Independent Investigation into the Care and Treatment Provided to Ms X

October
2012

Contents

Acknowledgements

The independent investigation panel wishes to thank all those who helped us in gaining a better understanding of the complex issues in this case. Given the nature of the case we met with or interviewed various members of the Trust and other agencies. With the understandable exception of the victim's family we are able to record that all who were asked to do so agreed to meet with us.

Those who were interviewed were open and frank in their discussions even though this sometimes proved to be deeply upsetting for them.
We particularly wish to thank Ms X and her mother together with her friend for providing us with relevant details of aspects of the life of Ms X.

The Avon and Somerset Constabulary were most accommodating and helpful in their willingness to co-operate with us during the investigation. They all helped shed light on the history which surrounded the serious untoward incident.

The liaison person at the Trust who collated documents and arranged interviews had an exacting task. Finally, we were most grateful to the authors of the second level internal review who produced a succinct and informative report based on the information available to them at the time.

1 Executive Summary

1.1 Introduction

This catastrophic incident, which resulted in the death of a man, was set within a context of, what the sentencing judge commented as, one where drink was a factor; and by a young woman who was known to her local mental health services. The event occurred in the autumn of 2009 and on the 22nd March 2010 Ms X was found guilty of murder at Bristol Crown Court. However, this may be the subject of an appeal by Ms X

The nature of the incident, the context within which it occurred, and the age of this young woman at the time of the offence, attracted considerable media interest and subsequent publicity.

There had been a clear formulation of the mental health problems of Ms X by the Somerset Partnership NHS Foundation NHS Trust services although no distinct or formal diagnosis had been attributed to her.

The presentation of the signs of poor mental health of this adolescent included: a combination of dysfunctional personality traits, early onset of alcohol and poly-substance misuse, inter-personal relationship problems.

The specific and detailed Level 2 (Internal) Review by Somerset Partnership NHS Foundation Trust identified the pattern of her presentation to services being manifest as symptoms and behaviours that may have been viewed in clinical classification (DSM IV) as an emerging borderline personality disorder.

1.2 Purpose

The independent investigation was commissioned by NHS South West in accordance with guidance published by the Department of Health in circular HSG (94) 27 and the updated paragraphs 33 – 6 issued in June 2005. The aim was to examine the circumstances surrounding the care and treatment of Ms X (the perpetrator). This action is required where homicides are committed by people who have been receiving treatment under the auspice of specialist mental health services. This is the report of the outcome of the investigation.

The investigation was conducted by Dr Colin Dale (Chief Executive Caring Solutions (UK) Ltd and Mr Tony Thompson, a senior associate of Caring Solutions UK Ltd, and Dr Michael Rosenberg a Consultant Psychiatrist. Caring Solutions (UK) Ltd specialises in the coordination and conduct of investigations, reviews and inquiries within health and social care organisations.

Administration, coordination and support was provided by the Somerset Partnership NHS Foundation Trust and NHS South West. Transcripts of interviews were recorded and returned to interviewees for accuracy checks.

The level 3 Independent Investigation should increase public confidence in statutory mental health service providers. The purpose of this investigation is to not only examine the care and treatment delivered by Somerset Partnership NHS Foundation Trust to Ms X but to also put into context the care and treatment that she received up to her subsequent conviction and whether or not such an outcome could have been prevented. The process also includes establishing whether any lessons can be learned for future service provision

1.3 Methodology

Consent was sought from and given by Ms X to access relevant health and criminal justice records prior to these being seen by any member of the Panel. Information about the scope of investigation, its Terms of Reference and procedures, and information about the panel members was sent to relatives of Ms X and the relatives of the victim, and staff who were invited to interview.

The documentation viewed was significant in volume (details in Appendix 5) and the panel in producing this report has gleaned from it that which it considered to be important to the key questions we had to address.

The panel adopted a Root Cause Analysis (RCA) approach to its work. Root Cause Analysis seeks to identify the origin of a problem. It uses a specific set of steps to find the primary cause of the incident or problem to determine what happened; determine why it happened and what to do to reduce the likelihood that it will happen again. RCA assumes that systems and events are interrelated. Basic types of causes are:

- **Human causes** – People did something wrong, or did not do something that was needed.
- **Organisational causes** – A system, process, or policy that people use to make decisions or their work is faulty.

Root Cause Analysis helps discover specific actions that contributed to the incident under scrutiny. This often means that RCA reveals more than one root cause and helps identify what is the reason the problem occurred.

The Panel utilised this approach in analysing the documentation and information from interviews. The Panel considered that, in this case, such fundamental underlying factors could not be identified.

The independent investigation process was informed by:

- Interview with Ms X (perpetrator)
- Interview with Mrs A (perpetrator's mother)
- Interview with Ms B (former employer of Ms X)
- Interviews with Trust Head of Corporate Services
- A review and analysis of Ms X's health record, including records from the specialist mental health trust and the General Practitioner
- A review and analysis of the police information for Ms X
- A review and analysis of the Trust's key policies and procedures in place at the time of the homicide and currently
- A review and analysis of the Trust's internal report and appendices
- A review of the relevant NICE Guidance – evidence-based/best practice

The investigation team invited the victim's family to meet with them; the invitation was declined although they requested a copy of the final report. The Trust's SUI report was benchmarked against current NPSA guidance.

1.4 Summary of main findings

We heard and received evidence that Ms X had an interim diagnosis of emerging personality disorder. This was the nearest classification of a disorder Ms X received during her contact with services. It seems that a co-morbid alcohol/substance misuse existed alongside possible post-traumatic stress as a reaction to adverse life events at a critical time in her development.

Personality disorder is a recognised mental disorder but it remains a relatively underdeveloped field within mental health care services. It affects many people within the general community, most of whom do not commit offences. However, for some, it significantly contributes to risk behaviours and offending.

We were unable to find any evidence from examining the chronology and clinical records that the offence which resulted in the conviction and imprisonment of Ms X could be attributed to an escalating degree of personality disorder.

The case reinforced the value and vital nature of early intervention which utilises the Child and Adolescent Mental Health Service (CAMHS) model of treatments. Ms X represented a typical young person who was facing increasing psychological problems, her short experience with the CAMHS was apparently successful in as much as it started to detect problems and to assist her with coping mechanisms to tackle these.

The then current and outstanding mental health needs of Ms X had been subjected to informed analysis as part of the process of the internal investigation. These needs were referenced to contemporary research and evidence based practice.

It follows that the identified needs would require to be continued to be addressed by skilled practitioners.

We are pleased to note and record that the Somerset Partnership NHS Foundation Trust continues to implement a specific training model for care provider teams to support them in working with people with personality disorder. This is further described in the response to the action plan based on the internal investigation recommendations.

We felt that the internal investigation resulted in a report which gave a clear description of Ms X's periods of disengagement with services. These were identified on the time – line which depicted the history and chronology of the service points of contact by Ms X.

The direct cause that led to the death of Mr Y on 4th September 2009 was identified at trial in May 2010 as murder by Ms X. The action was fuelled by excessive alcohol intake.

Our Independent Investigation concluded that the findings of the level 2 internal investigation which attributed a root cause as that of patient factors was a reasonable and logical explanation. Ms X appeared to present periodically to services following accurate and timely referrals from the GP service. Her presenting symptoms were those aligned with an emotionally unstable emerging personality disorder.

Ms X had the opportunity and was encouraged to access competent mental health care during her short and intermittent contact with specialist services. This included the CAMHS team and later the Community Mental Health Team (CMHT).

Whilst it was identified during her last assessment by the CMHT (2 days prior to the SUI) that she presented as a significant risk of self harm /suicide, her propensity for impulsivity did not feature as a risk to others.

The planned care package was appropriate and if the opportunity to implement this had coincided with positive engagement by Ms X it may well have assisted her in modifying her life style and adopting more effective means to cope with stress.

During the course of her contact with services Ms X was prescribed anti-depressants by her GP. On one occasion she lost these but later retrieved them after receiving a repeat prescription. Her logic was to

take both the dose of the retrieved batch and that of the replenished batch. Whilst this aspect was perceived by the Mother of Ms X as a possible weakness of support, there is no evidence to suggest the management of medication was linked to the actions which led to the offence. It did, of course reflect the importance of a service user being able to understand the need to be concordant with prescribed medication.

Since the homicide the Somerset Partnership NHS Foundation Trust has identified an action plan based on the recommendations of the internal investigation. This includes developing training which is intended to increase knowledge and competence for cross agency staff working in the complex area of personality disorder. Considerable work is being undertaken by the Trust in the related area of risk assessment and management.

To reinforce this process the electronic record system (RiO) has been modified to address one of the findings of the internal investigation and is under continuing review based on any lessons learned from other SUI's. RiO has been modified to enable clinicians to register both chronic and acute risk and this was actioned in October 2011. The Health Informatics Service has recently concluded focus groups with clinicians to gain feedback about RiO and any improvements the Trust could make to maximise its benefits for clinicians

The lessons learned from examination of this tragic event were those identified in the internal review panel's findings. Although they do not appear to constitute those lessons of a type or nature that may be transferrable or be of specific value to the wider mental health services in the NHS, we feel that wider distribution of these could be beneficial. The lessons reflect our points of consideration when we examined the contact that Ms X had with the Somerset mental health services. We were able to record progress that the Trust had made when implementing the three recommendations, these were grounded in the

three areas identified by the internal review team aligned with the lessons learned:

1) The Somerset Partnership NHS Foundation Trust continues to develop a specific training model for care provider teams, to support them when they work with people with a personality disorder.
2) High priority to be given by the Trust in modifying the RiO risk module, together with implementing clinical risk training.
3) Consideration of commissioning new models of outreach working which span the interface between organisations and agencies currently working with personality disorder.

The independent investigation panel considered the progress made against implementation of the action plan. This plan arose from the Trusts internal investigation of the incident; in particular those lessons learned which are described above.

The Trust provided us with a detailed Action and Progress Plan which was updated in March 2012.

In order to facilitate the analysis of this we adapted a framework of measurement similar to that utilised by the National Health Service Litigation Authority (NHSLA). This uses a set of risk management standards within health care organisations. They are set at three and the principle applied to each level can be aligned with the action plan progress. These comprise:

- Level1 Policy – evidence has been described and documented

- Level2 Practice - evidence has been described, documented and is in use.

- Level 3 Performance-evidence has been described, documented and is working across the organisation(s) as appropriate.

1.5 Recommendations

Any improvement and development of services aimed at assisting young people who present as Ms X did will require investment in training and the forging of effective collaboration between agencies. We have identified from the policies and procedures, together with the Somerset Partnership NHS Foundation Trusts organisational structures and the results of the internal investigation that this is likely to be achieved by a continuing improvement approach. This seems to be embedded in the framework of clinical governance of the Trust and its partnership agencies.

Consequently our few recommendations which are based on the actions already being taken as a result of the internal investigation are intended to encourage partnership and the dissemination of learning from good practice.

1. The development of standardised tools which specifically measure alcohol/substance dependency should be promoted for common use in services when risk assessment indicates a problem with alcohol and substance misuse.
2. The Trust and commissioners should seek evidence by audit that young people are able to access the fullest possible range of specialist alcohol and substance misuse services which relate to health and clinical interventions.
3. The Trust should seek evidence and reassurance that GP and carer groups are consulted when policies are developed which are aimed at improving service delivery to young people with alcohol misuse problems.

4. Consideration of the design of shared care protocols between various agencies that offer services to young people who may have alcohol/substance misuse problems be promoted by the Trust.
5. An up to date audit of the quality of joint plans with community mental health and primary care services for children and adolescents should be undertaken by the Trust and commissioners and the results disseminated to carer and interested parties.
6. The work being undertaken by the Somerset Partnership NHS Foundation Trust in the area of specialist supervision, support and training in personality disorder, should continue and include a wider dissemination of the results of the evaluation of the programme.
7. Clear statements should be made on the philosophy and values of the contributing specialist services and agencies. These should describe professional interventions which satisfy service users, families and carers, and degree of risk. They should promote risk sharing and management, inclusiveness e.g. those with personality disorders and young people who are actively using alcohol and substances, together with a culture of on-going engagement with treatment.
8. Research and development of new treatment approaches should be encouraged and supported to examine the needs of patients and carers who have previously been considered difficult to engage and treat e.g. young people and people with personality disorders in the community.
9. The implementation of the action plan arising from the Trusts internal investigation should be subject to on-going audit and evaluation to demonstrate full compliance with the recommendations.

2 Terms of Reference

2.1 Overall aims and Objectives of an Independent Investigation of the case of Ms X

2.1.1 To evaluate the mental health care and treatment of the individual including risk assessment and risk management;

2.1.1 To identify key issues, lessons learnt, recommendations and actions by all directly involved health services;

2.1.2 To evaluate the internal investigation into the care of Ms X already undertaken by the Trust and any recommendations and assess progress made on delivery of action plans following internal investigation; and

2.1.3 Identify lessons and recommendations that have wider implications so that they are disseminated to other agencies and services.

2.2 Terms of Reference

2.2.1 Review the quality of the health and where relevant social care provided by the Trust and establish if this was in line with Trust Policy and best practice/national guidance.

2.2.2 To identify whether any risk assessments were timely appropriate and followed by appropriate action (and whether any training issues arise).

2.2.3 To examine the adequacy of care plans, delivery and monitoring and whether Ms X, and where appropriate her family, were engaged in the care planning process.

2.2.4 To communicate with the victim's and perpetrator's families and provide an opportunity for them to input to the investigation.

2.2.5 To consider the appropriateness of services that both were, and should have been, available to patients with personality disorder and drug and alcohol difficulties. Also the extent to which they were offered to the patient and taken up.

