Independent Investigation

Into the

Care and Treatment Provided to Mr. X

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
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Contents

1. **Brief overview of Mr. X's contact with the Sussex Partnership NHS Foundation Trust** **Page 3**
2. **Terms of Reference for the Independent Investigation** **Page 5**
3. **Investigation Team** **Page 7**
4. **Findings of the Investigation** **Page 8**
5. **Conclusion** **Page 15**
6. **Recommendations** **Page 16**

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

Mr. X was placed with his long-term foster parents when he was two-years old. He had a troubled childhood being excluded and expelled from school and placed in a residential school for children with Emotional and Behavioural Difficulties (EBD) at the age of 11 years. Mr. X was eventually expelled from this school and at the age of 15 years his formal education ended.

From an early age Mr. X came into conflict with the law and by the time he arrived in Brighton in November 2010 he had spent 13 of the previous 15 years in prison for a mixture of acquisitive and violent crimes.

Mr. X's foster parents reported that almost from the time he came into their care Mr. X had problems with impulse control and appeared to be unable to learn from his experiences. As a child he was diagnosed as suffering from a Conduct Disorder and at 17 years he was diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD). In adult life the diagnoses of adult ADHD and Personality Disorder were repeatedly considered but given Mr. X's repeated incarcerations and peripatetic life style no firm diagnosis was ever arrived at and no consistent plan of treatment was put in place.

From the age of 14 years Mr. X abused both alcohol and illicit drugs. This complicated his presentation. From around 2008 Mr. X consistently informed those assessing him that he no longer abused illicit drugs or alcohol and, in consequence, was reluctant to engage with Substance Misuse Services when this was suggested. However, despite his repeated assertions that he was not using illicit drugs those caring for him were not entirely convinced as to the accuracy of Mr. X's reports.

Mr. X moved to Brighton in November 2010 having been released from Winchester Prison. He was homeless and applied to the Local Authority for accommodation. He was provided with emergency accommodation over the Christmas period but following an assessment was deemed not to be vulnerable and not in 'Priority Need'. From this point onwards Mr. X and his partner, according to their own account, were *"sofa surfing"* in the Brighton area. It appears that from mid/late March they stayed at the flat of Mr. X's victim, Mr. A.

Mr. X informed his new GP in Brighton that he had been diagnosed as suffering from ADHD in the past and was keen to be re-assessed and treated for this. The GP referred Mr. X to the local Secondary Mental Health Services on 4 January 2011 with this information and a request that Mr. X be reviewed with a view to recommencing Quetiapine.

Mr. X was not identified as being a homeless person at this point and his referral was not passed to the Mental Health Team for Homeless People. However a second GP at the same Practice referred Mr. X at the end of January 2011, this time to the Team for Homeless People and the referral was dealt with promptly.

Mr. X was contacted by telephone immediately and offered an appointment for 7 February 2011. He failed to attend this appointment and was contacted and offered a further appointment on 28 February. Following this assessment Mr. X was referred for a specialist assessment for ADHD. The team was informed, however, that there was a waiting time of at least six months before Mr. X would be seen. In the interim the Psychiatrist who had assessed Mr. X consulted a colleague experienced in the treatment of ADHD. He suggested a trial of the medication Concerta XL (methylphenidate). This was commenced at Mr. X's next appointment on 11 April 2011.

Between these two appointments the Social Worker in the Homeless Team maintained contact with Mr. X and with his foster mother who was concerned about her foster son's well-being. The Social Worker also liaised with the Probation Service and the Rough Sleepers' Team. Mr. X was under the care of the Mental Health Team for Homeless People for a relatively brief period of time, 10 weeks between the time his referral was passed to the Team and his arrest on 16/17 April 2011.

Mr. A was found dead in his flat on 15 April 2011 and Mr. X was arrested on 16/17 April 2011. He was convicted of murder at Lewes Crown Court on 23 January 2012 and sentenced to 36 years imprisonment with a minimum term of 18 years.

