Independent Investigation

into the

Care and Treatment Provided to Mr. X

by the

Avon and Wiltshire Mental Health Partnership NHS Trust

Commissioned by

NHS South West
Strategic Health Authority

Independent Investigation: HASCAS Health and Social Care Advisory Service

Report Author: Dr Len Rowland

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1. Preface to the Independent Investigation Report

The Independent Investigation into the care and treatment of Mr. X was commissioned by NHS South West, The Strategic Health Authority (SHA) pursuant to *HSG (94)27*[1]. The Investigation was asked to examine the circumstances associated with the death of Mr. C on the 11/12 April 2008.

Mr. X received care and treatment for his mental health condition from the Avon and Wiltshire Mental Health Partnership NHS Trust (the Trust) between May 2005 and 8 April 2008. It is the care and treatment that Mr. X received from this organisation that is the subject of this Investigation.

Investigations of this sort aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations.

We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted at all times in a professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

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

The relatives of Mr. C were contacted by the SHA and invited to contribute to the Independent Investigation. They indicated that they did not want to be part of the Investigation but preferred to discuss the findings of the Investigation when it was completed. The SHA intends to invite Mr. C's family to discuss the Independent Investigation report prior to it being published.

The SHA wrote to the family of Mr. X inviting them to contribute to the Investigation. However at the time of completing this report Mr. X's family had not responded to this invitation.

2. Condolences to the Family and Friends of Mr. C.

The Independent Investigation Team would like to extend its condolences to the family and friends of Mr. C.

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3. Incident Description and Consequences

Mr. X had contact with the Children's Mental Health Services from around the age of six. On one occasion he was admitted to a paediatric ward for assessment following an overdose.

In 2005 Mr. X presented to the Accident and Emergency Department at his local hospital on two occasions following him taking overdoses. He was diagnosed as suffering an adjustment disorder and was discharged to the care of his GP. The Community Mental Health Team (CMHT) contacted Mr. X suggesting that he make contact with them. He did not respond to this offer.

In 2006 Mr. X was detained on a Section 136 of the Mental Health Act (1983) following an argument at his grandmother's house. Mr. X said that he had been drinking alcohol but the custody sergeant reported that he did not appear to be drunk. He was assessed at the local police station and found not to have a mental illness serious enough to warrant a hospital admission. He declined offers of support and was discharged.

Mr. X was again detained on 26 March 2008 following an argument at his grandmother's house. His grandmother had been frightened by his behaviour and called the police. When Mr. X was assessed he reported that he regularly drank heavily and used illicit drugs, particularly cannabis. He also reported that his grandmother had suggested that he was hearing voices but he denied that this was the case. It was concluded that Mr. X was not showing any evidence of mental illness. He was discharged and given the contact details of the drug counselling service.

On 31 March 2008 Mr. X contacted the Adult Mental Health services. He said that he was concerned that his use of drugs and alcohol had damaged his mental health and he feared that he was suffering from schizophrenia. He was seeking support to prevent his mental health deteriorating. Mr. X reported that he was abstaining from drugs and alcohol at that time.

Mr. X was displaying a number of symptoms consistent with a diagnosis of psychosis and it was concluded that he was suffering from a drug induced psychosis or hypomania. The

Community Psychiatric Nurse (CPN) who assessed Mr. X discussed his formulation with Mr. X's GP and with the Community Mental Health Team (CMHT) and arranged to see him again a week later to assess if his mental state had improved as the effects of the drugs and alcohol wore off. A risk assessment was carried out and Mr. X was rated as not posing a risk to others, though it was noted that he had had problems in controlling his anger in the past.

Mr. X was again detained by the police on 2 April 2008. He was described as expressing bizarre and psychotic type thoughts. He attended his review appointment on 8 April 2008 accompanied by his grandmother. The CPN and the Mental Health Team Leader, who assessed Mr. X on this occasion, concluded that Mr. X's mental state was much improved. This improvement in Mr. X's mental state appeared to support the diagnosis of a drug induced psychosis and Mr. X was discharged. Mr. X's grandmother's opinion of his mental state and behaviour was not sought.

At this time Mr. X was living with a friend, Mr. C, who was to be Mr. X's victim. Mr. X told the CPN that he was having problems with Mr. C and created the impression that he was being exploited by him.

On 12 April 2008 Mr. X was arrested on suspicion of murder. He was assessed at Salisbury police station. A preliminary drug screen was carried out which suggested that Mr. X had been smoking cannabis. He reported that he had been drinking heavily on 11 April. The conclusion of the assessment was that Mr. X was suffering from a drug induced psychosis and was not fit to be interviewed by the police.

Mr. X was assessed again on 14 April and though his mental state had improved it was felt that he was still not fit to be interviewed. When he was assessed on 15 April 2008 it was concluded that Mr. X had an eccentric way of expressing himself but that he was not, at that time, mentally ill and was fit to be interviewed by the police.

On 24 April 2008 the Regional Laboratory for Toxicology reported that the urine sample that had been taken from Mr. X on 12 April 2008 was negative for all the drugs they had tested for, including cannabis.

Mr. X was remanded to HMP Reading where he continued to display symptoms consistent with a diagnosis of psychosis and was prescribed anti-psychotic medication. He was transferred to HM Young Offenders Institution Feltham on 18 April 2008 where he remained until 30 June 2008. During this time his mental state gradually stabilised. However, Mr. X was transferred to a medium secure unit on 30 June 2008 on Section 48/49 of the Mental Health Act. A forensic report prepared in August 2008 concluded that Mr. X was suffering from a bipolar affective disorder (manic type). A further report in October 2008 also identified bipolar affective disorder as the most probable diagnosis but also identified drug and alcohol dependency misuse and a personality disorder as possible differential diagnoses. This report noted that it was possible that Mr. X's illness was continuing to develop and that he might develop a psychotic illness such as schizophrenia.

Mr. X was convicted of manslaughter on the grounds of diminished responsibility at Winchester Crown Court in November 2008. He was sentenced to be detained for an indeterminate period under sections 37/41 of the Mental Health Act (1983).

4. Background and Context to the Investigation (Purpose of Report)

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South West, the Strategic Health Authority (SHA), to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 4, issued in 1994 to all commissioners and providers of Mental Health services. In discussing 'when things go wrong' the guidance states:
"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved*".

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist Mental Health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimize the possibility of a reoccurrence of similar events, and to make recommendations for the delivery

of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what would have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interests of the wider public. This case has been fully investigated by an impartial and independent Investigation Team.

5. Terms of Reference for the Independent Investigation

The Terms of Reference for the Independent Investigation were set by South West Strategic Authority (the SHA). They are as follows:

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

- to evaluate the mental health care and treatment including risk assessment and risk management;
- to identify key issues, lessons learnt, recommendations and actions by all directly involoved in health services;
- to assess progress made on the delivery of action plans following the Internal investigation;
- to identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies.

2. Terms of Reference

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

- Review any communication and work with families of victim and perpetrator.

- Establish appropriate contacts and communications with family/carers to ensure
- appropriate engagement with the Internal Investigation process.

3. Outcomes

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

6. The Independent Investigation Team

Selection of the Investigation Team

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

Investigation Team Leader and Chair

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

Investigation Team Members

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

Support to the Investigation Team

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

7. Investigation Methodology

7.1 Classification of Independent Investigations

Classification of Independent investigation

Three types of Independent Investigation are commonly commissioned, these are:

- Type A – a wide-ranging investigation carried out by a team examining a single case;
- Type B – a narrowly focused investigation by a team examining a single case or a group of themed cases;
- Type C – a single investigator with a peer reviewer examining a single case.

Each of these categories has its own strengths which make it best suited to examining certain cases. This Investigation was commissioned by NHS South West, the Strategic Health Authority as a Type C Independent Investigation.

A Type C review is principally a documentary analysis review which utilises:

- clinical records;
- Trust policies and procedures;
- the Trust Internal Investigation report;
- the Trust Internal Investigation archive.

A Type C review does not seek to reinvestigate a case from the beginning if it can be ascertained that the internal review was robust. In a Type C review the Independent Investigation is charged with building upon any investigative work that has already taken place.

7.2 Consent

Mr. X gave consent for the release of his clinical records on 22 October 2010.

7.3 Communication and Liaison

7.3.1 Communication with the Family of the Victim and of Mr. X.

The SHA wrote to the family of Mr. X inviting them to contribute to the Independent Investigation. However at the time of writing the family has not yet responded to this invitation.

The SHA also wrote to the family of Mr. C inviting them to contribute to the Independent Investigation. They indicated that they preferred only to be informed of the findings and recommendations of the Independent Investigation.

7.3.2 Communications with the Avon and Wiltshire Mental Health Partnership NHS Trust

The SHA wrote to the Avon and Wiltshire Mental Health Partnership NHS Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. X.

The Independent Investigation Team worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished;
- on 23 November 2010 the Chief Executive of HASCAS Health and Social Care Advisory Service and the Chair of Independent Investigation met the nominated Trust liaison person, and representatives of the SHA, the Local Authority, the Primary Care Trust and the police. The purpose of the meeting was to clarify the arrangements for the forthcoming Independent Investigation;
- a workshop for witnesses to the Independent Investigation was held on 6 May 2011. The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible;
- on 14, 15, and 16 June 2011 interviews were held at the Avon and Wiltshire Mental Health Partnership NHS Trust Headquarters in Chippenham, Wiltshire. The Investigation Team were afforded the opportunity to interview witnesses and meet with the Trust Corporate Team;

- on 9 November 2011 a meeting was held between the Chair of the Independent Investigation, CEO of the HASCAS Health and Social Care Advisory Service and the Trust Corporate Team, in order to discuss the findings and to invite the Trust to contribute to the recommendation development.

7.3.3 Communication with Wiltshire Primary Care Trust

The Independent Investigation Team met with representatives of the Wiltshire Primary Care Trust on 8 November 2011.

7.4 Witnesses called by the Independent Investigation

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon processes.

Table 1: Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
14 June 2011	**Trust** • Executive Director: Nursing, Compliance, Assurance & Standards; • Clinical Director: Adult acute Inpatient Services; • Clinical Director: Specialist Drug and Alcohol Services; • Clinical Director: Service Redesign.	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist, • Investigation Team, Nurse • Investigation Team, Social Worker • In attendance: Stenographer
14 June 2011	**Trust** • Rural Team CPN • Consultant Psychiatrist	**Investigation Team,** • Investigation Team Chair,

	• Service Manager	Clinical Psychologist, • Investigation Team, Nurse • Investigation Team, Social Worker • In attendance: Stenographer
14 June 2011	**Trust** • Author 1 of the Internal Investigation report • Author 2 of the Internal Investigation report	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist, • Investigation Team, Nurse • Investigation Team, Social Worker • In attendance: Stenographer
15 June 2011	**Trust** • Medical Director	**Investigation Team,** • Investigation Team Chair, Clinical Psychologist, • Investigation Team, Nurse • Investigation Team, Social Worker In attendance: Stenographer

7.5 Salmon Compliant Procedures

The Investigation Team adopted Salmon compliant procedures during the course of their work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a colleague, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign;

(h) that they will be able to access copies of the clinical records both before and during their interviews to refresh their memory.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

7.6 Independent Investigation Team Meetings and Communication

7.6.1 Initial Team Processes

The Independent Investigation Team Members were recruited following an examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood, the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual' manner and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general questions that they could expect to be asked.

7.6.2 The Team met on the following occasions:

31 May 2011. On this occasion the Team met in order to plan the interviews with the Trust Senior Management Team and Clinical Witness.

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

7.6.3 Other Meetings and Communications

Other communications were maintained via email and telephone in order to complete the Investigation report and to develop recommendations.

7.7 Root Cause Analysis (RCA)

The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.
RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this, causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Decision Tree and the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team avoids generalisations and seeks to use findings of fact only. It should also be noted that it is not practical or reasonable to search

indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

7.8 Anonymity

The staff of the Avon and Wiltshire Mental Health Partnership NHS Trust have been referred to in this Investigation report by their role titles.

The individual whose care and treatment is the subject of this report has been referred to throughout as Mr. X. The victim has been referred to throughout this report as Mr. C.

8. Information and Evidence Gathered (Documents)

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

1. Mr. X's Avon and Wiltshire Mental Health Partnership NHS Trust records.
2. Mr. X's GP records.
3. The Avon and Wiltshire Mental Health Partnership NHS Trust Internal Investigation Report.
4. Avon and Wiltshire Mental Health Partnership NHS Trust action plans.
5. Secondary literature review of media documentation reporting the death of Mr. C.
6. Independent Investigation Witness Transcriptions.
7. Avon and Wiltshire Mental Health Partnership NHS Trust Clinical Risk Clinical Policies, past and present.
8. Avon and Wiltshire Mental Health Partnership NHS Trust Incident Reporting Policies.
9. Avon and Wiltshire Mental Health Partnership NHS Trust *Being Open* Policy.
10. Avon and Wiltshire Mental Health Partnership NHS Trust Operational Policies.
11. Healthcare Commission/Care Quality Commission Reports for Avon and Wiltshire Mental Health Partnership NHS Trust services.
12. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006.
13. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005.

9. Profile of the Avon and Wiltshire Mental Health Partnership NHS Trust

9.1 The Avon and Wiltshire Mental Health Partnership NHS Trust

The Avon and Wiltshire Mental Health Partnership NHS Trust provided the following description of its organisation and the services it provides.

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

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

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

- Specialist Drug and Alcohol Service SBU;
- Adults of Working Age SBU;
- Liaison and Later Life SBU;
- Specialised and Secure Services SBU.

The Trust identifies its strategic objectives as follows:

1. To be the organisation of choice for service users, staff and commissioners, providing a comprehensive range of services in primary, secondary and tertiary care settings, across our existing geographical area.

2. To provide person-centred services that intervene early, are highly accessible, focused on recovery, are high quality and leading edge.

3. To be a financially sustainable Trust through robust financial management, use of innovative technologies efficiency and increased productivity.

Avon and Wiltshire Mental Health Partnership NHS Trust provides a full range of Mental Health services in Salisbury, all of which are based together on the one site at Fountain Way. These include the following
South Wiltshire Community Mental Health Team;
South Wiltshire Assertive Outreach Team;
Beechlydene Acute Inpatient Services;
South Wiltshire Psychological Therapy service;
South Wiltshire IAPT (improved access to psychological therapies- primary care).

Since 2008 the services have worked hard to reduce the number of service users who are admitted to hospital for acute care and the present average length of stay in hospital of below 28 days reflects this hard work. The crisis and home treatment team works 24 hours a day over the seven-day week and there are plans to extend the size of this team in the next few months to make home treatment available to many more service users in the community. This team also provides a gate-keeping service to the inpatient beds ensuring that every service user referred for admission to hospital is assessed prior to admission to ascertain whether home treatment and care would be a preferred option. Similarly the team will work with service users who have been admitted to hospital to work towards a timely and comfortable discharge process from hospital back into the home environment.

The community mental health team In South Wiltshire has been one single team since 2008. It was created from the two smaller teams. This has enabled the team to work more flexibly and make better use of the combined manpower and resources across the area. As part of this

amalgamation the medical model of working has been altered, the inpatient unit now has a dedicated Inpatient Consultant psychiatrist and the community teams have 2.5 whole time equivalent consultant psychiatrists who do only community based work.

The community service is intended for individuals with the full range of mental health problems. The integrated multi-disciplinary team approach provides a single point of entry into secondary Mental Health services. Most people treated by the CMHT will have time-limited disorders that can benefit from specialist interventions and will be referred back to their GPs when their condition has improved. A substantial minority of people, with more complex and enduring needs, will remain with the team for ongoing specialist treatment, care and monitoring for a longer period of time.

Those individuals who have very specialised needs which require admission to hospital on a regular basis may have care provided by the assertive outreach team who will work very closely with service users over a lengthy period to try to reduce the need for admission to hospital.

10. Chronology of Events

10.1 This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. X and on his care and treatment from Mental Health services.

10.2 Chronology

Chronology

At least between **May 1994** and **November 2003** Mr. X was in contact with Children's Mental Health services.[1]

On **22 September 2003** Mr. X was admitted to a paediatric ward following an overdose. He had also been drinking alcohol and smoking cannabis. At this time Mr. X was living with his grandmother. He was reported as getting drunk every two weeks and smoking cannabis with his friends.[2]

On **8 May 2005** Mr. X attended the Accident and Emergency Department of Salisbury District Hospital after impulsively taking an overdose of his grandmother's medication. He was assessed by a Senior House officer and a CPN from the Intensive Home Support Service (IHSS).

Mr. X reported that he had been accused by members of his family of stealing money from his grandmother, with whom he lived. He denied that he had stolen any money, although he admitted that he had been guilty of such behaviour in that past.

[1] Forensic Records p.16
[2] Ibid

While Mr. X was waiting for the police to arrive he became angry, frustrated and felt helpless. He had kicked and pulled at cupboards and, on discovering his grandmother's medication, had impulsively taken this. He reported that his aim was to escape from a difficult situation. He had no thoughts of harming or killing himself.

Mr. X reported that he had frequent arguments with his mother and described their relationship as a parent /child relationship. He reported that he had been a boisterous, nasty character at school and had received counselling as a result of his behaviour, though he could give no details.

He said that he had last drunk alcohol four weeks previously. He occasionally smoked cannabis and had tried other illicit substances in the past. He also reported that he had received warnings from the police for theft and shoplifting.[3]

The Avon and Wiltshire Mental Health Partnership NHS Trust's risk screening form was completed at this assessment. Mr. X was described as follows:

	Past	Current
Suicide risk:	No	Yes
Risk to others:	No	No
Risk from others	Yes	No

It was noted that in the past Mr. X had abused alcohol and other substances. It was unclear whether he was continuing to misuse drugs. He was identified as displaying some psychiatric symptoms and as showing limited insight.

A number of social risks were identified including: significant debts, lack of stable employment, conflict in personal relationships, difficulties with neighbours, relationship problems and domestic violence.[4] He was assessed as presenting a low risk in all categories, both currently and in the future.

Mr. X was diagnosed as experiencing an adjustment reaction to stress.[5]

[3] Clinical Records, p. 83, 95, 157-159
[4] Clinical Records p. 15
[5] Clinical Records p.95

The identified plan was to discharge Mr. X back to his GP and to provide him with information as to who to contact if he felt anxious or distressed in the future. The Senior House Officer (SHO) wrote to Mr. X's GP on 26 May 2005 informing him of the outcome of this assessment.[6]

Mr. X's next contact with the Mental Health services was on **29 November 2005.** He again presented at the Accident and Emergency Department following an overdose and was assessed by an SHO and a Medical Student.[7]. On this occasion the overdose followed Mr. X splitting up with his girlfriend of one year, although in the course of the assessment he reported that he had been low in mood for some time.

At this time Mr. X was identified as having problems in managing his anger and his personality was described as emotionally unstable and impulsive. It was noted that Mr. X was reporting aggressive thoughts particularly towards his ex-girlfriend's new boyfriend. The question was raised as to whether Mr. X was experiencing delusions of jealousy. He reported that he felt "used" by other people. He also reported that he had received a caution for grievous bodily harm.[8]

Mr. X's view of his problems at this time was that he was depressed. However, he did not want to be prescribed medication but he was willing to accept counselling.

A Trust risk assessment was completed and Mr. X was described as:

	Past	Current
Suicide risk:	Yes	Yes
Risk to others:	Yes	Yes (Particularly ex-girlfriend's current boy friend)[9]
Risk from others	Yes	Yes

Additional risks identified were: alcohol abuse in the past; substance misuse, currently; and Mr. X having limited insight. The social risk identified was: conflict in personal relationships.

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[6] Clinical Records p.157
[7] Clinical Records p. 75ff
[8] Clinical Records p. 79
[9] Clinical Records p.82

Overall Mr. X was rated as presenting a low immediate risk of self harm and a moderate future risk. He was rated as presenting a moderate immediate risk to others and a high future risk "*Depending on patient controlling anger*".[10]

Mr. X was diagnosed as suffering from an 'adjustment disorder' and 'anger management problems'.[11]

The management plan was to:

- *"refer Mr. X to [Crisis Home Treatment Team] IHSS";*
- *"refer him to the primary care counsellor via his GP";*
- *"advised him about the adverse effects of cannabis use";*
- *"provide him with contact details and information regarding anger and stress management programmes at a local centre."*

The SHO wrote to Mr. X's GP on 2 December 2005 informing him of the outcome of this assessment.[12]

On **14 December 2005** the CMHT wrote to Mr. X informing him that if he made no contact with them within the next month he would be discharged. It was noted that he had been contacted by Intensive Home Treatment Team (IHTT) although there is no record of such a contact in Mr. X's notes.[13]

On **13 February 2006,** as Mr. X had not made contact with the CMHT, his file was closed.

On **27 June 2006** Mr. X was detained under a Section 136 of the Mental Health Act (1983). His family had complained about the noise of his music and Mr. X had become angry. The police had been called. Mr. X had left his grandmother's house telling the police he "*wanted to go out with a knife and find the people who I hate and cause them harm"*. [14]

[10] Clinical Records p.21
[11] Clinical Records p.167
[12] Clinical Records p. 166
[13] Clinical Records p. 147
[14] Clinical Records p. 161

Mr. X reported that prior to the argument he had been drinking alcohol. He said that he "*gets out of his face*" every day to *"make life bearable*"[15]. Although the Custody Sergeant reported that Mr. X did not appear to be drunk.

Mr. X said that he felt like the *"black sheep"* of the family; he felt he could never please his family and felt angry towards them. He reported that other young people taunted him and "*he goes out of his way to engineer confrontational situations".*[16]

Mr. X was assessed by an Approved Social Worker and a Section 12 Approved Doctor at 5.45am. They found no mental disorder of a seriousness to warrant hospital detention. The Section 136 was therefore discharged. Mr. X declined offers of support.

It was noted on the Emergency Duty Services (EDS) contact sheet that Mr. X was not known to that service and, having checked with CMHT, he was not known to the Mental Health services.

On **26 March 2008** the EDS was informed that Mr. X had been detained for a public order offence. He was intoxicated. He was assessed the next day, **27 March 2008,** by a Specialist Registrar and an Approved Social Worker.

Mr. X had been arrested for criminal damage at his grandmother's house, where he lived. He had broken a kitchen cupboard, a kitchen door and a remote control. His grandmother had felt frightened and had called the police.[17]

Mr. X's account of the event was that he had returned home feeling tired and had found some *"coke-heads"* in his bedroom taking cocaine. He had become angry with his grandmother for allowing these people into the house. He believed that they stole from her and caused her problems but she could not see this. He had threatened to leave. His grandmother was at first upset by this suggestion but subsequently told him to leave. Mr. X reported that he had been drinking heavily for four years "*to try to blank out problems with nan*".[18]

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[15] Ibid
[16] Ibid
[17] Clinical Records p. 153
[18] Clinical Records p. 153

Mr. X said that his grandmother had suggested that he heard voices but he denied this. He claimed that he had paid for the house in which he and his grandmother lived, using his investments. He said that he did not have a mortgage. He said that he had been self employed but was currently unemployed.

The Specialist Registrar concluded that Mr. X showed no evidence of psychosis; he was cognitively orientated and, although he was very angry, he did not at that time present a significant threat to himself or others. [19]

In her letter to Mr. X's GP the Specialist Registrar concluded:
"Overall I did not feel this young man showed any evidence of mental illness. He was somewhat inconsistent in the history he gave us, however, it appears he is living in a stressful situation at the moment and is appropriately angry about this. He is aware of his alcohol and cannabis misuse and has contact details for ADAS.
We advised him to see yourselves if he had any further concerns regarding his mental health".[20]

Mr. X was discharged. Mr. X's plan on release had been to return to live with his grandmother, however after some discussion he said that he would speak to his mother and discuss returning to live with her.

The Internal Investigation reported that the Police Medical Examiner had reviewed Mr. X on the morning of 27 March 2008 after the effects of alcohol had time to wear off. He found that Mr. X's mental state had not improved and had therefore requested a Mental Health Act assessment.

The allocated Approved Social Worker spoke to Mr. X's GP at 10.15. From a quick review of Mr. X's notes she noted no history of mental health problems but a history of drug and alcohol misuse, and that Mr. X had taken an overdose two years previously. Mr. X's GP offered to make himself available for a Mental Health Act assessment. The Social Worker checked the information about Mr. X on the Trust's electronic record system and on the Rural Team's local electronic records system. From her review of the available clinical notes she

[19] Clinical Records p. 183
[20] Clinical Records p.154

concluded there were no concerns at that time regarding ongoing mental health problems and she found no evidence of later contacts.

The Social Worker contacted the Specialist Registrar (SpR) and asked if she would undertake the Mental Health Act assessment. They decided they would assess the situation before deciding whether to call on the GP. The Social Worker also attempted to contact Mr. X's grandmother without success.

The information that Mr. X had been detained on a public order offence and was being detained at the police station overnight was faxed to the Rural team CMHT at 1.17 on 27 March 2008.

On **31 March 2008** Mr. X presented to the Adult Mental Health ward. He was advised to go to the City Community Health Team base. The City CMHT identified that Mr. X lived in the catchment area of the Rural CMHT and contacted that team. The Rural CMHT agreed to undertake the assessment at the City team base.

The City CMHT Duty referral form noted that Mr. X had referred himself to the Mental Health services. He had reported that he was *"off all drugs"* and had given up alcohol but he feared that he had schizophrenia. He felt that he needed support "*to prevent it again"*.[21]

Mr. X was seen by a CPN from Rural CMHT, who carried out a core assessment. Mr. X told the CPN that his drinking was a problem and that his use of drugs was detrimental to his mental health. Mr. X reported that he was not currently using any illicit drugs. The CPN noted that Mr. X had been detained under section 136 the previous week when he was drunk and disorderly but the section was discharged when Mr. X was sober. It was also noted: *"Some family stressors arguments with grandmother"*[22]

The CPN noted that Mr. X had experienced some paranoia but this had *"gone now that he is clean"*.[23]

[21] Clinical Records p. 73-74
[22] Clinical Records p. 57
[23] Clinical Records p.58

Mr. X's speech was jumbled, he displayed flight of ideas and he expressed some grandiose beliefs such as engaging in a project with a famous pop singer, having a doctorate in science and feeling that he was due a knighthood. His thoughts appeared to be racing but he denied that he was experiencing any hallucinations. His memory and concentration were poor.