2.2.6 Review the quality of documentation and the recording of key information (requesting available information from the police that arose during the prosecution), and to interview the police surgeon involved at the time of the incident and review the records relating to this.

2.2.7 To examine the adequacy of collaboration and effectiveness of communication with any other agencies (to include GP and social services and the police) who may have been involved in the care and treatment.

2.2.8 To examine the adequacy and effectiveness of the Trust's policy and practice of working with difficult to engage people.

2.2.9 Review the communication and involvement of the family of Ms X prior to the homicide.

2.2.10 To consider the terms of reference of the internal investigation and extent to which they have been investigated and identify if any further investigation is required.

2.2.11 To evaluate the internal investigation into the care of Ms X already undertaken by the Trust and any recommendations and subsequent actions.

2.2.12 To consider any other matters that arise from the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence that the public interest may require.

2.3 Outcomes

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

2.4 Principles of the Investigation

Approach The investigation is being commissioned to build upon the internal investigation.

Publication The outcome of the review will be made public. NHS South of England will determine the nature and form of publication. The decision on publication will take into account the view of the chair of the investigation panel, relatives and other interested parties.

Data Protection The completed investigation reports contain details of the clinical care and treatment the service user received and is therefore subject to the Data Protection Act and if made public could also breach the Human Rights Act. It is the responsibility of NHS South of England to ensure that there is a balance within the report that would protect the rights of those individuals involved in the incident whilst also discharging its duty to publish what is deemed to be in the public interest.

Support to Victims, Perpetrator, Families and Carers When an incident leading to death or serious harm occurs, the needs of those affected need to be of primary concern to the Foundation Trust, Strategic Health Authority and the independent investigation panel. This should be reflected through the principals of the NPSA guidance, which are:

- the principle of acknowledgement,
- principles of truthfulness, timeliness and clarity of communication,
- the principle of apology.

The families of the victims and perpetrator within this process were contacted and in this case where reasonable were offered a meeting with the independent investigation panel. The victim's family chose not to participate but wished to receive a copy of the final report. The perpetrator, their nearest relative and a friend responded to the invitation to meet with the panel and their contribution is described later in the report. In general families wish to:

- Know what happened
- Know why it happened
- Know how it happened
- Know what can be done to stop it from happening to anyone else
- Tell their account of events

It is important that the debate on the matters of public concern which may arise from this case are grounded on an accurate account of the facts.

Procedure All investigations have to consider what procedure is appropriate for the particular issues to be considered. The objectives must be to conduct an inquiry which as far as is practicable:

- investigates the matters within the terms of reference thoroughly;
- ensures objectivity;
- ensures all the relevant information is considered;
- is fair to those who are under scrutiny;
- recognises the position and interests of all those concerned with the events which led to the inquiry.

Principles The independent investigation panel believes that at the core of any mental health service delivered to people with a mental disorder there must be four principles:

- clarity in current diagnosis, objectives, needs, changing the diagnosis, needs and risk assessment and the strategies to clarify and deal with them;
- coordination of the delivery of service, sharing of information and action;
- checking on the outcome of service provision by regular review;
- changes in the diagnosis needs and risk assessments, and service provision in light of the review.

3 Methodology

3.1 Data Collection and Analysis

Consent was sought from and given by Ms X to access relevant health and criminal justice records prior to these being seen by any member of the Panel. Information about the scope of investigation, its Terms of Reference and procedures, and information about the panel members was sent to relatives of Ms X and the relatives of the victim, and staff who were invited to interview.

The documentation viewed was significant in volume (details in Appendix 5) and the panel in producing this report has gleaned from it that which it considered to be important to the key questions we had to resolve.

A Root Cause Analysis approach was utilised. Root Cause Analysis seeks to identify the origin of a problem. It uses a specific set of steps to find the primary cause of the incident or problem to determine what happened; determine why it happened and what to do to reduce the likelihood that it will happen again. RCA assumes that systems and events are interrelated. Basic types of causes are:

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The independent investigation process was informed by:

- Interview with Ms X (perpetrator)
- Interview with Mrs A (perpetrator's mother)
- Interview with Ms B (former employer of Ms X)
- Interviews with Trust Head of Risk and Compliance

- A review and analysis of Ms X's health record, including records from the specialist mental health trust and the General Practitioner
- A review and analysis of the police conviction and intelligence information for Ms X
- A review and analysis of the Trust's key policies and procedures in place at the time of the homicide and currently
- A review and analysis of the Trust's internal report and appendices
- A review of the relevant NICE Guidance – evidence-based/best practice

The investigation team invited the victim's family to meet with them; the invitation was declined although they requested a copy of the final report.

3.2 External Review Panel

The independent investigation was commissioned by NHS South West in accordance with guidance published by the Department of Health in circular HSG (94) 27 and the updated paragraphs 33 – 6 issued in June 2005. The aim was to examine the circumstances surrounding the care and treatment of Ms X (the perpetrator). This action is required where homicides are committed by people receiving treatment under the auspice of specialist mental health services. This is the report of the outcome of the investigation.

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Administration, coordination and support was provided by the Somerset Partnership NHS Foundation Trust and NHS South West. Transcripts of interviews were recorded and returned to interviews for accuracy checks.

4 Introduction

4.1 Summary of the Incident

This catastrophic incident, which resulted in the death of a man, was set within a context of, what the sentencing judge commented as, one where drink was a factor; and by a young woman who was known to her local mental health services. The event occurred in the autumn of 2009 and on the 22nd March 2010 she was found guilty of murder at Bristol Crown Court. However, this may be the subject of an appeal by Ms X.

The nature of the incident, the context within which it occurred and the age of this young woman at the time of the offence, attracted considerable media interest and subsequent publicity.

Consideration 1

The period of contact with the local health services which were focussed on the state of mind of Ms X was precisely three years. This began in September 2006 when she visited her GP and complained of feeling low in mood. It terminated on being remanded in custody in September 2009. Features of her life during this time included; agoraphobic symptoms, bulimic symptoms, wrongful identification of her unknown father, self-harming, experience of planned abortion, excessive alcohol intake, being unsure whether she had experienced non-consenting sex due to the effects of alcohol, substance misuse. All

of these features impacted on Ms X during the formative years of her adolescence. The CAMHS would have been the appropriate service and access to this was sought by the GP. It subsequently proved unable to be effective in helping Ms X as she did not maintain treatment once her symptoms subsided.

There had been a clear formulation of the mental health problems of Ms X by the Somerset Partnership NHS Foundation Trust services although no distinct or formal diagnosis had been attributed to her.

The presentation of the signs of poor mental health of this adolescent included: a combination of dysfunctional personality traits, early onset of alcohol and poly-substance misuse, and inter-personal relationship problems.

The specific and detailed Level 2 (Internal) Review by Somerset Partnership NHS Foundation Trust identified the pattern of her presentation to services being manifest as symptoms and behaviours that may have been viewed in clinical classification (DSM IV) as an emerging borderline personality disorder.

4.2 Background and Context

It was reported to us that the childhood of Ms X was not remarkable; she was raised solely by her mother. She also benefitted from support of her aunt and close friends. Apart from childhood ailments no significant areas of psychological distress are recorded or reported. Her mother had to respond to difficult but natural enquiry from her daughter regarding the identity of her father from about the age of three years.

Her early school years were uneventful. Her mother informed us that apart from the odd instance of school absence in her teens her progress was fine. She was not known to be confrontational with

authority but she was capable of speaking her mind. Her final exams were interrupted by pregnancy and she attained only minimal qualifications.

Following her 14th birthday her mother reluctantly agreed to disclose the identity of the man she believed to be her father. This was to be proved wrong later when a DNA test did not confirm this.

It was at this juncture that a marked change in the personality of Ms X was reported by family and friends to have occurred. Her mother clearly recalled periods of anxiety and depressed moods together with episodic self harm.

Ms X became pregnant in April 2009 and after she had discussed the implications with her boyfriend and his mother she opted for elective termination. Her mother recounted to us during interview how she regretted the way that she had reacted to her daughter's pregnancy. She described how Ms X was "steam rollered" by the opinion of others whilst her daughter was ambivalent in her decision to end the pregnancy. She was clear in her view about how Ms X showed a marked decline in her self-esteem and state of mind following these events and the effects on her relationships.

During a most helpful and informative interview with the mother of Ms X and DU a friend/work colleague of Ms X, it was possible to confirm this presentation of psychological difficulties, specifically the depressed emotional state of Ms X and periods of self-harming and destructive behaviour. When we interviewed Ms X she was able to recount to us her fluctuating emotions when she sought help from the mental health services. She was equally regretful of her previous unwillingness to engage with specialised services during the critical period of her adolescence.

It does not fall within the duty of this Independent External Investigation to identify any aggravating or mitigating circumstance which Ms X could have used in her defence.

5. Chronology of Events

The Level 2 Internal Investigation utilised the Somerset Partnership NHS Foundation Trusts' electronic record system (RIO), the Yeovil District Hospital clinical notes, together with the Wells City Practice EMIS system in order to illustrate a chronology of significant events in the pattern of services sought or provided to Ms X.

This time-line offers a succinct overview of critical periods and most is utilised by our Independent Investigation and is included as Appendix 4 of this report.

6 Addressing the Terms of Reference

6.1 Review the quality of the health and where relevant social care provided by the Trust and establishing if this was in line with Trust Policy and best practice/national guidance.

From the outset of this Independent Investigation we were able to establish that a precise and robust Internal Level 2 Investigation had taken place. This was wide ranging and traversed the initial contact with all of the health services up to the time of the incident.

The external investigation was able to gather further information from the perpetrator (Ms X) her mother and the police. This latter process was precluded during the Internal Investigation in order that the level 2 investigators could comply with specific advice from the Avon and Somerset Constabulary.

The level two internal investigation was conducted according to the techniques of Root Cause Analysis and it was correctly published only for Internal and restricted distribution. We have found its contents helpful, particularly with regard to the nature and quality of the care offered and received by Ms X. We have done so for two main reasons:

1. The overall quality of the report and its contents

2. Because we feel that if Ms X and her mother had been able to see the report it would have increased their confidence in the methods sought by the health and social services to confirm or otherwise the proper provision of mental health services in Somerset.

In order to reinforce the points above we thought it would be helpful to reproduce the pertinent documentation examined during the internal review and confirm that the Independent Investigators accessed the same. We were then able to pursue aspects of the external investigation regarding the quality of care provision, when we met with key representatives, particularly the mother of Ms X and the officers of the Somerset Constabulary. This, in turn, allowed us to cross match the policies, procedures and protocols with both local and national best practice whenever possible;

Sample of Internal Documentation

- Risk assessment information from Somerset Partnership NHS Foundation Trust Rio Record.
- HONOS assessment2009 May 2009.
- HONOS assessment2009 May 2009.
- Witness statement from DW, Ms X's last care coordinator.
- Report from MD of the Trust's Mendip Crisis Resolution Team.

- Letter to the Investigator from Ms X's GP at Wells City Practice.
- Re-referral letter from Wells City Practice to the Primary Mental Healthcare Services dated 27 August 2009.
- Referral letter from Wells City Practice to the Mendip Crisis Team dated 27 August 2009
- Referral letter to Psychological Therapist from Wells City Practice dated 11 May 2009.
- Appointment letter to Ms X from the Primary Mental Health Service dated 17 June 2009.
- Discharge summary from Yeovil District Hospital received 23 April 2009 at Wells City Practice.
- Discharge summary from Mendip Crisis Team to Wells City Practice dated2009 June 2009.
- Discharge summary from the MIU, West Mendip Hospital received 15 April 2009 at Wells City Practice.
- Letter to Specialist CAMHS Mendip from Wells City Practice dated 25 February 2008.
- Letter to Ms X from Wells City Practice dated 25 February 2008.
- Referral letter to Psychological Therapist from Wells City Practice dated 13 February 2008
- Primary healthcare EMIS record for Ms X from Wells City Practice.
- Transcript of the Somerset Partnership NHS Foundation Trust Rio Record Progress notes.
- Records for Ms X from Yeovil District Hospital.

Consideration 2

In a number of ways Ms X was somewhat typical in her inconsistent approach to seeking and receiving professional mental health services. This typically is observed in the paradoxical way in which someone in late adolescence who may have an emerging borderline personality

disorder cannot be relied upon to effectively engage with relevant services.

The policies and procedures in the Somerset Partnership NHS Foundation Trust were grounded in the National Guidance for Mental Health Services for England. The effective application of these relied to a large extent in the implementation of the Care Programme Approach. This model was in use during the short time Ms X was involved with mental health services but she was an adolescent and therefore the focus on specialised child and adolescent services was initially pursued.

The CAMHS was the appropriate service for Ms X and had she been able to adhere to the service offered she may well have been assisted to better cope with the stresses she faced as her adolescence progressed. However, as Ms X informed us at interview, she much regretted her erratic attendance in mental health services. Her association with the Mendip Child and Adolescent Mental Health Services in the spring of 2008 collapsed when Ms X did not attend three appointments. This resulted in her discharge from the service in April 2008. The process ended after an example of good practice standards was demonstrated in the offer of a period of open access to a flexible appointment at her request, which she did not utilise.

