment in which he lived militated against him engaging with any therapeutic activity in a consistent manner. This was exemplified by the fact that following a brief admission in January 2008 the Crisis Team managed to see Mr. Z only once over the two-week period that he was under their care.

Under these circumstances a compulsory admission to hospital was the most appropriate response and the Act was appropriately employed.

In addition to employing the Act in these crisis situations the clinicians caring for Mr. Z felt that he needed a prolonged period of assessment in a stable and drug free environment so that the relationship between his use of illicit drugs and his symptomatic presentation could be clarified and appropriate interventions put in place in a planned and systematic manner.

In August 2007 Consultant Psychiatrist 1 wrote *"I am sure we are not far from a tragedy. If there was an opportunity to stabilize him with a period of assessment and possible treatment on a formal basis, I am sure the restrictions to his personal liberty would be far outweighed by the advantages of an assessment, a period of detoxification and a re-examination of his mental state of formal mental illness."*

With this strategy in mind it was decided at the MAPPA meeting that Mr. Z's name would be placed on the Police National Computer with a view to him being assessed by the Mental Health Team whenever he was detained by the Police. As noted above this strategy worked well in as far as it triggered a number of assessments; however Mr. Z was consistently found not to be manifesting symptoms which would justify his detention under the Act. Again

employing the Mental Health Act in this proactive manner to understand Mr. Z's needs and deliver appropriate care was good practice.

11.5.4.2 Consultation and Assessment

When he was detained under the Mental Health Act in April 2007 Mr. Z appealed against his detention. However, on 18 April 2007 the Mental Health Review Tribunal decided to uphold his detention under Section 2 of the Act. Following this, as Mr. Z's Section 2 was due to expire at the end of April 2007, Consultant Psychiatrist 2 decided that in was in Mr. Z's best interests that he remained in hospital for a further period of assessment and treatment. On 23 April she spoke with Mr. Z's mother who agreed that Mr. Z should remain in hospital. As he had repeatedly absconded from the ward and frequently used illicit drugs when absent, Mr. Z's mother agreed that he should be detained under Section 3 of the Act. On 25 April Consultant Psychiatrist 2 requested that Mr. Z be assessed with a view to placing him on Section 3.

Consultant Psychiatrist 2 was employed as a locum psychiatrist and had only very recently arrived at the Trust. She had received no induction and was unfamiliar with the Trust Protocols. Having requested an assessment under the Mental Health Act she was advised to complete her recommendation and leave this with Mr. Z's clinical notes. She understood that she would be contacted when the assessing doctor and the Approved Social Worker arrived to interview Mr. Z.

Prior to interviewing Mr. Z ASW 1 tried, unsuccessfully, to contact Mr. Z's mother as the nearest relative. However he did succeed in speaking to her by telephone later in the day to inform her of the outcome of the assessment. He spoke to CPN 2 who, as Mr. Z's Care Coordinator, was the member of the clinical staff who knew him best. CPN 2 was of the opinion that Mr. Z needed a significant period in hospital before community care could be successfully delivered. She felt that Mr. Z's suicide attempts were rooted in his mental illness, not a consequence of his drug use, though his illicit drug use exacerbated the risk of him harming himself. She also pointed out that that the Community Team had tried to care for Mr. Z after a previous suicide attempt; he had agreed to the plan that had been put in place but despite this he had again attempted to commit suicide.[187]

187 Clinical notes p.1-1 603

ASW 1 interviewed Mr. Z together with Mr. Z's GP. Mr. Z reported that his mental health had improved while he had been in hospital, *"he felt that he had been able to co-operate fully"* though he acknowledged that he had at times absconded. Mr. Z said the suicide attempts had been driven by him feeling *"a bit low"*. He agreed to remain in hospital, informally, *"until Wednesday"* but not for four weeks as recommended by Consultant Psychiatrist 2. He said that he would try to abstain from illicit drugs and avoid his drug using friends and that he would seek help if his mood began to deteriorate. ASW 1 and the GP noted no signs of psychosis or depression during the interview.

Given Mr. Z's presentation when Mr. Z's GP assessed him, the fact that he reported that he had been able to work co-operatively with the nursing staff over the previous days, the assurances that he was willing to give and the fact that he had not seen Mr. Z for some time, and so other information about Mr. Z was for him second hand, the GP did not feel able to recommend that Mr. Z be detained under Section 3 of the Mental Health Act.

Mr. Z's GP, ASW 1 and Consultant Psychiatrist 2 did not meet to discuss their differing views although they did speak by telephone. As noted above Consultant Psychiatrist 2 was under the impression that she would be informed when Mr. Z's GP and ASW 1 arrived to assess Mr. Z. ASW 1's notes record that he contacted Constant Psychiatrist 2's secretary at 9.15 on the 25 April to inform her that a Mental Health Act Assessment had been provisionally booked for 11.00 a.m. and called Constant Psychiatrist 2 again at 10.10 a.m. to confirm the time of the assessment[188]. Mr. Z's GP and SW 1 were under the impression that she was not available and could only be contacted by telephone. It remains unclear how this confusion arose.

Part of the object of having two medical opinions is to have available two points of view which can act as checks and counter balances to each other. The differing opinions of Consultant Psychiatrist 2 and of Mr. Z's GP is not, therefore, the issue of concern here. The issue of concern is the lack of consultation between those involved in this assessment and the adequacy of the Risk Management Plan put in place.

[188] Witness statement

The Code of Conduct accompanying the Act indicates that where there is such a difference of opinion a plan of action should be agreed that best meets that needs of the service user.

"4.101 Where there is an unresolved dispute about an application for detention, it is essential that the professionals do not abandon the patient. Instead, they should explore and agree an alternative plan – if necessary on a temporary basis. Such a plan should include a risk assessment and identification of the arrangements for managing the risks. The alternative plan should be recorded in writing, as should the arrangements for reviewing it. Copies should be made available to all those who need them (subject to the normal considerations of patient confidentiality)."[189]

The question which needs to be addressed is whether this guidance was followed.

The ASW recorded in Mr. Z's clinical notes: *"I advised that nursing staff should monitor mental state. If there is deterioration or Mr. Z is not keeping to the informal care he agreed to then the staff should consider a S 5(2) or 5(4) and request a further MHA assessment."*[190]

Mr. Z's GP indicated that if Consultant Psychiatrist 2 continued to be concerned about the safety and well-being of Mr. Z it would be appropriate that a further Mental Health Act Assessment was undertaken by a doctor who was more familiar with Mr. Z's recent history. Consultant Psychiatrist 2 did request a further Mental Health Act Assessment with a Section 12 Approved Doctor but was informed that as Mr. Z's situation had not changed this was inappropriate. She recorded in the clinical notes that she had been advised by the Duty ASW to use Section 5 (4) of the Mental Health Act (1983) and noted that it is poor practice to plan to use the emergency Sections 5 (4) or Section 5(2).[191]

As events turned out Mr. Z absconded from the ward and discharged himself against medical advice when his Section had lapsed.

Mr. Z's GP contacted him on 2 May 2007 to ensure that Mr. Z had a supply of medication. Mr. Z reassured him that he would make contact if he began to feel low in mood.

189 Department of Health *Code of Practice: Mental Health Act 1983*
190 Ibid
191 Clinical notes p. V1-2 63

This chain of events raises a number of concerns.
It would have been good practice for the two doctors and the ASW (Approved Social Worker) to have met to discuss their assessment of Mr. Z's needs, the reasons Consultant Psychiatrist 2 had for making her recommendation and identifying what alternative forms of care might be available.

This did not happen. Consultant Psychiatrist 2 was new to the Trust, she had received no induction and was unaware of the protocols in place. She expected to be informed when the ASW 1 and Mr. Y's GP attended the ward but this did not happen, although ASW 1 had confirmed the time of the assessment. ASW 1 and Mr. Z were under the impression that Consultant Psychiatrist 2 was available only by telephone. While it cannot always be guaranteed that those undertaking an assessment can meet with each other in person good practice suggests, particularly when there is a disagreement as to whether an individual should be detained, that the opportunity should be created for a full discussion to take place. Trust protocols should promote this best practice and the responsibilities for facilitating this should be identified.

The guidance indicates that where there is a disagreement a Plan, based on a Risk Assessment, should be drawn up. ASW 1 did record that the nursing staff should monitor Mr. Z's mental state, consider using an Emergency Section to detain him, if this seemed appropriate, and request a further Mental Health Act Assessment.

Additionally Mr. Z's GP suggested that if Consultant Psychiatrist 2 continued to be concerned about Mr. Z's wellbeing she might seek a further assessment using a doctor who was more familiar with Mr. Z's recent history. However this was not recorded in Mr. Z's notes and not presented as part of the rationale when Consultant Psychiatrist 2 requested a further Mental Health Act Assessment.

Mr. Z's GP contacted Mr. Z when he discharged himself from hospital and ensured that he had a supply of medication and would seek help if his mood or mental state deteriorated. This was good practice but again it had not been included in a plan as a response to an identified risk.

Although an embryonic plan was recorded in Mr. Z's notes this was not based on an assessment of the risk posed to and by Mr. Z as is recommended by the Guidance, nor was there any exploration of alternative ways of meeting Mr. Z's needs recorded in the notes or incorporated into the plan. As noted above Trust Protocols should be in place to promote best practice and in those cases where there is a disagreement it should be made explicit who is responsible for ensuring that a Risk Assessment is recorded and that a plan is put in place and shared appropriately to ensure the safety and meet the needs of the service user.

With the benefit of hindsight it is not clear that had Mr. Z been detained under Section 3 of the Act it would have made a significant difference to his mental health and well being. However this must be regarded as a missed opportunity. Following this admission Mr. Z increasingly disengaged from the Mental Health Service and on subsequent occasions when he was assessed he was found not to be detainable.

11.5.4.3 Use of Emergency Sections

Consultant Psychiatrist 2 recorded in Mr. Z's clinical notes that she felt that the advice she had been given by the Duty ASW on 27 April 2007 to use or consider using Section 5 of the Mental Health Act was inappropriate. The Independent Investigation would agree that it is inappropriate to plan to use an Emergency Section of the Act. They are available to be used in an emergency and at the discretion of the nurse or doctor and should not form part of a pre-determined plan.

11.5.4.4 Induction and familiarity with protocols

Consultant Psychiatrist 2 had only recently been employed by the Trust as a Locum Consultant but she had received no induction and was not familiar with the protocols of the Trust. This may have contributed to the confusion about availability and the failure to ensure that the three professionals met. It also meant that Consultant Psychiatrist 2 was unclear about whom to make representations to when her request for a further Mental Health Act Assessment was denied. If clinicians are to practice in a safe and competent manner and comply with Trust Policies it is essential that they have a timely induction, supervision and an identified individual whom they can consult.

Service Issue 2

Those undertaking the Mental Health Act Assessment of Mr. Z did not meet to discuss their assessment. Good practice suggests that, especially when there is a difference of opinion, this should happen. The Code of Practice guidance further recommends that when there is such a difference of opinion then a Plan, based on a Risk Assessment, should be put in place. This should be recorded and shared appropriately. Again although some appropriate actions were taken no protocol was followed to ensure that immediate risks were identified and an appropriate plan was put in place. The Trust should ensure that it has protocols in place to ensure that this best practice and Code of Practice guidance is followed. The Protocol should also clearly indicate the responsibilities of the various professionals involved in a Mental Health Act Assessment.

Service Issue 3

Consultant Psychiatrist 2 was employed as a locum consultant. She had received no induction, no supervision arrangements had been identified and no senior member of staff whom she could consult was identified. If clinicians are to practise safely and adhere to Trust Policies it is essential that they receive a timely induction and that supervision and consultation arrangements are in place.

11.6. Treatment

11.6.1 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.

11.6.2 Local Context

Following the Department of Health Guidance (2001)[192] the Avon and Wiltshire Mental Health Partnership NHS Trust Bristol Early Intervention (EI) Service aspired to realise the following principles:

- *"Culture, age and gender sensitive;*
- *Family oriented;*
- *Meaningful and sustained engagement based on assertive outreach principles;*
- *Separate, age appropriate facilities for young people;*
- *Emphasis on normal social roles and service user's development needs particularly involvement in education and achieving employment;*
- *Emphasis on managing symptoms rather than diagnosis".*[193]

The Early Intervention (EI) Team espoused a Recovery Model when addressing the needs of the young people it served and elaborated this concept as follows in their operational policy:

- *"Comprehensive psychosocial assessment;*
- *Active attempts to engage and maintain engagement;*
- *Medication management:*
    - *To include use of low dose atypical antipsychotics as first line treatment; with regular review of treatment efficacy and side effects to ensure effective treatment and longterm concordance;*
- *Relapse prevention work undertaken with all service users to minimise risk of relapse and promote positive coping strategies and symptom control;.*
- *Support in meeting needs around money, housing, diet, exercise and social contact;*
- *Family interventions: ongoing information, support and problem solving to be offered to families;*
- *CBT to be offered to those experiencing persistent symptoms and to assist clients in understanding their problems including the impact of psychosis;*
- *Assessment and treatment of psychological difficulties e.g. anxiety and depression;*
- *Assessment and management of substance misuse;*
- *Assessment of vocational needs and social roles:*

192 Department of Health (2001) A Mental Health Policy Implementation Guide
193 Avon and Wiltshire Mental Health Partnership NHS Trust (2007) Bristol Early Intervention in Psychosis Team: Operational Policy

- *From the outset consideration of the support needed to maintain/develop social roles and access appropriate employment, training or education.*[194]

11.6.3 Medication

11.6.3.1 Context

Psychotropic medications (medication capable of affecting the mind, 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 called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and electrocardiographic (ECG) changes. Side effects can be managed by changing dosage, changing to a different type of antipsychotic medication or by prescribing specific medication to address the side effects.

Wherever practicable consent for treatment should be obtained from the patient. 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".*[195]

11.6.3.2 Findings

Mr. Z was admitted to hospital in September 2002 when he was prescribed the antipsychotic medication Quetiapine. He responded well to this and continued to be prescribed Quetiapine on his discharge.[196] In April 2003 Mr. Z was readmitted to hospital following an acute relapse and his medication was changed to the antipsychotic Risperidone. Again he was reported to have responded well to the medication.[197]

194 Avon and Wiltshire Mental Health Partnership NHS Trust (2007) Bristol Early Intervention in Psychosis Team: Operational Policy
195 Department of Health (2008) Code of Practice, Mental Health Act (1983)
196 Clinical notes 1-1 803
197 Ibid

Mr. Z's medication remained unchanged when he was transferred to the Adult Mental Health services in 2006.[198] In December 2006 an out of hours GP introduced Diazepam to address Mr. Z reported anxiety.[199]

Mr. Z's medication was next revised at his CPA Review in February 2007. He had, at this time, been treated with Risperidone for four years but was still hearing voices and experiencing distressing thoughts. In response to this situation Consultant Psychiatrist 1 changed Mr. Z's medication to the anti-psychotic Olanzapine and the hypnotic Zopiclone.[200] In March 2007, at an urgent out-patient appointment, it was concluded that Mr. Z was experiencing rapidly cycling and non-mood congruent hallucinations. Mr. Z's medication regimen remained unchanged but it was decided that if his mental state did not improve an alternative anti-psychotic, Clozaril, and a mood stabiliser, Lithium, would be considered.[201] However before this plan could be acted on Mr. Z made a serious attempt to harm himself and was admitted to hospital under Section 2 of the Mental Health Act.

Soon after he was admitted to hospital the possibility of prescribing Mr. Z the mood stabiliser Sodium Valporate in response to his rapidly fluctuating mood was considered.[202] However when he discharged himself at the end of April 2007 his medication regimen remained Olanzapine and Zopiclone.[203]

From May 2007 Mr. Z increasingly disengaged from Mental Health Services and it was not possible to monitor his compliance with medication. In August 2007, for example, at a MAPPA meeting it was acknowledged that Mr. Z might not be taking his medication regularly, however when he was seen he was not showing signs of mental illness.[204]

No further changes were made in Mr. Z's medication before the events of May 2008

198 Clinical notes 1-2 215, 1-1 793
199 Clinical notes 1-1 702 ff
200 Clinical notes p.1-1 512, 1-2 214
201 Clinical notes 1-2 223
202 Clinical notes p. 1-1 19
203 Clinical notes V1-1 715
204 Clinical notes V1-2 262

11.6.3.3 Conclusion

From the time of his first contact with the Mental Health Services in 2002 Mr. Z reported symptoms, such as hearing voices and believing that others might harm him, which were consistent with him suffering from a psychotic disorder. He was prescribed anti-psychotic medication and appeared to respond well to this. Subsequently when either Mr. Z's mental state deteriorated or he complained that he was not benefiting from the medication it was changed to another appropriate medication.

