Independent Investigation

Into the

Care and Treatment Provided to Mr. Z

by the

Sussex Partnership NHS Foundation Trust

Commissioned by

NHS South of England
Strategic Health Authority

Executive Summary

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

Contents

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

Background

Mr. Z was born on the 7 June 1989. He had suffered a degree of physical abuse as a young child and had subsequently accessed Child and Adolescent Mental Health Services as a teenager for related trauma.

On the 21 April 2010 Mr. Z visited his GP surgery accompanied by his father. It was reported that Mr. Z had been released from prison two to three weeks earlier and that he was feeling angry, irritable and paranoid.[1] The GP sent a referral to the Sussex Partnership NHS Foundation Trust West Access Team in Brighton for an urgent assessment. On the 28 April 2010 Mr. Z was seen by the West Access Team where an initial screening was undertaken. He was not thought to require further secondary care intervention at this stage and Mr. Z was referred back to his GP. [2]

On the 16 June 2010 Mr. Z returned to his GP who made a second referral to the West Access Team for an urgent assessment. Mr. Z was anxious and depressed. Mr. Z had described some reckless behaviour and the GP decided that he would benefit from secondary care intervention.[3] On the 17 June 2010 the West Access Team telephoned Mr. Z. However it was not possible for the Team to arrange an early appointment and Mr. Z became upset and hung up. On the 24 June 2010 Mr. Z was discharged from the service as he had not got back in contact to arrange an appointment.[4]

On the 15 July 2010 Mr. Z telephoned the West Access Team. He was having difficulty with crowds and found it difficult to visit his GP. He was still feeling anxious and depressed. He said that he wanted to see a psychiatrist. Mr. Z was told that he would have to be re-referred to the service by his GP and could not be seen otherwise. Mr. Z had no further contact with secondary care services.

Incident

Shortly before noon on 4 September 2010 a badly burnt body was found on a golf course north of Brighton. DNA tests found the body to be that of Mr. X who was known to local substance misuse services. He had suffered severe trauma to the brain prior to being set alight. It became apparent that Mr. X had been killed at an address in Brighton and later moved to the golf course where his body was burnt in an attempt to conceal its identity.

1. Clinical Record P.4
2. Clinical Record PP. 7-11
3. Clinical Record PP. 17-18
4. Clinical Record P. 24

Mr. Z was subsequently arrested for the murder of Mr. X on the 8 September 2010 and was remanded in custody. The two men had apparently been friends having met whilst they had both previously been on remand.

Mr. X was described in Court as being *"vulnerable, defenceless and completely without malice".*[5] On the 31 March 2011 Mr. Z was convicted of the murder of Mr. X and was jailed for life with a further seven-year sentence for attempting to pervert the course of justice. Mr. Z's father and brother were also jailed for attempting to pervert the course of justice for seven and six years respectively. These sentences were handed down as Mr. Z's father and brother were found guilty of helping him to conceal the murder of Mr. X.

When being tried for the murder of Mr. X the Court was told that Mr. Z had formerly been remanded for robbery and the actual bodily harm of a 15-year old boy. The Court was also told that Mr. Z was on the Sex Offenders' Register for the sexual assault of a 15-year old girl. The only mitigating factor cited during the Judge's sentencing remarks was Mr. Z's young age. No mention was made of any existing, or pre-existing, mental health condition that could have influenced his actions in the killing of Mr. X.[6]

5. BBC News Sussex 31 March 2011
6. Court Transcriptions

2. Terms of Reference for the Independent Investigation

The Independent Investigation was commissioned by NHS South of England, South East Coast. The Investigation was commissioned in accordance with guidance published by the Department of Health in *HSG (94) 27 The Discharge of Mentally Disordered People and their Continuing Care in the Community* and the updated paragraphs 33 – 36 issued in June 2005. This Investigation was commissioned as a 'B' grade review. A 'B' grade review comprises a specialist team who are requested to build upon the work of internally commissioned investigation reports in order to ensure proportionality. This is an investigation with two investigators generally with access to expert advice as needed. It is appropriate in cases that appear to be less complex and where the investigation will focus on one agency and where the issues appear to be clear. As well as staff there will be a need to offer interviews to perpetrators, their families and families of victims. The outcome of this type of investigation is a report which provides a detailed chronology and analysis of the care and treatment of an individual and may include recommendations which relate to the organisation's managerial/clinical policy and practice.

