HASCAS

Health and Social Care Advisory Service

Independent Investigation

Into the

Care and Treatment Provided to Mr. Y

by the

Sussex Partnership NHS Foundation Trust

Commissioned by

NHS South of England
Strategic Health Authority

Executive Summary

Independent Investigation: HASCAS Health and Social Care Advisory Service
Report Author: Dr. Androulla Johnstone

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

The Independent Investigation into the care and treatment of Mr. Y was commissioned by NHS South of England (South East Coast) Strategic Health Authority pursuant to *HSG (94)27*.[1] The Investigation was asked to examine a set of circumstances associated with the deaths of Mr. and Mrs. Y who died on 23 December 2007. The Investigation examines the care and treatment Mr. Y received from the Sussex Partnership NHS Foundation Trust between 26 November and 6 December 2007, but does not examine that provided by The Priory Hospital between 6 and 23 December 2007 as this falls outside of the scope of HSG (94) 27. It should be noted that Mr. Y was no longer a patient with the Sussex Partnership NHS Foundation Trust at the time of his death, and that of Mrs. Y, having been discharged at his request to The Priory three weeks before.

Background

On 26 November 2007 Mr. Y was taken to the Accident and Emergency department of St Richard's General Hospital, Chichester. It was reported that Mr. Y and his wife had been experiencing marital difficulties for some time. Mr. Y was preoccupied with thoughts of whether his wife was a virgin when they married 46 years previously. His wife had disclosed that day, for the first time, that she was not. On this day Mr. Y left the house to play golf. He returned at around 09.30 hours knowing that his wife was out. He took between five and seven 7.5mg Zopiclone tablets and took a pipe and connected this to the exhaust of his car and switched on the engine. He later reported that he could see the fumes but nothing happened. He then took a canister of gas which he took into the car and opened the outlet valve once he had enclosed himself within the vehicle. Mr. Y had left a letter for his wife and family. He was found by his daughter and wife at around 12.30 hours. He was reported to be very drowsy and confused when he was found.[2] He was admitted to the Harold Kidd Unit, Chichester, which is part of the Sussex Partnership NHS Foundation Trust.

By 29 November 2007 Mr. Y claimed that he was no longer suicidal and both he and his family commenced discussions about him being transferred to The Priory, an independent sector service. At this time the family became concerned that he was stating his intention to kill his wife and these concerns were communicated to his Consultant Psychiatrist (Consultant Psychiatrist 1) at the Harold Kidd Unit. The transfer process to The Priory was halted and Mr. Y was kept on the unit with his consent as an informal patient and where he was assessed on a daily basis. His mental state appeared to improve.

On 6 December 2007 Mr. Y was transferred to The Priory as an informal inpatient. Mr. Y appeared to continue with his progress and weekend leave was arranged on 13 December. Following consultation with Mr. Y and his wife on 17 December (the Monday following his weekend leave) he was discharged from The Priory.

1. Health Service Guidance (94) 27
[2] Clinical notes V1 pp 52 & 55

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Incident

Mr. Y killed himself in a car accident which took place on 23 December 2007, he died later in hospital on 24 December 2007. When the Police went to the family home to notify Mrs. Y of the accident they found her slumped on the floor dead. She had suffered from multiple stab wounds and blunt trauma injuries. The police treated the deaths as a case of homicide/suicide.

HM Coroner Penelope Schofield said *"…[Mr. Y] died on the 24 December 2007 having attempted to take his own life whilst driving a motor vehicle on 23 December 2007 whilst suffering from a disturbed mind having been discharged as a voluntary patient of The Priory Hospital Hove on 17 December 2007 but remaining under their care as an outpatient."*

The Coroner found that Mrs. Y had been unlawfully killed and that the Police confirmed there was no evidence to suggest any third parties were involved.

2. Terms of Reference for the Independent Investigation

The Independent Investigation was commissioned by NHS South of England, South East Coast. The Investigation was commissioned in accordance with guidance published by the Department of Health in *HSG (94) 27 The Discharge of Mentally Disordered People and their Continuing Care in the Community* and the updated paragraphs 33 – 36 issued in June 2005.