Mr. X reported that he had successfully completed his GCSEs and A-levels. He had then gone to College and to Oxford University from where he dropped out. He reported that he had been excluded from junior school for a year for fighting.

It was recognised that Mr. X was not a reliable historian.

The CPN's formulation was that Mr. X was suffering from drug induced psychosis/hypomania. But he also noted that Mr. X had some strange personality traits.

Mr. X's assessment of his needs was that he needed to stop lying. He also realised that his use of drugs and alcohol had caused his problems. It was recorded in this assessment that Mr. X had no forensic history.

Given Mr. X's presentation and the CPN's impression that Mr. X was suffering from a drug induced psychosis or hypomania his plan at this stage was to discuss Mr. X with his GP and to monitor Mr. X's mental state to see if this improved as the effects of the drugs and alcohol wore off.[24]

Given Mr. X's presentation he was unsure whether Mr. X met the criteria for secondary Mental Health services. He planned to discuss Mr. X's case with the Community Mental Health Team.

The CPN completed the Trust's risk assessment. Mr. X was described as:

	Past	Current
Suicide risk:	Yes	No
Risk to others:	No	No (But poor anger control in the past)
Risk from others	No	No.[25]

[24] Clinical Records p.71
[25] Clinical Records p.12-14

Alcohol and substance abuse, and the presence of psychiatric symptoms were identified as risk factors. Employment problems and conflict in personal relationships were identified as social risks. Domestic violence was identified as a past issue but was left blank with respect to current issues.

On the same day the CPN wrote to Mr. X's GP reporting his assessment. He concluded: ...*"I think it is possible he may have suffered a drug induced psychosis. If he remains abstinent this should resolve itself. I would like to see him again and see if this is the case. I will keep you informed of his progress..."*[26] This letter was copied to Mr. X.

On **2 April 2008** Mr. X was sent an appointment letter to see the CPN on 8 April 2008.

On **2 April 2008** an EDS Contact Information Sheet was completed at 23.42. It noted that *"[The Police Medical Examiner was] seeking information about [Mr. X] who is expressing bizarre and psychotic type thoughts. He knows he was assessed on the morning after EDS was contacted on 26/3/08 and wondered what the outcome was. I advised we had no record of that as it would have been an assessment by daytime services and suggested he ring Fountain Way, which he will do."*[27]

The EDS had a record of one previous contact in June 2006 when Mr. X's Section 136 had been discharged.

At 23.56 the Advanced Nurse Practitioner sent an e-mail to the CPN which said:
"The Police Doc called me tonight to enquire on present support for [Mr. X] as he was at the station, I think it was an injunction breach but he wasn't sure. I read him your last assessment letter and said I would let you know".[28]

At 8.19 on **3 April 2008** the EDS Contact sheet from the previous evening was faxed to the Rural CMHT.[29]

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[26] Clinical Records p. 156
[27] Clinical Records p. 144
[28] Clinical Records p.143
[29] Clinical Records p.144

On **8 April 2008** Mr. X **attended** his appointment with the CPN. This appointment was also attended by Mr. X's grandmother and the Rural Community Team Leader. The CPN noted:
"Much improved from last week likely drug induced psychosis now resolving. No delusional or grandiose beliefs. Good insight realises it was cannabis related. A rather rambling account of things, having problems with [Mr. C] his unofficial employer who he is staying with. Seems to be being exploited doing cash in hand work but not willing to be assertive about this. Says he will be homeless from Monday and advised to go to Council about this and claim benefits. He seemed lucid today and is left with various social stressors does not require ongoing CMHT involvement."[30]

There is a letter in Mr. X's notes dated **8 April 2008** from the Specialist Registrar (SpR) to Mr. X's GP reporting the assessment of the 27 March 2008. However there is a postscript to this letter by the Consultant Psychiatrist noting that Mr. X had been arrested on suspicion of having committed a murder on 11/12 April 2008. The Consultant Psychiatrist recorded that he had assessed Mr. X on three occasions over the following four days.[31] Given this postscript it would seem that this letter was not sent to the GP until sometime after 12 April 2008.

On **9 April 2008** the CPN wrote to Mr. X's GP reporting his assessment of 8 April. He informed the GP that Mr. X's mental state was much improved as compared to the previous week. Mr. X recognised that "*he was psychotic and expressing some bizarre beliefs*". He recognised that his mental state was related to his use of cannabis.

The letter also reported that Mr. X had been fined for criminal damage; he had a "*variety of social problems"*; and *"working in an unofficial capacity for a friend, who may be exploiting him"*.

Mr. X was diagnosed as suffering from: *"Drug inducing psychosis (now resolving)"* Mr. X was given advice on benefits, housing and the dangers of using illicit drugs. Given his improvement Mr. X's was discharged from the CMHT case load.[32]

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[30] Clinical Records p.185
[31] Clinical Records p. 153-154
[32] Clinical Records p. 152

On **12 April 2008** Mr. X was arrested on suspicion of murder.

On **12 April 2008** after arresting Mr. X at 16.30 the police requested a Mental Health Act assessment. Mr. X was assessed by the Consultant Psychiatrist, an Approved Social Worker (ASW) and a Section 12 Doctor at Salisbury police station. The Consultant Psychiatrist completed the Trust's core assessment form.[33]

The assessors were informed that a man had telephoned the police in the early hours of the morning making outlandish accusations. The same man made a second, rather confused, telephone call sometime later. The police traced the telephone call and later found a man dead in the river near to where they believed the phone calls had been made. Mr. X was found wandering near-by later in the afternoon and was arrested. It appears that in the meantime Mr. X had signed into a local hotel as *"Sir [X] PhD (God)"*. At the police station he signed consent for bloods to be taken as *"King [X] III"*.[34]

The conclusion of this assessment was:

"*This evening presented with emotional labiality, over relaxed, mild pressure of speech, marked flight of ideas and v. incoherent speech with strong persecutory and grandiose themes.*

- This is strongly suggestive of a drug-induced psychosis;

- Preliminary drug test (dip stick) suggestive of being positive for cannabis;

- He is not fit for interview;

- His mental state is likely to improve over next 48 hours. May then be fit for interview."[35]

The EDA Contact Sheet for 17.30 on 12 April 2008 recorded that the police had requested a Mental Health Act assessment having arrested Mr. X on suspicion of murder.

Mr. X had reported that he had gone out drinking with the victim, they had fallen out and were verbally abusive to each other. Mr. X denied taking anything other than alcohol although he was offered other "substances". He took a taxi to a hotel where he watched television but could not sleep. He then went to his mother's home by taxi but did not go in.

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[33] Clinical Records p. 37
[34] Clinical Records p.37
[35] Clinical Records p. 54

It was concluded, following this assessment, that Mr. X was not fit to be interviewed by the police. It was noted that had Mr. X not been detained for a serious offence he would have been detained on section 2 of the Mental Health Act (1983).[36]

On **14 April 2008** Mr. X was again assessed by the Consultant Psychiatrist. On this occasion he was found to be orientated in time and place. He reported that he was "*coming down from taking cannabis and alcohol 'which had removed a bubble of LSD from my brain'*."[37] The Consultant Psychiatrist recorded that Mr. X was co-operative but disinhibited; his mood was labile, at times angry and then friendly and apologetic; he expressed some bizarre ideas and grandiose and persecutory beliefs; he exhibited a mild pressure of speech, and shouted, almost spitting, when he was angry. The Consultant Psychiatrist concluded that Mr. X had limited insight. He commented: "*probably still psychotic but need to know his premorbid personality as the grandiose, persecutory themes and arrogance could be part of a disorder of personality of paranoid, narcissistic type*".[38]

The Consultant Psychiatrist concluded that Mr. X was not yet fit to be interviewed by the police.

On **15 April 2008** Mr. X was assessed again by the Consultant Psychiatrist. On this occasion he was accompanied by a nurse from the Rural CMHT. Mr. X was initially hostile during this interview, shouting that he was not mentally ill, however he calmed down when the purpose of interview was explained to him and his conversation was subsequently coherent. He spontaneously reported that he had been "high" on the previous weekend when he had been assessed and when the Rural Team CPN had seen him, but did not consider himself to be mentally ill.

The Consultant Psychiatrist concluded that Mr. X had an eccentric way of expressing himself but that he was not, at that time, mentally ill. He recorded that Mr. X's presentation was "*best understood as those of an angry, stressed man with strong narcissistic, grandiose features to his personality.*"[39] Mr. X was deemed fit to be interviewed by the police at this time.

[36] Clinical Records p. 148
[37] Clinical Records.p.31
[38] Clinical Records p. 35
[39] Clinical Records p.27

The Consultant Psychiatrist had a telephone interview with Mr. X's mother on **15 April 2008** in which she provided him which information on Mr. X's pre-morbid personality and his recent behaviour.[40]

On **24 April 2008** the Regional Laboratory for Toxicology reported on their analysis of the urine sample that had been taken from Mr. X. This was tested for: amphetamines, benzodiazepines, cannabinoids, cocaine, methadone metabolites and opiates. The sample was found to be negative all of these. A further more sensitive test was done for cannabis metabolites. This confirmed the earlier negative results

[40] Clinical Records p.28

11. Timeline and Identification of the Thematic Issues

11.1 Thematic Issues

The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Mr. X received from the Avon and Wiltshire Mental Health Partnership NHS Trust. These thematic issues are set out below.

11.2 The Care Programme Approach: Assessing Needs and Planning Care

11.2.1 Sound assessment is the foundation on which good care is based. Each time Mr. X presented to the Mental Health services he was appropriately assessed, on most occasions the Trust Core Assessment form was completed. However, there is no record of Mr. X's family being involved in any of the assessment undertaken prior to the 12 April 2008.

11.2.2 Service Issue 1
Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice, however it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

11.3 Risk Assessment and Management

11.3.1 On three of the four occasions that Mr. X was assessed by Trust staff, the Trust's confidential screening tool was used. On most occasions it was concluded that Mr. X did not pose a risk to others.

11.3.2 It was noted that Mr. X coped poorly with his anger and he was provided with details of an anger management course. Mr. X was detained by the police on at least three occasions. When assessed by mental health staff they concluded that he was not suffering from a

significant mental health problem. The result of this was that Mr. X was passed between agencies without any co-ordinated approach being adopted. This was a missed opportunity.

11.3.3 Good practice is that sound assessment builds on previous assessments. There is little evidence in Mr. X's notes that this accretitive approach was adopted or that there was any reflection on why Mr. X was detained by the police on a number of occasions. However, it has to be acknowledged that Mr. X's contact with the Mental Health services was brief and episodic.

11.3.4 Contributory Factor 1

The Service Issues here is the same as that identified above in Service Issues 1

11.3.5 Each time Mr. X was assessed he identified difficulties in his relations with his family and on at least one occasion his grandmother reported that his violent behaviour caused her to be afraid of him. Given the intimate involvement of Mr. X's family in his outbursts of violent behaviour it would have been good practice to have consulted them when assessing the degree of risk he posed.

11.3.6 Service Issue 1

Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs, Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice. However it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

11.4 Diagnosis

11.4.1 When Mr. X was assessed in 2005 he was diagnosed as suffering from an adjustment reaction/disorder. In 2006 it was concluded that he was not suffering from a mental illness. On 31 March 2008 he was diagnosed as suffering from a drug induced psychosis. Although his mental state appeared to have improved on 8 April 2008 by 12 April 2008 it had again deteriorated. The possibility of his suffering from a personality disorder was also raised. Two

independent forensic psychiatric reports in August and October 2008 concluded that Mr. X was most probably suffering from a bipolar affective disorder, though the second report raised the possibility that Mr. X's mental illness might still be evolving.

11.4.2 Corroboration and the reliability of information: It was known that the information Mr. X provided was often unreliable. However corroboration of his drug and alcohol use was not sought prior to his arrest in April 2008.

11.4.3 Availability of information: The clinical staff who assessed Mr. X were under the impression that he had no history of mental health problems. However, Mr. X had been in contact with various Mental Health services from at least 1994 when he was six/seven years old. It would be good practice to have the clinical notes from Mr. X's childhood included in his adult clinical notes.

11.4.4 Differential diagnosis: It is good practice explicitly to consider alternative explanations of an individual's behaviour. Entertaining a range of possible formulations forces one to consider a range of possible interventions and adds clarity to the assessment. There is no evidence in Mr. X's notes that differential diagnoses were considered.

11.5 Treatment

11.5.1 Mr. X was referred to the crisis team, the CMHT and the drug and alcohol services. He was given the contact details of a drug counselling service and anger and stress management courses and it was recommended that he saw he saw his GP to discuss referral to a primary care counsellor. There is no evidence that Mr. X availed himself of any of these services.

11.5.2 The Trust's Dual Diagnosis policy and national guidance suggest that where both mental health needs and substance misuse problems are present the individual should be treated in a holistic manner, normally within mainstream Mental Health Services. It would have been good practice to have considered how these inter-related problems might have been addressed rather than discharging Mr. X as soon as his mental state appeared to improve.

11.5.3 Given that there were only three days between Mr. X's review appointment and the events of 11 and 12 April 2008 it is unlikely that any intervention would have had a significant impact on Mr. X's health and well-being.

11.6 Safeguarding Adults

11.6.1 From his first contact with Adult Mental Health services in May 2005 it was noted that Mr. X had a difficult relationship with his family. This manifested itself in outbursts of anger which he found difficult to control. His grandmother found Mr. X's behaviour frightening. Mr. X stole money from his grandmother. He introduced his friends into her home, where they drank alcohol and used illicit drugs. He argued with his grandmother and damaged her property. On a number of occasions the police were called to Mr. X's grandmother's home because of his behaviour. It seems that Mr. X had little insight into the effects of his behaviour.

11.6.2 Given the information available it would have been good practice to formally assess the risk Mr. X posed to his grandmother and to consider to what degree she met the criteria of being a vulnerable adult. It would have been good practice to include Mr. X's grandmother in these deliberations and, in consultation with her, a plan should have been put in place to address any identified issues.

11.6.3 Service Issue
The Service Issues here is the same as that identified above in Service Issues 1

11.7 Service User Involvement in Care Planning

11.7.1 Given his brief and episodic contact with the Adult Mental Health services there was limited opportunity to demonstrate Mr. X's involvement in his assessment and care planning. On two of the three occasions, prior to his arrest in April 2008, when the Trust's core assessment form was completed the section for recording the user's views was completed. This was good practice. However, on only one occasion is it indicated that a letter regarding

Mr. X's presentation was copied to him. It would have been good practice to copy all relevant correspondence to Mr. X.

11.7.2 Following most assessments Mr. X was given information about relevant services or was referred to relevant services. There is no evidence that he availed himself of these services.

11.8 Involvement of the Family

11.8.1 On a number of the occasions Mr. X reported that his distress was the result of conflict with his family. On at least two occasions Mr. X's family called the police for assistance and on one occasion Mr. X's grandmother felt frightened by his behaviour. On a number of occasions it was noted that Mr. X was not a reliable historian. Given these circumstances it would have been good practice to have consulted his family to corroborate his account of events and to understand better how he might have been helped. However prior to his arrest there is only one record of an attempt to involve Mr. X's family being made.

11.8.2 Service Issue 1

The Service Issue here is the same as that identified above in Service Issues 1

11.9 Communication

11.9.1 Although Mr. X was seen on only seven occasions as an adult there is evidence of good and consistent communication between the Mental Health services, Mr. X's GP and the out of hours emergency duty service.

11.9.2 However the Emergency Duty Service (EDS) electronic records system did not speak to the Avon and Wiltshire Mental Health Partnership NHS Trust's electronic system. The EDS, therefore, had to fax information to the CMHT when they had contact with a service user out of hours. This interface was a point of weakness in the communication system.

11.9.3 There was a local electronic records system as well as a paper clinical record used only by the community teams in Salisbury. This was a point of weakness in the communication system.

11.9.4 A third point of weakness in the communication and record keeping system was that records of multi-disciplinary team discussions were not available in Mr. X's case notes.

11.9.5 A Trust-wide electronic record system is currently being put in place. This will address some of the concerns noted here. However, access to and inputting of information when an assessment is undertaken out of hours and away from Trust premises remains an issue to be addressed; the out of hours EDS service will continue to have a separate electronic system which will not speak to the Trust system and this remains a point of weakness in the communication system.

11.9.6 Only notes relating to Mr. X's contacts with adult services were available to clinicians, however, Mr. X had been seen by the Children's Mental Health services. If clinical staff are to undertake sound assessments it is important that they have timely access to all relevant information.

11.9.7 Service Issue 2

If assessments are to be robust and reliable then it is important that all relevant clinical information is available to those undertaking the assessment. This information should be readily accessible and available in a timely manner. Because of the systems of recording and storing information in place at the time, the details of Mr. X's presentation, his behaviour and the fact that his grandmother was sufficiently afraid to call the police was not available to the CPN when he undertook his assessment on 31 March 2008. This was a significant weakness in the communication and record keeping system however it can not be reasonably concluded that that this failure had a direct causal relationship with the events of 11/12 April 2008

11.10 The Management of Mr. X's Care

11.10.1 Because of the manner of Mr. X's presentation and because he was only briefly and infrequently in contact with the service, there was no explicit plan for the management of his care. Mr. X was referred to the crisis team[41], to the CMHT[42] and to the drug and alcohol services.[43] However there was no mechanism in place to monitor whether Mr. X took advantage of these referrals.

11.10.2 The staff of the mental health service did not appear to be aware of the substantial contact Mr. X had had with Children's Mental Health Services. If clinical staff are to take a longitudinal view of an individual's problems then historical information has to be readily available. The fact that Mr. X's assessments were unplanned and undertaken at times of crisis illustrates the importance of historical notes being easily accessible.

11.10.3 It was consistently noted that Mr. X misused drugs and alcohol to the detriment of his psychological well-being. Good practice indicates that where substance misuse impacts on an individual's psychological mental health s/he should be assessed and offered intervention by mainstream Mental Health services, with appropriate support from the specialist substance misuse service, to address these inter-related difficulties. Such a service was not offered to Mr. X.

11.10.4 Mr. X's care was not planned and co-ordinated. This was because he presented infrequently and in crisis. However, where an individual presents in crisis on a number of occasions good practice suggests that the assessment should go beyond the immediate

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[41] Clinical Records p.167
[42] Clinical records p. 147
[43] Clinical records p. 124

presentation and address the question of what need is being made manifest by repeated crisis presentations. The Trust together with the clinicians who undertake assessments might reflect on how this might be built into both routine and emergency assessments.

11.11 Adherence to Local and National Policy, Best Practice and Clinical Guidelines

11.11.1 The Trust had in place relevant clinical policies and procedures. These were informed by best practice guidance, updated during the period that Mr. X was under the care of the Trust and were fit for purpose. However Trust staff did not implement these in a consistent manner.

11.12 Clinical Governance and Performance

11.11.1 The Trust has a fit for purpose set of governance arrangements which are overseen by the Trust Board. However failures to adhere to Trust policies do not appear to have been identified and addressed by the governance structures in place during the time Mr. X was under the care of the Trust.

11.13 Internal Investigation

11.13.1 The Internal Investigation was competently prepared and produced a relevant set of recommendations to which the Trust has responded appropriately. The Independent Investigation Team concurs largely with the findings of the internal review.

12. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

12.1 RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key causal, contributory and service issue factors.

In the interests of clarity each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'key causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team have concluded had a direct causal relationship with the events of 11/12 April 2008. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user received and any subsequent homicide perpetrated by them.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Mr. X's mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified

service issues in this report whilst having no direct bearing on the events of 11/12 April 2008, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

12.2 The Care Programme Approach: Assessing Needs and Planning Care

12.2.1. Context.

The Care Programme Approach (CPA) became the main vehicle for delivering high quality Mental Health Care following the NHS and Community Care Act (1990). From April 1991 Health Authorities, in collaboration with Social Services Departments, were required to put in place CPA arrangements for the care and treatment of people with mental health problems.
In *Building Bridges (1995)*[44] the Department of Health identified the four main elements of the CPA:

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

12.2.2. Local Context

The Avon and Wiltshire Mental Health Partnership NHS Trust echoed the national guidance in its 2007 CPA policy which was in force when Mr. X had his main contact with the Trust. The Trust policy states:
[The Integrated Care Programme Approach] ICPA is the way in which effective mental health multi-disciplinary care and treatment are co-ordinated and delivered in secondary mental health (Health and Social Care Services).[45]

[44] Dept of Health (1995) *Building Bridges: A guide to arrangements for inter–agency working for the care and protection of severely mentally ill people*.
[45] Avon and Wiltshire Mental Health Partnership Trust (2007) *Integrated Care Programme Approach (ICPA) and the Assessment and Management of Risk Policy, Procedures and Guidance.* p.5

The policy identifies the importance of: *"systematic arrangements for **assessing** the health and social care needs of service users."*[46]

The policy continues: *"It is recognised that assessment is an ongoing and continuous process and information from a variety of sources may be sought to gain an accurate picture of the service user's circumstances (especially carers). Where possible, information to assist in validating assessments should be obtained from as wide a range of sources as possible, in particular, histories should be obtained from the service user's immediate family and carers, and all relevant health and social care records obtained……*

The purpose of the initial assessment is to identify the person's health and social care needs and to determine if the person meets the criteria for acceptance into the service.

***If the criteria for acceptance are not met**, then the assessor should feedback the reason to the referee and the referrer, and if appropriate, offer specialist advice and support to the referrer.*

The purpose of the core assessment is to establish:

- *the service user's health and social care needs;*
- *to identify eligible social care needs;*
- *a record of the Formulation – Bio-Psychosocial, including (where appropriate) the diagnosis and/or differential diagnoses;*
- *the level of risk;*
- *the service user's strengths;*
- *identify opportunities to promote social inclusion;*
- *whether further specialist assessments are needed;*
- *whether the service user continues to meet service entry criteria;*
- *the current level of ICPA;*
- *identify any Advance Statement;*
- *the information needed to support the care planning process."*[47]

[46] Ibid p.7
[47] Ibid p.15

12.2.3. Findings of the Internal Investigation

The Internal Investigation did not comment on the application of the CPA process and the assessments that were undertaken.

12.2.4. Findings

Mr. X was assessed on five occasions prior to the 12 April 2008. On three of these occasions: 8 May 2005, 29 November 2005 and 31 March 2008 the Trust Core Assessment form was completed and, in consequence, there is evidence of a clear and structured assessment. Each of these assessments contains a formulation and identifies the actions taken. Each of these assessments was followed with a letter to Mr. X's GP, describing his presentation, the formulation and the actions taken.

On 27 June 2006 Mr. X was assessed by an Approved Social Worker and a Section 12 Approved Doctor. The only account of this assessment is contained in the Emergency Duty Service's contact sheet which was faxed to the CMHT. This presents a brief but detailed account of Mr. X's presentation and the conclusions of the assessors. There is no record in Mr. X's clinical notes of Mr. X's GP being informed of this assessment.

Mr. X was again assessed in Salisbury police station on 27 March 2008. On this occasion he was assessed by the Specialist Registrar and an Approved Social Worker (ASW). The SpR's notes of this assessment are contained in Mr. X's clinical notes and the SpR wrote to Mr. X's GP informing him of the assessment, Mr. X's presentation and the outcome of the assessment. This letter was not sent until some time after the 12 April 2008.

The SpR did not use the Trust assessment form on this occasion. The Internal Investigation commented: *[The SpR] made an entry on the Police form in respect of the consultation. She did not fill in the pink core assessment documentation for the health record nor the risk assessment documentation. This is entirely in line with normal practice in these circumstances ie urgent assessments at the request of third parties. She followed up the assessment with the letter to the patient's GP."*[48]

[48] Internal Investigation Report

Following Mr. X being arrested on suspicion of murder on 11/12 April 2008 he was assessed by a Consultant Psychiatrist. He recorded his assessment on the Trust Core Assessment form and on 22 April 2008 wrote a comprehensive letter to the Forensic Psychiatrist caring for Mr. X at that time. This letter provided a history of Mr. X's contact with the Mental Health services and an account of his assessment.[49] The Consultant Psychiatrist also wrote a postscript to the SpR's letter to Mr. X's GP informing him that Mr. X had been arrested on suspicion of murder, that he had assessed him on three occasions over a four day period and he had concluded that Mr. X was probably suffering from cannabis induced psychosis.[50]

12.2.5. Conclusion

As both the national guidance and the Trust CPA policy identify, sound assessment is the foundation on which good care is based. There is evidence in Mr. X's notes that each time he presented to the Mental Health services he was appropriately assessed. On most occasions the Trust Core Assessment form was completed, ensuring that the assessment was both appropriate and comprehensive. Using the Trust assessment form provided the added advantage that the information collected in the assessment was clearly structured. This would have been of significant benefit to those assessing Mr. X at a later date. The assessments consistently provided a formulation or diagnosis and identified the actions taken or planned. This was good practice.

The Internal Investigation noted that when the Specialist Registrar (SpR) and Approved Social Worker (ASW) assessed Mr. X on 27 March 2008 at Salisbury police station the Trust Core Assessment form was not completed. The Internal Investigation report commented that this was in accordance with normal practice, when such an assessment was undertaken, at the time. It is noteworthy however that when the Consultant Psychiatrist undertook a similar assessment at the same police station only a few days later he did complete the Trust Core Assessment form. This structured assessment is available in Mr. X's notes. This was good practice.