Both Consultant Psychiatrist 1 and Consultant Psychiatrist 2 considered introducing a mood stabiliser to address Mr. Z's fluctuating moods. However the degree to which these fluctuations were a manifestation of Mr. Z's primary mental health problems or the result of his use of illicit drugs use could not be clarified as the Clinical Teams were unsuccessful in realising their plan to assess him for a prolonged period in a stable and drug free environment. In consequence a mood stabiliser was never introduced into Mr. Z's medication regimen.

Following Mr. Z discharging himself from hospital at the end of April 2007 he increasingly disengaged from the Mental Health Service and, as a result, it became increasingly difficult to monitor his compliance with medication. Nevertheless there were a number of examples of good practice in this area. When Mr. Z discharged himself from hospital against medical advice and without a supply of medication, his GP promptly contacted him and ensured that he was prescribed a supply of his current medication. Similarly in June 2007 when both Mr. Z and his mother expressed their displeasure at Mr. Z's case having been referred to Children's Social Services and said that they wanted no further contact with the Mental Health Services Consultant Psychiatrist 1 contacted Mr. Z's GP, informed him of the situation and that Mr. Z would prefer to have his medication prescribed by his GP.

Although Mr. Z became increasingly disengaged from the EI Team from May 2007 they did continue to see him whenever possible and to assess his mental state whenever he was detained by the Police. It was noted on a number of occasions that his compliance with his medication regimen was uncertain however there was no evidence that his mental state was deteriorating.

Mr. Z was, prescribed appropriate medication for the symptoms, suggestive of psychosis, which he was reporting. The efficacy of the medication was monitored and the medication changed when it appeared to be ineffective.

Given the fluctuating nature, especially of the affective component, of Mr. Z's symptomatology prescribing him with a mood stabiliser was considered. This was appropriate although for a variety of reasons it was never realised.

After May 2007 it became increasingly difficult to monitor Mr. Z's compliance with his medication however his mental state was assessed whenever possible and no obvious deterioration was identified.

Overall Mr. Z's pharmacological treatments and the monitoring of the efficacy of the interventions were appropriate given Mr. Z's presentation, his engagement with the service and his continued use of illicit drugs.

11.6.4 Substance Misuse

11.6.4.1 Context

The Department of Health in its Good Practice Guide on services for those with a mental illness and a substance misuse problem noted:

"1.1.2 A fundamental problem is a lack of clear operational definitions of "dual diagnosis". In many areas a significant proportion of people with severe mental health problems misuse substances, whether as "self medication", episodically or continuously. Equally, many people who require help with substance misuse suffer from a common mental health problem such as depression or anxiety. Sweeping up all these people together would result in a huge heterogeneous group many of whom do not require specialist support for both mental health and substance misuse issues. Integrating services therefore requires a clear and locally agreed definition of dual diagnosis supported by clear care pathways (care coordination protocols). It is essential to acknowledge that gatekeeping by specialist services is a valid activity which enables them to focus their efforts, and agreed and justifiable gatekeeping practice with clear accountability should ensure that clients are included in the right services, rather than excluded from services they desperately need."[205]

205 DoH (2002) *Dual Diagnosis Good Practice Guide* p.6

The Guidance goes on to note:

"1.5.1 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."[206]

11.6.4.2 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. 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:

- *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*

206 Ibid p. 9

illness, to ensure those in highest need receive the treatment they require from our services." [207]

11.6.4.3 Findings of the Internal Investigation

11.5.3 Management of drug use

[Mr. Z's] use of drugs complicated diagnosis, engagement and treatment, and could not be effectively managed by the team because of [Mr. Z's] passive resistance to addressing this issue. His drug use appears to have escalated over the course of his contact with the Team. When [CPN 2] first had contact, [Mr. Z] reported using some cannabis, but in the months that followed he began to use other drugs, including crack cocaine.

- *[CPN 2] did attempt to address [Mr. Z's] drug use with him. However he was reluctant to talk with her about what he was using in any detail, and did not see his drug use as a problem. This limited [CPN 2's] ability to work on aspects of his drug use, for example, raising his awareness of the harmful effects of his drug use, talk about harm reduction strategies, triggers, high risk situations etc.*
- *Additionally, [Mr. Z] tended to be seen with his mother, who strongly believed he should stop using drugs, which limited the sorts of conversations that may have helped to build [Mr. Z's] motivation to change or may have focused on harm reduction.*
- *The Team did attempt to refer to specialist organisations that could help [Mr. Z] change his drug use.*
- *He was given support in accessing the Bristol Drugs Project, which is a non-statutory organization in Bristol which offers drop ins, regular groups, support and counselling to people motivated to stop using street drugs. However [Mr. Z] appeared ambivalent about attending. After several failed attempts, he did accompany the community care worker to an assessment appointment and was offered a place in a regular group. The CCW arranged a lift for [Mr. Z] from a social work student to facilitate his subsequent attendance but [Mr. Z] did not take this up and failed to attend the group.*
- *[CPN 2] did talk with the consultant at the Bristol Specialist Drug Service, and although this service would not normally see someone whose main problem was*

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

with crack cocaine, the consultant agreed to do an assessment, given [Mr. Z's] age and the severity of his problems. [Mr. Z], however, refused to attend

- *The team had some training in Motivational Interviewing, together with some specialist supervision, from a Consultant Nurse for Dual Diagnosis. Although they did not specifically discuss [Mr. Z], they did discuss a number of other service users with very similar presentations.*

The ability to deliver interventions that may assist someone with changing a drug habit depends to a large degree on the person's willingness to engage, which [Mr. Z] would not do."[208]

11.6.4.4 Findings

When Mr. Z was seen by the CAMH service it was believed that he was not using illicit drugs although later information threw some doubt on this belief. By January 2007 it was clear that Mr. Z was using illicit drugs although he frequently denied this.[209] Mr. Z was using mainly crack cocaine, cannabis and possibly heroin. At his first Enhanced CPA Review in February 2007 one of the identified actions was to arrange for him to meet with a drugs counsellor and his Care Co-ordinator spoke with him about the detrimental effect that the use of illicit drugs had on his mental health.[210] He was given information leaflets on the Bristol Drug Project and on crack cocaine.[211]

In March 2007 the Community Care Worker arranged to take Mr. Z to the Bristol Drug Project. However, having initially agreed to this plan when the Community Support Worker called to accompany him to the Project Mr. Z declined to go with him.[212] The Community Support Worker did, however, manage to take Mr. Z to the Drug Service drop-in when he was an in-patient in April 2007. Mr. Z agreed to attend a further session the following week but failed to do so.[213]

In August 2007 CPN 2 contacted the Bristol Specialist Drug Service and after discussing Mr. Z's case with the Psychiatrist referred Mr. Z to the Drugs Service. However when she later

208 ROOT CAUSE ANALYSIS REPORT: On the alleged fatal stabbing of [Mr. A] by [Mr. Y]
209 Clinical notes 535
210 Clinical notes 1-1 512
211 Clinical notes p. 1-2 222
212 Clinical notes p.1-2 224
213 Clinical notes p. V1-2 229

met Mr. Z at his home he said he did not need help to stop using illicit drugs and was reluctant to access any formal help.[214]

11.6.4.5 Conclusion

Mr. Z's use of illicit drugs was recognised by the Adult Mental Health Services soon after he was transferred to their care. His continued use of illicit drugs made it difficult for those caring for Mr. Z to clarify the extent of his mental health difficulties and the degree to which these were exacerbated by his use of drugs. It also made it difficult for the Mental Health Services to deliver interventions in a consistent manner. Mr. Z's continued and, apparently, escalating use of drugs brought him into increasing conflict with the Criminal Justice Service and placed him at risk of harm from others involved in illicit drugs.

Given the increasing impact of Mr. Z's drug use on his mental health, his general level of functioning and the risks he posed and was exposed to, many services might have considered transferring his care to specialist substance mis-use services. However it is to the credit of those caring for Mr. Z that this option was not actively considered. In line with both National and Local Policy he was retained in mainstream Mental Health Services with his access to more specialist services encouraged and supported.

There are numerous references throughout Mr. Z's notes to discussions with Mr. Z about the detrimental effects of his use of illicit substances; appointments were arranged for him to contact various drug services and on some occasions he was accompanied to appointments. There was a good example of inter-service co-operation when CPN 2 consulted the Psychiatrist of the Bristol Specialist Drug Service who agreed to assess Mr. Z although he would not normally have fallen within remit of that service. However, again, although he had originally agreed to this referral Mr. Z declined to attend an appointment. While Mr. Z at times agreed that he should address his drug mis-use problem this motivation was never sustained.

The Mental Health Team caring for Mr. Z recognised that Mr. Z was mis-using drugs and tried over a prolonged period to help him to address this problem. They tried a number of strategies and put Mr. Z in contact with a number of drugs services but Mr. Z was not

214 Clinical notes p.V1-2 248

motivated to address this problem and the Mental Health Team had no way of compelling him to address it.

11.6.5 Recovery and social inclusion

11.6.5.1 Findings of the Independent Investigation

In keeping with the identified approach of the Early Intervention service Mr. Z's first Enhanced CPA Care Plan drawn up in February 2007 aimed to support him in moving to more independent accommodation, to help him engage in structured activities such as joining a gym and to explore the possibility of him taking a college course when he was ready. Mr. Z had reported that he found it difficult to talk to people about his inner experiences and preferred to go to the gym to release frustration.[215]

However although he was allocated a Community Care Worker (CCW) Mr. Z was reluctant to engage in any activities when the Support Worker called. Indeed when the CCW called to see Mr. Z in February 2007 Mr. Z informed him that he was not interested in receiving any help other than support in finding alternative accommodation.[216] In June 2007 the CCW wrote to Mr. Z informing him that as he was not able to visit him at home he was not longer able to offer him community support and, in consequence, was discharging him.[217]

The Early Intervention Service continued however, whenever possible to try to engage Mr. Z in age appropriate activities and in February and March 2008 CPN 2 arranged for him to attend meetings at the Fairbridge Project in Bristol, a Project which aimed to help young people develop personal, social and life skills. Although Mr. Z had expressed an interest in the project when it was discussed with him, he failed to attend his appointments with the Project.[218] [219]

11.6.5.2 Conclusion

Although the Early Intervention Service had in place an approach which was consistent with national guidance and they identified activities which were age appropriate and in which Mr. Z had expressed an interest, because of his disorganised life style, his mis-use of illicit drugs and the increasing difficulties the Team had in engaging him in the service, the goals

215 Clinical notes p.1-1 512, 1-2 214
216 Clinical notes p. 1-2 216
217 Clinical notes p.1-1 742
218 Clinical notes p. V2 402
219 Clinical notes p. V2 403

identified in Mr. Z's initial CPA Care Plan were never realised. As discussed elsewhere in this report a new CPA Care Plan was not agreed with Mr. Z and the main effort of the Team became maintaining contact with him and monitoring his mental state whenever possible with a view to assessing him in a stable and drug free environment and then initiating appropriate interventions.

11.6.6 Housing

11.6.6.1 Findings of the Internal Investigation

11.5.7 Housing

"The [Early Intervention Team] did make all reasonable attempts to provide [Mr. Z] with alternative accommodation. The initial strategy of providing [Mr. Z] with individual supported accommodation probably stood the best chance of offering him a successful outcome as it would have provided him with an opportunity to break away from the stressful social circumstances that he was trying to cope with at the family home ….

[Mr. Z] was not in favour of this option and was requesting a one bedroom flat as this would allow him a more independent and unsupervised lifestyle. Unfortunately that strategy required [Mr. Z's] mother to declare him as homeless, which after some consideration she refused to do. The team then considered a second option (requested by [Mr. Z's] mother with his agreement) of pursuing a larger council property for all of the family. This inevitably delayed the housing application process due to the demand on this type of property. This delay may in part have contributed to the reason why the Team were unable to achieve their desired outcome before the homicide occurred. From the information available there is strong evidence to support the fact that the Team were aware of the complex social and associated accommodation issues and that they made assertive attempts to try to resolve these issues".

11.6.6.2 Findings of the Independent Investigation

There are frequent references in Mr. Z notes to the unsatisfactory nature of his accommodation. Soon after he was transferred to the Adult Mental Health Services Mr. Z reported that hat his main concern was with his accommodation; he was sharing a room with his younger brother and his uncle was sleeping on the sofa in the living room.[220] In his CPA

220 Clinical notes p.1-1 677

Care Plan drawn up in February 2007 one of the goals identified was to support Mr. Z in moving to more independent living accommodation.

With this in mind both CPN 2 and the Community Care Worker helped Mr. Z complete housing application forms and took him to the Housing Department to support him in finding more independent accommodation [221] [222] [223] [224] [225]. Mr. Z was a low priority for council accommodation and he was not interested in moving into supported living accommodation. His mother's support for this move was equivocal. She was not confident that Mr. Z had the skills to live independently and her preferred option, at least latterly, was for Mr. Z to remain with her and his younger siblings and for the whole family to move to a larger property.

11.6.6.3 Conclusion

Consistent with the CPA approach of identifying and meeting needs in a comprehensive manner and with the Recovery Model approach of supporting people in becoming more independent and accepting responsibility for their well-being the EI Team identified and supported Mr. Z in addressing his accommodation problems. The problems with Mr. Z's accommodation, the stress and at times the distress this caused him and the desirability of him moving to a more independent living situation were all identified by the Early Intervention Team. However the provision of such accommodation was not in their gift. The option they recommended, supported accommodation, was the one most likely to be realised and the one most likely to enable Mr. Z to move successfully towards independent living. This was not a route that Mr. Z favoured, however. He would have preferred to have his own, independent accommodation. The EI Team accepted that this was Mr. Z's preferred option and provided him with appropriate advice and support in seeking such accommodation. However, given the demand for such accommodation and the very limited supply to which the local housing authorities had nomination rights, Mr. Z was a low priority and was very unlikely to have obtained such accommodation in the short term.

Latterly the solution favoured by Mr. Z's family was that the whole family should move to a larger property. Again this was not in the gift of the EI Team but again they provided appropriate support to Mr. Z and his family.

221 Clinical notes p. 1-2 216
222 Ibid
223 Clinical notes p. 1-2 222
224 Clinical notes p. 1-2 222
225 Clinical notes p. V1-2 260

11.6.6 Psychological Therapies

11.6.6.1 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."[226]

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."[227]

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)".[228] *(p.157)*

226 NICE (2009) Schizophrenia: *Core interventions in the treatment and management of Schizophrenia in adults in primary and secondary care.* CG82 p. 244
227 Ibid p. 274
228 NICE (2009) *Depression; Treatment and management of depression in adults, including adults with chronic pain.* CG 90 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".*[229]

11.6.6.2 Finding

The only explicit reference to initiating psychological therapy in Mr. Z's notes was the observation that this was considered as part of his CPA Review in February 2007. This observation is not, however, elaborated on.

There is no record, in Mr. Z's clinical notes, of him being offered or engaging in formal psychological therapy to address the symptoms associated with either low mood or psychosis.

11.6.6.3 Conclusion

The NICE guidance on both schizophrenia and on depression recommends that service users suffering with these problems should be offered access to psychological therapy. The Early Intervention Team's operational policy also notes:

"CBT to be offered to those experiencing persistent symptoms and to assist clients in understanding their problems including the impact of psychosis."

As has already been noted that the EI Team found it was difficult to engage Mr. Z in a consistent manner, given this involving him in formal psychological therapy would have proved challenging. However there are a number of forms of brief interventions, particularly focusing on coping with symptoms and developing strategies to deal with problems and distressing situations, which might have been considered and included in each contact that the team had with Mr. Z. This may have been the practice of the EI Team but it is not identified either in Mr. Z's clinical notes or in his Care Plan.