Terms of Reference

The Terms of Reference for this Investigation were set by NHS South of England (South East Coast) Strategic Health Authority. Due to the passage of time that had elapsed between the time of the incident and the time of the commissioning of the Independent Investigation it was agreed that the case would be managed as a desk top review instead of as a full panel, wide-ranging process. The Terms of Reference were as follows:

"The independent inquiry is commissioned by NHS South East Coast. It is commissioned in accordance with guidance published by the Department of Health in HSG (94)27 The Discharge of Mentally Disordered People and their Continuing Care in the Community and the updated paragraphs 33 – 36 issued in June 2005.

Terms of reference

1. To examine the care and treatment of Mr. Y, in particular:

- *The history and extent of his involvement with health and social care services.*
- *The suitability of his treatment, care and supervision in respect of:*
  - *Clinical diagnosis*
  - *Assessed health and social care needs*
  - *Assessed risk of potential harm to self and others*
  - *Any previous psychiatric history*
  - *Any previous forensic history*

- *The assessment of the needs of carers and his family.*
- *The extent to which Mr. Y complied with his prescribed care plans.*
- *The extent to which Mr. Y's care and treatment corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health.*
- *The quality of Mr.Y's treatment, care and supervision, in particular the extent to which his prescribed care plans were:*
  - *Appropriate*
  - *Effectively delivered*
  - *Monitored by the relevant agency.*
- *The adequacy of the framework of operational policies and procedures applicable to the care and treatment of Mr. Y and whether staff complied with them.*
- *The competencies of staff involved in the care and treatment of Mr. Y and the adequacy of the supervision provided for them.*

- *The internal investigation completed by Sussex Partnership NHS Foundation Trust and the actions that arose from this.*
- *The Trust clinical governance and assurance systems as they relate to care and treatment provided to Mr. Y, this in particular regard to:*
  - *Audit*
  - *Clinical supervision*
  - *Clinical leadership*
- *Any other matters that the investigation team considers arise out of, or are connected with, the matters above.*

2. To examine the adequacy of the collaboration and communication between all the agencies involved in the care and treatment of Mr. Y, or in the provision of services to him, including Sussex Partnership NHS Foundation Trust and relevant agencies and GP services.

3. To prepare a written report that includes recommendations to the strategic health authority so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.

Approach

The investigation team will conduct its work in private and be expected to take as its starting point the Trust's internal investigation supplemented, as necessary, by access to source documents and interviews, as determined by the team. The team is encouraged to engage relatives of Mr. Y and his wife and any relevant staff in the inquiry process.

The team will follow good practice in the conduct of interviews by, for example, offering the opportunity for interviewees to be accompanied and giving them the opportunity to comment on the factual accuracy of their interview transcript.

Timetable

The precise timetable will be dependent on a number of factors including the availability of Mr. Y's clinical records, the investigation team's own assessment of the need for information and the number of interviews necessary. The team is asked to have completed the inquiry, or a substantial part of it, within six months of starting its work. Monthly reports on progress should be provided to NHS South East Coast.

Publication

The outcome of the investigation will be made public. The nature and form of publication will be determined by NHS South East Coast. The decision on publication will take account of the views of the relatives and other interested parties."

It should be noted that at the time of his death, and of the killing of his wife, Mr. Y was no longer a patient with the Sussex Partnership NHS Foundation Trust having transferred his care and treatment to The Priory. The powers of *EL(94)27, LASSL(94) 4* were not thought by NHS commissioners to extend to the independent sector in cases where the service user has commissioned their own care and treatment under private funding arrangements. For this

reason no Investigation has been conducted into the care and Treatment provided by The Priory which is an independent sector provision and which was not funded by any NHS contribution.

