

**REPORT TO NHS ENGLAND OF THE
INDEPENDENT INVESTIGATION INTO THE
HEALTH CARE AND TREATMENT OF
PATIENT G**

Contents

The Investigation

- Terms of Reference
- The Panel
- Methodology

Executive Summary

Chapter 1 - Case Chronology

- childhood and adolescence till 1992
- period from 1992 to 2005
- period from 2005 till January 2009

Chapter 2 - Forensic History

Chapter 3 - Psychiatric Overview

Chapter 4 - Physical Health Care

Chapter 5 - Provision of Services

Chapter 6 - Risk Assessment and Risk Management

Chapter 7 - The Care Programme Approach

Chapter 8 - Record Keeping and Communication

Chapter 9 - Inter Agency Working

Conclusions and Recommendations

Terms of Reference for an Independent Inquiry into the Care and Treatment of Patient G in accordance with HSG (94) 27 (as amended)

To examine the circumstances surrounding the health care provision and treatment of the above patient, in particular:

- the quality and scope of his health care and treatment, in particular the assessment and management of risk;
- the appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary Care Programme Approach and the assessment of risk in terms of harm to himself or others;
- the standard of record keeping and communication between all interested parties;
- the quality of the interface between mental health services and other agencies
- the extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health;
- to prepare a report of the findings of that examination and make recommendations to NHS England (North).

This report was originally commissioned by the North East Strategic Health Authority.

The panel

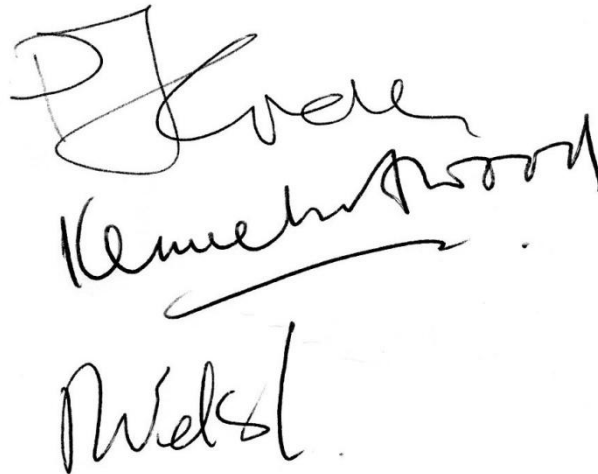
The members of the panel were:

- Philippa Graham - Solicitor and Tribunal Judge (Chair)
- Dr Kenneth Wood - Consultant Psychiatrist, Cumbria Partnership NHS Foundation Trust
- Tom Welsh - Former Head of Nursing and General Manager for Mental Health Services, Craven Harrogate and Rural District Primary Care Trust

Philippa Graham

Dr Kenneth Wood

Tom Welsh



The image shows three handwritten signatures in black ink. The top signature is 'P Graham', the middle one is 'Kenneth Wood', and the bottom one is 'Welsh'.

Acknowledgement

The investigating panel wishes to express its sincere gratitude and appreciation to the panel coordinator, Ms Barbara Milligan, for her hard work, assistance and support in the administration of this inquiry.

Methodology

1. The panel met on 19 occasions between June 2011 and April 2013.
2. The panel considered 3041 pages of documentary evidence including:-
 - the file prepared by Northumbria Police in relation to the murder investigation
 - GP records
 - Northumberland Tyne and Wear (NTW) NHS Foundation Trust records relating to the health care and treatment of Patient G
 - Bridge View records
 - Court records
 - Prison records
 - Probation records
 - Social services child care records
 - the internal investigation conducted by NTW NHS Foundation Trust

Unfortunately Community Mental Health Team records were not available to the panel for reasons set out in the body of the report.

3. The panel interviewed the following witnesses:-
 - three of the psychiatrists from the Hadrian Clinic responsible for care and treatment of Patient G from 2006 – 2008.
 - Patient G's GP
 - three doctors from the Bridge View Drug Treatment Service
 - a nurse from the Bridge View Drug Treatment Service
 - one probation officer
 - the team manager of the Community Mental Health Team
 - a doctor from the Crisis Assessment and Treatment Service
 - a member of the Cognitive Behavioural Team
 - a senior employee of the Plummer Court Drug and Alcohol Service
 - a team manager from NTW NHS Foundation Trust
 - a senior employee of the NHS North of Tyne
 - a manager from the NHS North of Tyne Primary Care Trust
 - a chief inspector from Northumbria Police

4. All formal witnesses were provided with transcripts of their evidence and given the opportunity to approve or amend their evidence.
5. The panel met with Patient G himself.
6. The panel records its thanks to the witnesses who attended and for the assistance they provided to the panel.

Executive Summary

On 3 January 2009 Patient G killed Victim G with a claw hammer in a savage and brutal attack at the hostel in Newcastle where the two men lived.

Victim G was a vulnerable man. He was 61 years old and had significant physical disabilities. Patient G had described Victim G as a friend. The two men had consumed large amounts of alcohol together in the victim's room in the hours leading up to the assault. Patient G was also under the influence of prescribed medication including benzodiazepines and, in all probability, illicitly obtained diazepam.

Immediately after the murder, Patient G met up with his girlfriend and her friend. Later that evening and the next day Patient G spent money that he had stolen from Victim G's wallet on takeaway food, alcohol and clothing. He then handed himself into a police station, reporting that he had blood on his shoes and was experiencing flashbacks of killing Victim G.

At his trial at Newcastle Crown Court, Patient G pleaded guilty to the murder of Victim G. The guilty plea was accepted by the court and no mental health disposal was considered. The trial judge found that the murder was motivated by financial gain. He received a life sentence, with a minimum tariff of 21 years.

The panel had the benefit of considering Patient G's complete history with mental health services, the majority of which related to the period from 2006 to 2008, as well as records from children's services, police, probation, GP and a drug addiction service. The documentation available to the panel is set out in the bibliography attached.

It was necessary to consider in some detail the entire life history of Patient G to gain an understanding of the various problems he experienced and the challenges he presented.

However, the panel concentrated mainly upon the period from 2005 to the murder. During the whole of this period he lived in Newcastle and was engaged with a drug addiction service. He was also engaged for the majority of this time with mental health services within the Northumberland Tyne and Wear NHS Foundation Trust. The panel heard evidence from a number of professional witnesses who were involved with Patient G over this period, as well as managers of various services. All formal interviews were recorded and the witnesses provided with transcripts for correction.

Neither of the families of Patient G or Victim G responded to approaches made by the panel with a view to ensuring that their views were taken into consideration.

The panel is mindful that they had an overview of Patient G's history and treatment which would not have been available in its entirety to clinicians and other professionals responsible for his care and treatment. The panel acknowledge that those professionals involved with Patient G would also have had responsibility for balancing the needs of numerous other service users.

Patient G suffered from significant emotional and physical abuse throughout his childhood and experienced rejection and abandonment from his parents. The majority of his teenage years were spent in local authority children's homes and residential placements. He had convictions for petty offending. Patient G started using illicit drugs in his mid-teens and was involved for a short time with drug and alcohol services whilst still a minor. He had brief involvement with mental health services when he took an overdose at the age of 16 years, but no evidence of mental illness was reported.

The period from 1992, when he entered adulthood, to 2005, when he moved to Newcastle, was characterised by drug and alcohol abuse (there was evidence of him injecting heroin at times), offending behaviour and instability in both relationships and accommodation. Until 1996, the bulk of Patient G's offending behaviour related to dishonesty. However, in 1996 when intoxicated with alcohol mixed with an overdose of temazepam taken from his grandmother, he attempted to rob an elderly lady, threatening her with a knife. Following this incident he was admitted briefly to Cherry Knowle hospital for assessment. No evidence of mental illness was noted but it was recorded 'probable antisocial personality with long forensic history – does not seem to be depressed'.

In this period he received three prison sentences for offences involving knives, including a sentence of five years in 1997 for the attempt to rob the elderly lady, a sentence of six months for wounding in 2002, when he had slashed the throat of a man whom he had described as a friend with a Stanley knife and a sentence of five months in 2003 for possession of an offensive weapon, a knife.

Patient G subsequently described that during this period he was raped in prison and suffered the death of his baby daughter. Both of these incidents were the subject of flashbacks, which later led to a diagnosis of Post Traumatic Stress Disorder (PTSD).

In 2005 Patient G successfully engaged with drug addiction services for the first time when he was placed on a methadone programme. Shortly afterwards he moved to Newcastle and the responsibility for treatment of his drug addiction was transferred to Bridge View Clinic. A doctor at Bridge View, Bridge View Doctor 1 (BVD1), referred Patient G to the Community Mental Health Team (CMHT) for assessment in September 2005 due to her concerns about his low mood and issues around his impulsive violence and anger. She also reported that Patient G complained of flashbacks about the death of his daughter the year before and of being raped in prison.

In 2006, Patient G was seen at Hadrian Clinic and diagnosed with drug dependence, depression and PTSD. Patient G was treated by a succession of junior doctors and trainees at Hadrian Clinic under the supervision of Consultant Psychiatrist 2 (CP2), although CP2 never met Patient G. No formalised risk assessment was ever carried out by Hadrian Clinic and he does not appear to have been regarded as presenting with a risk of violence by Hadrian Clinic despite the contents of the initial referral letter from Bridge View and a number of other indicators, both prior to and during his period of treatment, in particular, the significant forensic history of violence.

Prior to the referral by Bridge View in 2005, he had been evicted from a number of hostels due to his intimidating behaviour to other residents.

A Cognitive Behavioural Therapist (CBT1), who had assessed Patient G in 2007, reported back to Hadrian Clinic that he had described to her that "he could not sit next to another man without wanting to kill him". Later that same year, Patient G reported to a doctor at Hadrian Clinic that he had thoughts of hurting himself and others.

He was the subject of knife attacks which occurred during the period of his engagement with Hadrian Clinic, being stabbed in the eye and slashed on his back in separate incidents (although a conflicting account describes him as a perpetrator and having assaulted his girlfriend in the latter attack), and he reported having played Russian roulette with a crossbow.

A number of doctors at Hadrian Clinic recognized that Patient G would benefit from enhanced care co-ordination and three separate referrals were made to the CMHT in 2006 and 2007.

As well as suffering from mental health problems and drug dependence, Patient G had a number of significant physical health needs requiring outpatient appointments for investigation and treatment, such as hepatitis C and 'blackouts'. He missed many appointments, which, in turn, delayed the opportunity for effective treatment for his PTSD. He also voiced that he wanted more support and more time to talk about his problems, as well as asking for supported housing. The various referrals to the CMHT were intended to address these issues.

Regrettably, the records from the CMHT were not available to the panel, having been lost, and it is not possible to ascertain why he was not assessed for enhanced care co-ordination. Had he been allocated for enhanced care coordination, it is likely that the risk of violence would have been identified more accurately, not only by virtue of a formalised risk assessment, but also because an enhanced care coordinator would have been likely to have access to more information about Patient G's presentation and functioning in the community.

Patient G was continuously involved with Hadrian Clinic from 2006 until August 2008 when a decision was made to transfer responsibility for prescribing medication for his

mental health to his GP. Patient G did not know his GP having had only minimal involvement with her and the panel struggled to understand the rationale for this decision. Thereafter the patient disengaged from Hadrian Clinic. At least two letters to Patient G were incorrectly addressed and would not have reached him. He was subsequently discharged on 22 December 2008 without reference to or discussion with staff at Bridge View. The panel found this decision inexplicable. Had the matter been discussed it would have become apparent that, by this time, staff at Bridge View had significant concerns about Patient G's deteriorating presentation. It was also known that historically Christmas was a particularly difficult time for Patient G.

The panel notes some elements of good practice in the care and treatment of Patient G. In particular, a detailed history was taken when he first assessed at Bridge View, Patient G had a good relationship with his main doctor at Bridge View (BVD1), the first doctor to assess him at Hadrian Clinic Staff Grade Psychiatrist 1 (SGP1) identified a number of needs and made appropriate referrals, a good assessment was carried out by a cognitive behavioural therapist at Plummer Court and details of treatment that could have been offered to him at Plummer Court were highlighted by her. In addition the panel is aware that in a number of respects Patient G's presentation appeared to have been more settled in this period compared to his early years. He had successfully engaged with a methadone programme and remained in the same accommodation from 2005 until the murder.

Nevertheless, a number of factors, had they been addressed, could have led to better care and treatment for Patient G. These are detailed in the report which follows but critical factors include:

- the failure to construct an achievable management plan with the appropriate review processes together with an absence of mechanisms designed to promote the engagement of Patient G.
- the failure of Hadrian Clinic to carry out an effective assessment of the risk of violence posed by Patient G, taking into account in particular the significant forensic history and reports of Patient G's thoughts of violence expressed to a number of professionals involved with his care and treatment
- the failure to manage or, in some cases, recognise Patient G as a complex case, which, inter alia, may have led to his treatment for his mental health and substance abuse being transferred to one provider, such as the specialist addiction services at Plummer Court
- the repeated failure of the CMHT and Hadrian Clinic to pursue allocation for enhanced care co-ordination for Patient G, which was likely to have led to a more accurate assessment of the risk of violence and a better understanding

of his presentation, particularly in the community, and his physical and social needs.

- the lack of input by the GP which was a major obstacle to the formation of a coherent multi agency management plan.
- the deleterious effect of the combination of prescriptions of sedating drugs and the impact of alcohol
- the decision of Hadrian Clinic to transfer responsibility for prescribing to the GP and the decision to discharge him from secondary mental health care without discussion with, or reference to, Bridge View.

Chapter 1 - Chronology of Key Dates and Events

Patient G was born in Sunderland on 30 July 1974. He was 34 years of age when he murdered Victim G on 3 January 2009.

Birth to 18 years (1974 to 1992)

Patient G's parents married in their late teens. His parents' relationship was described as very disruptive and they were reported as being unable to place their children's needs before their own. From a young age Patient G experienced abandonment, rejection and abuse and was cared for in a number of placements.

Patient G has one full sibling, a sister. There are various references in the records to his being a twin. In fact they were not twins. His full sibling was born the following year.

He was separated from her at an early age. She was cared for by a neighbouring family, who also looked after Patient G from time to time. Patient G's parents separated when he was around four years of age and his mother moved away to the Luton area leaving Patient G in the north east. His sister's carers were unable to care for Patient G full time and his mother placed him with another family. Patient G's father formed a relationship with the daughter of the family who were caring for Patient G's sister. They married and subsequently took over the care of his sister. It appears that Patient G had no further contact with his father or his full sibling until he was 16 years old.

Whilst she was living away from the north east, Patient G's mother received a lengthy custodial sentence for offences of violence and she did not return to the Sunderland area for around four years. On her return, she met and married the man who was to become Patient G's stepfather. He is reported to have been a very violent man, described by Patient G as a gangster. Patient G's first half sibling was born in 1981 and it appears that Patient G's mother then resumed the care of Patient G in or around 1982 when he would have been about eight years old. His mother and her husband went on to have a further three children, the youngest being born in 1987.

Patient G told the consultant psychiatrist (CP1) who prepared a report for the murder trial that he had been physically abused by his birth father and that he had also been sexually abused by a third party, including abuse by way of anal penetration, when he was around five years of age. He stated that the perpetrator had threatened to kill him if he disclosed the abuse. GP records from 1981 refer to Patient G suffering from nocturnal enuresis and this remained an issue well into adulthood. Later social services records from 1987 also make reference to Patient G suffering from encopresis.

There is a scant and unsupported reference in the GP records to 'behavioural problems' in 1984 and in the same year he was reported to have received a caution for stealing food from a supermarket. The educational psychology department became involved in early 1987, having received a referral from his school arising from concerns about his challenging behaviour. That work was hampered by poor compliance with appointments. Information about his behaviour at school is somewhat contradictory,

with some reports of behavioural problems including stealing, bullying and fighting and other reports of him not being regarded as a particular problem. His school attendance was good.

Child protection procedures were invoked in 1987 when Patient G was punched in the jaw by his step father. This assault appears to have been prompted by Patient G breaking into his school, having taken younger half siblings with him. This assault was sufficiently serious to warrant an admission to hospital and a child abuse case conference was held. His school reported that they had suspected that Patient G had received non accidental injuries the year before, when he had presented at school with facial injuries, although they had not made any referral. Patient G's mother was said to have been assaulted by her husband on a number of occasions, including one assault when her jaw was broken. The decision of the child abuse case conference was that Patient G should return home, that it should be explained to Patient G 'that breaking into school is not acceptable and that his stepfather should be informed that it is inappropriate to chastise the child by hitting him on the jaw'. No police action was taken in respect of the assault against Patient G but Patient G received a caution for breaking into the school. His name was placed on the 'At Risk' register, a social work assessment was undertaken and an assessment by an educational psychologist was completed.

These assessments identified problems relating to his emotional development, his poor relationship with his stepfather, poor parental supervision and lack of engagement by his parents with professional agencies. It was noted that Patient G's mother had unrealistic expectations of the level of care and responsibility Patient G should have for his siblings.

There was a reference in the social services documentation to a teacher stating that Patient G had a dreadful temper. There were allegations that Patient G and a friend had been involved with a couple of incidents when they had strangled pigeons, although these incidents were not substantiated. When the panel interviewed Patient G in prison he stated that he had been involved in incidents of cruelty to animals when he was a young person.

A report from the educational psychologist dated 29 October 1987 stated that school did not report Patient G to be a problem. The report did not make reference to IQ levels and did not appear to identify a learning disability. Patient G was reported to have attained 'permanent literacy', although he was in some of the lowest sets at school and received some special help, which was said to be in line with the findings of the educational psychologist.

Given the lack of engagement from his parents, it was agreed that future social work involvement should be focussed on Patient G as he appeared to react positively to such intervention. The recommendations of the social work assessment were that Patient G should remain at home, for social services to see Patient G every fortnight and for the educational psychology department to continue to liaise with school.

The involvement of the educational psychologist ceased in 1988 when Patient G appeared more settled at school. Unfortunately, Patient G's school closed down and he did not settle at his new school. He again became involved in offending, his behaviour at school was challenging, he truanted from school and his relationship with his mother

broke down. In late 1988, when Patient G was 14 years old, he was accommodated by the local authority at his mother's request and was admitted to a residential assessment unit, where he remained for a period of some three months.

He was then assessed by another educational psychologist on 12 December 1988 and judged to be of low average intellectual ability. Some positive characteristics were noted at the assessment centre. He was described as being highly responsive to the care and consistency afforded by staff and presented no management problems when working on a one to one basis or in very small groups. At such times he was well motivated, attentive and capable of working with minimum oversight, though it was noted that he was very easily influenced by more disruptive and dominant peers who could adversely affect his performance in any group situation.

He was described in the Penshaw House Assessment Centre report of November 1988 as 'a sad, rather intense and lonely boy who seems bereft of warmth and affection'. He was distressed that his mother did not contact him, or visit, and he particularly missed his half siblings. He was said to be totally bewildered about his place in his family. Following a series of home visits, he was rehabilitated home to his mother's care, attending a new school, where he received positive reports.

The improved relationships at home were short lived and Patient G ran away from home, on occasions sleeping rough. He committed an offence of burglary, which appeared to relate to him trying to find somewhere to sleep, for which he received a conditional discharge. He returned home but then committed a similar offence of burglary and theft. The circumstances mirrored those of the previous offence in that he had been sleeping rough in a vacant house and had entered a neighbouring house to obtain food. He again returned home and continued his education. By the time he was sentenced he was doing well and had been made a school prefect but, despite this, he received a Detention Centre Order of 21 days at the age of 15 years. Thereafter, apart from very brief spells, he never again lived with his family.

He was accommodated in a series of local authority community placements until adulthood, (approximately six between the ages of 14 and 17) which did not appear to provide him with the stable and consistent care he needed.

In one placement, he was reported to have been distressed at being shaken aggressively by a member of staff. This episode was felt to be 'threatening to Patient G and his sense of safety... Although not physically struck, this incident mirrors Patient G's relationship with his father, and is a reminder of the non accidental injury he was subject to.' He continued to suffer from enuresis and this was said to have been a product of his anxiety.

He was admitted overnight to hospital when he was 16 years old, having been thrown from the back of the residential school mini bus which had skidded and gone out of control. This overnight admission was necessary in view of the traumatic nature of the incident, but no fractures or serious injuries were identified.

Following a recommendation from a social services meeting, a referral was made to child and family psychiatric services to look at 'himself and his relationships'. They

reported no indication of mental illness but thereafter there is no information as to whether the referral was pursued.

Patient G had briefly made contact with his birth father and full sibling but his father was unwilling to offer a home to him and contact thereafter appears to have been sporadic.

The following year, in April 1991, when Patient G was nearly 17 years old, he took an overdose of medication which had been prescribed for his enuresis, following an argument with his girlfriend and was admitted to Sunderland District General hospital overnight. A psychiatric review identified a very complicated psycho-social history but did not recommend any psychiatric follow up. It was noted in the psychiatric review that he was probably destined for a life of crime and that he might be overdosing as a coping strategy. The prognosis was described as poor.

Around this time he received a conditional discharge for a burglary (non-dwelling) and a similar disposal for possession of cannabis.

At a social services review in August 1991 (then aged 17 years) Patient G admitted he was using drugs (LSD, cannabis and speed). He briefly attended the Sunderland Drug and Alcohol Advisory Service for no more than a few weeks until his arrest for further offending. He was then remanded in custody for seven offences of dishonesty, mainly burglary and theft. He received a three month custodial sentence in a Young Offenders Institution, subsequently returning to local authority accommodation.

In January 1992, aged 17 years, he was required to leave what would be his last social services residential placement due to his behaviour, and bed and breakfast accommodation was found for him. A further attempt by Patient G to resume his relationship with his birth father failed and this was said to have increased his feelings of rejection. By the time he reached 18 years of age he was in an on-off relationship with his girlfriend (GF1), who was pregnant with their first child.

Comment

There is no doubt that Patient G suffered significant emotional and physical abuse during his childhood. By his own account he was sexually abused. He experienced rejection and abandonment throughout his childhood. It is of note that his mother was convicted of a number of violent offences and served a lengthy prison sentence for these assaults.

Social services became involved when he was 13 years of age as a result of him being physically abused by his stepfather. He was exposed to domestic violence perpetrated on his mother by his stepfather. It was the view of social services that his mother was unable to put his needs before her own. Nevertheless, he was returned home very soon and there is little or no evidence of any improvement in the standard of parenting.

From the age of 14 years, until he moved into independent living at the age of 18 years, he lived for the majority of time in a series of local authority children's homes and residential placements. In a similar way to his early life experiences, his period in care was characterised by instability and a multiplicity of placements. As a result of his

experiences and the poor parenting he received, his ability to make and sustain attachments was likely to have been damaged.

Given his background and experiences, it is unsurprising that Patient G's behaviour deteriorated, culminating in him committing a number of offences, at least some of which were related to him running away and becoming homeless. His mother responded by requesting that he was accommodated by social services and she then failed to make contact with him for some time. Attempts at rehabilitation were short lived.

There is evidence that he was cruel to animals, and research suggests¹ that cruelty to animals can be an indicator of a predisposition to violence in later life. There are contradictory reports that he bullied other children at school but on other occasions there are suggestions that he backed down from conflict especially when older peers were involved. However, he had no convictions for violence during this period.

Patient G started using drugs in his mid-teens. Later reports refer to him using heroin at around the same time, although that is not mentioned in contemporaneous reports. He received a conviction for possession of cannabis in 1991. During this period he had some, albeit brief, involvement with the Sunderland Drug and Alcohol Service, which suggests that his drug abuse was a significant problem even at that time.

He was referred to a child and family psychiatrist when he was 16 years old, although the panel is not aware of the outcome. Some months later he took a drug overdose resulting in his admission to hospital. However, it was reported that there was no evidence that he had a mental illness.

¹ Childhood Cruelty to Animals and Subsequent Violence against Humans Merz-Perez et al

1992 (Independent living at 18 years) to 2005 (Engagement with addiction services and his move to Newcastle)

By now Patient G was in independent accommodation, although he still had a social worker until 1993. Patient G's mother reported in September 1992 that his drunken landlord had beaten him up. Patient G had a number of injuries, including extensive bruising, and stated that the landlord had hit him with a hammer and damaged his property.

Alternative accommodation was found for Patient G for but he subsequently moved again to live with his girlfriend (GF1) and their first child. He was reported to be a proud father and to have responded well to the responsibilities of fatherhood. According to a social services report dated 8 January 1993, he was due to appear before the Crown Court in January 1993. His solicitor had advised the social worker that Patient G had committed two burglaries with two other youths and that the other two youths then went on to commit two further burglaries in the course of which a man was murdered. The Chief Inspector (CI1) who gave evidence to the Panel could find no evidence of such a murder. He does not appear to have been sentenced until April 1994, when he received a Community Service Order (CSO) of 100 hours.

Patient G received a probation order for producing a controlled drug (growing a small number of cannabis plants) in February 1993. He was referred to the Community Addiction Team (CAT) on two separate occasions in 1993 but failed to attend appointments. He did not co-operate with the requirements of the probation order and was brought back before the court on two occasions for non-compliance for which he received small fines. Throughout the course of 1994 and 1995 Patient G continued to commit offences of an acquisitive nature although he did not receive any further custodial sentences.

He became estranged from GF1, but they reconciled and she went on to give birth to their second child in 1994 or 1995. In August 1995, Patient G was placed on probation again for theft. A report from probation stated that he subsequently obtained employment as a security guard and described himself as very settled and happy with GF1 and the children. He said he was no longer taking cannabis and acknowledged that drug and alcohol misuse had played a significant part in his previous pattern of offending. He stated he was no longer interested in using drugs. Unfortunately, this settled period did not last when several months later, in late 1995, Patient G was imprisoned for two weeks for non-payment of fines and lost his job. Patient G and his girlfriend (GF1) separated for the last time in early 1996. These events may well have contributed to his resumption of drug and alcohol abuse.

After the end of this relationship he went to live at his grandmother's home for a short period of time.

In August 1996, Patient G approached an elderly woman, who was walking her dog in the street, threatened her with a knife and demanded money. She managed to knock the knife out of his hand. When she went to pick it up, he tried to kick her in the head, but she was able to avoid the kick. He then ran away. He was chased by a security guard who happened to be in the vicinity, before collapsing. He was apprehended following a minor scuffle then collapsed again and was taken by ambulance to

Sunderland District Hospital. He reported having taken an overdose of between 50 and 100 temazepam tablets and a bottle of whisky.

He was transferred to Cherry Knowle Hospital on 29 August where his mental state was assessed. He claimed to have no memory of the attempted robbery. He stated that he was fed up with life and wanted to die. He had been abusing drugs including £20 per day of amphetamines, £15 per day of cannabis and £40 per day of heroin, although denied having used heroin in the three days before the offence. He was drinking heavily. No evidence of formal psychiatric disorder was found and the main problem was said to be substance abuse. He expressed no remorse or empathy with his victim.