229 Ibid p.298

The Guidance is clear that psychological therapy should not be delayed until a patient is discharged but should begin, or at least be considered, while s/he is an in-patient. When he was an in-patient in April 2007 Mr. Z repeatedly absconded and, at least initially, was not co-operative with the in-patient team. There was a plan to continue his in-patient assessment and initiate appropriate treatment. As events turned out this did not happen and Mr. Z discharged himself against medical advice. It may have been part of the plan that psychological interventions would be introduced during the continued admission but this is not made explicit in Mr. Z's clinical notes.

11.6.7 Family

11.6.7.1 Context

Appropriately involving the family is important for all service users but particularly so for young people. Reflecting this the Early Intervention Team Operational Policy identifies that: *"Family interventions: ongoing information, support and problem solving to be offered to families."*

Mr. Z's mother was involved in identifying her son's needs and, at times when Mr. Z was disengaging from the Mental Health Services, she was the main contact with and source of information for the Team. In this context the Internal Investigation noted that Mr. Z was usually seen together with his mother and, given her known opposition to him misusing drugs this made it difficult to engage Mr. Z in a discussion of his drugs use and to plan a way of addressing this. It is possible that Mr. Z might have been more amenable to addressing his drug misuse problems if he had been seen more regularly on his own. Given Mr. Z's general level of functioning, his chaotic life style and his increasing use of drugs it is unlikely that he would have regularly attended appointments had he not been brought to them by his mother.

An alternative approach might have been to engage Mr. Z's mother and other relevant members of his family in some form of family intervention. This might have been a challenging exercise and there is no guarantee that it would have been successful but it would have acknowledged the role Mr. Z's family played in his life and the importance of addressing this if he was to move forward successfully. It might also have provided an

additional method of maintaining Mr. Z's engagement with the service. There is no evidence, however, from Mr. Z's clinical notes that such a strategy was considered.

11.7. Safeguarding

11.7.1 National Context

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

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

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

- Lord Laming's report (2003, Climbié Report) provided safeguarding recommendations and influenced the subsequent developments in Safeguarding Guidance and Policy;
- Every Child Matters (2003), the Government's response to the Laming Report, outlined five key improvement outcomes – be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing;
- National Service Framework for Children (2004) included a recommendation for Care Programme Approach meetings to take account of children's needs and any risks of harm to them;
- Children Act (2004) stated that all organisations have a responsibility to prioritise safeguarding and to ensure that effective arrangements are in place;

- Working Together (2006) established a benchmark that all organisations should ensure that safeguarding arrangements are in line with national requirements.

The 2010 guidance[230] 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. Z 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

230HM 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 the responsibilities of Mental Health Services and mental health practitioners the 2006 guidance comments:
"2.92 Adult Mental Health Services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. These staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse. They should follow the child protection procedures laid down for their services within their area. Consultation, supervision and training resources should be available and accessible in each service….

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

The Laming Form
Following the Climbié Report NHS Mental Health Trusts were required to record whether users of Mental Health Services had regular contact with children. 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;
- if a patient is regarded as a potential risk.

The form covers a wide range of potential triggers including:

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

In order to realise the goals of promote 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."[231]

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

231 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 health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
c) he is disabled.

Section 47(1) of the Children Act 1989 states that:
Where a local authority:
a. are informed that a child who lives, or is found, in their area (i) is the subject of an emergency protection order, or (ii) is in police protection, or (iii) has contravened a ban imposed by a curfew notice imposed within the meaning of Chapter I of Part I of the Crime and Disorder Act 1998; or
b. have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm:
The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare…."[232]

232 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*

11.7.2 Local Context

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

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

2.2 *An assessment, using the Trust's ICPA and risk assessment tool, should be made of the impact of the parental mental health difficulties on the adult's ability to protect their children and to parent. In some cases, a joint assessment might be needed with the local Social Services Children and Families Team. If, as a result of the assessment, a child is thought to be vulnerable or at risk of harm, the clinician must discuss the concerns with their Line Manager or Supervisor and the relevant Safeguarding Children Lead. When appropriate, a referral should be made to the relevant Children and Families team (Social Services) and the local LSCB Child Protection Procedures followed."*[233]

11.7.3 Findings of the Independent Investigation

Mr. Z was a young man identified as suffering from mental health problems from his early adolescence. He had made several serious attempts to take his own life, following one of which he had been discovered by his younger brother hanging from an attic hatch. He shared a room with his younger brother who was frightened and distressed by Mr. Z's behaviour.

Mr. Z was known to use illicit drugs. His mother disapproved of this and, on one occasion, reported that she had hit him with a metal bar and kicked him because of his drug use. Mr. Z lived in an atmosphere of violence. He had threatened people with a knife and his mother had said that when he was unwell she was afraid of him; it was stated that people, possibly drug

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

dealers, had called to see Mr. Z at his home and threatened him with a knife. It was reported that a car had been set alight on the driveway of the family home.

When asked, Mr. Z's mother was, normally, of the opinion that he represented no danger to his younger siblings, though on at least one occasion she reported that she had concerns about the risk he posed to them.[234]

The Clinical Team were sufficiently concerned about the risk associated with Mr. Z that they took the decision not to visit him at home and arranged to see him only in environments they considered to be safe. It was in this context that Mr. Z was discussed at the MAPPA meeting on 14 June 2007. CPN 2 voiced her concerns about the well-being and safety of Mr. Z's younger siblings and the meeting felt it appropriate that a Section 47 (of the Children Act 1989) referral should be made.[235] A representative of Bristol CYPS was present at this meeting.

On 15 June 2007 CPN 2 telephoned the Bristol CYPS and made the referral.[236] On 19 June 2007 she informed Mr. Z's mother of the referral[237] and left a message at the CYPS that the case should "*go live*".[238] On 21 June 2007 CPN 2 received a telephone call from a Child Care Social Worker who said that she would discuss Mr. Z's referral with her manager.[239] This is the last reference to this referral in the Mr. Z's clinical case notes.

CPN 2 made what she considered to be a Section 47 referral to the CYPS, however the Independent Investigation was informed by the CYPS that their record of the conversation between CPN 2 and the CYPS worker indicates that they understood CPN 2 to be sharing concerns about the welfare of the children that should be looked into.

The Independent Investigation Team was informed that CPN 2 followed up her referral with a telephone call to Social Services who informed her that they had called Mr. Z's mother. She had said that she did not want any help from Social Services and no further action was taken. A confidential report by Bristol CYPS reported that the duty Social Worker made several,

234 Clinical notes p.1-1 695
235 Clinical notes p. V1-2 268
236 Clinical notes p. V1-2 272
237 Clinical notes p. V1-2 272
238 Ibid
239 Clinical notes p. V1-2 273

unsuccessful, attempts to contact Mr. Z's mother and on 23 June wrote to her, informing her that concerns had been raised about the effect Mr. Z's behaviour was having on his younger siblings. The letter advised "*that if the situation is becoming dangerous for your younger children, then [Mr. Z] can apply for housing in his own right…Lastly [Mr. Z's] behaviour will have an effect on his siblings and it is your responsibility to protect them, if the situation is becoming dangerous."*[240]

Over the following months CYPS were notified by the police on at least three occasions that a domestic incident had occurred involving Mr. Z and his family but no action was taken in relation to any of these notifications.

Despite identifying that concerns had been raised, that Mr. Z's behaviour had an effect on his siblings and that it was Mr. Z's mother's responsibility to protect her children. The Bristol CYPS appear to have closed the case without assessing the safety and wellbeing of the children.

11.7.4 Conclusion

11.7.4.1 As has already been noted, the aim of the Safeguarding of Children Policy is to ensure that children and young people are healthy, safe, enjoy life, achieve their potential, make a positive contribution to society and are well prepared to secure their economic well-being in future years. (Every Child Matters (2003); Section 11 of the Children Act 2004). The 2006 Guidance identified a number of factors which inhibit the realisation of this aspiration:

- a failure to share information;
- the absence of anyone with a strong sense of accountability;
- poor co-ordination;
- frontline workers trying to cope with staff vacancies;
- a lack of effective training.

11.7.4.2 A failure to share information.

Concerns regarding the well-being of Mr. Z were shared at a multi-agency meeting and this meeting recommended that a particular course of action was taken: a Section 47 referral was made to the CYPS. Up to this point good practice appears to have been adhered to.

240 Confidential Report by Bristol Children's and Young People's Services (2009) p.3

There is no record in Mr. Z's clinical notes as to the action taken by CYPS or the reasons for their adopting a particular course of action, although, as noted above, the CYPS notes indicate that they were under the impression that concerns about the welfare of the children were being shared rather than that a Section 47 referral was being made.

11.7.4.3 The absence of anyone with a strong sense of accountability.

As noted above when a referral to the Local Authority is made under Section 47(1) of the Children Act 1989:

"Where a local authority: …

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."[241]

CYPS did not undertake an assessment of the well-being of Mr. Z's siblings. It is not clear why this was so.

It was suggested that Mr. Z's mother did not want support from CYPS. It is certainly the case that she was angry that the referral had been made and had told CPN 2 that she would refuse to speak to CYPS if they contacted her. However, the point of the referral was not, primarily, to identify whether Mr. Z's mother wanted or needed help or support, but that an assessment should be undertaken to assure the safeguarding and promote the welfare of the younger children. Mr. Z's mother's reluctance to engage with CPYS should not have unduly influenced the decision as to whether an assessment should have been undertaken.

It has been suggested that as the Mental Health services raised the concerns regarding the well-being of Mr. Z's siblings and these were shared with MAPPA, the Mental Health services and the multi-agency forum should have followed up the concerns in a more assertive fashion.

241 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*

It was reported to the MAPPA meeting on 23 August 2007 that the Section 47 referral had been made but there is no record of any discussion or feedback on the actions taken by CYPS. It was at this meeting that Mr. Z's MAPPA status was changed to Level 1 (Single Agency Management) and the involvement of other agencies, under the MAPPA umbrella, ceased.

In discussion with the clinical witness the Independent Investigation Team was informed that AWP now has in place a Safeguarding Team who provide advice and support to clinicians. The clinical witness felt that with the support of this Team they would be able to alert CYPS of their concerns in a more forceful manner than had been the case at the time of the referral of Mr. Z's case.

It is the opinion of the Independent Investigation that, as in other similar cases, there was an absence of anyone with a strong sense of accountability who ensured that the well-being of Mr. Z's younger siblings was promoted.

11.7.4.4 Poor co-ordination.

It has already been noted that although concerns about the well-being of Mr. Z's younger siblings were identified and shared and an appropriate referral made, there was no effective mechanism in place to ensure that a coherent action plan was brought together which addressed both the concerns about the well-being of Mr. Z's younger siblings and Mr. Z's needs. The letter sent by CYPS advised that Mr. Z might apply for housing in his own right. There is no evidence that this suggestion was discussed with those caring for Mr. Z. Such disjointed interventions are not likely to promote the safety and well-being of the members of such a close knit, dynamic system as Mr. Z's family.

11.7.4.5 Frontline workers trying to cope with staff vacancies.

It was suggested to the Independent Investigation Team that a combination of a shortage of resources and an acceptance of certain patterns of behaviour within identifiable groups may have influenced the decision not to undertake an assessment. The Independent Investigation Team does not have access to information which would allow it to comment on this speculation. All we can say in this context is that it is the duty of the Local Authority to safeguard and promote the well-being of all children irrespective of their social circumstances.

11.7.4.6 A lack of effective training.

The Independent Investigation Team was informed that the staff of the Avon and Wiltshire Mental Health Partnership NHS Trust have regular safeguarding training. There is no suggestion in this case that those providing care and treatment to Mr. Z failed to identify their responsibilities with respect to Safeguarding. The only issue raised in this context is the awareness of staff of the observation in the Guidance that one of the failures in implementing good safeguarding procedures is often the lack of professional staff taking personal responsibility for ensuring that the well-being of children is promoted and believing that their responsibilities have been fulfilled when another agency has been alerted.

Service issue 4

Although concerns about the well-being of Mr. Z's younger siblings were appropriately shared and a referral was made to Children's Services, no assessment was undertaken into the well-being of these children. This was poor practice.

There are no records of any communication by the Children's Service with the referrers following the referral nor any on-going discussion as to the implications of the actions they had decided to take. Given that the Mental Health Services had an on-going responsibility towards Mr. Z, some co-ordination and planning of the responses of these agencies to the needs of this family would have been good practice. It is neither effective nor good practice to view and deal with the members of a dynamic system in isolation.

While the primary responsibility to ensure the well-being of Mr. Z's younger siblings lay with Children's Services, the available guidance emphasised that this responsibility rests, to some extent, with all those involved with the family and, with this in mind, the mental health professionals might have made their concerns known in a more assertive fashion.

11.8. Service User Involvement in Care Planning

11.8.1. 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"*.

11.8.2. Findings of the Independent Investigation Team

In February 2007 Mr. Z attended his first Enhanced CPA. It was recorded that he agreed with the formulation of his problems that was arrived at during this meeting. A Care Plan and Risk Management Plan were drawn up at the meeting but these were not signed by Mr. Z. [242]

In May 2007 following Mr. Z discharging himself from hospital he was given an urgent appointment with Consultant Psychiatrist 1 and CPN 2. Mr. Z failed to attend this appointment nevertheless, given the manner in which he had left hospital, a Risk Assessment was completed and a Risk Management Plan drawn up. It was recorded that it was decided not to share this plan with Mr. Z immediately as he found it difficult to discuss past traumatic events. CPN 2 was to discuss the plan with Mr. Z after consultation with the Clinical Team.[243]

Mr. Z's next scheduled CPA Review was in March 2008. He failed to attend this. The meeting, however, went ahead in his absence and a Care Plan and a Risk Management Plan were drawn up. [244] CPN 2 recorded in the care plan:

"I am sorry you and your mum have not been able to attend the care plan meetings we arranged. Therefore I have reviewed and completed this plan based on your last one and what I understand to be your current situation. If you would like to have a meeting to discuss this plan please let me know and I will arrange it. Otherwise we will wait for the next review date in September. We can make a firm date nearer the time."[245]

242 Clinical notes p.1-1 512, 1-2 214
243 Clinical notes p. 1-1 545
244 Clinical notes p. V2 345, 403
245 Clinical notes V2 344

A further Enhanced CPA Meeting arranged for April 2008. Mr. Z did not attend this Meeting.[246] A Risk Assessment was recorded for 09 May 2008.[247]

11.8.3. Conclusions

As noted above engaging a service user in the assessment of his/her needs and the drawing up of a care plan to meet those needs is both national policy and best practice. The most common way in which this aspiration is realised is through the service user's involvement in the Care Programme Approach's comprehensive assessment and care planning. Evidence of the service user's involvement is usually provided by his or her signing that care plan. In Mr. Z's case however there appear to have been only three CPA Reviews during the time he was under the care of Adult Mental Health Services. He failed to attend two of these and did not sign the care plan drawn up at the third. A further a Risk Management Plan drawn up in May 2007 recorded that the Plan was not to be shared with Mr. Z immediately as he found it difficult to discuss past traumatic events.

Without the benefit of a context these bald facts would appear to suggest that Mr. Z was not actively involved in identifying his needs and planning his care. However these facts have to be interpreted in the knowledge that Mr. Z was a young man who lived a somewhat chaotic life style, was increasingly involved in mis-using illicit drugs and in criminal activity to support his drugs habit. Almost from the beginning of his involvement with the Adult Mental Health Service the Team's main contact with Mr. Z and his family was at times of crisis. Initially the crises involved Mr. Z making serious attempts to harm himself; latterly they involved him being detained by the police following alleged criminal acts. Regular, planned involvement was made difficult by the fact that restrictions were placed on where and when Mr. Z could be seen because of the risks associated with him.

There is evidence in Mr. Z's notes to demonstrate that efforts were made by the clinical staff to identify with Mr. Z what he saw as his needs and what he wanted to achieve. However having put plans in place Mr. Z often failed to adhere to them. He identified that he wanted to go to the gym but was unwilling to go when the Community Care Worker called to take him;

246 Clinical notes p. V2 335
247 Clinical notes p. V2 489

he expressed interest in the Fairbridge Project but failed to attend interviews for this when they were arranged. He, at least at times, said that he wanted to address his drug mis-use problem but failed to take advantage of the opportunities that were arranged for him.

