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

Executive Summary

Independent Investigation: HASCAS Health and Social Care Advisory Service

Report Author: Dr Len Rowland

Contents

Brief overview of Mr. Z's contact with the Mental Health Services

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 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 Arrangement (MAPPA) meeting.

Mr. Z was bailed to his mother's address with a curfew from 8 pm to 7 am.

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.

Terms of Reference for the Independent Investigation

1. The overall objectives of the Independent Investigation of the Case of Mr. Z

- 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 Referenece

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

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

3. Outcomes

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

The Independent Investigation Team

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

Investigation Team Leader and Chair

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

Investigation Team Members

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

Support to the Investigation Team

Mr. Christopher Welton	Investigations Manager, HASCAS Health and Social Care Advisory Service
Fiona Shipley Transcriptions Ltd	Stenography Services
Independent Legal Advice	Kennedy's Solicitors

Findings of the Independent Investigation

The Care Programme Approach

Mr. Z's care was not formally transferred from the Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health services until almost year after he was initially referred. No planning appears to have taken place during most of this period. Mr. Z was referred and eventually transferred to Adult Mental Health services before the Early Intervention in Psychosis Service was established, indeed he was one of its first clients when it was brought into being in January 2007. The Independent Investigation Team was informed that as a result of this service development there are now much closer relationships between CAMHS and Adult Mental Health services and transfers between the two services now reflect current best practice.

Following his transfer to adult services Mr. Z was placed on the standard level of CPA. 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. However, when Mr. Z's care was transferred to the Early Intervention in Psychosis Service a comprehensive assessment of his needs took place.

Much of Mr. Z's early contact with the team was in response to crises, frequently at the instigation of either Mr. Z's mother or the police. The assessments which took place in this context tended to focus on addressing Mr. Z's immediate problems. He increasingly disengaged from the Early Intervention Team and the services that it was offering him. 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 both him 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.

Risk assessment and Management

The level of risk posed by Mr. Z was formally assessed on a number of occasions and he was discussed at Multi-Agency Public Protection Arrangement (MAPPA) meetings on two occasions. 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. There was no recorded exploration of the risk associated with Mr. Z and no recorded formulation to help understand his behaviour and inform a risk management plan. Perhaps as a result of this the risk action plans recorded in Mr. Z's clinical notes are not grounded in an explicit 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.

Diagnosis

Although most relevant diagnoses were considered during the time Mr. Z was under the care of the Avon and Wiltshire Mental Health Partnership NHS Trust, at the time of the homicide the clinical team had not arrived at a definitive diagnosis and formulation. The national guidance to Early Intervention Teams was that they should be prepared to live with diagnostic uncertainty, focus on symptom management and adopt a Recovery approach to intervention. The Early Intervention Team followed this guidance and worked within the Recovery Model. The Team also identified the need to understand the nature of the relationship between Mr. Z's mental state, behaviour and his use of illicit drugs if a clear formulation, to guide its interventions, was to be arrived at. With this goal in mind the Team felt that a period of observation and assessment in a drug free environment was needed.

Use of the Mental Health Act (1983)

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.

In April 2007 the Consultant Psychiatrist responsible for Mr. Z's care requested that Mr. Z be assessed with a view to placing him on Section 3 of the Mental Health Act (1983). Given Mr. Z's presentation when he was interviewed for a second medical opinion, the second doctor did not feel able to recommend that Mr. Z be detained. Although the Consultant Psychiatrist, the second doctor and the Approved Social Worker did speak by telephone they did not meet to discuss their differing views. The Code of Practice accompanying the Act indicates that where there is a disagreement a plan, based on a risk assessment, should be drawn up. Although an embryonic plan was recorded this was not based on a recorded assessment of the risk posed to and by Mr. Z, nor was there any exploration of alternative ways of meeting Mr. Z's needs.

Use of emergency sections

The Locum Consultant Psychiatrist was advised to use, or consider using, Section 5 of the Mental Health Act. While it may be appropriate to bring to the notice of the clinicians caring for an individual that these emergency powers are available it is inappropriate to plan to use an emergency Section of the Act. They are available to be used in emergency situations and at the discretion of the nurse or doctor managing the emergency and should not form part of a pre-determined plan.

Induction and familiarity with protocols

The Consultant Psychiatrist responsible for Mr. Z's care when he was an in-patient was employed as a locum consultant. She had received no induction, no supervision arrangements had been identified and she had no individual identified whom she could consult. If clinicians are to practice safely and adhere to Trust policies it is essential that they receive a timely induction and that supervision and consultation arrangements are in place.