The psychiatrist assessing him wrote in his notes that he was 'probably anti-social personality type with long forensic history – does not seem to be depressed'. He was discharged on 30 August 1996 when he was arrested and charged with attempted robbery. Robbery is defined as 'taking the property of another with intent to permanently deprive the person of that property by means of force or fear.' This was the first recorded conviction for violence.

Following a short period on remand, he was bailed to an address in Gateshead as his grandmother refused to allow him to return to her home. He failed to co-operate with referrals to the Community Addiction Team (CAT) to deal with his alcohol and drug misuse. His offending behaviour and lifestyle spiralled out of control and he committed a number of offences of TWOC (taking a vehicle without the owner's consent), aggravated TWOC and dishonesty. He was sentenced to 120 days imprisonment for those offences on 24 December 1996 and to five years imprisonment for the attempted robbery on 10 February 1997, which he served at HMP Risley in Warrington.

He was released on licence on 25 August 2000, the licence period expiring on 12 February 2001. On release from prison he stated that he had been drug free since February 1997 and blamed his offending upon his substance abuse. He was described in a risk assessment form completed by probation on his release from prison on 29 August 2000 as low risk to himself and to the public. He resided with his mother for a while, but the reconciliation was short lived due to conflict with his stepfather.

He obtained employment in a factory and formed a relationship with a woman he had met at work Girlfriend 2 (GF2), who soon became pregnant and gave birth to a daughter, Patient G's third child, in around 2001. Patient G completed his licence period without further offending in February 2001. There was no evidence of drug abuse.

On 11 March 2001, he was involved in a further offence of violence in Sunderland. The victim, a security guard whom Patient G described as a friend, stated that he was outside a store when he was threatened by Patient G, who tried to goad him into a fight. Patient G had a Stanley knife. It was said that the victim tried to strike out at Patient G, who retaliated by slashing him with the knife, causing a four inch wound to the victim's throat. Patient G stated that he acted in self-defence. He was charged with an offence of unlawful wounding (section 20 Offences against the Person Act 1861) and was bailed.

According to a pre-sentence report from probation prepared in December 2001, his offending had led to him losing his job and his relationship. In November 2001, he had moved to Merseyside 'for a fresh start and to get away from his family and his own

reputation'. There was no report of drug or alcohol abuse. On 4 January 2002, he pleaded guilty to the offence of wounding and was sentenced to six months imprisonment for the offence of wounding and to 12 months concurrent imprisonment for breach of his licence conditions, which he served at HMP Liverpool. He was released on licence on 3 July 2002, the licence period to run to 2 October 2002. On release he settled in Merseyside for a short period before returning to the north east. An analysis by the probation service described the risk of harm as medium to high and the risk of re-offending as medium.

On 2 September 2002 Patient G was arrested in the north east on a charge of street robbery. A knife was involved. Patient G stated that he was confronted by some people he knew and a fight ensued. The charge was subsequently reduced to a Section 4 Public Order offence (using threatening, abusive, insulting words or behaviour with intent to cause fear or provocation of violence) and possession of an offensive weapon. It was recorded in a pre sentence report by probation dated 19 June 2003 that Patient G had been drinking prior to the incident and acknowledged that alcohol increased his tendency to react violently. He stated that he carried a knife as a result of his experiences in a high security prison following the imposition of the sentence for attempted robbery in 1997. He also stated that he was agitated as he was trying to withdraw from heroin, which had been particularly problematic for the past few months, and had used alcohol combined with diazepam to combat the withdrawal symptoms. The report stated that Patient G was 'still injecting heroin on a daily basis'. His previous supervising officer in Liverpool was said to have been aware of his heroin use but did not believe it was a major issue.

A recommendation was made in the report for an assessment for a Drug Treatment and Testing Order (DTTO). That assessment was carried out in July 2003, but Patient G was not deemed suitable due to the unresolved issues about his past and because he attended for the appointment under the influence of heroin. The assessment reported that Patient G felt his depression was due to 'volatile incidents which had occurred whilst in prison' when aged 21 years and that he suffered from 'paranoia'.

Patient G was sentenced to five months imprisonment on 4 August 2003.

According to the probation records, Patient G then came to the attention of the authorities again in June 2004, when he was charged with handling stolen goods and attempted theft.

A pre-sentence report dated 25 August 2004 records that Patient G had formed another relationship some three years previously, residing with his partner and her son until April 2004 when their two day old daughter died. He stated that he had struggled to come to terms with her death and relapsed into drug misuse as a means of coping. Patient G was again assessed for a DTTO but, once again, was not found to be suitable for such an order as he had recently left a residential detoxification unit after only three days. He had expressed an interest in moving out of the Sunderland area to distance himself from known drug users. This report failed to include a reference to the offence of attempted robbery in respect of which he received a five year sentence of imprisonment in 1997. On 27 August 2004 Patient G was convicted of offences of shoplifting and handling stolen goods and was sentenced to two periods of imprisonment of three months, to run consecutively.

On his release from prison, Patient G continued to commit petty offences. There is a record from the police national computer that he was arrested for a robbery on 13 March 2005 but that the 'injured party' refused to prosecute.

A pre-sentence report dated 16 March 2005 dealing with the offences relating to shoplifting and TWOC records that Patient G had deliberately shop lifted in front of a security guard in order to access a referral to a methadone programme. A referral was made and this led to him commencing a methadone programme in February 2005 with the Drugs Intervention Programme in Sunderland. A recommendation was made for a Community Rehabilitation Order (CRO) with a requirement for him to attend a 'One to One' programme (OTO). The court accepted this recommendation and made a CRO for 12 months. It is of note that the pre-sentence report mentioned the offences of violence committed from 2001 onwards but omitted to mention the offence of attempted robbery leading to the sentence of imprisonment of five years imposed in 1997.

Patient G attended his first appointment with probation under the CRO on 22 March 2005. He was living in a squat and sought supported accommodation in Newcastle. He had refused to attend at the Hendon office, expressing fears for his safety and alleging he had been stabbed the previous year. He wanted to get away from the drug scene in Sunderland.

Patient G was aware that a number of providers would not accept him due to his past behaviour in such hostels. In April 2005, Patient G was assisted by probation to move to a hostel in Newcastle upon Tyne at Virginia House.

Comment

This period of Patient G's life, from moving into independent living aged 18 years in 1992 to 2005, was characterised by drug and alcohol abuse, offending (including a number of instances of offending using knives) and instability, both in his relationships and accommodation. There is little evidence of him receiving support from his family or of any enduring relationship. He had three surviving children to two different partners, but did not maintain contact with any of them. He had separated from the mother of his deceased child. He had obtained employment only sporadically.

Patient G told CP1 who prepared a report in connection with the murder trial that between the ages of 17 and 31 he lived in approximately ten different hostels or flats, punctuated by periods of living on the streets. In fact, the evidence suggests that the number of moves was very significantly higher than this.

Although he had taken another overdose during this period, the psychiatrist assessing him at Cherry Knowle Hospital in 1996 noted no evidence of mental illness but recorded 'probable anti social personality with long forensic history – does not seem to be depressed'.

Up until 1996, the bulk of his offending related to dishonesty and there had been no evidence of Patient G being involved in crimes of violence although there is evidence of anti social and aggressive behaviour in his adolescence. In 1996, he attempted to rob an

elderly woman when under the influence of drugs and alcohol using a knife. There are a number of references thereafter to Patient G carrying a knife as well him sustaining knife wounds. He was convicted of a public order offence in 2003 for having an article with a blade in a public place, receiving a further sentence of five months imprisonment.

It is of note that in 2002 he received a sentence of six months for wounding and a sentence of twelve months for breach of licence conditions. The breach of licence referred back to his conviction for attempted robbery in 1997. Had the twelve month sentence been imposed for the wounding offence rather than the breach of licence that would have triggered a referral to the Multi Agency Public Protection Arrangements (MAPPA), which would have led to a more comprehensive risk assessment and monitoring.

It is unfortunate that the pre-sentence reports from 2003 and 2004 did not make reference to the significant offence of attempted robbery committed in 1996. This was an integral part of his forensic history and such reports may have been relied on by subsequent probation officers. In any event, routine consideration of his antecedent history in the course of preparation of these reports should have prompted further enquiry in relation to those offences of violence.

Patient G was abusing drugs and alcohol regularly and there is the first reference to him injecting heroin during this period. It appears that his drug and alcohol abuse was a significant factor in his offending and violent behaviour.

Patient G identified two particular traumatic events in this period, which were accorded particular significance in his future care and treatment.

Firstly, he alleged that he had been raped in prison. The panel has not been able to verify this incident or when it may have occurred. The probation report dated June 2003 makes reference to Patient G commenting that he carried a knife as a result of experiences in a high security prison from 1997. The community assessment report prepared in July 2003 referred to 'volatile incidents' in prison when Patient G was 21 years old (which would be around 1995/1996). A letter from a staff grade psychiatrist written in 2005 reported Patient G's assertion that he was gang raped in prison in 1996.

Secondly, he reported that his daughter died aged 2 days old in 2004. There are later references to slightly different descriptions of this event, but whatever the exact circumstances, Patient G seemed to have been significantly affected by this.

Patient G commenced with the Drug Intervention Programme (DIP) in Sunderland in 2005. It appears that he was motivated, given that he was reported to have deliberately offended in order to be put on a drugs programme. He commenced methadone for the first time and maintained engagement with the service.

Patient G moved to Newcastle in April 2005, which was very much in accordance with his wishes to get away from the "drug scene".

The period from May 2005 to January 2009

By April 2005 Patient G was living in a hostel in Newcastle although he continued to be supervised by probation services from Sunderland.

Patient G continued to present with difficulties. His probation officer noted that he continued to grieve over the death of his daughter the previous year.

In May 2005 he attended at accident and emergency with a swollen hand and a head injury (graze to forehead noted), having been involved in a fight at the hostel. There is the first record (by probation) of Patient G stating that he had blacked out, although he had earlier claimed not to recall the events leading to the attempted robbery of an elderly lady in 1996. He was drinking, was noted to smell of alcohol and was stopped and searched by the Police when he was found drinking alcohol in the street. In May he was given a warning by the hostel about his behaviour as a result of him being involved in fights and taking alcohol onto the premises.

On 19 May 2005 Patient G commenced counselling at Ron Eager House, a drop in centre run by the Cyrenians in Newcastle, and agreed to transfer his drug treatment from DIP in Sunderland to addiction services in Newcastle, given that he was no longer living in Sunderland.

On 31 May 2005 Patient G was assessed at Bridge View Treatment Centre (a community based drug treatment service) and his drug treatment was subsequently transferred to that service from the Sunderland DIP. A summary of his drug history was taken which recorded cannabis use from 16 years, smoking heroin daily from 18 years, increasing to injecting, daily use of benzodiazepines and use of other street drugs such as speed, ecstasy, cocaine and crack cocaine. He denied heroin use for the last three months. He described his distress as a result of the death of his daughter in 2004 and as a result of being raped in prison, although it is not clear when this occurred. He complained of disturbed sleep and nightmares.

On 10 June responsibility for the supervision of Patient G's probation order was transferred from Sunderland to Newcastle. A decision was made for his case to be co-worked by two probation officers, one male and one female, Probation Officer 1(PO1) and Probation Officer 2(PO2). In his evidence, PO1 suggested two possible reasons for this – firstly, his rather chaotic lifestyle meant that he had a habit of turning up without an appointment, and when he did attend it meant that he was more likely to be able to see someone familiar with his current circumstances and secondly, there was some evidence in the records that he displayed a tendency to manipulative behaviour which, it was believed, could be better managed with two separate workers involved.

By June 2005, PO1 commented that Patient G now seemed to have a 'good package of support' including accommodation, counselling and drug treatment.

Shortly afterwards Patient G reported to PO1 that he had a new partner, girlfriend 3 (GF3), but that he had been arrested for an assault upon her. He alleged she had broken one of his ribs. He was bailed to keep away from her, although no further action was taken in respect of the alleged assault. There was a concern that he was still drinking.

The manager at the hostel reported concerns that Patient G might harm himself and that he was distressed because his 14 year old sister had died. Subsequent enquiries with his family revealed that this was not true.

Patient G's attendance at his probation appointments was somewhat erratic citing various reasons for non-attendance indicative of his chaotic lifestyle.

He had been taken to accident and emergency (A&E) by the police in July 2005 with a nine inch laceration to his back but was uncooperative and took his own discharge. He stated that his girlfriend had slashed his back with a craft knife but she had alleged he had slashed his own back. He was arrested on suspicion of assaulting his girlfriend who had been bleeding from the mouth, although no further action was taken.

Within days he was evicted from the Salvation Army hostel for being abusive. Concerns were raised by staff at the hostel about him drinking excessively which led to them requesting a review of his diazepam. He was said to be 'intolerant' when he was drinking. In early September he was evicted from another hostel for bullying older residents for money and threatening another resident with a knife. He was again homeless.

He self presented at A&E and was referred to the Crisis Assessment and Treatment Service (CATS) by an A&E doctor on the evening of 9 September 2005. He stated that he was depressed and wanted to join his daughter and his mother. He stated that his mother had died two weeks before (although this was not true and she was still alive). He presented as intoxicated from drugs and alcohol and appeared drowsy. The completion of a care co-ordination assessment form was therefore delayed until the early hours of 10 September. Although a history of offending was completed, this relied on his self reporting and it was not accurate. It records that Patient G stated "Been in prison 'loads of times' theft – shoplifting. No violent crimes". Patient G stated that he had been gang raped in prison. He was homeless and said he could not return to Sunderland because he had stolen £50,000 from local gangsters, who would shoot him. No evidence of mental illness was found and his depression was felt to be reactive to his circumstances. He was discharged with advice to seek help from the local authority Emergency Duty Team (EDT) at Newcastle Civic Centre about his homelessness.

He was seen by Bridge View again on 19 September. He was still homeless but did not appear intoxicated. He denied recent alcohol abuse but repeated threats to jump off a bridge. He was put on daily pick-ups for his medication and advised to return to A&E, CATS having agreed to review him again. He was assessed by the CATS team on the evening of 19 September 2005 at Newcastle General Hospital. He was dishevelled, homeless and was threatening suicide. Another care coordination assessment form was completed. Patient G stated he had been drinking a bottle of wine a day. The history of offending section simply stated 'See previous assessment. Been jailed several times'.

At the end at the assessment under the heading 'Further Action', there was a record of a phone call with PO1 who suggested 'alcohol and PD (personality disorder) issues' and asked to be made aware of further contact. No evidence of mental illness was found and his distress was reported to be secondary to his homelessness. As a consequence, CATS decided there was no further role for them.

An undated and unsigned FACE (Functional Assessment of Care Environment) risk assessment, which appears to have been carried out at the same time, recorded that Patient G had no convictions for violent offences, although it did record under the heading 'behaviour indicative of risk' that there was a history of physical harm to others and threats/intimidation.

Within a few days, with the help of a friend, Hostel Resident 1 (HR1), Patient G obtained accommodation in a privately run 12 bedded hostel for single men. The friend, later occasionally described as Patient G's brother or cousin, was living at the hostel. He offered considerable support to Patient G. Patient G remained at this hostel until the murder.

He was seen a few days later on 26 September 2005 at Bridge View by Bridge View Doctor 1 (BVD1) who recorded 'struggles with violent impulses - suddenly feels aggressive and if someone in the way will hurt them including with knives etc.'. She noted his account of a significant history of violence including 'attempted murder when he slashed a friend's throat, armed robbery and S20 offences² and S47³ offences' and decided to refer Patient G to the local CMHT at Clifton Mount .

She wrote a detailed letter outlining the history. She referred to a forensic history of violent offences and noted reports that he was continuing to exhibit aggressive behaviour to other residents within the hostel accommodation. She specifically requested an assessment of his low mood and the issues around his impulsive violence and anger and also highlighted issues relating to the death of his daughter and the alleged rape in prison. Unfortunately, this letter was addressed to the Hebburn CMHT team (located south of the Tyne where the patient had lived until very recently) rather than Clifton Mount. The CMHT records were not available to the panel. The CMHT office at Clifton Mount is now closed down and the panel was told that the records could not be located. There is no evidence that this letter was ever forwarded to the correct team by the Hebburn CMHT, returned to Bridge View or even acknowledged.

A few days later, according to police records, Patient G's friend from the hostel, HR1, alleged to the police that four men had attacked him and Patient G in a park and that HR1 had been stabbed. Nothing seems to have come of this.

According to the police records, Patient G was fined for a Section 5 public order offence (using threatening, abusive or insulting words or behaviour, or disorderly behaviour within the hearing or sight of a person likely to be caused harassment, alarm or distress thereby) in November 2005. PO1 had not been aware of the conviction although Patient G subsequently told him that he had been fined for abusive language. Around the same

² Unlawful wounding, contrary to s20 Offences against the Person Act 1861

³ Assault occasioning actual bodily harm s47 OAPA 1861

time, PO1 noted that Patient G seemed well settled at the hostel although there were allegations that he had assaulted other residents. BVD1 and PO1 discussed Patient G's case and his forensic history in December 2005 which included mention of s20 and s47 offences (although there are no recorded convictions for s47 offences) and five years for attempted robbery. BVD1 noted in the records 'no mention of a stabbing though'.

In January 2006, BVD1 saw Patient G when he complained of nightmares regarding the death of his daughter and the alleged rape. At that point BVD1 recognised that the referral letter to the CMHT had been sent to the wrong office. The letter was readdressed to the Clifton Mount office with a request for an urgent appointment given the delay. BVD1's record states 'CMHT message they've had a referral meeting and Consultant Psychiatrist 2 (CP2) will get in touch with us as soon as possible'.

BVD1 saw Patient G again in February. He told her that the probation order had now ended and that he would like more support. He asked for a referral for supported accommodation, which would have had the advantage of key worker support.

Following the referral to the CMHT Patient G was offered an appointment at the Hadrian Clinic (the psychiatric outpatient unit) in February 2006 but denied receiving the letter. He missed a second appointment in March, when he attended the wrong location. He also missed an appointment with a housing provider, Norcare, stating he had got the times mixed up. He attended all his appointments at Bridge View and was complying with treatment there. He denied alcohol and heroin use, and produced negative urine screens.

At the third attempt, Patient G attended for an initial appointment at Hadrian Clinic in May 2006 and was seen by Staff Grade Psychiatrist 1(SGP1). Diagnoses of post-traumatic stress disorder (PTSD) and opiate dependency (currently well controlled on maintenance) were made. He found no evidence of psychosis and little evidence of depression.

Patient G said he had found the counselling at Ron Eager House too probing and stressful. SGP1 referred him to a Chartered Clinical Psychologist (CCP1) at Newcastle General Hospital for assessment for CBT (Cognitive Behavioural Therapy) for PTSD. In the referral letter he described that Patient G had reported being gang raped in prison 'in 1996' and the death of his daughter. Although a history of violence was described, he was said to have kept out of trouble for several years. He stated that Patient G had played Russian roulette with a crossbow earlier that year. The letter made no reference to the impulsive violence and anger mentioned by BVD1. SGP1 stated in the letter that he was not sure whether to refer Patient G to clinical psychology or, given the complexity and long standing nature of his problems, to Plummer Court (where the CBT service for Newcastle was based). The letter was sent to CCP1 but the referral was forwarded to Chartered Clinical Psychologist 2 (CCP2) at the CBT Centre at Plummer Court due to the complexity of the case.

The Plummer Court cognitive behavioural therapist apparently wrote to Patient G at the beginning of August asking him to contact the department to arrange a time for an assessment appointment. They advised him that if he did not respond within three weeks they would assume he no longer wished to be seen. He did not respond, and he was discharged from their waiting list at the end of August 2006. A copy of a letter

confirming he had been discharged from the waiting list was sent to his GP, (GP1) but the panel could find no evidence that SGP1 was ever notified.

Patient G seemed to engage with both Bridge View and his appointments with the psychiatric outpatient department at Hadrian Clinic. Bridge View continued to be responsible for prescribing his substitute medication for heroin and for prescribing diazepam. They later prescribed nitrazepam, following discussions with his psychiatrist, to help with sleep. Hadrian Clinic prescribed medication for his mental health, commencing with paroxetine for the symptoms of PTSD. There were subsequently many changes to his medication prescribed by Hadrian Clinic, including mirtazapine, risperidone, sulpiride, trazodone, quetiapine, citalopram, sodium valproate and temazepam which are detailed in the psychiatric overview in this report.

In July 2006 Patient G told SGP1 that he was often going round looking for trouble and getting into arguments. He also stated that his mother had been diagnosed with leukaemia (which does not appear to be true). He reported that he was continuing to have flashbacks, had been experiencing blackouts for some months and was seeing things that were not there. He denied drinking.

In the same month Patient G was found to be hepatitis C positive on laboratory testing for blood borne viruses. He was not informed of this straight away. On 18 August 2006 he was diagnosed by SGP1 as depressed in addition to suffering from PTSD, and an anti-depressant, trazodone, was recommended in the clinic letter.

A few days later Patient G was informed of his diagnosis of hepatitis C by BVD1.

SGP1 saw patient G again on 31 August. He reported seeing things out of the corner of his eye, which SGP1 described as possible completion illusions. He reported that he had heard his hi-fi telling him to 'piss off' but denied any other auditory hallucinations or paranoia. In SGP1's opinion, this was unlikely to represent psychosis and the possibility of a number of explanations was given, including intoxication, an epileptic phenomenon, or flashbacks.

On 5 September 2006 SGP1 wrote to Bridge View informing them that he would refer Patient G to the CMHT for a care coordinator and to a neurologist for investigation of the blackouts. In the referral letter to the neurologist on 12 September 2006 he reported the history of 'some kinds of blackouts', and the background of drug misuse and mental health problems. SGP1 mentioned that he could sometimes smell alcohol on Patient G's breath but that Patient G denied alcohol misuse.

On 2 October 2006, Patient G told SGP1 that he had not experienced auditory hallucinations again, but that he heard whispered voices - 'he could not tell what they were saying, or who they were.' Patient G told SGP1 that he had not heard from the neurology department. The panel has seen an undated, unsigned, handwritten note in the Hadrian Clinic records which states that he was discharged by the consultant neurologist as he did not attend for his appointment on 11 October 2006.

Patient G attended Hadrian Clinic on 20 November 2006. SGP1 described him as 'much more lucid and calm than on previous occasions although his speech was slightly

slurred'. There is no mention in the Hadrian Clinic records of the referrals to the neurologist or the CBT service.

Patient G attended Hadrian Clinic in January 2007. The clinical records are dated 10 January, although the resulting correspondence referred to two different dates. Patient G had found Christmas difficult and was given information about a mental health drop in and a club to encourage him to socialise. He stated that he had not heard anything from the Cognitive Therapy Centre at Plummer Court. It appears that SGP1 was not aware that Patient G had been offered an appointment, failed to attend and was then discharged in August 2006. SGP1 re-referred him on 15 January 2007, explaining that Patient G had problems with his mail and asking to be copied into correspondence in order to assist with facilitating attendance. He also re-referred him to the neurologist.

SGP1 saw Patient G on 2 February 2007. Patient G felt that people were talking about him when he went out. His medication was changed again. SGP1 noted that Patient G did not wish to have enhanced care as he said he did not like social workers.

BVD1 wrote to Hadrian Clinic on 5 February 2007 stating that Patient G had gone downhill since Christmas. He had admitted to using heroin twice. This was the first urine sample that had been positive for heroin since he had been in treatment with Bridge View, although on occasions the medical records state that Patient G was unable to give a urine sample. He had asked to be admitted to an open psychiatric ward for monitoring and to be safe. He was anxious about SGP1 leaving the service. BVD1 requested that he be referred for supported housing. She stressed that he did not receive his mail.

In February BVD1 and SGP1 had a telephone discussion. SGP1 confirmed that he was leaving Hadrian Clinic but he would see Patient G once more before he left and would encourage Patient G to have a care coordinator, particularly to look at housing. There is no mention in the records of SGP1's intention - in September 2006 - to refer Patient G to the CMHT for a care coordinator, or whether the referral was ever made.

Patient G missed another appointment with the CBT Centre on 26 February 2007. It is not clear whether Hadrian Clinic had been copied into the appointment letter as requested. There is no copy of the appointment letter within the Hadrian Clinic records. SGP1 wrote on 8 March requesting another appointment and advised that he had referred Patient G to Clifton Mount CMHT for a support worker to help him attend important appointments as he was anxious about going out on his own. He suggested that the appointment with the CBT centre be delayed for a few weeks whilst matters were finalised with Clifton Mount.

SGP1 wrote to Clifton Mount CMHT on 8 March 2007, stating he would like to re-refer Patient G to the CMHT. He stated 'as mentioned in the past Patient G has a number of problems'. He felt Patient G would benefit from the team for general support, specific advice about housing and assistance with attending appointments, stressing that treatment of his psychiatric problems had been severely hampered by his non-attendance at CBT and the neurologist. He wondered whether Patient G would be suitable for E5 (accommodation for people with mental health problems).

SGP1 also re-referred Patient G to the neurologist, advising that Patient G was continuing to have blackouts and had had some sort of blackout in the clinic. Before SGP1 left the clinic, he reduced the dose of trazodone, with a view to it being stopped at the next appointment, as this may have been the cause of an increase in fits experienced by Patient G.

Senior House Officer 1 (SHO1) took over Patient G's care from SGP1 at Hadrian Clinic in March 2007. Following a clinic appointment with Patient G on 29 March she wrote to Patient G's GP on 4 April advising her that Patient G was still awaiting a CMHT allocation. The letter was copied to Clifton Mount CMHT.

BVD1 wrote to Hadrian Clinic on 17 April seeking advice about the management of Patient G's physical and mental health. She mentioned, inter alia, that recent liver function test results had been abnormal and were consistent with excessive alcohol intake, which Patient G had denied. He stated he was drinking six to seven bottles of brown ale twice a week but not daily and not on a morning.

On 29 April 2007 police intelligence records note that alcohol was taken off Patient G in the street at 15.15hrs.

On 1 May 2007 Patient G attended an appointment at the CBT Centre at Plummer Court accompanied by his friend, HR1, also described as his stepbrother. The CBT Centre reported to SHO1 that he had scored highly on the impact of events scale, a quick measure of PTSD symptoms and described his symptoms as chronic. However, he was not felt to be ready for CBT at this time as his priority since first being referred had changed to physical health and safety issues. His priority related to tests for epilepsy and on his liver, given the diagnosis of hepatitis C. A concern regarding these approaching tests raised a risk issue as Patient G stated that 'he wasn't bothered and looked forward to dying'. Reference was made to his strong distrust of men and to him saying "I can't sit next to another man without wanting to kill him". His current need was said to be for support and practical help and he indicated again that he would like sheltered accommodation. It was noted that he gained support and appeared to have a good relationship with BVD1. The letter to SHO1 went on to state that a possible option was to consider a worker from Plummer Court jointly trained in methadone maintenance and CBT for PTSD symptoms. A re-referral or further discussion was suggested once his physical tests were completed. GP1 and BVD1 were copied into the correspondence.