The Trust CPA policy advises: *"Where possible, information to assist in validating assessments should be obtained from as wide a range of sources as possible, in particular*

[49] Clinical Records p. 124
[50] Clinical Records p. 154

histories should be obtained from the service user's immediate family and carers, and all relevant health and social care records obtained."

There is no record of Mr. X's family being involved in any of the assessment undertaken prior to the 12 April 2008. Given the events which preceded Mr. X's detention on 26 March 2008, the fact that Mr. X's grandmother had called the police because she was afraid following his violent behaviour, it would have been good practice to have consulted Mr. X's family as part of this assessment. Mr. X was assessed again on the 31 March 2008; as noted elsewhere in this report, it is not clear what information was available to the Community Psychiatric Nurse (CPN) when he was undertaking his assessment. However he was aware that Mr. X had argued with his grandmother prior to his being sectioned. Mr. X's grandmother was present when he was seen for his follow-up appointment on 8 April 2008 but her views were not sought and no corroboration of Mr. X's account of events was obtained. This failure to include Mr. X's family in the assessment of his needs and mental state is the blemish on what were otherwise good assessment practices.

Again it is noteworthy, in this context, that the Consultant Psychiatrist did consult Mr. X's mother when he undertook his assessment following Mr. X being arrested on 12 April 2008.

Service Issue 1

Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice. However it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

12.3 Risk Assessment and Management

12.3.1 Context

Risk assessment and planning should not be seen as free standing activities. They are integral elements of the overall Care Programme Approach to assessing and meeting a service user's health and social care needs.

In his forward to *Best Practice in Managing Risk (2007)* Louis Appleby commented:
"*Safety is at the centre of all good health care. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk.*"[51]

The guidance lists 16 principles which should characterise the assessment and management of risk. These are listed below:

"*Best practice*

1. *Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience and clinical judgement.*

Fundamentals

2. *Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.*

3. *Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.*

4. *Risk management must be built on a recognition of the service user's strengths and should emphasise recovery.*

5. *Risk management requires an organisational strategy as well as efforts by the individual practitioner.*

Basic ideas in risk management

6. *Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.*

7. *Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.*

8. *Knowledge and understanding of mental health legislation is an important component of risk management.*

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

9. *The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.*
10. *Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.*
11. *Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.*

Working with service users and carers
12. *All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.*
13. *Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.*

Individual practice and team working
14. *Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.*
15. *All staff involved in risk management should receive relevant training, which should be updated at least every three years.*
16. *A risk management plan is only as good as the time and effort put into communicating its findings to others."*[52]

12.3.2 Local Context

The Trust's Integrated Care Programme Approach (ICPA) and the Assessment and Management of Risk policy in force from 2006 commented:
"Risk assessment and management, as a continuous and ongoing process, is fully integrated into every stage of ICPA, which provides a collaborative framework for staff, service users, and carers within which to make potentially difficult decisions.
It is acknowledged that service users are more likely to be at risk of injury from others, rather than the cause of violence to others. This policy addresses the specific issues of risk of

[52] DoH (2007), *Best Practice in Managing Risk.* P.5-6

violence by service users, risk of suicide or self-harm, risk from others, risk to others, risk to children, driving risk, and self-neglect. Risk cannot be eliminated, it can be thoroughly assessed and managed, but despite best endeavours, outcomes cannot be guaranteed." [53]

The policy continues:

"A confidential risk screen must always be completed:

- *whenever a person new to the service is initially assessed;*
- *whenever a person is re-referred to the service…;*
- *In assessing risk, information should be obtained from as wide a range of sources as possible, wherever possibly independently, including the service user themselves. Previous mental health and social care records should always be sought and obtained, and collateral information should always be obtained from carers and family members or significant others;*
- *When assessing risk, any risk associated with a differential formulation or diagnosis should be fully considered, appropriately taken into account within the risk management plan, and recorded."*[54]

12.3.3 Findings of the Internal Investigation

"10.5 With the benefit of hindsight & as noted above at section 9, we think it unfortunate that a full collateral history was not taken from any one of those close to [Mr. X] in particular his grandmother, [….], with whom he lived. Although [Mr. X's grandmother] attended a follow up appointment with the team on the 8th April she did not feel she had the right to say things and was not specifically asked. However, she was given the chance to ask questions and did so. It has since become clear that [Mr. X's grandmother] would have been capable of giving important information that would have been of use to clinicians with her own observations about [Mr. X's] mental state and her concerns about him. It is our opinion that her evidence would have shaped the formulation of the case & the response of clinical staff and may have led to different strategy for management. It remains possible that the emphasis and focus may still have been on the issue of his misuse of substances and therefore may not have changed the clinical management plan to any significant degree. Nevertheless, standard practice

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[53] Avon and Wiltshire Mental Health NHS Partnership Trust (2006), *Integrated Care Programme Approach (ICPA) and the Assessment and Management of Risk: Policy, Procedures and Guidance.* P. 21
[54] Ibid p. 22-23

would normally include taking a collateral history from third party informants & we consider that in this case, despite the availability of family members who could assist, there was a failure to take a sufficiently detailed history from such individuals."[55]

12.3.4 Finding of the Independent Investigation

On **8 May 2005** Mr. X attended the Accident and Emergency Department of Salisbury District Hospital after taking an overdose. He had been accused by members of his family of stealing money from his grandmother. While he was waiting for the police to arrive he became angry and frustrated. He kicked and pulled at cupboards and, impulsively, took his grandmother's medication. He reported that his aim was to escape from a difficult situation. He had no thoughts of harming or killing himself. Mr. X reported that he occasionally smoked cannabis and had tried other illicit substances. He had last drunk alcohol four weeks previously.

Mr. X reported that he had frequent arguments with his mother. He said that he had been a boisterous, nasty character at school and had received counselling as a result of his behaviour. More recently he had received a warning from the police for theft and shop lifting.[56] The Avon and Wiltshire Mental Health NHS Partnership Trust's risk screening form was completed at this assessment. Mr. X was described as follows:

	Past	Current
Suicide risk:	No	Yes
Risk to others:	No	No
Risk from others	Yes	No

A number of social risks were identified including: significant debts, lack of stable employment, conflict in personal relationships, difficulties with neighbours, relationship problems and domestic violence. He was assessed as presenting a low risk in all categories, both currently and in the future.[57]

On **29 November 2005** Mr. X again presented at the Accident and Emergency Department following an overdose.[58]. Mr. X was identified as having problems in managing his anger and

[55] Internal Investigation Report
[56] Clinical Records, p. 83, 95, 157-159
[57] Clinical Records p. 15
[58] Clinical Records p. 75ff

his personality was described as emotionally unstable and impulsive. It was noted that Mr. X was reporting aggressive thoughts particularly towards his ex-girlfriend's new boyfriend. He reported that he felt "used" by people. He also reported that he had received a caution from the police for grievous bodily harm.[59]

A Trust risk assessment was completed and Mr. X was described as:

	Past	Current
Suicide risk:	Yes	Yes
Risk to others:	Yes	Yes (Particularly ex-girlfriend's current boy friend)
Risk from others	Yes	Yes

Additional risks identified were: alcohol abuse in the past; substance misuse currently; and Mr. X having limited insight. The social risk identified was: conflict in personal relationships.

Overall Mr. X was rated as presenting a low immediate risk of self harm and a moderate future risk. He was rated as presenting a moderate immediate risk to others and a high future risk "*Depending on [patient's] controlling anger*".[60]

The management plan was to:

- refer Mr. X to the Crisis Service (IHSS);
- refer him to the Primary Care Counsellor via his GP;
- advise him about the adverse effects of cannabis use;
- provide him with contact details and information regarding anger and stress management programmes at a local centre.

On **27 June 2006** Mr. X was detained under Section 136 of the Mental Health Act (1983). His family had complained about the noise of his music and Mr. X had become angry. The police had been called. Mr. X had left his grandmother's house telling the police he "*wanted to go out with a knife and find the people who I hate and cause them harm*". [61]

[59] Clinical Records p. 79
[60] Clinical Records p.21
[61] Clinical Records p.161

Mr. X reported that prior to the argument he had been drinking alcohol. He said that he "*gets out of his face*" every day to *"make life bearable*"[62]. However, the Custody Sergeant reported that Mr. X did not appear to be drunk.[63]

Mr. X was found not to be suffering from a mental disorder of a seriousness to warrant hospital detention. The Section 136 was therefore discharged. Mr. X declined offers of support.

On **26 March 2008** the Emergency Duty Service (EDS) was informed that Mr. X had been detained for a public order offence. He had been arrested for criminal damage at his grandmother's house. He had broken a kitchen cupboard, a kitchen door and a remote control. His grandmother had felt frightened and had called the police.[64]

Mr. X reported that he had returned home feeling tired and had found some "coke-heads" in his bedroom taking cocaine. He had become angry with his grandmother for allowing these people into the house. He believed that they stole from her and caused her problems. Mr. X reported that he had been drinking heavily for four years "*to try to blank out problems with nan*".[65]

The letter to Mr. X's GP following this assessment concluded: *"Overall I did not feel this young man showed any evidence of mental illness. He was somewhat inconsistent in the history he gave us, however, it appears he is living in a stressful situation at the moment and is appropriately angry about this".*[66]

On **31 March 2008** Mr. X presented to the Adult Mental Health services and was seen by a CPN from the Rural CMHT, who carried out a core assessment and a risk assessment**.** Mr. X told the CPN that his drinking was a problem and that his use of drugs was detrimental to his mental health. Mr. X reported that he was not currently using any illicit drugs. The CPN noted on the assessment form: *"Some family stressors arguments with grandmother"*[67] It was also noted that Mr. X had experienced some paranoia but this had *"gone now that he is*

[62] Ibid
[63] Ibid
[64] Clinical Records p. 153
[65] Clinical Records p. 153
[66] Clinical Records p.154
[67] Clinical Records p. 57

clean".[68] Mr. X reported that he had been excluded from junior school for a year for fighting but he had no forensic history. It was recognised that Mr. X was not a reliable historian.

The CPN completed the Trust's risk assessment. Mr. X was described as:

	Past	Current
Suicide risk:	Yes	No
Risk to others:	No	No (But poor anger control in the past)
Risk from others:	No	No.[69]

Alcohol and substance abuse, and the presence of psychiatric symptoms were identified as risk factors. Employment problems and conflict in personal relationships were identified as social risks. Domestic violence was identified as a past issue but was left blank with respect to current issues.

On **2 April 2008** Mr. X was again detained by the police and at this time was described as *"expressing bizarre and psychotic type thoughts".*[70]

On **8 April 2008** Mr. X attended his review appointment with the CPN. This appointment was also attended by Mr. X's grandmother and the Rural Community Team Leader. The CPN noted:

"Much improved from last week likely drug induced psychosis now resolving. No delusional or grandiose beliefs. Good insight realises it was cannabis related. A rather rambling account of things, having problems with [....] his unofficial employer who he is staying with. Seems to be being exploited doing cash in hand work but not willing to be assertive about this. Says he will be homeless from Monday and advised to go to Council about this and claim benefits. He seemed lucid today and is left with various social stressors does not require ongoing CMHT involvement."[71]

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[68] Clinical Records p.58
[69] Clinical Records p.12-14
[70] Clinical Records p. 144
[71] Clinical Records p.185

On **12 April 2008** Mr. X was arrested on suspicion of murder. He reported that he had been drinking with the victim. They had fallen out and were verbally abusive to each other. Mr. X denied taking anything other than alcohol although he had been offered other "substances".[72]

On **14 April 2008** Mr. X was again assessed. On this occasion he was found to be orientated in time and place. He reported that he was "*coming down from taking cannabis and alcohol 'which had removed a bubble of LSD from my brain'.*"[73] The Consultant Psychiatrist recorded that Mr. X was co-operative but disinhibited; his mood was labile, at times angry and then friendly and apologetic; he expressed some bizarre ideas and grandiose and persecutory beliefs; he exhibited a mild pressure of speech, and shouted, almost spitting, when he was angry.[74]

On **15 April 2008** Mr. X was assessed again. Mr. X was initially hostile during this interview, shouting that he was not mentally ill, however he calmed down when the purpose of the interview was explained to him and his conversation was subsequently coherent. The Consultant Psychiatrist concluded that Mr. X was not, at that time, mentally ill. He recorded that Mr. X's presentation was "*best understood as those of an angry, stressed man with strong narcissistic, grandiose features to his personality".*

12.3.5 Conclusion

On three of the four occasions that Mr. X was assessed by Trust staff, the Trust's confidential screening tool was used. The Consultant Psychiatrist who assessed Mr. X following his arrest on 12 April 2008 also employed this tool in line with Trust policy.

Each time Mr. X was assessed, the theme of him becoming angry and him coping with this poorly was identified. However, despite this, on most occasions it was concluded that Mr. X did not pose a risk to others. The exception to this was in November 2005 when he was rated as presenting a moderate immediate risk to others and a high future risk: "*Depending on patients controlling anger*".[75]

There appear to have been a number of factors which influenced this appraisal of the risk Mr. X posed: he was assessed as not being mentally ill, at least not suffering from a mental illness

[72] Clinical Records p. 148
[73] Clinical Records.p.31
[74] Clinical Records p. 35
[75] Clinical Records p.21

serious enough to warrant the involvement of secondary Mental Health services. He was seen as having an emotionally unstable and impulsive personality; his outbursts of anger were seen as reactions to external stressors or frustration: arguments with his family, being rejected by a girlfriend, finding people taking drugs in his room; on one occasion the opinion was expressed that: *"…he is living in a stressful situation at the moment and is appropriately angry about this"*[76]. The strategies he adopted to cope with stressful situations, drinking alcohol and taking drugs, were seen as maladaptive and increasing the likelihood of him behaving in an impulsive and disinhibited manner.

In response to this appraisal of the risk Mr. X posed he was referred to his GP and on one occasion was provided with details of an anger and stress management course. He was also consistently given information about the dangers of taking drugs and, on at least one occasion, was given information about the drug counselling service.

Mr. X was detained by the police on a three occasions when a mental health opinion was sought, suggesting that they believed that the genesis of his disinhibited behaviour was a problem with his mental health. The mental health practitioners who assessed Mr. X consistently came to the conclusion, however, that he was not suffering from a significant mental health problem and, in consequence, Mr. X's maladaptive behaviour should be responded to by other agencies. The Best Practice guidance quoted above advises:
***"14.** Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice."*

As a result of the approach adopted Mr. X was, effectively, passed between agencies without any co-ordinated approach being adopted. This was a missed opportunity.

The current version of the Trust's Risk Management Procedures (2010) provides the following guidance:
"Each assessment should:

- *be a "live" assessment;*
- *incorporate learning from all previous assessments;*
- *provide a longitudinal assessment and assessment of risk;*
- *not require service users and carers to continually re-tell their stories."*

[76] Clinical Records p.154

Good practice at the time Mr. X was under the care of the Trust would also have been that one should not regard each risk assessment as a stand alone event but that a sound assessment builds on previous assessments. There is little evidence in Mr. X's notes that this accretitive approach was adopted or that there was any reflection on why Mr. X was detained by the police on a number of occasions.

It has to be acknowledged that Mr. X's contact with the Mental Health Services was brief and episodic. He was seen on only three occasions in 2005 and 2006 and then not again until March 2008. He was then seen by mental health staff on three occasions between 27 March 2008 and 8 April 2008. Nevertheless given that Mr. X was detained by the police twice within a few days in March/April 2008, contact and joint planning between the two agencies would have been good practice.

Contributory Factor 1

Good practice suggests that the assessment of risk should be ongong, accretitive and, where appropriate, multi-agency. Had this approach been adopted in Mr. X's case a different view of the risk he posed and how this might have been responded to, might have been taken. However, given the brief and transient nature of Mr. X's contact with Mental Health services it would not be reasonable to conclude that there was a direct and causal association between the approach adopted by the Mental Health Services and the events of 11/12 April 2008

Involvement of the family

Trust IPCS policy states:

"*In assessing risk, information should be obtained from as wide a range of sources as possible, wherever possibly independently, including the service user themselves. Previous mental health and social care records should always be sought and obtained, and collateral information should always be obtained from carers and family members or significant others.*"

Each time Mr. X was assessed he identified difficulties in his relations with his family. On one occasion he reported that he had been drinking heavily for four years "*to try to blank out*

problems with nan".[77] On the other hand on a number of occasions Mr. X's family had called the police because of his behaviour. In March 2008 his grandmother, with whom he lived and who knew him well, reported that his violent behaviour at that time caused her to be afraid of him. Given the intimate involvement of Mr. X's family in his outbursts of violent behaviour it would have been good practice to have consulted them when assessing the degree of risk he posed.

In addition, on a number of occasions when Mr. X was being assessed it was noted that he was not a good historian. Again, despite staff noting that the information on which they were basing their assessments was not entirely reliable, Mr. X's family were never included in any assessment and corroboration was not sought from them, as both good practice and Trust policy indicated.

Service Issue 1

Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs, Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice. However it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

12.4 Diagnosis and Formulation

Diagnosis

An often critical element in the assessment of need and the planning of care, within the general framework of the CPA, is the diagnostic process.

12.4.1 Context:

There is an on-going debate in the academic literature about the reliability and utility of categorical diagnostic schemas and what is sometimes, imprecisely, referred to as the medical model. What is not in debate, however, is that if an individual is to receive effective and efficient treatment then there has to be a clear formulation of his/her difficulties, which

[77] Clinical Records p. 153

informs a plan determining how the individual might be helped to achieve identified goals. Diagnosis can be considered an important element in the formulation or understanding of an individual's problems.

12.4.2. Findings of the Internal Investigation

The Internal Investigation did not comment on the diagnostic process directly in its findings but it did consider four hypotheses relating to Mr. X's mental state. These are reported below:

"9.1 [Mr. X] killed [Mr. C] an acquaintance, as a direct result of an acute psychotic illness induced by illicit drugs and alcohol

We believe there is ample evidence that [Mr. X] had developed an acute psychotic illness. The history from the family (obtained subsequently) and his own self report together with the observations of those who came into contact with him note a range of typical features. The professional staff all concluded that the cause for his presentation was use of alcohol and/or street drugs. Their conclusions were determined in the greater part by [Mr. X's] own self report which was supported by information gained from other sources. Further on his contact in March [2008] his condition had apparently improved in follow up in early April [2008]. In retrospect it seems likely that the role of alcohol and street drugs was overplayed by [Mr. X] himself and those around him. It seems at least possible that both [Mr. X] and those around him were attempting to explain his unusual experiences and behaviours as being secondary to drugs or drink in the absence of any previous experience or understanding of other potential causes such as mental illness itself. Our opinion is that having identified the association between his psychosis and his self reported use of alcohol and street drugs, professionals felt this was sufficient explanation and closed their mind to other potential causes. Having said that, there is evidence of care to check for signs of improvement in response to acting on advice to moderate his intake of street drugs and attempts to clarify psychotic symptoms only to be met with his denial of typical psychotic experiences.

9.2 ***[Mr. X] killed [Mr. C], an acquaintance, as a direct result of an acute psychotic illness not linked to alcohol or substance misuse***

We consider that there is ample evidence that [Mr. X] developed a psychotic illness. The evidence of the family is clear and consistent with the diagnosis of schizophrenia and his subsequent course provides sufficient confirmation that is the most likely and preferred diagnosis. Whilst it is difficult to properly exclude the role of misuse of alcohol and street

drugs in his case not least because of his own repeated assertions supported by observations of his family, we note that despite his assertions near the time, there was no evidence of street drug use immediately prior to the killing and only minimal evidence of significant alcohol intoxication. Accordingly it seems likely that the principal driver for his behaviour on the night in question is abnormal beliefs arising out of his psychosis.

9.3 [Mr. X] killed [Mr. C], an acquaintance, as a direct result of alcohol and drug intoxication

Although [Mr. X] was known to use street drugs his self report was variable and the opinions of others was variable also. Of note is that blood and urine tests at the time of his arrest showed no evidence of street drugs present.

Similarly, he was known to use alcohol in large quantities. He bragged about how much he had drunk on the night in question, but did not appear to be intoxicated at the time of psychiatric examination.

There was no suggestion that he was alcohol dependent although it seems likely he was using alcohol at the level of harmful use.

There is evidence of complicating factors namely psychotic features both before and in the immediate aftermath of the killing. Accordingly there is no cause to suppose that the killing was as a direct result of simple alcohol or drug intoxication.

9.4 [Mr. X] killed [Mr. C], an acquaintance in revenge for earlier victimisation.

There is no direct evidence of such victimisation. [Mr. X] has mentioned some aspects of victimisation but not coherently to date. His family have concerns that [Mr. C] was victimising [Mr. X] but again this is hearsay with no known evidence on this. Whilst this hypothesis remains a possibility there seems ample evidence that he was using alcohol at least in high doses at the time and there was evidence of psychotic features both before and immediately after the killing so a simple revenge motive is not sustainable.

9.5 [Mr. X] killed Mr. C, an acquaintance as a result of any combination of the above

Subject to a verdict in court and even with the benefit of a detailed analysis of the case records in retrospect it is not often possible to be certain as to which particular component of

an individuals presenting features carried most weight. Indeed it may be that this hypothesis is the most likely scenario taken overall."[78]

12.4.3 Findings of the Independent Investigation

In **May 1994** Mr. X was referred by his GP to a Child Psychiatrist. He was experiencing problems at school and attacking other children.[79]

In **March 1996** Mr. X was referred by his teacher to a psychologist. He was described as attention seeking, not mixing well, not obeying rules and regularly destroying his work.[80]

In **April 1996** it was recorded that Mr. X was seeing a family therapist. His behaviour had improved at home but remained a source of concern at school.[81]

In **February 1998** an Educational Psychologist reported that Mr. X was experiencing difficulties in all areas of the curriculum.[82]

In **April 1998** a Child Psychiatrist reported that Mr. X had a low self-image, acted as the school "joker" and was the cause of conflict. It was felt that he needed to develop his social skills.[83]

In **April 1999** Mr. X was referred to the Child and Family Psychiatric service.[84]

In **May 2002** Mr. X was referred by his GP to the Child Psychiatry Service. Mr. X was reported as becoming irritated at school and then "taking it out" on the family. He was described as *"flying off the handle"*. He was not depressed at this time. His mother felt that he was deteriorating.[85]

On **22 September 2003** Mr. X was admitted to a paediatric ward following an overdose. He had also been drinking alcohol and smoking cannabis. At this time Mr. X was living with his

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[78] Internal Investigation Report
[79] GP notes p.2
[80] GP notes p.77, 78
[81] GP notes p. 78
[82] GP notes p. 91
[83] GP notes p.77
[84] GP notes p. 68
[85] GP notes p. 62

grandmother. He was reported as getting drunk every two weeks and smoking cannabis with his friends.[86]

In **October 2003** Mr. X was seen by a Child Psychiatrist. He was well at that time and determined to make different friends. Mr. X felt that he needed help in controlling his anger.[87]

In **November 2003** Mr. X was seen by a Child Psychiatrist. He was seeing a School Counsellor who was advising him on anger management. No mental health disorder was identified at this time.[88]

On **8 May 2005** Mr. X attended the Accident and Emergency Department of Salisbury District Hospital after impulsively taking an overdose of his grandmother's medication.[89] Mr. X reported that in the past he had abused alcohol and other substances. It was unclear whether he was continuing to misuse drugs. He was identified as displaying some psychiatric symptoms and as showing limited insight. Mr. X was diagnosed as experiencing an adjustment reaction to stress.[90]

Mr. X again attended the Accident and Emergency Department **29 November 2005** following an overdose.[91] On this occasion the overdose followed Mr. X splitting up with his girlfriend, although in the course of the assessment he reported that he had been low in mood for some time. At this time Mr. X was identified as having problems in managing his anger and his personality was described as emotionally unstable and impulsive. Mr. X reported experiencing aggressive thoughts particularly towards his ex-girlfriend's new boyfriend. The question was raised as to whether Mr. X was experiencing delusions of jealousy.[92]

Mr. X was diagnosed as suffering from an adjustment disorder and anger management problems.[93]

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[86] GP notes p. 54
[87] GP notes p.53
[88] GP notes p. 52
[89] Clinical Records, p. 83, 95, 157-159
[90] Clinical Records p.95
[91] Clinical Records p. 75ff
[92] Clinical Records p. 79
[93] Clinical Records p.167

On **27 June 2006** Mr. X was detained under a Section 136 of the Mental Health Act (1983). His family had complained about the noise of his music and Mr. X had become angry [94] He reported that he was drinking heavily on a daily basis to *"make life bearable*"[95]. Mr. X was assessed by an Approved Social Worker and a Section 12 Approved Doctor. They found no mental disorder of a seriousness to warrant hospital detention. The Section 136 was discharged.

Mr. X was assessed on **27 March 2008,** by a Specialist Registrar and an Approved Social Worker following him being detained the previous evening.[96] He reported that he had been drinking heavily for four years "*to try to blank out problems with nan*".[97]

During this assessment Mr. X said that his grandmother had suggested that he was hearing voices but he denied that this was the case. He claimed that he had paid for the house in which he and his grandmother lived, using his investments. The Specialist Registrar concluded in her letter to Mr. X's GP:

"Overall I did not feel this young man showed any evidence of mental illness. He was somewhat inconsistent in the history he gave us, however, it appears he is living in a stressful situation at the moment and is appropriately angry about this. He is aware of his alcohol and cannabis misuse and has contact details for ADAS.

We advised him to see yourselves if he had any further concerns regarding his mental health".[98]

Mr. X was discharged.