The following key documents were reviewed:

- The RCA Management Report
- The Report of the Internal Review by Somerset Partnership NHS Foundation Trust
- Clinical and multi-disciplinary records relating to the Health and Social Care provided to Ms X.
- Relevant DoH guidance including:
- National Service Framework (NSF) for Mental Health Services – Modern Standards and Service Models 1999

- Effective Care Co-Ordination in Mental Health Services – Modernising the Care Programme Approach 1999
- NSF Mental Health Policy Implementation Guide
- No Health Without Mental Health across governmental health outcome strategy, for people of all ages, February 2011
- The Trusts' response to the above relating to operational policies and staff guidance procedures specifically in relation to: CPA; Risk Assessment; RCA Management Investigations
- University of Manchester – Five Yearly Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Avoidable Deaths 2011
- Re-Focusing the Care Programme Approach, Policy and Positive Practice Guidance, DH, March 2008
- Department of Health 'Best Practice in Managing Risk; Principles and Guidance for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services
- Transcript of Log- emergency services

The investigation team also reviewed a range of reports and assessments prepared by a number of psychiatrists and psychologists prior to her court appearance. These included:

- Final psychiatric report on the defendant
- Addendum Psychiatric report on the defendant
- Confidential Medical Report
- Psychiatric Report prepared
- Addendum Psychiatric Report
- Preliminary Confidential Medical Report
- Clinical Psychology Report
- Second Addendum Clinical Psychology Report
- Clinical Psychology Report

Ms X was then a young woman who was vulnerable to stress which manifest in behaviour including excessive consumption of alcohol with its attendant dangers at such a young age.

We were clear from our dialogue with Ms X, her mother, friend and associated professionals that she was not without the opportunity to access professional services, if she had the motivation to do so during 2008 - 2009.

Consideration 3

The route to help for Ms X was via persistent and accurate referrals from her GP in the Wells City Practice. Of particular note was the endeavour of a Locum GP in the Practice. In his determination to ensure that Ms X received appropriate psychiatric support he referred her firstly to specialist psychological therapy. She was too young to be considered for this – hence he referred her to the Mendip Specialist CAMHS. He took this action and supported his stance whilst forecasting that without help Ms X would deteriorate. This action took place in February 2008.

Clearly the Locum GP based his earnest referral on his knowledge of the pattern of presentation by Ms X at the Wells City Practice two years earlier. This was later to be of significance as it was during 2006 that Ms X discovered that a man she believed to be her father was not so. This was confirmed after DNA analysis.

It would be speculative to infer that had Ms X been referred to the CAMHS earlier in her history, she may have been more willing to engage. However, Ms X herself stated she may have been more likely to benefit prior to her reaching adolescence. It would be difficult to disagree with this view as a number of stressors impacted on her life during early adolescence.

The organisation of the mental health services which were available to assist Ms X were contemporary and functional. They reflected a typical structure in order to respond to the needs of a demographic profile such as that found in Somerset. When Ms X was eligible to access adult services, these were composed; the Adult Community Mental Health Team in Wells. The team provides for the acute mental health needs and for the service users who have enduring mental health problems.

The service is flexible and is multi-disciplinary in composition and function. Further, it is able to offer assessment and treatment in a wide range of community settings. These include primary care settings such as GP surgeries, educational and employment venues.

Consideration 4

The implementation of the service is based on a rational planning concept, that is following an initial assessment a care plan based on recovery is designed. The recovery plan is constructed in collaboration with the service user. The type of service and the level of care and support agreed is identified. The process is completed by regular review and evaluation by the team. It can be deduced that such a process does require the commitment and motivation for compliance by the service user, if benefit is to be gained from access to skilled intervention.

The above process can be circumvented for those people with mental health needs who require in-patient care during an acute phase of illness. Those who are required to be compulsory detained under the Mental Health Act 1983 must of course meet strict criteria including suffering from an illness of a nature or degree that would require such loss of liberty.

There is no evidence that we could find that would have supported such an action for Ms X based on her presenting symptoms. However, it was interesting to hear Ms X during interview state that perhaps if she had been 'sectioned' she would have benefitted in the end. She did understand however that engagement is the basis on which successful therapy can be introduced. Despite her previous reluctance she holds the view that her chaotic life as an adolescent meant a missed opportunity to work with committed, competent and experienced practitioners. Those practitioners worked to a model of recovery that would have contributed positively to the care and treatment benefits for Ms X.

The overall care and treatment grounded as it was in policies and procedures based on recovery and care planning had the quality that such a model reflects. We would not wish to suggest or over emphasise that full engagement with the services by Ms X would have resulted in avoidance of the index offence. However, it may have provided her with a greater degree of optimism and confidence when confronting stressful situations. Of course any failure to properly understand the aims of her care plan would carry risks. These would not necessarily be lessened by more assertive approaches to engagement with service users who maybe have a disorder of personality.

We were able to evidence some indication of Ms X's state of mental health at the time of the incident from the clinical notes. Of particular significance was that she was again referred by the GP service to the Trust during the latter part of August 2009. This was necessary due to her mental state which manifest in ideas of self-harm and suicide. The reaction from the service was to arrange an urgent reassessment by the Wells CMHT and the Crisis Team. This joint assessment took place on the 2nd September, just forty eight hours before the serious incident occurred.

Consideration 5

It is likely that this phase of referral and subsequent assessment represented a 'tipping point' in the methods likely to have been effective in supporting Ms X and her maintenance in the local community.

The joint assessment followed shortly after a re-referral for Primary Care Psychological Therapy – a service from which Ms X had disengaged earlier.

The outcome of the joint assessment resulted in Ms X being accepted into the Secondary Care Service. This meant that in line with good practice Ms X was allocated a care-coordinator. An important part of this procedure was the planned intention to arrange a comprehensive medical review and a referral for secondary care psychological therapy. This was to be augmented by a prompted self-referral to Turning Point in order to address drug and alcohol problems. Ms X did not pursue the service and the Homicide occurred before the aims of any treatment plan could be furthered.

6.2 Identification of risk assessments, their timing and appropriateness together with any training issues arising.

We were able to examine the Trusts policies and procedures which were pertinent to the identification of risk. The specific policy which was relevant is the 'Clinical Assessment and Management of Risk of Harm to Self and Others'. The details contained in the results of the internal investigation were the result of careful scrutiny of the application of risk assessment, together with a risk formulation.

The internal reviewers identified a systematic and consistent approach to the risk assessment process and this was reinforced during our

independent analysis of documented history and clinical records. The implementation of local risk assessments relied on the application of standardised tests and scales. Amongst these the two Health of the Nation Outcome Scales (H.O.N.O.S) which were completed in the months of May and June 2009 showed an improvement in risk presentation. The internal reviewers stated that the improvement during that time may have been indicative of the positive effects of the intervention of the crisis team. Whilst we concur with this view it is also agreed that the effectiveness of the intervention may have been short term and the fact that Ms X subsequently disengaged from the service would seem to reinforce this view.

The Trust utilises the electronic recording system, RiO and in the internal review it was found that the Risk Information section of the system was adequate for the purpose. The form and content allowed a recovery based care plan to be formulated. In turn the plan promoted the management of identified risks which would be addressed in the process of crisis intervention.

Consideration 6
The risks did not include those which may have indicated that Ms X was likely to have a propensity for significant harm to others. This outcome was further reinforced by the view of the GP service and that risk prediction was not affected by any reference to prior history of a violent nature or an overt threat to harm others.

The nature and degree of the symptoms presented by Ms X were not considered to be of sufficient risk for the medical health practitioners to seek grounds to compulsorily detain Ms X on the 2nd September 2009. Ms X had no forensic or criminal justice history up to the time of the index offence and the facts available to the assessors did not point to

features which could increase the likelihood of the offence to be foreseen.

The only possible weakness in the risk information was that seen and detected by the internal review. This was that maintained in the RiO electronic record. The internal reviewers expressed the view that risk information in the RiO record could have been more robustly formulated and then linked to the component of the Recovery Care Plan relating to crisis or relapse.

We believe that as part of an on-going monitoring and improvement project the RiO system has been reviewed and modified by the Trust in the years following the serious incident.

Consideration 7

The fact that the overall risk formulation could have been documented and recorded in greater detail has resulted in improved in-service educational teaching in the Trust. Further, a specific managerial push has been made in order to facilitate training in the management of personality disorders. The nature of risk assessment and competence in risk management is included in the programme.

The managers of the Trust scrutinise all serious untoward incidents and collate them for emerging themes. It is our understanding that any aspect of the risk assessment failures would appear in the corporate clinical governance committee business and be reflected in the risk register.

The relevant risk assessment forms in the clinical notes provided for external independent investigation were appropriately signed by the Care Co-ordinator and updated and met the criteria for sound practice.

The resultant recovery based care plan focussed on preventing self-harm and confronting the need to tackle Ms X's alcohol use. Therefore, the general aim of alleviating Ms X's serious anxiety and the more specific aims of addressing risk factors associated with excessive alcohol intake were accurate.

The internal review of the incident did not reveal any significant aspects of service delivery based on risk management or assessment. This included no professional or agency being defensive about their role when they sought to assist Ms X. Our external review reinforces this and we consider that from within the chronology of events, the type of violent reaction from Ms X whilst she was under the influence of alcohol could not have been predicted.

Scrutiny of the clinical pathway followed by Ms X in her relatively short contact time with the Trust did not appear to reveal any missed clues that Ms X would respond as she did in the context of the events which occurred on 4th September 2009.

We acknowledge that the fact that the incident which transpired was not foreseeable does not infer that it could not have been averted. However, based on the cumulative history of risks, the service offered to Ms X was intended to promote her mental health. It also encouraged a professional input in times of crisis based on Ms X being able to trust that practitioner. Of course, regardless of the level of risk the chances of a recovery plan depended on meaningful engagement by Ms X.

The local policies of risk assessment appear to comply with national guidance in use at the time. This was mainly the work published by the Department of Health 'Best Practice in Managing Risk; Principles and Guidance for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services.

The guidance emphasises that the recording of risk assessment is not an end in itself. It is simply a tool to inform the handling of risk. Had Ms X had the benefit of a period of planned intervention based on the model of recovery, she may have been better prepared to see the need to avoid specific risk situations. Ms X herself and her mother expressed their view that the problems of alcohol and substance misuse in conjunction with an emotional state in turmoil, which was the case for Ms X, is a formidable challenge for the person, the family, the friends and the mental health services.

6.3 Examination of the Adequacy of care plans, delivery and monitoring and whether Ms X, and where appropriate her family, were engaged in the care planning process

We were able to consider the aspects of care planning and the involvement of Ms X and her family in this process, against practice guidelines. These were grounded in the local application of care planning based on the implementation of statutory obligations. The internal review considered specific guidance relating to CPA which was issued in 1990 as a Health Circular. The central discharge guidance was that issued in HSG 1994. Whilst these documents provided a template with criteria which the internal reviewers could measure important aspects of Ms X's care by, they had been superceded and the local procedures and policies were adapted to reflect the contemporary practice standards in 2008. Within the above context the internal investigation sought to examine the extent to which Ms X's treatment and care plans were:

- documented
- agreed with her
- communicated with and between relevant agencies and her family
- carried out
- complied with by her

Consideration 8

The framework which was extant at the time could only be loosely used to design care for Ms X. This was because she was only transient in her contact with specialised services and did not have an established diagnosed illness which resulted in a formal care plan and the early appointment of a care-coordinator. This did not occur until two days before the index offence and therefore any accurate evaluation is precluded.

The key components of the care programme approach which informed the policies and procedures of the Trust at the time were comprised of:

- Systematic arrangements to be put in place for assessing the health and social needs of people accepted by the specialist mental health services
- The formulation of a care plan to address the identified health and social care needs
- The appointment of a key worker to keep in touch with the service user and monitor the care plan
- Undertaking regular reviews and implementing agreed changes to the care plan, if required

We were most grateful to meet with Ms X's mother and friend who were able to provide an insight into what benefits there may have been to Ms X if she had qualified by both age and diagnosis to be under the umbrella of CPA earlier than she was able to in September 2009.

On the formation of the Somerset Partnership NHS Trust into an integrated Health and Social Care Trust in 1999, the Care Programme Approach was adopted and later become the Recovery Care Plan Approach following discussions with service users

The local policies adapted further guidance and changes to CPA after the national review of the process by the D.O.H. in 1999. This confirmed that CPA would continue to be the key systematic approach to assessing and delivering mental health services to people of working age in contact with mental health services. Of course, Ms X was not of formal working age as she was an adolescent at the time of her first contact with services.

The main changes introduced to CPA which the Trust had to adopt in 1999 included:

- The integration of the Care Programme Approach and Care Management. This change was included to overcome the issues of lead roles between health services and social services, which had hitherto been somewhat vague.
- Health and social services were to appoint a lead officer to straddle work across the agencies
- The role of key worker was to be replaced by that of the care-coordinator
- There was two levels of CPA identified, standard and enhanced
- Reviews of care plans would be flexible and take place as required rather than the hitherto fixed six monthly meetings
- Risk assessment/management to form an integral part of the CPA. Those service users who had complex needs and who were on enhanced CPA were to have crisis and contingency plans
- Systematic audit of CPA to be implemented

Subsequently in common with all other Trusts the Somerset Partnership NHS Foundation Trust has featured CPA as part of performance management. It also forms a standard by which the Care

Quality Commission reviews a mental health service as part of its judgement framework.

Consideration 9
Although Ms X would have been excluded from a formal CPA process due to her age when she first came to the attention of mental health services, the ethos was reflected in the documentation and methods of contact with her.

Following a review of CPA in November 2006 the D.O.H. issued new policy and practice guidance in March 2008

It was under this refocused guidance that the Trust was required to design a plan of care for Ms X but as stated earlier this only occurred some two days prior to the tragic incident

The internal Level 2 review considered the treatment plan. It appeared to conform to good practice and of course it is regrettable that there was insufficient time for Ms X to have engaged with the plan and any subsequent modification based on her changing needs.

Despite the late treatment plan which was designed following a re-referral to CMHT services by her GP the form and content of prior assessments and treatments from the Somerset Partnership NHS Foundation Trust were accurately documented and were composed of:

- Regular clinical progress notes
- Standardised risk assessments
- Supporting practitioner correspondence

Further, a care plan based on the concept of the Recovery Model had been established in June 2009 and some level of engagement by Ms X with the plan was apparent.