A few days later, Patient G was admitted to the Royal Victoria Infirmary for several days for treatment for lacerations to his eye. He alleged a female at a party had stabbed him in the eye. His treatment was described to be complicated by his extreme somnolence. He failed to attend a follow up appointment.

BVD1 saw Patient G on 4 June and noted that his mental health was deteriorating. Bridge View wrote to the GP practice on 6 June with a copy to Hadrian Clinic stating that they did not have the resources to offer good enough CBT to Patient G. She acknowledged that it might not be the best time to get him to engage with a talking therapy, but that he would need this sort of treatment for his mental health. She suggested a review of the situation in a few weeks once physical health tests had been

completed. There was no mention of the option of considering a worker from Plummer Court jointly trained in methadone maintenance and CBT for PTSD.

SHO1 wrote to the CMHT on 11 June 2007 requesting community support for Patient G. SHO1 said that 'he feels that a half an hour appointment is not long enough time to speak and he would like to talk about some recent events and how he is feeling on a day-to-day basis.'

SHO1 left Hadrian Clinic in June 2007 and Patient G was then seen by another SHO, Senior House Officer 2 (SHO2). CP2 from Hadrian Clinic, who never saw Patient G, stated in his Serious Incident Management Review report that there was a full review of Patient G's presentation and treatment towards the end of June and that his case was discussed with another GP in the practice and BVD1. Patient G had not seen his GP since 2005. There is no mention in Patient G's clinical records of any discussions with the CMHT about the referral for a care co-ordinator save for an entry in the Hadrian Clinic records dated 28 June 2007 that Patient G remained on the CMHT waiting list for allocation. SHO2 subsequently mentioned in a letter to the GP a possible referral for occupational therapy once Patient G's physical needs were understood. There is a record of a telephone discussion between SHO2 and BVD1 regarding his presentation and treatment by Bridge View. BVD1 asked again to be copied into correspondence from Hadrian Clinic.

According to police records, Patient G was twice stopped in July during the day and searched in the street drinking alcohol with his friends. It was also recorded that in August 2007 a resident at Patient G's hostel had treatment for a knife wound at Newcastle General Hospital accompanied by Patient G and had indicated that Patient G had caused the injury in a fight.

Patient G was seen in mid-July at the Freeman Hospital for an assessment of his hepatitis C, which identified that it might have progressed to advanced fibrosis or cirrhosis. He did not however attend for any further investigations.

In September 2007, Patient G and his friend were again stopped and searched twice by the police for drinking in the street. Later that month, Patient G's then girlfriend was arrested for breach of an ASBO (Anti Social Behaviour Order). She was with Patient G and said Patient G had been vomiting blood, although he was noted to be still drinking alcohol with her in the street.

On 28 September, SHO2 saw Patient G in clinic and stressed the importance of him attending hospital for his physical health appointments. Three appointments were arranged for the following month at two different hospitals (neurology, hepatology and the fibroscan of the liver). SHO2 wrote to GP1, with a copy to Bridge View, stressing the importance of him attending. He also reported that Patient G was feeling worse, including having thoughts of hurting himself or others.

In October he was stopped and searched by the police for drinking alcohol in the street.

Patient G continued to miss appointments with the hepatologist and with neurology although he did attend the epilepsy clinic in October 2007. Further tests were recommended but the neurophysiologist (NP1) advised that Hadrian Clinic treat him for

a non epileptic seizure disorder pending further investigations. In the event no further investigations took place.

SHO2 left Hadrian Clinic in late 2007 and Patient G was seen in December by a locum staff grade psychiatrist, SGP2. It is not clear whether he had read the letter dated 19 October 2007 from the neurology department as he stated that there were no new developments and that Patient G had failed to keep his appointment with the neurology department. (In fact Patient G had attended the epilepsy clinic on 15 October 2007). He also said he would discuss his accommodation needs with the community health team. There is no evidence in the Hadrian Clinic records that this was done.

Patient G turned up at the Hadrian Clinic without an appointment in early January 2008, reporting feeling very depressed since just before Christmas and that this was a particularly difficult time of year for him.

BVD1 noted that Patient G failed an appointment at the end of January 2008, which was out of character. She then went on extended leave.

Patient G was distressed to have yet another change of doctor at Hadrian Clinic when he was seen by a staff grade psychiatrist, SGP3, at the end of February 2008. Patient G was very upset that his friend, HR1, whom he described as his brother, had died suddenly at the hostel at the age of 34 years. Patient G complained he had no support from services save from Bridge View.

Patient G subsequently saw Bridge View Doctor 2 (BVD2) on 27 February and described his distress at the death of HR1 and his girlfriend's recent miscarriage.

Patient G had failed to attend further appointments for neurology and for hepatology.

At appointments at the Hadrian Clinic in April and June, he continued to complain of terrifying nightmares and that he did not feel safe. He again requested supported accommodation. SGP3 felt he had support from his parents whom he was said to phone regularly, and his girlfriend, and described him as functionally improving. Concerns were expressed that he was running out of medication early and Patient G indicated that his girlfriend might have used his medication.

Patient G was repeatedly requesting an increase in his methadone from Bridge View which was refused. He saw SGP3 in July and asked for inpatient admission. Patient G described excessive paranoia and suicidal ideation. A clinical note refers to low mood, nightmares and flashbacks. After discussion with CP2, SGP3 wrote to GP1 on 22 July requesting that she take over responsibility for prescribing apart from the methadone and diazepam which he was to continue to receive at Bridge View. The reason given for this change was that there would be only one point of access for his medication.

Patient G attended a further appointment with SGP3 at the beginning of August. He stated that he had mood swings, and became very angry and destructive. He again requested inpatient admission. SGP3 changed some of his medication, recording that it would have an adverse effect on his epilepsy, although the consultant clinical neurophysiologist (NP1) had requested he was treated for a non epileptic seizure disorder. His symptoms were said to relate to his dependency on methadone and

diazepam. Patient G was given a four week prescription, and informed that in future he would need to attend at his GP's surgery to obtain his prescribed medication. This was the last time he attended the Hadrian Clinic.

Patient G had continued to attend Bridge View and had usually seen BVD2 in the absence of BVD1. In September his pick-ups were reduced to weekly and in October they were reduced to daily due to concerns that Patient G was drinking more, had impaired balance and was struggling with date and time. His methadone was reduced.

In October 2008 he was found to be in possession of cannabis when stopped and searched by the police. A police doctor who examined him stated his speech was slurred due to learning difficulties and 'that he would need an appropriate adult to be present at interview'. A member of the EDT team attended at interview.

He saw Bridge View Nurse 2 (BVN2) on 21 October and complained of feeling over sedated in the morning. He was not always picking up his medication regularly. The nurse who saw him put him on the list to be allocated a key worker. He was still reporting distress about the death of his 'brother', HR1.

The next day he attended at Bridge View again. An ambulance was called as he appeared very sedated. A&E noted a head injury from a fight the previous night. Patient G called into Bridge View again the next day, 23 October 2008, to say he had been attacked in the hostel on 21 October and did not feel safe. A duty officer noted that he had an appointment with a housing project on Westgate Road that afternoon.

He was not given his medication by the pharmacist on 29 October as he had fallen over in the shop and banged his head. The pharmacist believed this was due to him being over sedated.

BVD1 returned from extended leave and saw Patient G on 7 November 2008. She remarked upon his deterioration and the impact of the death of his 'brother'. Patient G reported that he was using additional illicit diazepam. She requested an update from his GP. She noted that an assessment of his mental health was needed but was likely to be compromised by his current use of benzodiazepines. She recorded that he would benefit from key working and treatment for his depression.

He had previously failed to attend an appointment on 12 September at Hadrian Clinic. Hadrian Clinic wrote to Patient G on 17 September, noting that he did not attend his appointment on 12 September and informing him of another appointment. This letter was sent to Patient G's correct address but no copy was sent to Bridge View or the GP. Another letter was written on 20 October stating that he had not attended on 17 October and offering another appointment on 21 November. Unfortunately the address was incomplete and again the letter was not copied to the GP or Bridge View.

A warning letter dated 26 November, again with an incomplete address was sent to Patient G, noting that he had failed to attend his appointment on 21 November. He was asked to contact the clinic within fourteen days of the letter; otherwise they would presume he did not want to be seen. Bridge View was not copied into the correspondence, although a copy was sent to GP1.

He attended Bridge View on 25 November. In discussions the next day, other personnel at Bridge View expressed concerns about Patient G's physical and mental health and an appointment was made for him to see BVD1 on 28 November. He failed to attend having woken late. When she saw him the following week he reported intrusive nightmares again. Urine samples around this time tested positive for amphetamines. She noted 'I feel he is prob missing the blunting/sedating effect of the methadone which helped take the edge of his PTSD rather than having WD (withdrawal) symptoms'. She commented that he needed work around his PTSD symptoms and housing, relationships etc. etc.'

On 22 December 2008 CP2 wrote to GP1 discharging Patient G from the service. No copy was sent to Bridge View.

On 23 December 2008 BVD1 wrote to Hadrian Clinic requesting a further appointment for Patient G and referring to the deterioration in his presentation since the beginning of the year. She asked if he might benefit from psychological therapy for his ongoing problems with PTSD.

Patient G received his state benefits on 23 December 2008 which he withdrew the same day. He made an unsuccessful attempt to draw out money on 30 December. On 31 December or 1 January 2009, a resident at the hostel heard scuffling from outside the room of the victim, (a 61 year old disabled resident of the same hostel) Victim G. He found Victim G on the floor clutching his wallet. Patient G exchanged blows with the same hostel resident over an earlier incident and then went to Victim G's room.

Two days later on 2 January 2009 Patient G's girlfriend, Girlfriend 4 (GF4), told the manageress of the hostel that Patient G had stolen money from Victim G. Later that day the manageress called the police as GF4 alleged Patient G had punched her in the face. He was arrested but released the same day.

On 2 January 2009, Patient G called into Bridge View and asked to see someone. He saw BVN2 who recorded that he was concerned that his benefit money had not been paid in. She telephoned the benefit office, who told her that the payment was late due to Christmas but that he should have it by 6/7 January. She recorded that Patient G was fine with this and was aware of his next appointment with Bridge View on 9 January.

On Saturday 3 January, after an all-day drinking session in the victim's room, Patient G attacked Victim G with a claw hammer, inflicting fatal wounds in a savage and brutal assault. He then emptied the victim's wallet which he later spent on alcohol, takeaway food and clothing in the company of GF4 and another female friend.

The following afternoon he went to the police station and handed himself in, stating he thought he had killed someone as he was having flashbacks and had blood on his shoes. Victim G's body was found by the hostel manageress who immediately notified the police.

Patient G was charged with the murder of Victim G. He pleaded guilty to murder on 3 July 2009 and received a sentence of life imprisonment with a minimum tariff of 21 years.

Comment

It is significant that no professional involved with Patient G's care attempted to devise a care plan based on his social, psychiatric and forensic history. The records that exist display a heavy reliance on Patient G's own account of his past history and little attempt appears to have been made to validate what he reported with other relevant agencies. This was particularly the case in relation to his childhood experiences, his social circumstances, including his personal relationships and his forensic history.

Patient G was engaged with local health care agencies from May 2005 until the commission of the index offence in January 2009. During the whole of that period the only formalised risk assessments ever completed were the CATS risk assessments, and the initial assessment by BVN1.

The CATS team completed two FACE risk assessments in September 2005. Their involvement was prompted by Patient G's suicidal threats which were said to be linked to his homelessness. The history in those documents was necessarily compiled entirely from Patient G's own account, as it was compiled 'out of hours'. Although it reports that he had been in prison 'loads of times', it goes on to say 'no violent crimes'. As a result key information relating to his forensic history was not documented. The summary concluded that there was no risk of violence and no risk management plan was thought necessary. A subsequent conversation with Patient G's then probation officer did not result in any change to the outcome and did not refer to the actual forensic history. Moreover, there is no evidence that the assessments, inaccurate as they were, were shared with Bridge View despite the CATS team noting that Patient G had been advised to attend A&E by Bridge View.

The following week he was seen at Bridge View by BVD1 who referred him to the CMHT for an assessment of his mental health as a result of her concerns about his low mood and impulsive violence. As a result of this referral he was eventually seen by SGP1 at Hadrian Clinic. He was aware of the CATS assessments but was able to take a full history from Patient G himself, including details of the two serious offences of violence which resulted in custodial sentences. He did not, however, complete a risk assessment despite his own acknowledgment that Patient G was "clearly a complex case", because, in SGP1's words, "it was not routine to carry out a FACE risk assessment on someone on standard care coordination.....had he been taken on for 'enhanced care coordination', i.e. been assigned a separate care coordinator from the CMHT (which was the purpose of my referral to them), then a FACE assessment would have been carried out". No risk assessment was ever carried out through this route as he was never allocated an enhanced care coordinator.

It was at this point he was diagnosed with a mental illness (PTSD) which, combined with his drug addiction, placed him in the category of dual diagnosis. This might have merited consideration of the appropriateness of the services he was then receiving, and his level of care coordination. The option of a referral to the addiction team at Plummer Court

was not pursued, nor was there any consideration of the appropriateness of a referral to the Forensic Community Team (FCT).

In the absence of effective care coordination, the provision of services to Patient G lacked continuity. This was particularly relevant between 2005 and 2009. Despite him being described as a clearly complex case there is no evidence of a structured or enhanced care programme approach. This was highlighted by his lack of engagement with key health and social care providers and was repeatedly recognised as a barrier to effective treatment by those working with him. His physical health problems were a significant contributor to his complex presentation.

It is surprising that repeated referrals to the CMHT for such support did not achieve this. The panel were unable to analyse the rationale behind this as the CMHT were unable to find the relevant records.

During the two and a half years that Patient G was involved with Hadrian Clinic he was seen by five different junior doctors but was never seen by the consultant psychiatrist in the team, CP2, who was also named as care coordinator following the departure of SGP1. There is inconsistent evidence of CP2's clinical supervision of the junior doctors – the majority of whom were sub consultant career grade doctors and some locums – who were actually managing the patient's care. This may be why the medical management at times falls outside good practice, such as the multiple changes of psychotropics and emphasis on antipsychotics, sedative medication and the manner in which the diagnosis of epilepsy was made.

Patient G appeared to engage well with Hadrian Clinic until the decision was taken in July 2008 to transfer the responsibility for prescribing his psychiatric drugs to his GP. Patient G had not seen his GP since 2005, the year he registered with the practice. The rationale behind the decision was that he would have one point of access for his medications. In fact, he would still have had two points of access for his medication as his GP would not prescribe methadone, and he would therefore have to continue to attend Bridge View for that purpose. The effect of this decision was that there were three points of contact for treatment of his mental health and addiction – namely Hadrian Clinic, GP and Bridge View. In addition, it appears that this decision may have resulted in his disengagement from the mental health service at Hadrian Clinic as the inducement of collecting medication was removed. Patient G last attended Hadrian Clinic on 1 August 2008.

Two letters were sent to Patient G offering further appointments, and a warning letter was sent in November. In these last two letters the address was incomplete and it is unlikely the letters reached him. None of those letters was copied to Bridge View, although the third and final letter of 26 November 2008 was copied to the GP. In this same letter he was asked to contact the service if he felt he needed to be seen. They would presume he did not want to be seen if he did not contact them. He was told that if he had any further problems after that time he should contact his GP.

The decision to discharge him was made without reference to Bridge View or the GP, and the final letter discharging him from the service, sent on 22 December 2008, to GP1 was not copied to Bridge View.

Chapter 2 - Summary of Offending History and Police Involvement

04.87	Caution for stealing food from a supermarket.
07.87	Warning or caution for breaking into school.
26.01.89	Conviction (1) - Burglary and theft of dwelling – conditional discharge of 12 months.
06.07.89	Conviction (2) - dwelling house burglary (entered house to obtain food) – Detention centre 21 days YOI Kirklevington
18.04.91	Conviction (3) – burglary and theft (non dwelling) conditional discharge 12 months
19.06.91	Conviction (4) – possession controlled drug – conditional discharge 12 months
25.11.91	Conviction (5) - 7 offences burglary/theft/shoplifting/attempting or obtaining property by deception – 3 months concurrent YOI Wetherby
03.03.92	Conviction (6) – criminal damage to room at Residential Unit and Bail Act offence – conditional discharge 12 months
1993	Referred to psychiatric and community drugs team but did not attend (DNA)
22.02.93	Conviction (7) – producing controlled drug (growing four cannabis plants from seed) - 12 months probation
20.08.93	Conviction (8) – breach of probation – fined.
26.11.93	Conviction (9) – breach of probation – fined.
15.04.94	Conviction (10) – dwelling house burglary and theft (offence possibly from 1992) – CSO 100 hours
05.08.94	Conviction (11) – breach of CSO.
06.01.95	Conviction (12) – dwelling house burglary and theft – CSO 60 hours. Resulting from original conviction of 15.04.94.
25.01.95	Conviction (13) – possession of a controlled drug – fined
15.03.95	Conviction (14) – theft from motor vehicle – fined
21.04.95	Conviction (15) - breach of CSO – fined.
07.08.95	Conviction (16) – theft x 2 – one year probation order
12.06.96	Conviction (17) - breach of probation order – order to continue.
30.07.96	Caution – attempting/obtaining pecuniary advantage by deception.
24.12.96	Conviction (18) - TWOC x 2 (taking/being carried in motor vehicle without owner's consent. 13 offences TIC (taken into consideration). Imprisonment 120 days concurrent and disqualified from driving.
10.02.97	Conviction (19) - Attempt robbery and TWOC x 2 - 5 years imprisonment. Has alleged he was gang raped in prison during this time but details and timing unclear
04.01.02	Conviction (20) - s20 wounding (knife) six months imprisonment and breach of licence 12 months concurrent. imprisonment

04.08.03	Conviction (21) - carrying a blade/s4 public order offence 5 months imprisonment
27.08.04	Conviction (22) – attempt/theft 3 months imprisonment and 3 months consecutive.
01.02.05	Arrest breach of bail condition not to enter Sunderland City – taken to Court and rebailed.
17.02.05	Arrest at Superdrug for breach of bail. Taken to Court and re-bailed.
22.02.05	Intelligence – care to be taken when dealing with Patient G by police – lot of weeping scabs all over body and face noticed during a custody search. Blood disease suspected.
13.03.05	Arrest for robbery. IP (injured party) refuses to prosecute.
18.03.05	Intelligence – another man arrested with Patient G’s diazepam script – Patient G said left at mate’s house and he was returning it.
21.03.05	Conviction (23) - shoplifting (20.1.05 - Wilkinsons) and TWOC (11.1.05) – 12 months CRO and OTO
02.04.05	Arrest – drugs search – none found – NFA (no further action)
16.04.05	Stop and search – warning re begging.
20.05.05	Stop and search – drinking alcohol in the street at 09.55 hours.
27.05.05	Stop and search – noted that Patient G evicted from Virginia House for bringing in alcohol.
28.06.05	Intelligence of shoplifting spirits and toiletries with associates and selling on.
29.06.05	Arrest – section 47 assault (of girlfriend?) NFA.
04.07.05	Arrest for breach of bail conditions NFA
11.07.05	Intelligence – arrested to prevent breach of peace, running around in drunken state. Taken to NGH (Newcastle General Hospital) with large cut on back, described by NGH as superficial.
11.07.05	Arrest for Section 47 Assault NFA.
11.07.05	Domestic dispute at 20.55 hours. Arrested on suspicion of assault of girlfriend who was bleeding heavily from mouth. Both heavily intoxicated.
18.07.05	Intelligence – Patient G and associates said to be selling on spirits.
16.08.05	Arrest – possession of cannabis.
23.08.05	Conviction (24) - possession of cannabis – conditional discharge 6 months
15.09.05	Allegation Patient G had disappeared with some money he had been sent to buy alcohol with.
16.09.05	Intelligence – said to be heavily into heroin.
26.09.05	Intelligence – Patient G with HR1 - alleges they were attacked by 4 unidentified males and one of them was stabbed in the back – refuses to make complaint.
25.10.05	Patient G drinking in exclusion zone – kicked off with police – subsequently charged with Public Order Offence.
01.11.05	Conviction (25) – Section 5 Public Order offence (25.10.05) – fined £60
16.01.06	Stop and search – matched description of offender for robbery – NFA
05.05.06	Intelligence that Patient G has a crossbow in his home.
24.06.06	Arrest for possession of offensive weapon – a ring at fair – drinking alcohol. Ring confiscated. NFA.
24.06.06	CIS warning – Patient G says he deliberately shot himself in chest with crossbow.

19.08.06	Arrested for theft – charged. (See conviction on 29.08.06).
29.08.06	Conviction (26) – theft - absolute discharge
28.12.06	Arrest – robbery – NFA.
31.12.06	(N.Y. Eve) drinking alcohol in street at 12.20 hours with HR1.
29.04.07	Stop and search – drinking alcohol in street at 15.15 hours. Alcohol disposed of.
06.05.07	Intelligence – Patient G at RVI after being stabbed in eye.
03.07.07	Stop and search with HR1 started drinking alcohol at 11.20 hours on street.
30.07.07	Stop and search – drinking alcohol in street at 16.25 hours – alcohol disposed of.
11.09.07	Stop and search – drinking alcohol in street – alcohol seized at 12.45 hours with HR1.
16.09.07	Stop and search with HR1 – both drinking in street at 17.10 hours.
18.09.07	Stop and search – Patient G and HR1 with a woman said to be Patient G’s girlfriend who was arrested for breach of ASBO. Both claimed Patient G has leukaemia and is vomiting blood but still sitting drinking alcohol.
11.10.07	Stop and search – 15.03 hours. Alcohol surrendered.
24.06.08	Stop and search alcohol seized at 11.30 hours.
25.07.08	Intelligence – Patient G believed to be carrying a knife, as is his “sister”.
27.09.08	Stop and search – going equipped and looking into unattended motor vehicles NFA.
07.10.08	Arrest - possession of cannabis. Interviewed with appropriate adult from EDT on recommendation of FME – Forensic Medical Examiner (trained in dealing with mental health issues), who reported Patient G to be slurring ‘because of learning difficulty’. Cannabis warning given.
18.11.08	Stop and search – drinking with girlfriend at 13.25 hours.
02.01.09	Arrest – report of domestic – alleged to have punched girlfriend. NFA.
04.01.09	Arrest for murder – charged.
03.07.09	Conviction murder – life imprisonment

Chapter 3 Psychiatric Overview

Introduction

This chapter addresses Patient G's contacts with and management by mental health services, psychology and addiction services until the time of the murder. It will not address Patient G's assessments and management following the offence, though it does call on information presented to the Court by expert witnesses. The first portion gives a chronological outline and the remainder of the chapter gives some comments on particular aspects of the assessments and interventions that Patient G received.

Listed contacts with the services are not exhaustive.

Chronology

At the age of 16 years Patient G was recorded as taking an overdose of medication following a relationship breakdown. He was felt to have demonstrated no suicidal intent, nor features of any depressive illness. In 1993, at the age of 18 years, he was referred to the psychiatric and community drugs teams, since he had by then established a pattern of abuse of street drugs. Unfortunately he failed to attend these appointments.

In August 1996, having been drinking heavily and taken a large amount of temazepam, Patient G attempted to rob an elderly lady. She knocked his knife out of his hand and he was eventually apprehended by security guards. The blade of the knife had been sharpened to a point. His reduced conscious level and utterances suggesting suicidal ideation led to his assessment at A&E and subsequently admission to East Willow Ward, Cherry Knowle Hospital in Sunderland. The overdose of temazepam was speculated to have been suicidal. On the admission clerking a comment was made *en passant*, 'probable antisocial personality type with long forensic history – does not seem to be depressed'. His behaviour on the ward gave no hints of any mood disorder, and rather seemed to confirm a need for intervention by the drugs treatment team. In the discharge letter there was said to be 'no evidence of formal psychiatric disorder, apart from substance misuse'. He was, the letter said, 'rather angry with society in general, but it was undirected'. There was no restatement of evidence of personality disorder or trait. He was discharged into police custody.

Although Patient G was referred to the Community Addiction Team he was recorded as having no real interest in detoxification and in early October failed to attend an outpatient clinic to discuss a detoxification programme. In December of that year he is recorded as having removed his grandmother's temazepam.

An attempt at detoxification was made in August 2004 when Patient G was admitted to the Tunstall Unit in Sunderland. Unfortunately this broke down after one week. Later that month he was assessed as being a potential subject for a DTTO, but, because of the breakdown in attempts at detoxification a few weeks prior to this, he was deemed as unsuitable for the order. In March 2005 Patient G was said to have deliberately shop lifted in front of a security guard in order to gain access to a methadone substitution programme. He was still at this stage living in Sunderland,

but later in the spring he moved to Newcastle-upon-Tyne with the rationale that he could escape the illicit drug scene south of the Tyne. In early April 2005 he was described as taking 90 mg methadone daily and 30 mg diazepam, but in addition to the prescribed medication was topping up from a street supplier.

At the end of May Patient G was assessed at Bridge View in Newcastle, whence he had been transferred from the Sunderland Drug Intervention Project. The service at Bridge View took over responsibility of substitute prescribing and in early June he was said to be taking methadone 140 mg and diazepam 20 mg daily. Patient G was also claiming to be accessing counselling following the death of his baby daughter. In July he claimed to staff at the Salvation Army hostel that his 14 year old sister had died, though the existence of this child was refuted by his family.

In mid July 2005 Patient G was reviewed at Bridge View in Newcastle and was said to be taking 140 mg of methadone and 30 mg of diazepam. From the start of August he was said to be using large amounts of alcohol. Later that month his methadone remained at 140 mg, but the diazepam was increased to 36 mg.

Following attendance at the Accident and Emergency (A&E) Department at Newcastle General Hospital and a report that he had tried to jump off the Tyne Bridge, Patient G was assessed by the CATS. He was described as having suffered bereavement with the death of his mother two weeks prior to the attendance and the death of a daughter a year prior, although his mother had not actually died. He was said to be homeless. In the absence of evidence of mental illness no further action was taken by the CATS team, but ten days later on 19 September 2005 CATS re-assessed him following his attendance at A&E on the recommendation of a doctor at NECA (North East Council for Addictions). He was once more felt not to be showing signs of mental illness, but a number of aspects of his assessment were worthy of further comment, most particularly with regard to a history of violence. This is discussed further below. There was a telephone call between the CATS and PO1 who queried whether Patient G was showing evidence of a personality disorder and made a request to be kept informed about future contact.