3. The Independent Investigation Team

Selection of the Investigation Team

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

Investigation Team Leader

Dr. Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service and Investigation Nurse Member and Team Leader

Investigation Team Members

Dr. David Somekh	HASCAS Health and Social Care Advisory Service Associate and Consultant Psychiatrist Member of the Team
Dr. Len Rowland	Director of Research and Development, HASCAS Health and Social Care Advisory Service and Clinical Psychologist Member of the Team

Support to the Investigation Team

Mr. Greg Britton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Ms. Fiona Shipley	Transcription Services

Independent Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

4. Findings of the Independent Investigation

The Independent Investigation Team identified 12 thematic issues that arose directly from analysing the care and treatment that Mr. Y received from the Sussex Partnership NHS Foundation Trust. These thematic issues are set out below.

1. **Diagnosis.** This is a case where diagnosis, or the lack of it, played a significant role in the failure to appreciate risk. Mr. Y was assessed as having an acute stress reaction and pathological jealously. Mr. Y's condition was not assessed in the context of his psychiatric history and the formulation did not acknowledge the chronic nature of his mental health problems.

- ***Service Issue One. The lack of diagnostic formulation meant that an incomplete picture of Mr. Y emerged which was based largely on his own unreliable account. During this period the Trust did not require older people's services to develop a formulation as part of an ongoing risk assessment process and in the case of Mr. Y this served to minimise the degree of risk that he presented.***

2. **Medication and Treatment.** This appeared to have been appropriate considering the short period of time that Mr. Y was a patient with the Trust.

3. **Use of the Mental Health Act (1983 and 2007).** Mr. Y was detained twice under the Act whilst a patient with the Trust, once on Section 5(4) and once on Section 5(2), however he was transferred to The Priory without a Mental Health Act assessment being conducted. Considering that he had been detained a more in depth assessment was indicated. However this was made problematic by the fact that Mr. Y agreed to stay in hospital as a voluntary patient thereby obviating the need for an assessment under the Act. Whilst this thinking was logical it rather 'side stepped' Mr. Y's ongoing risk to both self and to others should he decide that he no longer wished to receive secondary care services.

4. **Care Programme Approach (CPA).** Mr. Y was a patient with the Trust for a total of eleven days. It is not possible to assess the quality of the CPA he received during this time.

5. **Risk/Clinical Assessment.** At the time of the incident the Trust's guidance relating to risk assessment and management was subsumed into the CPA policy and was not specifically developed to provide guidance about assessment and formulation. MARAC processes were not developed at this time therefore Mr. Y's threat to kill his wife was not assessed in the light of the risk that he presented to her and no protective measures with the police were jointly put into place.

Most of the time Mr. Y appeared to be calm and charming and the risk to either himself or to his wife did not appear to be genuine; staff described them as *"fantasies."* However based on the fact that he had made a serious attempt on his life and had been detained under the Mental Health Act it would have been good practice to have undertaken a full risk assessment instead of the simple risk screen which was instead utilised. This constituted a failure to provide an adequate level of care.

- ***Service Issue Two. Poor Trust risk assessment and management systems meant that Mr. Y did not receive a robust risk assessment in the context of his diagnostic formulation. This meant that his levels of risk were neither identified nor managed sufficiently whilst at the NHS Trust, and communication was not managed appropriately at the point of his transfer to The Priory.***

- ***Service Issue Three. Trust procedures regarding communication with the police were unclear and under developed and could not ensure that the concerns about Mr. Y that were made known to the NHS were passed on and managed in an appropriate and timely manner.***

6. **Referral, Admission, Transfer and Discharge Planning.** Mr. Y was admitted appropriately to an inpatient facility following his unsuccessful suicide attempt. Once on the Harold Kidd Unit it was evident that Mr. Y presented in an unusual manner for a person normally treated in an older person's facility. It became evident that Mr. Y was not happy on the unit and wanted to leave.

   The NHS Trust Consultant Psychiatrist attempted to have Mr. Y referred to the forensic service for an emergency assessment. This attempt was to fail and Mr. Y was not seen by the service. There was an apparent lack of system for response to urgent forensic referrals despite recommendations form an earlier serious untoward incident report.