Although the overall treatment and care plan which was designed in September 2009 was not properly reflected in the electronic RiO system, this could be attributed to the short period of time taken between the formulation and the serious untoward incident.

Consideration 10

The treatment plan was comprehensive and we felt that if only there had been time to introduce it with the co-operation of Ms X, it may have addressed a number of the anxieties and concerns that family and friends held which they genuinely expressed during our dialogue with them. However, only limited influence, if any, seemed to have been able to be exerted on Ms X by her family and friends when she was referred to primary care counselling or Turning Point.

The plan identified options for a range of professional interventions. These included, care-coordination, comprehensive psychiatric assessment, and specific assessment for psychological therapy.

The plan was underpinned with the advice to Ms X to self-refer to Turning Point in order to address her immediate needs to control her proclivity for alcohol.

It was significant that this plan was agreed with Ms X and when we interviewed her she was regretful that she had not been able to demonstrate any commitment prior to the serious incident and the resultant conviction following her trial. We were able to confirm by our dialogue with Ms X's mother that there had been opportunity for her to have input into aspects of Ms X's care, but she found this difficult to do.

Consideration 11

We considered that the recall from Ms X's mother, particularly with regard to the recorded early onset of alcohol intake was significant. Her clear emphasis of how in the history of Ms X the age of onset had

been distorted was compelling. This explained why some areas with regard to possible care and treatment from the age of twelve appeared vague.

Mrs A disputed the record of onset of Ms X's drinking. She explained that the reason this was recorded as 12 years of age, and later referred to in the trial, was due to misinterpretation. Mrs A felt that drinking alcohol became "out of hand" when Ms X was 16 years of age. This coincided with Ms X experiencing a number of anxiety provoking situations in her development as an adolescent.

6.4 Communicate with the victim's and perpetrator's families and provide an opportunity for them to input to the investigation

At the onset of the External Independent Investigation, the appropriate family members of both the victim and the perpetrator were contacted and informed with regard to the process which would be followed.

All parties were supplied with the details of the process and the reasons behind this. Each were supplied with our Terms of Reference and comments were invited.

The relatives of the victim declined the opportunity to meet the Independent team but requested that a copy of the completed report be sent to them.

Mrs A the mother of Ms X responded positively to the invitation to meet with the Independent Investigation team and to contribute to the process. Prior to accepting the invitation she had consulted with Ms X and both were most willing to assist us as much as they were able.

We felt the contribution of Mrs A and her family friend (who had worked with Ms X in a local Public House in Wells) to be particularly valuable and we understood how difficult and upsetting this was for them. A

transcript of our interview was made and sent to Mrs A. This proved to be a useful process and it enabled us to place the chronology of events which brought Ms X into contact with services into perspective. We were able to gain an understanding of the local social context and the circles that Ms X moved in. Mrs A was helpful with regard to the background of traumatic events experienced by Ms X and the way in which some of the consequences of these were manifested by Ms X in her responses and behaviour.

The opportunity was taken to explain to Mrs A that an Internal Investigation had been completed. She appreciated that the internal review team could not involve Ms X or her family on the advice of the Avon and Somerset Constabulary. This was due to the on-going criminal justice investigation at the time. We were able to reassure her that the internal investigation had been robust and objective. Mrs A also appreciated that Ms X had only been in contact with specialist services a relatively short period of time.

Mrs A and Ms X's friend were actively helpful to the Independent Investigation, they spoke openly and freely and we appreciated their cooperation and candour. They provided an important perspective which assisted us when we scrutinised the clinical documentation and records of Ms X.

Our communication with Mrs A and the friend also allowed the opportunity for us to stress that whilst it was not possible to predict the likelihood of the tragedy, we did recognise that good practice in mental health can reduce risk of harm to self and others.

We hope to have conveyed both these aspects in our examination of the facts and to reassure the victim's family that they were considered in our Terms of Reference.

6.5 Consider the appropriateness of services that both were, and should have been, available to patients with personality disorder and drug and alcohol difficulties. Also the extent to which they were offered to the patient and taken up.

Ms X is a young woman who was considered by professionals to display an emerging borderline personality disorder. This conclusion was drawn as she had demonstrated a combination of dysfunctional personality traits and had a short history in her adolescence of significant alcohol and poly-substance misuse. Her pattern of behaviour and stress responses were displayed in episodes of self-harm and depression.

Amongst the care and service delivery problems identified by the internal reviewers were those associated with lack of engagement and sporadic attendance at appointments. She was not referred to specialist services until the year before the index offence. These features were significant as it was the opinion of the internal investigators that Ms X may have benefited from intervention by three separately managed yet overlapping services. These were comprised of: the Somerset Partnership NHS Foundation Trust Secondary Care mental health services, Improving Access to Psychological Therapies (formerly Primary Care Counselling) and the Turning Point drug and alcohol services.

Examination of the pattern of service provision to Ms X reinforces the comments made in the internal review report that only the Somerset Partnership NHS Foundation Trust services appeared pro-active in their response to non-engagement by Ms X. They did this by offering multiple appointments, undertaking domiciliary visits and then giving Ms X a period of open access by encouraging self-referral. The specialised addiction services were more reliant on self-referral by a service user being motivated to seek help. The IAPT service (Primary Counselling) would not be likely to offer a service to a person under 18

years of age, it would in any case have referred Ms X back to the GP if attendance was not sustained or there was ambivalence.

Consideration 12

In some ways the services available to Ms X represented typical options within most PCT's at the time. They also highlighted the need for collaboration between services and agencies when they attempt to deliver services around the problems of alcohol and substance misuse. A major cause of frustration and despondency amongst service users and families is the perceived lack of co-ordination and integration of care services.

When examining some of the national organisational and clinical service difficulties presented by service users who require help with both mental health and that of alcohol and substance abuse, some common features of difficulty are recognised in the challenges which were presented by Ms X to local services. These include:

- Difficulty of client engagement
- Carers and families dissatisfaction with the co-ordination of care
- Clients ability to access services
- The management of waiting lists
- Collaborative risk assessment
- Contact with Criminal Justice system
- Prevention of self-harm or harm to others (Appleby 2000)
- Serious Untoward Incidents
- Morbidity and mortality including undiagnosed or untreated physical health problems
- Staff knowledge and competencies

The treatment model which the NHS Trust appeared to promote was that of integration. It did so by latterly, in the care of Ms X, attempting to facilitate use of the three separately managed local services. This model is the preferred method of trying to stop service users who have dual mental health and alcohol/substance use problems from 'falling through the net'.

The integrated model promotes on-going co-ordination, support, satisfaction and relapse prevention. The specific treatment factors that are considered important include access, engagement and risk assessment.

The findings of the internal review addressed these issues and emphasised them when they considered organisational and strategic factors. They recognised that when looking deeper into the antecedents to the root cause related to patient factors, that if it had been possible to attain early, co-ordinated and pro-active engagement with Ms X by the full range of local mental health services, there may have been a chance that the risks of sudden harm to others in the situation Ms X found herself in may have lessened.

The difficulties we have listed in the above are parallel to those found when a service attempts to provide input for those people with a personality disorder.

Consideration 13

We are aware that it is fortuitous that the Somerset Partnership NHS Foundation Trust has been instrumental in pursuing organisational and clinical change as part of the response to serious incidents involving service users with personality disorders. This innovation aims to ensure that an evidence based model of training for teams working with such a client group are supported. Further, this programme is designed and implemented in partnership with practitioners in health

and social care in other organisations. It is hoped that if the aims are achieved the treatment outcomes for a young woman such as Ms X may be improved in the future. There is now also guidance available which encourages services offering the IAPT to offer this to younger persons, this may also assist in service provision when a young person is psychologically vulnerable due to various factors which are likely to contribute to dysfunction.

In order to reinforce the above points, the Trust were able to provide the investigators with good examples of progress in these and associated areas. We incorporate this in full within this report as it offers clear organisational direction, together with reassurance to the family of the continued development of their local services. Several areas of work have been progressed in the last twelve months:

- Personality disorder training has been delivered to adult acute inpatient wards including the Psychiatric Intensive Treatment ward, the rehabilitation services and the CAMHS inpatient service. Training is planned to be rolled out to all community teams over the course of the next year.
- Each inpatient ward has a well established Reflective Practice Group led by a skilled clinician and these are well attended.
- The Trust has an 'Expert Panel' which is set up to look at the care of specific patients who are causing concern within the Trust and with other agencies – the guided formulation process is used and senior clinicians offer support, advice, ideas to the team and the clinician who is the care co-ordinator.
- Meetings with the Police and Ambulance Services are not unusual when working to provide a sound and holistic service for some patients and this has proved very successful for the small number of patients for whom this would be useful.
- The Trust has increased the number of Personality Disorder Locality Leads, one for each of the 4 localities and these staff

advise and support team members and carry a caseload of some of our more challenging patients.

- The Trust was successful in winning the bid to deliver the 'Knowledge and Understanding Framework' across the South West which has proved a helpful opportunity to provide information, advice and support to a range of agencies who come into contact with patients with a personality disorder.
- Recent funding has been provided to run a two year pilot of a service for young people (17/18 to 20 years) who are seen as having an emerging personality disorder – funding has also been made available to ensure this is well evaluated.
- In August 2011 the Trust acquired the Somerset Community Health Services and the Mental Health & Social Care Directorate took over the management of the IAPT services and this has been of benefit to patients in ensuring a clear pathway for patients for counselling and therapy services and connecting with the wide range of psychological therapies provided by the Trust.
- There are regular meetings with the Police at both a local and central level plus there is a group, the Criminal Justice and Liaison Group that meet quarterly to ensure there are good links with Police, Probation, the Courts and other external agencies.
- As a Health and Social Care Trust the social care services are embedded with the Trust.
- The Trust has an Early Intervention Service (STEP) which is very well established and available in each of the four localities in hub and spoke model.
- The CAMHS community teams in each of the four localities has an experienced substance misuse worker within the team and this has been in place for several years.
- The Trust has recently appointed a Consultant Psychologist who is a specialist in substance misuse recognising the increasing and on-going issues with many patients in these areas and they

will work across inpatient services and support community teams.

National policy guidance seems to have underpinned the Somerset Partnership NHS Foundation Trust procedures in place at the time as they related to dual diagnosis. This was the D.O.H. 'Dual Diagnosis Good Practice Guide' 2002. The key message being that alcohol and substance misuse was already part of mainstream mental health services and that was the right place for skills and services to be developed.

The guidance also suggested that mental health services must also work closely with specialist substance misuse services to ensure that care is comprehensive and co-ordinated. The internal review of the serious incident with Ms X reinforced such objectives. It also recognised that such aims do rely on a client being prepared to engage with the service and we comment on this later in our report.

6.6 Review the quality of documentation and the recording of key information (requesting available information from the police that arose during the prosecution), and to interview the police surgeon involved at the time of the incident and records relating to this.

The Independent Investigation was able to capitalise on the information which was provided to us by both the Somerset Partnership NHS Foundation Trust and the police records. We had the additional benefit of access to the detailed chronology of all significant events in the short period of time that Ms X was in contact with the mental health services.

We were grateful to Ms X who willingly gave permission for all of her medical records to be examined by us.

Consideration 14

The Avon and Somerset Police were particularly helpful in providing the Independent Investigation access to the relevant records and documentation held by them. In the spirit and act of cooperation we were able to hold dialogue with a range of officers, all of whom facilitated progress in the investigation and quality information was provided for us.

The above process enabled us to inspect the nature, content and quality of documentation, this included:

- All of Ms X medical records
- GP records
- Progress notes
- Risk assessments
- Referral letters from GP to specialist services
- CAMHS letters to Ms X
- HONOS assessments
- RiO entries (electronic record)
- Witness statements on police file
- Police surgeon (forensic) statement

The independent investigation process included undertaking a systematic examination and cross referencing of the medical records disclosed to us. We were able to confirm agreement with the notable practice finding of the internal reviewers; that Ms X's care assessment and treatment from the Somerset Partnership NHS Foundation Trust was adequately documented with regular progress notes, risk assessments, care planning and appropriate correspondence.

The GP letters which sought to find a relevant service for Ms X were a professional response to her presentation at the surgery and illustrated

an obvious desire to seek help to alleviate the distressing state which Ms X was in when affected by significant stressors during her adolescence.

There were no recorded attempts by the Trust practitioners within specialised mental health services to seek police knowledge of any criminal justice contacts. Such enquiries are not standard practice without over-riding concerns for safety of individuals and this was not indicated on any risk assessments. It later transpired that Ms X had no convictions for violence and it would have been unlikely that the police would have been able to furnish details of criminal justice history based on a basic request to complete a risk profile.

The Independent Investigation was informed by being able to trawl and analyse the content of the documentation and where relevant to follow up points raised by subsequent interview with relevant individuals. We did not find it necessary to interview the police surgeon as his statement and record of examination notes were well compiled and sufficiently detailed to provide an in-depth account of his expert observations and examination of Ms X subsequent to her arrest and detention.

Detailed reports were provided to us regarding forensic evidence including that of a Home Office pathologist, a forensic medical examiner and a forensic scientist who analysed blood samples from Ms X. No illegal substances were detected in the samples but excessive alcohol intake was present.

It is not within our remit to comment on the legal evidence or facts of the case but we can conclude this section by reporting that a fastidious and exacting documentation of police records was maintained. These in turn, helped us gain insight into the antecedents to the index offence and the context in which it took place.

6.7 Examine the adequacy of collaboration and the effectiveness of communication with any other agencies (to include GP and social services and the police) who may have been involved in the care and treatment.