By 26 September when Patient G was seen by BVD1 at Bridge View, he was described as low in mood and was remarked as having received counselling at Ron Eager House (part of the Cyrenians) for the loss of a baby in April 2004. BVD1 decided to refer Patient G to the CMHT and in particular she asked for their assessment of his history of impulsive violence and poor anger management as well as the depressed mood. Although she appeared to intend referring him to the Clifton Mount Team the referral was sent to the CMHT at Hebburn in South Tyneside. Later in October BVD1 reduced Patient G's diazepam dose to 28 mg daily. In January 2006 BVD1 redirected the referral letter to the CMHT at Clifton Mount, citing opiate and diazepam dependence, alcohol intoxication, a history of violence and psychological trauma. Patient G did not attend the first appointment at Hadrian Clinic which was offered in early February 2006, nor did he attend a second appointment later in March. At the end of that month BVD1 re-referred Patient G direct to CP2 at Hadrian Clinic explaining that the patient had difficulties in getting his mail. She continued to follow-up at Bridge View and in April of 2006 remarked that he seemed to be doing well.

On 26 May 2006 Patient G attended Hadrian Clinic for the first time and was assessed by SGP1. He made a diagnosis of PTSD and opiate dependence. An anti-depressant (paroxetine) was started as treatment for the PTSD. A referral was

made to the psychology department at Newcastle General Hospital to seek the patient's access to Cognitive Behaviour Therapy (CBT). In mid-June SGP1 reviewed Patient G, stopped his paroxetine and commenced mirtazapine, another anti-depressant characterised by greater sedating effects. However, just over ten days later the mirtazapine was also stopped because of complaints of nightmares and risperidone (an anti-psychotic drug) was tried instead. On 23 June SGP1 speculated that Patient G smelt of alcohol. At this relatively early stage the complexity of Patient G's management was becoming evident with multiple diagnoses, multiple substances of abuse, multiple prescribed medications supplied by more than one prescriber, four or more agencies involved, and the prospect of additional treatments in the future.

On 6 July CCP2 wrote to SGP1 confirming Patient G's referral for CBT at Plummer Court and he was added to the relevant waiting list.

In July SGP1 again changed Patient G's psychotropic treatment, stopping his risperidone and reporting that he seemed to be seeing things that were not really there. Sulpiride, another anti-psychotic drug, was commenced. "Flashbacks" were described. BVD1 at Bridge View later that month increased Patient G's diazepam dose to 40 mg and at the end of July 2006 SGP1 again altered the psychotropic regime, stopping sulpiride and re-starting risperidone. Insomnia was remarked on and visual misperceptions, some of which were described after a further review in mid-August as completion illusions. Around this time he was again described as smelling of alcohol.

On 18 August 2006 SGP1 diagnosed Patient G as suffering a depressive illness in addition to his PTSD. An antidepressant, trazodone, was recommended for prescription.

On 21 August 2006 BVD1 counselled Patient G that he was positive for hepatitis C. She reduced his dose of diazepam, but prescribed nitrazepam, another benzodiazepine, in order to help him sleep. SGP1 described Patient G as being depressed because of the diagnosis of hepatitis C. Very shortly afterwards Patient G was discharged from the waiting list for CBT as he did not arrange an assessment appointment. The benzodiazepine doses for Patient G were said to be diazepam 28 mg daily and nitrazepam 10 mg nocté.

In early September SGP1 expressed a view that Patient G was somewhat calmer on risperidone, but he still complained of low mood and also reported "blackouts". The doctor decided to refer Patient G to the CMHT for care co-ordination and a higher level of support. The blackouts were said to be occurring every other day and Patient G was persistently low in mood. Trazodone, an anti-depressant drug again with sedating properties, was started. An electro encephalogram (EEG) was requested and the intention expressed that a referral would be made to neurology once the EEG was reported. The dose of risperidone was increased. Although he reported hearing the hi-fi telling him to "piss off" and that something in his head was telling him to steal things, his experiences were said to be unlikely to be psychotic in origin, but instead SGP1 preferred the interpretation that they could be flashbacks or a result of epilepsy or iatrogenic (related to medical intervention).

On 12 September SGP1 referred Patient G for a neurological opinion. He described blackouts without incontinence, possible hallucinations (seeing animals in a field which were not there). These experiences were said to have occurred after risperidone was prescribed, but continued after risperidone was stopped. By the

time of that letter the risperidone had been re-started. In another letter SGP1 reported that the patient's flashbacks and nightmares were less frequent than previously. A month later Patient G was described as still having blackouts and also to be hearing whispered voices. He was, though, not taking his risperidone and trazodone reliably. He did not attend his appointments with the neurologists for assessment of his blackouts (possible epilepsy), nor a few days later did he attend for his psychiatric appointments at Hadrian Clinic. Patient G continued his follow up with BVD1, who remained positive about his progress and recommended a reduction in the dose of his diazepam.

By the end of November SGP1 reported that Patient G's blackouts were continuing and that his symptoms of PTSD were particularly prominent at night. In January 2007 SGP1 re-referred Patient G for CBT and re-referred him for neurological assessment. When BVD1 saw Patient G in early February he reported that he was rather anxious about SGP1's imminent departure and he was generally said to be not doing so well and to be rather sensitive to other people's intentions towards him. BVD1 speculated that Christmas was particularly problematic for him and that this might be the reason he had again used heroin. Possibly conscious of his precarious mental state Patient G asked to be admitted to a psychiatric ward to be kept safe.

At his review early in the same month SGP1 reported Patient G to be taking methadone, diazepam and nitrazepam prescribed from Bridge View, and also to be taking quetiapine (another anti-psychotic) and trazodone prescribed by himself. SGP1 stopped the quetiapine and commenced olanzapine. In early March BVD1 reported Patient G as being rather slow in speech and that he was taking 24 mg diazepam. Shortly after, SGP1 reported that at his consultation Patient G fell to the ground and apparently had a blackout. The olanzapine had been stopped, but the trazodone had been increased. He not only referred to the CMHT, but also to neurology.

Later that month SGP1 stated the diagnosis to be PTSD, possible depression, blackouts of uncertain aetiology and opiate dependency. The anti-depressant trazodone was reduced and another, citalopram, commenced in addition.

At the end of March SHO1, who had taken over from SGP1, reported that Patient G was suffering worse nightmares, that he was falling over often, that he did not attend CBT and was not attending his GP for physical reviews. She elected to stop the citalopram and commenced sodium valproate, a drug which can be used to manage epilepsy. At around the same time BVD1 witnessed Patient G in a state suggestive of withdrawal symptoms. She increased his methadone to 150 mg, though reduced his diazepam to 10 mg. The nitrazepam was still being prescribed at 10 mg at night. A couple of weeks thereafter Patient G reported having used IV heroin and to be drinking 24 units of alcohol weekly (12 units twice per week).

On 1 May Patient G attended for a CBT appointment with his close friend. The psychologist, using a standardised scale (Impact of Events Scale) supported a diagnosis of PTSD and remarked on flashbacks regarding the death of his baby. Unfortunately Patient G was not felt to be suitable for CBT at that time because of a substantial focus on physical health matters, such as the blackouts and hepatitis C. A willingness to accept re-referral when the physical tests were completed was stated and it was suggested that a therapist jointly trained in methadone maintenance and CBT for PTSD should be considered. The letter from the CBT therapist reports that Patient G had said "I can't sit next to another man without

wanting to kill him". On 11 June 2007 SHO1 said that Patient G was frightened to sleep because of 'flashbacks' to being stabbed in his eye, an assault which had taken place about a month before. What were then described as seizures were said to be reduced from daily to one or two per week. Patient G was taking sodium valproate and trazodone, alongside methadone 140 mg and nitrazepam 20 mg at night.

In late June 2007 a new junior doctor, SHO2, saw Patient G in clinic. He described sleep problems and anxiety that the family of the female assailant who had stabbed him in the eye might be looking for him. SHO2 carried out a review of the CATS and Hadrian Clinic records, and by telephone discussed Patient G with BVD1, and CP2 the supervising consultant at Hadrian Clinic. A four point description of future management was handwritten:

1. ?Trazadone (sic)
2. ? OT (work placement)
3. Sodium valproate Depending on Neurology and Bloods; (the drug is to be stopped if these are refused)
4. Look to discharge in the future'

In August SHO2 confirmed a diagnosis of PTSD, opiate dependency and seizures. The trazodone was increased to address the PTSD symptoms, although in his case note review (19 March 2007) there is a comment '?blackout ↑ by trazodone'.

Review by SHO2 at Hadrian Clinic and by BVD1 continued into the summer. In October Patient G attended for an EEG, which showed only diffuse slowing, a non-specific finding particularly given the extensive range of psychotropic drugs being taken by the patient. NP1 wrote to SGP1 (though he had left his post by then) suggesting that the blackouts were possibly non-epileptic attacks and that this diagnosis should form the basis for their future management.

In early 2008 BVD1 went on extended leave. Seeking review without an appointment Patient G attended Hadrian Clinic and was seen by a locum, SGP2. In the light of depressive symptoms the trazodone was increased and mirtazapine given at a dose of 15 mg nocté. Ideas of suicide were described and an accompanying girlfriend described "on-going paranoia". SGP2 increased the mirtazapine to 30 mg nocté in early February. At this time BVD2, who was now reviewing Patient G at Bridge View, stated that the dose of methadone was 150 mg daily, nitrazepam 10 mg nocté and diazepam 18 mg daily. A few days later Patient G attended Hadrian Clinic to find a further junior doctor in post, SGP3, and expressed his annoyance with this. He complained of lack of support from services. On 20 February a letter from SGP3 indicated that he had commenced Patient G on temazepam and further increased the mirtazapine. The nitrazepam had been stopped.

The various mental health and Bridge View reviews continued into April and at this time Patient G was said to be taking 400 mg of trazodone at night, 600 mg of sodium valproate, 45 mg of mirtazapine and 20 mg of temazepam. He was said to exhibit problems relating more to his drug dependence, including prescribed drugs, rather than severe mental health problems. Shortly after this BVD2 reduced Patient G's methadone to 145 mg daily and remarked that he was receiving 18 mg of diazepam. She felt that Patient G was relatively stable.

In early June 2008 SGP3 remarked that he was intending to wean Patient G off temazepam in part because of its potential interaction with methadone. Patient G was said to be functionally improving. On 20 July SGP3 again confirmed a diagnosis of PTSD, opiate dependence and a depressive episode, alongside another recent bereavement. The nitrazepam was stopped and temazepam 20 mg was prescribed, alongside trazodone 400 mg nocté, mirtazapine 45 mg nocté, sodium valproate 600 mg daily and the methadone and diazepam from Bridge View. On 22 July SGP3 reported that Patient G was using his medication at a faster rate than that prescribed, but he stopped the mirtazapine at Patient G's request, starting instead quetiapine for the treatment of anxiety. The temazepam was stopped. SGP3 outlined his intention to request Patient G's GP to continue prescribing in future, a request accepted by the GP at the end of July 2008. Reviews continued and in later October 2008 BVD2 found Patient G to be very sedated and he was taken by ambulance to the A&E Department. There was uncertainty as to whether the drowsiness was caused by prescribed medication or to a head injury sustained in a fight the night before. A few days later the dispensing pharmacist rang Bridge View to remark that Patient G was over-sedated to the point where it was felt appropriate to withhold medication.

BVD1 returned from extended leave in early November 2008 and found Patient G to have deteriorated markedly in the intervening few months. He had lost weight, could not remember who his GP was, and had many physical complaints. He was obviously affected markedly by the death of his very close friend in February, HR1, following which he had been using additional diazepam (buying up to 40 mg daily on the street). She remarked that Patient G was no longer seeing a psychiatrist and asked for clarification of prescribed medication from Patient G's GP. A few days later Patient G was again very sedated and had again fallen. She was concerned regarding the large amounts of diazepam being used and ascertained that a key worker would be of benefit to look holistically at Patient G's needs and management.

Following non-attendance at Hadrian Clinic for the second time CP2 indicated that Patient G would be discharged from follow up, but this letter was not copied to Bridge View. In early December Patient G sought an increase in methadone from 95 mg daily, but this was declined by BVD1. He was buying an additional 30 – 40 mg daily of diazepam in addition to the prescribed 24 mg daily. Amphetamine was found in his urine.

Just prior to Christmas 2008 BVD1 wrote to CP2 requesting a further review for Patient G, noticing that his presentation had deteriorated over the previous few months, that he had stopped his illicit diazepam use and was more diligent in attending his follow ups at Bridge View. He was taking methadone 95 mg, diazepam 24 mg daily (and this was only prescribed). He was additionally taking sodium valproate 600 mg b.d., quetiapine 100 mg nocté and trazodone 400 mg nocté. Symptoms of PTSD were still evident.

On 3 January 2009 Patient G awoke, took his prescribed psychotropics and methadone and a few hours later when drinking a great deal of alcohol, murdered Victim G.

Diagnosis

Accurate diagnosis may be problematic in some patients and may change over the course of their contact with services but is crucial in allowing the development of a robust management plan and prognostication. Modern practice embraces the use of standardised diagnostic criteria to facilitate better communication and treatment planning.

Psychiatric diagnoses were clinical, and did not refer to standardised criteria such as ICD 10 (International Classification of Diseases) or DSM IV (Diagnostic and Statistical Manual of mental disorders).

In the course of his treatment Patient G was attributed with several diagnoses, which mostly represented a number of co-morbid or simultaneous conditions and were not all felt to be exclusive or contradictory. The diagnoses were:

- *Opiate addiction*, made by Sunderland and Bridge View Addiction Services on the basis of reported use and biochemically confirmed presence of street heroin.
- “*Valium*” (*diazepam*) *addiction*, as evidenced by history taken at Bridge View.

In the opinion of NICE⁴ having appraised the evidence, and drawn up clinical guidelines for detoxification, amongst other steps, planning for physical health assessment and management of concurrent mental disorder is important.

The usual upper end of maintenance dose of methadone is said to be around 120mg per day. The importance of supervision of staff competent to deliver the intervention is stated. Had Patient G wished to undergo detoxification, the complexity of his concurrent mental and physical health and use of alcohol and benzodiazepines might have made an inpatient setting appropriate.

- *Post-traumatic Stress Disorder* made by staff (most prominently a staff grade psychiatrist) at Hadrian Clinic and by an experienced cognitive behavioural therapist supported by an objective symptom rating scale. NICE has developed a clinical guideline⁵ for PTSD, and states quite clearly ‘Drug treatments for PTSD should not be used as a routine first-line treatment for adults...in preference to trauma-focused psychological therapy’. NICE acknowledges that some adults may prefer not to engage in psychological therapy and drug treatment is an appropriate first choice in such individuals.
- *Possible depression/ depressive episode* reflecting low mood, suicidal ideas, and possible biological symptoms of depression, such as loss of appetite, insomnia, and lack of energy. Depression is a common accompaniment of PTSD. It is also a common consequence of, or association with, alcohol and illicit drug abuse, poor physical health and personality disorder. Depressive symptoms may be situational, and are very common in the homeless population. Formulating such a diagnosis is difficult in such circumstances and did not, in Patient G’s case, stand alone. NICE guidance on the treatment

⁴ NICE Technology Appraisal 114 (methadone and buprenorphine in opiate maintenance) and Clinical Guidelines 51 and 52 (for detoxification)

⁵ CG26

of depression⁶ emphasises the role of psychotherapy instead of, or in addition to, drug treatment according to the severity of the condition. In unresponsive cases, the guidance acknowledges the potential benefits of changing from an ineffective anti-depressant to a different anti-depressant, adding a second anti-depressant to the first and adding other drug treatments such as an anti-psychotic. NICE draws attention to the limits of the evidence base regarding augmentation of anti-depressants with a number of certain other psychotropics. The importance of consultant supervision of cases seen in secondary care, the use of good multidisciplinary care plans, and sharing these with the GP, key others and the patient is emphasised.

- *Epilepsy*, a diagnosis made by a sub consultant psychiatrist on the basis of the history, and for which anticonvulsants were commenced by a trainee in psychiatry. The diagnosis of epilepsy is often highly challenging especially in the setting of co-morbid conditions such as alcohol and benzodiazepine abuse. In this case the EEG was not supportive of the diagnosis. NICE Guidelines⁷ emphasise the role of the epilepsy specialist in diagnosing epilepsy, and limitations in the use of the EEG.
- *Non-epileptic attacks*, a provisional diagnosis made by a consultant neurophysiologist on the basis of history and EEG. Non-epileptic and epileptic attacks are not mutually exclusive, but the neurophysiologist felt that the former should form the focus of treatment, by implication erring on the side of not using anticonvulsants but adopting psychotherapeutic intervention. Further investigations were intended.
- *“Blackouts ? cause”* reflecting uncertainty as to the presence of epilepsy or other causes of loss of consciousness, of which there are many.
- *Hepatitis C with possible progression to cirrhosis*

This will be discussed below under physical health in chapter 4.

Drug Choice

Polypharmacy (see Appendix 1)

It is perhaps unsurprising that with several diagnoses, a number of psychotropic drugs were prescribed. This in itself is not necessarily problematic, indeed in some circumstances additive or augmented pharmacotherapy is evidence based but nonetheless carries a higher risk of iatrogenic symptoms including drug interactions. The purpose of polypharmacy needs to be clearly understood and not be the product of therapeutic confusion or uncertainty. Patient G's exposure to polypharmacy is of concern through its magnitude: several drugs many of which shared similar unwanted effects, and some prescribing which lacked a basis in clear diagnosis such as epilepsy. At various times and often simultaneously, Patient G was prescribed highly sedating medication ranging from benzodiazepines for substitution of a street supply or for treatment of anxiety or hypnotic use (diazepam, nitrazepam, temazepam), to antidepressants (mirtazapine and trazodone), to antipsychotics

⁶ CG 90 and CG23

⁷ CG137 and CG 20

(olanzapine, risperidone, quetiapine) to anticonvulsants (sodium valproate). Methadone is sedating. An example of the complex polypharmacy being prescribed to Patient G is given by Cognitive Behavioural Therapist 1(CBT1) on 2 May 2007: methadone, sodium valproate, diazepam, trazodone. All these drugs are sedating; all interact with alcohol and with each other to heighten sedative effects, and potentially the risk of death as an adverse outcome. He was often buying street drugs and seeking additional prescriptions of the psychiatrists.

The medicines were often changed quickly from one to another, over days or a week or two, despite the well-recognized delay in onset of therapeutic effects of most psychotropics, especially the antidepressants and antipsychotics (which will generally require seven to ten days or more at optimal dose to show benefits). This is most evident in the early treatment at Hadrian Clinic.

Unwanted effects

All the psychotropics used in this case may cause various unwanted effects, but of particular concern is the potential for sedation, and for diversion into street sale. Some sedation may be beneficial in cases where insomnia or agitation is prominent, but it carries the risk of falls, injury, respiratory depression and benzodiazepines especially may disinhibit violent or other challenging behaviour. The list of sedating medication in use with Patient G is given above; taken together these will cause additive effects.

Some antidepressants and antipsychotic drugs may rarely provoke irritability or aggressive behaviour, particularly in the early phase of treatment.

Unwanted effects generally are more likely where polypharmacy is used, including cardiac problems: high dose methadone and quetiapine share the potential to cause abnormalities in the heart's conduction or electrical activity. According to the records, Patient G showed an abnormal waveform in his ECG (thought not to be due to his medication) and low blood pressure on standing (with consequent light-headedness and falls). Patient G exhibited derangement of his hepatic function, and since many of the drugs used are metabolised by liver enzymes he was at increased risk of toxicity from prescribed or street drugs. Where liver function is severely impaired, psychotropics may even precipitate encephalopathy (a form of impaired brain function) with drowsiness. An EEG showed some abnormalities which – and this possibility is handwritten on the report – might have been the result of psychotropic effects on cerebral function.

Many psychotropics may increase the frequency of seizures in epileptic patients: citalopram and trazodone fall into this category, for instance.

Although the neurophysiologist speculated about brain disorder causing tingling in the patient's legs, this is also described in background literature as an uncommon, unwanted effect of trazodone.

Interactions with alcohol

Alcohol may potentiate the sedative effects of psychotropics, methadone and street drugs, including the disinhibition of problem behaviours. As a point of good practice patients should be warned not to drink alcohol and take sedating medications. Prescription may have to be limited in those with addictions. In 1996 Patient G had

committed a violent offence whilst under the influence of a benzodiazepine (temazepam) and alcohol, threatening a vulnerable person with a knife in an attempt to rob. The significance of this earlier behaviour, well recorded in the Cherry Knowle record, did not seem known to the staff at Bridge View and Hadrian Clinic, but the consequence for Patient G for intoxication with such a combination was clear in the light of his past forensic history and seems to have been replicated at the time of the murder. Bridge View and Hadrian Clinic provided benzodiazepine drugs and other sedatives; the diazepam used by the former to substitute for illicit supplies did not reduce over the course of a lengthy period of treatment. Hadrian Clinic instituted temazepam use (a drug historically abused by Patient G and with a relatively high street value).

Comment

The use of psychotropic medication in the case of Patient G did not apparently conform to good practice by virtue of the diagnostic uncertainty, habitual polypharmacy, use of sedating and disinhibiting medicines and compounds open to diversion.

Psychiatric diagnoses were clinical and did not refer to standardised criteria such as ICD 10 or DSM IV. Diagnoses not explicitly used were personality disorder (beyond the comment made on admission to Cherry Knowle in 1996), and alcohol abuse or addiction, or polydrug abuse. The former was additionally the subject of speculation by a probation officer and could be supported by many of the clinical features shown by Patient G, most notably the forensic and substance abuse history, mood related symptoms, abnormal experiences, the pattern of disordered behaviour (manipulative, antisocial, aggressive) stretching back into childhood; the second through admitted use of and habitual intoxication with alcohol possibly including deranged liver function, and often remarked on; and the third through the history and biochemical finding of other drugs of abuse including amphetamines. All, individually or collectively, might have influenced effective management, and called other resources into play.

Chapter 4 Physical Health Care

This section is based on records available from Hadrian Clinic, Bridge View and Patient G's general practice, and restricted to the period 2005 to 2009. Acute service files were not utilised by the panel, so any comments on those are informed by correspondence and the copies of any results sent to mental health and addiction services.

Initial screening: Bridge View

The initial screening received by Patient G following his referral to Bridge View was additionally to those about illicit drug use. There were questions about needle use, abscesses and blood borne viruses (BBV); about sexual health; and about general physical health. Patient G received a brief physical examination, excluding abdomen and neurological elements. A urine sample was sent to the laboratory but not bloods; the patient had declined these until his venous access had improved. The results of the assessment were notified to Patient G's GP.

Initial screening: Hadrian Clinic

SGP1 assessed Patient G on 26 May 2006. In the handwritten history there was no recorded past medical history but a brief comment 'no physical problems'; in the letter to the referrer he commented: 'Physical health: (Patient G) is otherwise fit and well'. There is no evidence of physical examination, nor any plan or proposal for medical investigations.

Blood Borne Viruses/Hepatology

On 5 June 2006, G was given a hepatitis B booster vaccination at Bridge View, the fourth. Later in the year he was immunised against hepatitis A, and further against hepatitis B. On 17 July 2006 he was tested at Bridge View for BBV; he was found to be showing evidence of active hepatitis C infection. On 21 August 2006, BVD1 counselled him regarding the implications of the diagnosis, and he was given an information leaflet and referred on to a specialist nurse. The nurse was said to have arranged for his assessment at the Freeman Hospital.

Liver function, full blood count and C-reactive protein were rechecked on 3 April 2007 at Bridge View. A fortnight later BVD1 wrote to CP2 and expressed her concern about the possible impact of G's abnormal liver function tests on his mental

symptoms. That day she referred him to the hepatologists at Freeman Hospital, asking that copies of all appointment letters be sent to the senior nurse at Bridge View who was to support him through that process. He attended there on 20 July 2007.

Hepatologist 1 (HP1) summarised his opinion on 4 September 2007, and reflected on Patient G's fears of addressing his hepatitis status. He also noted that there had been difficulty in Patient G receiving his appointment for a liver scan, important because of indications that his infection had progressed to cirrhosis.

Unfortunately, Patient G failed to attend the subsequent four appointments with the liver unit and an appointment for a liver scan. Bridge View made apparently unsuccessful efforts to get him to re-engage through the Liver Specialist Nurse (LSN1).

Epilepsy

On the fourth review by him, SGP1 recorded that the patient had experienced 'blackouts since 10'. On the sixth review, falls and blackouts (loss of consciousness) were recorded and SGP1 took a brief history of these. He physically examined Patient G, and planned for an ECG and EEG to be taken.

By the 21 August 2006, Patient G told SGP1 that he had been advised that he was hepatitis C positive. On 31 August, a further discussion about the "blackouts" was recorded and Patient G's blood pressure was checked. On 1 September 2006, SGP1 received the result of the EEG, which showed no evidence of epilepsy. Later that month, Patient G was seen with an informant (girlfriend) and a further neurological history was taken. SGP1 referred Patient G for neurological assessment on 12 September 2006, in a very full letter which contained details of the ECG and EEG result, physical examination and BBV results. After he failed to attend the neurology appointment, Patient G was re-referred by SGP1 in January 2007, remarking that if a copy appointment were sent to Hadrian Clinic efforts would be made to facilitate his attendance. SGP1 requested a support worker from Clifton Mount CMHT "to help him attend important appointments," saying "treatment of his psychiatric problems has been severely hampered by his non-attendance at CBT and the neurologist."

On 2 March 2007, SGP1 reported a further physical examination, and reflected on a history of the unexpected death of Patient G's aunt at an early age, after going into hospital, which resulted in Patient G's reluctance to go to casualty if he experienced further fits. On 20 March he wrote to GP1 and mentioned what he believed to be a slightly prolonged QTc (a marker of cardiac conduction) and its potential relationship to psychotropics.

Despite the EEG result, and that the patient had not by then been seen by neurology (though he had an appointment for a few weeks hence), on 29 March 2007, SHO1 (a

psychiatric trainee) talked of seizure activity and interictal (between seizure) depressive symptoms and commenced an anticonvulsant, sodium valproate.

On 2 August 2007, Patient G was again re-referred to neurology, this time by SHO1's successor SHO2 (locum SHO, later staff grade in psychiatry). His seizures were said by SHO2 to present in an 'inconsistent way'. By then the patient's hepatitis, derangement of liver function and prescription of sodium valproate (which can affect liver function very significantly) caused concern for the psychiatrist. He speculated that early subjective benefit reported by Patient G might have been due to a reduction in anxiety and impulsivity, brought about by the sodium valproate. SHO2 reflected to the GP that the seizures "may have been non-epileptic in origin" and therefore the sodium valproate "may well not be needed."