   Both Mr. Y and his family wanted a transfer to The Priory to take place. This was duly arranged. However whilst concerns had been raised about Mr. Y on the Harold Kidd Unit a robust set of assessments had yet to be undertaken prior to the transfer and no formulation had been made. Specific information about the levels of risk that Mr. Y presented with was not adequately communicated to The Priory. Therefore the transfer represented a transition where continuity was lost and important information did not travel with the patient.

- ***Service Issue Four. At the time Mr. Y received his care and treatment from the Trust all adults above the age of 65 years were placed with the older peoples' service. This occurred regardless of clinical need and presentation. Mr. Y found himself in a facility which could not provide the level of assessment and management that he needed and one which both he and his family found to be inappropriate for him, hence wanting him to be transferred to The Priory.***

- ***Service Issue Five. Referral processes for emergency assessment with forensic services did not operate in a timely manner leaving the NHS Trust Consultant Psychiatrist without access to a specialist second opinion.***

- ***Service Issue Six. The transfer process between the NHS Trust and The Priory was not managed well in that professional communication was limited and no copy of Mr. Y's clinical records were sent. This meant that an incomplete picture of Mr Y was given and continuity lost.***

7. **Service User Involvement in Care Planning and Treatment.** Mr. Y appeared to have been involved fully in his care and treatment and his wishes and needs were taken into full account during his time with the Trust.

8. **Carer Involvement.** Mr. Y was with services for a very short interval of time, and it is probable that had he been engaged with the service longer carer issues would have been addressed more fully. However it is of note that despite Mr. Y's children and wife voicing their concerns about his violence and levels of risk their concerns appear not to have been addressed. The prevailing thought was that Mr. Y's clearly articulated plans of violence were nothing more than a fantasy. The risks to the wife regarding domestic violence were not addressed. The internal investigation found that processes for working with the police at this time were weak. This contributed to the family's vulnerability.

9. **Documentation and Professional Communication.** The standard of written documentation appears to have been of a good standard. However the level of professional communication with The Priory and the GP were not of a standard which would have ensured a suitable continuity of care.

- ***Service Issue Seven. During the period in which Mr. Y received his care and treatment from the NHS Trust there were no protocols in place to inform practitioners how best to liaise with the both the police and the private sector in relation to reporting ongoing concerns about the service users in its care. This served to prevent important information about Mr. Y from being shared in a timely manner with services which could have ensured further assessment was made and the necessary management plans put into place.***

10. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** At the time Mr. Y received his care and treatment from the Trust there was no dedicated clinical risk assessment and management policy. This was not good practice.

- ***Service Issue Eight. The Trust did not have in place sufficiently robust evidence-based policy guidance to direct clinical staff. This impacted upon the quality of the risk assessment that Mr. Y received and upon communication and liaison processes with the police and The Priory.***

11. **Clinical Governance and Performance**. It is difficult to understand how clinical governance practices worked within the Trust at the time of the incident due to the passage of time. However it was the conclusion of the Independent Investigation Team that clinical governance services at the present time are robust and fit for purpose.

12. **Summary of the Management of the Care and Treatment of Mr. Y.** Mr. Y's admission to the Harold Kidd Unit failed to provide an appropriate level of assessment in the context of the risk that he presented. The Independent Investigation Team did not however find any causal or contributory factors linked to the deaths of Mr. and Mrs. Y as Mr. Y's care and treatment continued after his discharge from the Harold Kidd Unit and there was opportunity for assessment and management processes to be developed further, and that any act or omission on the part of the NHS Trust did not in itself lead to a situation that could not have been mitigated against within the interval of time between Mr. Y's discharge and the deaths of both him and his wife.

5. Conclusions

Care and Treatment

Mr. Y was appropriately admitted as an informal patient following an unsuccessful suicide attempt. Clinical staff could not identify any signs of a mental illness and even though Mr. Y went on to be detained on a Section 5(4) and then a Section 5(2), because he tried to leave the ward, he agreed to be treated as a voluntary patient and appeared to have recovered from his acute distress. Both Mr. Y and his family wanted him to be admitted to The Priory so that he could continue his recovery before returning home and there appeared to be no clinical reason why this should not take place. However the ensuing emphasis upon his transfer seemingly displaced the focus away from the risk that Mr. Y posed to his wife, whether it related to a mental illness or not.