The Independent Investigation Team questioned whether Mr. Z was a suggestible individual who agreed to whatever intervention or course of action was suggested to him. However all the clinical witnesses felt that this was not an accurate characterisation of Mr. Z. They were of the opinion that he was clear what he wanted and what he would and would not engage in. His lack of consistency in following plans was explained more as a result of his immaturity, his responding to the desires of the moment and the consequences and effects of his drug mis-use.

The one area of his life in which Mr. Z did clearly express the desire for help was in obtaining independent accommodation. The Mental Health Services did not have the power to provide allocate accommodation but they consistently provided what advice and support they could.

Mr. Z's involvement in identifying his needs and planning how to meet them within the Mental Health Services was limited. This was because, increasingly, Mr. Z's life was centred on his drug mis-use which he did not view as a problem and which he did not want to address.

11.9. Family Involvement

11.9.1. 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."[248]

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." [249]

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-operation. 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 cannot 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 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."[250]

However a review by the King's Fund and The Sainsbury Centre for Mental Health[251] 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." [252]

248 DoH (2008) Refocusing the Care Programme Approach *p. 8*
249 Ibid p.18
250 DoH (2008) Refocusing the Care Programme Approach p. 25
251 Warner, L., Mariathasan, J., Lawton-Smith, S., Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health.
252 Warner, L., Mariathasan, J., Lawton-Smith, S, Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health p.80

11.9.2 Findings

Mr. Z's mother alerted the Mental Health Team when she felt that her son was at risk or his mental state was deteriorating. He was seldom seen without her except when he was an inpatient. When he was disengaging from the Mental Health Service it was Mr. Z's mother who kept the Mental Health Services informed of his behaviour and mental state.

When Mr. Z's mother was not available other members of his family, in particular a sister-in-law, assumed the role of liaising with the Mental Health Team.

11.9.3 Conclusion

Mr. Z belonged to a close knit, extended family which played an important role in his life. His family provided a great deal of support to Mr. Z but at times was also a source of stress. Mr. Z's mother played a particularly important role in her son's life. She often acted as his advocate and it was she who alerted the Mental Health Services when she felt that her son was at risk. She was often the main source of information about her son's mental state and well-being. This was the case both when he attended appointments with her, because he was often not forthcoming as to his moods, mental state and experiences, and when he was disengaging and failed to keep apartments with the Mental Health Services.

Mr. Z's mother was very clear about what she saw as her son's problems and had strong opinions as to how these should be addressed. She was not always impressed, however, by the service her son received from the Early Intervention Team and, particularly, from the Crisis Team and compared them unfavourably with the services her son had received from the CAMHS team and the relationship she had had with the CAMHS staff.

11.10. Communication and Documentation

11.10.1. Communication

"Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion."[253]

253 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy,* (2002) Pg.121

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[254]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticises agencies for not sharing information and not liaising effectively.[255] 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 pays a central role in ensuring that service users receive a co-ordinated service, with all those having in-put 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 multi-disciplinary 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.

11.10.2. Findings of the Internal Investigation

The Internal Investigation noted that that there was a prolonged referral process between CAMHS and the Adult Mental Health Services but concluded that communication was satisfactory when the transfer finally occurred. The Internal Investigation concluded that there was good communication between the EI Team and MAPPA but noted in this context that arrangements established before Consultant Psychiatrist 1 retired were not cancelled on his retirement with the result that information about Mr. Z's behaviour was not passed to the Clinical Team. The Internal Investigation suggested that had this information been available an earlier re-referral to MAPPA might have taken place.

The Internal Investigation concluded that Mr. Z had a good relationship with his care co-ordinator CPN 2 and with Consultant Psychiatrist 1, though the decision that Mr. Z should not be seen at his home made it more difficult for them to maintain an effective working relationship with Mr. Z.

The Internal Investigation noted that Mr. Z's mother was a key link between the EI Team and Mr. Z. It was noted that she was angry when the Mr. Z's case was referred to Children's

254 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999). P.144.

255 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

Social Services and said that she wanted nothing more to do with the Service. However six weeks later she was receptive to CPN 2 contacting her and the relationship between them appears to have been repaired.

The Internal Investigation noted Mr. Z came under the medical care of different consultants when he was an in-patient and when he was under the care of the City Wide Home Intervention Team.

"It does not appear that there was always a full handover between consultants when care was transferred.

Consultants do appear to have held different views about [Mr. Z's] diagnosis, which were not fully discussed or integrated.

When [Consultant Psychiatrist 1] retired, the locum psychiatrist was not in post, so he was unable to make a full handover. It is important to note that [CPN 2] maintained the continuity of care and has reported that she provided the locum psychiatrist with a full handover of [Mr. Z's] care."

The Internal Investigation concluded that communication between the Trust staff and the Housing Authorities, and Trust staff and the Children's Social Care Team could have been improved.

However communication between the Mental Health Team and voluntary organizations such as the Fairbridge Project and the Bristol Drug Project was good, as was communication between the EI Team and the Bristol Specialist Drug Service. Communication between the CARS worker and the EI Worker was described as excellent.

11.10.3. Findings and conclusion

In the opinion of the Independent Investigation Panel the Internal Investigation identified and provided a good synopsis of the major issues relating to communication.

11.10.3.1 Communication within the Clinical Team

There is evidence of good communication within the Clinical Team caring for Mr. Z. Consultant Psychiatrist 1, CPN 2 and the early Intervention Team Manager discussed Mr. Z on a regular basis both informally and in regular team meetings. They made concurrent, timely entries in Mr. Z's clinical notes and Consultant Psychiatrist 1 wrote to CPN 2 to keep her informed of events e.g. feeding back on the discussions and decisions taken at the MAPPA meeting in August 2007.

11.10.3.2 Communication between Clinical Teams within the Trust

The first incidence of inter-team communication was when Mr. Z was referred from CAMHS to Adult Mental Health Services. The CMHT responded to the referral within two weeks but it then took almost a year from the transfer between the two services to be completed. During the latter part of this period there did appear to be good communication, at least between the two CPNs involved, but there were no inter-service/inter-team meetings to jointly identify Mr. Z's needs and plan how these might best be met.

Almost as soon as he was transferred to the Adult service Mr. Z's attempts to harm himself resulted in the Crisis Team becoming involved in his care. It is not always clear from Mr. Z's notes what level of communication there was between the Early Intervention Team and the Crisis Team but CPN 2, Mr. Z' care co-ordinator, spoke to the Crisis Team on a number of occasions, she held a joint meeting with both Mr. Z and the Crisis Team when his care was being transferred and the Crisis Team sent e-mails to CPN 2 to inform her when they had been contacted regarding Mr. Z. Overall it appears that there was good, on-going communication at least between CPN 2 and the Crisis Team.

When Mr. Z was admitted to hospital CPN 2 maintained contact with him as well as establishing contact with the Inpatient Team. There is no record of any formal CPA meeting having been held while Mr. Z was an in-patient; however this would have been the normal forum for sharing information and joint planning. Although Mr. Z's eventual discharge from hospital in April 2007 was unplanned he had been in hospital almost a month at this time and

the failure to hold a formal CPA meeting was a lost opportunity to share information between the two teams and plan his on-going care. It is unclear why such a meeting was not held.

Mr. Z was assessed on several occasions by the Court Assessment and Referral Service (CARS). On each occasion this service contacted the Early Intervention Service to inform them that Mr. Z had been arrested, to obtain information which would inform their assessment and to organise a joint assessment with Mr. Z's care co-ordinator, CPN 2. This provided an excellent example of inter-service communication and co-operation.

Although communication between the Early Intervention Team and the Specialist Drug Service was limited when the Specialist Drug Service was contacted by CPN 2 the Psychiatrist in the Specialist Drug Team provided advice and agreed to assess Mr. Z despite the fact that he would not normally have come within the remit of that team. This was an example of good co-operative inter team working.

11.10.3.3 Communication between Avon and Wiltshire Mental Health Partnership Trust staff and external agencies.

The Multi-Agency Public Protection Arrangements (MAPPA) meetings were used effectively as a means of communication especially around the risks associated with Mr. Z. The Trust clinical staff commented that they found the meetings and the information shared at those meetings particularly useful in enabling them to make informed decisions about how to respond to the risks associated with Mr. Z. It was also at a MAPPA Meeting that the issues relating to the well-being of Mr. Z's siblings was discussed and, as a result of that inter-agency discussion that the decision was made to refer Mr. Z's case to Children's Social Services.

The issues relating to Children's safeguarding have been dealt with elsewhere in this report and will not be repeated here. Suffice it to say in this context that the recommendations about sharing information and accepting responsibility identified in Lord Laming's Report were not evident. Had those involved in this referral had better, on-going and proactive communication it is possible that the response to the referral might have been somewhat different.

11.10.4 Retirement and communication

It was agreed at the MAPPA Meeting in June 2007 that when Mr. Z was detained by the Police the Mental Health Team would be alerted so that he could be assessed with a view to admitting him to hospital. As many of these detentions were out of hours and to facilitate contact, Consultant Psychiatrist 1 provided his mobile telephone number as the contact number for the Police. This worked well while Consultant Psychiatrist 1 remained working as part of the Clinical Team. As he took these calls not only out of hours and at week-ends but when he was on leave there was continuity and a consistent approach to Mr. Z's care. However Consultant Psychiatrist 1 retired from his clinical post in October 2007, although he returned to work in the Trust in another capacity. In this post-retirement period Mr. Z was detained by the Police on a number of occasions. They then contacted Consultant Psychiatrist 1. Consultant Psychiatrist 1 reported that on each of these occasions after discussion with the police officers concerned it was concluded that Mr. Z was not displaying signs of a mental illness and a mental health assessment was not called for. Given that Mr. Z was not displaying any signs of mental ill health and no further action, on the part of the Mental Health Services, was called for, Consultant Psychiatrist 1 did not pass the details of these contacts on to the Early Intervention Team. He does recall advising the Police that as he was no longer part of that Clinical Team they should in future contact that Team.

When CPN 2 assessed Mr. Z with the CARS Manager on 23 May 2008, following him being arrested for burglary, she discovered that he had been detained on a number of other occasions. On the basis of this information she determined to re-refer Mr. Z to MAPPA. In the event Mr. Z was arrested on suspicion of murder before this could happen.

That Consultant Psychiatrist 1 was prepared to be the main contact for the Police and continued in this role even when not on duty and on holiday speaks well of his commitment to providing a consistent and responsive service to Mr. Z. This arrangement worked well while he was part of the Clinical Team and had a close relationship with CPN 2. However after he left the clinical team a situation arose where he was in possession of information about Mr. Z which was not passed on to the Clinical Team and, conversely, he was not aware of any developments in or plans for the care and treatment of Mr. Z but was placed in a situation of offering advice as to whether a Mental Health Act Assessment was appropriate.

Consultant Psychiatrist 1 noted that he had advised the Police that they should be contacting the Clinical Team responsible for Mr. Z's clinical care but that it proved difficult to have his name and details removed from the Police system.

This was an unsatisfactory and potentially dangerous situation, although it would not be reasonable to conclude that this had any direct effect on Mr. Z's behaviour and the events of May 2008.

Had another Psychiatrist been identified to succeed Consultant Psychiatrist 1 it is possible that there would have been a smoother transition and the continued involvement of Consultant Psychiatrist 1 would have been avoided. As it was, no successor to Consultant Psychiatrist 1 was identified at the time of his retirement and so no handover took place. As the Internal Investigation identified CPN 2, who was Mr. Z's Care Co-ordinator, did provide the Locum Psychiatrist who succeed Consultant Psychiatrist 1 with a handover. As Mr. Z's Care Co-ordinator she was well placed to do this and to facilitate continuity and consistency in his care. This handover did not however include revising the contact arrangement when Mr. Z was detained by the Police.

Unfortunately in recent years it has not been uncommon, for a variety of reasons, for consultant psychiatrist posts to be left unfilled by a substantive incumbent. Given that this is not an uncommon situation the Trust should ensure that it has in place robust mechanisms for handing over clinical information and responsibilities. This might form part of the *New Ways of Working* protocols.

Systems Issue 5

Following an agreement at the MAPPA Meeting that whenever Mr. Z was detained by the Police the Mental Health Services should be contacted and a Mental Health Act Assessment considered. Consultant Psychiatrist 1's contact details were recorded on the Police computer system as the main contact point. He provided continuity and consistency and while he was working as part of the Clinical Team caring for Mr. Z this arrangement worked well. However following Consultant Psychiatrist 1's retirement from the clinical Team he continued to be contacted by the Police when Mr. Z was detained. On each of these occasions it was determined that Mr. Z was not displaying signs of mental illness and a Mental Health Act Assessment was not called for. However this was an unsatisfactory

and potentially dangerous situation. The Clinical Team were not aware that Mr. Z had been detained or provided with information about his mental state and Consultant Psychiatrist 1 was not aware of any developments or changes to Mr. Z's Care Plan.

Consultant Psychiatrist 1 did advise the Police to contact the Clinical Team caring for Mr. Z and requested that his contact details be removed from the Police computer system. Despite this he was contacted by the Police on a number of occasions.

It would not be reasonable to conclude that this situation had any direct effect on Mr. Z's behaviour and the events of May 2008, however it would be prudent for the Trust to put in place a protocol, in agreement with the Police, to ensure that when a clinician ceased to be involved with a service user that the contact details contained on the Police computer system are revised in a timely manner.

Service Issue 6

When Consultant Psychiatrist 1 retired no successor had been identified and, in consequence, he was unable to provide a handover to his successor. Best practice would recommend that there should be some successor planning and a departing Consultant should provide his or her successor with a comprehensive handover to ensure continuity and consistency of care, however in reality, for a variety of reasons, it is not uncommon for there to be delay in appointing a successor. This being the case the Trust should ensure that it has in place robust mechanisms for handing over clinical information and responsibilities. This might form part of the New Ways of Working protocols.

11.11. The Role of the Appropriate Adult

11.11.1 Context

The role of the Appropriate Adult was created by the Police and Criminal Evidence Act (1984) (PACE). The Appropriate Adult acts as a safeguard for the vulnerable person, helping to ensure that his/her rights are respected, that s/he is able to understand what is happening and is understood. It is not the role of the Appropriate Adult to give legal advice.

An Appropriate Adult must be called for any young person or vulnerable adult detained in Police custody. In this context the detained person does not have to have a recognised mental illness or learning disability to be classed as vulnerable. The Code of Practice associated with the Act states:

"If an officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, in the absence of clear evidence to dispel that suspicion, the person shall be treated as such for the purposes of this Code." [256]

An Appropriate Adult can be a parent, relative, carer, social worker or other professional or:

"Failing these, some other responsible adult aged 18 or over who is not a Police Officer or employed by the Police." [257]

The National Appropriate Adult Network reported in 2011 *"Currently no statutory authority has the responsibility for the provision of an appropriate adult service for vulnerable adults. The services therefore vary across the country. In nearly half of the country, there is some sort of organised scheme run on similar lines to services for juveniles, with appropriate adults (either paid or volunteers) being CRB checked, trained and supported. In other areas the service is at best ad hoc, with perhaps the local Social Services Emergency Duty Team (EDT) responding to requests if they have no higher priority."*[258]

The National Appropriate Adult Network (NAAN) produced a set of standards relating to the selection training and activities of Appropriate Adults. These were approved by the Home Office and Department of Health in 2011.

There are four sets of standards relating to i. recruitment, ii. support and supervision, iii. training and iv. service delivery.