By 15 October 2007, Patient G was assessed by NP1. He suggested that Patient G should be treated for a 'non-epileptic seizure disorder' and indicated his intention to investigate further to 'allow a more formal diagnosis'. By implication, he concurred with SHO2 that the valproate ought to be stopped. Prescription of valproate in fact continued until the homicide. There were no further contacts with the neurology service.

Trauma/ophthalmology

On 5 May 2007, Patient G was stabbed in the eye and required exploration and repair of the injury under a general anaesthetic. Post-operatively he was observed to exhibit extreme somnolence, responding partially to naloxone, a medication which reverses the effects of opiate drugs such as methadone. Overnight, he was nursed in the high dependency unit. An ECG was normal.

On 10 May, while Patient G was still an inpatient the ophthalmic team contacted Hadrian Clinic seeking advice about the use of methadone and benzodiazepines, the likely cause of the sleepiness. They were signposted to Bridge View by SHO1, who left a mobile answer phone message. She made no effort to review the patient in person.

The episode was communicated to the GP practice in a discharge letter which the practice copied onward to Hadrian Clinic. The ophthalmologist reported at the same time that Patient G had failed to attend an outpatient review but that another appointment would be sent.

It could be argued that both Hadrian Clinic and Bridge View needed to know about the circumstances of his presentation to hospital. It would have been helpful therefore if direct copies of the discharge letter had been sent to Hadrian Clinic and Bridge View. Commendably, however, the ophthalmology team communicated

invaluable information and sought support from the Hadrian Clinic psychiatry team in a prudent manner.

Physical consequences of psychotropic treatment

Many of the medications being taken by Patient G carry with them the risk of unwanted effects on physical health. For instance the second generation antipsychotic drugs, such as quetiapine, may lead to changes in the heart's conduction (prolonged QTc) and the development of metabolic syndrome, with its abdominal obesity deranged blood lipids, high blood sugar, and hypertension. Methadone may affect heart conduction in the same way. Sodium valproate can cause increases in liver enzymes, or toxicity to the liver. A number of health tests are recommended by drug manufacturers and in clinical guidelines to monitor for the development of these unwanted and potentially life threatening effects.

It is also necessary to be mindful of the impact of pre-existing or emerging health problems on the metabolism and effects of prescribed medication; for example liver impairment may reduce the elimination of benzodiazepines; epilepsy may be provoked or made worse by many antidepressants and antipsychotics.

Patient G's ECG was checked explicitly to monitor the impact of high dose methadone and his antipsychotics. Liver function was episodically checked by Bridge View, alongside renal function, a full blood count and C reactive protein. Copies of some results were requested from the GP by Hadrian Clinic, who passed the request on to Bridge View.

Other unwanted effects were uncovered through inquiry: erectile difficulties for example, to which SGP1 responded with the offer of a referral to the psychosexual clinic.

General Practice

Despite the expertise of general practitioners in the management of physical health problems, their position at the centre of the communication web, and the encouragement of SGP1 (recorded in a letter of 27 July 2006), Patient G had little contact with the practice. Virtually all record entries relate to interventions carried out elsewhere.

In September 2007 he did not attend but a letter had been received by the surgery notifying them of the patient's hepatitis C status. The surgery wrote to the patient but the hepatitis B vaccinations were carried out at Bridge View.

A year later in September 2008, (by which time responsibility for prescribing had been transferred to the practice) Patient G attended GP1 at the surgery complaining of shortness of breath and requesting a repeat prescription of psychiatric medication. There is a note recorded that 'he is very sedated on meds'. It is not clear whether that was Patient G's complaint or GP1's observation. He complained of shortness of breath. No examination is recorded.

In November 2008 he attended with a girlfriend complaining of dizziness. He was described as being on 'lots of potential sedativeshence Bridge View cutting down', and smoking cannabis. Following a request from Bridge View for information about his prescribed medication, a medication review was carried out by another GP at the practice who confirmed the prescribing but Patient G's complaint of dizziness was not shared with either Bridge View or Hadrian Clinic.

Comment

Though some issues were only slowly progressed, Patient G's physical healthcare seems overall to have been of an acceptable standard. There are a number of areas where improvement might have been achieved.

1. Increased support in facilitating his attendance at the various clinics, which was imperfect not only because of his lifestyle and mental disorder, but because he was understandably anxious, for instance about his hepatitis and the implications of the diagnosis.
2. Facilitation of the role of the primary healthcare team, who were better equipped to have addressed some issues, such as the diagnosis and management of Patient G's 'black-outs'; and holistic management of his hepatitis including progression to cirrhosis.
3. A single source of prescribing would have been invaluable, potentially including delivery of controlled drugs. This outlook better recognises the general practitioner as the overall "manager" of resource utilisation in the NHS.
4. Psychiatric management of Patient G's "black-outs" was sound in its initial assessment and referral, but weak in diagnosis and failed to include the neurophysiologist's recommendations into the management plan.

Chapter 5 Provision of Services

The key period when Patient G was most involved with health care services was during the years from 2005 to committing the murder in 2009. Several teams and individuals offered a service during this time addressing both mental and physical health issues.

The following offers a broad description of the health care services with which he was involved or which might have had a major impact on his care had he been referred to them. The services are:

- Bridge View Drug Treatment Service
- Hadrian Clinic Psychiatric Outpatient Service
- Plummer Court Drug and Alcohol Service
- Cognitive Behavioural Therapy Service.
- Clifton Mount Community Mental Health Team
- Crisis Assessment and Treatment Service
- General Practitioner

The description of each of these services is taken from operational policies, or from information presented by the agencies themselves.

Bridge View Drug Treatment Service

Bridge View Drug Treatment was established in July 2003.

This is a primary care drug treatment service based in central Newcastle and originally staffed mainly by GPs with expertise in drug treatment issues. The service is available to any Newcastle resident aged 18 or over with identified problematic drug use. Clients can self refer or be referred into the service by any professional.

Comment

Patient G was well engaged with this service from May 2005 until January 2009. During the course of his involvement he was seen primarily by one GP save for a period of extended leave in 2008 when his care was transferred from BVD1 to BVD2, another GP. Only towards the end of his engagement, in November 2008, was he allocated what Bridge View described as a key worker, a member of the nursing staff, although he continued to see BVD1 as well. The decision to have a key worker was in keeping with the centre's developing policy of reducing GP involvement and increasing the nursing service to provide clients with more generalised support with the aim of adopting a role more consistent with care coordination. This type of support had it been available would have been of particular value to Patient G at an earlier stage to assist him attending hospital appointments. It appears that there was no intention to transfer the responsibility for his care to the key worker as BVD1 continued to take a major role in advocating for Patient G and negotiating with other agencies on his behalf. This view is supported by a letter from BVD1 to the GP

practice wherein she describes the role as one of a 'co-worker who is helping Patient G with practical and social issues'. However in a letter of the same date to CP2, BVD1 requested that Hadrian Clinic address Patient G's housing needs. This demonstrates confusion over who was leading and coordinating Patient G's care, and over which agency bore responsibility for addressing his housing needs.

Hadrian Clinic

The Hadrian Clinic, part of the Northumberland Tyne and Wear NHS Foundation Trust, (NTW) is situated within the grounds of Newcastle General Hospital and provides mental health assessment, treatment and outpatient services for adults (16 to 65 years of age) within the population of Newcastle West and Tynedale.

Hadrian Clinic provides a range of services including inpatient and outpatient care. There is also a day care service.

The care co-ordination system of care planning and delivery is operational across the NTW Trust. This is a single care planning system joining together health and social services specialist mental health care teams.

Comment

The only service accessed by Patient G was the outpatient clinic. At those appointments he was seen by a number of junior psychiatrists, with supervision provided by a consultant psychiatrist, CP2. He attended more or less monthly from May 2006 until August 2008 which coincided with the decision to transfer responsibility for prescribing his psychiatric medication to his GP. He was formally discharged from the service in December 2008.

It was recognised that the Hadrian Clinic would care for his mental health needs, and that Bridge View would deal with his drug addiction.

Patient G had considerable physical health problems and, although Hadrian Clinic seemed to make most of the referrals to the relevant specialities, it was unclear whether they, the GP or Bridge View, should have taken responsibility for ensuring his attendance at those appointments. This is one example of the lack of clarity of effective care coordination. It is recorded that both SGP1 and CP2, at different times, were designated Patient G's care coordinator on standard CPA.

NHS Drug and Alcohol Service Plummer Court

This service is part of NTW NHS Foundation Trust and is a multidisciplinary team comprising of psychiatric medical and nursing staff, psychology and technical staff. It provides services for adults aged 18 and over who live in the Newcastle and North Tyneside area.

It provides multidisciplinary clinical services for any addiction but primarily treats alcohol and drug related problems and gambling. In addition it specialises in the treatment of complex problems for example poly-drug use, drug and alcohol use combined and dual diagnosis (mental health problems combined with substance misuse).

The service provides a full assessment of physical and mental health. In addition it offers a range of services from needle exchange through to prescribing services (including injectables) and psychotherapeutic interventions.

Patients are treated in a variety of settings, having community based, day unit and inpatient facilities depending on the level of need.

The team also shares care with general practitioners and undertakes joint clinics with other medical disciplines e.g. ante-natal clinics with obstetrics, with the Liver Unit at Freeman Hospital and for those with enduring mental illness, the service works in a shared care capacity with mental health services.

Comment

Patient G was never referred to this service though the benefits accruing from such a referral were acknowledged by various witnesses in their evidence to the panel. The key benefit would have been the opportunity to take a holistic approach to his care. This would have included, within one service, treatment for his drug addiction and mental health problems. In addition this team would have been able to offer effective care coordination including psychotherapeutic interventions and pharmacological treatment.

The panel note that the CBT therapist (CBT1) who assessed Patient G in May 2007 suggested 'a possible option would be to consider a worker from Plummer Court jointly trained in methadone maintenance and CBT for PTSD symptoms'. On receipt of this letter BVD1 responded to Hadrian Clinic by saying that Bridge View were not in a position to offer him good enough CBT within their service at that time. No comment was recorded in the Hadrian Clinic notes.

The rationale for not referring him to this service was that, firstly SGP1 thought he was well engaged with Bridge View, and that a change to another service might result in his disengagement from services, and secondly in the course of BVD1's evidence to the panel, that his diagnosis of PTSD did not fall into the category of a severe and enduring mental illness and he could be managed within Bridge View.

Cognitive Behavioural Therapy Service

The Cognitive Behavioural Therapy Service is an NHS specialist service. It provides a tertiary, non-sectorised highly specialised/expert CBT service, taking complex and difficult to treat referrals from psychiatrists, clinical psychologists, specialist nurses,

community mental health teams, general practitioners, from across the north of England. The service is currently based at Plummer Court in Newcastle.

Comment

Patient G was referred for CBT by SGP1 at Hadrian Clinic on 26 May 2006 and the letter was sent to the clinical psychology department at Newcastle General Hospital who forwarded it on to the CBT service at Plummer Court. He was placed on their waiting list on 11 July 2006 but was subsequently discharged on 22 August 2006 as he did not arrange an assessment appointment. SGP1 re-referred to CBT on 15 January 2007 and following a missed appointment he eventually attended on 1 May 2007 with his friend HR1. On 2 May 2007 CBT1 wrote to SHO1 at Hadrian Clinic advising that Patient G was not ready for CBT as his priorities were his physical health and safety. He was therefore discharged from the CBT caseload with the option to be re-referred at a later date.

It is quite likely that CBT would have been beneficial in helping Patient G to resolve issues relating to his PTSD. It is unfortunate therefore that steps were not put in place to overcome the obstacles which prevented successful engagement with the service.

Community Mental Health Teams (Clifton Mount)

Clifton Mount was one of four multi-disciplinary mental health teams in Newcastle. It was located in the West End of Newcastle where Patient G lived.

The Community Mental Health Teams have three functions:-

- to provide specialist advice and liaison to primary care.
- to provide time limited interventions to common mental health disorders.
- to provide long-term health and social care to those with severe or complex disorders.

Its operational guidelines state that CMHTs aim to provide a reliable, efficient and user-friendly access into Newcastle mental health services for local people experiencing mental health problems, their carers and other service providers. It further states that a needs assessment will be provided to all persons referred, unless it is evident that another service or agency would be more appropriate. Information and advice will be provided and resources targeted to those with more significant need in order to promote recovery and increase social inclusion.

This will be achieved by:-

- providing the referrer with advice and information.
- offering a comprehensive health and social care needs assessment, known as care coordination assessment.

- negotiating a care plan, according to individual need, for users accepted into the service and regular reviews (at least every six months) involving users, carers, professionals and other agencies.
- collaboration with other specialist mental health services.
- liaison with primary care and voluntary and statutory agencies, e.g. GPs, police, housing departments.

The CMHT consists of team manager, CPNs (Community Psychiatric Nurses), social workers, support workers and administrative staff. CMHTs also include consultant psychiatrists, specialist registrars and senior house officers who work collaboratively to deliver medical and psychological interventions following diagnosis.

The following extracts regarding the referral process have particular relevance to Patient G's case:-

- referrals are made to the Team, mainly by GPs, liaison psychiatry, CATS Team, other health agencies, local authority housing and social services directorates, voluntary sector providers, police etc.
- all referrals are reviewed prior to the Multi Disciplinary Team (MDT) meeting (some CMHTs also discuss referrals at MDT) and agreed for allocation. The aim is to assess all referrals accepted within four weeks of receipt.
- all appropriate referrals will be offered a comprehensive health and social care assessment of need, using the care coordination assessment format (including FACE risk assessment) and discussed at the MDT.
- referrals considered inappropriate will be re-directed to a more appropriate service and the referrer advised.

Comment

Patient G was referred by BVD1 to the CMHT on 27 September 2005 but the letter was sent to the Hebburn office, rather than Clifton Mount. There is no evidence that the Hebburn office acknowledged receipt of this letter, forwarded it to Clifton Mount or advised Bridge View that they were not the relevant team. The re-referral to the correct office was therefore not made till three months later, on 4 January 2006. The referral to Clifton Mount was allocated to SGP1. However, the panel were advised that the records relating to this decision could not be found as all records relating to the referral meetings for this CMHT appear to have been lost following the closure of the office.

It would appear that this referral was treated as a psychiatric outpatient referral, and did not follow the standard procedure. The panel were told that SGP1 was regarded as care coordinator for Patient G under standard CPA, but there was no documentary evidence for this, save for one reference on a RiO record.

Crisis Assessment and Treatment Service (CATS)

The description of this service is taken from the operational policy provided by the Trust.

The Newcastle and North Tyneside Crisis Assessment and Treatment Service (CATS) Service provides a service for people experiencing an acute psychiatric crisis within the metropolitan region of Newcastle and North Tyneside. The aim of this service is said to be the provision of the least restrictive and most appropriate form of assessment and home treatment services.

Criteria for the CAT service are:-

- the person must be presenting with significant risk of self-harm or, harm to others
- that inpatient admission is being considered or
- that the person needs to be seen within the next 24 hours

The CAT service is made up of the following components:

Triage

Located at CAT service base twenty-four hours, seven days a week.

This service provides a single point of contact for community and/or health service providers (GPs, police, emergency departments, CMHTs, EIP (Early Intervention Psychosis), AOT (Assertive Outreach Treatment, A&E etc.) for psychiatric Crisis Assessment and Treatment. The CAT service provides this for mental health service (MHS) naïve or known consumers presenting in crisis.

Home Treatment

CATS provide ongoing assessment and home based treatment (HBT) services to patients, relatives and carers in the community to known and (MHS) naïve clients of the area MHS, 24 hours a day, 365 days a year.

Numbers of people on HBT will be determined by capacity within the CAT service and degree of risk/acuity of the patient and energy state of carers/relatives.

Early Discharge Planning

CATS provide Early Discharge Planning (EDP) from inpatient units in Newcastle. As additional funding comes into CATS, a similar service will be offered to North Tyneside. EDP provides an opportunity for patients to be discharged earlier than normal because they are willing to accept HBT and because HBT is seen as providing the best quality outcome (processes for EDP are explained in Section 5).

The service operates at all times. The service provides rapid access to psychiatric assessment and treatment. Ninety per cent of people ought to be seen within two hours of acceptance by CATS.

Gate Keeping

The CAT service provides a gate-keeping role to acute psychiatric in-patient facilities. All requests for admissions are made to the CATS bed administrator during Monday to Friday 9.00 a.m. to 5.00 p.m. and to triage after-hours. All people fulfilling the CAT service intake criteria will be screened for community treatment, with the view of their suitability for community based treatment.

The CAT service provides community assessment and treatment for people who are experiencing an acute psychiatric crisis and who do not require inpatient treatment.

The team comprises of psychiatric nursing, medicine, social work and occupational therapy and has psychological input on a sessional basis.

Team members will see patients anywhere convenient governed by a common sense safety sense. New patients will not ordinarily be assessed at home after the hours of 10.00 p.m. but will be assessed in a place of safety e.g. accident and emergency departments.

Following assessment, the team considers if appropriate treatment in the community can be offered. Intensity and frequency of visits are negotiated with the patient and family members and will depend upon good clinical practice, safety and therapeutic goals. Upon acceptance into the CAT service HBT the service will stay involved until resolution of the crisis. There is therefore no set time limit, but most crises usually resolve within 6 weeks. Upon successful HBT, the CAT service, in agreement with the patient, will undertake either

discharge from mental health services or return to CMHT care, or GP or specialist service care.

Comment

Patient G was first seen by CATS on 9 September 2005 in the A and E dept. having been reported as having tried to jump off the Tyne Bridge. He was seen for a second time on 19 September 2005 after being referred by his NECA doctor to A&E for threatening suicide.

On both occasions CATS undertook a FACE risk assessment which highlighted 'no risk to others' and 'no evidence of mental illness.' They determined there was no role for the CATS.

The assessment outcome was formulated mainly on self reporting by Patient G and little effort was expended on attempts to gather information from other sources who had greater knowledge of Patient G's history.

General Practitioner Services

Patient G registered with a local GP practice following his relocation to Newcastle in 2005. The following practice description is sourced from their website circa June 2011:

'Cruddas Park Surgery started in the 1930s in Dr Caller's front room in Gloucester Street.

We now serve the population of Cruddas Park and North Kenton from purpose built modern buildings. Six doctors supported by very able and committed nursing, administrative and attached clinical staff who look after the health needs of approximately 9500 patients.

We are a teaching practice for undergraduates and also train doctors who are prospective GPs.

Our aim is to provide high quality medicine and continuity of care'.

Services

- Management of patients who are terminally ill
- Management of chronic diseases

Additional Services

- Cervical screening
- Contraceptive services
- Childhood immunisations
- Travel vaccinations
- Child health surveillance
- Ante natal and post natal care
- Minor surgery

There are currently six GPs based in the practice and there are a number of mental health staff attached including psychologists and counsellors

The surgery is based on Westmorland Street in Newcastle Centre'.

Comment

Patient G attended the surgery very rarely for routine physical monitoring, immunisations etc. The relationship which he had with the practice was uneventful and the panel was informed by GP1 that she only saw him twice, once in 2005 and again in 2008.

The surgery was kept well informed of the inputs which Patient G had with the various agencies with whom he came in contact, in particular, Hadrian Clinic and Bridge View. There is little evidence in the records however that GP1 played an active part in either the management of Patient G's mental illness or addictions. It is interesting to note that the panel were informed by GP1 that Patient G's Consultant (CP2) regularly attended the practice on a monthly basis to discuss patients whom the practice wanted to refer and patients who were currently being seen by the Consultant. There is no evidence available to the Panel that Patient G was ever discussed in this forum. There is also no evidence to indicate that Patient G was ever considered as a candidate for counselling within the practice by the attached mental health staff.

Chapter 6 Risk Assessments

Given the context of this report the focus must be on the identification of harm to the patient or others. There is evidence in the clinical record of attempts to describe the chance of harm befalling Patient G and others in contact with him. This is achieved both through the use of subjective personal, 'clinical' judgement (which may or may not be articulated in a standardised way such as in a referral or communication form or letter) and adoption of objective structured, "standardised" assessments (to shape clinical assessment or generate a quantifiable description of risk such as numerical rating scales). Good practice over many years has acknowledged the importance of this in most, if not all cases, to facilitate safe and effective clinical management, communication and description of change. There are additional benefits in using standardised instruments, tested over large populations, to quantify often historic fixed, or static as opposed to modifiable, or chronic current risk factors. Many of these instruments are now available, and some were used for Patient G.

Standardised assessment or rating scales may cover broad areas of risk to give an overview, but increasing numbers focus on discrete areas. Some are intended to be predictive. "Best Practice in Managing Risk" (National Mental Health Risk Management Programme, 2007) captures the role of such scales (whilst limiting its scope to risk of violence, self-harm/suicide and self-neglect) in clinical practice: 'Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach'.

FACE (Functional Analysis of Care Environments) promotes an assessment and presentation of several risk factors (violence, self-harm, self-neglect/vulnerability) for both screening and a more in-depth examination; it is especially helpful in general settings. This was the tool used by CATS. In contrast, a tool such as HCR-20 (Historical Clinical Risk 20) consists of 20 items, dividing risk assessment into three components: historical factors, clinical factors and risk management factors. These are seen as informing the clinician of relevant issues in a service user's past history, evaluating the presence of current dynamic issues in risk, and informing the practitioner of future risk management requirements. It can be used in general settings but is probably in more common use by forensic teams. So far as can be established, this was not used in Patient G's case.

After reviewing the files, key risks for Patient G can be briefly summed up (and this is not an exhaustive list) as:

1. Intentional self-harm, e.g. for suicide or for self-management of symptoms
2. Unintentional self-harm, e.g. overdose of illicit drugs
3. Self-neglect, perhaps as a result of intoxication, impoverishment or mental illness
4. Physical ill-health, through drug and alcohol abuse especially, including hepatitis and other BBV.

5. Certain mental disorders, which are strongly associated with suicide and with violence
6. Vulnerability to others
7. Manipulation of others
8. Malignant alienation, whereby under the influence of psychodynamic factors Patient G felt increasingly rejected by, angry towards and dismissive of key others, including sources of help, such as family, health services and housing. If present, marked deterioration might have been seen in relationships between Patient G and mental health team members; the alienation may be characterised by emotional distance and hostility, perhaps bilateral. The patient seemed to some clinicians and other professionals, angry and unappreciative of efforts to deliver assistance. In the literature it is associated with an elevated risk of suicide and violence
9. Diversion of prescribed medication, for sale or use by associates
10. Iatrogenic symptoms, including unwanted effects of medication, drug interactions; and interactions between street drugs & alcohol and prescribed medications
11. Violence; criminal record
12. Homelessness, which is strongly associated with mental disorder, substance abuse and a shortened life expectancy
13. Unemployment
14. Systemic risk, or collapse in the overall activity or effectiveness of certain clinical-professional groups or processes: for instance through service discontinuity or incoherence, resource restriction or failures of communication. It refers to the interlinkages and interdependencies in the system of care delivery, and extends beyond the failure of a single individual or action.
15. Recent disruption of a close interpersonal relationship increases the risk of suicide in alcohol and/or drug abusers.

These risks do not stand independently of each other and many will be heightened by the presence of others; for instance the risk of violence might be increased by the interaction of alcohol and benzodiazepine or other sedative psychotropic drugs. Physical ill-health influences the risk of mental disorder and mental disorder might lend itself to violence and self-neglect. Many of the risks are open to modification and prevention, either directly or through work on facilitating factors such as mental illness.

For each key agency the following risks were identified – though not necessarily managed - through structured, standardised or unstructured means.

Bridge View

Following referral by Tyneside Cyrenians on 24 May 2005, Patient G was assessed on 31 May by BVN1 who used a structured format to record this. Abuse of various psychotropics was recorded, both prescribed and illicit, including alcohol and

cigarettes. Harm minimisation including risks caused by blood borne viruses were discussed; blood testing was offered and at that time refused by Patient G until “veins better”, and condoms were offered and declined. There is a brief forensic history which refers to past custodial sentences and violent offences. He was noted to have been allocated a named probation officer. Patient G’s past self-harm was denied by him, but a diagnosis of depression noted. A brief physical examination was performed including a urine sample.

The quality of information gathering is of a good standard particularly given that the only source of information at that time was Patient G himself. Needs identified include BBV testing and housing. However, there is no entry under the summary section of the document which refers to ‘harm to others’ or ‘risk factors identified and action taken’.

In addition, consent was obtained for contact to be made with other agencies involved with Patient G at that time, principally the probation service. A helpful summary letter is sent to GP1.

On 6 June a treatment contract was signed by Patient G and BVD3. This is quite clear regarding the risks of opiate use and the potential for interaction with alcohol and benzodiazepines, and sedation. Management was commenced by Bridge View using a combination of methadone (to substitute for heroin) and diazepam (to substitute for street valium or diazepam). For a number of months nitrazepam was prescribed alongside a lower dose of diazepam: the former is more slowly eliminated from the body and may be more helpful in patients suffering symptoms of insomnia such as Patient G. However, it may also accumulate especially in older people, or those (such as Patient G) with liver disease.

Risk factors then emerge in the course of unstructured observations and communications. On a number of occasions thereafter, Patient G was recorded as buying additional benzodiazepines to that prescribed, to have been drinking, and to be sedated. The latter was both directly observed and reported by community pharmacists as well as by Bridge View and the ophthalmologist. Examples are: 11 July 2005 ‘intoxicated-alcohol;’ 1 August 2005 ‘Still taking 10mg valium on top...no alcohol then drank 1 bottle of wine;’ 19 September 2005 ‘presents as intoxicated’. On 26 September 2005, following discussion with Patient G about his violent impulses and behaviour BVD1 referred Patient G to the CMHT for assessment. This is referred to in more detail elsewhere in the report. On 5 June 2006 there is reference to ‘a bottle of wine shared on alternate days’. On 5 February 2007, and on repeated occasions BVD1 requests that the prescribed medication is not issued if Patient G shows signs of alcohol consumption. (Methadone is a sedating psychotropic and may be preferred in substitution for street opiates because of this effect, compared to the less sedating buprenorphine).

The dose of methadone used was over 100mg, almost throughout prescribed by Bridge View clinicians. This required ECG monitoring for cardiac side-effects which was undertaken; all the more so because of the polypharmacy. Quetiapine, for instance, shares a potential adverse effect on cardiac conduction.