Terms of Reference

1. *"To examine the care and treatment of Mr. Z, in particular:*

- *The history and extent of Mr. Z's involvement with the health and social care services.*
- *The suitability of Mr. Z's treatment, care and supervision in respect of:*
  - *his clinical diagnosis;*
  - *his assessed health and social care needs;*
  - *his assessed risk of potential harm to himself and others;*
  - *any previous psychiatric history;*
  - *any previous forensic history;*
  - *the assessment of the needs of carers and Mr. Z's family.*
- *The extent to which Mr. Z complied with his prescribed care plans.*
- *The extent to which Mr. Z's care and treatment corresponded to statutory obligations, the Mental Health Act (1983 & 2007), and other relevant guidance from the Department of Health.*
- *The quality of Mr. Z's treatment, care and supervision, in particular the extent to which his prescribed care plans were:*
  - *appropriate;*
  - *effectively delivered;*
  - *monitored by the relevant agency.*
- *The adequacy of the framework of operational policies and procedures applicable to the care and treatment of Mr. Z and whether staff complied with them.*
- *The competencies of staff involved in the care and treatment of Mr. Z and the adequacy of the supervision provided for them.*
- *The internal investigation completed by Sussex Partnership NHS Foundation Trust and the actions that arose from this.*

- *The Trust clinical governance and assurance systems as they relate to care and treatment provided to Mr. Z, this in particular regard to:*
    - *audit;*
    - *clinical supervision;*
    - *clinical leadership.*
- *Any other matters that the investigation team considers arise out of, or are connected with, the matters above.*

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

3 *To prepare a written report that includes recommendations to the Strategic Health Authority, or successor organisations, so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.*

Approach

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

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

Timetable

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

Publication

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

3. The Independent Investigation Team

Selection of the Investigation Team

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

Investigation Team Leader

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

Investigation Team Members

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

Support to the Investigation Team

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

Independent Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

4. Findings of the Independent Investigation

1. Diagnosis. Despite two urgent referrals being made by primary care Mr. Z was not seen by a psychiatrist in secondary care and consequently no medically-derived diagnosis was made. Mr. Z's presentation was such to merit a medical examination. He had been recently released from prison, was known to have had a substance misuse problem and was also experiencing paranoid symptomology, intense anger and self-harming behaviour.

It was evident to this Investigation that the GP made the two referrals to primary care in order for an urgent assessment to be undertaken. It was known that:

- Mr. Z had been recently released from prison;
- Mr. Z was having some kind of adjustment difficulties;
- Mr. Z was self medicating with Diazepam (which was not being prescribed for him) and *"weed"*;
- Mr. Z's father was extremely worried about him;
- Mr. Z was paranoid, experiencing feelings of extreme anger, was anxious and agoraphobic and was self harming.

Clinical witnesses to this Investigation stated that it was not acceptable for a service user such as Mr. Z not to be seen by a Psychiatrist but that this was how the service was managed at the time. The Independent Investigation Team concurs with the reflections of the clinical witnesses in that a medically-led assessment was indicated for Mr. Z.

- ***Service Issue One. The service in operation at the time Mr. Z was receiving his care and treatment was not always conducive to the development of robust clinical assessments due to both time pressures and inherent difficulties with the service model. This was to have implications when providing a diagnostic formulation and any subsequent care, medication and treatment package.***

2. Medication and Treatment. Despite no diagnosis being given the nurse who assessed Mr. Z at the West Access Team suggested that Mr. Z ask his GP for an SSI. The fact Mr. Z reported he was self medicating with Diazepam was ignored. The medication and treatment advised by secondary care services was not as the result of a well thought through assessment and diagnostic formulation.

3. Mental Health Act (1983 and 2007). The Assessment of the use of the Mental Health Act was not relevant to this Investigation as at no time was the Mental Health Act indicated.

4. Care Programme Approach (CPA). Due to the brevity of contact with secondary care services it was not possible to assess the CPA process Mr. Z was subject to. However it is the finding of the Independent Investigation Team that Mr. Z's history and presentation met the criteria for being placed on CPA.