2. Terms of Reference for the Independent Investigation

The Terms of Reference for this Independent Investigation are as follows:

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

Terms of reference

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

- *The history and extent of Mr. X's involvement with health and social care services.*
- *The suitability of Mr. X'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. X's family.*
- *The extent to which Mr. X complied with his prescribed care plans.*
- *The extent to which Mr. X's care and treatment corresponded to statutory obligations, the Mental Health Act (1983 and 2007), and other relevant guidance from the Department of Health.*
- *The quality of Mr. X'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. X and whether staff complied with them.*
- *The competencies of staff involved in the care and treatment of Mr. X 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. X, 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. X, or in the provision of services to Mr. X, including Sussex Partnership NHS Foundation Trust and relevant agencies and GP services.*
3. *To prepare a written report that includes recommendations to the strategic health authority so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.*

Approach

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

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

Timetable

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

Publication

The outcome of the investigation will be made public. The nature and form of publication will be determined by the NHS South of England. 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 Sussex Partnership NHS Foundation Trust 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. Len Rowland	Director of Research and Development, HASCAS Health and Social Care Advisory Service and Clinical Psychologist Member of the Team

Investigation Team Members

Dr. Androulla Johnstone	Chief Executive, HASCAS Health and Social Care Advisory Service and Nurse Member of the Team
Dr. David Somekh	Associate, HASCAS Health and Social Care Advisory Service and Consultant Psychiatrist Member of the Team

Support to the Investigation Team

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

Advice to Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

4. Findings of the Independent Investigation

4.1. Diagnosis

From the time Mr. X was 12 or 13 years of age two possible diagnoses were consistently considered by all who saw him: ADHD and Personality Disorder, or Conduct Disorder when he was a child. From around the age of 14 years the complicating effects of illicit drugs use and excessive alcohol use was also noted.

The three most obvious possible diagnoses: adult ADHD, Personality Disorder of either the Antisocial or Emotionally Unstable type and Mental and Behavioural Disorder due to the harmful effects of alcohol and multiple drug abuse, were identified and considered by the Specialist Registrar (SpR) in the Mental Health Team for Homeless People. She reported that she had a strategy for refining her diagnosis. This involved taking the opportunity to build up a detailed picture of Mr. X and approach his diagnosis in a systematic manner. However, as had happened before in Mr. X's history, circumstances intervened and the opportunity to pursue the strategy was denied.

The SpR reported her strategy to the Independent Investigation at interview however, it would have been good practice to have articulated the differential diagnoses and the strategy for arriving at a clear formulation in Mr. X clinical notes. However it has to be acknowledged that Mr. X was under the care of the Mental Health Homeless Team for just 10 weeks from the time of referral to that team and just six weeks from the time that he was first seen. He was seen by the SpR on only two occasions before he was arrested on 15 April 2011.

4.2. Medication and Treatment

Prior to his arrival in Brighton there was no continuity in the care Mr. X received. In their letters to a range of services and professionals Mr. X's foster parents expressed their concern that although various professionals had tried to help Mr. X, the continuity that was needed was always lacking. This was, in part, because Mr. X had spent 13 of previous 15 years in prison.

Mr. X was keen to be prescribed Ritalin (methylphenidate). The SpR discussed this option with a senior, experienced colleague and was advised to start a trial of Concerta XL, the prolonged release version of methylphenidate. It might be argued that it would have been good practice to wait for the outcome of the ADHD assessment before commencing treatment, however, the Team was informed that there would be a waiting time of at least six months before the assessment would take place. In these circumstances it was not reasonable to wait and make no decision about treatment. The SpR started a trial of Concerta XL when Mr. X was reviewed in April 2011. However he was arrested for the murder of Mr. A only a few days later, so this trial never got under way.

The NICE Guidance on the treatment of ADHD recommends that medication for the treatment of ADHD should only be prescribed under the guidance of someone with

appropriate experience in the area. The SpR consulted a senior colleague who was experienced in this area before she prescribed Concerta XL.