On 29 January 2008 BVD1 expressed concerns regarding polypharmacy with sedating medication: at that point mirtazapine had been commenced at Hadrian Clinic. From September 2008 further concerns regarding sedation and alcohol consumption were in evidence, even comments on unsteadiness and poor memory. On 5 December 2008 the prescribed dose of diazepam was increased to 24mg daily

on the understanding that Patient G would limit his use of street valium to 25mg daily (totalling 49mg, well in excess of usual clinical doses, generally no more than 30mg). By 19 December Patient G claimed to have stopped buying benzodiazepines and remains on prescribed methadone and diazepam.

A number of instances are recorded where there is telephone discussion between Bridge View clinicians and other services such as probation (19 December 2005), hostels (26 August 2005; 7 September 2005), pharmacies (2 October 2006, 10 March 2008), ophthalmology (10 and 11 May 2007) and the Hadrian Clinic Mental Health Team (12 February 2007, 18 May 2007, 24 July 2007). These are not a complete list. There is also an extensive sharing of letters between Hadrian Clinic and Bridge View especially, with each agency offering observations and prescription summaries, generally via the GP practice. The correspondence is not complete in that some letters were not copied to Bridge View as might be expected, so, for instance, BVD1 did not appreciate the disengagement of Patient G from Hadrian Clinic for some time afterwards.

Non-medical management of symptoms such as insomnia was at times discussed with the patient.

On a number of occasions, Patient G was the subject of concerns regarding aggressive or intimidating behaviour: for instance in August and September 2005. This prompted referral from BVD1 to the mental health services, and this anxiety was clearly articulated in the referral letter. On 19 December 2005 BVD1 discussed the history of violence with Patient G probation officer, PO1, but concluded 'no mention of a stabbing, though'.

During BVD1's absence a close acquaintance (HR1) of Patient G died, heightening the risk of an adverse outcome. The frequency with which Patient G failed to attend appointments increased significantly. On review following this (7 November 2008) Patient G was felt to have shown significant clinical decline. Only a week later and years after transfer to the Bridge View service, he was referred for the attentions of a key worker BVN2 'to look at the whole picture inc housing'.

Within the Bridge View records there is an extensive capture of risk factors, some in a structured way, most unstructured in the course of clinical interventions. Some systemic risks become evident in this and other services, especially staff discontinuities. Upon her return from leave, BVD1 found Patient G to have deteriorated noticeably during her absence although this had not been noted by other clinicians involved with his care.

Iatrogenic risks were emerging through psychotropic choice and dose. (This issue has been previously discussed in Chapter 3.)

BVD1 described a team approach to managing Patient G. He was first assessed by a nurse member of the team; he gave informed consent for treatment after discussion with BVD3; the lead clinician was BVD1, another doctor: it is of note that she was away on leave for several months. Although her notes and an unaddressed e-mail sketched out some treatment issues, there was no process for allocating his case to any single individual to ensure both progression of treatment and communication with the other speciality teams and key individuals contributing.

CATS

Across all its involvement with Patient G, the CATS assessments are structured to a greater or lesser degree, with the greatest level of structure being through use of the FACE Risk Profile. Unfortunately many pages of the CATS record are undated, which complicates review of clinical activities over two assessments and several days.

Turning first to the FACE Risk Profile (probably from the assessment on 19 September 2005), Patient G is adjudged as at no risk for violence, suicide, adult abuse, abuse of children or of exploitation. He was at low risk, it was said, for self-harm and 'severe self-neglect/domestic'. There was said to be no risk to staff, nor to show any history of 'significant risk/behaviour'. Overleaf, a positive response was given to ideas of self-harm and impulsivity, both current and historic; a history of physical harm to others, threats and intimidation and drug abuse are checked but there is no response (whether positive or negative) in the box for current warning signs of harm to others or intimidation. Convictions for violent offences are checked negative, as are historical and current 'severe stress'. In the formulation preceding this there are some contradictory comments: 'He is homeless and barred from three homeless facilities due to fighting with other residents. He has a history of poly-substance and alcohol misuse and is receiving help from NECA who had directed him to the A and E department) and a methadone programme....He was assessed nine days previously by CATS...He stated he was suicidal, as he could no longer bear sleeping rough...He left angrily'. His mental state exhibited irritability, and suicidality. He was dirty with poor self-care. He was reported to be taking both methadone and 36mg daily 'valium'. Four days prior to presentation he was said to have stopped drinking but this is only present in the handwritten record. A record of imprisonment 'several times' is reported, as is a discussion with the probation officer (PO1) who 'Thinks alcohol & PD (Personality Disorder) issues'.

Chronologically earlier on 9 September 2005, a triage form completed by CATS reported Patient G's presentation to A&E whilst intoxicated, having tried to jump from the Tyne Bridge. The list of problems recorded the few days before included, in addition to the suicidality, homelessness and poly-drug abuse, a history of trauma (gang rape in prison; bereavement), addiction and risk to life from a 'creditor'. Patient G is said to have been imprisoned 'loads of times' but not for violent offences. Mental state examination revealed that he was well-kempt, drowsy, and connecting his situation with his mental state. The FACE assessment seems to have been completed but only the summary section is available in the electronic record. This indicated an assessed low risk for self-harm and severe self-neglect/domestic. No further action was taken by CATS, including any feedback to Bridge View.

Hadrian Clinic

There was no evidence of structured risk assessment either in the handwritten record, or in correspondence. Many entries and letters highlighted risk factors, however.

The reasons for referral by Bridge View in January 2006 included a request to assess his mood, ideas of self-harm, and 'issues he has surrounding impulsive violence and anger'. A forensic history of violent offences, and aggression aimed at fellow hostel residents was clearly described by BVD1. Opiate and diazepam

dependence was diagnosed. Two presentations to the service in a state of intoxication were noted.

These observations were confirmed in the assessment letter in reply, from SGP1 who additionally described a resentment of authority and a knife assault precipitated by a feeling that the victim was trying to exert authority over him. Recent possession of a weapon, a crossbow, said by Patient G to be used for Russian roulette and earlier use of a knife were described.

In the handwritten record Patient G was said to 'hate authority'. On 23 June 2006 Patient G was said to smell of alcohol yet denied drinking. Later that day there was a report from the pharmacists that they felt intimidated by Patient G.

In August Patient G again smelt of, but denied, drink. He described falling over and feeling as if he is drunk every two days. In October anger was reported.

In February 2007 Patient G said he was so fearful of being threatened that he was not leaving his flat. His speech was slurred. March found him taking 400mg trazodone daily despite being prescribed 250mg. In May 2007, following being stabbed in the eye, he was admitted to the General Hospital and the psychiatric trainee (SHO1) was asked to see him by the ophthalmologist because of anxiety about his level of drowsiness. SHO1 responded by leaving a message on the ophthalmologist's mobile asking him to refer the matter to Bridge View. At the end of that month the trainee speculated that he was abusing his medication, taking more than the prescribed dose. In June Patient G was quoted by SHO1 as saying "you've messed us around for five weeks". Suicidal ideas were frequent (daily).

In June Patient G was reluctant to attend review for his physical health (hepatitis).

At the end of SHO2's review of the case notes (the only one in the record), his brief management plan referred only to medication, OT (work placement) and an intention to discharge 'in the future'. By this point, between the CATS assessments and the Hadrian Clinic notes alone, 12 out of 14 of the extant risk factors listed above had been noted either explicitly or implicitly; diversion of prescribed medication was absent though even that (by April 2008) was present in an allegation that Patient G's girlfriend was stealing his medication. His close friend (described as "brother") died later, in February 2008. Systemic risks were emerging though were undocumented.

In the spring of 2008 there seems to have been increased evidence of abuse of prescribed medication, with Patient G presenting early for fresh supplies from Hadrian Clinic. By then he was taking temazepam alongside his other psychotropics, and was drinking daily (one can daily is admitted to). Although the "blackouts" find recognition as a potential consequence of the use and abuse of sedating medication and alcohol, this does not appear to be reflected in consistent modification of prescribing.

By the last review in August 2008, the temazepam had been stopped by SGP3 reviewing Patient G, as had his mirtazapine; and quetiapine (an antipsychotic that has some anti-anxiety/antidepressant properties) had been commenced. He was, though, said to exhibit spells of anger, during which he smashed things (the item referred to is illegible). He was given a month's supply of psychotropics and told that future prescriptions should come from his GP. Thereafter he did not attend any further appointments at Hadrian Clinic, and was subsequently discharged in November 2008. BVD1 was not informed, or given the courtesy of any liaison

despite having referred Patient G in the first place. Essentially the bulk of risk was left in Bridge View's hands.

Clinical Supervision

For over a decade and a half, increasing emphasis has been placed by health professionals on supervision, both hierarchical and through peer groups, managerial and developmental. It is now enshrined in the appraisal and revalidation processes for all grades of medical staff, whether in substantive or training grades.

At Hadrian Clinic, Patient G received interventions from a number of doctors at several different grades. None was a consultant; all were substantive or locum senior house officers (doctors in training) or staff grade doctors. All these sub-consultant grades have now changed their terms and conditions of service and title, except for a few staff grade doctors who have remained on the old contract. This grade was closed to new entrants in April 2008.

In common with most, if not all, trusts, Newcastle, North Tyneside and Northumberland Mental Health Trust (now superseded by Northumberland Tyne and Wear NHS Foundation Trust) produced a Clinical Supervision Policy (3NTW(C)12), approved in May 2003. With regard to trainees, paragraph 2.2.1 describes some of the processes:

- the presence of the consultant at ward round/team meeting.
- easy access to the consultant through the working week to discuss points of diagnosis, treatment, risk assessment or management.
- it is good practice to have one or more mini-reviews in addition to the weekly team meeting.
- new patients should be supervised "live" by the consultant.
- regular review of the outpatient case load for size, complexity, appropriateness of management, and need for transfer of cases to a more senior person...on at least two occasions over a six month period.
- opportunities to discuss problems with outpatients.

This is superseded by version NTW(C) 31 in October 2008.

The guidance provided by the General Medical Council (Good Medical Practice, 2006 edition) says that where the consultant has undertaken a supervisory arrangement with the trainee, he is deemed to be accountable not directly for the outcomes of the trainee's work, but for ensuring the quality of the doctor's training and supervision, and skills for the task in hand.

Staff grades do not receive a mention in the Trust guidance. BMA Guidance in 2003 stated:

'The staff grade is a non-training career grade intended to provide a secure and satisfactory career in hospital medicine for doctors who do not wish or are unable to train for consultant status. Staff doctors exercise an intermediate level of clinical responsibility as delegated by the consultant to whom they are responsible. Their commitments relate solely to service requirements and they do not have continuous, 24-hour responsibility for their patients'.

Consultant accountability for the outcome of staff grade decisions regarding patient management should be read across from the GMC Guidance; but so too should trust

statements about supervision, given that these were applicable to all clinical staff. Though superseded, Department of Health (DoH) Advance Letter MD 4/97 (25 July 1997) regarding staff grade contracts is illuminating, however:

'Practitioners in the staff grade are senior hospital doctors, but ultimate clinical responsibility for the patients they treat rests with the relevant consultant. As staff doctors will display a range of clinical skills that will change with time, it is important that an appropriate level of consultant supervision is provided. The degree of direct supervision will depend on a number of factors, including the skills and experience of the individual staff doctor.

It is important for the staff doctors to know to whom they are accountable and it is essential that the consultant responsible for their work develops a mechanism for regular appraisal of the individual's skills'.

No records of consultant supervision of clinicians have been seen by the panel. Some case note entries confirm discussions between at least two sub-consultant doctors and the consultant regarding Patient G. SGP1 did not seem to have undertaken any such supervision.

The adequacy of psychiatrist supervision or not, is quite different from whether a highly complex, potentially high risk case should have remained under discontinuous management for several years by sub-consultant doctors.

At Bridge View, which was not managed by the mental health trust at the time, BVD1 was quite clear that when she first began work in the team, "there wasn't a formal timetable of supervision". By the time she left, there had been instituted a protected regular time to meet and discuss patients who she did not feel were straightforward. Nonetheless it is quite clear that a significant portion of Patient G's management took place in the absence of a clinical supervisory process for BVD1 or other team members despite the complexity of his presentation, the risks of the case, the burden of such patients on the managing clinicians and the risk of adverse emotional response to the patient becoming established, including consequential malignant alienation. In the management of addiction, NICE Clinical Guidelines⁸ are not only clear about the need for clinical competence but clinical supervision. The investigation panel have not seen any records of the supervision meetings that were later instituted.

As is the case with Hadrian Clinic, a number of clinicians were discontinuously involved with Patient G's treatment. Although BVD1 held a prominent role, she was on leave for several months in 2008; she remarked how on her return Patient G had lost ground. At least two other doctors at Bridge View were involved along with nurses. No key worker was nominated until shortly before the homicide.

Comment

The supervision of medical staff in contact with Patient G is seen to be patchy at best, and, where it did exist did not conform to the standards set out by the trust.

⁸ 51 and 52(2007)

More specifically this was concurrent with the involvement of a large number of doctors. The highly variable, poor prescribing practice may have been one consequence, another was the harm caused to Patient G by the discontinuities in his care.

The quality of risk assessment by the various teams and agencies involved with Patient G was inconsistent. Aside from CBT1, and the substance abuse nurse BVN1 at Bridge View and some historic work by probation there was minimal use of structured records let alone standardised instruments. Some risk-related information is incomplete and some incorrect. The flow of this information around the agencies was similarly impoverished in some key areas. There was no coordinated or consistent sharing of risk between the agencies. The general practitioner had virtually no involvement but was generally kept informed.

With the exception of systemic risk (which by its nature is difficult for the professionals involved in his care to grasp and act upon), all the risks postulated on earlier were in some way or another identified. What was lacking was a single individual or shared forum to share all the perceived risks, seek the unseen risks and formulate a coherent cross-agency risk and clinical management plan. To differing degrees all individuals managing Patient G were ignorant of some element of risk. This can only have been compounded by the scale and variety of risks, and the challenge of effectively managing his mental and physical illnesses.

It is perhaps unhelpful to try and quantify the magnitude of all the risks, but questions must be raised regarding the risk of violence as evidenced by Patient G's forensic history stretching back to 1996 and encompassing convictions for violent offences including use of weapons; it is unclear how much of this was known and the extent to which this history was passed on to other agencies to reduce harm to the public and to manage risk to their own staff. Patient G seems to have habitually threatened, bullied and manipulated others; he possessed poor anger management and this was exacerbated by the effects of alcohol, street and prescribed substitute drugs, and other psychotropic sedating medications. He held weapons, at times both knives and a crossbow. He grew up in a culture of violence. He was malleable under the effects of his inhabited counter-culture. Patient G often rejected interventions by the various agencies though did work well with some clinical staff. Unfortunately discontinuities of care exacerbated his predisposition to alienation, as did the death of his close friend.

Probation

His lengthy forensic history (the police national computer records 26 convictions for 41 offences) resulted in contact for Patient G with probation services in several geographic areas. In the post-sentence report after the murder trial, risk factors for serious harm were summarised. Excluding the homicide, they included convictions for wounding, possession of offensive weapons including a bladed article and attempted robbery. 'His victims have included vulnerable people such as the elderly lady he attempted to rob at knifepoint'. His history of mental health issues was relevant and included 'depression and antisocial personality disorder. He has self-harmed and attempted suicide in the past, and disclosed being raped and stabbed in prison previously...used manipulation tactics and has threatened and made allegations against staff from other agencies'. All of the above information was available to probation in 2005.

The last entry in the probation record prior to the offence in question, by Northumbria Probation Service was on 20 March 2006. The first contact with that office was in March 2005; at that point he was homeless, and feared for his safety after being stabbed the previous year. A placement for housing had been refused because of a history of violence. In April he was said to be receiving methadone and valium, the latter of which 'the GP is looking to reduce as it seems to be having too strong an effect'. On 19 April 2005 Patient G – who was acknowledged to have been in 'desperate' need of housing – 'felt neither probation nor DISC (Developing Initiatives Supporting Communities) had done enough to help him with his housing crisis'. Later that month the probation officer summed up Patient G's comments as, 'the staff there do not care about him and that all the agencies involved with him were not doing enough to help'. Patient G was said to employ manipulative tactics with different agencies to the extent that co-working was necessary. His intimidation of others caused his eviction from the Salvation Army hostel; he was involved in fights; he was warned for taking alcohol into Virginia House. Suicidal ideas were voiced. On 26 May 2005 Patient G accused his probation officer of letting him down, and having lied to him.

Patient G was evicted from Virginia House for threats and intimidation to fellow residents, and abuse to staff. He in turn made a complaint that staff were behaving unprofessionally. His behaviour, he said, had been the fault of others.

In June 2005, Patient G said he had been arrested for an assault on his then partner; he continued to drink. In July he expressed distress because of the death of a sister but this proved to be untrue. Later that summer he was moved on from Coppergate hostel for bullying other residents, especially older men, for money. A knife was used to make threats. On 20 September Patient G's contact with CATS was recorded; a reciprocal entry was found in the CATS clinical notes about PO1's concerns regarding 'alcohol and PD (sic: personality disorder) issues'. The following day, after being advised about security of his belongings, Patient G spoke to his probation officer who recorded 'wouldn't listen...telling me to stuff my advice...I had done nothing for him...left with his £5 calling me "a wanker" '.

Numerous risks posed to and by Patient G are captured in narrative form in the most recent probation notes; there is limited use of standardised, structured instruments or forms: a self-assessment OASys (Offender Assessment System) form dated 7 March 2005 noted Patient G's acknowledgement of accommodation problems;

difficulties dealing with authority; being bored, lonely, stressed, depressed and taking drugs. The pre-sentence report (26 February 2005) emphasised a history of dishonesty but pointed out a change in the pattern of offending behaviour from 2002/3, with the emergence of assault, possessing a blade, and threatening behaviour. In fact he had been sentenced to five years in prison for attempted robbery in 1996, in the course of which he had carried a weapon. There was no reference to his five year prison sentence in the report.

A Risk of Harm Register form of 20 March 2006 did not identify any risk of harm and recorded only the termination of probation. Although there are records of telephone contacts with Bridge View and CATS, the extent to which the described risks were shared with health care agencies is unknown. However, BVD1 recorded, following a discussion with PO1 'no mention of a stabbing though'.

Other historic documentation is illuminating. The 25 August 2004 saw another pre-sentence report comment: 'Patient G's record of convictions and previous involvement in serious offences would indicate a continued risk. To ensure (his) offending is reduced he will need to seriously address his drug misuse'. The associated OASys self-assessment saw Patient G's acknowledgement of alcohol abuse, impulsivity, repeating the same mistakes, and violence when annoyed.

The pre-sentence report of 19 June 2003 (Public Order and Possession of an Offensive Weapon on 2 September 2002) described an escalation in the seriousness of offending 'similarly linked to alcohol misuse'. 'He admitted a tendency to react more violently, especially when under the influence of alcohol although he also acknowledged a problem with temper control...these factors, combined with his lifestyle, suggest a significant risk of reoffending and of harm to others'.

A Risk of Harm Register form of 8 March 2003 indicates moderate risk to the public. OASys self-assessment again flags violence when annoyed, alongside loss of temper and dealing with authority.

In 2001, another pre-sentence report (Patient G was charged with a Section 20 wounding with a Stanley knife) presented an assessment of risk: 'Patient G's record of convictions and involvement in this current serious offence would indicate a continuing risk...Drugs have been largely involved in previous criminal behaviour, although not this current matter'. The supporting evaluation and monitoring assessment, scored as a low risk of reoffending. A comment is appended, 'was a regular drug user until his last prison sentence...not used since release...needs keeping an eye on'.

A risk assessment form completed on 26 February 2001 stated the risk to the public, staff, and self, was low. The associated ACE (Assessment Case recording and evaluation system) re-offending related score was 26 (i.e. fell within the parameters of medium risk), with drug use and associations being high score factors. The previous robbery was attributed to the impact of drug abuse; this had ceased during his period of imprisonment.

Though he was seen to be intoxicated, the witness statements pertaining to the 1996 robbery illustrate the severity of the attack on an elderly lady: he was armed with a 'five or six inch blade' and demanded "is (sic) fucking money." When the victim knocked the blade from his hand, Patient G tried to kick her in the head.

Chapter 7 The Care Programme Approach (CPA)

The CPA has been in existence in excess of twenty years and was introduced to assist health and social care staff to plan care more effectively for those referred to the specialist mental health services. The requirement for a new approach to care was driven by two key elements: the move away from psychiatric institutions to a more community focused care provision and the increasing complexity of managing care across multiple agencies. The possibility that someone may 'slip through the net' was ever present and required that needs were assessed, risks identified, care plans formulated and effectively coordinated.

The panel acknowledges that whilst applied nationally, the CPA is an 'approach' which is subject to local interpretation and, although audited centrally, does include local variations in its application. This has been recognised and addressed through the publication of the 2008 version, which in effect has removed much of the bureaucracy associated with previous approaches and has simplified the eligibility criteria for determining who should be subject to CPA.

The CPA has been subject to three major reviews since its inception in 1990 and the key elements are set out in the policy context below:-

- 1. In 1990, the Department of Health issued Health Circular (HC (90)23) entitled: 'The Care Programme Approach (CPA) for people with a mental illness referred to the specialised psychiatric services'**

The CPA was introduced as a response to concerns regarding the quality of care being provided to those with mental illness who were being cared for under care in the community arrangements and followed on from a number of serious incidents where the care appeared to fall short of the standards required.

It was intended to provide a framework for effective mental health care and applied to all who came into contact with the secondary mental health services.

Its five main elements were:

- systematic arrangements for assessing the health and social care needs of people accepted into the specialist mental health services;
- formulation of care plans which identified the health and social care required for the patient from a variety of providers;
- a minimum, medium or complex care approach level, depending on need;
- the appointment of a key worker to keep in close touch with the service user and to coordinate care;
- regular review and, where required, revision of care plans.

However, there was general recognition throughout England, that the application of CPA was too bureaucratic and that there was a reluctance to engage with the process.

2. In an attempt to simplify matters and to bring together the key elements of the health led CPA and the social care led 'care management', the NHS Executive and the Social Services Inspectorate issued new guidance in 1999 entitled 'Effective care coordination in mental health services - Modernising the Care Programme Approach (CPA)'.

This reduced the number of levels to two in order to simplify care co-ordination. These were known as standard and enhanced.

A care coordinator would be identified who would pull together all aspects of care and there was to be an emphasis on recognising the needs of carers subsequent to the Carers (Recognition & Services) Act 1995. The guidance clearly illustrates that it is critical that the care coordinator has the *authority* to coordinate the delivery of the care plan and that this is respected by all those involved in delivering it, regardless of agency or origin.

An emphasis was also placed on risk assessment and management. Risk assessment is an essential and ongoing part of the CPA process. Care plans for severely mentally ill service users should include a mechanism to ensure urgent follow up within one week of hospital discharge. Care plans for all those requiring enhanced CPA should include a 'what to do in a crisis' and a contingency plan. It goes on to say that where service users are the shared responsibility of mental health and criminal justice systems, close liaison and effective communication over care arrangements including ongoing risk assessment are essential.

In respect of care plans and reviews, the 1999 guidance states:

- good practice dictates a move towards more integrated operational practice. Integrated records are an example of such practice. The maintenance of shared records will further reduce unnecessary form filling and bureaucracy, will improve communication and, most importantly, will contribute to a streamlined care process to the advantage of the service user and provider;
- there is no longer a requirement for a nationally determined review period of six months for care plans. Review and evaluation of the service user's care plan should be ongoing. At each review meeting the date of the next review must be set and recorded. Any member of the care team or the user or carer must also be able to ask for reviews at any time. All requests for a review of the care plan must be considered by the care team. If the team decides that a review is not necessary the reasons for this must be recorded. The annual audit of CPA should check that reviews of the care plan have been carried out;
- to reduce risk, the plan as a minimum, should include the following information:
 - who the service user is most responsive to;
 - how to contact that person and;
 - previous strategies which have been successful in engaging the service user.

This information must be stated clearly in a separate section of the care plan that should be easily accessible out of hours.

The guidance goes on to illustrate what is regarded as a 'whole systems approach' to mental health care and states that all mental health service users have a range of needs which no one treatment service or agency can meet. Having a system which allows a service user access to the most relevant response is essential - getting people to the *right place* for the *right intervention* at the *right time*.

This principle is, of course, particularly important in the case of individuals who need the support of a number of agencies and services and there are some who, as well as their mental health problem, will have a learning disability or a drug/alcohol problem. In all these cases a coordinated approach from the relevant agencies is essential to efficient and effective care delivery.

Effective care coordination should facilitate access for individual service users to the full range of community supports that they need in order to promote their recovery and integration. It is particularly important to provide assistance with housing, education, employment and leisure and to establish appropriate links with the criminal justice agencies and the Benefits Agency.

3. The Care Programme Approach was further reviewed and new guidance issued in 2008. The key elements of the new guidance are summarised below:-

Individuals with a wide range of needs from a number of services, or who are most at risk, should receive a higher level of care coordination support. From October 2008, the system of coordination and support for this group only will be called the Care Programme Approach.

Assessments and care plans should address the range of service users' needs. Risk management and crisis and contingency planning are integral to the process. A number of critical issues are highlighted, including assessing the needs of parents; dual diagnosis; physical health; housing; employment; personality disorder; history of violence and abuse; carers; and medication.

Whole systems approaches should support CPA. Services and organisations should work together to: adopt integrated care pathway approaches to service delivery; improve information sharing; establish local protocols for joint working between different planning systems and provider agencies. The role of commissioners is key in ensuring a range of services to meet service users' needs and choices. Joint planning across agencies through Local Strategic Partnerships and Local Area Agreements is also critical.

To ensure that services are person centred and values are evidence based an appropriately trained and committed workforce is needed. For individuals requiring the support of CPA the role of care coordinator is vital. National competencies for the care coordinator are outlined and the development of national training for care coordination, risk and safety has been commissioned. Guidance is given on measuring and improving capacity and effectiveness.

The quality of assessment and care planning should be focused on improving outcomes for service users and their families across their life domains. Attention to local audit, performance management, national regulation and issues of equalities is needed to ensure equitable outcomes for all.

Care Programme Approach in respect of Patient G

Patient G's childhood was characterised by neglect and physical and psychological trauma. He was the subject of a child abuse conference in 1987 when he was 13 years old and was subsequently placed on a child

protection register. He was already involved with the criminal justice system and committed a string of offences through the 80s and into the 1990s. He was first referred to the secondary mental health services when aged 18 in 1993 with drug related problems but failed to attend appointments.

In August 1996, having been drinking heavily and having consumed a large amount of temazepam, he then attempted to rob an elderly lady at knife point. He was admitted to Cherry Knowle Hospital in Sunderland for further assessment in light of the overdose, but was discharged the following day into police custody. It was recorded that 'there was no evidence of a formal psychiatric disorder apart from substance misuse' and there was no basis for implementing CPA at that time. However, a referral was made to the Community Addiction Team (CAT).