- ***Service Issue Two. Mr. Z's presentation was such that at the time of his referral to, and assessment by, the West Access Team he should have been considered eligible for full CPA. The failure to ensure that this was considered meant that Mr. Z continued in a state of distress necessitating a second urgent GP referral.***

5. Risk Assessment. Risk assessment was a tick box process which did not address what was known about Mr. Z and did not lead to a formulation of risk being made. The risk assessment process was not in keeping with national or local policy and guidance and fell short of the standard to be expected from a secondary care provider. The standard of recording was poor. The risk assessment process consisted of an initial risk screen only.

Two urgent referrals were made by primary care to secondary care services. During this time it was known that Mr. Z had recently been released from prison following a conviction for actual bodily harm. It was also known that Mr. Z:

(28 April 2010)

- was self harming;
- was self medicating with Diazepam and cannabis;
- was angry and impulsive and had a history of violence;
- had recently been released from prison;
- was paranoid and at risk of getting into fights;
- was depressed;
- found it difficult to go outside without his father.

Despite this profile Mr. Z received a rudimentary assessment and was discharged back to the care of his GP.

(June 2010)

- Mr. Z was becoming increasingly reckless;
- Mr. Z was described as not caring whether he lived or died;
- Mr. Z was agitated and aggressive.

Despite this when he did not book in for an appointment he was discharged from the service within seven days. Mr. Z presented with a substantial risk both to himself and to others. Without a robust assessment of his mental state, based on what was known about him at the time, it was poor practice to provide Mr. Z with such a rudimentary service.

- ***Service Issue Three. The failure to conduct a professional level of clinical and risk assessment was a significant omission. Based upon what was known about Mr. Z, in conjunction with his presentation and concerns raised by both his GP practice and father, a robust clinical and risk assessment process should have been deployed in order to inform the management of Mr. Z in a systematic and evidence-based manner.***

6. Referral, Discharge and Handover Processes. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"There seem to be gaps in understanding between the expectations of the referrer as to what would happen as a result of the referral and the understanding of the Access Team as to their role. The term 'comprehensive assessment' requires some clarification within an Access context so that referrers can be clear about this".*[7] The contributory factors set out below relate to the poor management of Mr. Z's care and treatment rather than to a specific contribution relating to the death of Mr. X and were developed by the Trust's internal investigation.

- ***Contributory Factor One. There is a clear policy governing the management of referrals which has been ratified by the Access Integrated Governance Team. Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type. The West Access Team management needs to address this issue as a matter of urgency and ensure that appropriate governance around the management of emergency referrals is in place.***

- ***Contributory Factor Two. When the 'back up duty worker' contacted the service user by telephone to try to arrange a second face to face appointment with a duty worker, there may have been a blurring of the assessment function. It is certainly clear that the service user turned down the offer of a second face to face assessment and ended the telephone call before an appointment was set up. Given this, the decision to write to the service user to offer a further appointment seems reasonable in most circumstances given that Access do not have a remit to actively engage service users who have turned down the offer of treatment. However, the urgent nature of the referral means that the duty worker should also have contacted the GP directly to let the GP know that the service user had turned down the appointment. This would have enabled the GP to make a decision about whether any further action was required, including whether they needed to refer the service user to a service which does have the resources to actively engage people at risk.***

7. Carer Assessment and Experience. Whilst this appears to have been of a reasonable standard in the primary care context it would appear that Trust mental health care services did not take carer concerns and issues into consideration.

8. Service User Involvement in Care Planning and Treatment. Whilst it is difficult to assess this due to the short length of time Mr. Z was in contact with secondary care services, it would appear that Mr. Z did not access a service that could respond to his presentation and needs.

7. Trust Internal Investigation Report P. 6

9. Documentation and Professional Communication. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"The written documentation falls significantly below expected governance standards".*[8]

- ***Service Issue Four. Poor levels of professional communication led to Mr. Z's case not receiving a timely consideration of whether or not he required a different approach being taken. This meant that his distress and mental health problems remained largely unassessed and untreated requiring a second urgent referral.***

- ***Service Issue Five. The standard of clinical documentation was of a poor standard in the case of Mr. Z and fell short of Trust policy expectations.***

10. Adherence to Local and National Policy and Procedure. The Independent Investigation Team concurs in full with the findings of the internal investigation. *"There is a clear policy governing the management of referral which has been ratified by the Access Integrated Governance Team. Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type".*[9]

- ***Service Issue Six. Staff within the West Access Team appeared to have had poor levels of awareness regarding Trust policy and procedure and their obligations regarding them.***

11. Management of the Clinical Care and Treatment of Mr. Z. Overall the care and treatment provided by the West Access Team was of a poor standard. The Independent Investigation did not however find any contributory (save those already found by the Trust Internal Investigation Team) or causal factors linked to the killing of Mr. X as no links could be made linking any abnormality of mind Mr. Z may have been suffering from at the time and the killing of his victim.