On **31 March 2008** Mr. X presented to the Adult Mental Health services[99] and was assessed by a CPN from the Rural CMHT**.** Mr. X told the CPN that his drinking was a problem and that he believed that his use of drugs was detrimental to his mental health. He reported that he was not using any illicit drugs at that time. The CPN noted that Mr. X had been detained

[94] Clinical Records p. 161
[95] Ibid
[96] Clinical Records p. 153
[97] Clinical Records p. 153
[98] Clinical Records p.154
[99] Clinical Records p. 73-74

under Section 136 the previous week when he was drunk and disorderly but that the section was discharged when Mr. X was sober.[100]

The CPN noted that Mr. X had experienced some paranoia but this had *“gone now that he is clean”.*[101] Mr. X’s speech was jumbled, he displayed flight of ideas and he expressed some grandiose beliefs. His thoughts appeared to be racing but he denied that he was experiencing any hallucinations. His memory and concentration were poor. It was recognised that Mr. X was not a reliable historian.

The CPN’s formulation was that Mr. X was suffering from a drug induced psychosis/hypomania.He also noted that Mr. X had some strange personality traits. Given Mr. X’s presentation and The CPN’s plan was to discuss Mr. X with his GP and with the Community Mental Health Team, and to monitor Mr. X’s mental state to see if the this improved as the effects of the drugs and alcohol wore off.[102] The CPN wrote to Mr. X’s GP reporting his assessment. He concluded: “*I think it is possible he may have suffered a drug induced psychosis. If he remains abstinent this should resolve itself. I would like to see him again and see if this is the case. I will keep you informed of his progress...”*[103]

On **2 April 2008** at 23.42 the police Medical Examiner contacted the EDS seeking information about Mr. X, who had been detained by the police and was expressing bizarre and psychotic type thoughts.[104]

On **8 April 2008** Mr. X attended his review appointment with the CPN. This appointment was also attended by Mr. X’s grandmother and the Rural Community Team Leader. The CPN noted:

“Much improved from last week likely drug induced psychosis now resolving. No delusional or grandiose beliefs. Good insight realises it was cannabis related. A rather rambling account of things, having problems with [Mr. C] his unofficial employer who he is staying with. Seems to be being exploited doing cash in hand work but not willing to be assertive about this. Says he will be homeless from Monday and advised to go to Council about this

[100] Clinical Records p. 57
[101] Clinical Records p.58
[102] Clinical Records p.71
[103] Clinical Records p. 156
[104] Clinical Records p. 144

and claim benefits. He seemed lucid today and is left with various social stressors does not require ongoing CMHT involvement."[105]

On **9 April 2008** the CPN wrote to Mr. X's GP informing him that Mr. X's mental state was much improved. He reported that Mr. X recognised that "*he was psychotic and expressing some bizarre beliefs*"; he also recognised that his mental state was related to his use of cannabis.

Mr. X was diagnosed as suffering from: *"Drug inducing psychosis (now resolving)"*. Given this improvement Mr. X's was discharged from the CMHT case load.[106]

On **12 April 2008** Mr. X was arrested on suspicion of murder. The police requested a Mental Health Act assessment and Mr. X was assessed by a Consultant Psychiatrist, an ASW and a Section 12 Doctor at Salisbury police station.[107] The conclusion of this assessment was:
"*This evening [Mr. X] presented with emotional labiality, over relaxed, mild pressure of speech, marked flight of ideas and v. incoherent speech with strong persecutory and grandiose themes.*
- This is strongly suggestive of a drug-induced psychosis;
- Preliminary drug test (dip stick) suggestive of being positive for cannabis;
- He is not fit for interview;
- His mental state is likely to improve over next 48 hours. May then be fit for interview."[108]

On **14 April 2008** Mr. X was again assessed by the Consultant Psychiatrist. On this occasion he was found to be orientated in time and place. He reported that he was "*coming down from taking cannabis and alcohol 'which had removed a bubble of LSD from my brain'*."[109] The Consultant Psychiatrist recorded that Mr. X was co-operative but disinhibited; his mood was labile, at times angry and then friendly and apologetic; he expressed some bizarre ideas and grandiose and persecutory beliefs; he exhibited a mild pressure of speech, and shouted, almost spitting, when he was angry. The Consultant Psychiatrist concluded that Mr. X had limited insight. He commented: "*probably still psychotic but need to know his premorbid*

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[105] Clinical Records p.185
[106] Clinical Records p. 152
[107] Clinical Records p. 37
[108] Clinical Records p. 54
[109] Clinical Records.p.31

personality as the grandiose, persecutory themes and arrogance could be part of a disorder of personality of paranoid, narcissistic type".[110]

On **15 April 2008** Mr. X was assessed again by the Consultant Psychiatrist. On this occasion he was accompanied by a nurse from the Rural CMHT. Mr. X was initially hostile during this interview, shouting that he was not mentally ill however he calmed down when the purpose of interview was explained to him. His conversation was subsequently coherent. He spontaneously reported that he had been "high" when he had been assessed on the previous week-end and when the Rural team CPN had seen him, but he did not consider himself to be mentally ill.

The Consultant Psychiatrist concluded that Mr. X had an eccentric way of expressing himself but that he was not, at that time mentally ill. He recorded that Mr. X's presentation was "*best understood as those of an angry, stressed man with strong narcissistic, grandiose features to his personality.*"[111]

On **24 April 2008** the Regional Laboratory for Toxicology reported on their analysis of the urine sample that had been taken from Mr. X on 12 April 2008. This was tested for: amphetamines, benzodiazepines, cannabinoids, cocaine, methadone metabolites and opiates. The sample was found to be negative all of these. A further more sensitive test was done for cannabis metabolites. Again cannabis was not found to be present.[112]

12.4.4 Conclusion

When Mr. X presented in May and November 2005 he told those assessing him that he abused alcohol and illicit drugs and had difficulty controlling his anger. On both occasions Mr. X's overdose was identified as a response to a discrete event: being accused of stealing from his grandmother and being rejected by his girlfriend. On both occasions Mr. X was diagnosed as manifesting an adjustment reaction/disorder.

[110] Clinical Records p. 35
[111] Clinical Records p.27
[112] Clinical Records p.114

Mr. X's next contact with the Mental Health services was in June 2006. Again Mr. X's behaviour was identified as a response to a particular event, an argument with his family. No diagnosis is recorded for Mr. X on this occasion but as on the two previous occasions it was concluded that he was not suffering from a mental illness.

Mr. X's presentation began to change by March 2008. He was again detained by the police and a Mental Health Act assessment was requested. Once again he reported that he had been drinking alcohol and again it was concluded that Mr. X was not suffering from a mental illness. However on this occasion some significant features were noted. He was disinhibited and confused. He volunteered the information that his grandmother had suggested that he was hearing voices though he denied that this was the case. He also claimed that he had paid for the house in which he and his grandmother lived, using his investments, though he was unemployed. As on the previous occasion when he had been assessed Mr. X was the sole informant and Mr. X's account of events was not corroborated.

Mr. X was assessed again four days later, on 31 March 2008. His mental state had deteriorated. He was reporting a range of symptoms consistent with a diagnosis of psychosis: flight of ideas, grandiose beliefs, racing thoughts, jumbled speech, elated mood, poor memory and concentration. Again Mr. X reported that he drank heavily and used illicit drugs. It was noted that he had been detained four days earlier when he was drunk but when assessed when he was sober it was concluded that he did not have a mental health problem.

On the basis of the information available to him the CPN concluded that Mr. X was suffering from a drug induced psychosis or drug induced hypomania. He discussed his formulation with Mr. X's GP and with the Community Mental Health Team and he put forward the hypothesis that if Mr. X was suffering from a drug induced psychosis this should quickly resolve if he abstained from alcohol and illicit drugs. The CPN arranged to assess Mr. X again a week later, on 8 April.

When Mr. X was reassessed he appeared to be significantly improved, although not all of Mr. X's abnormal features had disappeared. This was taken as evidence of the diagnosis of drug induced psychosis was correct.

Mr. X was assessed again four days later following his arrest on suspicion of murder. Again his mental state appears to have deteriorated. His mood was labile, he was displaying pressure of speech and flight of ideas, and he was expressing both grandiose and persecutory ideas.

Again Mr. X reported that he had been drinking heavily though his account of whether he had been using cannabis was inconsistent. On one occasion he said that he had been using cannabis throughout the 11 April[113] and on another occasion he said that he had been offered cannabis but he had not taken any.[114] The Consultant Psychiatrist carried out a preliminary drug screening for cannabis which suggested that Mr. X had been using cannabis. Given Mr. X's presentation, his account of his heavy drinking and the apparent evidence that he had been smoking cannabis the Consultant Psychiatrist concluded that there was a strong suggestion of a drug induced psychosis.

The Consultant Psychiatrist did consider an alternative diagnosis. Following his assessment of Mr. X on 14 April 2008 he commented: "*Probably still psychotic but need to know his premorbid personality as the grandiose, persecutory themes and arrogance could be part of a disorder of personality of paranoid, narcissistic type."*[115] He then conducted a telephone interview with Mr. X's mother who informed him that her son's personality had changed when he began to use drugs at around the age of 17.

Mr. X was interviewed on 15 April and his mental state appeared to have improved. The Consultant Psychiatrist concluded that Mr. X had an eccentric way of expressing himself but that he was not, at that time, mentally ill. He recorded that Mr. X's presentation was "*best understood as those of an angry, stressed man with strong narcissistic, grandiose features to his personality."*[116]

This rapid deterioration and equally rapid improvement when drugs and alcohol were removed seemed to strengthen the case that Mr. X had suffered from a drug induced episode of psychosis.

[113] Clinical Records p. 31
[114] Clinical Records p.150
[115] Clinical Records p.35
[116] Clinical Records p.27

Given the information available to the CPN and the Consultant Psychiatrist in March/April 2008 that Mr. X had been assessed on a number of occasions and had been found not to be suffering from a mental illness, his report that he drank heavily and used illicit drugs and that his mental state appeared to deteriorate rapidly and then to improve when he abstained from drugs and alcohol, the hypothesis that Mr. X had suffered from a drug induced psychosis was not an unreasonable one.

Both the CPN and the Consultant Psychiatrist took some steps to test their hypothesis. The CPN arranged to review Mr. X after a week to see if his mental state had improved. He contacted Mr. X's GP to discuss with him whether the diagnosis of a drug induced psychosis was a reasonable hypothesis. He discussed his formulation at a team meeting and his manager accompanied him when he reviewed Mr. X. This was all good practice.

The Consultant Psychiatrist carried out a preliminary drug screening which appeared to indicate that Mr. X had been using cannabis. He also contacted Mr. X's mother to obtain further information on Mr. X's personal history and personality. Again this was good practice.

However subsequent events have thrown doubt on the diagnosis of drug induced psychosis. The analysis of Mr. X's urine sample taken on 12 April was found to be negative for a range of commonly used illicit drugs, including cannabis, suggesting that contrary to, at least some of, Mr. X's assertions he had not been smoking cannabis on 11 April 2008.

Although Mr. X's symptoms appeared to be improving in the days immediately following the events of 11/12 April 2008 when he was remanded to prison, he continued to display psychotic symptoms and was transferred to a medium secure unit on Section 48/49 of the Mental Health Act (1983) in June 2008.

A forensic report on Mr. X's mental state undertaken in August 2008 commented:
"*My conclusion is that [Mr. X] was suffering from bipolar affective disorder (manic type) from about February 2008, but that his mental state fluctuated, so he could appear relatively normal at times.*

He was also affected at times by the toxic effects of drugs, as he had been for several years past. In his interview with the police, he said that he had taken no drugs for two days before

the fatal stabbing, and the negative drug screening seems to confirm that this was the case."[117]

A second forensic report in October 2008 concluded

"*There is evidence to suggest that [Mr. X] suffers from a psychotic condition, in my view most appropriately described as bipolar affective disorder …The presence of drug misuse may have masked the onset of the disorder or precipitated it."*[118]

This second forensic report also raised the question of whether Mr. X was suffering from a personality disorder.

It is not the function of this Independent Investigation to adjudicate on which diagnosis was correct. Indeed the second forensic report commented

"The diagnosis has been difficult to reach in the case … because of the complexity and constellation of [Mr. X's] reported symptoms, and the possibility that his disorders are in the process of emerging….There are questions about differences of his reported symptoms and history over time and with different practitioners which may influence the degree which one can safely rely on his account. At this stage my provisional diagnosis includes bipolar affective disorder, drug and alcohol dependence misuse and a possible personality disorder."[119]

The function of the Independent Investigation is to identify if the clinical staff undertook the process of diagnosis and formulation in an appropriate manner and if there are lessons to be learned which might improve future practice.

Corroboration and the reliability of information

It was known that Mr. X was not a good historian and the information that he gave was often unreliable. However when he reported that he was drinking heavily and using illicit drugs, on a regular basis, his uncorroborated account of his behaviour was accepted and formed the basis of the explanation of his behaviour and the diagnoses which were arrived at. However it

[117] Forensic notes p. 14
[118] Forensic notes p.38
[119] Forensic notes p.38

is noteworthy that on at least two occasions doubt was thrown on Mr. X's account of his drug and alcohol consumption.

When he was detained in June 2006 he claimed to have been drinking heavily, yet it was recorded that he did not appear drunk to the custody sergeant[120] who, presumably, had considerable experience in this matter.

Following his arrest on 12 April 2008 Mr. X's reports as to whether he had been smoking cannabis were inconsistent, at times claiming that he had been smoking cannabis and at others that he had not. The Consultant Psychiatrist did a preliminary drug screen which appeared to indicate the presence of cannabis. However the analysis by the Regional Toxicology Laboratory was negative for cannabis, suggesting that Mr. X had not been smoking cannabis.

It is probable that had the clinical staff been more cautious in accepting Mr. X's account of events they may have entertained other diagnoses for him and considered other possible explanations for his behaviour.

Availability of information

The clinical staff who assessed Mr. X were under the impression that he had no history of mental health problems. They believed that each of the events they were aware of was a discrete event, a response to a particular situation that Mr. X found stressful. However, Mr. X had been in contact with various Mental Health services from at least 1994 when he was six/seven years old. It is, of course, not possible to say what difference knowledge of this prolonged contact with Mental Health services would have had on the assessment of Mr. X's needs and the formulation of his problem. It is, however, probable that it would have given the clinical staff an opportunity to pause for thought and prompted them to consider whether there was some longer term problem influencing Mr. X's behaviour. It might also have prompted them to ask why Mr. X was resorting to alcohol and drugs rather than simply relating his mental state to the alcohol and drugs. The information regarding Mr. X's early contact with Mental Health services is not contained within his adult clinical notes. It is important, if clinicians are to make sound assessments, that all relevant information is readily

[120] Clinical Records p.160

available. It would be good practice to have the clinical notes from Mr. X's childhood included in his adult clinical notes.

Differential diagnosis

We have already noted that given the information available in March and April 2008 it was reasonable to consider a diagnosis of drug induced psychosis. However it is good practice to consider alternative possible diagnoses. The possibility that Mr. X was manifesting a developing psychotic illness such as schizophrenia, whose course was either masked or exacerbated by his use of drugs and alcohol, does not appear to have been explicitly considered, nor does the possibility that Mr. X was using drugs and alcohol to ameliorate the symptoms of a developing illness. Both forensic reports concluded that a diagnosis of bipolar affective disorder was the most probable diagnosis. Again this possibility was not considered. The issue here is not which diagnosis emerges as the correct or most useful one in the fullness of time but rather that it is good practice to explicitly consider a range of alternative explanations and not to reject the possibility of alternative diagnoses too early.

As noted above diagnosis is only one element in arriving at an understanding of an individual. A good formulation takes into account a range of factors both internal and external to the individual and leads to an understanding of the individual's behaviour and mental state and what effect various interventions might be expected to have. Entertaining a range of possible formulations forces one to consider a range of possible interventions and adds clarity to the assessment. Any chosen intervention is then measured against the criteria which will differentially support one formulation as opposed to others.

12.5 Treatment

12.5.1 Context

The treatment of any major mental health problem is normally multi-faceted employing a combination of psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care,

community support, vocational rehabilitation and pharmacological interventions (medication).

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

"1.1.2 A fundamental problem is a lack of clear operational definitions of "dual diagnosis". In many areas a significant proportion of people with severe mental health problems misuse substances, whether as "self medication", episodically or continuously. Equally, many people who require help with substance misuse suffer from a common mental health problem such as depression or anxiety. Sweeping up all these people together would result in a huge heterogeneous group many of whom do not require specialist support for both mental health and substance misuse issues. Integrating services therefore requires a clear and locally agreed definition of dual diagnosis supported by clear care pathways (care coordination protocols). It is essential to acknowledge that gatekeeping by specialist services is a valid activity which enables them to focus their efforts, and agreed and justifiable gatekeeping practice with clear accountability should ensure that clients are included in the right services, rather than excluded from services they desperately need."[121]

The guidance identifies alcohol as the most common form of substance misuse. Commenting on the impact of substance misuse the Guidance notes:

"1.5.1 Substance misuse among individuals with psychiatric disorders has been associated with significantly poorer outcomes including:

- *Worsening psychiatric symptoms;*
- *Increased use of institutional services;*
- *Poor medication adherence;*
- *Homelessness;*
- *Increased risk of HIV infection;*
- *Poor social outcomes including impact on carers and family;*
- *Contact with the criminal justice system.*

Substance misuse is also associated with increased rates of violence and suicidal behaviour. A review of inquiries into homicides committed by people with a mental illness identified

[121] DoH (2002) *Dual Diagnosis Good Practice Guide* p.6

substance misuse as a factor in over half the cases, and substance misuse is over-represented among those who commit suicide."[122]

12.5.2 Local Context

In 2008 the Avon and Wiltshire Mental Health Partnership NHS Trust approved a new Dual Diagnosis strategy. This strategy document reviewed the relevant national policy and good practice guidance. In its executive summary it states:

"The provision of high quality services for individuals with a dual diagnosis and associated complex needs is one of the greatest challenges facing mental health services today. This strategy promotes 4 key approaches and a range of interventions to support their delivery.
The 4 key approaches are to ensure that AWP:

- *Delivers alcohol and drug treatment as a core part of day to day practice within all mental services, that they are 'mainstreamed' into services;*
- *Provides these services simultaneously, within an integrated treatment approach;*
- *Views alcohol and drug treatment within the recovery approach;*
- *Promotes entry criteria to secondary mental health care based on individual 'needs' and 'risk management', and not just on a diagnosis of severe and enduring mental illness, to ensure those in highest need receive the treatment they require from our services."* [123]

12.5 3 Findings of the Independent Investigation

On **8 May 2005** Mr. X attended the Accident and Emergency Department of Salisbury District Hospital after impulsively taking an overdose. Mr. X was diagnosed as experiencing an adjustment reaction to stress.[124] He was discharged to the care of his GP and provided with information on who to contact if he felt distressed in the future.[125]

Mr. X's next contact with the Mental Health services was on **29 November 2005.** He again presented at the Accident and Emergency Department following an overdose.[126] He was diagnosed as suffering from an 'adjustment disorder' and 'anger management problems'.[127]

[122] Ibid p. 9
[123] Avon and Wiltshire Partnership NHS Trust (2008) Dual Diagnosis Strategy - Co-existing Mental Health and Alcohol and Drug Use Problems. P. 4
[124] Clinical Records p.95
[125] Clinical Records p.157
[126] Clinical Records p. 75ff
[127] Clinical Records p.167

Mr. X felt that he was that he was depressed. However, he did not want to be prescribed medication but he was willing to accept counselling.
The management plan on this occasion was to:

- refer Mr. X to the Crisis Service;
- refer him to the primary care counsellor via his GP;
- advise him about the adverse effects of cannabis use;
- provide him with details of local anger and stress management programmes.[128]

On **14 December 2005** the Rural CMHT wrote to Mr. X informing him that if he made no contact within the next month he would be discharged from their caseload. It was noted that he had been contacted by the Intensive Home Treatment Team (IHTT) although there is no record of such a contact in Mr. X's clinical notes.[129]

On **13 February 2006,** as Mr. X had not made contact with the CMHT, his file was closed.

On **27 June 2006** Mr. X was detained under a Section 136 of the Mental Health Act (1993).[130] He reported that he got drunk every day to *"make life bearable*"[131]. He also reported that other young people taunted him and "*he goes out of his way to engineer confrontational situations"*.[132] Mr. X was assessed but found not to be suffering from mental disorder serious enough to warrant hospital detention. The Section 136 was discharged. Mr. X declined offers of support.

On **26 March 2008** Mr. X was arrested for criminal damage at his grandmother's house. His grandmother had felt frightened and had called the police.[133] He was assessed on **27 March 2008**.[134] It was concluded that Mr. X showed no evidence of psychosis; he was cognitively orientated and, although he was very angry, he did not, at that time, present a significant threat to himself or others.[135] A letter to Mr. X's GP following this assessment concluded: *"[Mr. X] is aware of his alcohol and cannabis misuse and has contact details for ADAS.*

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[128] Clinical Records p. 166
[129] Clinical Records p. 147
[130] Clinical Records p. 161
[131] Ibid
[132] Ibid
[133] Clinical Records p. 153
[134] Clinical Records p. 153
[135] Clinical Records p. 183

We advised him to see yourselves if he had any further concerns regarding his mental health".[136] Mr. X was discharged.

On **31 March 2008** Mr. X presented to the Adult Mental Health services and was assessed by a CPN from Rural CMHT**.** He told the CPN that his drinking was a problem and his use of drugs was detrimental to his mental health though he was not currently using any illicit drugs. The CPN's formulation was that Mr. X was suffering from a drug induced psychosis or hypomania. His plan was to discuss Mr. X with his GP and to monitor his mental state to see if this improved as the effects of the drugs and alcohol wore off.[137]

On **2 April 2008** The Police Medical Examiner reported that Mr. X had been detained and was expressing bizarre and psychotic type thoughts.[138]

On **8 April 2008** Mr. X attended his review appointment with the CPN. This appointment was also attended by Mr. X's grandmother and the Rural Community Team Leader. The CPN concluded that Mr. X was much improved and did not require input from the CMHT. He was discharged to the care of his GP.[139]

12.5.4 Conclusion

Mr. X was seen by mental health staff on only six occasions over a three year period. On two of these occasions he presented to the Accident and Emergency Department following him taking an overdose. On two other occasions he was assessed following him being detained by the police. On all of these occasions Mr. X was deemed not to have a significant mental health problem. Given this pattern of presentation and the consistent conclusion that Mr. X was not suffering from a mental health problem there was limited scope for intervention.

Following his overdoses in 2005 the clinical staff wrote to Mr. X's GP informing him of Mr. X's presentation and suggesting that he was referred for counselling. In May 2005 he was provided with information on who to contact if he felt anxious or distressed.[140] In November 2005 he was referred to the CMHT. However Mr. X failed to respond to a letter from the

[136] Clinical Records p.154
[137] Clinical Records p.71
[138] Clinical Records p. 144
[139] Clinical Records p. 152
[140] Clinical Records p.157

CMHT asking him to make contact. He was also provided with the contact details of a local anger management programme.[141] There is no evidence that Mr. X made use of this information. Given Mr. X's presentation, the information available to the clinical staff and the assessment that he was not suffering from a significant mental health problem, to refer Mr. X to Primary Care services with advice on how he might be supported was not an inappropriate response.

In March 2008 Mr. X was assessed twice in the space of five days. Although he was deemed not to have a mental illness serious enough to warrant detention on the 27 March 2008 he did report some symptoms consistent with a diagnosis of psychosis. By the 31 March his mental state appears to have deteriorated and he was diagnosed as suffering from a drug induced psychosis or hypomania. The CPN reviewed Mr. X a week later, on 8 April. He appeared to have improved significantly by this time and in consequence he was discharged.

The question arises as to whether any intervention could reasonably have been initiated at this point. Mr. X was diagnosed as suffering from a drug induced psychosis and his mental state was reviewed to identify whether this improved as the effects of the drugs and alcohol wore off. This was appropriate. However, given Mr. X's presentation, the fact that he had presented twice in a short period of time, the fact that he was detained by the police between his two appointments with the CPN, and the suggestion that his mental state deteriorated on each presentation, it would have been reasonable to consider why Mr. X was using drugs and alcohol to such deleterious effect. Similarly it would not have been unreasonable to have considered whether there was something that might have been done to decrease the likelihood of another psychotic episode, with further damage to Mr. X's mental health, occurring.

Mr. X was advised about the dangers of using illicit drugs and was given the contact details of the drug counselling service. In a letter dated 22 April 2008 the Consultant Psychiatrist who had assessed Mr. X following his arrest reported that Mr. X had been offered appointments by the local drug and alcohol team in 2007 but he had not attended these. There is no record of these appointments in the clinical notes made available to the Independent Investigation. However the current Trust Dual Diagnosis policy, reflecting national guidance and best policy observes:

[141] Clinical Records p. 166

"Following an assessment, substance misuse is considered the primary problem and the service user may be referred back to substance misuse services without fully considering the impact of mental health problems on functioning, distress and risk, and the contribution which mental health services could make to improve treatment outcomes.

This response is inconsistent with both national policy guidance (CPA) and the available evidence regarding good practice and effective treatment: treating the two conditions concurrently in an integrated approach has better outcomes than treating the two conditions in succession….

Services need to respond to need, in accordance with this guidance, treating both conditions together as appropriate."[142]

The current Trust policy, then, is clear, that where there are both mental health needs and substance misuse problems the individual should be treated in a holistic manner and, normally, within mainstream Mental Health services. The diagnosis of drug induced psychosis explicitly relates substance misuse to mental health difficulties. It would have been good practice to have considered how these inter-related problems might have been addressed rather than discharging Mr. X as soon as his mental state appeared to improve.

Given that there were only three days between Mr. X's review appointment and the events of 11 and 12 April 2008 it is unlikely that any intervention would have had a significant impact on Mr. X's health and well-being.

12.6 Safeguarding Adults

12.6.1. National Context

In the preamble to *Safeguarding Adults: A National Framework of Standards* it is noted that:

"All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the Human Rights Act (1998) to intervene proportionately to protect the rights of citizens. These rights include Article 2: 'the Right to life'; Article 3: 'Freedom from torture' (including humiliating and degrading treatment); and Article 8: 'Right to family life' (one that sustains the individual).