We have commented earlier regarding the innovative approach being taken by the Trust in its attempts to improve support for practitioners who work with people with varying degrees of personality disorder. Such work often shows the need for effective inter-disciplinary care together with efficient and effective inter-agency collaboration.

There were times when services which Ms X may have benefited from could not be offered, for instance she was excluded from the Community Counselling (IAPT) services due to her young age. She did not benefit from any service that the Mendip CAMHS team may have offered in the spring of 2008 due to her non-attendance. Of course erratic or non-compliance with a service such as this is a feature of a person with an emerging personality disorder. When another crisis appeared Ms X only briefly engaged with the local crisis team before being discharged and returned to the primary care services. This cycle of events is typical of a young person with an immature personality who pursues a life which is increasingly propped up by periods of excessive alcohol intake and/or substance misuse. The cycle then begins again when another presentation is made to the GP as was the case of Ms X.

The Internal Investigation recognised this phenomenon when they scrutinised key events in the clinical history of Ms X and in our opinion, usefully considered any transferable issues within the wider context. They recognised the possible value of looking more broadly at services across Somerset. The examples given included Primary Care, Social Services, IAPT, Turning Point, Secondary Care mental health and social care, Police and Probation services. They suggested there may be a case for developing earlier and more co-ordinated interventions for people with emerging personality disorder. This type of early

intervention service is now established in some areas throughout the UK, they tend to be focussed on the early intervention in psychosis as opposed to disorders of personality. The internal reviewers used certain characteristics displayed by Ms X as a yardstick to measure such need and these include:

- The early presentation of anti-social behaviour
- Criminal justice contact
- Drug and alcohol problems
- Complex social issues

Consideration 15
It was helpful to note that the internal reviewers had identified an interesting project based in Australia, which utilised Cognitive Analytical Therapy and a model which used out-reach which showed promise. They offered to elaborate their views to local service providers. We are unsure if this was actually realised but felt it would be worth pursuing in the light of contemporary research in the area.

We recognise however, that in the current period of financial constraints such an endeavour may be dependent on the individual practitioners in securing small research grants or awards in order to pursue this objective,

Communication, both within an organisation and externally to it, is frequently a significant feature of services success or failure when health and social care is subjected to scrutiny. Specifically, the issue of documentation, record keeping, and information sharing is essential to ensure information from competent sources is available for professional use. Such processes are critical in areas of accurate risk assessment.

In the case of Ms X, the type of written information and personal knowledge particularly that held by family and friends was quite

considerable given her young age. However, the main agency involved was health. The information was at least in theory available to be shared with contributing partners, although this was not really tested. The most likely chance of this occurring would have been as a result of her last contract assessment with the CMHT but the index offence occurred less than two days after this.

Records and documents were maintained by different practitioners on a number of sites. The importance of accurate electronic patient recording was highlighted in the internal reviews criticism of the quality of risk management documentation captured (or not) on the RiO system. The Somerset Partnership NHS Foundation Trust has however undertaken a review and improved the linkage between Risk Information and crisis/relapse planning. This is intended to make the risk screen able to accept 'signatures' or patient specific factors.

Consideration 16
Even when information systems are sophisticated and utilise modern technology, human factors such as inter-personal relationships, trust in colleague's judgement, holding effective meetings and sharing information are essential in underpinning care and treatment.

It is for these reasons that the care programme approach is used within mental health services. It is regrettable that such an approach was not designed for Ms X until less than forty eight hours before the serious incident. Of course any more assertive approach which could have been aimed at motivating MS X with the service, could really only be taken had she chosen to re-engage properly with a designed care programme.

At the commencement of our Independent Investigation we were able to hold a valuable meeting with all the major health and social service (now the Safeguarding Board) agencies being represented.

We sought and gained assurance that no child protection or at risk/vulnerability issues were known to the Social Services. Similarly, we were informed by the Avon and Somerset Constabulary that no significant records which involved Ms X had been held by them.

From our analysis of the disclosed medical records it appears that the relationship between the community services was based mainly on referral processes. In essence this showed that the GP referred Ms X to a specialist mental health service. If she was accepted the GP would issue any prescribed medication and see her for any physical ailments. Therefore, it appears that the main type of inter-disciplinary communication was routine and confined to written letters of referral.

As Ms X was not given CPA status it was unlikely that no matter how comprehensive any mental health assessment might have been, it would not have resulted in the fully integrated mental health service package which may have assisted Ms X and her family.

The wealth of information available from within the GP service, the family, friends and Ms X herself did not appear to become shared knowledge that might have promoted a better understanding of Ms X's depressive feelings and self-harming behaviour.

6.8 Examine the adequacy and effectiveness of the Trust's policy and practice of working with difficult to engage people

The main family link with the service was only transient and this was focussed on her mother. Ms X was an only child and even though later adolescence increased a level of conflict in her relationships, Mrs A was seen as a source of support by the crisis team. In the spring of 2009 the crisis team liaised with Mrs A and after an abandoned visit to the family home due to Ms X being asleep, they agreed with Mrs A to telephone them to rearrange a future visit.

Prior to the crisis team intervention the CAMHS nurse wrote to Ms X in February 2008 offering her an appointment the following month. The invitation was extended to any family members to attend the appointment including on an individual basis. The letter emphasised the willingness of the CAMHS team to be flexible with regards to the appointment dependent upon Ms X's wishes and needs. Unfortunately, she did not avail herself of this opportunity.

We do not imply that the Trust could have implemented any other mechanism which could have enabled them to benefit from integrated information from the family but with hindsight this period may have been an opportunity.

Consideration 17

This was also a missed opportunity for Mrs A to inform the team of the early development of Ms X prior to her presenting signs and symptoms of psychological distress.

The Independent Investigation was however; candidly informed by Mrs A about the childhood and adolescence of Ms X and we were most appreciative of this. The basic biographical details which were supported during our short conversation with Ms X reflect that.

Ms X grew up not knowing the identity of her biological father. Mrs A recalled the early years of Ms X with pleasure as they were considered to be a happy and loving time. She attended a local junior school and secondary school in Wells. Her school record was described by Mrs A as being fine, she always spoke her mind but that was never confrontational, rude or abusive.

Ms X gained only minimal qualifications from school and her first exams were interrupted due to pregnancy.

Ms X was registered and began a performing arts course at Bath College. This was to capitalise on her enjoyment of song and dance. Due to Ms X having issues with two other students and feeling unable to cope with the situation Ms X left the course and did not return.

Mrs A described how as Ms X was growing up, her desire to know the identity of her father increased. Whenever Ms X was in the company of her mother's friends she would try hard to extract pieces of information which may have led to discovering her father.

Mrs A decided to put her own feelings regarding paternity to one side and following the 14th birthday of Ms X she approached the man she believed to be her daughter's biological father. This later proved not to be the case as DNA tests were undertaken and shown to be negative.

Following the disappointment of the result there was a marked change in Ms X's personality. This led to Ms X suffering periods of depression accompanied by self-harm. Her mother describes a scenario when at 14 years of age Ms X would jump to conclusions without thought or reason and have knee-jerk reactions when she felt insecure.

In April 2009 Ms X became pregnant. Initially, she informed her boyfriend's mother and as a result of discussion with her boyfriend and his mother she decided to terminate the pregnancy.

Mrs A admitted to reacting badly to news of her daughter's pregnancy and believes this led to a decline in self-esteem of Ms X and negatively affected her state of mind.

Following the trauma of the abortion Ms X suffered depressive episodes, and she could not understand the emotions she was experiencing during these interludes. Mrs A states that an over-riding factor in her daughter's behaviour was an increasing reliance on alcohol which she observed had a detrimental effect on her daughter's

character. She described signs of this being seen in Ms X suffering periods of memory loss when drunk and at times having no recollection of the previous evening's events.

Mrs A was able to recall her optimism after Ms X had made her last visit to the CMHT less than two days before the serious incident. This was due to her feeling that Ms X had responded positively to the intervention and when linked to anti-depressant medication she had been hopeful of improvement.

The evening before the index offence Ms X had slept at home and had been upbeat about the next few days. She had arranged to go shopping with her boyfriend and had agreed to set off early on Friday 4th September to attend Bridgwater College to commence another performing arts course.

Mrs A lost mobile phone contact with her daughter on the evening of the 3rd September but was able to establish with her that she was in a public house in Wells.

The index offence was committed in the early hours of Friday the 4th September.

The Internal Review identified in the chronology that the times of crisis remarked upon by Mrs A as those reflected in visits to the GP service and/or referral and interaction with specialist mental health services in Somerset Partnership NHS Foundation Trust.

Consideration 18

The clinical assessments made appeared to be appropriate when Ms X presented in critical times and these were multi-disciplinary in the Adult Mental Health team. However, Mrs A, Ms X and her friend felt that it would have been helpful if Ms X had been seen by a Consultant Psychiatrist.

We would find it difficult to argue contrary to this as apart from being a further reassurance to the family, it may have overcome some of the likely frustration of the GP service regarding a point of access to a service and guidance regarding prescribed medication. We feel that the family can be reassured that the initial assessment was undertaken by an experienced mental health practitioner who had specialised in community practice for many years.

As a result of our helpful interview with Mrs A and her friend we do not find any deficit in the relationship between the mental health services and the family of Ms X, only missed opportunities. Had Ms X been established as an adult on CPA Mrs A would have had a carer's assessment and we feel sure that her assistance with any therapeutic input to Ms X would have been forthcoming.

Consideration 19

We were concerned about the absence of a Consultant Psychiatrist input although we realise that after the last (2nd September 2009) assessment this would have been likely. Setting aside the benefit of hindsight we believe that it may have benefited Ms X and the GP service if she had been brought to the attention of such a senior and experienced practitioner.

We temper this consideration in the contemporary practice which is prevalent in many Trusts that utilise expert multi-disciplinary assessment. However, the effectiveness of this model continues to differ in its implementation. Professional arguments regarding the nature of inter- disciplinary or multi- disciplinary working are well rehearsed and we do not wish to reproduce these – only to state that examination of the local effectiveness of such a model is always worthwhile.

We did not see from the evidence and documentation that lack of clear diagnosis or medication decisions were inappropriate in Ms X's circumstances. However, we did feel after interviewing Mrs A that her daughter's non-compliance with medication was made known to staff in the mental health and GP services. On that basis alone her care and treatment might have been better dealt with in a more assertive manner. We also agreed with the Internal Reviewers comments that if psychotherapy was to be the main focus of treatment, this could not be forced on a recipient.

6.9 Review the communication and involvement of the family of Ms X prior to the homicide

It is apparent from the chronology of significant events in the young life of Ms X when she came into contact with services that there was a lack of engagement between her and the practitioners who were there to help her utilise those services effectively.

The Somerset Partnership NHS Foundation Trust can evidence from the results of the referral systems to its services and the correspondence which followed when Ms X missed appointments or disengaged from a service that it was aware of the need to attempt to maintain contact with her. At the time of the majority of contact with mental health services the National Service Framework for Mental Health (1999) was the umbrella policy from which local practice and procedures were developed.

The National Service Framework was clear in its stance regarding the importance of engagement. This applied to practice in mental health whether or not the service user was thought to be of low risk of causing harm to self or others. The framework confirmed that successful long term treatment and management of mental illness in the community will almost always be based on proper engagement between the user and provider of such specialised services.

It appeared to us that the CAMHS service, the GP service and the Wells CMHT were responsive to Ms X when she sought help. This was confirmed by Ms X in our short conversation with her and indeed Mrs A. However, the nature of the response meant that there would likely have been benefit to Ms X if a more assertive approach could have been taken by the respective teams during the periods when Ms X was least receptive. This approach however would have been difficult because as Ms X and her mother informed us, at that time any overzealous input would have been interpreted by Ms X as interfering with her life style and need to use alcohol as a prop to help her cope with stressors. Of course, since the index offence and subsequent imprisonment Ms X has reflected on and appreciates the value of engagement.

The particular model of treatment which was offered by the various services really influenced the approach to engagement. In common with most service development in the UK, the Somerset services adopted a number of styles, these revolved around:

- The service method of attempting to provide a specific input based on what Ms X stated she needed. (GP and medication)
- The paternalistic method which attempted to get Ms X to understand what the specialist service could tell that she required (CAMHS)
- A recovery based method of trying to help Ms X understand how to adapt and cope with difficult situations (the final assessment and plan for CMHT) prior to the offence.

The influence of these methods to some extent affects whether the service user is more responsible for engaging with a particular service, or the service provider being responsible for actively pursuing

engagement with the service user. It has to be recognised however, that users are individuals and whilst broad policy and service concepts can assist in delivery of services they cannot always succeed in compliance and engagement or otherwise. This is because it is considered essential to have a pre-morbid or pre-illness baseline of someone's' presentation. This allows any deterioration from that point of wellness to be assessed, in terms of their ability to engage or not. Gradual deterioration of psychological state and the motivation to engage may be missed if each assessment period is simply contrasted with the previous one. Unfortunately, the last engaged appointment which was so near to the index offence was likely to be the one which may have allowed a specialised team to persuade Ms X to accept a shared view of how her needs might have been met.

We have already described the relatively short period of contact time that Ms X had with mental health services. This in itself meant that there was little opportunity for longitudinal assessment of Ms X and any emerging illness or condition. Continuity of care is the means by which to undertake such an assessment. The plan made 2 days before the index offence laid the foundations for this. We recognise that expert practitioners may be reluctant to confirm a diagnosis of emerging personality disorder on a young person. Such a label can bring its own problems and hence we believe the need for an interim (or working) diagnosis was correct as it was based upon a professional assessment which was informed by available data at the time. Any diagnostic uncertainty is usually best handled by a consultant psychiatrist as lack of a clear and accurate diagnosis may lead to varying opinions over time and this can prove frustrating for both the service user and those team members working with them. Such factors can also be important when establishing a correct medication regime. In other words, engagement, continuity of care, diagnosis and correct medication are inter-linked and are necessary to give confidence to a young person such as Ms X. We do not suggest that the interim diagnosis at such an early phase of contact with the Trust was inappropriate.