The Guidance also comments that where there is concern about drug misuse and diversion, then consideration should be given to prescribing Atomoxetine rather than Ritalin/Concerta XL. There is no evidence in the clinical notes that this recommendation was considered or that a medicines management plan was put in place.

The NICE Guidance on the treatment of ADHD, of Antisocial Personality Disorder and of Substance Misuse all emphasise the importance of front-line clinicians having appropriate training, supervision and access to consultation and advice. Disappointingly the liaison workers from the Substance Misuse and Forensic Services and the monthly psychology consultation and supervision session had been removed from the Team, there was no Personality Disorder Service which the Team could access, the Substance Misuse Service did not accept referrals of people who were not yet at the stage of displaying motivation to address their substance misuse problems, and the Team did not receive regular training on the issues identified in the NICE guidance on these disorders. This is an area in need of review by the Trust and its commissioner.

4.3. Use of the Mental Health Act (1983 & 2007)

Although Mr. X did, on one occasion, report that he had been detained under the Mental Health Act there is no evidence of this in any of the clinical records available to the Independent Investigation.

During the brief time Mr. X was under the care of the Mental Health Team for Homeless People there were never any indications that his mental state was such that he required an assessment under the Mental Health Act (1983 & 2007)

4.4. The Care Programme Approach

The Independent Investigation concluded that the standard identified in *Refocusing the Care Programme Approach* an assessment of needs, the development of a care plan and a review of the efficacy of the care, was met in Mr. X's case. The Independent Investigation concluded that the care Mr. X received was compliant with Trust policy.

However, given Mr. X's complex presentation it would have been good practice to have considered providing Mr. X's care under the CPA protocols.

Had Mr. X been cared for under the CPA protocol his assessments and care planning would have had a more formal and prescribed structure and there may have been more multi-disciplinary involvement and discussion of his needs and the most appropriate ways in which to meet these. However, having said this the Independent Investigation Team acknowledges that there was a multi-disciplinary dimension to his care, and given his relatively brief contact with the Homeless Team it seems unlikely that him being cared for under the CPA process would have made a substantial difference to the care he received. However had Mr. X

remained under that care of the Team for a longer period this situation may have changed and the CPA process might have ensured a more robust, comprehensive and recovery focused care package.

4.5. Risk Assessment

At an early age it had been noted that Mr. X had difficulty with impulse control and learning from the consequences of his actions. Mr. X exhibited violent and disinhibited behaviour towards others and placed himself in danger as a result of his ill-considered behaviour.

As required by the Trust Clinical Risk Management Policy a risk assessment was completed and corroborative information was sought from Mr. X's partner and foster mother. This assessment was an initial assessment and given the limited information available the management plan was to seek further information. This was not inappropriate.

However given the information that was available the risk formulation and risk planning were not as robust as one might have expected. The risk formulation did not provide an understanding of the risk, risk triggers and protective factors or inform the plan to reduce and manage risk.

Given Mr. X's forensic history it would have been appropriate to have considered a referral to the Forensic Services. It would also have been good practice to have considered how the various agencies with whom Mr. X was involved might have been brought together to share information, arrive at a common view of the risks Mr. X posed and agree a common approach to addressing these needs.

4.6. Referral and Engagement

The Central Access Team did not recognise that Mr. X was a homeless person and pass his referral on to the Team for Homeless People. There is no record that the Central Access Team made contact with the GP, had they done so it is possible that Mr. X would have been identified as a homeless person and his referral passed to the appropriate clinical team in a more timely manner. As Mr. X was homeless and, therefore, likely to be more difficult to contact and engage it was important that his referral was responded to promptly. This was a weakness when accessing Secondary Mental Health Services.

Once Mr. X was referred to the Mental Health Team for Homeless People he was contacted quickly, timely efforts were made to engage him and his GPs were kept informed of his appointments and the outcome of his assessment. The only possible blemish on this example of good care is there is no evidence in the records available to this Investigation that Mr. X's GP was informed when he failed to attend his initial appointment on 7 January 2011. It is possible however that the appointment letter informing Mr. X of his appointment on 28 February was copied to Mr. X's GP.