[142] Avon and Wiltshire NHS Partnership Trust (2010) *CPA Dual Diagnosis Procedure* p.5

Any adult at risk of abuse or neglect should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse. It follows that all citizens should have access to relevant services for addressing issues of abuse and neglect, including the civil and criminal justice system and victim support services." [143]

To promote the realisation of the goal of ensuring that individuals are able to live their lives "*free from violence and abuse"* the Department of Health issued its guidance *No secrets*[144] in 2000. This guidance notes:

***"1.1** In recent years several serious incidents have demonstrated the need for immediate action to ensure that vulnerable adults, who are at risk of abuse, receive protection and support…. This guidance builds on the Government's respect for human rights and results from its firm intention to close a significant gap in the delivery of those rights alongside the coming into force of the Human Rights Act 1998.*

***1.2** The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agency's primary aim should be to prevent abuse where possible."*

The guidance goes on to define a vulnerable adult as a person who is over the age of 18 and:

"2.3 who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation"

Abuse is broadly defined as:

"2.5 Abuse is a violation of an individual's human and civil rights by any other person or persons."

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[143] Association of Directors of Adult Social Services (2005) *Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work.* P. 4/5

[144] DoH (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*

When considering whether it is appropriate to intervene, the guidance offers the following advice:

***"2.19** The seriousness or extent of abuse is often not clear when anxiety is first expressed. It is important, therefore, when considering the appropriateness of intervention, to approach reports of incidents or allegations with an open mind. In making any assessment of seriousness the following factors need to be considered:*

- *the **vulnerability** of the individual;*
- *the **nature and extent** of the abuse;*
- *the **length of time** it has been occurring;*
- *the **impact** on the individual; and*
- *the risk of **repeated or increasingly serious** acts involving this or other vulnerable adults."*[145]

12.6.2 Local Context

The Trust's Safeguarding Adults policy in force at the time Mr. X was under its care states:

"The purpose of safeguarding adults is to prevent, detect and manage the risk of abuse or neglect of an adult, particularly where they is an increased level of vulnerability (either permanent or transitory)."[146]

In goes on to identify the following forms of abuse, amongst other:

***"Physical** – including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions…*

***Psychological** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation, or withdrawal from services or supportive networks.*

***Financial or material** – including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits..."*[147]

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145 Internal Investigation Report
146 Avon and Wiltshire Mental Health Partnership NHS Trust (2007) *Trust Policy to Safeguard Adults.* p. 4
147 Ibid

The policy also identifies the following support for staff
"When an adult protection concern or issue is identified, staff or volunteers can contact the Trust Public Protection and Safeguarding Team to discuss their concern(s) and seek advice on the protection of the person(s) concerned and/or on the need to make a referral under local Safeguarding Adults procedures. They can also seek advice and support within their general clinical, practice or supervision arrangements. "[148]

12.6.3 Findings

On **8 May 2005** Mr. X attended the Accident and Emergency Department of Salisbury District Hospital after impulsively taking an overdose of his grandmother's medication. Mr. X had been accused by members of his family of stealing money from his grandmother, with whom he lived. He denied that he had stolen any money, although he admitted that he had been guilty of such behaviour in that past. While Mr. X was waiting for the police to arrive he became angry and frustrated. He had kicked and pulled at cupboards.

Amongst the social risks identified at this time were: including: significant debts, conflict in personal relationships, relationship problems and domestic violence.[149]

Mr. X's next contact with the Mental Health services was on **29 November 2005.** He again presented at the Accident and Emergency Department following an overdose.[150] Mr. X was identified as having problems in managing his anger and his personality was described as emotionally unstable and impulsive. It was noted that Mr. X was reporting aggressive thoughts particularly towards his ex-girlfriend's new boyfriend.[151]

On **27 June 2006** Mr. X was detained under a Section 136 of the Mental Health Act (1983). His family had complained about the noise of his music and Mr. X had become angry. The police had been called. Mr. X had left his grandmother's house telling the police he "*wanted to go out with a knife and find the people who I hate and cause them harm".* [152] He said that he felt like the *"black sheep"* of the family; he felt he could never please his family and felt angry towards them.[153]

[148] Ibid p. 6
[149] Clinical Records p. 15
[150] Clinical Records p. 75ff
[151] Clinical Records p. 79
[152] Clinical Records p. 161
[153] Ibid

On **26 March 2008** Mr. X was arrested for criminal damage at his grandmother's house, where he lived. He had broken a kitchen cupboard, a kitchen door and a remote control. His grandmother had felt frightened and had called the police.[154]

Mr. X's account of the event was that he had returned home feeling tired and had found some *"coke-heads"* in his bedroom taking cocaine. He had become angry with grandmother for allowing these people into the house. He believed that they stole from her and caused her problems but she could not see this. He had threatened to leave. His grandmother was at first upset by this suggestion but subsequently told him to leave. Mr. X reported that he had been drinking heavily for four years "*to try to blank out problems with nan*".[155]

In her letter to Mr. X's GP the Specialist Registrar who had assessed Mr. X concluded:
"Overall I did not feel this young man showed any evidence of mental illness. He was somewhat inconsistent in the history he gave us, however, it appears he is living in a stressful situation at the moment and is appropriately angry about this. He is aware of his alcohol and cannabis misuse and has contact details for ADAS."[156]

A Social Worker had attempted to contact Mr. X's grandmother without success as part of this assessment.

On **31 March 2008** Mr. X presented to the Adult Mental Health service and was assessed by a CPN from Rural CMHT. The CPN noted that Mr. X had been detained under Section 136 of the mental Health Act the previous week when he was drunk and disorderly but the section was discharged when Mr. X was sober. The CPN noted: *"Some family stressors arguments with grandmother"*[157]

The CPN completed the Trust's risk assessment. Alcohol and substance abuse, and the presence of psychiatric symptoms were identified as risk factors. Employment problems and conflict in personal relationships were identified as social risks. Domestic violence was identified as a past issue but was left blank with respect to current issues.

[154] Clinical Records p. 153
[155] Clinical Records p. 153
[156] Clinical Records p.154
[157] Clinical Records p. 57

On **2 April 2008** Mr.X was detained by the police. The Police Medical Examiner reported that Mr. X was expressing bizarre and psychotic type thoughts.[158]

On **8 April 2008** Mr. X attended his appointment with the CPN. Mr. X's grandmother and the Rural Community Team Leader were also present at this meeting. The CPN concluded that Mr. X's mental state was much improved. He was discharged from the care of the CMHT. Although Mr. X's grandmother was present at this meeting her opinion was not sought on either Mr. X's behaviour and mental state or whether she continued to feel afraid of and at risk from her grandson.

On **12 April 2008** Mr. X was arrested on suspicion of murder.

12.6.4 Conclusion

People suffering with mental health problems are more commonly the victims of violence and abuse than the perpetrators. This being the case there is a danger that those working with individuals suffering from mental illness will view their patients as a potential victim rather than a potential abuser.

From his first contact with Adult Mental Health services in May 2005 it was noted that Mr. X had a difficult relationship with his family. This manifested itself in outbursts of anger which he found difficult to control. His grandmother found Mr. X's behaviour frightening. Mr. X stole money from his grandmother. He introduced his friends into her home, where they drank alcohol and used illicit drugs. He argued with his grandmother and damaged her property. On a number of occasions the police were called to Mr. X's grandmother's home because of his behaviour.

It seems that Mr. X had little insight into the effects of his behaviour. When those assessing him on the 27 March 2008 discussed with him where he intended to live following his discharge from police custody, he said that he intended to return to his grandmother's house. It had to be pointed out to him that given his recent behaviour this might not be the most appropriate course of action.

[158] Clinical Records p. 144

Given this catalogue of events it would have been prudent to assess the risk Mr. X posed to his grandmother. It would have been good practice to discover how concerned she was about her grandson's behaviour and how fearful she was for her safety. It would have been good practice to assess her vulnerability. However, although Mr. X's grandmother was present at his review interview on 8 April 2008 she was not consulted on these matters.

It can be difficult to identify when a reasonable risk turns into an unreasonable one. Similarly it can be difficult to determine at what point an individual becomes vulnerable, especially when they appear to have the capacity to make decisions for themselves. The Trust had in place a Public Protection and Safeguarding Team which was available for consultation and advice, to help clinical staff address these challenging issues. There is no record, however, that those assessing Mr. X consulted this team; that they explicitly considered the risk he posed to his grandmother; or that they considered how vulnerable she was.

Given the information available: Mr. X's reports of his conflictual relationships with his grandmother, the fact that the police had been called to Mr. X's grandmother's home on a number of occasions because of his aggressive behaviour, Mr. X apparent lack of insight into the effects of his behaviour and the fact that his grandmother had reported that she was afraid of him, it would have been good practice to formally assess the risk Mr. X posed to his grandmother and to consider to what degree she met the criteria of being a vulnerable adult. It would have been good practice to include Mr. X's grandmother in these deliberations and, in consultation with her, a plan should have been put in place to address any identified issues.

12.6.5 Service Issue 1

Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs, Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice. However it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

12.7 Service User Involvement in Care Planning

12.7.1. Context

The engagement of service users in their assessing their needs and planning their care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

"The individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

The National Service Framework for Mental Health (DH 1999) stated, in its guiding principles, that *"people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. It also stated that Mental Health services would *"offer choices which promote independence"*.

12.7.2 Local Context

The Avon and Wiltshire Mental Health Partnership NHS Trust's CPA policy in place from 2007 commented:

"The philosophy that underpins ICPA is that care is planned in partnership with service users and their carers.

The following principles encourage service user and carer involvement. They are applied with awareness and sensitivity to issues of diversity, which have a bearing on equity of access, provision of services, and also on the way information is provided (for example, in the use of interpreters or provision of translated material).

The service user has the right to:

- *request a change of care co-ordinator....*
- *request the involvement of the voluntary sector for advocacy and service provision...*
- *receive relevant and appropriate information to enable them to be active partners….*
- *receive a copy of their assessment and of their ICPA care plans….*
- *receive local information outlining access to services, including 24-hour support, specialist services, and local support agencies for service users and carers;*
- *be offered additional and accessible information about specific care pathways…."* [159]

[159] Avon and Wiltshire Mental Health Partnership NHS Trust (2007) *Integrated Care Programme Approach (CPA) and Assessment and management of Risk: Policy, Procedure and Guidance*.p.8

12.7.3. Findings of the Independent Investigation Team

Mr. X was seen on six occasions by staff in the Adult Mental Health services. On three of these occasions he presented himself either via the Accident and Emergency Department or directly to the mental health ward. A fourth contact was a review assessment appointment with a CPN from the Rural CMHT. The two other contacts were when Mr. X was assessed following him being detained by the police. There is a record of Mr. X being detained by the police a further time, on 2 April 2008[160], but there is no record of him being seen by Trust staff on this occasion.

12.7.4. Conclusions

Given his brief and episodic contact with the Adult Mental Health services there was limited opportunity to demonstrate Mr. X's involvement in his assessment and care planning. However, given that he took the initiative in contacting the services, albeit at times following overdoses, he was, at least to this extent, involved in identifying his needs.

On two of the three occasions, prior to his arrest in April 2008, when the Trust's core assessment form was completed, the section for recording the user's views was completed. This was good practice. However, on only one occasion is it indicated that a letter regarding Mr. X's presentation was copied to him. It would have been good practice to copy all relevant correspondence to Mr. X particularly where this related to his identified needs and problems or provided advice about future support or treatment.

Following most assessments Mr. X was given information about services e.g. the Crisis Service, the Drug Counselling Service and a local anger management course. There is no evidence that he availed himself of these services. Similarly when he was assessed in June 2006 following him being detained on a Section 136 it was recorded that he had declined all offers of support.

In December 2005 Mr. X was invited to make contact with the CMHT but he did not do this and, according to a letter dated 22 April 2008 from the Consultant Psychiatrist, Mr. X was offered appointments by the local drug and alcohol team which he failed to keep.[161]

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[160] Clinical records p.144

[161] Clinical records p.124

Overall it would seem that Mr. X had considerable control over the contact he had with the Mental Health services and, at least to this degree, the services he received.

12.8 Involvement of the Family

12.8.1. The National Context

It has long been accepted as good practice that the family and carers of service user's should be involved in the assessment and planning of care of those they care for.

In its most recent guidance on the CPA the Department of Health notes:

"To make sure that service users and their carers are partners in the planning, development and delivery of their care, they need to be fully involved in the process from the start. Processes should be transparent, consistent and flexible enough to meet expectations of service users and carers without over promising or under delivering. Service users will only be engaged if the care planning process is meaningful to them, and their input is genuinely recognised, so that their choices are respected."[162]

Later in the same document it is noted that:

"Trust and honesty should underpin the engagement process to allow for an equitable partnership between services users, carers and providers of services." [163]

The guidance points out that the family and carers should be involved in the assessment and care planning process because they provide a privileged source of information and the implementation of the care plans often requires their co-operations. It continues:

"Mental illness can have a major impact on carers, families and friends as well as on the person with the illness. It may cause social and financial disruption and restrict educational and employment opportunities for both the carer and the person being supported. The demands of caring can also affect the physical and emotional health of the carer….Their needs can be overlooked by adult services."[164]

[162] DoH (2008) Refocusing the Care Programme Approach *p. 8*
[163] Ibid p.18
[164] DoH (2008) Refocusing the Care Programme Approach p. 25

However a review by the King's Fund and The Sainsbury Centre for Mental Health[165] into how well the guidance had been implemented concluded:
"Carers were frustrated and disillusioned with the care their loved ones are given. They felt that professionals did not listen to them and gave little information. They felt that they were not regarded as part of the service users' care; rather they were treated like part of the problem. Their main support came from voluntary organisations." [166]

12.8.2. Local Context.
The Avon and Wiltshire Mental Health Partnership NHS Trust's 2007 CPA policy advises:
"It is recognised that assessment is an ongoing and continuous process and information from a variety of sources may be sought to gain an accurate picture of the service user's circumstances (especially carers). Where possible, information to assist in validating assessments should be obtained from as wide a range of sources as possible, in particular histories should be obtained from the service user's immediate family and carers, and all relevant health and social care records obtained."[167]

12.8.3. Findings of the Internal Investigation

"10.5 With the benefit of hindsight & as noted above at section 9, we think it unfortunate that a full collateral history was not taken from any one of those close to [Mr. X] in particular his grandmother, […], with whom he lived. Although [Mr. X's grandmother] attended a follow up appointment with the team on the 8th April she did not feel she had the right to say things and was not specifically asked. However, she was given the chance to ask questions and did so. It has since become clear that [Mr. X's grandmother] would have been capable of giving important information that would have been of use to clinicians with her own observations about [Mr. X's] mental state and her concerns about him. It is our opinion that her evidence would have shaped the formulation of the case & the response of clinical staff and may have led to a different strategy for management. It remains possible that the emphasis and focus may still have been on the issue of his misuse of substances and therefore may not have changed the clinical management plan to any significant degree. Nevertheless, standard

[165] Warner, L., Mariathasan, J., Lawton-Smith, S., Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health
[166] Warner, L., Mariathasan, J., Lawton-Smith, S, Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health p.80
[167]Avon and Wiltshire Mental Health Partnership Trust (2007*) Integrated Care Programme Approach (ICPA) and the Assessment and Management of Risk Policy, Procedures and Guidance.* p.15

practice would normally include taking a collateral history from third party informants and we consider that in this case, despite the availability of family members who could assist, there was a failure to take a sufficiently detailed history from such individuals."[168]

12.8.4. Findings

On **8 May 2005** Mr. X attended the Accident and Emergency Department of Salisbury District Hospital after impulsively taking an overdose of his grandmother's medication. He was assessed by a Senior House officer and a CPN from the Intensive Home Support Service (IHSS).

Mr. X reported that he had been accused by members of his family of stealing money from his grandmother. He denied that he had stolen any money. Mr. X reported that he had frequent arguments with his mother and described their relationship as a parent/child relationship. He reported that he had been a boisterous, nasty character at school and had received counselling as a result of his behaviour, though he could give no details.[169]

On **29 November 2005** Mr. X again presented at the Accident and Emergency Department following an overdose.[170] This overdose followed Mr. X splitting up with his girlfriend, although he reported that he had been low in mood for some time. Mr. X was identified as having problems in managing his anger.[171]

On **27 June 2006** Mr. X was detained under a Section 136 of the Mental Health Act (1983). His family had complained about the noise of his music and Mr. X had become angry. The police had been called. Mr. X had left his grandmother's house telling the police he "*wanted to go out with a knife and find the people who I hate and cause them harm*". [172]

Mr. X said that he felt like the *"black sheep"* of the family; he felt he could never please his family and felt angry towards them.[173]

[168] Internal Investigation Report
[169] Clinical Records p.83ff
[170] Clinical Records p. 75ff
[171] Clinical Records p. 79
[172] Clinical Records p. 161
[173] Ibid

On **27 March 2008** Mr. X was assessed following him being detained by the police. He had broken a kitchen cupboard, a kitchen door and a remote control at his grandmother's house where he lived. His grandmother had felt frightened and had called the police.[174]

Mr. X reported that he had been drinking heavily for four years "*to try to blank out problems with nan*".[175] Mr. X said that his grandmother had suggested that he heard voices but he denied this. He claimed that he had paid for the house in which he and his grandmother lived, using his investments. He said that he did not have a mortgage. He said that he had been self employed but was currently unemployed.[176]

In her letter to Mr. X's GP the Specialist Registrar concluded:
"Overall I did not feel this young man showed any evidence of mental illness. He was somewhat inconsistent in the history he gave us, however, it appears he is living in a stressful situation at the moment and is appropriately angry about this".[177]

Mr. X's plan on release had been to return to live with his grandmother, however after some discussion he said that he would speak to his mother and discuss returning to live with her. The Social Worker also attempted to contact Mr. X's grandmother without success.

On **31 March 2008** Mr. X presented to the Adult Mental Health ward and was seen by a CPN from Rural CMHT, who carried out a core assessment**.** Mr. X told the CPN that his drinking was a problem and that his use of drugs was detrimental to his mental health. The CPN noted on the assessment form: *"Some family stressors arguments with grandmother"*[178]

Mr. X's speech was jumbled and he expressed some grandiose beliefs. Mr. X reported that he had successfully completed his GCSEs and A-levels. He had then gone to College and to Oxford University from where he dropped out.
It was recognised that Mr. X was not a reliable historian.

[174] Clinical Records p. 153
[175] Clinical Records p. 153
[176] Clinical Records p. 183
[177] Clinical Records p.154
[178] Clinical Records p. 57

On the same day Mr. X signed the Trust's "Confidentiality/Consent to Sharing Information" form as: Sir [X] III.[179]

On **2 April 2008** an EDS Contact Information Sheet was completed at 23.42. It noted that *"[The Police Medical Examiner was] seeking information about [Mr. X] who is expressing bizarre and psychotic type thoughts."*[180]

On **8 April 2008** Mr. X attended his appointment with the CPN. This appointment was also attended by Mr. X's grandmother and the Rural Community Team Leader.[181] It was concluded that Mr. X's mental sate was much improved and he was discharged from the care of the CMHT.[182] Although she was present at this interview no information was sought from Mr. X's grandmother on his behaviour or mental state.

On **12 April 2008** Mr. X was arrested on suspicion of murder. The police requested a Mental Health Act assessment. Mr. X was assessed by the Consultant Psychiatrist, an ASW and a Section 12 Doctor at Salisbury police station.[183]

The Consultant Psychiatrist had a telephone interview with Mr. X's mother on **15 April 2008** in which she provided him with information on Mr. X's pre-morbid personality and his recent behaviour.[184]

12.8.5 Conclusion

On at least two occasions Mr. X's family had called the police because of his behaviour. On a number of the occasions on which Mr. X presented to the Mental Health services he reported that his distress was the result of conflict with his family. He reported that he had frequent arguments with his mother and drank heavily "*to try to blank out problems with nan*".[185] He also reported that he felt that he could not please his family and perceived himself to be the black sheep of the family. Given the repeated reports of the involvement of Mr. X's family in his emotional and mental health problems and his reported maladaptive strategies for coping

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[179] Clinical Records p. 215
[180] Clinical Records p. 144
[181] Clinical Records p. 185
[182] Clinical Records p. 152
[183] Clinical Records p. 37
[184] Clinical Records p.28
[185] Clinical Records p. 153

with the stress that he reported experiencing, it would have been good practice to have consulted Mr. X's family and involved them both in the assessment of his needs and in planning how these might be best met.

As already noted on at least two occasions Mr. X's family called the police for assistance and on one occasion it was recorded that Mr. X's grandmother felt frightened by his behaviour. On this occasion Mr. X is reported to have smashed a door, a cupboard and a remote control. Again given Mr. X's reported behaviour on these occasions it would have been appropriate to have consulted Mr. X's family to corroborate Mr. X's account of what had happened and to better understand both the triggers of these behaviours and how he might be helped to address these problems.

On a number of occasions it was noted that Mr. X was not a reliable historian. His accounts of his childhood, the qualifications he had obtained and his financial situation were inconsistent and, it was noted, at times grandiose. Having noted this lack of reliability it would have been good practice to have sought corroboration of Mr. X's account of events so that a more robust formulation of his problems could be arrived at.

It is of note that Mr. X consistently reported using cannabis and drinking heavily. This led those assessing him to conclude that he was experiencing a drug induced psychosis. Given the information available this was not an unreasonable conclusion to arrive at. Yet it is note worthy that when Mr. X was detained on a Section 136 in June 2006 he reported that he had been drinking heavily yet the Custody Sergeant is reported to have remarked that he did not appear to be drunk.[186] Similarly the Regional Laboratory for Toxicology reported that the sample Mr. X provided on 12 April 2008 was negative for all the drugs they tested for including cannabis despite his reported drug use.

The question of Mr. X's insight into his problems was raised on a number of occasions. On 27 March 2008 following the incident when the police had been called to his grandmother's house because of his aggressive behaviour, Mr. X is recorded as planning to return to live with his grandmother. When the appropriateness of this course of action was discussed with him he decided that he would speak to his mother to explore the possibility of staying with

[186] Clinical Records p.160

her. The Internal Investigation reported that on this occasion the ASW did try to contact Mr. X's mother but was unsuccessful. There is no record of any contact being made with Mr. X's mother. Again, best practice would have been to involve the family not only in identifying Mr. X's problems but in identifying possible solutions.

The opportunity to receive information on Mr. X's behaviour and mental state presented itself when Mr. X brought his grandmother to his follow-up interview on 8 April 2008. Unfortunately this opportunity was not taken.

In contrast to this failure to involve Mr. X's family, following his arrest on suspicion of murder on 12 April 2008 the Consultant Psychiatrist who undertook the Mental Health Act assessment at that time did speak to Mr. X's mother and used the information she provided in arriving at his formulation.

The Independent Investigation agrees with the conclusions of the Internal Investigation "*… standard practice would normally include taking a collateral history from third party informants & we consider that in this case, despite the availability of family members who could assist, there was a failure to take a sufficiently detailed history from such individuals.*"[187]

Having said this it must be noted that prior to March 2008 Mr. X had been seen on only three occasions over a three-year period, on each occasion at a time of crisis. On each occasion it was decided that he was not suffering from a mental illness serious enough to merit treatment by secondary Mental Health services. Between 26 March 2008 and 8 April 2008, 14 days, Mr. X was seen on three occasions, once in response to him being detained by the police, once when he presented seeking advice and only on one occasion when an assessment interview was planned. On this final occasion, as on previous occasions, it was decided that he did not require care and treatment from secondary Mental Health services. We cannot know what decision about Mr. X's need for future care would have been made had his family been consulted. It is possible that Mr. X's family were not involved because be had such fleeting contact with, and was immediately discharged from, the mental health service. The

[187] Internal Investigation Report

lesson to be learned here is that it is always good practice to seek corroborative information when undertaking an assessment whenever this is possible.

12.8.6 Service Issue 1

Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice however it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

12.9 Communication

12.9.1. Communication

Context

Timely, relevant, clear communication is key to the delivery of safe, effective and efficient care. Clinical records are the main instrument of communication and of capturing and storing information. The General Medical Council (GMC) has commented: *"Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off".* [188]

Pullen and Loudon (2006) noted that: *"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised".*[189]'

In order to realise this goal of having at least adequate record keeping most statutory regulatory bodies governing health and social care professionals, including the GMC and the

[188] http://www.medicalprotection.org/uk/factsheets/records

[189] Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) PP. 280-286

Nursing and Midwifery Council (NMC), have issued guidance regarding clinical record keeping.

Of course, creating the clinical record is only part of the necessary process. Clinical records and the information and plans that they contain must be readily available to the clinicians providing care and treatment in a timely manner if they are to be of use in ensuring sound assessment and the consistent delivery of care.

12.9.2 Findings of the Internal Investigation

"11.2 Access to the case record

There are some relatively minor issues in respect of retrieving case records out of hours. Case records are held at a central point near the inpatient unit which means that records are not always immediately or readily available to team members working at different locations. This can inhibit team members from seeking full access to earlier recorded clinical material. There is no suggestion that in this case access was particularly delayed. Similarly, there is no indication that information obtained from individuals who had not seen the record would have significantly changed their opinion or the course of action.

11.3 A further concern in respect of records management is that, although everyone understands there is a single health and social care record for each patient there is insufficient confidence in the systems, which results in people keeping components of their health record separate from the main body of the record. Thus components of the record are held in the team's computer "w" drive, and social services personally retain their component of the record on a separate file. Having said that, we note the good practice by EDS who routinely fax through their assessments to the teams so that a record can be held on file. Despite this good practice one such contact was not available to the team for inexplicable reasons."[190]

12.9.3 Findings of the Independent Investigation

Between **May 2005** and **April 2008** Mr. X was seen by the staff of the Mental Health services on six occasions. In addition he was assessed by the Police Medical Examiner on 2 April 2008. On the first two occasions, in 2005, Mr. X presented to the local Accident and

[190] Internal Investigation Report.