The Trust's policies and practices relating to engagement appeared to be benchmarked against the guidance of the National Service Framework. Therefore, the primary task of the CMHT and CAMHS particularly, regardless of the setting, was to engage with Ms X. This was sometimes difficult but the goal was that of attempting to improve Ms X's life chances and more accurate and personalised risk assessment to take place. Our examination of the documents, records, correspondence and formal risk assessments revealed that specialised services could provide thoughtful and competent staff that held skills to assist Ms X.

6.10 Evaluate the internal investigation into the care of Ms X already undertaken by the Trust and any recommendations and subsequent actions

The quality and presentation of the report of the internal investigation which was completed on 16th March 2010 was analysed. The panel utilised the audit tool developed by Caring Solutions (UK) ltd in recent years for the singular purpose of evaluating serious untoward incident reports. The tool also offers an immediate analysis which informs the commissioning authority with regard to the quality and likely impact on the reader of these reports.

The audit tool was originally developed from a HASCAS (2005) publication and draws upon a number of published and unpublished research reports and evidence bases. This includes contemporary national, regional and local guidance. All sources are listed in an attached bibliography contained in our critique (appendix 5).

The audit tool includes a basic information check list regarding the report and investigation overall; together with seven audit categories. For each category an audit statement indicates the overall standard that should be

met and a number of more specific criterion statements are given. These categories comprise:

- Reporting of the incident
- Establishing the review process
- Undertaking the review
- Analysis
- Corrective actions developed and implemented
- Clarity over accountability and responsibility for action
- The report

Provision for comments has been made after the evaluation of each statement to identify:

- A summary of any positive practice highlighted in the report, that we felt should be disseminated, any practice issues (areas for improvement) and space for any further comments not specifically addressed.
- Recommendations regarding the quality of the level 2 investigation process

Following the audit the panel has highlighted the main areas of interest and concern. The completed document including scoring is exempted as it is not anonymised. The Somerset Partnership NHS Foundation Trust is in receipt of the 34 page audit. There follows the key findings of the review of the internal investigation.

6.11.1 Incident reporting

Whilst the date of commencement of the internal investigation (5th February 2010) indicates a protracted time lapse from the actual incident (4th September 2009), justification of the reason for this is given in the internal report. This revolved around the fact that the

incident occurred away from the Health service and also the direction given to the Trust from the Avon and Somerset Constabulary.

The Trust relied on information about the incident involving the service user (Ms X) which was relayed by the media. This process meant that the internal investigation panel eventually commenced its task without reference to an initial service management review (72 hours). However, it was able to maintain helpful links with the local police service.

The 2nd level investigation proceeded and maintained a thorough and detailed, systematic process throughout the investigation. This aspect was apparent in the overall analysis of their findings, particularly as there was a relative paucity of information available to them from any mental health care records. Neither did they have the advantage of gaining information from the subject of the investigation or her family on initial reporting due to the aforementioned police restrictions, which is usual practice in these cases.

The completion of the Independent Investigation took place nearly one year after the event. This enabled more informative facts to be highlighted as the police liaison and court transcripts were available to the panel.

6.11.2 Establishing the Internal Investigation Process

Two professionally well qualified practitioners undertook the investigation. Neither of these was directly involved in care delivery with the specific service (Wells) under review. Both of the investigators on the panel were clearly competent and thorough in the implementation of such investigations utilising the methodology of Root Cause Analysis. It was apparent that the case under investigation was likely to attract continuing public interest and media involvement and

the investigation process was sensitive to these features when it was initiated and further examined on completion in August 2010.

Therefore, the investigation was methodical and thorough with the two person panel utilising information from reliable and logically presented data.

Robust terms of reference were set and these were wide ranging and demanded a considerable depth of initial analysis. The panel had to work within a timescale which required flexibility in order to accommodate the limitations and restrictions due to the simultaneous interest from the police and judicial processes.

The task was a particularly difficult one for the panel as the perpetrator was a young person with an unclear or unreliable specific diagnosis. This meant that the panel worked with a construct of someone likely to be suffering from an emerging borderline personality disorder. This manifested with features of self-harm and usage of alcohol and illicit substances.

The complexity of the needs and clinical history of Ms X did not distract the internal investigation from describing key findings from the available medical notes, progress note entries and risk focussed supporting information.

There were no transcribed interviews of witnesses taken by the investigators. This was due to the parallel police investigation. However, an individual statement from the care co-ordinator from the Wells Adult Community Mental Health Team was examined by the level 2 panel.

Other appropriate documentation and information was scrutinised by the level 2 panel. This was listed in the contents of the report but only appeared as title pages due to anonymity

The internal report relied on a letter from one of the GP's of the Wells City Practice which was examined by the reviewers and therefore no dialogue with any of the GP's involved with Ms X actually took place. Sufficient evidence from the collation of entries in case notes and third party reports, provided the level 2 investigation with a clear description of communication between primary and secondary care services.

As already emphasised parallel police investigation meant that the level 2 reviewers were unable to seek direct views from relatives and carers. This meant also that family members were precluded from the opportunity to contribute to setting the Terms of Reference for the investigation. Such a contribution is recognised as good practice by the NPSA but the nature of the police advice is appreciated by the level 3 panel. This aspect is pursued during our further investigation.

6.11.3 Undertaking the Investigation

The quality of the narrative within the report reflects a clear objective of following NPSA guidance of how and when to set up a level 2 inquiry. The Trust identified competent and skilled investigators to undertake the review and compile the subsequent report. Relevant history of Ms X's care and treatment, although limited in terms of her contact with mental health services, is described in the level 2 report. The history covers the significant times up to the date of the incident.

Relevant supporting information was used and this, in turn, captured the elements necessary to fulfil the criteria for a comprehensive level 2 report. This included:

- Case records
- Risk assessment information letter from the GP to the investigating team

- A detailed chronology of events (timeline)
- Referral letters to specialised services
- Discharge summaries

A complete paper trail exists for the enquiry process from inception to presentation of the report to the Trust's internal serious incident review group in May 2010 and the further amendment and analysis in August 2010.

The initial investigation process elicits a thorough attempt to understand and describe aspects of care and treatment issues surrounding Ms X. The panel appear to have subjected the evidence and information available to them to an appropriate level of scrutiny.

They may have been hampered in some aspects as some documents were either incomplete or contained a paucity of information, particularly some areas of Risk information in the RiO record and the association between this information and the crisis or relapse plan.

The overall report identifies interesting contemporary clinical research which may assist other service users with complex mental health needs based on aspects of personality disorder. Further, the report reflects an understanding of the pattern and chronology of Ms X's presenting features and her often distressed life style.

The report provides sufficient recognition of the chaotic and sometimes destructive nature of the relationship Ms X had with drugs and alcohol to illustrate some reasons for her limited engagement with mental health services.

The issue of non-effective engagement with available services was considered by the internal investigators. Although not a causal factor, the internal report identifies the need for separately managed services

that were expected to be involved at any one time with Ms X to be likely to gain from better co-ordination. The review and report indicated that of the services involved, it was the Somerset Partnership NHS Foundation Trust services that appeared most pro-active in facilitating Ms X's engagement with the service.

The above elements contained in the internal report as measured against our audit criteria contributed to the quality of the presentation of the report. Therefore, we considered that the internal investigation and report had been informed by a systematic and professional approach to retrieving information. In turn, this resulted in factual elements being formulated and a transparent process appears evident in the report.

The level 2 investigation did not seek to identify any relevant national or central policies, or guidance which may have had some relevance to the case. However, the team accessed local pertinent Trust policies and procedures which had been formulated to comply with national guidance. These appeared to assist the investigators to benchmark specific areas of practice. This process appears to have enabled the investigators to identify potential areas of weakness in both human and material resource areas. In turn, any areas such as the nature and use of the RiO system and staff training needs are reflected in both the recommendations and the lessons learned from reviewing the event.

6.11.4 Analysis

Focussed and useful analysis was apparent by the level 2 investigators. This included reference to contemporary evidence bases relevant to a young person with an emerging personality disorder with the associated manifestation of behaviour which is destructive. This reference was adequately sourced and further exploration from the source may assist the Trust as it develops services in this challenging area. The level of scrutiny and subsequent analysis of the case was proportionate to the detail required for a level 2 investigation and was

helpful in illuminating important facets of similar presentation in other areas.

The analysis resulted in a succinct and logical presentation of the facts known at the time. The investigation process itself was able to ensure that the team delivered an initial report in the allocated time-scale and to re-visit its conclusions later when more details had become available after the trial and subsequent imprisonment of Ms X.

Analysis of the way in which Ms X had first presented, with needs that well co-ordinated and collaborative services may have assisted her and subsequent referrals to services was undertaken. This process resulted in several Care and Service delivery problems being identified. These areas are listed in the level 2 report and were helpful to the further review by level 3 Independent Investigation, when examined in detail.

The narrative within the report based on the analysis also identified and listed a number of areas of notable practice. These areas also helped inform the Independent Investigation and may assist the Trust when it considers any knowledge and practice transfer issues to similar areas of concern identified in other SUI's.

6.11.5 The Report and its Conclusions

The aforementioned process resulted in a concise but adequately detailed level 2 report which was likely to prove helpful to the service and to the subsequent review by External Independent Investigation.

The report had a number of strengths, these were predominantly:

- A clear identification of Ms X's periods of non-engagement with the services by the production of a detailed log on the time-line

- An informed analysis of the presenting needs of Ms X with reference to contemporary research and evidence based practice
- Adherence to the principle of NPSA guidelines and RCA
- Informed commentary with regard to any service delivery problems
- Identification of areas of notable practice associated with the provision of services to Ms X
- Identification of treatment outcomes which may have been improved by more robust or assertive input to enable Ms X to confront her alcohol and substance misuse issues
- Identification of weaknesses in separately managed health services which could assist in the treatment and education of service users if better collaboration was to have taken place
- Although not explicitly stated, the report raised aspects of care provided to Ms X reflective of an increasing national problem for mental health services and associated agencies. These issues revolve around the challenge of providing services for difficult to engage young people with chaotic life-styles who do not adequately respond to conventional referral processes.
- The only area of weakness in the report was that which could be attributed to the process of investigation being undertaken when the necessary constraints of the Criminal Justice system were in place.
- No specific action plan is identified in the report but reference is made in the lessons learned which facilitated the Independent Investigation to check progress in these areas. Likewise, arrangements for any shared learning were referenced as being agreed by the Trust Serious Untoward Event group in collaboration with the Strategic Health Authority and NHS Somerset. This aspect was examined during the level 3 Independent Investigation.

6.11.6 Conclusion

As indicated previously in this section the synopsis is informed by the completed Caring Solutions UK Ltd Audit Tool. The criteria used to measure aspects of the internal investigation and report is consistent with NPSA guidelines, facilitates the Independent Investigators to "drill down" in areas that may add to the relevant information available including the views of the perpetrator. This, in turn is intended to ensure that the Terms of Reference for such an investigation are met and that all interested parties including the public can be assured of transparency in the process.

6.11 Consider any other matters that arise from the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence that the public interest may require

This level 3 report reinforces the findings of the internal review completed on 16th March 2010. The areas we have been able to consider have been augmented by, the passage of time and access to contemporary policies and procedures, the benefit of discussion with Avon and Somerset Constabulary and individually with Ms X, her friend and her mother.

The lessons learned from examination of this tragic event were those identified in the internal review panel's findings. Although they do not appear to constitute those lessons of a type or nature that may be transferrable or be of specific value to the wider mental health services in the NHS so we feel that wider distribution of these could be usefully shared. The lessons reflect our points of consideration when we examined the contact that Ms X had with the Somerset mental health services. We were able to record progress that the Trust had made when implementing the three recommendations, these were grounded

in the three areas identified by the internal review team aligned with the lessons learned:

1. The Somerset Partnership NHS Foundation Trust continues to develop a specific training model for care provider teams, to support them when they work with people with a personality disorder.
2. High priority to be given by the Trust in modifying the RiO risk module, together with implementing clinical risk training.
3. Consideration of commissioning new models of outreach working which span the interface between organisations and agencies currently working with personality disorder.

The independent investigation panel considered the progress made against implementation of the action plan. This plan arose from the Trusts internal investigation of the incident; in particular those lessons learned which are described above.

The Trust provided us with a detailed Action and Progress Plan which was updated in March 2012. The Action Plan can be found in Appendix 6.

In order to facilitate this analysis we adapted a framework of measurement similar to that utilised by the National Health Service Litigation Authority (NHSLA). This uses a set of risk management standards within health care organisations. They are set at three and the principle applied to each level can be aligned with the action plan progress. These comprise:

- Level 1 Policy – evidence has been described and documented
- Level 2 Practice - evidence has been described, documented and is in use.

- Level 3 Performance - evidence has been described, documented and is working across the organisation(s) as appropriate.

When considered against this framework it is clear that in respect of recommendation 1 (Somerset Partnership NHS Foundation Trust training and model of consultation and supervision to help teams work with people with personality disorder should be rolled out and embedded in Trust services. Consideration should be given to more collaborative training with partner organisations) evidence has been described and documented. However, the implementation of this is still in progress (a target date of May 2012 for in-patient services and December 2012 for all community services for training implementation for example). This would suggest level 1 compliance in our framework. We would recommend therefore that this implementation is kept under regular review and that an audit of compliance is conducted in the early part of 2013.