The standards on recruitment include the recommendation that Appropriate Adults will as far as possible reflect their local community, will be given a role and job description and be CRB (Criminal Records Bureau) checked. Importantly the standards specify that "*Appropriate*

256 Home Office (2008) Police and Criminal Evidence Act: Code C: Code of Practice for the detention, treatment and questioning of persons by Police Officers. (Code C 1.4)

257 Home Office (2008) Police and Criminal Evidence Act: Code C: Code of Practice for the detention, treatment and questioning of persons by Police Officers. (Code C 1.7)

258 National Appropriate Adult Network (2011) *The Provision of Appropriate Adults in England and Wales*

Adults will not undertake solo visits to Police Stations until they have successfully completed the minimum training and have completed at least 2 and ideally 3 shadowing visits." [259]

The standards also require that the Appropriate Adult receives regular individual supervision and has access to a manager or equivalent by phone in an emergency.
The training standards specify, amongst others things that:
1. Each Appropriate Adult should receive a minimum of 18 hours training, in order to ensure a level of competency in fulfilling the role as defined by the Police and Criminal Evidence Act 1984 (PACE) Codes of Practice.
2. The training should include:

- a basic introduction to the relevant parts of the Criminal Justice System and the role of the Appropriate Adult in a Police Station (including PACE and the Home Office 'Guidance for Appropriate Adults');
- An introduction to police interviews;
- An introduction to the role of the defence solicitor and the forensic physician.

The document also notes*: "The [Police and Criminal Evidence Act (1984)] codes make it clear that Appropriate Adults can be present at the detainee's private consultation with his/her legal representative, if the detainee wishes it. However the Appropriate Adult is not covered by legal privilege and all parties should be made fully aware of the possible consequences of this before an Appropriate Adult agrees to sit in on these interviews. An Appropriate Adult can continue in role if s/he witnesses a confession AFTER taking on the role at a police station but again needs to be aware of the implications of the lack of legal privilege."* [260]

A National Appropriate Adult Network leaflet on the provision and role of the Appropriate Adult notes:
"Appropriate adults are not covered by legal privilege. For this reason the appropriate adult should not be present at any consultation that is covered by privilege, such as taking instructions or giving legal advice. If it is felt that the appropriate adult's presence is needed in order to ensure effective communication, the lawyer and detainee need to be aware that

259 National Appropriate Adult Network (2005/2011) National Standards for Approved Adults
260 Ibid

although the appropriate adult is bound by a duty of confidentiality, they could be called as a witness."[261]

11.11.2 Findings of the Independent Investigation

Following Mr. Z's arrest on suspicion of murder on 26 May 2008 CPN 2 was asked to act as the Appropriate Adult for him. As she was the member of staff who knew him best and because there did not appear to be anyone else to undertake this role she agreed to act in this capacity.

While this was a supportive act by a clinician for a service user it raised a number of issues and placed CPN 2 in a difficult position with potentially conflicting responsibilities. As noted above the recommendation of the National Appropriate Adult Network is that those acting as Appropriate Adults should receive training and, appropriate, support and supervision. In the case of CPN 2 none of these were in place when she agreed to act as the Appropriate Adult.

CPN 2 was present at Mr. Z's Police Interview when he was questioned about his role in a murder. During this interview she heard accounts and saw photographs of the injuries of the victim. She was subsequently interviewed by the Police in the role as Mr. Z's care co-ordinator. This was a confusing and distressing situation when, as the guidance suggests, support and informed advice should have been readily available.

As noted above when acting as an Appropriate Adult one does not have legal privilege and can be identified and called as a witness. This was in contrast to the other professionals involved in Mr. Z's care who were granted anonymity. CPN 2 was left in the difficult position of being both Mr. Z's Care Co-ordinator and having acted as an Appropriate Adult. She was left with the uncertainty as to whether she would be called as a witness. Those she consulted were unable to provide her with appropriate advice and support in a timely manner.

11.11.3 Conclusion

It is not appropriate that those caring for an individual, e.g. in the role of care co-ordinator, should be put in the position of having to decide whether they should act as an Appropriate Adult for one of their clients/patients, especially as such decisions normally have to be made

261 National Appropriate Adult Network (2011) *The Provision of Appropriate Adults in England and Wales*

with some urgency or at times of crisis. The Trust, together with its Local Authority partners and the local Police Force, should have a clear policy in place. The procedure for identifying Appropriate Adults should follow the guidance set out by the National Appropriate Adult Network and endorsed by Home Office and the Department of Health. Where a member of the clinical staff is asked to act in this role there should be a senior member of staff available who can advise them as to the appropriate course of action and where clinicians do act in this role clear legal and procedural advice, and appropriate support and supervision should be readily available.

11.12. The Management of Mr. Z's Care

11.12.1 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[262]. 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.

11.12.2. Findings

11.12.2.1 Transfer of Care

The CAMH service referred Mr. Z to the Adult Mental Health Services in August 2005 but, because of the restructuring of the team and staff vacancies the Adult Mental Health Services could not assume responsibility for his care at that time. In May 2006 the two services attempted to undertake a joint assessment, however this had to be postponed and the

262 DoH (2007) Mental Health: *New Ways of Working for Everyone*

assessment and formal transfer of care did not take place until August 2006, a year after the initial referral.

Transfer between any two services is a time of increased vulnerability and this is particularly so when a service user's care is being transferred from Children's to Adult Services. Knowing this it would have been prudent to have used this period of delay in a planned fashion, to increase the likelihood that Mr. Z was successfully engaged in Adult Services. It was the view of Mr. Z's family that he was well engaged with the CAMH Service but never achieved the same level of engagement with Adult Services although he did form a good relationship with CPN 2 who was his care co-ordinator for much of the time Mr. Z was under the care of Adult Services.

This failure to plan a smooth transition from Children's to Adult Services was a missed opportunity. However the Early Intervention in Psychosis Service came into being only in February 2007 and Mr. Z was one of its first clients. The Independent Investigation Team was informed that since the inception of this Team there are much closer relationships between CAMHS and Adult services and transfers between the two services now reflect best practice.

11.12.2.2 CPA and Assessment

When Mr. Z was accepted by the Adult services he was placed on the Standard level of CPA. Given his history and identified vulnerability it would have been more appropriate to have placed him on the Enhanced Level of CPA which, in turn, would have triggered a more comprehensive assessment of his needs, a more comprehensive care plan and by addressing Mr. Z's needs in a more timely manner may have fostered the engagement that the CAMH Service had achieved with Mr. Z and his family. This again was a missed opportunity.

11.12.2.3 Transfer to the Early Intervention in Psychosis Team.

In December 2006 Mr. Z was transferred to the case load of CPN 2 in anticipation of the establishment of the Early Intervention in Psychosis Service. This was a positive and appropriate move.

CPN 2 placed Mr. Z on the Enhanced Level of CPA and organised a multi-disciplinary CPA Review of Mr. Z as soon as this was feasible. She served as Mr. Z's Care Co-ordinator until

he was arrested in May 2008, providing continuity of care. Given the ethos of the Early Intervention Service CPN 2 was able to work in a flexible manner with Mr. Z and she formed a good relationship with him.

Particularly after Mr. Z discharged himself from hospital in late April 2007, his use of illicit drugs increased and he increasingly disengaged from the Mental Health Services. However, because of the good relationship CPN 2 had forged with him and the tolerant and flexible approach adopted by the Early Intervention Service, contact was maintained with Mr. Z and his family and the team continued to try to deliver a service. They continued to see Mr. Z and assessed him whenever the opportunity arose. This continuity and commitment was an example of good practice.

11.12.2.4 Use of the Mental Health Act (1983 and 2007)

Mr. Z was admitted to hospital in April 2007 following a serious attempt to harm himself. He frequently absconded during this admission and on a number of occasions used illicit drugs when he was absent from the ward. Consultant Psychiatrist 2, who was responsible for his care while he was an in-patient, believed that Mr. Z needed a longer period in hospital, a stable and drug free environment, to clarify the relationship between his mental health problems and his mis-use of illicit drugs and, subsequently, to initiate an appropriate intervention. Consultant Psychiatrist 1 and CPN 2, who were responsible for his care while in the community, were of a similar opinion. With this strategy in mind Consultant Psychiatrist 2 requested a Mental Health Act assessment with a view to placing Mr. Z on Section 3 of the Act. However, Mr. Z's GP, who provided the second medical recommendation, felt that he could not recommend that Mr. Z be detained given his presentation when the he interviewed Mr. Z.

Although Mr. Z was admitted to hospital at a time of crisis it would have been good practice to have assembled those responsible for Mr. Z's care, during this admission, and articulated and recorded a long term plan to meet his needs. This might have included the consensus opinion that Mr. Z would benefit from a longer period of assessment in a stable, drug free environment. This might have formed the basis of the recommendation that he be detained under Section 3 of the Mental Health Act. There is no guarantee that such a plan would have ensured that Mr. Z would have been detained for this longer period or that being part of a

discussion would have increased Mr. Z's compliance, nevertheless it was a missed opportunity for putting into place a longer term strategy for his care.

The Code of Practice accompanying the Mental Health Act indicates that where there is a difference of opinion as to whether an individual should be detained under the Act a plan, based on a current risk assessment, should be put in place. The comprehensive assessment and planning entailed in a CPA review would have provided the opportunity to consider alternative ways of meeting Mr. Z's needs and provided the basis of such a plan.

11.12.2.5 On-going engagement

Mr. Z discharged himself from hospital at the end of April 2007 when his Section 2 lapsed. From this time on his use of illicit drugs appeared to increase, his involvement with the Criminal Justice System increased, his engagement with the Mental Health Services was more sporadic and he increasingly disengaged form this Service. As noted above the Early Intervention Team strove to maintain contact with Mr. Z and to offer him a service. Given Mr. Z's chaotic life style and the restrictions placed on when and where he could be seen, because of the risks associated with him, the Team felt that they were doing all that could be done to engage Mr. Z. However the CPA process is designed to provide an opportunity for reflection and exploration of alternative ways of offering services. The multi-disciplinary format of the CPA Review is designed to allow different perspectives to be considered and to promote the development of care plans to meet the unique needs of the individual. Given Mr. Z's increasing disengagement from the service, despite the best efforts of those involved with him, it would have been good practice to have held a CPA Review Meeting or a Professionals Meeting, perhaps involving individuals with relevant expertise e.g. from the Specialist Drug Service, to explore ways in which Mr. Z's continued disengagement might have been addressed. It is possible that no definitive solution would have been identified but nevertheless this was a missed opportunity.

11.12.2.6 Risk

A number of risks were associated with Mr. Z, some of these were related to his use of illicit drugs. In response to the risks identified restrictions were placed on when and where Mr. Z could be seen. The Independent Investigation Team was informed that this was a proactive stance to ensure that potentially dangerous situations were not allowed to drift and risks increased without proper reflection. This was appropriate and good practice. However it also

made it more difficult to maintain Mr. Z's engagement and to deliver a planned service. The difficulty in delivering a service to Mr. Z is well illustrated by the fact that the Crisis Team managed to see Mr. Z only once in a two week period following his brief admission to hospital in January 2008. At the end of this period they discharged him from their care.

There was clearly a tension between the need to respond appropriately to identified risks and the duty to deliver a service. There was no easy solution to this problem but it could have been more fully explored as part of the review discussed above.

11.12.2.7 Retirement and Continuity of Care

CPN 2 and Consultant Psychiatrist 1 demonstrated substantial commitment and flexibility to delivering a service to Mr. Z. Consultant Psychiatrist 1 provided his contact details to the Police so that whenever Mr. Z was detained he could be contacted and Mr. Z could be assessed. Consultant Psychiatrist 1 continued to take these calls when he was not on duty and when he was on annual leave which demonstrated considerable commitment. However this arrangement was not revised when Consultant Psychiatrist 1 retired from clinical work. Following his retirement he continued to be contacted by the Police whenever Mr. Z was detained. This was an unsatisfactory situation. While the commitment and dedication of individual clinicians is a key factor in delivering high quality services there has also to be coherent management of the case so that all those involved in providing care are adhering to a single plan to meet identified needs. This ensures that there are no inconsistencies in the care the individual receives and to avoid, as far as possible, a lack of continuity in the care of the individual.

Clinicians have to ensure that they are competent and their knowledge is up-to-date so that they can deliver services competently. They also have a responsibility to contribute to the planning of the individual's care and, when a plan is agreed, to adhere to this.

Managers, particularly team managers, have a responsibility to ensure that there is a proper structure in place for the delivery of care to each of the service users receiving care from their team and that the care plans reflect best practice and Trust policy.

The Trust has the responsibility for ensuring that there are appropriate policies in place which reflect best practice which inform and support the delivery of high quality care.

In Mr. Z's case Consultant Psychiatrist 1 found it difficult to have his details removed from the police computer system and there did not appear to be a protocol in place, agreed between the Trust and the Police, to enable such contact details to be revised in a timely manner. Consultant Psychiatrist 1 was unable to hand over Mr. Z's care to a successor psychiatrist as no successor had been identified at the time of his retirement.

Consultant Psychiatrist 1 retired from clinical work in October 2007 however there does not appear to have been a Review at this time to plan Mr. Z's on-going care or to ensure that commitments given to other organisations could be honoured.

Although Consultant Psychiatrist 1's continued support for Mr. Z when he had retired was praiseworthy it would have been more appropriate if he had more assertively informed the Police that he was no longer involved in the care of Mr. Z and had directed them to the Clinical Team.

11.12.2.8 Co-operative working

When Mr. Z was arrested by the police on suspicion of criminal activity he was assessed by the Court Assessment and Referral Service. This Service contacted Mr. Z's Clinical Team and organised joint assessment so that an informed decision as to Mr. Z's needs for care could be arrived at and the Courts provided with appropriate advice. This co-operative working was an example of good management of Mr. Z's care in crisis situations.

11.12.3 Conclusion

Mr. Z lived a somewhat chaotic lifestyle. He increasingly misused illicit drugs and although those caring for him tried to help him address this problem he was of the view he did not have a drug mis-use problem and did not want or need help in this area. Given this situation and Mr. Z's associated disengagement from the Mental Health Services it proved difficult to deliver a coherent and planned service to him. Nevertheless the Early Intervention Team, and CPN 2 and Consultant Psychiatrist 1 in particular, showed considerable commitment and flexibility in trying to maintain contact with Mr. Z and to deliver what care and support they could. Having said this there were a number of occasions when the opportunity to reflect on how a service could be best be delivered to Mr. Z might have been taken and were not. These were missed opportunities.

Given the path Mr. Z had decided to take in his life there is no guarantee that had these opportunities been taken a more successful strategy for delivering care to Mr. Z would have been identified. It would not be reasonable to conclude that had these opportunities been taken the events of 24 May 2008 would have been avoided.

11.13. Clinical Governance

11.13.1 Context

"Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish".[263]

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. Z 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 consult the

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

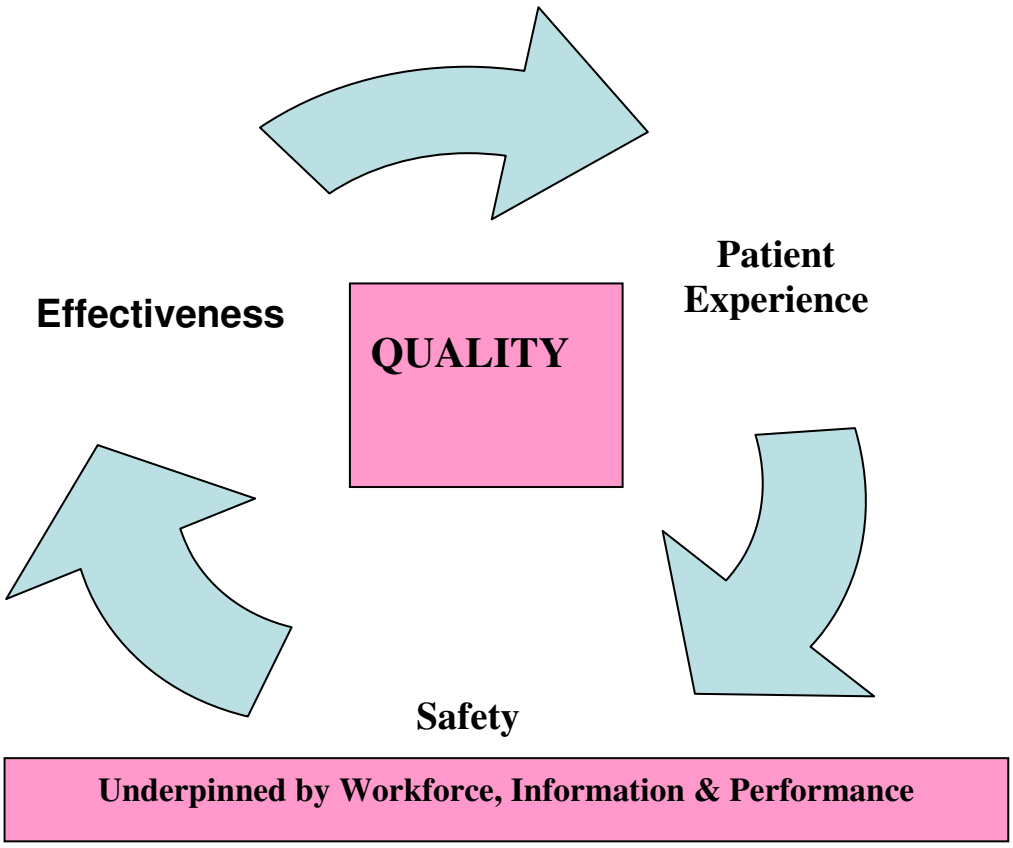
Care Quality Commission website for more information. The CQC employs a four point scale to evaluate the care provided by Trusts: compliant, minor concerns, moderate concerns and major concerns. It was the judgement of the CQC that the Trust was compliant in most of its sites on most of the standards. In its overall review of the Trust the CQC noted minor concerns in relation to three standards: supporting workers, assessing and monitoring the quality of the service provided and record keeping. A moderate concern was identified against the standard: care and welfare of the people who use the service.