Emergency Department following him taking an overdose. On both occasions the SHOs who undertook the assessments wrote to Mr. X's GP informing him of the outcome of the assessment. On both occasions the IHSS, the local mental health Crisis Team, were either informed of, or involved in, the assessments.

In **June 2006** Mr. X was detained on Section 136 of the Mental Health Act (1983). This assessment and its outcome were recorded on the Emergency Duty Service (EDS) contact sheet.[191] There was a copy of this in Mr. X's clinical notes but it was not clear from the available documentation exactly when this was sent to the Mental Health services. The Independent Investigation Team was informed that the normal practice at the time was, when a person was seen by the EDS out of hours, for the relevant information to be faxed to the CMHT at the end of the shift during which the contact had occurred. Information was always faxed within 48 hours.

Mr. X was again detained **26 March 2008** following a call to the police by Mr. X's family. An EDS contact form, completed at 23.00, was faxed to the CMHT at 1.17 a.m. on 27 March 2008. This records that Mr. X had been arrested on a *"public order offence - he is intoxicated with alcohol."*[192] The record continued that Mr. X was to be assessed by the Police Medical Examiner who anticipated that Mr. X would be kept in the cells overnight and reassessed in the morning when he was sober.

Mr. X was assessed on **27 March 2008** by a Specialist Registrar in Psychiatry (SpR) and an Approved Social Worker (ASW). They concluded that Mr. X was not displaying evidence of mental illness. There is a handwritten record of this assessment in Mr. X's clinical notes and a letter to Mr. X's GP reporting his presentation and the outcome of the assessment. In her handwritten notes the SpR had recorded that the plan was to discharge Mr. X from the Section 136. The letter is dated 8 April 2008 but as there is a postscript referring to the events of the 12 April 2008 it is evident that the letter was not sent until after this latter date. The clinical witnesses interviewed by the Independent Investigation were of the opinion that the handwritten notes would probably have been with the Secretary, who was typing the letter to the GP, and so not available to anyone assessing Mr. X between the 27 March and 12 April 2008.

[191] Clinical Records p. 160-162
[192] Clinical Records p.146

Mr. X's next contact with the Mental Health services was four days later, on **31 March.** On this occasion Mr. X was assessed by the CPN from the Rural CMHT. It is unclear what information was available to him when he undertook this assessment. As noted above the information faxed by the EDS on 27 March contained no detail of Mr. X's presentation. The letter from the SpR who had assessed Mr. X and which contained a more detailed account of his violent behaviour, recorded that he had been arrested for criminal damage and that his grandmother had called the police because she was afraid, had not been typed by the 31 March.[193] The CPN recorded on the assessment form: *"Taken in under Section 136 last week. Drunk and disorderly, discharged when sober. Some family stressors arguments with Grandmother."*[194] On the risk assessment form completed as part of the same assessment, the CPN recorded that both in the past and currently Mr. X had "conflict in personal relationships". Under the category "Domestic Violence" it is recorded that this had been an issue in the past but the "Current" column on the form this item had been left blank.[195] The CPN wrote to Mr. X's GP on the day of the assessment. In this letter he notes that: *"[Mr. X] was arrested under Sec 136 MHA on 26/3/08. He was intoxicated at the time and not felt to be detainable. The Police were called following an argument with his grandmother with whom he is currently residing*."[196]

The CPN also telephoned Mr. X's GP to discuss Mr. X's presentation and discuss his formulation.[197]

On **3 April 2008** an EDS contact sheet was faxed to the CMHT at 08.19 informing that team that the Police Medical Examiner had made contact at around 23.00 on 2 April seeking information about Mr. X who was "*expressing bizarre and psychotic type thoughts."*[198] He was seeking information regarding the outcome of the assessment which had been undertaken on 27 April 2008. The EDS advised the Doctor to contact the IHSS. He appears to have done this as the Advanced Practitioner in the IHSS sent an e-mail to the CPN at 23.56 informing him that the Police Doctor had contacted the service asking what support was currently being provided for Mr. X. She had read the CPN's assessment letter to the doctor.

[193] Clinical records p.153
[194] Clinical Records p.57
[195] Clinical Records p.14
[196] Clinical Records p.155
[197] Independent Investigation Interview
[198] Clinical records p. 144

Mr. X was seen for a planned follow-up appointment by the CPN on **8 April 2008**. He wrote to Mr. X's GP on 9 April 2008 informing him that Mr. X's mental state was much improved and he was discharged from the care of the CMHT.[199]

12.9.4 Conclusion

Although Mr. X was seen on only seven occasions as an adult there is evidence of good and consistent communication between the Mental Health services, Mr. X's GP and the out of hours emergency duty service.

On each of the occasions Mr. X was seen by the Mental Health services, contact was made with Mr. X's GP. Following his assessment of Mr. X on 31 March 2008 the CPN telephoned Mr. X's GP to discuss his formulation and obtain the GP's opinion. This was good practice.

Prior to the events of 12 April 2008 the EDS had contact with Mr. X on three occasions. There is a copy of the EDS contact sheet in Mr. X's notes for June 2006. This provides a brief but detailed account of Mr. X's behaviour, presentation and the decisions made. It is unclear, from the records available, when this was sent to the CMHT.

When Mr. X was detained on Section on the 26 March 2008 the EDS contact sheet was faxed immediately to the CMHT. However it contained only minimal information about Mr. X's presentation.

Again on the 3 April the EDS contact sheet was faxed to the CMHT in a timely manner, although again there was little information about Mr. X's presentation.

From the information available it would seem that the EDS contact sheets were faxed to the CMHT in a timely manner. However, the assessment of 31 March 2008 raises some questions as to the adequacy of the system of communication in place at the time.

The Emergency Duty Service was a Local Authority service and its electronic records system did not speak to the Avon and Wiltshire Mental Health Partnership NHS Trust's electronic

[199] Clinical Records p. 152

system. It was for this reason that the EDS contact sheets were faxed to the CMHT. However even when the fax had been sent there was still the requirement that someone in the CMHT, normally an administrator, had to note that a fax had been received and make it available either by placing it within the paper clinical record or scanning it on to the local electronic record. This interface is a point of weakness in the communication system: information might not be faxed in a timely manner, not identified and deal with appropriately when it was faxed, or not made available in a timely manner.

From the record of his assessment interview on 31 March 2008 it is evident that the CPN was aware the Mr. X had been detained by the police four days earlier. However he was unable to recall how he had come by this information. He did not appear to have a detailed description of Mr. X's behaviour and presentation at that time of his detention.

This information was contained in the clinical notes of the SpR who had assessed Mr. X on 27 March. It appears that these notes were not available to the CPN when he undertook his assessment. A rather cumbersome system was in place at the time. Clinicians handwrote their clinical notes; these were then typed and uploaded on to a local records system. This system did not have an interface with the EDS electronic system and was available only to the Salisbury based CMHTs, not universally throughout the Trust. There was a Trust-wide system available at the time but the Independent Investigation Team was informed that this was very *"clunky"* and was only used for administration and not usually for clinical record keeping. Given this system it was the opinion of the clinical witness that the handwritten notes of the SpR would probably have been with the secretary, who was typing the letter to the GP, and not available in the clinical notes to the CPN when he was conducting his assessment.

This system of a local electronic records system on to which information was placed by an administrator was a point of weakness in the communication system.

There was a third point of weakness in the communication and record keeping system. Following his assessment of Mr. X the CPN took the case to the multi-disciplinary team meeting where his formulation and proposed further actions were discussed. This was again good practice. However there is no record of this discussion and why decisions were made in Mr. X's clinical notes. It was reported that the discussion would have been recorded within

the notes of the team meeting. However for anyone reviewing Mr. X from his clinical notes, the accepted main source of information on a service user, this discussion, its insights and the options reviewed, are lost.

It is not possible to say whether the CPN's assessment, his decision not to seek Mr. X's grandmother's views, and his decision to discharge Mr. X would have been different had he known that Mr. X had damaged his grandmother kitchen, she had been frightened enough by his behaviour to call the police and that they were sufficiently concerned by his behaviour to detain him and request a Mental Health Act assessment. What we can conclude is that the information and clinical record systems available should ensure that such information is available to clinicians when they are undertaking an assessment.

The Independent Investigation Team was informed that a Trust-wide electronic record system RiO, is currently being put in place. This will address some of the concerns noted here. Clinicians will input information directly on to the system, all clinicians will have access to relevant data, and team discussions of a service user's care will be included in his/her clinical notes.

There remain two issues, raised by this case, to be addressed however:
(i) Access to and inputting of information on to the electronic system when an assessment is undertaken out of hours and away from Trust premises remains an issue to be addressed.

(ii) The out of hours EDS system, provided by the Local Authority will continue to have a separate electronic system which will not speak to the Trust system and so the cumbersome system of: printing out a record, faxing this, then scanning it into the Trust system, will continue.

The notes available to the clinicians assessing Mr. X related only to his contacts as an adult with the Mental Health services provided by the Avon and Wiltshire Mental Health Partnership NHS Trust and, as discussed above, with the EDS. Mr. X had, however, been seen for a considerable period of time by the Children's Mental Health Services.[200] The clinical staff did not have access to these notes. It is not possible to say how knowledge of his

[200] Forensic Records p. 16

contact with the Children's Services would have influenced the assessment of Mr. X's needs and mental state, but if clinical staff are to undertake sound, robust assessments of need and risk then it is important that they have timely access to all relevant information.

12.9.5 Service Issue 2

If assessments are to be robust and reliable then it is important that all relevant clinical information is available to those undertaking the assessment. This information should be readily accessible and available in a timely manner. Because of the systems of recording and storing information in place at the time, the details of Mr. X's presentation, his behaviour and the fact that his grandmother was sufficiently afraid to call the police was not available to the CPN when he undertook his assessment on 31 March 2008. This was a significant weakness in the communication and record keeping system, however it can not be reasonably concluded that that this failure had a direct causal relationship with the events of 11/12 April 2008.

12.10 The Management of Mr. X's Care

12.10.1 Context

If a service is to function effectively each of its component parts must have a clear remit as to its responsibilities, the functions it is to undertake, the services it is to provide, and the client group it is to serve. These parameters need to be set by the organisation in clear and relevant policies.

The Department of Health published *New Ways of Working* in 2007[201]. This required a change to the established team working practice. A successful implementation of *New Ways of Working* required clear multi-disciplinary team management and clinical leadership. These roles were no longer identified with particular disciplines. The purpose of introducing this new policy was to promote patient-centred care and to ensure that the available resources were employed most efficiently and effectively for the benefit of service users. In this sense *New Ways of Working* supported the central role given to the care co-ordinators.

[201] DoH (2007) Mental Health: *New Ways of Working for Everyone*

12.10.2 Findings and Conclusions

Mr. X presented in crisis to the Mental Health Services on a number of occasions. In part because of the manner of his presentation and in part because he was only briefly and infrequently in contact with the service, there was no explicit plan for the management of his care. Prior to him being seen on the 31 March 2008 those assessing him concluded that there was no evidence that he suffered from a serious mental health problem. They, therefore, passed his care back to his GP. He was, at various times, referred to the crisis team[202], to the CMHT[203] and to the drug and alcohol services.[204] These referrals were the initiatives of the clinicians assessing him. However, because he was not retained within the secondary Mental Health services, there was no mechanism within that service to monitor whether Mr. X took advantage of these referrals.

Looking over Mr. X's record there is a suggestion that his mental health was deteriorating over the time he was known to the Trust. If his mother and grandmother had been consulted it is likely that they would have confirmed this.[205] This again emphasises the importance of involving the family in the assessment of a service user's needs. It also points to the importance of not viewing each presentation of an individual as an isolated, discrete episode. At some point the question has to be asked why an individual keeps presenting to the service. It is likely that the answer to this question in Mr. X's case would have been that he found it difficult to cope with stressful situations or he had maladaptive personality characteristic and, in consequence, misused alcohol and drugs to enable him to cope with his perceived stressors to the detriment of his mental health. This being the case if Mr. X was to be offered an effective service, it was necessary to go beyond the immediate manifestations of distress and construct a more sophisticated formulation of the behaviour. On the basis of this revised formulation a more comprehensive package of care might have been designed to address the identified needs. This was not done and each presentation was viewed more or less in isolation.

The staff of the mental health service did not appear to be aware of the substantial contact Mr. X had had with Children's Mental Health Services. If this information had been known to them it is possible that their assessments and responses to his presentations might have

[202] Clinical Records p.167
[203] Clinical records p. 147
[204] Clinical records p. 124
[205] Clinical records p.127

been different. This is something we cannot know. It is clear however, that if clinical staff are to take a longitudinal view of an individual's problems then historical information has to be readily available. The fact that Mr. X's assessments were unplanned and undertaken at times of crisis illustrates the importance of historical notes being easily accessible.

It was consistently noted that Mr. X misused drugs and alcohol to the detriment of his psychological well-being. It has been noted that both good practice and Trust policy indicate that where substance misuse impacts on an individual's psychological well-being and mental health s/he should be assessed and offered intervention by mainstream Mental Health services, with appropriate support from the specialist substance misuse service, to address these inter-related difficulties. Such a service was not offered in to Mr. X.

Mr. X's care was not planned or co-ordinated. This was because he presented infrequently and in crisis. However, where an individual presents in crisis on a number of occasions good practice suggests that the assessment should go beyond the immediate presentation and address the question of what need is being made manifest by repeated crisis presentations. The Trust together with the clinicians who undertake assessments might reflect on how this might be built into both routine and emergency assessments.

While the care and treatment Mr. X received could have been based on more reflective practice and more effectively co-ordinated, as indicated above, the Independent Investigation Team concluded that there were no acts or omissions on the part of the staff of Avon and Wiltshire Mental Health Partnership NHS Trust which could reasonably be concluded to have had a causal relationship with the events of 11/12 April 2008.

12.11 Clinical Governance and Performance

12.11.1 Context

'*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*'[206]

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

NHS Trusts clinical governance systems aim to ensure that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

The Care Quality Commission (CQC) is the health and social care regulator for England. The vision of the Care Quality Commission is to *"... make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere."*

During the time that Mr. X was receiving his care and treatment the Avon and Wiltshire Mental Health Partnership NHS Trust was subject to two main kinds of independent review from the NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second took the form of a Clinical Governance evaluation.

The Avon and Wiltshire Mental Health Partnership NHS Trust was registered without condition by the CQC in April 2010. Subsequently CQC began a programme of planned reviews of the Trust's 18 registered locations in relation to CQC's essential quality and safety outcomes. To date five planned reviews and two responsiveness reviews have been undertaken. It would be inappropriate to report the details of these reviews here and the reader is asked consult the Care Quality Commission website for more information. However, in summary, the CQC reported its assessment of the 18 registered locations against five sets of standards:

- treating people with respect and involving them in their care;
- providing care, treatment, and support that meets people's needs;
- caring for people safely and protecting them from harm;
- staffing;
- management.

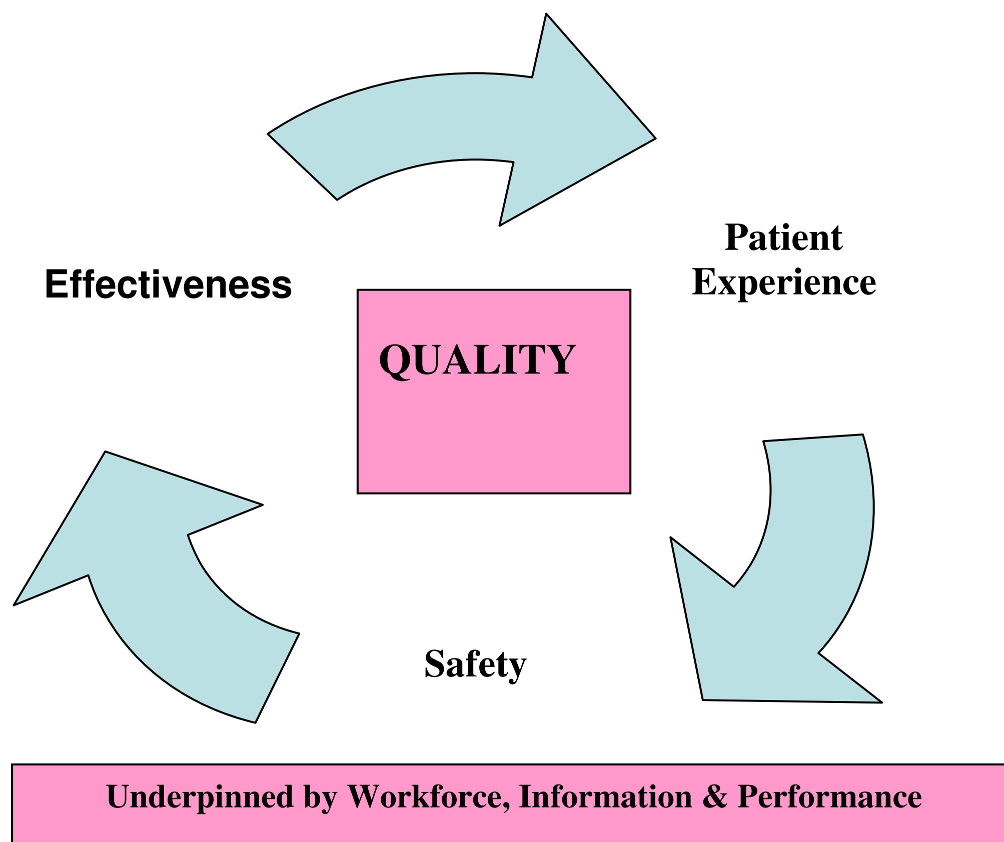
The Trust was found to be compliant with these standards with the exception of one outcome at each of two units, neither of which were relevant to the Salisbury area.

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

12.11.2 Findings

12.11.2.1. Clinical Governance Systems and Performance

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



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

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

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

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

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

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

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

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

Service modernisation and redesign:
To ensure clinical involvement and influence in service redesign the Trust has established Clinical Reference Groups and Practitioners for Change Forum. These

groups enable structured and timely engagement and influence in the modernisation and service redesign process.

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

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

Education, training and continuous personal and professional development:
The Trust Learning and Development Policy aims to:

- improve the quality of the service as experienced by users and carers;
- ensure that learning needs are identified in a systematic way linked to service development and organisational priorities;
- promote a philosophy of continuous personal development;
- ensure that the Trust delivers modern and effective services through enabling staff to develop their skills in line with changing national priorities, policy guidance and service development.

Supervision and appraisal process are identified as important in helping to ensure that staff to take appropriate advantage of development options.

Governance and assurance processes and structure:
The Trust Board leads and directs clinical quality and its governance. Lead responsibility for scrutinising and assuring clinical quality, safety and performance is delegated to the Quality and Healthcare Governance Committee. The Committee is composed of three Non Executive Directors, the Chief Executive, the Executive Director for People and the Executive Director of Nursing, Compliance, Assurance and Standards. The Committee is also attended by the Trust SBU clinical directors

and two representatives from the Professional Council. The Chair of the Committee reports formally to the Board.

The Trust Mental Health Legislation Committee plays a key role in clinical governance. This Committee is composed of two Non Executive Directors and meetings are attended by the Executive Director of Nursing, Compliance, Assurance and Standards, the Mental Health Act Lead, SBU managers, a social work representative, the Mental Health Act and Mental Capacity Act Manager and a consultant psychiatrist. The Chair of the Committee reports formally to the Board.

To support continuous clinical quality improvement the Trust has established a number of management groups chaired by Executive Directors which report to the Performance Executive Management Team. The management groups:

- scrutinise and review compliance with core quality and safety standards and outcomes;
- peer review draft policy, guidance, protocol and strategy;
- manage and co-ordinate engagement of Strategic Business Units and relevant corporate leads.

The Strategic Business Units contribute to the clinical governance system by attending the Trust management groups and Board Committees, disseminating good practice, implementing quality improvement plans, coordinating operational activity against set standards, and providing an evidence base of delivery against clinical quality standards.

The Trust has identified the importance of ensuring that it has processes in place, processes that enable the early identification of potential failings in patient care. The Trust’s ability to spot the early signs of failings is strengthened by:

- the provision and understanding of regular information on key clinical indicators;
- staff being empowered to engage in management processes, raise concerns and be involved in quality improvement processes;

- service users and carers voices and experiences being heard and shared from ward to Board.

12.11.3. Adherence to Local and National Policy and Procedure

12.11.3.1 Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[207] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. They also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty to implement all Trust clinical policies and procedures fully wherever possible, and to report any issues regarding the effectiveness of the policies or procedures and to raise any implementation issues as they arise with immediate effect.

12.11.3. Findings

Quality of Local Policies and Procedures

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[207] Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) p. 328

The Trust has an appropriate set of clinical policies and strategic documents which are informed by both best practice guidance and national guidelines. It is noteworthy that the Trust’s clinical policies are informed by the learning accrued from previous incidents and investigations.

Implementation of Trust Policies

Mr. X’s contact with the Trust was brief and largely restricted to assessment at times of crisis. Prior to his being arrested in April 2008, other than on the occasions when he was assessed at Salisbury police station, the Trust’s core assessment and risk assessment tools were employed in line with Trust policy. When Mr. X was assessed at Salisbury police station following his arrest, again both the Trust’s core assessment form and the Trust’s risk assessment tool were used. This was good practice.

12.11.4. Conclusion

The Trust has in place an appropriate set of clinical policies informed by best practice guidance. When Mr. X presented to the Trust in times of crisis the Trust assessment schedule and risk assessment tools were employed in line with Trust policy.

13. Findings and Conclusions

13.1 Root Cause Analysis

In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

1. **Key Causal Factor.** The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team has concluded had a direct causal bearing upon the homicide that occurred in 11/12 April 2008. In the realm of mental health service provision it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide perpetrated by them.

2. **Contributory Factor.** The term is used in this report to denote a process or a system that that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to a breakdown in Mr. X's mental health and/or the failure to manage it effectively.

3. **Service Issue.** The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation.

13.2 Key Causal Factors

The Independent Investigation identified no direct causal factors connecting the care and treatment of Mr. X by the Avon and Wiltshire Mental Health Partnership NHS Trust and the events of 11/12 April 2008.

13. 3 Conclusion of the Independent Investigation into the Care and Treatment of Mr. X

Mr. X presented to Adult Mental Health services on three occasions and was detained by the police on a further three occasions between 2005 and 2008. On each occasion that the Mental Health services were asked to assess Mr. X they responded promptly and usually completed the Trust's core assessment schedule and the Trust's risk assessment form. When Mr. X presented himself to the "wrong" part of the service in March 2008 the service showed appropriate flexibility and a duty worker travelled to Mr. X to assess him immediately. This was good practice.

Prior to Mr. X approaching the Mental Health services on 31 March 2008 the consistent opinion of those who assessed him was that he was not suffering from a major mental illness. However given his presentation on 31 March and his reported use of alcohol and illicit drugs it was hypothesised that he was suffering from a drug induced psychosis. Given the information available this was a reasonable hypothesis. The Community Psychiatric Nurse (CPN) who assessed Mr. X discussed his formulation with Mr. X's GP and with the multi-disciplinary team. He also arranged to see Mr. X a week later, together with the Team Manager, to monitor his mental state. Again this was good practice.

Mr. X's mental state appeared to have improved by the time of his review appointment. This was taken as confirmation of the diagnosis of drug induced psychosis and Mr. X was discharged from the service.

Overall Mr. X received prompt and appropriate care. However there are lessons to be learnt from Mr. X's case. Mr. X consistently reported friction with his family, on a number of occasions his family called the police because of his behaviour and on at least one occasion Mr. X's grandmother, with whom he lived, reported that she was afraid of him. It was also noted that Mr. X was a poor historian and the information he provided was not always reliable. Despite this Mr. X's family were not involved in the assessment of his needs or the risks he posed, or in planning his treatment. The fact that Mr. X's grandmother had summoned the police and had reported that she was afraid of him did not prompt an

assessment of the risk she might be exposed to. Best practice suggests that Mr. X's family should have been consulted.

The utility of assessments rests on the availability and reliability of information. In general there was good communication between the Mental Health services, Mr. X's GP, and the Emergency Duty Service (EDS). However, because the EDS's electronic records system could not communicate with the Trust's electronic system, a cumbersome system of printing information, faxing, and either filing this within the paper clinical records or scanning it onto the electronic record was employed. While this usually worked well, this was a point of weakness in the communication system. In Mr. X's case it was unclear whether, because of the inherent delays in the system of faxing information, important information was unavailable when he was assessed on 31 March 2008.

Assessment, particularly the assessment of risk, relies on historical information being available. Mr. X had been seen by the Children's Mental Health services however this information and the clinical notes relating to this period were not available to those assessing him. This was a weakness in the communication system.

During the time Mr. X was in contact with the Trust, Mr. X was referred to the Crisis Team, to the CMHT and to the Drug and Alcohol service. He was given the contact details of a local anger management course and a drug counselling service and advised to consult his GP about being referred to a primary care counsellor. Mr. X did not avail himself of any of these opportunities. Because he was not retained in the Mental Health services there was no mechanism for monitoring his compliance with the advice given to him. When Mr. X was re-assessed on 8 April, and his mental state appeared to have improved significantly, he was discharged from the care of the Mental Health services. However, as on previous occasions, the question why Mr. X kept presenting and why he was using drugs and alcohol to such damaging effect was not asked. As Mr. X was discharged from secondary Mental Health services no mechanism was put in place to monitor his mental state. The combination of drug misuse and mental health problems is a common one in the Mental Health service. Both national guidance and the Trust's Dual Diagnosis policy recommend that when an individual presents with both drug mis-use and mental health problems s/he should be assessed and cared for within mainstream Mental Health services. If this is not done there is the danger that the focus will be on the aetiology of the immediate presenting problem and the individual

will be passed between the criminal justice system, Drug and Alcohol services and Mental Health services. In Mr. X's case it would have been good practice for the Mental Health services to have taken the lead in managing his care instead of discharging him as soon as his mental state appeared to have improved.