In early 2005 he engaged with the Sunderland Drug Intervention Programme (DIP) and was put on a methadone programme. He subsequently moved to Newcastle to, as he reported, get away from the 'drug scene'. He was assessed at Bridge View, a community drug treatment agency in May 2005 and his prescribing was transferred to this team in June 2005. In September 2005 he was assessed by the CATS who determined there was no evidence of mental illness.

Also in September 2005, he was referred to the CMHT by a doctor at Bridge View to assess his low mood and issues around impulsive violence and anger. Unfortunately this referral was sent to the wrong address and he was re-referred in January 2006. Following a non-attendance, Patient G was subsequently seen by a staff grade psychiatrist at outpatient clinic for the first time in May 2006.

At this appointment Patient G was diagnosed as suffering from PTSD and was referred for CBT. This in effect was the first time that Patient G had formally been diagnosed with a mental illness co-morbid with his addiction issues. It is recognised from the documentation that SGP1 at the clinic was described as the care co-ordinator.

The referral to CBT was discussed by the primary care psychology service. Due to the complexity of his history and the likely need for a longer engagement process he was referred to the CBT service at Plummer Court.

Patient G continued to attend Bridge View and the outpatient appointments at Hadrian Clinic and had counselling at the Cyrenians but found it too probing and stressful. He was discharged from the waiting list for CBT as he did not attend his appointment. He was referred to a neurologist regarding blackouts and to the hepatologist regarding hepatitis C. He was displaying signs of depression during this period exacerbated by his homelessness. His attendance at physical health appointments was sporadic.

SGP1 at the Hadrian Clinic referred Patient G back to the CMHT in September 2006 for a care coordinator, although he himself was named as care coordinator. He intended that Patient G be placed on enhanced CPA. To this end he was placed on a waiting list as the team were working at capacity and Patient G's needs had to be prioritised against others on the list. Patient G never made it onto the CMHT caseload and was removed from the waiting list.

In January 2007 Patient G was re-referred for CBT but missed his appointment.

In March 2007 SGP1 made a formal referral to the CMHT for a care coordinator for general support, advice about housing and help in attending appointments. There is no record of a response. He wrote to the CBT centre requesting a delay in sending an appointment 'until things were finalised in Clifton Mount'. He also wrote to the GP, the neurologist and Bridge View to confirm a referral had been made. The CBT centre wrote to SGP1 at Hadrian Clinic on 12 April 2007 (although he had left by then, and CP2 was noted on the record as standard care coordinator) to say they had tried to contact both him and Clifton Mount to check whether a support worker had been identified, but had received no response.

Patient G eventually attended a CBT appointment in May 2007 and was judged to be unsuitable for that service at that time due to his focus on physical problems. It was noted however that he 'had developed a strong distrust of men, and could not sit next to a man without wanting to kill him'.

A third referral was made in June 2007 to the CMHT by SHO1, who was then managing his care. There is no record of a response. The next trainee doctor (SHO2) notes further missed appointments in August 2008, but there is still no record of response or action.

He continued to be managed at Hadrian Clinic and Bridge View and underwent numerous changes to his psychotropic medication as well as many changes in personnel at Hadrian Clinic and in addition, early in 2008 his regular doctor at Bridge View went on long term leave, not returning until November 2008. Several other issues arose during 2008, most significantly the death of his close friend. Patient G became increasingly erratic and agitated as the year progressed, to the point where he asked for inpatient admission for treatment of mood swings. He started drinking more and his girlfriend reported that he was forgetting his medication. The staff at Bridge View reported that they felt Patient G was becoming increasingly sedated.

In November when Patient G's regular Bridge View doctor (BVD1) returned from long term leave, she reported a marked deterioration in his condition, e.g. weight loss, memory impairment, lots of physical complaints, and

depressed due to the loss of his close friend. His urine tested positive for amphetamines and he was asking for his methadone to be increased. Patient G was said by BVD1 to be consistently topping up his medication with large amounts of street acquired diazepam. Coincidentally Patient G was discharged from Hadrian Clinic in December but the letter confirming discharge was not copied to Bridge View. At around the same time Bridge View wrote on 23 December 2008 requesting a review appointment for him at the Hadrian Clinic.

He was never allocated an enhanced care coordinator.

The murder occurred on 3 January 2009.

Comment

One of the key features of this case is that Patient G, whilst having a relatively chaotic childhood and troubled adolescence, did not actually engage with psychiatric services locally until 2006 after the prescribing for his drug addiction transferred from Sunderland to Newcastle. He accessed a tier three agency, Bridge View, which had been recently established to provide substitute medication and was staffed by GPs as an extension of shared care services. In common with drug services elsewhere Bridge View did not adopt the CPA, instead that responsibility was discharged by the general practitioner at Bridge View who he saw on a regular basis. Towards the end of 2008 a formal key worker system was introduced, and he was allocated a key worker BVN2, but her involvement with Patient G was very brief.

The earliest opportunity for CPA to be applied could have been when Bridge View referred him to the CMHT in September 2005 but the letter was sent to the wrong office and did not appear to have been passed on, returned to Bridge View, or acknowledged. This is not consistent with good practice and led to significant delay. He was eventually referred again by Bridge View to the CMHT at Clifton Mount in January 2006. The outcome of the referral resulted in Patient G being allocated to SGP1 and this started his engagement with a number of psychiatric medical staff at Hadrian Clinic from May 2006 to August 2008. It appeared to be custom and practice within that team that when someone who only has contact with the specialist mental health services through medical outpatient clinics, the psychiatrist is notionally recognised as the care coordinator under standard CPA.

The next opportunity for a review of his status in respect of CPA came when the SGP1 at Hadrian Clinic referred Patient G back to the CMHT in September 2006 and then again in March 2007 for consideration for enhanced CPA with a care coordinator allocated within the team.

The evidence of registration is confusing and contradictory.

A CPA activity sheet logged on the RiO system records that he was on enhanced care coordination from 6 to 16 February 2007 when his care coordinator is stated to be an acting team manager within the CMHT. There is no mention of this member of staff in any of the documentation.

SHO1 made a further referral in June 2007.

It is recorded on RiO (electronic recording system used by the trust) that he was not on CPA from 16 February 2007 to 22 December 2008 although SGP1 is recorded as his care coordinator or lead health care professional, even though SGP1 left the service in March 2007.

Oral evidence given to the panel suggests that a decision was taken by the CMHT to regrade him to enhanced care coordination. Unfortunately, none of the records of these meetings was available to the panel, and there is no record of such decisions in the clinical notes. The panel were told that following the closure of the CMHT office at Clifton Mount it was not possible to retrieve the records. It has therefore been impossible to see how cases were prioritised and allocated, and what concerns were presented to the CMHT about Patient G.

It was recognised that Patient G's points of engagement with services were proliferating. He had been referred to psychology, neurology, hepatology and CMHT as well as attending Hadrian Clinic and Bridge View. He had housing and social problems including unemployment and absence of meaningful daily living strategies as well as issues with alcohol abuse and non-compliance with psychotropic medication. There were concerns regarding his ability to manage his anger and his relationship problems with others. He had extensive and ongoing forensic issues including use of weapons.

The opportunities to act upon these issues were missed.

There was another missed opportunity at this time, in that with the increasing problems and the emerging picture of dual diagnosis, a referral to the specialist addiction team at Plummer Court could well have added value in that a comprehensive assessment of his needs could have been undertaken, risks appropriately assessed and his medication, both illicit and prescribed, could have been better managed within the same service. Given the close proximity to the CBT service at Plummer Court, Patient G may have been encouraged to actively participate, although the panel do acknowledge that whatever plans may have been considered purposeful, at the end of the day, Patient G himself would have had to agree to comply with the programmes arranged, and it is by no means certain that this would have happened.

A further point in respect of CPA relates to the management of Patient G during his journey through the psychiatric outpatient system. He was seen by five psychiatrists of varying grades, some of whom were locums. He was never seen by the consultant. Although the outpatient doctor was notionally the care co-ordinator, there is little evidence that the CPA guidance was followed, and he was managed within a traditional medical model. The Panel heard that the consultant psychiatrist would have an overview of his care and could be approached by junior medical staff should a need arise. This appears to have occurred infrequently.

Finally, it is surprising that Patient G was discharged from Hadrian Clinic on 22 December 2008, without notifying Bridge View or without any discussion with them. At this time Bridge View were noting that Patient G's presentation was deteriorating. Following a clinic review on 19 December 2008, Bridge View became aware that Patient G had been lost to follow up and wrote to the consultant at Hadrian Clinic on 23 December requesting a consultant psychiatrist review. Particularly given that this was the festive season, it was unlikely he would have been seen by Hadrian Clinic before 3 January 2009 when the murder was committed.

Chapter 8 Record Keeping and Communication

A: Record Keeping

A list of the records considered by the panel is set out in the bibliography appended to this report.

Community Mental Health Team (CMHT)

Unfortunately none of the CMHT records could be found despite extensive efforts. This applied both to the administrative record of the CMHT allocation meetings, and to the CMHT care plan documentation. This made it impossible for the panel to understand

- why there was a delay of four months in progressing the referral made by BVD1
- the allocation process
- why he was not placed on enhanced care coordination despite repeated referrals.

Hadrian Clinic

Notwithstanding Patient G was referred to the CMHT by Bridge View, this referral was allocated to a medical member of the CMHT and followed up through the psychiatric outpatient record system. Thus no other member of the CMHT had access to the records at their offices. The CMHT was entirely dependent on the individual clinician's judgment and advocacy skills when setting priorities for allocation to enhanced care coordination.

Nationally, there are a number of slightly differing standards for record keeping by clinicians produced by various professional bodies. The main thrusts are captured in modest recommendations by the Royal College of Psychiatrists:

'A psychiatrist must maintain a high standard of record-keeping. Good psychiatric practice involves keeping complete and understandable records and adhering to the following:

- i) handwritten notes must be legible, dated and signed with the doctor's name and title printed
- ii) electronic records must be detailed, accurate and verified
- iii) a record must be kept of all assessments and significant clinical decisions. The reasoning behind clinical decisions must be explained and understandable in the record and, if appropriate, an account of alternative plans considered but not implemented must be recorded

iv) the record should include information shared with or received from carers, family members or other professionals

v) notes must not be tampered with, changed or added to once they have been signed or verified, without identifying the changes, and signing and dating them.

In the interests of communication, many standards require records extending across professions to be unified into single volumes or electronic records.

Entries are generally recommended to be timed, additionally.'

Trusts standards for recording by nurses were based on the Nursing and Midwifery Council structure produced in 1998 and subsequently modified (3NTW (C) 16.

All Patient G's Hadrian Clinic records were handwritten save for correspondence with other agencies.

The standard of the record keeping in this case is often poor. More specifically:

1. The time of entries in the Hadrian Clinic notes is never recorded.
2. Signatures are often illegible, and names often unprinted, and not designated by grade.
3. Narrative in the entries is at times illegible.
4. The rationale behind certain decisions is unclear, and some records are incomplete. Examples include:-
 - following a referral by Hadrian Clinic for CBT an apparently valuable proposal made by CBT1 in May 2007 was to consider the use of a worker from Plummer Court jointly trained in methadone maintenance and CBT for PTSD symptoms. There is no record of any consideration of this option, and other key issues contained in the report such as re-assessment of risk.
 - in SHO2's treatment plan (probably of July 2007) there is the comment 'look to discharge in the future'. But at what point was discharge to happen? What symptoms were to resolve?
 - on 15 February 2008, why was the nitrazepam changed to temazepam, except that the patient requested it? The change ignored the patient's own complaints of terminal insomnia or early wakening (for which temazepam is of little use because it is quickly excreted from the body); it ignored its abuse potential; and it led to further changes in the point of prescription of drugs to which Patient G was addicted (to Hadrian Clinic from Bridge View, from where the nitrazepam had been prescribed).
 - the decision to transfer the responsibility for prescribing from Hadrian Clinic to the GP and consideration of the implications and attendant risks.

- though earlier letters were correctly addressed, the last two letters offering a further appointment to Patient G, and warning of the consequences of failure to attend, were sent to incomplete addresses. It was highly unlikely that Patient G received any of those letters.
5. The record of the history taken in Hadrian Clinic was not full, and the circumstances of the 1996 admission to Cherry Knowle and periods of imprisonment remained obscure to the mental health services. As a result there is only a partial record of Patient G's forensic history.
 6. Not all telephone conversations are fully recorded, for instance between SGP1 and the CBT Department in 2007.
 7. Most records are filed chronologically though the status and date of SHO2's summary history (the only summary and in other respects invaluable) required some interpretation.
 8. The trust did undertake case note audits but these audits indicated a high level of unsatisfactory record keeping.
 9. The wider clinical record was deficient. There are no records of meetings of the CMHT meetings, including allocation of care coordinators. Misleading and inaccurate RiO (electronic health records) hard copies were made available to the investigation including an undated and incomplete CPA registration document.
 10. No clinical supervision records were kept.
 11. According to the record, the patient's confidentiality was compromised when a junior psychiatrist left a message regarding his management on the mobile answer phone of a senior colleague in another speciality (albeit recording the fact of this in the mental health record).
 12. Nowhere in the records is a full and coherent care plan in evidence, as described in "Good Psychiatric Practice." Lacking too, is any attempt to establish Patient G's strengths and personal resources.

Bridge View

These were held as electronic records and were well populated with attributable quantitative information (contacts and actions). However, some entries lack qualitative information relevant to current and future care planning.

A copy of the letter from CBT1 to Hadrian Clinic referred to above was also sent to Bridge View. There is no record of consideration of the proposal to engage a worker from Plummer Court, despite BVD1 confirming to Hadrian Clinic that Bridge View were unable to provide CBT.

GP

The GP records contain extensive information relating to the patient stretching back over many years including contact with the Sunderland mental health services. This refers to the assault on an old lady by threatening her with a knife, and Patient G having stabbed a security guard. This invaluable repository of information might have helpfully contributed to Patient G's management.

The GP had agreed to take over responsibility for prescribing from Hadrian Clinic in August 2008 and it appears from the GP records that he was issued with prescriptions to this end.

Commendably, the GP practice in Newcastle was kept fully informed by both Hadrian Clinic and Bridge View but this did not translate into any active involvement in Patient G's mental or physical health care by the GP.

Crisis Assessment and Treatment Service

Their involvement was recorded in both manual and electronic records which essentially duplicated the case notes.

Comment

Many of the difficulties noted above could have been addressed by the adoption of an integrated record system which would have retained all the information generated by secondary mental health services in one file.

B: Communication

Communication between professionals was immediately compromised by deficiencies in the written and electronic record, as were handovers across time as one psychiatrist followed another. The content of team discussions about Patient G is not known, either at Hadrian Clinic or Bridge View. There was no evidence of care coordination. At Bridge View BVD1 was regarded as the patient's lead clinician, but a key worker from Bridge View was nominated only in the weeks before the homicide.

The first referral by BVD1 to the CMHT was misdirected, Patient G having moved five days before. Unfortunately the referral was not forwarded to Clifton Mount by the Hebburn office. This resulted in a delay of some four months in progressing the referral. This is not the only occasion on which letters or copy letters were misaddressed. Another example is a copy letter from CBT1 to Bridge View (2 May 2007). Copies of important letters were not always sent to relevant agencies such as an appointment letter from CBT to Patient G which was not copied to SGP1, even though SGP1 had specifically requested that he be copied in.

Agencies that had referred Patient G to other agencies were not always notified when Patient G was discharged. For example, when Patient G failed to respond to a pre-screen letter sent by CBT in August 2006, they did not notify Hadrian Clinic. Hadrian Clinic then sent a reminder some five months later, not being aware that he had already been discharged. In addition Hadrian Clinic did not notify Bridge View of Patient G's disengagement leading to discharge in autumn 2008, and had not even

discussed the proposed discharge with Bridge View. These events were not inconsequential: the former contributed to a significant delay in accessing CBT; the latter to Patient G being lost to follow-up at Hadrian Clinic.

Correspondence failure added to shortfalls in telephone communications and their recording, to prevent services building up complete intelligence on Patient G. An example is BVD1's conclusion, after speaking to probation that Patient G had never been involved in a stabbing. It is not clear how this inaccuracy came to enter the record. The contents of CATS discussions with probation are obscure. Nevertheless there is other evidence of telephone discussions with much fuller records, as when SHO2 drew up his review of the patient's history and spoke to BVD1 and CP2, and shortly afterwards the GP.

On this occasion, the substantial correspondence to the GP from both Hadrian Clinic and Bridge View achieved little, since the patient very rarely attended her surgery. Given that the referral to Hadrian Clinic had also, and in any case, derived from Bridge View any presumed coordinating role of primary care was misguided.

CATS made no correspondence with anyone save to forward the triage form to the GP and photocopy their notes to SGP1 on his request.

Comment

As previously noted, later letters from Hadrian Clinic to Patient G were incompletely addressed. It was known that Patient G lived in multi-occupancy accommodation, and the potential for correspondence to go astray was noted in the records by BVD1, and brought to the attention of Hadrian Clinic by BVD1, and was highlighted also by SGP1 in his correspondence with the CBT service.

Consideration should have been given by Hadrian Clinic to more pro-active ways of communicating with Patient G, for example, by telephone, particularly when discharge from services was being considered by Hadrian Clinic. The panel note that Bridge View was able to make contact with Patient G by telephone on several occasions either when he had failed to attend appointments or when they had concerns.

In the absence of effective care coordination there was no mechanism for establishing a channel of communication between the hostel manageress (who was in a good position to contribute to a discussion of risk related issues and needs) and Hadrian Clinic where the care coordinator was based.

Chapter 9 Inter-agency Working

Patient G had contact with a number of agencies from an early age, including social services (children's services), child psychiatry, drug and alcohol services and two overnight admissions at both the District General and Cherry Knowle Hospitals in Sunderland. Starting from his adolescence he was also in frequent contact with the police and criminal justice agencies and served several custodial sentences in both young offender institutions and prisons.

It was not until 2005 however that he commenced regular contact with primary and secondary care mental health services following his relocation from Sunderland to Newcastle. At the time he moved he was engaged with the Sunderland Drug Intervention Project (DIP), housing agencies and probation (as a result of a CRO). Patient G reported that he saw a counsellor in May 2005 at the Cyrenians at Ron Eager House which was a drop in centre. There appears to be no record of his contact with this agency.

In May 2005 following his move to Newcastle, his drug treatment programme was transferred from the Sunderland DIP to Bridge View Drug Treatment Service in Newcastle as a consequence of a referral from the Cyrenians. He was prescribed methadone for his opiate addiction and diazepam for his benzodiazepine addiction.

Patient G was assessed by the CATS in September 2005 following two attendances at the A&E department but did not have any further contact as they reported that there was no evidence of mental illness.

Bridge View attempted to refer Patient G to the CMHT for assessment of his mental state in September 2005 but due to communication difficulties the referral was not accepted by Clifton Mount CMHT until January 2006. He was subsequently allocated to SGP1, a staff grade psychiatrist, and seen at Hadrian Clinic in May 2006, having failed to attend his first two appointments in February and March 2006.

He continued to be seen on a regular basis at Bridge View and Hadrian Clinic until August 2008 when Patient G attended Hadrian Clinic for the last time prior to being discharged by Hadrian Clinic. Bridge View maintained their involvement.

The general practitioner regularly received correspondence regarding Patient G's various contacts with the agencies, though he was rarely seen at the practice.

In August 2008 GP1 accepted responsibility from Hadrian Clinic for prescribing his psychiatric medication with the exception of substitute prescribing. The request for GP prescribing came from the psychiatrists treating him at Hadrian Clinic who felt that all his prescribing should be managed by one source even though he would continue to receive prescriptions for his addiction from Bridge View. His medication was dispensed by the community pharmacist

There is no record however, that GP1 took an active part in the management of Patient G's mental health problems or ever saw Patient G in that context.

At various times during his engagement with Hadrian Clinic, Patient G was referred to other health care agencies, including a referral back to the CMHT for enhanced care co-ordination. He was seen in cardiology for an electrocardiograph (ECG), neurology for an electroencephalography (EEG) and should have attended hepatology for treatment of Hepatitis C, but did not attend appointments.

Patient G was also referred for treatment of his PTSD and was seen once by the cognitive behavioural therapy service at Plummer Court in May 2007. It was determined however, that he was not suitable for CBT at that time. A letter to that effect was sent to Hadrian Clinic.

Patient G continued to come in to contact with the police on a fairly regular basis during the period 2005 to 2009. This was mainly related to petty offending and the consumption of alcohol in the street.

A referral was made by BVD1 to CP2 on 23 December 2008 asking that Patient G be seen again by the psychiatric team, but this did not come to fruition prior to the murder.

The last appointment with healthcare services prior to the offence occurred on 2nd January 2009 when Patient G saw BVN2 at Bridge View with a query about his benefit.

Comment

Apart from an overnight stay in Cherry Knowle hospital, Sunderland in August 1996 and a referral to the drug and alcohol service following discharge (which he never attended) Patient G was not known to the psychiatric services until 2006 after he moved to Newcastle. There was never any formally recorded diagnosis of mental illness until he was seen by a psychiatrist at Hadrian Clinic in 2006. It was recognised that he was addicted to drugs and to a lesser extent, alcohol.

There is a well recorded history of offending up to the time of his relocation to Newcastle including several spells in prison but apart from recognition that he abused drugs and alcohol, there is no evidence within probation or GP records that any mental illness or disorder was identified whilst in prison.

The first evidence of comprehensive inter-agency working occurred in 2005 when he was involved with probation, housing, Cyrenians and DIP and then Bridge View and there is written evidence of communications taking place with regard to his housing, probation and addiction issues. There is documentary evidence in probation and

Bridge View records of communication between Bridge View and probation and between various housing providers and probation.

He was also seen twice by the CATS, having presented at the A&E department with low mood, threatening suicide and complaining of homelessness. As the FACE risk assessment was conducted out of hours, it relied on self-reporting by Patient G who reported that he had been barred from a number of hostels for fighting, had been in prison "loads of times" but had committed no crimes of violence. CATS scored his risk of violence to others at zero (no apparent risk).

Although CATS were aware he had attended A& E on the suggestion of his Bridge View doctor, CATS did not seek to obtain any information from Bridge View, or feedback the outcome of their assessment, namely that he did not have a mental illness. It was only a week later that Bridge View referred Patient G to the CMHT to look at his low mood, and issues around his impulsive violence and anger. Patient G's probation officer (PO1) learned through Patient G that he had been assessed by CATS and telephoned a member of the team for more information. There is a note on the FACE risk assessment that PO1 had suggested a personality disorder, but there is no evidence that the CATS took this opportunity to verify Patient G's self-reported history, and in particular his assertion that he had no offences of violence. PO1 would have had access to the full forensic history.

The next evidence of interagency working was between Bridge View and Hadrian Clinic. This covered the period 2006 to 2008. The medical staff at Bridge View were concerned regarding Patient G's low mood and issues around impulsive violence and anger and referred him to the CMHT. Several months later he was allocated to SGP1 and seen at Hadrian Clinic.

It was subsequently identified that Patient G would benefit from assistance to attend numerous appointments connected with his physical health, advice about housing, and some assistance with structured daily activities as well as management of his drug abuse and treatment for his PTSD and depression.

There do not seem to be any clear written accounts that Bridge View and Hadrian clinic were actually working together to jointly plan a package of care for Patient G to address these issues. SGP1, as the standard care coordinator, did not feel he was best placed to deal with the complex issues which Patient G presented and referred him back to the CMHT for enhanced care coordination. Had his care been coordinated at that level, this would have brought together the key agencies to jointly work together to achieve the desired outcomes.

By the time SHO1 made the third referral to the CMHT in June 2007, SGP1 had left the service and CP2 then assumed the role as Patient G's care coordinator until his discharge from Hadrian Clinic in December 2008. There is no evidence that any change to Patient G's CPA status occurred as a result.

It is noteworthy that the input to Patient G's care was almost exclusively medical, yet many of his needs were socially driven, i.e. housing, employment and other daily living issues. It is recognised that Patient G was reluctant to engage with activities and professionals outside of the prescribing environment, but there appeared to be a significant lack of effort employed to help in addressing these issues with appropriately skilled professionals.

The active involvement of a skilled and properly qualified care coordinator could have enabled a consistent and properly managed care plan to have been developed that would have identified objectives and how they could be achieved. An effective coordinator would have recognised which agencies needed to be involved in each aspect of Patient G's care and would have been well placed to monitor the impact of the contributions made by each. There would also have been in place mechanisms to ensure that Patient G attended appointments with agencies involved in his physical, mental health and social care and that the outcome of these interventions was shared and evaluated on an inter-agency basis.

It is of note that SGP1 at Hadrian Clinic recognised that Patient G was a 'complex' case and felt that his needs would be best served through enhanced care coordination, yet despite his regular attendance at meetings of the Clifton Mount CMHT he was unable to bring this about. SHO1 made a further referral to Clifton Mount when she took over from SGP1. As the CMHT's records of those meetings and the records of correspondence have been lost it is impossible to establish why he was not placed on enhanced care coordination, how long he remained on the waiting list, and whether he was ever discharged.

There continued to be an exchange of correspondence and occasional telephone contact between the key agencies involved, i.e. Bridge View, Hadrian Clinic and the GP, none of which seemed to reach conclusions on how best objectives could be set to resolve Patient G's presenting issues, and each continued to work in parallel but separate ways although the role played by the GP was minimal.

The disjointed approach was highlighted towards the end of 2008 when Patient G was discharged by Hadrian Clinic and Bridge View were not notified, even though it was Bridge View who referred him initially and who were still a key care provider. Bridge View referred him back to Hadrian Clinic as soon as they discovered he had been discharged from that service.

It is also noteworthy that no referral was made to the NHS Drug and Alcohol service at Plummer Court, either for advice or therapeutic intervention. This would have addressed his need for methadone maintenance, CBT and management of his mental illness. Both Hadrian Clinic and Bridge View were aware of the role and function of this team, particularly with regard to patients with dual diagnosis, yet neither considered this a proper resource to meet Patient G's needs.

CONCLUSIONS AND RECOMMENDATIONS

The North East Strategic Health Authority commissioned this independent investigation as Patient G had been in receipt of specialist mental health services for a period of some three years prior to the commission of the offence.

The investigation panel's formal terms of reference required it to consider the quality and scope of Patient G's health care and treatment, the assessment and management of risk, the appropriateness of his treatment in the context of the CPA, record keeping and communication between all interested parties and compliance with statutory obligations and guidance by those treating Patient G.