In relation to recommendation 2 (concerning modifications to the RiO system) we note the progress made in adjustments to the system and that a draft report on this will be discussed at a forthcoming meeting. This would suggest a level 1 compliance in our framework. We would recommend that once the amendments to the RiO system have been made that this is evaluated to ensure its utility in practice after three months.

Recommendation 3 concerned the commissioning of new models of out-reach working that span the interfaces between organisations and agencies currently working with people with emerging personality disorder. Good progress on this recommendation has been made including the pilot funding for a 18 month Emerging PD Service project agreed and funded by commissioners. The Trust have now also acquired the IAPT services which will allow for greater integration and control of services. This would suggest level 2 compliance from our

framework. We welcome these developments but would encourage that these initiatives are subject to detailed and on-going evaluation as they progress.

During the time of the independent investigation it became apparent that some mental health services in the UK were at risk from austerity measures being taken by local councils. It is hoped that aspects of Ms X's case point to the importance of early intervention and the need to safeguard such services. Certainly, the Somerset Partnership NHS Foundation Trust appears to offer a service that spans a range of services, this includes; promoting good mental health, early intervention when problems first arise and specialised mental health interventions by skilled practitioners.

7 Findings – Contributory Factors

We have already confirmed our agreement with the factors which the internal investigation identified as contributing to this serious incident. To reiterate, these centred on patient factors (aligned with the signs of an emerging personality disorder). These factors were strongly influenced by adverse life events and trauma. Including:

- The experience of Ms X being unable to confirm the identity of her father.
- The experience of a termination of a pregnancy which Ms X felt coerced or pressured into undertaking.
- MS X being unsure whether she may have experienced non consenting sex due to the effects of alcohol.
- The internal report also highlighted the most important feature of this SUI as being the precise constellation of factors which resulted in Ms X being in the flat on the 4th September 2009 with the two other people - the conflict that arose between them and

the subsequent loss of self-control by Ms X exacerbated by high levels of alcohol intoxication.

In respect of Service Organisation the following points are made:

- The internal report made the point that despite the interplay of factors, there are limitations placed on mental health services when they attempt to reduce the risks which arise from alcohol and substance misuse superimposed on chaotic life styles It is both impractical and illegal to utilise mental health legislation to compel patients undergo counselling or psychotherapy.
- There had been the intention to engage Ms X in services provided by three separate service providers since her late adolescence. The period beginning in June 2009 showed a reasonable but short engagement with Somerset Partnership NHS Foundation Trust services during a crisis period with active attempts at re-engagement as ambivalence crept in again. The report goes on to state "The overall pattern for Ms X was that it may have been too easy for her to avoid help that was offered and not enough attempts at active engagement with her despite her ambivalence. Failure to engage her in being motivated to work at addressing her alcohol and drug use seems important."
- Looking deeper into the antecedents to the patient related factors identified earlier by the internal investigation it was determined that "it is possible, though not causal and possibly only achievable in a small proportion of similar cases, that early, co-ordinated and pro-active engagement with Ms X by the full range of local mental health services available may have lessened the risk of sudden harm to others in the situation Ms X found herself in".
- The risk formulation could have been documented in more detail and improved training across the Trust is likely to be beneficial in a general way for patients with personality disorders. Although

the internal investigators appear correct in their view that this would be a fair aim rather than a causal factor in this case.

- We re-examined these statements in the light of more detailed scrutiny of the additional evidence and documentation and could find no argument against the analysis. For this reason, supported by the benefit we had of speaking with Ms X ,her family and friends we understand why the level 2 (internal investigation)was able to conclude ….that it was shown from its analysis of the assessment on the 2nd September 2009 and the actions of the Somerset Partnership NHS Foundation Trust staff subsequently, that : the sequence of events leading to the index offence could not reasonably have been anticipated, that the risk formulation or clinical management was significantly deficient or that there was any statutory or legal framework within which to intervene in a way that would have been likely to have prevented the outcome.
- The Somerset Partnership NHS Foundation Trust mental health services are organised to confront many of the typical challenges faced by young people such as Ms X. Whilst the use of alcohol and street drugs is increasing, the culture associated with them is also part of their lives. For those young people with a fragile psychological make-up the use of both these substances is frequently associated with relapse and a poor health status. They use these substances for the same reason as others, only they are more vulnerable to suggestion and exploitation by others. The evidence base and service provision that is required to manage this problem continues to develop with the Trust's services.
- The external investigation was able to consider the components of this SUI and reinforce the opportunities that this tragic case presents for localised mental health services. These include the enhancement of the current provision and particularly with regard to personality disorder training, the possibility of making

an effective contribution to the leadership of novel local solutions to a national problem.

8 Recommendations

Any improvement and development of services aimed at assisting young people who present as Ms X did will require investment in training and the forging of effective collaboration between agencies. We have identified from the policies and procedures, together with the Somerset Partnership NHS Foundation Trust's organisational structures and the results of the internal investigation that this is likely to be achieved by a continuing improvement approach. This seems to be embedded in the framework of clinical governance of the Trust and its partnership agencies.

Consequently our few recommendations which are based on the actions already being taken as a result of the internal investigation are intended to encourage partnership and the dissemination of learning from good practice.

1. Standardised tools which specifically measure alcohol/substance dependency should continue to be promoted for common use in services when risk assessment indicates a problem with these.
2. Local services and commissioners should seek evidence by audit that young people are able to access the fullest possible range of specialist alcohol and substance misuse services which relate to health and clinical interventions.

3. Local services should seek evidence and reassurance that GP and carer groups are consulted when policies are developed which are aimed at improving service delivery to young people with alcohol misuse problems.
4. The design of shared care protocols between various agencies that offer services to young people who may have alcohol/substance misuse problems should be promoted by local services.
5. An up to date audit of the quality of joint care plans with community mental health and primary care services for children and adolescents should be undertaken by the Trust and commissioners and the results disseminated to carer and interested parties.
6. The work being undertaken by the Somerset Partnership NHS Foundation Trust in the area of specialist supervision, support and training in personality disorder, should continue and include a wider dissemination of the results of the evaluation of the programme.
7. Clear statements should be made on the philosophy and values of the contributing specialist services and agencies. These should describe professional interventions which satisfy service users, families and carers, and degree of risk. They should promote risk sharing and management, inclusiveness e.g. those with personality disorders and young people who are actively using alcohol and substances, together with a culture of on-going engagement with treatment.
8. Research and development of new treatment approaches should be encouraged and supported to examine the needs of patients and carers who have previously been considered difficult to engage and treat e.g. young people and people with personality disorders in the community.
9. The implementation of the action plan arising from the Trusts internal investigation should be subject to on-going audit and evaluation to demonstrate full compliance with the

recommendations.

9 Appendices

Appendix One: Interviewee's and documents reviewed

Interviews were held with the following:

Head of Corporate Services Somerset Partnership NHS Foundation Trust
One of the investigating Officers from the Police
Ms X's Mother (Mrs A)
Ms X's Friend (DU)
Perpetrator (Ms X)

The following key documents were reviewed:

- The RCA Management Report
- The Report of the Internal Review by Somerset Partnership NHS Foundation Trust
- Clinical and multi-disciplinary records relating to the Health and Social Care provided to Ms X to the date of the offence
- Relevant Department of Health guidance including:
- National Service Framework (NSF) for Mental Health Services – Modern Standards and Service Models 1999
- Effective Care Co-Ordination in Mental Health Services – Modernising the Care Programme Approach 1999
- NSF Mental Health Policy Implementation Guide
- No Health Without Mental Health across governmental health outcome strategy, for people of all ages. February 2011
- The Trusts' response to the above relating to operational policies and staff guidance procedures specifically in relation to: CPA; Risk Assessment; RCA Management Investigations
- Thematic Organisational Learning Report 2009/10
- University of Manchester – Five Yearly Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Avoidable Deaths 2011
- Re-Focusing the Care Programme Approach, Policy and Positive Practice Guidance, DH, March 2008

The investigation team also reviewed a range of reports and assessments prepared by a number of psychiatrists and psychologists prior to her court appearance. These included:

- Final psychiatric report on the defendant
- Addendum Psychiatric report on the defendant
- Confidential Medical Report
- Psychiatric Report prepared
- Addendum Psychiatric Report
- Preliminary Confidential Medical Report
- Clinical Psychology Report
- Second Addendum Clinical Psychology Report
- Clinical Psychology Report

Appendix Two: Members of the External Review Panel

Anthony Thompson

Tony brings many years of experience of representing mental health and learning disability services within a multi-disciplinary context. A former GNC for England and Wales Inspector and professional advisor to the ENB he has published a number of leading textbooks and continues to work at an International level within his field of nursing. His career has spanned senior positions in statutory service, academia, NHS and the Independent Sector. He is currently a Director of a non – profit company Bridge Research and Development International, Columnist for Health Care Business and a Senior Associate of Caring Solutions UK Ltd.

Colin Dale

Dr Colin Dale is the Chief Executive of Caring Solutions (UK) Ltd a mental health consultancy company based in the north west of England which carries out national, regional and local health care projects throughout the UK. He is the Vice Chairman of a NHS mental health foundation trust and has worked as an executive Director with three previous NHS Trusts for a period spanning 11 years. He is a Senior Research Fellow at the University of Central Lancashire; a member of the Mental Health Review Tribunal and a Trustee on the Board of the British Institute for Learning Disabilities. In 2006 Colin acted as adviser to the National Patient Safety Agency on mental health, and since then he has led and reviewed a series of independent investigations into Serious Untoward Investigations on behalf of four of the ten Strategic Health Authorities in England.

Michael Rosenberg

Dr Michael Rosenberg is a retired Consultant Psychiatrist, who worked as a general adult psychiatrist from 1981-2009 for the NHS in Brighton. Between 2003 and 2006 Michael was the Chief Executive and Honorary Consultant Psychiatrist South Downs Health NHS Trust; a Trust where he had previously been the Medical Director between 1998 and 2003. Michael was responsible for the Psychiatric Intensive Care Unit at Mill View Hospital from 1999 to 2005 (a modern 10-bedded unit caring for acutely mentally ill patients, requiring short-term intensive treatment). From 2006-2009 he worked as an inpatient Triage consultant. He is approved under Section 12(2) of the Mental Health Act 1983. Michael has extensive experience of the investigation of critical incidents and advised on the management of complaints in his Trust.

Appendix Three: Abbreviations and descriptions

Abbreviation	Meaning and description
A&E	Accident and Emergency
CMHT	Community Mental Health Team
CAMHS	Child and Adolescent Mental Health Service
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric nurse
DNA	Deoxyribonucleic Acid
DoH	Department of Health
EMIS	Electronic Medical Information System
GP	General Practitioner
HASCAS	Health and Social Care Advisory Service
HCC	Health Care Commission
HMP	Her Majesty's Prison
HONOS	Health of the Nation Outcome Scales
HSG	Health Service Guidance
IAPT	Improving Access to Psychological Therapies
MHA	Mental Health Act (1983)
Mrs A	Perpetrator's Mother
Ms X	Perpetrator
Mr Y	Victim
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
RC	Responsible Clinician
RCA	Root Cause Analysis
RiO	Electronic Patient Record System
SHA	Strategic Health Authority
SUI	Serious Untoward Incident
TOR	Terms of Reference

Appendix Four: Chronology of significant events

Chronology (timeline) of significant events taken from Trust Rio record, District Hospital notes and the GP Practice EMIS system.	
Date and Time	**Event**
22 September 2006 GP	Seen at GP Practice. Low in mood for last few months. Would like medication to help but not suicidal. Looked and sounded fine; did not look depressed.
06 October 2006 GP	Low in mood. Still upset to discover that the current biological father is not her father after a DNA test. Better now. Advised to learn how to cope and face life's challenges.
11 February 2008 GP	Seen at GP Practice. Low mood and low self-esteem. Ms X's mother had sent her as concerned Ms X was drinking a lot, felt everyone hated her. Had been missing school a lot; "everyone looking at me". Sometimes would not go out. Some bulimic symptoms. Friends said Ms X had not been right for the last year. Still an issue re identity of her father.
13 February 2008 GP	Referred by GP Locum at GP Practice, to Psychological Therapist of the Primary Care Mental Health Service, for counselling. Marks noted on forearm which Ms X said was from self-harming but that these were done some time ago.
25 February 2008 GP	Referral for counselling declined as Ms X was under 17 years. GP re-referred Ms X to the Specialist CAMHS Service. GP concerned that without help Ms X would deteriorate.
28 February 2008 Trust	Invited to attend for an appointment at CAMHS on 26 March 2008.
26 March 2008 Trust	Unable to attend appointment due to aunt being unwell. Further appointment given for 10 April 2008.
10 April 2008 Trust	Did not attend for appointment. Follow up letter sent requesting Ms X contact CAMHS. File to remain open until 01 May 2008 for Ms X to request another appointment.