As noted above, given the information available to the CPN the hypothesis that he had experienced a drug induced psychosis was not an unreasonable one. However subsequent events have thrown doubt on this diagnosis. In June 2008 Mr. X was transferred from prison to a medium secure unit on Section 48/49 of the Mental Health Act (1983). Subsequently two forensic reports concluded that Mr. X was suffering from a serious mental illness, the most probable diagnosis being bipolar affective disorder. The Court, taking note of these reports, accepted Mr. X's plea of guilt to manslaughter on the grounds of diminished responsibility and he was sentenced to be detained for an indeterminate period under sections 37/41 of the Mental Health Act (1983).

Given the nature of Mr. X's conviction and the fact that he was detained under the Mental Health Act the question arises whether any acts or omissions on the part of the staff of the Avon and Wiltshire Mental Health Partnership NHS Trust had a direct, causal, relationship with the events of 11 / 12 April 2008.

Mr. X's contacts with the Trust's Mental Health services were brief and episodic and, until March 2008, it was concluded that he did not suffer from a serious mental illness. When Mr. X's symptomatology appeared to be more serious the service responded in a prompt and flexible manner and arrived at a not unreasonable hypothesis as to the nature of his problem.

It has been pointed out that Mr. X's family might have been more closely involved in his assessments and it would have been good practice for the Mental Health service to have taken the lead in providing a holistic assessment and package of care for Mr. X. However, given the very brief gap between him being reviewed and the events of 11 / 12 April 2008 it would not be reasonable to conclude that any intervention would have had a significant effect on his behaviour or mental state within that time scale and there were no evident grounds for detaining Mr. X under the Mental Health Act (1983) at that time.

The Independent Investigation, therefore, concluded that while there are lessons that can be learned to improve the care are treatment received by other service users it would not be reasonable to conclude that there was any causal relationship between the actions or omissions of the staff of the Trust and the events of 11 / 12 April 2008.

14. Response of the Avon and Wiltshire Mental Health Partnership Trust to the Incident and the Internal Investigation

The following section sets out the response of Avon and Wiltshire Mental Health Partnership NHS Trust to the events of 11/12 April 2008.

14.1. The Trust Serious Untoward Incident Process

At the time of the incident the Trust had in place a clear Serious Adverse Incident Policy and Procedure. This set out the actions to be taken following a serious incident, who should be involved, the time scales, the methodologies to be employed and also provided guidance on contacting and supporting families.

The policy required a Management Investigation to be completed by the Locality Manager/Speciality Manager within 72 hours. A template for completing this report was provided. As required by the Trust policy a Management Investigation Report was completed. This report covers the events up to the 17 April 2008. It appears to have been started on 12 April 2008 and was updated until contact was made with the Prison In-Reach Team on 17 April 2008.

The report contains a clear and comprehensive time line and a good synopsis of Mr. X's contact with the Trust from his presentation in May 2005. It also identifies the actions taken by Trust staff on the days immediately following Mr. X's arrest.

The Trust's Serious Adverse incident policy advises that the service user and, where appropriate, his/her family should be contacted following a serious untoward incident. Where appropriate an apology should be given. The patient and his/her relatives should be informed that an investigation will be undertaken and an explanation provided as to how this will be conducted. Agreement should be reached with the patient and his/her relatives as to what continued support and information will be provided.

The management Investigation report records:
"Courtesy Phone call to [Mr. X's grandmother] following the recent of information regarding Mr. X as she had attended the last interview with him. Unable to get through."[208]
As Mr. X's grandmother was not available the identified action was to consider writing to her to offer support.

The attempt to contact Mr. X's family was in line with the Trust policy and the national *Being Open* policy. However this contact should have been more than a "courtesy phone call". It should, more explicitly, have been following the guidance set out in the Trust policy. Similarly it would have been good practice to have contacted Mr. X's mother.

The author of this report is not identified and the report is not signed.

14.2. The Trust Internal Investigation (Structured Investigation Report)

14.2.1 Terms of reference for the Internal Investigation

The Internal Investigation report did not record the terms of reference for the Investigation instead it reported the aims of an Investigation employing the Root Cause Analysis (RCA) methodology as follows:

4.1 Root Cause Analysis (RCA) is one method for objectively determining the underlying, as well as the immediate, causes of patient incidents, so enabling staff and management to learn from and avoid similar incidents in the future.

4.2 It seeks to do the following, in sequence:

Scope the incident, obtaining as much information as possible;
Generate hypotheses about why the incident happened (the immediate cause);
Investigate the hypotheses;
Determine if there were any Care Delivery Problems (CDPs), including any missing or inadequate safeguards;
Determine if there were any Service Delivery Problems (SDPs), including any missing or inadequate safeguards;

[208] Avon and Wiltshire Mental Health Partnership NHS Trust Management Investigation Report

Identify the factors contributing to the identified CDPs and SDPs;

Analyse the contributory factors to determine if the event would have happened if the factor had not been present. Any factors where the answer is 'no' are considered to be root causes;

Make recommendations aimed at ensuring that the identified root cause(s) cannot become root causes for another incident. The recommendations will aim to improve or implement safeguards."[209]

When discussing this issue with the Internal Investigation Team they reported that at the time this investigation was undertaken it was the custom to use generic terms of reference informed by the RCA methodology. While the RCA methodology is a widely accepted and employed methodology, it is a methodology for collecting and analysing data and does not, itself, identify the questions to be addressed by an investigation. The Independent Investigation was informed that the commissioning of investigations has become more sophisticated since the time this Internal Investigation was commissioned. In 2008 an RCA approach was taken to the investigations of all serious untoward incidents. Now a more proportionate approach is taken and the questions that investigations are asked to address are informed by the thematic analysis of incidents that is now undertaken on a regular basis. This is better practice, to have terms of reference drawn up for each investigation in such a way that specific and relevant questions, pertinent to the situation under investigation, are identified and stated clearly.

14.2.2 Investigation Team

The Internal Investigation Team was made up of three senior members of staff from the Avon and Wiltshire Mental Health Partnership NHS Trust all of whom had both clinical and managerial experience relevant to the investigation. All members of the Investigating Team had been trained in the Root Cause Analysis methodology and had experience of conducting investigations into serious incident.

The Investigation team had experience of Mental Health Services, Specialist Drug and Alcohol Services, Social Work and Forensic Psychiatry and as such were well equipped to undertake the investigation.

[209] Internal Investigation Report

14.2.3 Methodology

The Internal Investigation Team employed the RCA methodology. They identified a number of hypotheses which they tested in as part of the investigation. These are reported below.

The Investigation Team interviewed all those clinical staff involved in Mr. X's care between 27 March and 8 April 2008. The Internal Investigation Team also interviewed both Mr. X's grandmother and his mother. They were interviewed separately from each other in their own homes. The victim was not a service user and the Internal Investigation was unable to obtain contact details for his family.

The Internal Investigation Team reported that at the time they undertook the investigation in 2008 there was a relatively small pool of individuals available to undertake investigations of this nature. It is the nature of such incidents that they are unforeseen and a consequence of this unpredictability was that investigations had to be undertaken in addition to the normal duties of the member of staff. No additional resources were identified to support the investigations.

14.2.4 Conclusion

The Internal Investigation was competently conducted, employing an accepted methodology and adopting a client centred approach.

The Internal Investigation Team were aware that it was good practice to involve the families of both the perpetrator and victim in the investigation. They interviewed Mr. X's mother and grandmother. However they were unable to involve the family of Mr. C because they did not have contact details. More co-operative working with the police in the spirit of the Memorandum of Understanding (2006)[210] might have resolved this issue.

No resources were allocated to support the Internal Investigation Team. However the Independent Investigation was informed that the process of commissioning and undertaking Internal Investigations has evolved over the intervening three years. As noted above

[210] Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006.

investigations are now more clearly focused and are proportionate; more people have been trained to undertake investigations and there is now a rota system, with the result that people are aware, in advance, when they might be called on to undertake an investigation and can, therefore, organise their commitments appropriately. Support for investigations is now provided via the Risk Manager, though it was accepted by those interviewed by the Independent Investigation that the issue of providing appropriate resources to support those undertaking an investigation had not yet been satisfactorily addressed.

The Trust is now exploring how it can ensure that each Internal Investigation Team is made up of individuals with skills relevant to the investigation being undertaken.

Perhaps because no resources were identified to support the Independent Investigation no investigation archive was created. The Trust may wish to review this situation.

14.2.5 Findings of the Internal Investigation

The findings of the Internal Investigation are listed below:

[Mr. X] killed [Mr. A], an acquaintance, as a direct result of an acute psychotic illness induced by illicit drugs and alcohol

The Internal Investigation concluded:

"Our opinion is that having identified the association between his psychosis and his self reported use of alcohol and street drugs, professionals felt this was sufficient explanation and closed their mind to other potential causes. Having said that, there is evidence of care to check for signs of improvement in response to acting on advice to moderate his intake of street drugs and attempts to clarify psychotic symptoms only to be met with his denial of typical psychotic experiences."

[Mr. X] killed [Mr. C], an acquaintance as a direct result of an acute psychotic illness not linked to alcohol or substance misuse

The Internal Investigation concluded:

"We consider that there is ample evidence that [Mr. X] developed a psychotic illness….Whilst it is difficult to properly exclude the role of misuse of alcohol and street drugs in his case…. we note that despite his assertions near the time, there was no evidence of street drug use immediately prior to the killing and only minimal evidence of significant

alcohol intoxication. Accordingly it seems likely that the principal driver for his behaviour on the night in question is abnormal beliefs arising out of his psychosis."

"[Mr. X] killed [Mr. C], an acquaintance as a direct result of alcohol and drug intoxication"

The Internal Investigation concluded

"….There is evidence of complicating factors namely psychotic features both before and in the immediate aftermath of the killing. Accordingly there is no cause to suppose that the killing was as a direct result of simple alcohol or drug intoxication."

[Mr. X] killed [Mr. C], an acquaintance in revenge for earlier victimisation.

The Internal Investigation concluded

"There is no direct evidence of such victimisation. ….Whilst this hypotheses remains a possibility there seems ample evidence that he was using alcohol at least in high doses at the time and there was evidence of psychotic features both before and immediately after the killing so a simple revenge motive is not sustainable."

[Mr. X] killed [Mr. C], an acquaintance as a result of any combination of the above

The Internal Investigation concluded

"Subject to a verdict in court and even with the benefit of a detailed analysis of the case records in retrospect it is not often possible to be certain as to which particular component of an individuals presenting features carried most weight. Indeed it may be that this hypothesis is the most likely scenario taken overall."

As Mr. X had not been convicted of the killing of Mr. C at the time the Internal Investigation report was written the Investigation also identified the possibility that Mr. X had not killed Mr. C.

The Internal Investigation identified only one care delivery problem:

"With the benefit of hindsight & as noted above at section 9, we think it unfortunate that a full collateral history was not taken from any one of those close to [Mr. X] in particular his grandmother,…, with whom he lived."

The Internal Investigation identified the following service delivery problem:

"11.2 Access to the case record

There are some relatively minor issues in respect of retrieving case records out of hours. Case records are held at a central point near the inpatient unit which means that records are not always immediately or readily available to team members working at different locations. This can inhibit team members from seeking full access to earlier recorded clinical material. There is no suggestion that in this case access was particularly delayed. Similarly, there is no indication that information obtained from individuals who had not seen the record would have significantly changed their opinion or the course of action.

11.3 A further concern in respect of records management is that, although everyone understands there is a single health and social care record for each patient there is insufficient confidence in the systems which results in people keeping components of their health record separate from the main body of the record. Thus components of the record are held in the team's computer "w" drive, and social services personally retain their component of the record on a separate file. Having said that we note the good practice EDS routinely fax through their assessments to the teams so that a record can be held on file. Despite this good practice one such contact was not available to the team for inexplicable reasons."

The Internal Investigation identified the following root cause:

"[Mr. C] died as a result of an assault by [Mr. X] whilst [Mr. X] was in an abnormal mental state with markedly disorder organised and persecutory thinking, complicated by mis-use of alcohol and perhaps, other substances. It is not possible to determine precisely the nature of X's thinking at the time of the fatal assault."

14.2.6 Recommendations of the Internal Investigation

"1. Teams should take collateral history from third party informants wherever such informants are available. Although consent should always be sought for such enquiry, staff should bear in mind that the primary purpose at the initial presentation is information gathering rather than information giving. Such information could be gathered during any carers assessment for example.

2. Teams need to be sure that ready access to case records in the absence of electronic assess is possible at all times.

3. Teams should work to ensure that all staff groups have confidence in the records system to avoid the tendency to duplicate parts of the record electronically within sub sets of the clinical team."

Conclusion

The Internal Investigation was well conducted. Its report clearly sets out the information it collected and its findings are clearly derived from the evidence presented in the report.

The Internal Investigation identified the root cause of Mr. C's death as an assault by Mr. X while he was in an abnormal state of mind. It did not, however, identify a key causal factor as defined above. The Independent Investigation agrees that there was no act or omission by those caring for Mr. X which had a direct causal relationship with his actions on the 11 and 12 April 2008.

The Independent Investigation concluded that the recommendations made by the Internal Investigation Team are clearly based on the findings of the Investigation. They are soundly based and appropriate.

The Trust policy specified that the Internal Investigation, (Independent Audit/Root Cause Analysis) should be completed within six months of an incident. The Internal Investigation was completed by September 2008 in line with Trust policy. The Trust might wish to reflect on the utility of undertaking investigations with more limited scope which report more quickly. It is useful to differentiate amongst investigations. A broader more encompassing investigation is more likely to realise the goal of improving systems and processes. However its very comprehensiveness means that it is a relatively slow process and not well suited to ensuring immediate safety. In reviewing its policy on managing Serious Untoward Incidents the Trust may wish to differentiate between the goals of the immediate response to a serious incident; the focused and relatively quick internal investigation and the slower, more comprehensive review. It might then attach appropriate procedures and timescales to these various activities.

14.2. The Trust's Response to the Internal Investigation's Recommendations.

In response to the recommendations of the Internal Investigation the Trust drew up an action plan. This action plan was informed by the recommendations of the Internal Investigation

into the care and treatment of Mr. X and also by the recommendations of other investigations which had taken place around that time so that a thematic and co-ordinated approach to service improvement could be adopted. This was an appropriate response. In response to the Internal Investigation's recommendation that corroborative information should normally be collected the Trust action plan recorded that it has taken the following action:
"The ICPA (Integrate Care Programme Approach) Policy has been further developed to reference and deliver these recommendations within the new policy to manage care pathways and risk and the relevant PDG's."

In response to the Internal Investigation's recommendation that there should be ready access to clinical notes the Trust action plan recorded that it has taken the following action: *"Processes are in place to transport records within the Trust."* In addition the Internal Investigation was informed that now that a new Trust wide electronic records system is being implemented and a back-up system is being put in place to ensure that key clinical information is available when the electronic system is not. In response to the Internal Investigation's recommendation that duplicate sets of clinical notes should not be created the Trust action plan recorded that it has taken the following action:

"Records Management Policy re-drafted and submitted for February Board approval." When the Independent Investigation Team discussed this issue with the Trust it was confident that the new electronic record system, on which all clinical information will be stored and which will be available throughout the Trust, will address the perceived need to keep duplicate records. We have noted elsewhere in this report that there remain some issues relating to accessing clinical notes which remain to be addressed.

These are appropriate actions. However their efficacy will need to be monitored. In particular the implementation of the new electronic records system: while it should bring a number of advantages, is also likely to bring with it a number of challenges. There is now substantial experience with the RiO system, which the Trust is implementing, around the country. If the Trust is not already consulting with those who have already implemented this system it would be prudent to do so and to capitalise on the experiences of these earlier users of this system.

14.2.8 Notable Practice Identified by the Internal Investigation

The Internal Investigation recognised the following notable practice:

"13.1 Good arrangements to deal with the immediate transfer of care when Mr. X presented to the "wrong" team.

13.2 Excellent record keeping.

13.3 Good formulation and review of this case.

13.4 Follow through contacts during arrest phase and remand in custody."

14.3 Dissemination and Staff Involvement

The Internal Investigation Team reported that in other investigations they had undertaken consultation and feedback meetings had been held with the clinical team involved. The aim of these meetings was to discuss the findings of the investigation and the proposed recommendations. This kept the clinical team informed of the progress of the investigation, helped shaped the recommendations and promoted a sense of ownership of the recommendations by the clinical team. Such a meeting was not held as part of this investigation process though the reason for this is unclear. Both the Internal Investigation Team and the clinical witnesses agreed that it would have been useful to have had such a meeting.

The recommendations of the Internal Investigation were passed to the Specialist Business Unit (SBU) and were combined with the findings of other investigations to produce a comprehensive action plan. The clinical staff interviewed were not aware of any actions or changes that took place as a direct consequence of this Internal Investigation; this is perhaps in part because there have been significant changes in the Trust in recent years.

As noted above, when there have been a number of investigations it is appropriate to combine the recommendations of these in such a way as to ensure a co-ordinated development of the service and to ensure that the response to recommendations supports the Trust's initiatives in improving the quality and safety of the services it offers. However it is important, at the same time, to ensure that the clinical staff have a sense of ownership of the proposed and an understanding of the genesis of these. It is unlikely that there is one strategy which will

realise all these goals and, in consequence, it is appropriate for the Trust to engage in a number of ways of disseminating the learning resulting from investigations.

14.4 Staff Support

14.4.1Context

The Trust's Serious Adverse Incident policy[211] recognises that members of staff can be detrimentally affected by adverse incidents:

"11.2 The Trust recognises that staff can be deeply affected by adverse events and may require debriefing either as part of a team or personally. The level of support staff required will vary between individuals. Managers should be proactive in supporting staff."

14.4.2 Staff support during the Independent Investigation

The Trust worked with the Independent Investigation Team to support staff in practical ways to ensure that:

1. information was sent, and received, to advise each witness what was expected of them;
2. information was sent, and received, regarding the purpose of the investigation;
3. support was given if required in the writing of a witness statement;
4. witnesses received support during the day of their interviews and had the offer of a debriefing session afterwards;
5. witnesses received the opportunity to attend a findings workshop at the end of the process.

14.4.3 Conclusion

The staff interviewed by the Independent Investigation reported that at the time of the incident there was a team available within the Trust to conduct debriefings following serious incidents. It does not appear that this was made use of in this case. A staff support service was also available to provide on-going support.

[211] Avon and Wiltshire Mental Health Partnership Trust (2006) *Serious Adverse Incident Policy and Procedure*

One clinical witness reported that he had been accompanied at his interview with the Internal Investigation by a representative of his professional body. Other than this, clinical witness were unclear as to what support was available to them during the Internal Investigation.

The Trust policy acknowledges that staff may be affected by distressing events and it appears to have had in place some support systems, however, at least in this case, they do not seem to have been used. The Independent Investigation was informed that support services available to staff have been revised since 2008. The Trust may want to assure itself that the support mechanisms it has made available are effective and are being used appropriately.

14.5 Being Open

14.5.1 Context

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006[131]. The *Being Open* safer practice notice was consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who have been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.[132]

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may have occurred to members of the public resulting from a potential healthcare failure.

14. 5.2 Findings

The Trust had in place a *Being Open* policy which reflected the national guidance.
An attempt to contact Mr. X's grandmother by telephone was made on 17 April 2008. She was not available. An action note was made to considerer writing to her to offer support. Such a letter is not contained in Mr. X's notes.

Both Mr. X's mother and grandmother were interviewed as part of the Internal Investigation. They were interviewed in their own homes.

14.5.3 Conclusion

The Trust had an appropriate policy in place; an attempt was made to contact Mr. X's grandmother in the days following his arrest; and Mr. X's mother and grandmother were involved in the Internal Investigation. This was all good practice.

However the Trust's *Being Open* policy goes beyond making contact and, amongst other things, indicates that the distress of the family is acknowledged and regret or an apology is offered. These are not formally recorded in the records available to the Independent Investigation. It would have been good practice to have formally recorded that this had been done and the Trust policy followed.

Similarly there is no record of a discussion with the family about on-going support or the provision of information. Again good practice would indicate that these should have been discussed with the family.

Mr. X's victim was not a service user and the Trust had no contact details for his family and as a result, contact was not made with Mr. A's family. Where serious incidents occur it would be appropriate for the Trust to liaise with the police in the spirit of the Memorandum of Understanding who might facilitate communication with the victim's family

15. Commissioning

15.1 Structure of Commissioning

In October 2011 NHS Wiltshire and NHS Bath & North East Somerset were brought together into a new commissioning cluster. This cluster is responsible for commissioning Mental Health services for its geographical area; the South Gloucestershire PCT has acted as the local lead commissioner for Mental Health services for the larger geographical area. The largest local provider of Mental Health Services is the Avon and Wiltshire Mental Health Partnership NHS Trust.

Two members of the Internal Investigation Team met with a representative of NHS Wiltshire. The Team was informed that while there are examples of good clinical care, good care co-ordination and good clinical practice there is a perception that there are problems relating to the interface between the Trust and its commissioners and other service providers. The perception is that these difficulties are of an institutional and organisational nature. The Trust and NHS Wiltshire are working together to understand their different perspectives and to identify ways of improving local services and how these can be delivered more effectively and efficiently. They have recently put in place a plan to address these issues.

15.2 Governance and Monitoring

The Independent Investigation was informed that there have been substantial changes in both organisational structures and in personnel on the commissioning side of the local health service, while on the provider side there are a significant number of small providers in addition to the Avon and Wiltshire Mental Health Partnership NHS Trust. In reviewing the current situation the commissioners have concluded that commissioning has not always been as robust as they would have liked. This has reinforced the identified need to work more closely with service providers, in particular the Trust as the largest local provider, to put in place a more robust and effective commissioning and monitoring system.

Commissioners are responsible for monitoring that those services which have been commissioned are delivered and for assuring the quality of those services. In the current context this includes ensuring that effective investigations are undertaken, after a serious adverse incident has taken place, in a timely fashion and that these result in safe services of a desirable quality.

When the Independent Investigation Team spoke to NHS Wiltshire, due to changes of personnel and reorganisations of the commissioning body, the policies and protocols relating to the monitoring of investigations were not available. However NHS Wiltshire identified that it was their role to ensure that investigations took place in a timely manner, that these were of an acceptable quality, that they resulted in action plans which ensured that the services were safe, fit for purpose and met identified quality standards and current best practice guidance, and that they had a role to play in the monitoring the implementation of the action plan.

16. Notable Practice

It is perhaps the nature of an Investigation that its emphasis is on things that can be improved and, in consequence, the reports of such Investigations can appear somewhat unbalanced and overly critical. Although the current report, too, focuses on what might be improved this is not to be read as indicating that good practice was not also present. The Independent Investigation Team noted a substantial amount of good practice by those involved in the care of Mr. X. This has been noted throughout the report.

However, possibly as a consequence of Mr. X's brief and episodic contact with the Mental Health services, no practices identified as "notable" have been identified.

17. Lessons Learned

17.1 It is inappropriate to generalise to a whole service from a single case, particularly when, as in the case of Mr. X, the service user's contact with the service was brief and episodic. Nevertheless a detailed scrutiny of the care and treatment received by an individual provides an opportunity for reflection and to learn lessons.

17.2 Mr. X's case illustrates the importance of having relevant information available in a timely manner if clinicians are to offer a safe and effective service. It is the responsibility of the organisation to put in place systems that ensure information is available to clinicians in a timely manner. However it is the responsibility of clinicians to ensure that information is recorded in a timely manner and in a place and format that makes it easily accessible to and usable by others. It is also the responsibility of the clinician to ensure that the information on which s/he bases her/his conclusions is appropriately tested and, where possible, corroborated.

17.3 In clinical practice it is more common for people to deny or minimise certain behaviours than to exaggerate them. For this reason clinicians tend to be more cautious about basing conclusions on the denial of a behaviour or experience than when the behaviour or experience is reported. The present case, however, illustrates the importance of the clinician consistently adopting a disinterested stance towards all information and, wherever possible, testing it. Obtaining corroboration, however, does not guarantee that one will always arrive at the correct or even a clear formulation. In the present case it is likely that Mr. X's family would have confirmed that he drank heavily and used illicit drugs, while the only drug screen available suggests that Mr. X had not been using illicit drugs immediately prior to him killing Mr. C. What adopting a disinterested stance and testing information will ensure is that one will not jump too quickly to conclusions and makes it more likely that one will maintain an open mind with respect to both formulation and intervention.

17.4 Corroboration is at times not sought because clinical staff are concerned about breaking confidentiality. There is, at times, confusion between receiving and disclosing information. While, as a general rule, it is inappropriate to disclose information about the individual

beyond those who are involved in his or her care without his/her permission, in the interests of providing a safe and effective service to the individual one can almost always receive information.

17.5 The clinician has to achieve a balance between meeting the needs of the service user and their duty of care to others. This is of particular importance when assessing risk. One has a duty to keep the individual safe, as far as is reasonably possible, but one also has a duty to ensure that s/he does not harm others. This is of particular importance when those who may be placed at risk can be regarded as vulnerable. This can be a difficult balance to achieve. However, especially where those placed at risk are caring for the individual, wherever possible, they should be involved in the assessment of need and risk, their opinions sought and the risk they are exposed to assessed.

17.6 When Mr. X presented to the Mental Health services on 31 April 2008 he was reporting symptoms consistent with a diagnosis of psychosis. He also reported that he used illicit drugs and drank heavily. Given his presentation and his reported use of drugs it was hypothesised that he was suffering from a drug induced psychosis. The fact that his mental state appeared to have improved significantly a week later, in the absence of alcohol and drugs, appeared to confirm the hypothesis. However the question as to why he was using drugs in such a destructive manner was not asked and no plan was put in place to address Mr. X's problem.