The panel has concentrated on the period since 2005 when Patient G moved to Newcastle, engaged with local drug addiction services, and was referred to specialist mental health services.

The panel has had the benefit of considering extensive documentation relating to Patient G, some of which goes back to his childhood, such as social services records. Records made available include those from his GP, Bridge View and Hadrian Clinic, as well as records from probation and the police. The panel acknowledge that not all of this information would have been available to those responsible for his health care and treatment and that the panel have been able to consider the totality of that information with the benefit of hindsight.

The panel has, however, identified a number of areas where the health care and treatment of Patient G fell short due to a number of factors. In particular, steps should have been taken to assess more accurately the risks that Patient G posed to others and to monitor and reduce those risks.

Areas of concern have been identified as follows:

1. Risk Assessment and Risk Management

No effective, full risk assessment of Patient G was ever carried out. This is despite him having served three prison sentences for knife related offences, including an offence of attempted robbery of an elderly woman for which he received a lengthy prison sentence. The last prison sentence for knife crime served before his referral to specialist mental health services was in 2003, only two years prior to the referral. Although by then he was actively engaged in drug treatment for the first time, his behaviour continued to be unpredictable.

A nurse at Bridge View undertook an assessment following his transfer to that service but this was primarily an assessment of need rather than risk. In all other respects, it was a commendable piece of work.

The panel recognise that CATS did undertake two standardised FACE risk assessments in September 2005 but these were emergency, crisis assessments undertaken out of office hours, in the early hours, and relied solely upon self-reporting by Patient G. As he had denied any history of violence, the assessment of no risk of violence was fundamentally flawed. The opportunity to corroborate this information in a later telephone discussion initiated by Patient G's probation officer was missed and copies of the assessments were not forwarded to Bridge View, despite the fact that CATS were aware that Bridge View had referred him for assessment.

BVD1 identified a significant history of violence and noted current aggressive behaviour. She made a very appropriate and timely referral to the CMHT for a mental health assessment of the issues around his impulsive violence and anger.

When Patient G was eventually seen by Hadrian Clinic, no comprehensive risk assessment, standardised or otherwise, was undertaken, despite the risk of violence being brought to the attention of Hadrian Clinic by BVD1. Copies of the FACE assessments carried out by CATS were obtained but, with the benefit of more information about his offending history and subsequent indicators of aggression, it should have been obvious that these assessments did not present a complete picture of his risk profile..

Subsequent indicators, such as information reported to Hadrian Clinic by the CBT Centre that Patient G could not sit next to another man without wanting to kill him in April 2007 and comments made to a trainee psychiatrist at Hadrian Clinic that he had thoughts of hurting himself or others did not result in proper risk assessments being undertaken.

This is particularly remarkable given his offending history and continued involvement in incidents involving knives and a crossbow, both as a victim and an alleged perpetrator. None of the agencies appeared to consider seeking a forensic assessment.

Recommendation 1

All new referrals should receive a risk assessment, preferably standardised. There should also be an episodic re-assessment of risk which should be held in a way that is accessible to all involved clinicians. It is particularly important that there is robust supervision of trainee clinicians, who may carry out such assessments.

Recommendation 2

Within their governance arrangements the Northumberland Tyne and Wear NHS Foundation Trust should have procedures to manage and share risk. Where such

procedures exist, which is the case within this Trust, training should be provided, regularly updated, actively promoted and supported through in service education

Recommendation 3

Where the sole source of the information is the patient himself the appropriate weight should be accorded to the information, and efforts made to corroborate the information from other sources.

Recommendation 4

Where there is a history of violent or sexual offending, or where there is a concern about risk of harm to others in the future, consideration should be given to referral to the forensic service, or alternatively advice, support and guidance should be sought from that service. The Trust should actively promote the role of the forensic services in improving and sharing the management of a patient with such a forensic history and ensure their expertise in forensic matters is disseminated by means of shared training and through professional development.

2. Care Coordination

The requests from SGP1 and SHO1 for the case to be escalated to enhanced care co-ordination at Clifton Mount were ineffective. This was never implemented despite SGP1 and CP2 being members of the CMHT and attending their business meetings. In the absence of records from the CMHT, it is not possible for the panel to understand why. It was acknowledged by a number of professionals that Patient G often struggled to access appointments for both his mental health and his complex physical health needs. This had a major impact on his treatment. It was also acknowledged that the possibility of psychological treatment of Patient G's PTSD was unlikely to be effective until investigations relating to his physical health had been completed. Patient G needed help with such matters as housing and activities of daily living.

CP2 told the Panel that he did not consider that help with physical health appointments was part of the role of Hadrian Clinic. However, SGP1 was named as Patient G's care coordinator and it is recorded that CP2 subsequently took over that role. Effective care coordination is intended to look at all of a patient's needs, including mental health, physical and social needs, and matters such as housing.

Other agencies such as Bridge View and his GP were informed that referrals had been made, but did not appear to question the lack of progress. Any of the professionals involved with Patient G, including those at Hadrian Clinic, Bridge View and the GP, could have considered requesting a case conference to review his care.

It is quite likely that had Patient G been regraded to enhanced care co-ordination and allocated a more appropriate care co-ordinator, his engagement with services would have improved incrementally and that relevant information as to potential risk factors such as his vulnerabilities and behaviour in the community would have become more apparent. This view is supported by the appointment of a key worker from Bridge View in the last weeks of his involvement with that service which appeared to provide the type of support lacking up to that point.

Recommendation 5

Evidence of discussions at the CMHT should be incorporated into the patient's mental health records.

Recommendation 6

Each CMHT should maintain a record of how patients are allocated and to whom. The decision not to allocate should be justified and recorded. There are clear guidelines on eligibility for enhanced care and transparent processes on how priorities are managed.

If the patient is 'outposted' to a team member at another location, there should be a file held at the CMHT office which recognises this, and, at discharge from the team, these notes should be merged to form a CMHT record. In addition, consideration needs to be given, ideally at each review, as to whether the allocated care coordinator is fulfilling the role in a way that meets the patient's needs. In particular where social care elements are predominant, consideration should be given to employing the skills of social work colleagues.

At its regular business/allocation meetings, the CMHT should be mindful of each patient on its caseload wherever that patient is allocated and ensure that regular reviews take place. The allocation of patients within a team is part of a clinical process, the rationale for which needs to be recorded in the patient's notes.

The panel recognises that the 2008 CPA guidance will impact upon the context of this recommendation and ask that the Trust embraces the spirit of the recommendation in the revised arrangements.

3. Health Care and Treatment – Care Planning /Differential Diagnoses/Treatment Options

A

Almost all of Patient G's care was provided in a medical model between Bridge View and Hadrian Clinic. The absence of clinical supervision was evident in both teams. There was much movement between doctors as they came and went as part of their clinical placements within Hadrian Clinic. At Bridge View the situation was less problematic as BVD1 tended to act as the lead clinician. This position changed when she went on extended leave in 2008 and Patient G's care was not allocated to any particular clinician within the team. It could be argued that the impact of this culminated in Patient G's deterioration in autumn 2008 when he was discharged from Hadrian Clinic, which was noted when BVD1 returned to Bridge View in November 2008.

No full social history was ever assembled during Patient G's journey through the services. The closest was perhaps the history compiled by Bridge View on his initial referral. Had all the facets of his history been captured and handed over as he moved between agencies or changing staff, this may well have better informed the development of meaningful management strategies and planning.

Similarly, there was an absence of a clear care/treatment plan which should have been available to new staff working with Patient G and which should have been subject to regular assessment and evaluation. Patient G should have been made aware of that plan.

There was no evidence of meaningful or formal handovers between departing and arriving clinicians. This magnified the impact of deficient co-ordination of his care, which would have been mitigated to some extent by the allocation of a care co-ordinator by the CMHT.

Occasional references were made within the records to the possibility that Patient G might have a personality disorder. Unfortunately, this was never investigated fully and, therefore, resources allocated to that client group were never considered.

Recommendation 7

Each patient engaged with mental health services should have a care/treatment plan which is clearly understood and accepted by the patient. These plans should contain goals which are measurable, achievable and acknowledge the patient's strengths. They should be subject to regular assessment and evaluation, and incorporated into the Trust's audit records.

Recommendation 8

All clinical staff within mental health services who have responsibilities for formulating diagnosis should be aware of current evidence based guidance on the management of personality disorder. There are clear guidelines available many of which are supported with resources and which offer those with personality disorder a realistic opportunity of clinical improvement. Where clinicians suspect that personality disorder is a possibility this must be fully investigated and if substantiated, proper treatment plans put in place.

Recommendation 9

The trust should refine and audit its supervision standards so that no patient under medical management by mental health services should be managed by a trainee or a locum for more than a 12 month period without his or her care reverting to a substantive post holder.

Recommendation 10

There should be a recorded process for handover, which could be in the form of a checklist between clinicians working in the same post e.g. where a succession of trainee doctors or locums fill the same post consecutively, or where responsibility for management is passed between different professionals.

B

Despite a number of factors highlighted previously in this report such as his offending history, mental health difficulties, drug and alcohol abuse, poor support networks and complex physical problems, there was a failure to assess the benefits of transfer to specialist services. SGP1, SHO1 and BVD1 and the CBT service all noted Patient G's complexities.

There existed within the Trust a specialist addiction service based at Plummer Court, who could have treated Patient G for his dual diagnosis, managed his substitute prescribing, and which had trained staff who could have facilitated CBT for his PTSD. Given Patient G's clinical presentation and that this option was very appropriately suggested by CBT1, it is surprising that active consideration was not given to transfer to Plummer Court. There is no record of consideration of such a transfer by Hadrian Clinic. BVD1 had notified Hadrian Clinic that Bridge View did not have staff jointly trained in methadone prescribing and CBT.

The panel acknowledge that Patient G attended regularly at Bridge View, but Patient G made it clear that he wanted 'more time to talk' and frequently complained about the rapid turnover of doctors at Hadrian Clinic. His regular attendance was interpreted as good engagement. The panel do not share that interpretation, and in

any event, good engagement in itself is not an indicator of the quality of care management.

Patient G had been appropriately referred for CBT to treat his PTSD but the recommendations made by the CBT service were not acted upon. This could have been a real opportunity to engage him in talking therapies and was wasted due to the absence of any coordinated approach to his care. It is of note that BVD1 again recorded in the weeks before the murder and following Patient G's discharge from Hadrian Clinic (which she had been unaware of) that he would benefit from psychological therapy.

Had a transfer to Plummer Court been effected, it is likely that a proper assessment of his risks and needs would have been carried out, and he would have benefited from the appointment of a care coordinator or key worker to address his needs holistically.

Recommendation 11

Where patients present with a dual diagnosis, consideration should be given to whether a substitute prescribing service is the best resource to treat that patient. There is no doubt that in this respect the addiction team at Plummer Court have a wide range of expertise which could be deployed effectively, and is contained within one location. This option must be considered when patients such as Patient G present to either mental health or local addiction services. The trust should also ensure that clinical decisions are supported by local training programmes targeted at staff who may be engaged with dual diagnosis cases.

C

The prescribing regimes between Hadrian Clinic and Bridge View seemed to be somewhat haphazard. Inadequate consideration seems to have been given to the impact of constant changes of drugs, the interaction between prescribed medication, and alcohol and street drugs. It is probable that these factors made a very substantial contribution to Patient G's behaviour and presentation. There was encouraging evidence of feedback about Patient G's presentation from the community pharmacist, the neurologist and Bridge View but there was a failure to utilise any advice from the community pharmacist to inform drug choice.

Recommendation 12

There are already clear national and other expert guidelines on the prescribing and administration of benzodiazepines with methadone. Health care providers should ensure there is clear local guidance that wherever possible there should be a single

prescriber. Where more than one prescriber is unavoidable there should be effective communication between them.

Recommendation 13

Where polypharmacy is a feature of clinical management, expert advice should be sought from either hospital or community pharmacists on optimal dosing and potential adverse effects.

4. Inter-agency Working, Communication and Record Keeping

Inter-agency working was limited. Probation did communicate with Bridge View, CATS and housing but it is not clear whether Patient G's full forensic history was passed on to CATS and Bridge View. For example, BVD1 recorded following a discussion with PO1 about Patient G's forensic history 'no mention of a stabbing though'. For whatever reason, there was only a partial sharing of the history of his offending and associated risk factors. Had this been complete, it may have better informed the assessment current and future risk levels.

Following Patient G being discharged by probation, the two key providers, Bridge View and Hadrian Clinic, had little meaningful dialogue and almost none of it was through direct personal contact. There was appropriate exchange or copying in of correspondence at times, but this did not lead to the establishment of effective or coordinated care plans or treatment. At other times, Hadrian Clinic failed to copy Bridge View into important correspondence or discuss important decisions with them. It is extraordinary that the decision made by CP2 in conjunction with SGP3 to discharge him from the Hadrian Clinic in August 2008 was made without any reference to Bridge View and without even notifying them of the decision.

There was some evidence of poor communication between Hadrian Clinic and the CBT Centre at times. For example, the decision by the CBT centre to discharge Patient G when he had failed to arrange an appointment was not notified to Hadrian Clinic, who had made the referral, resulting in a delay of several months in Patient G being seen. Neither Hadrian Clinic nor the CMHT subsequently responded to enquiries made by the CBT Centre as to whether a care coordinator/support worker had been appointed.

The issues identified by CBT as a stumbling block to effective intervention were primarily concerned with concluding investigations into his physical health issues before any real attempt could be made to address Patient G's mental health. These could have been resolved by his GP or any other clinician involved with his care. This was not done and the more substantive recommendations were not pursued.

The input from Patient G's GP was virtually absent. It is noteworthy that of all the professionals involved, GP1 was probably the best informed through frequent correspondence but least active in having any engagement with Patient G. Throughout the period from 2005 to the end of 2008, the one constant who could have overseen his care was the GP but was, in fact, the least involved. This is all the more remarkable considering the potential impact of the hepatic and neurological problems which were present. These are hardly mentioned in practice notes and little or no effort was made to encourage medical intervention. There was little co-ordination when Hadrian Clinic transferred responsibility for prescribing and little evidence of a review by the GP at this time in order to gain a benchmark against which to monitor Patient G's progress. The responsibility and demarcation with Bridge View and Hadrian Clinic was unclear and undefined.

The last two letters to Patient G from Hadrian Clinic were incorrectly addressed and do not appear to have been checked even though his failure to respond led to him being discharged.

There was little, if any, discharge planning by Hadrian Clinic associated with Patient G's disconnection from Hadrian Clinic. It seems that the decision was taken as a response to his non-attendance for clinic appointments. Given that Patient G was a CMHT patient, his care co-ordinator (CP2) should have at least taken the circumstances back to a CMHT meeting for team discussion prior to discontinuation of care and there is no evidence this was done. This discharge was not discussed with Bridge View even though they referred him in the first place.

Shortcomings were identified in record keeping, and, in particular, the loss of records from the CMHT. However, although the CMHT records are lost, little or no response from the CMHT was identified in records held by other agencies which leads the panel to believe that record keeping within the CMHT was deficient, and that the CMHT failed to feed back to agencies who had made referrals.

Recommendation 14

All clinical records should be contemporaneous, legible, attributable and dated. Further, the Trust should continue its efforts to audit the quality of its note keeping. In addition there should be an indication in each clinical record of the reasons why a patient is engaged with the service, what the treatment plans are and what the ideal outcome should be. This should be agreed and understood between the clinician and the patient and subject to regular review.

Recommendation 15

Trusts should consider more diverse methods of contacting patients, e.g. by the use of mobile phones or text message to better promote attendance at appointments.

Recommendation 16

Non-attendance at clinic should not be used in isolation as a reason to discharge a patient from care. It should be for the care coordinator/lead clinician to review all current and future issues affecting the patient and to consider the views of other agencies with a regular input prior to a decision being taken which terminates care provision. Contingency planning arrangements should be established and clearly communicated to the patient.

Recommendation 17

GPs should ensure that opportunities exist within their practice to undertake case reviews. This is particularly important when patients are being managed by other professionals on their behalf and there is a regular flow of information arriving from those agencies. There are also opportunities within primary care for counselling and other psychological services and GPs should consider whether these services could have an impact on the overall clinical situation.

Recommendation 18

Commissioners should review the model of service provision for addiction services with particular reference to emerging good practice in shared care, supporting GP intervention in this client group.

The adequacy of the service response to individuals with a dual diagnosis is worthy of consideration. It is unlikely that anyone could have predicted that Patient G would commit murder at the time he did. Whether it was preventable is purely speculative as his offending history was in the past.

He was discharged from mental health services in December 2008 when he failed to keep his appointments. He was noticed to have deteriorated in November by his lead clinician at Bridge View when she returned from extended leave. It was recorded that Christmas time was a bad time for Patient G because of past incidents and he was short of money at the time leading up to the offence. It is possible that had he been attached to a regular care coordinator/key worker, these changes would have been noted and possibly acted upon.

Although it is not possible to find that the murder of Victim G could have been prevented, it is possible that the risk of such a tragic event occurring could have been reduced.

- A serious violent event was predictable but the form that would take and its timing, was not.
- There is some similarity between his conviction for robbery and the homicide – namely the victims were both elderly and apparently vulnerable, intoxication was present and the crimes were driven by an acquisitive impulse.

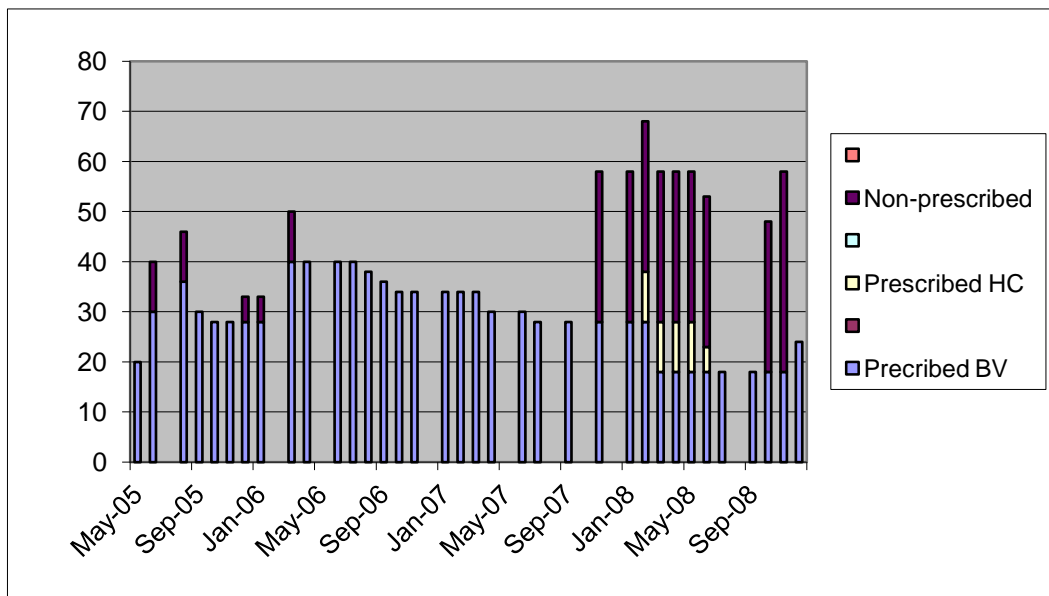
- There was significant information available most of which was in the records to suggest that he presented a risk to the public. There was no management plan that responded to those areas of concern.
- There was minimal evidence of his homicidal and indeed his suicidal ideation being explored by his many clinicians.

There was thus potential for prevention, and a significant reduction in risk would have been achievable if Patient G's treatment had been better delivered and managed.

Appendix 1

Diazepam Equivalent Dose (in mg) Street vs Prescribed

	Prescribed BV	Prescribed HC	Non-prescribed
May-05	20	0	
Jun-05	30	0	10
Aug-05	36	0	10
Sep-05	30	0	
Oct-05	28	0	
Nov-05	28	0	
Dec-05	28	0	5
Jan-06	28	0	5
Mar-06	40	0	10
Apr-06	40	0	
Jun-06	40	0	
Jul-06	40	0	
Aug-06	38	0	
Sep-06	36	0	
Oct-06	34	0	
Nov-06	34	0	
Jan-07	34	0	
Feb-07	34	0	
Mar-07	34	0	
Apr-07	30	0	
Jun-07	30	0	
Jul-07	28	0	
Sep-07	28	0	
Nov-07	28	0	30
Jan-08	28	0	30
Feb-08	28	10	30
Mar-08	18	10	30
Apr-08	18	10	30
May-08	18	10	30
Jun-08	18	5	30
Jul-08	18	0	?
Sep-08	18	0	?30
Oct-08	18	0	30
Nov-08	18	0	40
Dec-08	24	0	0



List of abbreviations

- ASBO: Anti-Social Behaviour Order
- BVD: Bridge View Doctor
- BVN: Bridge View Nurse
- CATS: Community Addiction Team
- CATS/CAT service: Crisis Assessment and Treatment Service
- CBT: Cognitive Behaviour Therapy
- CCP: Chartered Clinical Psychologist
- CMHT: Community Mental Health Team
- CP: Consultant Psychiatrist
- CPA: Care Programme Approach
- CPN: Community Psychiatric Nurse
- CRO: Community Rehabilitation Order
- CSO: Community Service Order
- DIP: Drug Intervention Programme
- DISC: Developing Initiatives Supporting Communities
- DTTO: Drug Treatment and Testing Order
- DNA: Did Not Attend
- EDP: Early Discharge Planning
- EDT: Emergency Duty Team
- FACE: Functional Assessment of Care Environment
- FCT: Forensic Community Team
- HBT: Home Based Treatment
- HCR: Historical Clinical Risk
- HP: Hepatologist
- HR: Hostel Resident
- LSN: Liver Specialist Nurse
- MAPPA: Multi Agency Public Protection Arrangements
- MDT: Multi Disciplinary Team
- MHS: Mental Health Services
- NECA: North East Council for Addictions
- NFA: No Further Action
- NICE: National Institute for Clinical Excellence
- NP: Neurophysiologist
- NTW: Northumberland Tyne and Wear NHS Foundation Trust
- OASys: Offender Assessment System (Probation)

- OTO: One to One (Probation)
- PCT: Primary Care Trust
- PO: Probation Officer
- PTSD: Post Traumatic Stress Disorder
- RiO: Electronic recording System used by NTW
- SGP: Staff Grade Psychiatrist
- SHO: Senior House Officer
- YOI: Youth Offender Institute

Bibliography

This list contains documents which may either be referred to in the report or have been accessed by panel members in compiling the report.

1. Effective Care Coordination in Mental Health Services –Modernising the Care Programme Approach - NHS Executive policy booklet October 1999
2. Care Programme Approach - Department of Health 1990 (HC)90 23/LASSL(90)(11)
3. National Service Framework for Mental Health - Modern Standards and Service Models Department of Health 1999
4. Clinical and multidisciplinary records provided by mental health services during the period 1996-2009
5. Social services records
6. Probation records
7. Police records
8. Court records
9. Serious Incident Management Review into the Care and Treatment of 2009/131 – Northumberland, Tyne & Wear NHS Trust. May 2009
10. National Service Framework Mental Health Policy Implementation Guide – Department of Health 2001
11. Multi Agency Public Protection Arrangements for Vulnerable People – Association for Directors of Social Services 1997
12. Multi Agency Public Protection Arrangements (MAPPA) – National Probation Service 2001
13. MAPPA (Multi Agency Public Protection Arrangements) Policy – Newcastle, North Tyneside and Northumberland Mental Health NHS Trust. March 2006
14. MAPPA (Multi-Agency Public Protection Arrangements) Policy - Northumberland, Tyne & Wear NHS Trust. February 2007
15. Personality Disorder – No Longer a Diagnosis of Exclusion – Policy Implementation Guidance for People with Personality Disorder – Department of Health January 2003.
16. Newcastle and North Tyneside Crisis Assessment and Treatment Service Operational Policy - Newcastle, North Tyneside and Northumberland Mental Health Trust. February 2004
17. National Probation Standards 2000
18. National Probation Standards 2005
19. Refocusing the Care Programme Approach (Policy and Positive Practice Guidelines) – Department of Health March 2008
20. National Drug Treatment Monitoring System (NDTMS) – National Treatment Agency for Substance Misuse. March 2011

21. New Ways of Working for Psychiatrists, Enhancing Effective Person Centred Services through New Ways of Working in Multi-Disciplinary and Multi-Agency Contexts - Department of Health October 2005
22. Profile of Working Age Adult Services within Northumberland, Tyne & Wear NHS Trust – Northumberland, Tyne & Wear NHS Trust. May 2008.
23. Giving Up the Culture of Blame – Risk Assessment and Risk Management in Psychiatric Practice. Royal College of Psychiatrists. February 2007.
24. Forensic Community Mental Health Team Service Specification – Northumberland Tyne & Wear NHS Foundation Trust. Undated.
25. Adult Forensic Services Community Personality Disorder Team, Service Specification - Northumberland Tyne & Wear NHS Foundation Trust. 2010-2011
26. Service Directory for Service Users – Safer Newcastle Drug Support Unit. Undated
27. Drug Misuse and Dependence – UK Guidelines on Clinical Management. UK Health Departments. September 2007
28. Post-Traumatic Stress Disorder – The Management of PTSD in Adults and Children in Primary and Secondary Care. National Institute of Clinical Excellence. March 2005
29. Clinical Supervision Policy - Newcastle, North Tyneside and Northumberland Mental Health Trust. May 2003.
30. Interagency Procedures and Practice Guidance - Prevention of and Response to the Mistreatment of Vulnerable Adults . Newcastle & North Tyneside Health Authority. October 2001
31. Working in Partnership with Psychiatrists and Carers - A Checklist for Psychiatrists. Royal College of Psychiatrists. December 2004
32. County of Northumberland's Practice Guidelines for the Protection and Empowerment of Vulnerable Adults. September 2003.
33. Housing LIN Briefing – Care Services Improvement Partnership. 2008
34. Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide. Department of Health. 2001
35. Offender Mental Health Care Pathway – National Institute for Mental Health in England. January 2005
36. Safeguarding Vulnerable Adults Procedure – Northumberland, Tyne & Wear NHS Trust. February 2007
37. Policy for the Management of People with Dual Diagnosis – Northumberland, Tyne & Wear NHS Trust. February 2009
38. Data Confidentiality Code of Conduct, Policy and Procedure - North East Strategic Health Authority. March 2011
39. Transfer of Personal Information Policy - North East Strategic Health Authority. March 2010
40. Annual Report and Accounts 2006/2007. Northumberland, Tyne and Wear NHS Trust
41. General Medical Council - 'Good Medical Practice', 2001

- 42.** Best practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services - Department of Health July 2007
- 43.** AL(MD) 4/97: Terms and conditions of service for the staff grade - Department Of Health July 1997