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Mr. Z. The issues that have been set out below are those which have relevance to the care and treatment that Mr. Z received.

11.13.2 Findings

11.13.2.1. Clinical Governance Systems and Performance

In 2010 the Avon and Wiltshire Mental Health Partnership NHS Trust put in place a five-year strategy for improving clinical quality. This is based on the integration of three core areas of quality improvement: patient experience, effectiveness and safety. Quality improvement is defined in this strategy document as the combined and continuous process of making the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning). The relationship between these elements is illustrated in the diagram below.



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

- quality metrics that will enable the measurement of quality across the whole spectrum of care;
- the implementation of best practice;
- regular clinical auditing and performance monitoring against national and local standards;
- the identification of ways for service users and carers to receive more personalised care;
- the provision of information on the accessibility and quality of services;
- the delivery of services in a safe environment;
- improving feedback from service users and carers and using that feedback to drive quality improvement;
- staffing, training, support and appraisal and continuous professional development.

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

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

The strategy recognises the importance of clinicians and practitioners in improving the quality of clinical care. It recognises that clinicians and practitioners should:

- fully engage with the Trust Clinical Governance arrangements;
- influence service modernisation and redesign;
- be able to reflect on their practice and actively contribute to quality improvement;
- have access to a full range of educational, training and continuous personal and professional development opportunities.

Engagement with clinical governance arrangements:
Each Strategic Business Unit (SBU) has an Integrated Governance Group led by the Clinical Director and clinicians are involved in local integrated governance activities and reviews.

The Trust Professional Council, Trust Medical Advisory Group and Trust Nursing Advisory Group are forums that enable clinicians and practitioners to provide professional scrutiny and advice on best practice, clinical effectiveness and service improvement. They also provide support to clinicians.

Service modernisation and redesign:

To ensure clinical involvement and influence in service redesign the Trust has established Clinical Reference Groups and Practitioners for Change Forum. These groups enable structured and timely engagement and influence in the modernisation and service redesign process.

Reflecting on practice and contributing to quality improvement:
The Trust approach to quality improvement has led to a number of initiatives:

- the Productive Ward/Team Programme enables nurses and practitioners to spend more time on clinical engagement and patient care;
- the Manchester Patient Safety Framework (MapSaF) is being used to help the Trust assess its safety culture;
- an annual programme of Chief Executive and Executive Director led Patient Safety Visits has been established.

Education, training and continuous personal and professional development:
The Trust Learning and Development Policy aims to:

- improve the quality of the service as experienced by users and carers;
- ensure that learning needs are identified in a systematic way linked to service development and organisational priorities;
- promote a philosophy of continuous personal development;
- ensure that the Trust delivers modern and effective services through enabling staff to develop their skills in line with changing national priorities, policy guidance and service development.

Supervision and appraisal processes are identified as important in helping to ensure that staff take appropriate advantage of development options.

Governance and assurance processes and structure:
The Trust Board leads and directs clinical quality and its governance. Lead responsibility for scrutinising and assuring clinical quality, safety and performance is delegated to the Quality and Healthcare Governance Committee. The Committee is composed of three Non Executive Directors, the Chief Executive, the Executive Director for People and the Executive Director of Nursing, Compliance, Assurance

and Standards. The Committee is also attended by the Trust SBU clinical directors and two representatives from the Professional Council. The Chair of the Committee reports formally to the Board.

The Trust Mental Health Legislation Committee plays a key role in clinical governance. This Committee is composed of two Non Executive Directors and meetings are attended by the Executive Director of Nursing, Compliance, Assurance and Standards, the Mental Health Act Lead, SBU managers, a social work representative, the Mental Health Act and Mental Capacity Act Manager and a consultant psychiatrist. The Chair of the Committee reports formally to the Board.

To support continuous clinical quality improvement the Trust has established a number of management groups chaired by Executive Directors which report to the Performance Executive Management Team. The management groups are expected to:

- scrutinise and review compliance with core quality and safety standards and outcomes;
- peer review draft policy, guidance, protocol and strategy;
- manage and co-ordinate engagement of Strategic Business Units and relevant corporate leads.

The Strategic Business Units contribute to the Clinical Governance system by attending the Trust Management Groups and Board Committees, disseminating good practice, implementing quality improvement plans, coordinating operational activity against set standards, and providing an evidence base of delivery against clinical quality standards.

The Trust has identified the importance of ensuring that it has processes in place that enable the early identification of potential failings in patient care. The Trust's ability to spot the early signs of failings is strengthened by:

- the provision and understanding of regular information on key clinical indicators;
- staff being empowered to engage in management processes, raise concerns and be involved in quality improvement processes;

- service users and carers voices and experiences being heard and shared from ward to Board.

11.13.3. Adherence to Local and National Policy and Procedure

11.13.3.1 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."*[264] 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. This implementation has to be 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.

264 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p. 328

11.13.4. 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.

12. Findings and Conclusion

12.1 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 24 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 failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr. Z'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 24 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.

12.2 Key Causal Factors

The Independent Investigation identified no direct causal factors connecting the care and treatment of Mr. Z by the Avon and Wiltshire Mental Health Partnership NHS Trust and the events of 24 May 2008.

The main findings of the Independent Investigation are reported below.

12.3. Conclusion of the Independent Investigation into the Care and Treatment of Mr. Z

12.3.1 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. The Independent Investigation identified no causal factors relating the care Mr. Z received from the Avon and Wiltshire Mental Health Partnership NHS Trust and the events of 24 May 2008, however as with all cases there are lessons to be learned which might promote the development of higher quality services.

12.3.2 Delivering Care and Treatment

Delivering care and support to Mr. Z was a difficult and challenging task but the challenges he presented were not unique. Mr. Z was a young man who as a child had manifested the symptoms of a serious mental illness and had been treated for this with apparent success. He and his family had engaged well with Children's Mental Health Services. By the time his care was transferred to Adult Services, however, contact was becoming increasingly determined by crises. Initially these were related to Mr. Z's often serious attempts at self harm and latterly they were related to him being detained by the Police. As time went by it became increasingly evident that his use of drugs was having a significant impact on his mental health and behaviour. Mr. Z's use of illicit drugs became pivotal in determining the delivery of his care.

At the conceptual level, because Mr. Z was reluctant to discuss his illicit drug use and because it was not possible to observe him in a drug free environment for a significant period of time there was an on-going lack of clarity about the degree and nature of his mental health problems, his pattern of drug mis-use and the relationship between these.

At the level of planning Mr. Z's care, because his life was increasingly centred on drug mis-use, which he did not identify as a problem, it proved difficult to engage him in identifying his needs and planning how to meet these. The only need he seems both to have consistently identified and been prepared to co-operate in addressing, was obtaining alternative

accommodation. However even in this area his co-operation was limited and he was not prepared to accept the advice of those trying to support him.

At the level of delivering care and support, Mr. Z's use of drugs, the risks associated with this and the restriction put in place to address these risks, together with Mr. Z's inconsistency in adhering to plans that had been agreed made it difficult to deliver a service in any coherent manner.

The central role played by drugs in Mr. Z's life and his reluctance to address this made it difficult to deliver a coherent and planned service. The Early Intervention Team, although they identified this problem, had no means by which they could compel Mr. Z to acknowledge and address this central problem.

12.3.3 Care Planning and Reflective Practices

Associated with Mr. Z's increasing drug use was his increasing disengagement from the service. Again the clinical team were aware of the problem. Despite this disengagement the Early Intervention Team continued to try to deliver a service to Mr. Z; they did not discharge him from the service and were flexible in their approach. It was the practice of CPN 2 to contact Mr. Z several times prior to an appointment to ensure that he was aware of it and to confirm that he was planning to attend. When Mr. Z did not attend appointments she would make contact with him to try to discover why he had not attended and, frequently arranged another appointment at short notice. Despite these efforts Mr. Z's attendance at appointments was at best sporadic and he appears never to have attended unless he was brought by a member of his family.

Latterly the plan put in place was that whenever Mr. Z was detained by the Police the Mental Health Services would be informed and Mr. Z would be assessed with a view to detaining him under the Mental Health Act. This strategy worked well in as far as Mr. Z was assessed on a number of occasions, but on each occasion he was found not to be displaying the symptoms of a serious mental illness and was not detainable under the Mental Health Act 2007.

The Early Intervention Team felt that there was nothing more they could do to ensure Mr. Z's engagement and to deliver a service to him. This was possibly true, however, what the Team

did not do, as Mr. Z's disengagement became more evident, was to convene a meeting, a Care Programme Approach Review or a Professionals Meeting, perhaps including individuals with relevant expertise. This would have provided an opportunity to reflect on Mr. Z's situation and explore alternative approaches to delivering a service and meeting his needs.

Mr. Z was identified as posing a risk to staff and in response restrictions were placed on when and where he might be seen. While this was appropriate the restrictions made it still more difficult to engage Mr. Z and deliver a service to him. There was no easy way to resolve this tension. However, again, the opportunity might have been created to reflect on how this issue might be addressed, if not entirely resolved. Others with relevant expertise, from outside the team, might have been beneficially involved in this discussion.

The second theme to emerge, then, is that while the Team caring for Mr. Z showed a great deal of commitment and flexibility, they might have benefited from adhering to the underlying principles of the CPA process. They could also create more opportunities to review the efficacy of their strategies and consulted others who might have been able to offer alternative insights or approaches.

12.3.4 Treatment

Given the difficulty in engaging Mr. Z and his sporadic attendance at appointments it was difficult for the team to initiate any sustained intervention or treatment. Mr. Z was prescribed anti-psychotic medication and, at least when he was being seen more regularly, he reported that he was compliant with this. The Best Practice Guidance recommends that individuals such as Mr. Z should have access to psychological interventions. It seems unlikely that Mr. Z would have engaged in any form of formal psychological therapy though there are some forms of brief psychological intervention which may have been used to inform the interactions between Mr. Z and the clinical staff when he was seen. Similarly given the important role that his family played in Mr. Z's life, some form of family intervention might have been considered. This would undoubtedly have been challenging but it would have acknowledged the important role his family played in him moving forward and might have improved the level of Mr. Z's engagement with the Service.

12.3.5 Conclusion

The Early Intervention Team caring for Mr. Z showed great persistence, commitment and flexibility in trying to deliver a service to him. There was good, co-operative working through sharing information relating to risk at MAPPA meetings, with the Court Assessment and Referral Service (CARS) and with the Specialist Drug Services. Commutation, co-operative working and identifying responsibilities were less evident when working with Children's Social Services. When Consultant Psychiatrist 1 retired from clinical work responsibilities he had assumed were not re-allocated in a timely manner. Engaging Mr. Z in clinical services was challenging and the Early Intervention Team discussed him, at least on an informal basis, at regular intervals. However, they would have benefited from creating the opportunity to evaluate and reflect on the success and efficacy of the strategies they were employing in a more timely and inclusive manner.

13. Response of the 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 24 May 2008.

13.1. 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 also provided 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.

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 relative as to what continued support and information will be provided.

A Trust Management Report was completed on 30 May 2008. This set out a very clear history of Mr. Z's mental health and other problems, his involvement with Mental Health Services, the risks he was identified as posing and the issues relating to engaging him.

This report noted: *"The initial issue identified by this initial Management Investigation relates to ensuring consistency and effective risk management of the threshold between MAPPA level 1 and 2."* It went on to recommend: *"That the need for further guidance on the management and movement between MAPPA level 1 and 2 be reviewed with the local partnership(s)."*[265]

265 Management Investigation Report For Serious incidents: Mr. Y

This Report does not, however, identify whether any attempt had been made to contact the families of the victim or perpetrator. Nor does it identify whether any support had been put in place for staff.

13.2. The Trust Internal Investigation (Structured Investigation Report)

13.2.1 Terms of Reference for the Internal Investigation

The Internal Investigation Report recorded that it conducted its Investigation under the following terms of reference.

"To review the circumstances relating to the care and treatment of [Mr. Z] while in the care of the Avon and Wiltshire Mental Health Partnership Trust, with specific attention to:

- *The quality and scope of care provided by AWP services and associated support agencies.*
- *The quality of the care planning process with specific attention to the implementation of CPA and clinical risk assessments.*
- *The effectiveness of single and multi agency communications, both verbal and written.*
- *The effectiveness of specific treatment strategies with particular attention to diagnosis and associated treatments and the application of the Mental Health Act."*[266]

13.2.2 Investigation Team

The Internal Investigation Team was made up of three senior members of staff from the Avon and Wiltshire Mental Health Partnership NHS Trust. These individuals came from Nursing, Psychology and Psychiatry backgrounds. The Team had expertise in delivering Early Intervention Services in particular and in the management and delivery of clinical services in general. The members of the Team had received training in Root Cause Analysis and experience of undertaking investigations into serious untoward incidents.

266 ROOT CAUSE ANALYSIS REPORT: On the alleged fatal stabbing of [Mr. A] by [Mr. Y] on the 26th of May 2008 (31.01.2009)

The Internal Investigation Team was unclear how its members had been chosen to undertake this Investigation and suggested that there might have been an element of fortuitousness in the composition of the team. Whether this was the case or not the experience and skills of the team members meant that the team was appropriately composed to undertake such a serious investigation.

13.2.3 Methodology

The Internal Investigation Team employed a Root Cause Analysis Methodology in which the members of the Team had been trained. The Investigation Team interviewed the clinical staff involved in Mr. Z's care as well as a number of senior staff who had particular expertise relevant to Mr. Z's care and treatment.

The Internal Investigation Team was unable, however, to speak to the family of either the victim or the perpetrator. The Investigation Team reported that although the Police were helpful, because a criminal investigation was ongoing, they, the Police, were insistent that the Internal Investigation Team did not have contact with the perpetrator's or victim's families. The Internal Investigation Team were not made aware of the Memorandum of Understanding and were unable to use this to agree with the Police how they might carry out their investigation without inhibiting or compromising the Police Investigation.

The Internal Investigation Team reported that no resources, either dedicated time for the investigators to undertake the Investigation or administrative support for the Investigation, were made available to the Team when undertaking this Investigation.

13.2.4 Conclusion

The Internal Investigation was very competently conducted employing an accepted methodology. The Internal Investigation Team was aware that it was good practice to involve the families and was keen to do this for a number of reasons. The Police, however, indicated that they were opposed to the Internal Investigation Team contacting those who were regarded as potential witness while a criminal investigation was on going. They did not provide the Internal Investigation Team with details of the victim's family and those members of Mr. Z's family most closely associated with his care were similarly unavailable.

The Independent Investigation Team was not made aware of the Memorandum of Understanding (2006).[267] The Memorandum identifies as its main purpose the establishing of a protocol to promote effective working relationships between the NHS, the Police and the Health and Safety Executive when investigations into serious untoward events, such as homicides, have to be undertaken. The Memorandum sets out the general principles to be observed when these three organisations liaise with one another in these circumstances and provides practical guidance as to how these challenging situations can be effectively managed so that all parties can realise their responsibilities.