17.7 In this case, focusing on the aetiology of the problems, rather that on Mr. X's symptomatology resulted in no service taking responsibility for ensuring that his problems were clearly assessed and addressed. The lesson to be learned here is that when an individual presents in a state of significant distress it is the responsibility of the statutory services to ensure that his needs are appropriately assessed and a plan put in place to address the identified needs. Where the problem is one of both drug use and manifest mental health problems, both national policy and the Trust's dual diagnosis strategy indicate that it is the Mental Health services which should take the lead in assessing need and co-ordinating care.

18. Recommendations

18.1 The Care Programme Approach: Assessing Needs and Planning Care

18.1.1 Service Issue 1

Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice, however it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

18.1.2 The Trust provided the following update:

Gathering information from family members and including this in the service user's care plan is embedded in the latest Trust CPA policy and guidance. The Trust mandatory CPA and Risk Management training was devised with input from carers and a Carer Trainer is almost always a member of the group of trainers delivering this training, thereby modelling partnership working as well as delivering carer - related course content.

Following practice guidance created in the last year, and in line with targets set by our commissioners, service users are routinely informed at the earliest opportunity that Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) clinicians seek to work in partnership with the friends and family that support them, in order to help them identify their carers. Within four weeks these carers are provided with an Initial Carer's Care Plan that informs them about how services work and how to get in contact, including the name and contact details of the relevant care coordinator.

The post of Clinical Lead for Carers is key to ensuring that the Avon and Wiltshire Mental Health Partnership NHS Trust has up to date practice guidance, which all clinical staff can easily access, on how to appropriately include family members in a service user's initial and on-going assessments, treatment plans and reviews.

18.1.3 Recommendation 1

Training:

- the Trust must ensure that all clinical staff receive training, which is updated on a regular basis, on working with and involving families and carers of service users in the assessment of needs and planning of care of the service user;
- where appropriate the '*Working in Partnership with Families and Carers'* workshop should continue to be offered as part of this training;
- the Trust Care Programme Approach (CPA) and Risk Management training should continue to use Carer Trainers to model partnership working;
- a mechanism to disseminate good practice in this area should be put in place.

Practice:

- the **expectation** that, wherever possible and appropriate, families and carers should be involved in the assessment of needs and planning of care of the service user should be enshrined in Trust policy and procedure;
- that this best practice is being followed should be reviewed on a regular basis in supervision;
- the Trust should ensure that there is easy access to advice and support in this area of clinical practice.

Monitoring and assurance:

- the Trust should put in place mechanisms, including regular audits, to assure itself that its policies and protocols in this area are being consistently implemented;
- building on the good practice the Trust has already developed, carers should be involved, appropriately, in these assurance exercises;
- the Trust should put in place a mechanism, for example audits and surveys, to assure itself that the involvement of carers and families is meeting the identified needs of this policy of improving the care and treatment of service users and appropriately involving carers and providing them with relevant information and support;
- the Trust should continue its good practice of consulting carers; it should obtain the views of carers and families on how they can most efficiently and effectively be involved in the planning and delivery of care for those they care for. This information should be used in the development of future policies and protocols.

18.2 Risk Assessment and Management

18.2.1 Contributory Factor 1

Good practice suggests that the assessment of risk should be on-gong, accretitive and, where appropriate, multi-agency. Had this approach been adopted in Mr. X's case a different view of the risk he posed and how this might have been responded to, might have been taken. However, given the brief and transient nature of Mr. X's contact with Mental Health services it would not be reasonable to conclude that there was a direct and causal association between the approach adopted by the Mental Health services and the events of 11/12 April 2008.

18.2.2 The Trust provided the following update:

As part of the review of the CPA and Risk Policy, information was reviewed to ensure that staff are more easily able to adhere to the requirements on them.

The previous policy had four separate guidance documents related to risk. These have been amalgamated into a single Risk Management Procedure, to ensure information is more easily identifiable and adhered to.

The Risk Management Procedure requires staff to consult with family members in undertaking risk assessment, consider risks in relation to the family as well as to the service user or others; ascertaining the families views in relation to any risk factors; and guidance for when risk information needs to be shared to protect others.

18.2.3 Service Issue 1

Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs, Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice. However it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

18.2.4 The Trust provided the following update:

In 2010 explicit practice guidance on how to include family members in a service user's assessment was written and posted on the 'Working with Carers' pages on 'Ourspace'. These guidelines are kept updated by the Trust Clinical Lead for Carers. AWP has developed a one day workshop: 'Working in Partnership with Families and Carers', designed to provide workers with an opportunity to develop the skills to work involve family members in care, to identify and understand barriers, and develop strategies to overcome any obstacles. The Trust Clinical Lead for Carers advises the trainers, in order to keep the course content up to date and relevant. This workshop has been run approximately 10 times per year for the past three years. It is very positively evaluated by participants who report that it increases their confidence to work with families.

In March 2008 AWP set up a Patient Advice and Liaison Service (PALS). This service has achieved a great deal since its inception to ensure carers are aware that they can use this service if they are having any problems in obtaining the service they desire/need from AWP. The PALS team has regular supervision from the Trust Clinical Lead for Carers. In cases where the PALS team identifies particular areas of concern with regard to teams working in partnership with carers that they cannot resolve, the Trust Clinical Lead for Carers provides advice to colleagues and/or works directly with carers to try to resolve the issues.

18.2.5 Recommendation 2

The Trust is currently concluding the review of its Risk Procedures.

Policy and Protocols:

The Trust should ensure that the new policy and associated procedures:

- promote robust risk assessment in line with the best practice guidance (e.g. Department of Health *Best Practice in Managing Risk,* 2007);
- as in previous Trust policies the revised policy should emphasise that risk assessment is an ongoing exercise, builds on previous assessments and historical information, wherever possible is multi-disciplinary and, where appropriate, is a multi-agency exercise;
- wherever possible and appropriate corroboration should be sought;
- the risk assessment should result in a clear formulation which enables all those providing care, treatment and support to make informed decisions;

- following a risk assessment a risk management plan should be drawn up:
    - this should set out how the identified risks are to be responded to and managed;
    - this plan should be more than a list of actions and more than a list of people who should be contacted in times of crisis;
- As the Trust is now employing the RiO electronic records system it must ensure that any changes in policy and protocols are reflected in the RiO system;
- following the updating of the risk management policy and protocols the Trust must ensure that all clinical staff are provided with appropriate training in a timely manner and this training should be repeated on a regular basis;
- the Trust might consider continuing its established good practice and involving carers in this training.

Practice:

- The Trust must ensure that families and carers are appropriately involved in both the risk assessment and risk management planning and that they are appropriately informed of risk management plans;
- the Trust should consider putting in place mechanisms to ensure that risk assessments and risk management plans are carried out on a planned and regular basis as well as at times of crisis and at points of change in the service user's life;
- the Trust should ensure that risk management plans are disseminated in a timely manner.

Monitoring and Assurance:

- The Trust should put in place mechanisms to assure itself that its policies are being implemented in a consistent manner, this might include surveys of service users and carers and others involved in the care of service users e.g. GPs, as well as clinical audits;
- the assurance exercises should address issues of quality, of assessment and planning, as well as the occurrence of assessment and the recording of plans;
- risk assessment and planning should be regularly addressed in supervision and clinical staff should have ready access to advice and support in this area.

18.3 Diagnosis

18.3.1 Corroboration and the reliability of information:

It was known that the information Mr. X provided was often unreliable. However corroboration of his drug and alcohol use was not sought prior to his arrest in April 2008.

18.3.2 The Trust provided the following update:

A recognition of difficulties of obtaining a full alcohol and drug misuse history has been acknowledged in the revised Dual Diagnosis Procedural document (2010), and family corroboration is highlighted (6.2.6), this document is hyper-linked from the CPA Policy.

The barriers to disclosure are considered as part of the PSI Dual Diagnosis training day, and strategies to minimise this highlighted.

The Trust has put in place a revised Dual Diagnosis procedure and related training.

18.3.3 Recommendation 3

- The Trust should ensure that all clinical staff receive regular, up-dated training addressing the assessment of substance misuse and dual diagnosis;
- the Trust should put in place a mechanism to assure itself that its policies relating to the assessment of substance misuse and dual diagnosis are being implemented in a consistent manner; this exercise should included an evaluation of the quality of the assessments as well as identifying that relevant information is recorded;
- The Trust should ensure that staff in Adult Mental Health services have ready access to advice, consultation, and support from Specialist Substance Misuse services and that protocols are in place and being employed to foster joint working to address the needs of the service user.

18.3.4 Availability of information:

The clinical staff who assessed Mr. X were under the impression that he had no history of mental health problems. However, Mr. X had been in contact with various Mental Health

services from at least 1994 when he was six/seven years old. It would be good practice to have the clinical notes from Mr. X's childhood included in his adult clinical notes.

18.3.5 The Trust provided the following update:

The Introduction of RiO has ensured that wider access to records is available to assessing teams at all times.

As the Trust no longer provides CAMHS services it is no longer the keeper of these clinical records.

Revised Guidance on Risk Assessment will include a prompt to ensure historical notes are accessed when indicated.

18.3.6 Recommendation 4

If clinicians are to conduct robust and reliable assessments of risk and need it is essential that they have access to all relevant historical information. Given that the Trust does not provide CAMH services it cannot, on its own, put in place a protocol or mechanism to ensure that information relating to a services user's contact with CAMH services is readily available.

Commissioner

- The commissioner should ensure that:
    - there are protocols in place to ensure that clinicians have timely access to historical information from Child and Adolescent Mental Health Services (CAMHS) and other relevant services;
    - that there are relevant information sharing protocols in place;
    - that service providers work in a collaborative manner with the aim of ensuring that service users receive the best possible care and treatment.
- These protocols might build on the protocols already in place relating to the transition from CAMHS to Adult Mental Health services.

The Trust

- The Trust must ensure that, at least, as part of the initial assessment of each service user:
    - information regarding the individual's mental health as a child is sought;

- relevant, corroborative information is sought and, where appropriate, access to clinical notes, assessments and plans is obtained.

Monitoring and Assurance

The commissioners in collaboration with the Trust and other relevant service providers should put in place appropriate mechanisms to ensure these protocols are being implemented in a consistent fashion.

18.3.7 Differential Diagnosis:

It is good practice to consider alternative explanations of an individual's behaviour. There is no evidence in Mr. X's notes that differential diagnoses were considered.

18. 3.8 The Trust provided the following update:

It is the expected practice within the Trust to formulate a working diagnosis until it is possible to reach a definitive diagnosis.

18.3.9 Recommendation 5

The Trust should ensure that:

- clinical staff have appropriate training in formulation and diagnosis;
- that all patients have a clear formulation of their needs, including a working diagnosis, which informs intervention and treatment, following their initial period of assessment;
- it puts in place a mechanism to assure itself that this policy is being adhered to in a consistent manner, and that diagnostic practices and formulations are of an acceptable quality.

18.4 Treatment

18.4 Treatment

18.4.1 Where both mental health needs and substance misuse problems are present the individual should be treated in a holistic manner, normally, within mainstream Mental Health services. It would have been good practice to have considered how these inter-related

problems might have been addressed rather than discharging Mr. X as soon as his mental state appeared to improve.

18.4.2 The Trust provided the following update:

The past four years has seen a range of developments to integrate Dual Diagnosis (DD) into existing systems, develop and implement a strategic response, and support the development of the workforce to provide good quality care, support and interventions for those accessing secondary mental health service with co-existing alcohol and drug needs. These developments have been framed by The Good Practice Guide (DH, 2002), CNST standards, known evidence base, and more recently DD NICE Guidelines (2011).

This has included

- *An agreed DD Trust strategy (2008-11) and its recent revision (2012-2014), developed with Clinical Leads and monitored through the Operations Directorate;*
- *Approval of a DD procedural Document, which provides a care pathway fro DD within the CPA framework;*
- *Written guidance on the Management of Alcohol and Drug Use on Trust Premises;*
- *Specific guidance for alcohol, opiate and benzodiazepine management;*
- *Developed a DD link worker model, with over 100 link workers to raise awareness and support DD interventions in every team and ward. This work has been recognised nationally, with publication in Advances in Dual Diagnosis (Edwards, 2011;*
- *The introduction of DD training into the Trust training matrix;*
- *Delivering specific PSI one day skills days for staff;*
- *A bespoke DD training day for medical staff;*
- *Helped develop a national e-learning DD package through the National Development Unit and Coventry University, which will be available at the beginning of March 2012, when the IT system has been upgraded;*
- *The integration of DD into service redesign, with the establishment of a dedicated DD practitioner role in each of the new recovery teams. The introduction of DD as a core component of the care plan library, the monitoring of prevalence as a Key Performance Indicator and the development of specific DD interventions as part of payment by result;.*

- *DD CNST have been compliant, and Quality and Effectiveness requests a regular Assurance a paper, and homicide recommendations are incorporated into an on-going action plan as part of the strategy.*

18.4.3 Recommendation 6

The Trust should put in place mechanisms to assure itself and its commissioners that those service users who have been identified as having a substance misuse or Dual Diagnosis problem are having their needs appropriately addressed, in line with the Trust's recent initiatives and policies.

- As part of this assurance exercise the Trust might conduct an annual audit of discharge CPA paperwork for those service users who have been identified as having Dual Diagnosis issues to ensure that substance misuse issues have been addressed as part of discharge planning.

18.5 Safeguarding

18.5.1 Given the information available it would have been good practice to formally assess the risk Mr. X posed to his grandmother and to consider to what degree she met the criteria of being a vulnerable adult. It would have been good practice to include Mr. X's grandmother in these deliberations and, in consultation with her, a plan should have been put in place to address any identified issues.

18.5.2 Service Issue 1

Despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs, Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice. However it would not be reasonable to conclude that it had a direct causal relationship with the events of 11/12 April 2008.

18.5.3 The Trust provided the following update:

The Policy to Safeguard Adults sets out individual practitioner's responsibilities to safeguard adults.

The RiO risk assessment screens identify risk to others, including vulnerable adults.

The 'Ourspace' Safeguarding Adult pages provide a range of information and resources for practitioners.
The South West Safeguarding Adult Threshold Guidance provides clear information to practitioners on raising Safeguarding Adult alerts and is available on 'Ourspace'.
The Head of Safeguarding is leading the review of the Wiltshire Multi Agency Safeguarding Adult policy, and will ensure the best practice set out in this section is fully incorporated into the multi agency policy.

18.5.3 Recommendation 7

- The Trust should ensure that its policy on Safeguarding Adults is reviewed:
  - with reference to the South West Safeguarding Adult Threshold Guidance;
  - to enshrine emerging locally agreed best practice and ensure that it employs language that is consonant with local multi-agency guidance, policies and protocols.
- The Trust should ensure that clinical staff have regular training on Adult Safeguarding and that advice and consultation are readily accessible.
- The Trust should put in place mechanisms to assure itself, its commissioners and other local agencies that its policies and the local Adult Safeguarding Guidance are being implemented in a consistent manner.

18.6 Communication

18.6.1 The Emergency Duty Service (EDS) electronic records system did not speak to the Avon and Wiltshire Mental Health Partnership NHS Trust's electronic system. Access to and inputting of information when an assessment is undertaken out of hours and away from Trust premises remains an issue to be addressed. This interface was a point of weakness in the communication system.

There was a local electronic records system as well as a paper clinical record used only by the community teams in Salisbury. This was a point of weakness in the communication system.

Records of multi-disciplinary team discussion were not available in Mr. X's case notes.

Clinical notes relating to Mr. X's contact with the Children's Mental Health services were not available to the clinicians assessing him.

18.6.2 Service Issue 2

If assessments are to be robust and reliable then it is important that all relevant clinical information is available to those undertaking the assessment. This information should be readily accessible and available in a timely manner.

Because of the systems of recording and storing information in place at the time the details of Mr. X's presentation, his behaviour and the fact that his grandmother was sufficiently afraid to call the police was not available to the CPN when he undertook his assessment on 31 March 2008. This was a significant weakness in the communication and record keeping system however it can not be reasonably concluded that that this failure had a direct causal relationship with the events of 11/12 April 2008

18.6.3 The Trust provided the following update:

The local authority and AWP electronic systems still do not talk to each other however the Emergency Duty service can access AWP systems 24 hours a day through the crisis team or representatives of those teams.

The Trust now employs the RIO system for recording clinical information and has adopted standards for data entry timeliness.

All clinical discussions and records of are expected to be recorded on the Trust's Clinical data entry system.

The Trust no longer provides the CAMHS service in Wiltshire and is therefore not the keeper of this record.

18.6.4 Recommendation 8

- The Trust should agree a protocol with the Local Authority, which provides the out of hours emergency duty system, to ensure that assessments undertaken out of hours are

forwarded in a timely manner to Mental Health teams who will ensure that these assessments are uploaded on to the Trust's systems within an agreed timescale.

- The Trust should put in place a mechanism to assure itself that information from out of hours assessments is available to clinicians in a timely manner;
- The Trust together with its Local Authority partners should put in place a mechanism to assure themselves and their commissioners that those undertaking out of hours assessments have ready access to relevant clinical information, assessments and plans.

18.7 The Management of Mr. X's Care

18.7.1 Mr. X's care was not planned and co-ordinated. This was because he presented infrequently and in crisis. Where an individual presents in crisis on a number of occasions good practice suggests that the assessment should go beyond the immediate presentation and address the question of what need is being made manifest by repeated crisis presentations. The Trust together with the clinicians who undertake assessments might reflect on how this might be built into both routine and emergency assessments.

18.7.2 The Trust provided the following update:

The revised CPA and Risk Policy identifies those service users who should be on CPA (DH, 2008). Any service user who is in contact with Crisis Resolution and Home Treatment Teams is now required to be on CPA.

Any service user on CPA will have a care coordinator who is responsible for overseeing care delivery, including devising and agreeing a crisis and contingency plan.

Within the CPA and Risk Policy, there is a Role and Key Responsibilities of Care Coordinator Procedure, this combined three previous guidance documents into a single procedure, to ensure information is more easily identifiable and adhered to.

This procedure outlines the responsibilities as set out in the National Occupational Standards: comprehensive needs assessment, risk assessment and management, crisis

planning and management, assessing and responding to carers' need; care planning and review, transfer of care or discharge.

The Trust's Nurse Consultants are undertaking a scoping exercise with stakeholders to develop an Early Warning Trigger tool.

18.7.3 Recommendation 9

The Trust should:

- complete its development of a its Early Warning Trigger tool in a timely manner;
- ensure that this device and/or associated protocols, together with relevant training, enable particularly those undertaking emergency assessments to understand and formulate why an individual is repeatedly presenting in crisis;
- consider putting in place a protocol to assess and address the needs of those who present in this manner;
- together with commissioners undertake a review of the needs and subsequent care required by such individuals to inform future service development and effective practice.

18.8 Commissioning

18.9.1 Recommendation 10

NHS Wiltshire should ensure that it has in place policies and procedures which ensure that:

- they are informed of any serious adverse incident in a timely manner;
- standards for the quality and time-scale of investigations are in place;
- the role of NHS Wiltshire is identified in assuring that the recommendations of the investigation are translated into meaningful and effective action plans which are consonant with the quality standards identified for the commissioned services;
- the role of NHS Wiltshire in assuring that the action plan is implemented in a timely manner is identified;
- all relevant staff in NHS Wiltshire are aware of the policy and protocol;

- that information concerning serious adverse incidents is fed into the governance and quality and performance monitoring structures in such a way that it can assure itself that local Mental Health services are safe and of an acceptable quality;
- it conducts regular assurance exercises, including audits, to assure itself that its policies are being implemented in a consistent and effective manner.

19. Glossary

Adjustment/Reaction Disorder	An Adjustment Disorder is an emotional and behavioural reaction to a life event or stress, which develops within three months of that event, and which is stronger than what would be expected for the type of event.
Approved Social Worker	An Approved Social Worker (ASW) is a Mental Health Social Worker with specialist training in the application of the Mental Health Act. It is normally the responsibility of the ASW to co-ordinated assessments under the Mental Health Act. They identify and consult the nearest relative and normally make the application for admission to hospital or for a guardianship order under the Act. The ASW has the responsibility for ensuring the individual is treated in the least restrictive manner possible. The role of the ASW was replaced by that of the Approved Mental Health Practitioner (AMHP) in the 2007 amendments to the Mental Health Act.
Bi-Polar Affective Disorder	Bi-polar affective disorder is a disorder of a person's mood which can swing from very low (depressed) to very elated (mania). The individual suffering from bi-polar affective disorder can also experience a range of abnormal experiences such as hallucinations or delusions.
Care Coordinator	The Care C00rdinator is a health or social care professional who co-ordinates the various elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
CPN	A CPN, Community Psychiatric Nurse, also sometimes

	known as a Community Mental Health Nurse, is a qualified Mental Health Nurse who delivers care, treatment and support in the community, usually as part of a community mental health team (CMHT).
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
CMHT	A Community Mental Health Team is a muli-disciplinary team which delivers care, treatment and support in the community to individuals with mental health problems. It normally employs the Care Programme Approach to guide its assessments and interventions.
Differential Diagnosis	This is the process of distinguishing between illness and diagnoses of similar character by comparing their signs and symptoms.
EDS	The out of hours emergency duty service.
Hypomania	A mild to moderate level of mania is referred to as hypomania. Hypomania is an abnormality of mood characterized by optimism, pressure of speech and activity, and decreased need for sleep. Some people believe that they are more creative during periods of hypomania while others manifest poor judgment and irritability.
ICPA	Integrated Care Programme Approach (See CPA).
Mental Health Act (1983)	The main purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

Mental Health Act: Section 2	Section 2 of the Mental Health Act allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days.
Mental Health Act: Section 12 Approved Doctor	The Mental Health Act requires that in those cases where two medical recommendations for the compulsory admission of a mentally disordered person to hospital or for reception into guardianship are required one of the two must be made by a practitioner approved for that purpose under Section12 (2) of the Mental Health Act 1983.
Mental Health Act: Section 35	A Crown Court or a Magistrates' Court can remand a person accused of a crime to hospital on evidence from one doctor that: i) there is 'reason to suspect' that he or she is suffering from a mental disorder; and ii) it would be 'impracticable' for a report on his or her mental condition to be made if he or she were remanded on bail.
Mental Health Act: Section 37/41	Section 37: A Hospital Order. This is a court order imposed instead of a prison sentence, if the offender is sufficiently mentally unwell at the time of sentencing to require hospitalisation. It has the same duration as a section 3 and in many ways operates in the same way. Section 37/41: Restriction order This is a court order, which can only be made by the Crown Court, which imposes a section 37 Hospital Order together with a section 41 Restriction Order. The restriction order is imposed to protect the public from serious harm. The restrictions affect leave of absence, transfer between hospitals and discharge, all of which require Ministry of Justice permission.
Mental Health Act: Section 47/49	This is a transfer direction under section 47 together with a restriction direction under section 49. The restrictions are the same as those in section 41. The prisoner can be transferred back to prison at any time, on medical advice or the advice of

	the Mental Health Review Tribunal In theory these patients can be discharged directly into the community, but in practice they are normally returned to prison when detention and treatment under the Mental Health Act is no longer deemed necessary.
Mental Health Act: Section 136	This section of the Mental Health Act gives the police powers to remove a person who appears to be suffering from mental disorder and who is "in immediate need of care or control" from a public place to a place of safety. Removal may take place if a police officer believes it is necessary in the interests of that person, or for the protection of others. The purpose of removing a person to a place of safety (usually a police station cell or a hospital) is to enable the individual to be assessed by a mental health professional.
NPSA	The National Patient Safety Agency is an arm's length body of the Department of Health. It was established to promote the improvement of safe patient care by informing, supporting and influencing organisations and people working in the health sector.
Personality Disorder	A Personality Disorder is an enduring pattern of inner experiences and behaviours that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has its onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.
Personality Disorder: Narcissistic	This Personality Disorder is characterised by a pattern of grandiosity, need for admiration and lack of empathy.
Personality Disorder: Paranoid	This Personality Disorder is characterised by a pattern of distrust and suspiciousness such that the motives of others are interpreted as malevolent.
Primary Care Trust	A NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and are involved in commissioning

	secondary care, such as services provided by Mental Health Trusts.
Prison In-reach Team	The NHS is responsible with the Prison Service for providing health care to those detained in prison. To meet this responsibility Mental Health In-reach Services have been introduced in prisons. These services comprise multi-disciplinary teams similar to Community Mental Health Teams and aim to offer prisoners the same kind of specialist care and treatment they would receive in the community. The In-Reach teams are commissioned from local Mental Health NHS Trusts and were first introduced in prisons in 2001/02.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others.
Schizophrenia	Schizophrenia is classified as a psychotic illness. It is a mental health problem associated with a range of psychological symptoms. These include: • hallucinations - hearing or seeing things that most other people believe are not present/do not exist; • delusions - unusual beliefs that are not based on reality and often contradict the evidence; • confused thoughts based on the hallucinations or delusions; • changes in behaviour. Schizophrenia is one of the most common serious mental health conditions. Approximately 5 in 1000 people experience a psychotic disorder (including schizophrenia and manic depression). Men and women are equally affected by the condition. In men, schizophrenia usually begins between the ages of 15 and 30. In women, schizophrenia usually occurs later, beginning between the ages of 25 and 30.

Service User	The term of choice of individuals who receive Mental Health services when describing themselves.
SHA	Strategic Health Authorities were created by the government in 2002 to manage the local NHS on behalf of the Secretary of State. There were originally 28 SHAs. In 2006, this number was reduced to 10. SHAs are responsible for: developing plans for improving health services in their local area; ensuring that local health services are of a high quality and are performing well; increasing the capacity of local health services so they can provide more services; ensuring that national priorities are integrated into local health service plans. SHAs manage the NHS locally and provide a link between the Department of Health and the NHS.
Specialist Registrar	A Specialist Registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order, eventually, to become a consultant.