Mr. Y required a more in-depth level of diagnostic formulation and risk assessment than he received. It was known that:

- he had consistent delusions about his wife being unfaithful to him over a 46-year period;
- he had made a serious attempt on his own life as a consequence of being told recently that his wife had not been a virgin at the time he met her;
- he had required detention under the Act;
- he had been voicing his intention to kill his wife in the context of his obsessional thoughts and feelings of intense jealousy;
- his family came forward with a history of his persistent physical violence towards his family;
- his children and wife believed that he was serious in his threat to kill her and felt so afraid that they notified the police.

Mr. Y's Trust-based treating team were concerned and consequently a referral to forensic services was made. However in the absence of a coherent diagnostic and risk formulation no robust treatment strategy was developed once the forensic service referral was blocked and Mr. Y's transfer to The Priory was progressed.

Mr. Y's case appeared to have been unusual for two main reasons:

- he wished to be transferred to The Priory and was self funding;
- he was placed within the older adult service, but at only 66 years presented with the problems and risks usually associated with an adult of working age.

The treating team also appeared to have been caught up in a series of contradictions.

1. Mr. Y was initially referred to the Harold Kidd Unit because he was depressed and had attempted suicide, but as time went by he was voicing his intent to kill his wife rather than to take his own life.
2. Mr. Y was charming and articulate, but his family said he was manipulative and dangerous and not to be trusted.
3. Mr. Y needed to be detained under the Act because he wanted to leave the ward but stated that he was happy to stay on the ward as voluntary patient hence obviating the need for full Mental Health Act assessment.

4. Mr. Y wanted to leave Trust-based inpatient services was happy to be admitted to The Priory.

The situation was undoubtedly complex. However a case such as this requires robust formulation and a management strategy. It was evident that a series of processes and systems failed to operate effectively in the care and treatment of Mr. Y. These were:

- risk assessment and diagnostic formulation;
- forensic service referral;
- professional communication and transfer liaison;
- family protection procedures and police notification.

Summary

Mr. Y's admission to the Harold Kidd Unit failed to provide an appropriate level of assessment and management in the context of the risk that he presented. The Independent Investigation Team did not however find any causal or contributory factors linked to the deaths of Mr. and Mrs. Y and any acts or omissions on the part of the NHS Trust. Mr. Y's care and treatment continued after his discharge from the Harold Kidd Unit and there was opportunity for assessment and clinical management processes to be developed further, this means that any acts or omissions on the part of the NHS Trust did not in themselves lead to a situation that could not have been mitigated against within the interval of time between Mr. Y's discharge and the deaths of both him and his wife.

Regrettably the deaths of Mr. and Mrs. Y were predictable. Mr. Y stated clearly his intentions to kill his wife. It is unusual for a perpetrator of homicide to be so explicit about their plans; consequently once stated such threats should always be taken seriously. However it is not a straight forward task to determine how, or if, the tragedy could have been prevented. In order for something to be preventable it has to be assumed that clinicians and treating teams have:

- the knowledge;
- the opportunity;
- the legal means.

In the case of Mr. Y it was evident that he had made plans to kill both himself and his wife and had shared these plans with his wife and Consultant Psychiatrist 1. Even though he went on to deny he would follow these though, his treating team had the knowledge and his family had no doubts that his threats would be realised.

Mr. Y was an inpatient on the Harold Kidd Unit for eleven days; his treating team therefore had the opportunity to assess him and develop a suitable clinical management approach.