4.7. Safeguarding Vulnerable Adults

There were four people whose vulnerability might be considered in the context of Mr. X's care and treatment: the victim, Mr. A, Mr. X's partner, Mr. X's foster mother and Mr. X himself.

Mr. A was not known to the mental health services in Brighton, though he had had some contact with the substance misuse services. It appears that Mr. A was a vulnerable person and the Brighton and Hove Safeguarding Adult Board commissioned a Serious Case Review. Although the Review is wide ranging and made recommendations including some related to interagency co-operation and co-ordination, it did not identify any findings or recommendations of immediate relevance to the care and treatment of Mr. X.

The care and treatment of Mr. X's partner is not the subject of this Investigation and, in consequence, there is very limited information available to the Investigation about her. However those who knew her, and the Court which subsequently tried her, were confident that she had capacity. There is no good evidence that she was exploited or abused and those who knew her did not regard her as a vulnerable person.

The clinical team caring for Mr. X identified potential vulnerabilities which Mr. X shared with many of the users of their service. However they felt that he was *"street wise"* and knew how to access the benefits system and other facilities that were available to him. Similarly the Homeless Persons' Officer at the Local Authority, having reviewed Mr. X's situation, decided that Mr. X was *"not in priority need"* and not a vulnerable person as defined by the criteria employed by the Local Authority Housing Department.[1]

Vulnerability implies the possibility of suffering harm but the opinion of those who met Mr. X and assessed him was that while he possessed characteristics which placed him at risk, and, in this sense rendered him vulnerable, there was no evidence at that time that he was the victim of abuse as a result of that vulnerability and no basis on which a safeguarding alert could have been initiated.

The clinical team identified that Mr. X's foster mother was vulnerable and possibly being financially exploited. It initiated some, not unreasonable, interventions. However it might have been better practice, having noted this situation, to have discussed the possible options and drawn up a clear plan to address the situation. This might have been done as part of the risk management planning when it was noted that Mr. X was asking his mother for money.

4.8. Carer Assessment and Carer Experience

It appears that Mr. X's partner was appropriately involved in identifying Mr. X's needs, with his active encouragement.

1 Clinical notes p 39

However as the internal investigation concluded, no consideration was given to Mr. X's partner's needs. She was an individual with a number of identified needs and given that she was already in contact with the Substance Misuse Services it would have been good practice to have assessed her and considered putting in place a carer's package together with those who knew her. There is no evidence that this was done.

Mr. X was in contact with the Homeless Team for only a short period of time and, with this in mind, it is tempting to conclude that there was not enough time to address Mr. X's needs and put in place a package of care for him and also to assess his partner's needs and address these. However it is good practice to consider the needs of carers from the beginning of one's contact with the service user. As a standard part of assessing the needs of the service user consideration should be given to offering a carer's assessment to his or her carers. There is no evidence in the records available to the Independent Investigation that this was done. This did not reflect best practice.

Despite his difficulties and challenging behaviour Mr. X foster parents remained supportive and nurturing towards him. They advocated strongly, on his behalf, that he had access to the services that they believed would help him.

The available information indicates that Mr. X's foster mother was appropriately involved in identifying his needs and planning his care. Her own needs were recognised and the team attempted to address these. Had Mr. X remained with the Homeless Team for a longer period of time a more formal and systematic way of meeting Mr. X's foster mother's need would have had to have been identified. The clinical Team recognised this and the need for such a plan was identified in Mr. X's clinical notes.

4.9. Service User Involvement in Care Planning

Although Mr. X was not being cared for under the formal CPA process and there are no records signed by him that he agreed with the conclusion of the assessment or the plan that was being put in place, it is evident from the records that Mr. X was proactive in identifying his needs and seeking help to address these. In this sense he was fully involved in the assessment of his needs and planning of his care.

There is no evidence that the Specialist Registrar's letters to Mr. X's GP and to the Neurobehavioural Clinic or the risk assessment completed on 8 March 2011 were copied to Mr. X. It would have been good practice if they had been.