It would have facilitated the work of the Investigation Team if the protocols identified in the Memorandum had been enacted and an Incident Coordination Group established.

It is a common complaint of those asked to undertake Internal Investigations that the resources to undertake these serious investigations are not made available. Investigating Team members are not given adequate time to undertake the Investigation in a competent and timely manner or provided with adequate and appropriate administrative support. As has already been noted the current Internal Investigation was of a high quality but if the Trust wishes to maintain this standard it may wish to review its policy on resourcing and supporting such serious pieces of work.

13.2.5 Findings of the Internal Investigation

The Internal Investigation concluded:

"13.2 The immediate cause of the incident was that [Mr. Z], along with three other family members, had been drawn into a dispute with the local landlord which had resulted in a serious assault leading to the murder of one of the two men attacked.

13.3 [Mr. Z] was not suffering from any form of active psychotic symptoms at the time of the incident.

267 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.

13.4 It was difficult to establish a working diagnosis due to the complexities of [Mr. Z's] presentation with regard to his dual disorder and his resistance to fully engaging with the treatment and support offered to him.

13.5 The clinical picture that [Mr. Z] presented, particularly his speedy recovery once detained under the Mental Health Act, resulted in the Team being unable to implement an early safeguard of a prolonged period of inpatient treatment under a Section 3. This would have offered the opportunity for a more comprehensive period of assessment and of an associated range of potential treatment options based on a more informed diagnosis.

13.6 A more assertive approach to engagement by the Team, especially following [Mr. Z's] failure to attend ICPA and Risk Planning Meetings in the four months prior to the incident, may have resulted in additional MAPPA safeguards being put in place that may have removed him from the scene of the homicide incident .

13.7 Assertive engagement was difficult for the Team to achieve due to the risks of harm posed to staff from [Mr. Z] and his family given their previous history with weapons, criminal activity and drug use.

13.2.6 Recommendations of the Internal Investigation

The Internal Investigation made the following recommendations:

14.1. Clinical care

14.1.1 Handover Communications

The Trust needs to have a clear handover policy in place for clinical handover, particularly when using temporary staffing. This is important for senior clinical roles such as consultant medical staff where a single clinician carries detailed knowledge for a large caseload. Handovers must include any specific arrangements that may have been made by an individual on behalf of the organisation. Care should be taken to ensure that any newly appointed staff can maintain any previous commitments / arrangements. Where this is not possible

a team or multi agency meeting should be arranged to establish alternative arrangements.

14.1.2 Retirement

The Trust should revisit their Staff Retirement Policy and ensure that specific attention is paid to the need for a detailed handover of care for all clinical staff, especially clinicians that manage individual caseloads, e.g., outpatient clinics or therapists managing individual client's caseloads.

14.1.3 Risk Assessment

14.1.3.1 There appears to be problem in relation to the interpretation of Standard and Enhanced Levels of ICPA, and the associated Level of Risk Assessment that aligns to the respective processes. The Trust has recently reviewed its ICPA policy in line with national guidelines. It is recommended that the Trust revisit the learning points from previous enquiries to ensure that they have clarified guidance around the required level of CPA and risk documentation for patients attending outpatient's clinics.

14.1.3.2 A risk screen needs to be fully completed for all service users (new and existing), and a full risk assessment completed if the screen identifies the need for this as per the policy. In particular the risks to others, in this case younger siblings, need to be screened and where indicated, fully documented with a supporting risk assessment and action plan.

14.1.3.3 The new ICPA policy should add a short section to ensure that any patients under the care of Early Intervention or Assertive Outreach Teams will have no more than one ICPA and risk review in their absence. Where non attendance is a particular problem, the care coordinator should request a professionals meeting to discuss next steps and where appropriate seek a second independent opinion from another similar Team elsewhere in the Trust.

14.1.3.4 Risk assessments need 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 into the current assessment of risk.

14.1.4 Training

The Trust needs to ensure that previous recommendations to ensure that staff are able to detect, assess, risk manage and treat individuals with co-morbid mental health and/or alcohol and drug difficulties in an integrated treatment approach are fully implemented.

14.1.5 Dual Disorder Strategy

The Trust has recently updated its Dual Disorder Strategy in collaboration with partners, service users and carers. Nominated Dual Diagnosis Leads must be tasked with leading a process to ensure that AWP staff receive supervision and support in the management of patients with co-existing mental health and substance misuse problems.

14.1.6 Information sharing (MAPPA)

There appear to be some issues in relation to the ability to share confidential information from MAPPA meetings, due to the highly sensitive nature of the personal data being discussed. More clarity is needed as to exactly what information staff can share following attendance at a MAPPA case review. The AWP Head of Safeguarding should be asked to review the nature of the information sharing protocols to see if greater clarity can be achieved in this area.

14.1.7 Referrals to Child protection

Clinicians should ensure that they complete a formal written referral for a Child Protection Assessment in addition to any verbal communication to the Child Protection Team.

14.1.8 Use of MHA

> *The RMO should always be consulted by the ASW and Second Opinion Doctor when considering an application for a section 3 detention order under the Mental Health Act...*
>
> *The AWP Mental Health Act Committee must ensure that staff are advised that any decision not to convert a section 2 to a Section 3 of the MHA should not be based on the ability of the ward staff to use an Emergency Section should things go wrong."*[268]

13.2.7 Conclusion

The description of the findings of the Internal Investigation are detailed and organised under the headings proposed by the National Patient Safety Agency. The findings are supported by evidence that is made explicit and in the view of the Independent Investigation are sound and appropriate.

Similarly the recommendations of the Internal Investigation are appropriate, practical and relevant to the findings of the Internal Investigation.

13.2.8 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. Z 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.

268 ROOT CAUSE ANALYSIS REPORT: On the alleged fatal stabbing of [Mr. AR] by Mr. Y } on the 26th of May 2008 (31.01.2009)

Trust Action Plan

Recommendation	Action	Action Completed	Action Outstanding
1. Handover Communications.	A protocol is required to ensure that there is a full written handover of care when a consultant or another clinician who manages individual case loads leaves the Trust. This potentially could form part of the Supervision Policy, ICPA Policy or a practice directive.	New CPA Policy Section 14; Section 5 of Care Delivery Procedure.	Re-designed services move to team based caseloads rather than individual practitioner caseloads, so contingency arrangements mainstreamed.
2. Retirement	Team managers must make appropriate contingency plans for sudden staff absences to ensure continuity of care.	Team managers instructed to print and keep up to date MHIS reports on caseload and manage absences accordingly.	
	Commence medical input into Early Intervention arrangements in the Trust through the re-design work.	Significant medical input into re-design processes with the appointment of Clinical Leads (medical) to lead the change processes.	Complete Adult Community redesign plans, including EI arrangements.
3. Risk Assessment	This recommendation to be picked up and addressed through ICPA review and the links with RIO, whilst remaining cognisant of previous inquiry findings. This should require any service user transferring from CAMHS to Adult Services to be placed on enhanced CPA.	New CPA Policy and procedures in place. Learning from previous inquiries used as part of the revision process.	
4. A risk screen needs to be fully completed for all service users.	This is already addressed in the relevant policy. An internal safety alert is to be produced based on a vignette of this case and circulated to all teams to share learning and heighten awareness.	Safety alert completed.	

5. Any patients under the care of Early Intervention or Assertive Outreach teams will have no more than one ICPA and Risk Review in their absence.	This recommendation should be picked up and fed into the CPA Review that is currently underway. The recommendation to be share with the Trust Early Intervention and Assertive Outreach forums for their consideration and to provide an opportunity for their views to be incorporated into the CPA Review.	New CPA Policy completed. Covered in Standards Operating Procedures for Early Intervention Team.	
Risk			
6. Risk Assessments need to be informed by an 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.	The functionality within RIO will enable the Trust to fulfil the requirements of this recommendation, and this will be supported by the introduction of guidance for staff.	Incorporated into CPA policy supported by guidance. Guidance also in RIO Clinical Manual.	
Training			
7. Ensure that previous recommendations to ensure that staff are able to detect, assess, risk manage and treat individuals with co-morbid mental health and/or alcohol and drug difficulties in an integrated treatment approach are fully implemented.	The Trust has a Dual Diagnosis Strategy in place together with an implementation action plan that is subject to regular review and assurance reporting.	Incorporated into CPA Policy supported by guidance. Guidance also in RIO Clinical Manual.	

Dual Diagnosis			
8. Nominated Dual Diagnosis leads must be tasked with leading a process to ensure that AWP staff receive supervision and support in the management of patients with co-existing mental health and substance misuse problems.	Check that the PDG in relation to dual diagnosis adequately addresses the need for supervision. Dual Diagnosis training now forms part of the Trust's mandatory training programme and no further action in respect of this is required.	Dual Diagnosis Strategy being rolled out. Consultant Nurse in post. Link Workers identified in all wards and teams. Dual Diagnosis performance indicator monitored as part of Monthly Board Scorecard**.**	
Public Protection and Safeguarding			
9. Information Sharing (MAPPA)	The AWP Head of Safeguarding should be asked to review the nature of the information sharing protocols to see if greater clarity can be achieved in this area.	New Caldicott arrangements have provided clarity. Protocols in place.	
10 Referrals to Child Protection.	The documentation for child protection has been completely overhauled and it is not felt that any further action is required in respect of this recommendation.		
Mental Health Act			
11. The RMO should always be consulted by the ASW and Second Opinion Doctor when considering an application for a Section 3. The AWP Mental Health Act Committee must ensure that staff are advised that any decision not to convert a Section 2 to a	The Mental Health Act Committee to prepare an internal safety alert for circulation of all Responsible Clinicians to remind staff of the Code of Practice and expected standard professional practice.	The Mental Health Act Committee to prepare an internal safety alert for circulation of all Responsible clinicians to remind staff of the Code of Practice and expected standard professional practice.	

Section 3 of the MHA should not be based on the ability of the ward staff to use an Emergency Section should things go wrong.			

13.2.9 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.

13.2.10 Notable Practice Identified by the Internal Investigation

The Internal Investigation noted that the Bristol Early Intervention Team had developed their practice in line with the National Policy Implementation Guidance; case loads were in line with national guidance and capacity controls were in place. The Investigation Team noted that there was "*strong evidence of a positive culture of both managerial and clinical supervision in this team.*"

The Internal Investigation Team acknowledged that "*Although problematic in relation to maintaining direct contact with [Mr. Z] the decision not to visit him at his home should be noted as a good practice point with regard to compliance with the AWP Lone Worker Policy. This decision was based on sound clinical judgement, supported by an appropriate risk assessment, and communicated via a MAPPA multi agency group*."

The Internal Investigation Team noted that *"a high level of multi agency communications did occur in this case. As the EI Team identified risks they were able to demonstrate that they followed these up by liaising with several agencies in a bid to resolve a range of complex issues...*

Of particular note in this case was the good communications and working relationship between the CARS Service and [Mr. Z's] Care Coordinator….. In addition the Review Team

were pleased to note the strong links between the CARS Team and the AWP Prison In-reach Service."

The Investigation Team noted *"the continued support and care that [CPN 2] and [Consultant Psychiatrist 1] provided to [Mr. Z] following his arrest on the 25-05-08."*

It also commented *"There were some excellent examples of detailed longitudinal risk assessments contained in the health records from both the inpatient and EI team notes."*[269]

13.3. Dissemination and Staff Involvement

The clinical staff interviewed as part of the Internal Investigation reported that they had the opportunity to meet with the Investigation Team to discuss the findings of the Investigation and to consider the likely recommendation. They found this a useful exercise and, independently of the formal recommendations contained in the Internal Investigation Report, this provided them with the opportunity to reflect on and revise their practice. This was good practice by both the Investigation Team and the clinical staff and is to be commended.

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 Internal Investigations. There was concern expressed, however, that there has been an emphasis on producing policies and protocols and less emphasis on helping clinical staff reflect on their practice and providing support for them to change or improve this.

[269] **ROOT CAUSE ANALYSIS REPORT: On the alleged fatal stabbing of [Mr. A] by [Mr. Y]**

13.4 Staff Support

13.4.1Context

The Trust's Serious Adverse Incident Policy [270] 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 require will vary between individuals. Managers should be proactive in supporting staff."

13.4.2 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.

13.4.3 Conclusion

The staff interviewed by the Independent Investigation Team reported that there was support available to those interviewed by the Internal Investigation and clinical staff were aware of this. They also reported that the Trust is generally supportive and provides helpful advice when clinical staff have to make statements or attend external inquiries or Court. They noted however that following a serious incident such as a homicide there may be several investigations being undertaken at the same time. This can be confusing, anxiety provoking, distressing and, at times, frustrating as the same information has to be reviewed on a number of occasions. It was suggested that the Trust might usefully provide some easily accessible

270 Avon and Wiltshire Mental Health Partnership Trust (2006) *Serious Adverse Incident Policy and Procedure*

information about the nature, purpose and relationships of these various inquiries. This is a suggestion the Trust might like to consider as a way of supporting its staff.

Those interviewed by the Internal Investigation were positive about the opportunity they had been afforded to discuss the findings of the Internal Investigation and found this a constructive experience.

13. 5 Being Open

13.5.1 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.

13.5.2 Findings

The Trust had in place a *Being Open* Policy which reflected the national guidance.

13.5.3 Conclusion

As reported elsewhere in this report as the victim of the homicide did not receive services from the Trust and as the Police were reluctant to provide the contact details of those who might be witnesses as part of the criminal proceedings associated with this homicide the Trust was unable to contact the family of the victim.

Similarly those members of Mr. Z's family who were most closely associated with his care were not available and the Police were, again, opposed to any contact being made with them. As a result the Trust was unable to contact the family of Mr. Z as their *Being Open* Policy recommended.

14. Commissioning

14.2 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.

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: (i) the City, (ii) areas, and (iii) 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 difficult to engage with because the Trust has its base in Chippenham.

In October 2011 NHS Bristol, North Somerset and South Gloucestershire published the results of an engagement exercise.[271] 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*".

271 NHS Bristol, North Somerset and South Gloucestershire (October 2011) *Engagement Exercise into Mental Health Services*

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."*

14.2. 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 Services is taking place in Bristol and, amongst other things, this review place emphasises the importance of collaborative working. This Review will no doubt impact on 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 ensured that services are safe, fit for purpose and meet identified quality standards and current best practice guidance, and they have an identified a role to play in the implementation and monitoring of the action plan.

When the Independent Investigation Team spoke to representatives of NHS Bristol and NHS North Somerset, due to changes of personnel and reorganisations of the commissioning body, the policies and protocols relating to the monitoring of investigations were not available and to date the Independent Investigation has not been able to review these.

15. 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. Z. The clinicians in the Early Intervention Team, in particular, showed the commitment, persistence and flexibility in trying to deliver a service to Mr. Z.

There were also a number of examples of good inter-team communication and co-operative working, the most noticeable being the collaborative method of working adopted by the Court Assessment and Referral Service.

16. Lessons Learned

16.1 Engagement

Perhaps the most important area for reflection in the case of Mr. Z is how one can deliver a service to an individual when s/he does not want to accept it. It would be easy to characterise Mr. Z's case as a situation of a Clinical Team trying to deliver a service and the service user refusing it. This is an unhelpful characterisation. A more fruitful conceptualisation might be to view the relationship between the clinicians and the service user as a collaboration on a journey to improve the quality of the individual's life.

Louis Appleby (2007), the then National Director of Mental Health commented:
"Increasingly, services aim to go beyond traditional clinical care and help patients back into mainstream society, re-defining recovery to incorporate quality of life - a job, a decent place to live, friends and a social life." [272]

This approach has been widely adopted in Mental Health Services and is particularly appropriate when delivering care to young adults. The model has, however, been criticised as being unrealistic, transferring responsibility from the service provider to the service user who, because of his/her mental health problems, is in no position to take on this responsibility, and as promoting a reactive stance by services and clinicians.

This criticism is based on a misunderstanding of the approach. While there are a number of versions of the Recovery Model they all describe a staged approach to recovery and care delivery. Andresen, Caputi and Oades's (2006)[273] identified five stages: moratorium, awareness, preparation, rebuilding and growth. The Ohio Department of Mental Health version of the Recovery Mode, which influenced the NIMHE (2004)[274] Model, identifies four stages: dependent-unaware, dependent-aware, independent-aware and inter dependent-aware.