The difficulty however rests with the legal means available to his treating team. No active mental illness could be detected. This meant that detention under the Mental Health Act if Mr. Y decided to discharge himself would not have been possible. This was the reason the referral to the forensic service was made so that Mr. Y could receive a specialist assessment to determine his level of dangerousness and whether he met the criteria for detention under the Act. It cannot be known what the forensic service would have advised had they met with

Mr. Y in December 2007 or if any mental illness or disorder would have been identified. Based upon the clinical judgement of Consultant Psychiatrist 1, who met with Mr. Y on several occasions, no mental illness was present and therefore there were no legal means to intervene. That being the case, in the absence of any other specialist intervention being available within the short window of time needed, the treating team had no choice but to acquiesce to Mr. Y's decision to be transferred to The Priory. The Independent Investigation concluded that at the point of discharge there were no legal means to detain Mr. Y based upon the clinical assessments that had been conducted to date.

At the point of Mr. Y's discharge from the Harold Kidd Unit the police had been notified by the family of his threats to kill his wife and shortly after Mr. Y's admission to The Priory the team there also became aware of the nature of these threats. Whilst the Independent Investigation Team concluded that the NHS Trust treating team should have been more proactive and sought to communicate and liaise with both the police and The Priory it cannot be known how either of these other stakeholders would have reacted or would go on to manage the case. The Independent Investigation Team concluded that, whilst the clinical team from the Sussex Partnership NHS Foundation Trust could have managed aspects of the care and treatment of Mr. Y more effectively, it could not have been expected to have prevented the events of 23 December 2007.

6. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Sussex Partnership NHS Foundation Trust to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

The Executive Directors of the Sussex Partnership NHS Foundation Trust had the opportunity to review the recommendations required for this case at both the preliminary feedback stage and during the factual accuracy checking stage. The Trust should be given recognition for the work that it has put into this process and the progress that it has already made. The HASCAS Independent Investigation Team recognises the fact that an interval of six years has passed since the time of the deaths of Mr. and Mrs. Y and the writing of this report. It is evident that Sussex-based services have changed significantly during this time and the recommendations have been set with this in mind.

6.1. Diagnosis

- ***Service Issue One. The lack of diagnostic formulation meant that an incomplete picture of Mr. Y emerged which was based largely on his own unreliable account. During this period the Trust did not require older people's services to develop a formulation as part of an ongoing risk assessment process and in the case of Mr. Y this served to minimise the degree of risk that he presented.***

Recommendation One
The Trust will ensure that all clinical policies and procedures are amended to instruct clinicians of the importance of providing a differential diagnosis where indicated as clinically appropriate. These amendments will also include instructions as to the importance of providing a clear formulation and the guidance for doing so.

6.2. Risk/Clinical Assessment

- ***Service Issue Two. Poor Trust risk assessment and management systems meant that Mr. Y did not receive a robust risk assessment in the context of his diagnostic formulation. This meant that his levels of risk were neither identified nor managed sufficiently whilst at the NHS Trust, and communication was not managed appropriately at the point of his transfer to The Priory.***

- ***Service Issue Three. Trust procedures regarding communication with the police were unclear and under developed and could not ensure that the concerns about Mr. Y that were made known to the NHS were passed on and managed in an appropriate and timely manner (please recommendations under section 17.3. below).***

Progress made by the Trust to-date

The Trust has developed a stand-alone risk policy which provides additional guidance to that previously offered by the CPA policy. Significant work has been undertaken to develop risk tools and all services are required to use the Trust comprehensive risk assessment; secure and forensic services may also use the HCR-20. This means that each service user has risk assessed in a comprehensive manner. This implementation has been supported by a comprehensive training programme and compliance audit process.