4.10. Housing

While living in Brighton Mr. X was homeless and for much of the time he and his partner were *"sofa surfing"*. From around late March they were staying in the flat of the victim, Mr. A. Mr. X's care was provided by the Mental Health Team for Homeless People and the Social Worker in this team provided Mr. X with the contact details of those who might help him find accommodation. To provide accommodation was not within the gift of the Homeless Team and there was little more that it could have done which would have secured Mr. X

appropriate accommodation. The Local Authority Homeless Person's Officer reviewed Mr. X's eligibility for accommodation and concluded that he was not in 'priority need'.

Had Mr. X been provided with accommodation it is unlikely that he and his partner would have been living in Mr. A's flat and the occasion of the killing would not have arisen at that time.

Given Mr. X's history, his personal characteristics and his social circumstances it was highly likely that he would, at some point, come into conflict with the law. To what degree the provision of appropriate accommodation would have ameliorated the situation and reduced this probability can only be a matter of speculation but it is likely that it would have reduced the likelihood to some extent.

4.11. Documentation and Professional Communication

The internal investigation found that the Risk Assessment completed on 8 March 2011 was saved in draft format and recommended that staff should be reminded not to do this.

The documentation relating to Mr. X provides a detailed account of the contact the Mental Health Team for Homeless People had with Mr. X and with other professionals and agencies. One improvement that the Trust might consider promoting is to ensure that the options considered and the reasons why decisions are taken are recorded in sufficient detail to allow the reader to understand why one option or action was decided on rather than another. This is particularly important where a formulation of a service user's problems is arrived at in a multi-disciplinary forum. The key elements of the discussion and the formulation should be captured in the clinical record.

4.12. Adherence to Local and National Policy and Procedure

The evidence available from this Investigation suggested that staff complied with Trust policies. However there were occasions where best practice would suggest that staff might have gone further. For example there might have been a more complete and robust formulation of Mr. X's needs, in particular a more robust formulation of the risks he presented; there could have been a more timely approach to the carer's assessment and a more proactive approach to Safeguarding Vulnerable Adults.

4.13. Management of the Clinical Care and Treatment of Mr. X

There was a delay in responding to the initial GP referral and the referral was not passed to the Homeless Team until a second GP referral was made. This was a weakness in accessing Secondary Mental Health Care.

Once Mr. X's care was allocated to the Homeless Team the processes of communication, engagement and assessing Mr. X's needs progressed in a more efficient and timely manner.

Mr. X did not attend his initial appointment and a further appointment could not be arranged for three weeks as the GP had asked for advice on medication and the Homeless Team did not have access to a full time psychiatrist. This delay represents a resource issue.

The Independent Investigation concluded that while Mr. X was under the care of the Mental Health Team for Homeless People he received care and support consonant with the principles of the Care Programme Approach, there was a multi-disciplinary element to his care, his partner and foster mother were appropriately involved in his care and there was cross-agency liaison. This was good practice.

Given Mr. X's history and complex presentation it might have been good practice to have considered providing his care under the CPA protocol, however given the short time he was under the care of the Homeless Team it is unlikely that had this been done it would have made a significant difference to the care he received.

5. Conclusions

The primary aim of an investigation undertaken under the auspices of HSG 94 (27) is to ensure that learning takes place which promotes the development of safer and higher quality services. The Independent Investigation identified no causal factors relating the care Mr. X received from the Sussex Partnership NHS Foundation Trust and the killing of Mr. A on 14 April 2011, however there are lessons to be learned which might promote the development of higher quality services.

Mr. X was referred to the Central Access Team, the point of entry for Secondary Mental health services but he was not recognised as being homeless and his referral was not passed to the Mental Health Team for Homeless People until a second GP referral was made. This represented a weakness in accessing mental health services.

However, once Mr. X was under the care of the Homeless Team he was quickly contacted. The approach to providing care followed the principles of the CPA. There was multi-disciplinary input into his care and multi-agency liaison and his foster mother and partner were appropriately involved. The relevant diagnoses were considered and, after consultation, relevant medication was prescribed.