[272] Appleby. L (2007) *Breaking down the barriers: the clinical case for change.* Department of Health
[273] Andresen, R., Caputi, P, & Oades, L. (2006) Stages of recovery instrument: development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry,* 40**,** 972–980.
[274] NIMHE (2004) Emerging Best Practices in Mental Health Recovery.

In the earlier stages the individual needs more information and support, with clinicians taking more of the initiative in identifying problems and delivering services. In the later stages the individual assumes greater responsibility for identifying goals and how these will be realised. At any point what the individual sees as determining the quality of his/her life is of central importance. This is not to deny that some areas may be of particular importance in achieving well being, but the challenge is to enable the individual to become aware that a particular problem is proving to be barrier to improving the quality of his/her life.

The Early Intervention Team espoused such an approach. While Mr. Z's drug mis-use and its impact on his mental health might have seemed the most important areas to address, Mr. Z was not committed to tackling this. He identified his accommodation needs as his highest priority and the Early Intervention Team supported him in addressing this.

The lesson to be learned here is that there is a reciprocal relationship: services have a responsibility to support the service user on his/her journey of recovery and if they do this services users are more likely to engage and co-operate. However, as the case of Mr. Z demonstrates, even employing such a collaborative model provides no guarantees of engagement and co-operation, at least in the short term.

16.2. Reflection and Creativity

At times it can appear obvious that a particular area of the individual's life should be the focus of intervention. However, one can easily get stuck finding it difficult to identify alternative approaches and persisting with ineffective strategies. Alternatively, when employing a more encompassing model, such as the Recovery Model, it is easy to lose focus; losing sight of what one is trying to achieve.

Part of the solution to both of these problems is to maintain the discipline of regular and thorough reviews and to have in place explicit care plans (or in the case of the Recovery Model, WRAPs: Wellness Recovery Action Plans) with clear goals which can be evaluated. The CPA review, if conducted well, provides the opportunity to assess need in a comprehensive manner and to plan ways of meeting those needs in a fashion that is unique to the individual. It should also provide the opportunity for the multi-disciplinary team to

reflect, to explore alternative ways of understanding the individual's problems and to consider alternative ways of addressing the individual's needs. The CPA review, used in this way, provides both a structure and an opportunity for creative thinking. In this context the NIMHE has produced a useful matrix which identifies who should be doing what at each stage of an individual's recovery journey. Particularly when a problem appears to be intractable it can be useful to review the activities of the team against such a matrix.

16.3 Communication and finding the best possible solution

A further theme to emerge from Mr. Z's case is the importance of maintaining good communication and identifying the best possible practicable solution. There were examples of good communication resulting in flexibility and co-operative working, for example the co-operation and communication between the Court Assessment and Referral Service and the Early Intervention Team, and the co-operative and flexible working of the Specialist Drug Services and the Early Interventions Team. There were also examples where communication and subsequent constructive planning was less effective such as when Mr. Z's case was referred to Children's Social Services and when there was a difference of opinion as to whether Mr. Z should have been detained under Section 3 of the Mental Health Act.

The lesson to be learned here is that good, on-going communication increases the likelihood of co-operation, flexible working and, when the opportunity arises, being able to put in place creative solutions to meet the individual's needs.

Exhortation on its own is unlikely to realise this goal. Similarly policies and protocols, alone, are unlikely to ensure that communication is improved. However putting in place protocols to support busy clinicians in communicating well and promoting a culture of meaningful communication, increase the likelihood of communication being improved.

17. Recommendations

17.1 The Care Programme Approach

17.1.1 Contributory factor 1.

Mr. Z became increasingly disengaged from the Early Intervention Team and the services that it was offering him. Contact with Mr. Z was increasingly at times of crisis and frequently at the instigation of either Mr. Z's mother or the Police. Mr. Z's agreed CPA Care Plan could not be delivered. Despite this CPA Reviews were not held in a timely manner. No strategy to address Mr. Z's non-attendance at appointments, increased disengagement and increasingly chaotic behaviour was recorded. While it cannot be certain that holding a CPA review would have resulted in improved strategies for engaging Mr. Z, it is reasonable to conclude that if CPA Reviews had been conducted in a timely manner Mr. Z's care would have had greater focus and achievable goals identified which would have been shared with Mr. Z and his mother.

Failure to hold such a meeting was a missed opportunity to establish a strategy to address Mr. Z's needs in the most effective manner. The inability to deliver, assertively, a service to Mr. Z possibly contributed to his disengagement which in turn may have affected his mental health and behaviour. It cannot be reasonably concluded, however, that this contributed directly to the events of 24 May 2008.

17.1.2 The Avon and Wiltshire Mental Health Partnership NHS Trust provided the following update:

The Adults of Working Age SBU has carried out a caseload assurance process as part of its service redesign. This has required every care co-ordinator to review every individual on their caseload, ensure that an appropriate care plan, risk assessment, and CPA arrangement is in place, and then sign to verify this is the case. This has been monitored on a case by case basis, and all care co-ordinators completed the process by mid May 2012. The Trust can therefore be assured that caseloads are up to date and appropriately managed.

From the beginning of May a caseload profiling supervision system was introduced. This is compulsory for all practitioners and requires the team manager or senior practitioner to

work through every individual on each care co-ordinator's caseload on a monthly basis at minimum, to ensure that appropriate plans, and CPA processes are in place. This will maintain the progress made through the caseload assurance process on an on-going basis.

17.1.3 Recommendation 1

The Avon and Wiltshire Mental Health Partnership NHS Trust should put in place appropriate mechanisms, including audit, to assure itself and its commissioner that CPA review meetings are held:

- at times of significant change in a service user's life;
- when it is evident that the existing care plan is either no longer effective or cannot be delivered in an effective and efficient manner.

17.1.4 Recommendation 2

Where existing care plans are no longer effective or cannot be delivered in an effective manner and the multi-disciplinary team cannot identify alternative interventions or delivery strategies the team manager should ensure that consideration is given to consulting individuals from outside the team who have relevant expertise. This consultation might form part of the multi-disciplinary CPA review.

17.2 Risk Assessment and Management

17.2.1 Service Issue 1

Although much of the information that one would expect to be considered in a comprehensive risk assessment was recorded in Mr. Z's clinical notes, no cumulative risk history was recorded and the information relating to risk was not gathered together in a single place with an accompanying exploration of the risks and a formulation, to help understand Mr. Z's behaviour, which would inform a risk management plan. Perhaps as a result of this the risk action plans recorded in Mr. Z's clinical notes are not explicitly grounded in a clear formulation and understanding of his behaviour and the actions identified in the plans are not explicitly related to the risks identified.

It would not be reasonable however to conclude that this had a direct causal relationship with the events of 24 May 2008.

17.2.2 The Avon and Wiltshire Mental Health Partnership NHS Trust provided the following service update:

In addition to the actions described above the Trust has invested in a rolling programme of training around formulation, to support less experienced practitioners in consolidating their skills in this area.

17.2.3 Recommendation 3

The Avon and Wiltshire Mental Health Partnership NHS Trust should put in place appropriate mechanisms, including audit, to assure itself and its commissioner that risk management plans:

- are informed by a current, up to date risk history;
- are founded on a clear formulation and understanding of the risks posed by the service user and to which s/he is exposed;
- identify actions designed to address identified risk;

as recommended in the Best Practice Guidance on managing risk.

17.3 Use of the Mental Health Act

17.3.1 Service Issue 2

Those undertaking the Mental Health Act Assessment of Mr. Z did not meet to discuss their Assessment. Good practice suggests that, especially when there is a difference of opinion, this should happen. The Code of Practice guidance further recommends that when there is such a difference of opinion a plan, based on a risk assessment, should be put in place. This should be recorded and shared appropriately. Although some appropriate actions were taken no protocol was followed to ensure that immediate risks were identified and an appropriate plan was put in place. The Trust should ensure that it has protocols in place to ensure that this best practice and Code of Practice guidance is followed. The protocol should also clearly indicate the responsibilities of the various professionals involved in a Mental Health Act Assessment.

17.3.2 Recommendation 4

The Avon and Wiltshire Mental Health Partnership NHS Trust, together with the local PCTs and Local Authorities and any other relevant partner organisation should ensure that:

- there is a protocol in place to ensure that the Code of Practice accompanying the Mental Health Act is followed where there is a difference of opinion as to whether a service user should be detained under the Act;
- the protocol should clearly indicate the responsibilities of the various professionals involved in a Mental Health Act Assessment with respect to:
    - ensuring that there is appropriate discussion between those undertaking the assessment;
    - ensuring that a risk assessment is undertaken or a recent risk assessment is in place;
    - ensuring that a risk plan is agreed and communicated to relevant people.

17.3.3 Service Issue 3

Consultant Psychiatrist 2 was employed as a locum consultant. She had received no induction, no supervision arrangements had been identified and no senior member of staff whom she could consult was identified. If clinicians are to practise safely and adhere to Trust Policies it is essential that they receive a timely induction and that supervision and consultation arrangements are in place.

17.3.5 The Avon and Wiltshire Mental Health Partnership NHS Trust has provided the following update:

The Trust has revamped its induction and supervision arrangements for temporary staff since the incident and it now satisfies CNST (Clinical Negligence Scheme for Trusts) requirements.

17.3.6 Recommendation 5

The Avon and Wiltshire Mental Health Partnership NHS Trust should ensure that all clinical staff, including locum staff, receive a timely induction and that supervision and consultation arrangements are in place from the time they begin to deliver clinical services.

17.4 Safeguarding

17.4.1 Service issue 4

Although concerns about the well-being of Mr. Z's younger siblings were appropriately shared and a referral was made to Children's Social Services, no assessment was undertaken into the well-being of these children. This was poor practice.

There are no records of any communication by the Children's Service with the referrers following the referral nor any on-going discussion as to the implications of the actions they had decided to take. Given that the Mental Health Services had an on-going responsibility towards Mr. Z, some co-ordination and planning of the responses of these agencies to the needs of this family would have been good practice. It is neither effective nor good practice to view and deal with the members of a dynamic system in isolation.

While the primary responsibility to ensure the well-being of Mr. Z's younger siblings lay with Children's Social Services, the available guidance emphasised that this responsibility rests, to some extent, with all those involved with the family and, with this in mind, the mental health professionals might have made their concerns known in a more assertive fashion.

17.4.2 The Avon and Wiltshire Mental Health Partnership NHS Trust has provided the following update:

The Trust has reviewed its method of recording contacts and concerns regarding children. In future these contacts will be recorded direct into RiO, the electronic clinical record system, (safeguarding children screen 1) and the children's assessment has been updated to reflect these changes and incorporate further guidance for practitioners. The new procedures will be launched by the 31st July 2012.

The safeguarding pages on RiO have been updated, offering additional guidance on safeguarding children and on sharing information with other agencies (using, recording and sharing information and Caldicott Guardian pages)

The Trust Policy to Safeguard Children has been reviewed to raise awareness of the need to promote the well being of children. Guidance on joint working was issued in May 2012 to support best practice in this area.

17.4.3 Recommendation 6

The Avon and Wiltshire Mental Health Partnership NHS Trust, possibly in conjunction with its partner agencies, 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;
- all staff are aware of the shared responsibility to promote the well-being of children.

17.5 Communication

17.5.1 Systems Issue 5

Following an agreement at the MAPPA meeting that whenever Mr. Z was detained by the Police the Mental Health Services should be contacted and a Mental Health Act Assessment considered. Consultant Psychiatrist 1's contact details were recorded on the Police computer system as the main contact point. He provided continuity and consistency and while he was working as part of the Clinical Team caring for Mr. Z this arrangement worked well. However following Consultant Psychiatrist 1's retirement from the Clinical Team he continued to be contacted by the Police when Mr. Z was detained. On each of these occasions it was determined that Mr. Z was not displaying signs of mental illness and a Mental Health Act Assessment was not called for. However this was an unsatisfactory and potentially dangerous situation. The Clinical Team were not aware that Mr. Z had been detained or provided with information about his mental state and Consultant Psychiatrist 1 was not aware of any developments or changes to Mr. Z's care plan.

Consultant Psychiatrist 1 did advise the Police to contact the Clinical Team caring for Mr. Z and requested that his contact details be removed from the Police computer system. Despite this he was contacted by the Police on a number of occasions.

It would not be reasonable to conclude that this situation had any direct effect on Mr. Z's behaviour and the events of May 2008. It would be prudent for the Trust to put in place a protocol, in agreement with the police, to ensure that when a clinician ceased to be involved with a service user that the contact details contained on the Police computer system are revised in a timely manner.

17.5.2 The Avon and Wiltshire Mental Health Partnership NHS Trust has provided the following update:

The Trust has developed a local reporting form to allow the updating on VISOR of mental health involvement in management of service users subject to MAPPA (Form G).

The Trust is developing a MAPPA policy that will reference Form 3, and will reinforce the need to update the Police VISOR record when there is any change in risk or significant change in the mental health services to the service user.

This Policy is due to be ratified by the Trust in the third quarter of the year on 20 December 2012.

17.5.3 Recommendation 7

The local Police Force, in collaboration with other relevant organisations including the Avon and Wiltshire Mental Health Partnership NHS Trust, should put in place a protocol to ensure that when a clinician ceases to be involved with a service user the contact details contained on the Police computer system are revised in a timely manner.

17.5.4 Service Issue 6

When Consultant Psychiatrist 1 retired, no successor had been identified and, in consequence, he was unable to provide a handover to his successor. Best practice would recommend that there should be some successor planning and a departing Consultant should provide his or her successor with a comprehensive handover to ensure continuity and consistency of care, however in reality, for a variety of reasons, it is not uncommon for there to be delay in appointing a successor. This being the case the Trust should ensure that it has in place robust mechanisms for handing over clinical information and responsibilities. This might form part of the New Ways of Working protocols.

17.5.5 Recommendation 8

The Avon and Wiltshire Mental Health Partnership NHS Trust should ensure that it has in place robust mechanisms for the handing over of clinical information and responsibilities when a clinician retires or moves from a clinical team.

The Trust should put in place appropriate mechanisms to ensure that these protocols are being implemented in a consistent manner.

17.6 Role of the Appropriate Adult

17.6.1 It is not appropriate that those caring for an individual should be put in the position of having to decide whether they should act as an Appropriate Adult for that person. The Avon and Wiltshire Mental Health Partnership NHS Trust, together with its Local Authority partners and the local Police Force, should have a clear policy in place following the guidance set out by the National Appropriate Adult Network relating to the availability, training and support of Appropriate Adults.

17.6.3 Recommendation 9

Relevant local agencies including the local Police Force, Local Authorities and the NHS should have a clear Policy relating to the use, appointment and availability of Appropriate Adults:

- this Policy should embody the standards set out by the National Appropriate Adult Network and approved by the Home Office and Department of Health;
- clinicians, including care co-ordinators, should not normally act as Appropriate Adults for their clients/patients;
- all those acting as Appropriate Adults should receive relevant training, as recommended in the national standards, and supervision.

The Avon and Wiltshire Mental Health Partnership NHS Trust should ensure that its staff are aware of and comply with best practice relating to the role of Appropriate Adult and with the Local Protocol.

A senior member of the Trust or an appropriate individual identified by the Trust should be available to provide consultation and informed advice when a member of staff has been asked to or has acted as an Appropriate Adult.

17. 7 Commissioning

17.7.1 Recommendation: 10

Bristol PCT should ensure that it has in place policies and procedures which ensure that:

- it is 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 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 in assuring that the action plan is implemented in a timely manner, is identified;
- all relevant staff in Bristol 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 PCT in such a way that it can assure itself that local Mental Health Services are safe and of an acceptable quality;
- it conducts regular assurance exercises, including audits, to assure itself that its policies are being implemented in a consistent and effective manner.

18. 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 Co-ordinator	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 to help patients 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 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 persons risk to both themselves and to others.
Risperidone	Risperidone is an antipsychotic medication used to treat mental illnesses including schizophrenia, bipolar disorder, and irritability associated with autistic disorder. Risperidone is a dopamine agonist.
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.