Recommendation Two

The Trust will conduct an audit of its risk assessment processes within six months of the publication of this report to determine:

- **the compliance of all clinicians in the completion of risk assessments for every service user;**
- **the compliance of all clinicians in the development of risk management plans;**
- **the compliance of all clinicians in completing all risk assessment documentation and not using drafts in place of comprehensive records.**

6.3. Referral, Transfer and Discharge Planning

- ***Service Issue Four. At the time Mr. Y received his care and treatment from the Trust all adults above the age of 65 years were placed with the older peoples' service. This occurred regardless of clinical need and presentation. Mr. Y found himself in a facility which could not provide the level of assessment and management that he needed and one which both he and his family found to be inappropriate for him, hence wanting him to be transferred to The Priory.***

- ***Service Issue Five. Referral processes for emergency assessment with forensic services did not operate in a timely manner leaving the NHS Trust Consultant Psychiatrist without access to a specialist second opinion.***

- ***Service Issue Six. The transfer process between the NHS Trust and The Priory was not managed well in that professional communication was limited and no copy of Mr. Y's clinical records were sent. This meant that an incomplete picture of Mr Y was given and continuity lost.***

Progress made by the Trust to-date

A protocol for referrals between Mental Health and Secure and Forensic Services has been developed. This ensures that referrers to the service understand what responses should be and

to resolve any difficulties that may occur. Disagreements and persistent difficulties are now resolved at Clinical Director level.

There has been an increase in the number of secure and forensic practitioners and services are now co-located with mainstream mental health services.

Services managed by the Trust today are 'ageless' in that each service user is directed according to diagnostic need rather than by age. Had Mr. Y been a patient with the Trust today he would most likely have been admitted to an adults of working age facility which would have been better placed to assess him and would have provided a more appropriate clinical environment.

Recommendation Three

The Trust will conduct an audit to ascertain the effectiveness of its new arrangements. These audits should be conducted within six months of the publication of this report and be developed in collaboration with commissioners. The Trust should:

- **audit all referrals made to the forensic service over the past 18 months to ascertain service response against the new protocol;**
- **review all complaints about accessing forensic services with a particular focus on those referred to Clinical Director level;**
- **ascertain the success of the 'ageless' service approach by surveying service users and consulting with primary care.**

6.4 Documentation and Professional Communication

- ***Service Issue Seven. During the period in which Mr. Y received his care and treatment from the NHS Trust there were no protocols in place to inform practitioners how best to liaise with the both the police and the private sector in relation to reporting ongoing concerns about the service users in its care. This served to prevent important information about Mr. Y from being shared in a timely manner with services which could have ensured further assessment was made and the necessary management plans put into place.***

Progress made by the Trust to-date

The Multi-Agency Risk Assessment Conference (MARAC), which is part of a coordinated community response to domestic abuse, is now working well. Trust personnel attend monthly meetings and working relationships with the Police have been developed. The Trust has been able to take several problematic cases through this route. Had Mr. Y been a patient with the service todays concerns would have been channelled via this process.

The Trust has developed a memorandum of understanding with local police services. This memorandum defines how communications should be managed and how concerns should be escalated. There is a named police liaison officer identified, the Trust Chief Executive has regular meetings with senior officers and there is also an annual conference to ensure that joint practice is examined.

Recommendation Four

The Trust should audit all new processes for effectiveness within six months of the publication of this report. The audit should ensure that Trust personnel attend MARAC meetings on a regular basis and should also serve to review how many cases have been referred to the police by the Trust and the consequent outcomes and lessons for learning.

6.5. Adherence to Local and National Policy and Procedure

- ***Service Issue Eight. The Trust did not have in place sufficiently robust evidence-based policy guidance to direct clinical staff. This impacted upon the quality of the risk assessment that Mr. Y received and upon communication and liaison processes with the police and The Priory.***

Progress made by the Trust to-date

The Trust has made significant progress to-date to ensure that new policies and procedures have been developed and are in place to provide guidance to clinical staff. The monitoring of their efficiency will be undertaken by the implementation of the recommendations set out above.

6.6. Other Progress made by the Trust To-date

A great deal of work has been undertaken to ensure lessons are learned from serious untoward incidents. There are several processes currently in place that allow the Trust to learn from these incidents. Usually there is an immediate debriefing of the whole team and then often a later debriefing as well, sometimes with a facilitator who is usually a psychologist. In terms of the medical staff the Trust has been encouraging people to use their Continuing Professional Development groups to discuss any serious incidents and also to present cases as a case conference in a multidisciplinary setting.