It is tempting in Mr. X's case to suggest that more could have been done but this temptation has to be weighed against what was possible. Mr. X was only in contact with the Homeless Team for approximately 10 weeks from the time of referral to that team and, as he failed to attend his first assessment appointment, only six weeks from the time he was first seen. Resources and the limited access to specialist services hindered a more speedy approach to addressing his needs.

There were aspects of Mr. X's care which were under the control of the clinical team which might have been improved: a clear and explicit formulation of Mr. X's problems and needs, a clear statement of the differential diagnoses and the strategy for arriving at a firm diagnosis, an explicit formulation of risk and a more robust risk management plan, improved multi-agency planning. Any of these might have had an impact on Mr. X's care had he remained under the care of the Homeless Team for longer but, given his short tenure with the Team, it would not be reasonable to conclude that any of these factors did significantly affect the care and treatment he received.

Overall Mr. X received supportive and proactively delivered care from the Mental Health Team for Homeless people. The Independent Investigation concluded that there were no acts or omissions on the part of the Mental Health Services which were causally related to Mr. A being killed by Mr. X on 14 April 2011. A number of service issues have, however, been identified which if appropriately addressed might improve the care and treatment of other service users in the future.

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 further improve services and consolidate the learning from this investigation process. It was noted by this Investigation that the action plan from the Trust's internal investigation process has been successfully completed. The recommendations set out below address the outstanding issues.

14.1 Diagnosis

The SpR reported her strategy to the Independent Investigation at interview however, it would have been good practice to have articulated the differential diagnoses and the strategy for arriving at a clear formulation in Mr. X's clinical notes. However it has to be acknowledged that Mr. X was under the care of the Mental Health Homeless Team for just six weeks and was seen by the SpR on only two occasions before he was arrested on 15 April 2011.

Recommendation One

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

14.2 Medication and Treatment

Service Issue

- **Although the Mental Health Team for Homeless People has to deal with a diverse population a significant proportion of whom have Personality disorders, substance misuse problems and/or ADHD the clinical staff did not have access to timely advice, support, supervision and training on the more specialist areas of these disorders as recommended in the relevant NICE guidance. It would not be reasonable, however, to conclude that in Mr. X's case this had a significant impact on his care or had any causal relationship with the killing of Mr. A.**

Service Issue

- **The workers from the Forensic and Substance Misuse services who had, formerly, been attached to the Mental Health Team for Homeless People and the psychology consultation and supervision had been removed and the team did not have ready access to a Personality Disorder service, a Dual Diagnosis service or an ADHD service. The absence of timely access to such services by a team which has to provide assessment, care and treatment to a population such as homeless people makes it difficult for that team to provide a responsive, effective, efficient and safe service. This is an issue which the Trust together with its commissioner should review.**

Progress Made by the Trust since the Completion of the Independent Investigation: Dual Diagnosis

Sussex Partnership NHS Foundation Trust (SPFT) has a Trust-wide dual diagnosis strategy with local implementation groups across the three core Divisions. The implementation of the strategy is supported by the Nurse Consultant for Dual Diagnosis. The implementation group in Brighton and Hove is led by the Clinical Commissioning Group and attended by both statutory and community and voluntary sector partners engaged in the delivery of adult mental health and substance misuse services in the City. Recent developments have included the development of a specific dual diagnosis care plan which is being trailed in Brighton & Hove. The evaluation of this project includes patient, carers and staff focus groups. If successful it is envisaged that this care plan will be expanded across the whole of Sussex.

Substance Misuse Services in Brighton & Hove are commissioned by the Council's Public Health Directorate since this has transferred from the Primary Care Trust in April 2013. Substance Misuse services in the City are currently delivered jointly between SPFT and the Crime Reduction Initiative. This service is due to tendered in the financial year 2014/2015. Prior to this mental health commissioners have created a short life working group to evaluate whether far greater integration between adult mental health and substance misuse services would be of benefit to patients and carers. SPFT are key stakeholders in this evaluation. It is proposed that staffs from substance misuse services are co-located with adult mental health staff specifically to meet the dual diagnosis agenda and improve both assessment and treatment outcomes for patients.