12. Clinical Governance and Performance.

The thematic issues were also checked against the requirements of the Terms of Reference and are explored in depth in Section 12 below. The internal investigation was of a high standard and this Investigation has been able to build upon it. The quality of the internal investigation is notable.

8. Trust Internal Investigation Report P. 6
9. Trust Internal Investigation Report P. 6

5. Conclusions

Mr. Z was a violent young man who presented to the West Access Team with a complex presentation. It was evident that Mr. Z was ambivalent about receiving services, but it is a fact that he presented himself on four occasions seeking help (twice to his GP in person, and twice to the West Access Team, once in person and once over the telephone). It was evident that the way in which Mr. Z's case was managed was suboptimal and did not follow prescribed Trust policy and procedure.

However despite the poor levels of care and treatment Mr. Z received from secondary care services the Independent Investigation Team could find no causal link between any act or omission on the part of the Sussex Partnership NHS Foundation Trust and the killing of Mr. X.

When being tried for the murder of Mr. X the Court was told that Mr. Z had formerly been remanded for robbery and the actual bodily harm of a 15-year old boy. The Court was also told that Mr. Z was on the Sex Offenders' Register for the sexual assault of a 15-year old girl. The only mitigating factor cited during the Judge's sentencing remarks was Mr. Z's young age. No mention was made of any existing, or pre-existing, mental health condition that could have influenced his actions in the killing of Mr. X.[10]

[10]. Court Transcriptions

6. Recommendations

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

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

Each recommendation is set out below in accordance with the relevant progress that the Trust has already made since the time of the incident.

6.1. Diagnosis

- ***Service Issue One. The service in operation at the time Mr. Z was receiving his care and treatment was not always conducive to the development of robust clinical assessments due to both time pressures and inherent difficulties with the model. This was to have implications when providing a diagnostic formulation and any subsequent care, medication and treatment package.***

Trust progress regarding current practice in relation to the Independent Investigation findings:
The Access Service has now been modernised and current provision falls within the 'Under One Roof' initiative. All service users being referred from primary care will now receive a psychiatric assessment.

Recommendation 1
The Trust will audit the effectiveness of the Under One Roof initiative within six months of the publication of this report with particular reference to:

- **appropriate response to specific referral information (such as PHQ9 scores);**
- **appropriate psychiatric assessment at the time of each initial service user referral;**
- **the presence and quality of diagnostic formulation;**
- **the consequent development of evidence-based care and treatment packages based upon the clinical assessment of the service user.**

6.2. Medication and Treatment (see service issue above)

Mr. Z's GP was advised by CPN 1 to prescribe SSRI medication which may not have been good practice in the light of his suicidal ideation and self-harming behaviors. This advice was also provided in the absence of robust clinical assessment.

Please see Recommendation 1 above.

6.3. CPA

- ***Service Issue Two. Mr. Z's presentation was such that at the time of his referral to, and assessment by, the West Access Team he should have been considered eligible for full CPA. The failure to ensure that this was considered meant that Mr. Z continued in as state of distress necessitating a second urgent GP referral.***

Trust progress regarding current practice in relation to the Independent Investigation findings

All services in Brighton and Hove provide care and treatment under the umbrella of the Care Programme Approach. The Trust has taken steps recently to revitalise the CPA in Assessment and Treatment Services across Sussex supported by the Trust-wide leadership group.

The Trust has recently undertaken a significant organisational change programme and reorganised clinical services around a 'functional' model rather than the traditional adults / older people service configuration. The current adult services in Brighton and Hove are now organised into Assessment and Treatment Teams and Recovery and Well Being Teams. The Care Programme Approach is used within these services but there is a differentiation between the role of Lead Practitioner and Care Coordinator. The distinction is made on the grounds of complexity, risk, diagnosis, assessed need and the requirements for on-going involvement from secondary care.