Treatment

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

The clinical team caring for Mr. Z recognised that he was mis-using drugs and tried over a prolonged period to help him address this problem. Mr. Z, however, was not motivated to address this problem and the Mental Health Team had no way of ensuring his compliance.

Psychological Therapies

The National Institute of Health and Clinical Excellence (NICE) guidance on schizophrenia and on depression recommends that service users suffering with these problems should be offered access to psychological therapy. The Early Intervention Team found it 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 brief interventions which might have been considered. Similarly given the important role Mr. Z's family played in his life some form of family intervention might have been considered.

Safeguarding

Concerns regarding the well-being of Mr. Z's siblings were shared at a multi-agency meeting following which a referral was made to Children's Social Services. When a referral is made under Section 47(1) of the Children Act (1989) the relevant Authority is required to make enquiries to enable it to decide whether they should take any action to safeguard the child's welfare.

Lord Laming in his report on Victoria Climbié and the Department for Children, Schools and families in its *Working Together* (2006)[1] guidance note that one of the obstacles to taking effective action to promote the well-being of children is the absence of any one with a strong sense of accountability. This appears to have been the situation in Mr. Z's case. Although several agencies were aware of the concerns regarding the safety and well-being of Mr. Z's siblings and an appropriate referral had been made to Children's Social Services there was an

[1]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*

absence of anyone with a strong sense of accountability who ensured that the well-being of Mr. Z's younger siblings was promoted.

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 rested, 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.

Service User Involvement

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.

Family Involvement

Mr. Z belonged to a close knit family which played an important role in his life. His mother often acted as his advocate and was the main source of information about her son's mental state. Mr. Z's mother was 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 favourably impressed by the service he received and compared them unfavourably with the service he had received from the Child and Adolescent Mental Health Service (CAMHS).

Communication

Following a discussion at the MAPPA meeting it was agreed 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 ceases to be involved with a service user that the contact details contained on the police computer system are revised in a timely manner.

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 succession 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.

The Role of the Appropriate Adult

Mr. Z's care co-ordinator was asked to act as an Appropriate Adult when he was arrested on suspicion of being involved in a homicide. It is not appropriate that those caring for an individual should be put in the position of having to decide whether s/he should act as an Appropriate Adult for one of his/her patient. The Trust, together with its Local Authority

partners and the local Police Force, should have a clear policy in place informed by the guidance set out by the National Appropriate Adult Network for the availability, training and support of Appropriate Adults.

Management of Mr. Z's Care

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 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.

Adherence to Local and National Policy, Procedure and Clinical Guidelines

The Trust had in place relevant clinical policies and procedures. These were informed by best practice guidance, updated during the period that Mr. Z was under the care of the Trust and were fit for purpose.

Internal Investigation.

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

Conclusions

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 NHS Partnership Trust and the events of 24 May 2008, however there are lessons to be learned which might promote the development of higher quality services.

Delivery of services

Delivering care and support to Mr. Z was a difficult and challenging task but the challenges he presented were not unique. Mr. Z was 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 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 ongoing lack of clarity about the degree and nature of his mental health problems, his pattern of drug mis-use and the relationship between these.

When 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 deciding how these would be met. The only need he seemed 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 restrictions 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. Although they identified this problem the Early Intervention Team, had no means by which they could compel Mr. Z to acknowledge and address this.

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 Community Psychiatric Nurse (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 CPN 2 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. The Team continued to assess Mr. Z whenever he was detained by the police.

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 disengagement became more evident, was to convene a meeting, a CPA review or a professionals' meeting, perhaps including individuals with relevant expertise, where they had the 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, once again, the opportunity might have been created to reflect on how this issue could be addressed, if not entirely resolved. Others with relevant expertise, from outside the team, might have been beneficially involved in this discussion.

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, creating more opportunities to review the efficacy of their strategies and from consulting others who might have been able to offer alternative insights or approaches.

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 could 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.

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.

Recommendations

Recommendation 1: The Care Programme Approach

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.

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.

Recommendation 3: Risk Assessment and Management

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.

Recommendation 4: Use of the Mental Health Act

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 discuss 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 agree and communicated to relevant people.

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.

Recommendation 6: Safeguarding

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.

Recommendation 7: Communication

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

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.

Recommendation 9: Role of the Appropriate Adult

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.

Recommendation 10: Commissioning

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.