Recommendation Two

- **The Trust will examine all extant clinical policies and procedures to ensure that NICE guidance is embedded within them. The Trust training and development needs analyses will be constructed to ensure that an explicit link is made to the requirements of the NICE guidance with particular reference to substance misuse and Personality Disorder.**

14.3 The Care Programme Approach (CPA)

Given Mr. X's complex presentation it would have been good practice to have considered providing Mr. X's care under the CPA protocols.

Progress Made by the Trust since the Completion of the Independent Investigation:
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 Three

- **The Trust will conduct a review of the role of Lead Practitioner and Care Coordinator within the Assessment and Treatment Centres in light of the requirements of CPA. This has been raised in Brighton and Hove and is being considered by the Divisional Leadership Team and the Community Governance Group in light of the Trust-wide evaluation of the Assessment and Treatment Service model being undertaken by Adult Mental Health and Dementia and Later Life.**

14.4 Risk Assessment

Service Issue

- **Although a risk assessment was undertaken in line with Trust policy the formulation and management plan accompanying this assessment were not as robust as might have been expected and did not fulfil the requirements of providing an understanding of the risks associated with Mr. X or how to manage these. However it would not be reasonable to conclude that this had any causal relationship with the killing of Mr. A.**

Progress Made by the Trust since the Completion of the internal investigation:
The Trust has already fulfilled the recommendation set by the internal investigation regarding the improvement of risk assessment procedures. In addition the Independent Investigation has set another supporting recommendation.

Recommendation Four

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

14.5 Referral and Engagement

Service Issue

- **Mr. X was not identified as a homeless person when he was initially referred to Secondary Mental Health Services. This delayed his assessment and engagement by the appropriate clinical team, the Mental Health Team for Homeless People, by almost a month. It would not be reasonable, however, to conclude that this delay had any causal relationship with the killing of Mr. A.**

Recommendation Five

- **The Trust will conduct an audit in conjunction with Primary Care stakeholders to ascertain the timeliness of referral processes. This audit to 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.**

14.6 Safeguarding Vulnerable Adults

Service Issue

- **It would have been good practice, having noted that Mr. X's foster mother was vulnerable and possibly being financially exploited by her foster son, to have reviewed the options available to address this problem and put in place an explicit plan of action.**

Recommendation Six

- **The Trust will:**
    - **review its vulnerable adults policy to ensure that a scenario such as that presented by Mr. X's mother is addressed;**
    - **review current vulnerable adult training and supervision processes to ensure that the vulnerability of the families and friends of service users are understood and clear pathways of protection and support are delineated.**

14.7 Service User Involvement in Care Planning

There is no evidence that the Specialist Registrar's letters to Mr. X's GP and to the Neurobehavioural Clinic or the risk assessment completed on 8 March 2011 were copied to Mr. X. It would have been good practice if they had been.

Recommendation Seven

- **The Trust will:**
    - **ensure that all relevant policies and procedures are reviewed, and amended where necessary, to ensure that all clinical staff are advised of the importance of copying in service users to all clinical letters and communications;**
    - **ensure that the Trust audits the compliance of this practice within six months of this report being published.**

14.9 Documentation and Professional Communication

One improvement that the Trust should consider promoting is to ensure that when clinical options are considered the reasons why decisions are taken are recorded in sufficient detail to allow the reader to understand why one option or action was decided upon rather than another. This is particularly important where a formulation of a service user's problems is arrived at in a multi-disciplinary forum. The key elements of the discussion and the formulation should be captured in the clinical record.

Recommendation Eight

- **The Trust will ensure that all relevant policies and procedures are reviewed, and amended where necessary, to ensure that all clinical staff are advised of the importance of recording the clinical decision making process and rationale within each service user's record.**