The Trust CPA Policy is currently undergoing a consultation process led by the adult mental health Strategic Governance Group.

Recommendation 2

The Trust will audit its revised CPA processes within six months of the publication of this report. This audit will be devised in conjunction with the relevant Clinical Commissioning Group. Particular focus on the following is required:

- **adherence to CPA policy assessment criteria when allocating service users to CPA or non-CPA;**
- **CPA training update uptake within the Brighton and Hove area.**

6.4. Risk and Clinical Assessment

- ***Service Issue Three. The failure to conduct a professional level of clinical and risk assessment was a significant omission. Based upon what was known about Mr. Z in conjunction with his presentation and concerns raised by GP practice and father a robust clinical and risk assessment process should have been deployed in order to inform the management of Mr. Z in a systematic and evidence-based manner.***

Recommendation 3
The Trust will conduct an audit of its risk assessment processes within six months of the publication of this report to determine:

- **the compliance of all clinicians in the completion of risk assessments for every service user;**
- **the compliance of clinicians in incorporating all relevant clinical information within the risk assessment documentation;**
- **the compliance of all clinicians in the development of risk management plans;**
- **the compliance of all clinicians in completing all risk assessment documentation and not leaving sections bank unless there are good reasons for doing so.**

6.5. Referral, Discharge and Handover Processes

- ***Contributory Factor One. There is a clear policy governing the management of referrals which has been ratified by the Access Integrated Governance Team. Despite this, from interviews with staff, it appears that there was confusion within the West Access Team about the policy for managing referrals of this type. The West Access Team management needs to address this issue as a matter of urgency and ensure that appropriate governance around the management of emergency referrals is in place.***

- ***Contributory Factor Two. When the 'back up duty worker' contacted the service user by telephone to try to arrange a second face to face appointment with a duty worker, there may have been a blurring of the assessment function. It is certainly clear that the service user turned down the offer of a second face to face assessment and ended the telephone call before an appointment was set up. Given this, the decision to write to the service user to offer a further appointment seems reasonable in most circumstances given that Access do not have a remit to actively engage service users who have turned down the offer of treatment. However, the urgent nature of the referral means that the duty worker should also have contacted the GP directly to let the GP know that the service user had turned down the appointment. This would have enabled the GP to make a decision about whether any further action was required, including whether they needed to refer the service user to a service which does have the resources to actively engage people at risk.***

Trust progress regarding current practice in relation to the Independent Investigation findings

The Trust has completed the recommendations set by the internal investigation process.

Recommendation 4

The Trust will conduct an audit in conjunction with Primary Care stakeholders to ascertain the timeliness of referral processes. This audit will be completed within six months of the publication of this report. The Trust will ensure that referral pathways are revised if necessary in the light of the audit findings. Particular attention will be given to the following:

- **GP satisfaction with current referral processes and the usefulness of terminology clarification processes;**
- **success in working the Access Pathway (for example four hours, five days and routine referrals);**
- **the quality of Duty Worker communication and liaison with GPs.**

6.6. Documentation and Professional Communication

- ***Service Issue Four. Poor levels of professional communication led to Mr. Z's case not receiving a timely consideration of whether or not he required a different approach being taken. This meant that his distress and mental health problems remained largely unassessed and untreated requiring a second urgent referral.***

- ***Service Issue Five. The standard of clinical documentation was of a poor standard in the case of Mr. Z and fell short of Trust policy expectations.***

Recommendation 5

The Trust will ensure that professional communication and liaison processes are built into all care pathways and all clinical policy and procedure documents. Professional communication and liaison processes will be made explicit regarding the interface between primary and secondary care. This review work will be completed within six months of the publication of this report.

Recommendation 6

The Trust will conduct an audit of Brighton and Hove community-based services to ensure that all clinical documentation is completed in accordance with Trust policy expectations. This will be completed within six months of the publication of this report.

6.7. Adherence to Local and National Policy and Procedure

- ***Service Issue Six. Staff within the West Access Team appeared to have had poor levels of awareness regarding Trust policy and procedure and their obligations regarding them.***

Recommendation 7

The Trust must revise all policy documentation in keeping with the findings of this Investigation report and as set out in the recommendations above. All policy documentation should be subject to review and audit for both compliance and effectiveness as part of the Trust audit cycle.