30 April 2008 Trust	As no contact made, Ms X discharged from CAMHS.
Late March 2009 GP	Ms X has a termination of pregnancy.
06 April 2009 YDH	Ms X attended A&E at District Hospital at 0110. Injured right hand having punched a wall when angry and upset. Had been drinking alcohol and also complained of abdominal pain. Wrist strapped and given analgesia.
11 April 2009	Attended Minor Injuries Unit at 1737. Requested support for right hand injury. Ms X had missed her clinic appointment and strongly advised to remake appointment. Bandage/support given with verbal advice.
19 April 2009 YDH	Ms X attended A&E at District Hospital at 23.32. Intoxicated. Superficial cuts underneath right hand and injury to right ankle. Not weight bearing. Mobilised with crutch No suicidal intent. Kept in overnight.
21 April 2009 GP	Seen at GP Practice. Tearful and low last two weeks, feeling guilty about the termination of pregnancy now despite counselling from Marie Stopes. Said she did not want termination but felt pressurised into it. Cut herself superficially with a glass a few days previously but not suicidal now. Supportive boyfriend but the relationship is struggling. Started on Fluoxetine medication.
29 April 2009 GP	Telephone call to Ms X from GP. Really needed to talk to someone, i.e. a counsellor. Crying for no reason. Recently self harmed two days previously. To pick up leaflets and be seen next week. Anger paramount but did not know why she was feeling the way she was.
06 May 2009 GP	Ms X would like to speak to a counsellor. Lots of issues brought to the fore by termination of pregnancy. Did not know who her father was. Drinking to subdue things. Starting to self-harm by cutting. Worried about recent weight gain with pregnancy. Alert, insightful, normal speech and well kempt. Plan to refer for counselling and continue with antidepressants.
08 May 2009	Telephone call to Ms X from GP. Low mood. Tearful on phone. Ms X's boss took over call and said she was drinking heavily. Had cuts all over her arms and needed help as soon as possible. To be seen in surgery.
08 May 2009 GP	Low mood. Said much worse over last few days. Tried to cut wrists at work today. Contemplated suicide a few days ago. Got very drunk last night. Drinking heavily off and on for five months. Very tearful and kept saying did

	not want to be there. Felt she would not be able to control what she did at the weekend and requested urgent help today. To be seen at CMHT offices today.
08 May 2009 Trust	Referred to Crisis Team by GP and seen on the same day of her referral. Preoccupied with suicidal thoughts, risk increased by impulsiveness due to increase in consumption of alcohol. Had smashed a glass at a BBQ 3 weeks ago and tried to cut her wrists resulting in Ambulance being called. She was restrained and eventually taken to hospital where it was established that she had fractured her fingers. When assessed for discharge at hospital she told them that she was feeling fine so that she could be sent home. Had also been in bedroom and contemplated suicide. Also experiencing sleep disturbance/poor sleep pattern. Recent increase in alcohol use and was drinking daily. Strongly denied use of street drugs, and stating she could have been subjected to non-consenting sex, but was unsure due to the effects of alcohol. Risks around suicidal ideation need to be established further. Unpredictable, continuous thoughts of suicide. Admitted to crisis team who would visit daily. Monitor suicidal thoughts. Monitor efficacy of antidepressant. Turning Point discussed at assessment Eating disorder/counselling could possibly be re-established. Review with consultant.
09 May 2009 Trust	Home visit. Reported sleep disturbance continued. Not been overwhelmed or distressed by suicidal thoughts. Talked about her alcohol consumption and how difficult it is to remain abstinent.
10 May 2009 Trust	Home visit but Ms X asleep in bed. Staff agreed with Mum to telephone to arrange another visit.
13 May 2009 Trust	Telephone call by CPN. Reported not had suicidal thoughts. Had wanted alcohol but had refrained.
14 May 2009 Trust	Telephone call by CPN. No reply, message left for her to contact the team re making an appointment.
15 May 2009 Trust	Did not initially attend appointment. CPN left message for her to call to arrange another appointment. Subsequently attended. Still had thoughts

	daily about ending her life. She had built up support from her network of friends and her mother, which she said was effective in lifting her mood when she was having a bad day. Had seen GP who gave a further prescription of fluoxetine and zopiclone. Had remained abstinent from alcohol.
15 May 2009 GP	Telephone call by GP to MD of Crisis team. Message received to only consider further Zopiclone if needed for a few days. GP asked Crisis Team to fax or ring and leave a message/speak to duty doctor re information if they have asked Ms X to see GP the same day. Reviewed and feeling a bit better with regular counselling. No alcohol for one week but struggling. Would be seeing drug and alcohol charity service soon. Sleep problems but seemed happier.
18 May 2009 Trust	Home visit by CPN but Ms X not at home. Telephone message left.
19 May 2009 Trust	Home visit following request by her mother. Had drunk excessive alcohol, had punched a car with her fist and had verbally abused someone. When brought home she had tried to harm herself but had been restrained by friends. Declined further appointment next day by CPN.
21 May 2009 Trust	Team review. Plan: further assessment. Three visits per week. Continue with medication.
26 May 2009 Trust	Home visit. Felt things were getting better for her.
31 May 2009	Home visit but Ms X was at work.
01 June 2009 Trust	Telephone call to Ms X but not at home. Subsequent call agreed to home visit.
03 June 2009 Trust	Home visit but Ms X not at home. Subsequent telephone call but no answer.
04 June 2009	Telephone call to Ms X but not at home.

Trust	
09 June 2009 Trust	Team review. Discharged from Crisis Team following recent failure to engage with the service. Prescribed medication to continue with primary care and offered one-month's post discharge telephone support. Team has had no recent contact with Ms X or her Mum despite numerous attempts to make contact. Team would deliver hand written confirmation of her discharge to home address.
09 June 2009 Trust	Discharge letter sent to Ms X's GP. Had been preoccupied by suicidal thoughts; risk increased by impulsiveness due to increase in consumption of alcohol. Also had experienced sleep disturbance and poor sleep pattern. Visited daily initially by the Crisis Team. This had been reviewed after some improvement in the presenting emotions and thoughts leading to Ms X not being available to be seen when visited. Medication on discharge: Fluoxetine 20mg; Zopiclone 7.5mg. All medication to continue to be prescribed in Primary Care. Usual path for referral from Primary Care should there be any concerns in the future.
10 June 2009 Trust	Letter sent to Ms X by Crisis Team informing Ms X she was being discharged from the team caseload as she had recently failed to engage with the team. Ms X informed she would have one month's post-discharge telephone contact but for any medical input Ms X would need to contact her GP.
18 August 2009 GP	Low mood. Thought she was feeling better and then got worse last two weeks. Had been feeling low and tearful for no reason and felt that everybody was against her. Started after her termination in March when it all started but felt more settled after talks with a counsellor. Was suicidal at one time and was seen by the crisis team. Citalopram started and to see crisis team as soon as possible.
24 August 2009 GP	Telephone call to Ms X from GP. Depressed. Felt everyone hated her. Tried suicide last night but was interrupted. To be seen in surgery.
24 August 2009 GP	Attended with two friends. Since termination low in mood, drinking too much in binges, fallen out with several friends. Low in self-esteem and tearful. Now confided in mother. Felt counselling helped last time but stopped as felt

	well for a week. Discussed impulsive behaviour and causes of low self-esteem. Both self-harm attempts when mother was in house and not planned. Felt now if knows going to get help will be able to address impulsiveness. Insightful, well kempt, good rapport and eye contact. Tearful but also giggly. Wanted everything to be as it was last year before the termination. Resume Fluoxetine medication.
25 August 2009 GP	Message left for CMHT. Advised to send a referral to team.
26 August 2009 GP	Urgent referral faxed over.
27 August 2009 Trust	Referred to CMHT by GP, following a relapse in her mental health problems. Ms X had been due to have counselling from the primary care therapists here but had felt better and decided not to attend these appointments. Her behaviour had become more erratic over the previous few weeks and had become more depressed. She was reported to have attempted suicide twice. Both acts had been spontaneous; her mother having been in the house on both occasions and had found her. Had been brought to the surgery by two friends. Admitted to drinking too much and had some recreational drug use recently. Her mood seemed to relate to the termination of her pregnancy in the early part of the year. Ms X had since separated from her boyfriend. Ms X had continued on an anti-depressant. Ms X felt counselling would be the best way to deal with her past issues plus the issue of the termination and the fact Ms X was not sure who her father was. GP also re-referred Ms X to the Primary Care Psychological Therapy Service. He believed Ms X to be at significant risk because of the impulsiveness of her behaviour and asked her to be seen as a matter of urgency.
02 September 2009 Trust	Seen by CMHT for urgent assessment. Presented as very distressed and low in mood with significant risk of serious self-harm/suicide due to her impulsive behaviour. The main stressors appeared to be, uncertainty regarding identity of father, a history of being bullied, a chaotic relationship, a recent termination of pregnancy, and problematic use of alcohol, cannabis and cocaine. Considered to be insightful and motivated to engage with the

	CMHT. The initial agreed plan for CPN to act as Care Co-ordinator, arrange a medical review, and to refer for assessment regarding specialist psychological interventions. Ms X also agreed to approach drug and alcohol voluntary service for additional support regarding her substance use
04 September 2009 Trust	Ms X is alleged to have murdered a man in Wells, Somerset.
04 September 2009 YDH	Seen at A&E at District Hospital at 1301. Had been referred by police surgeon having been involved in an altercation. Unable to recall what lead to injury. Right hand sore, lacerations on arms and stomach, bruise to right side of head.
06 September 2009 YDH	Re-attended A&E at District Hospital at 1930 having removed plaster cast herself. This was replaced. Could not remember how she was injured but stated had been staying at a friend's house and had intervened to help her friend who was being beaten by her boyfriend
08 September 2009 Trust	Letter sent to GP by Trust CPN confirming results of assessment on 2nd May and the fact that Ms X had been remanded in custody.
08 September 2009 GP	Request received by GP Practice from HMP for details of current medication. Advised only on Fluoxetine.
09 September 2009 GP	Summary of medical conditions and prescribed medication sent to HMP.
28 September 2009 Trust	Discharged from CMHT caseload. Team would reopen Ms X's case if necessary without a formal referral.
22 March 2010	Ms X found guilty of murder at Crown Court and sentenced to life (with a minimum term of 9 years). This may be the subject of an appeal by Ms X

Appendix Five: Bibliography

1. The 72 hour Report

2. The Report of the Internal Review by Somerset Partnership NHS Foundation Trust of the Care and Treatment of Ms X

3. Clinical and multi-disciplinary records relating to the Health and Social Care provided to Ms X to the date of the offence.

4. Relevant D.O.H. guidance including:

- National Service Framework (NSF) for Mental Health Services – Modern Standards and Service Models 1999
- Effective Care Co-Ordination in Mental Health Services – Modernising the Care Programme Approach 1999
- NSF Mental Health Policy Implementation Guide
- Talking Therapies fact sheet NICE Guidance IAPT

5. The Trusts' response to the above relating to operational policies and staff guidance procedures specifically in relation to:

- CPA
- Risk Assessment
- RCA Management Investigation

Ms X Action Plan October 2012

No.	RECOMMENDATION	ACTION	PROGRESS	TARGET DATE	ACHIEVED
1.	Somerset Partnership training and model of consultation and supervision to help teams work with people with personality disorder should be rolled out and embedded in Trust services. Thought should be given to more collaborative training with partner organisations.	Trust Personality Disorder (PD) Strategy is progressed through delivery of training package developed for acute inpatient ward staff	Training package delivered to Wessex House, Willow Ward, Ash Ward, Rydon Ward, Rowan Ward. Planned for St Andrews and Holford Wards for May 2012. Once inpatient roll out is completed training will be delivered to all community mental health teams.		**ACHIEVED**
		Provide an annual update for the SUE R group on the PD Service.	Joint Heads of Psychological Therapies provided annual report to SUE R Group on 28 April 2011.		**ACHIEVED**
		Establish reflective practice groups on acute wards	Reflective practice groups in place and ongoing.		**ACHIEVED**

No.	RECOMMENDATION	ACTION	PROGRESS	TARGET DATE	ACHIEVED
		Further develop PD locality leads by creating two more posts	Funding secured and posts advertised. Awaiting appointment.		**ACHIEVED**
		Deliver the Knowledge & Skills Framework (KUF) to Trust staff and partner organisations as agreed with NHS South West as Commissioners.	Training programme agreed and delivered to Trust staff and wide range of organisations.		**ACHIEVED**
		Deliver 'Understanding People' Level 1 Psychological Mindedness Course.	Training advertised and bookings in place.		**ACHIEVED**
2.	The modifications to the RiO Risk module commented on within the Level 2 RCA review and a sustained emphasis on delivering high quality, auditable, experiential and interactive clinical risk training and refresher training to all clinical and social care staff should be given a high	Review of RiO Functionality to be taken forward in the review of RiO functionality (SUE R Group action point 91/93)	Pilot of revised risk screen following staff discussions. Dual screen option to record chronic/acute risk. Implemented October 2011.		**ACHIEVED**
		Review of clinical functionality of RiO through IT Services via focus groups and meetings	Alterations to RiO risk screen have been made to enable recording of acute and chronic risk.		**ACHIEVED**

No.	RECOMMENDATION	ACTION	PROGRESS	TARGET DATE	ACHIEVED
	priority.		Review also looked at clinician usability.		
		Review risk training content.	Training reviewed and amended.		**ACHIEVED**
		Clinical risk training is mandatory for qualified staff and refreshed 3 yearly.	Mandatory for qualified staff and recommended for non-qualified staff.		**ACHIEVED**
		Provide regular reports to SUE R Group on training numbers of all professional groups.	Reports provided for each SUE R Group meeting and Trust Board.		**ACHIEVED**
3.	The Health and Social Care community in Partnership with NHS Somerset should consider commissioning new models of out-reach working that span the interfaces between organisations and agencies currently working with people with emerging personality disorder.	Acute Care Pathway Review	Final Acute Care Pathway report discussed in Trust Board Seminar on 21 October 2011. Diana to provide feedback to the November SUE R Group. Action plan in development to proceed from January 2012.		**ACHIEVED**
		Emerging Personality Disorder Services commissioning bid	Pilot funding for a 18 month Emerging PD Service project has been agreed and funded		**ACHIEVED**

No.	RECOMMENDATION	ACTION	PROGRESS	TARGET DATE	ACHIEVED
			by commissioners. Posts have been advertised.		
		Streamlining care pathways with IAPT Service	Since acquisition of the IAPT service by Somerset Partnership on 1 August 2011 the opportunity now exists to streamline psychological therapies care pathways and share training and expertise. Review of Psychological Therapies Care Pathway due in early 2012.		**ACHIEVED**