Independent Investigation into the Care of 'R' by Nottinghamshire Healthcare NHS Trust and Northamptonshire Healthcare NHS Foundation Trust

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The Independent Investigation Panel extends their thanks to the co-operation and assistance provided by the victim's sister, members of the extended family, his daughter and her partner, and to R's mother. They assisted us in understanding and incorporating the victim and carer perspectives into this investigation and report.

The Panel members express their sympathy to the victim's family for their tragic loss.

Contents

List of Abbreviations and Personnel

Organisational	
CAN	Council on Addictions Northamptonshire (CAN is an independent regional agency, established in 1972, which provides a range of drug, alcohol and homelessness services throughout Northamptonshire and Bedfordshire)
CFT	Community Forensic Team
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPS	Crown Prosecution Service
DLA	Disability Living Allowance
DPSD	Dangerous and Severe Personality Disorder
HMP	Her Majesty's Prison
NDAS	Northamptonshire Drug and Alcohol Service
MAPPA	Multi-agency Public Protection Arrangements
MHAC	Mental Health Act Commission
MHRT	Mental Health Review Tribunal
NPSA	National Patient Safety Agency
PCT	Primary Care Trust
RCA	Root Cause Analysis
Trust 1	Nottinghamshire Healthcare NHS Trust (provider of HSH and MSU which provided care for R)
Trust 2	Northamptonshire Healthcare NHS Foundation Trust (Provider of Community Forensic Mental Health service which provided care for R)
Personnel	
ASW	Approved Social Worker
Community FP	R's Community Consultant Forensic Psychiatrist (Trust 2)
Consultant FP	R's Consultant Forensic Psychiatrist (HSH, Trust 1)
CFT-CC1	R's first Community Forensic Team Care Coordinator (Trust 2)
CFT-CC2	R's second Community Forensic Team Care Coordinator (Trust 2)
CFT-CC3	R's third Community Forensic Team Care Coordinator (Trust 2)
CFT-CC4	R's fourth Community Forensic Team Care Coordinator (Trust 2)
CFT-CC5	R's fifth Community Forensic Team Care Coordinator (Trust 2)
Consultant W	Consultant Psychiatrist, responsible for R whilst he was a patient of the MSU (Trust 1)
Dr 1	Junior doctor on placement with CFT

Dr 2	Junior doctor on placement with CFT
GP	General Practitioner
PACO	Principal Accommodation and Commissioning Officer
PSW	Principal Social Worker
R	Perpetrator
RMO	Responsible Medical Officer
SMW	Substance Misuse Worker
V	Victim
Y	Young woman associated with V, known to R

1 Executive Summary

1.1 Introduction

1.1.1 The practice of two NHS Trusts which were involved in providing specialist assessment, treatment and care of R were examined in the course of this Independent Investigation, as was the multi-agency cooperation within R's home area.

1.1.2 Nottinghamshire Healthcare NHS Trust is referred to in this report as Trust 1, this included the High Security Hospital (HSH) and Medium Secure Unit (MSU). Northamptonshire Healthcare NHS Foundation Trust (providing the Community Forensic Mental Health Team) is described as Trust 2.

1.1.3 In September 2008 R, then aged 37, unlawfully killed a 67 year old man who was unknown to him but whom he believed to be exploiting a female acquaintance (there was no evidence to substantiate this). R had been discharged from a MSU of Trust 1 where he had been a patient for seven months having previously been a patient in a HSH, also of Trust 1, for some twenty two months and having been assessed in their Dangerous Severe Personality Disorder (DSPD) unit. Following R's assessment in this unit he was not judged to meet the criteria for that particular service. R had been voluntarily supervised by a community based forensic team of Trust 2 following his discharge from the MSU and his detaining hospital order. R engaged sporadically with the community team and was reverting to his old habits of drug abuse, intimidating others and abuse of his partner.

1.1.4 Prior to his admission to hospital R had served, after remission, some nine years in prison with one year in the community in-between two long sentences for serious robbery, burglary and assault. R had volunteered and actively sought admission to a secure psychiatric hospital to attempt to address his personality difficulties

1.1.5 R had been in the community for a period of one year prior to this homicide. The Community Forensic Mental Health Team (CFT), under the oversight of the Community Forensic Psychiatrist, (Community FP) was placed in a difficult situation in attempting to offer R support on his discharge. They were steadfast in their efforts and agreed to continue offering oversight when they had discussed discharging him from their service.

1.1.6 R had suffered repeated and persistent emotional abuse in his childhood from his father and exhibited signs of conduct disorder and delinquency from his childhood. R had serious problems in his capacity for satisfactory interpersonal relationships. R suffered from a mental disorder which manifested itself as a degree of emotional instability with low tolerance to frustration: there was a maladaptive behaviour pattern involving a tendency to act impulsively with both verbal and physical aggression without consideration for the consequences.

1.1.7 Following the incident both Trust 1 and Trust 2 commissioned their own internal investigations and the independent investigation panel concurred with the findings and recommendations of Trust 2's internal report into this homicide. The report of Trust 1 invited comment on the appropriateness of the MSU's decision making. The Consultant Forensic Psychiatrist undertaking this peer review concluded, "That in my opinion their approach was one that would have been taken by a responsible body of clinicians." The report made no recommendations although it noted that the reviewer experienced difficulty obtaining information from the HSH, "even for the purpose of this enquiry" and stated that, "serious consideration should be given to reviewing the operation of its (the HSH) Information Governance department".

1.1.8 The Panel interviewed key stakeholders and reviewed R's health record (with R's consent), and a review of appropriate documentation, including relevant policies and procedures.

1.2 Purpose

1.2.1 The independent investigation was commissioned by NHS East Midlands. An independent investigation is required when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the event. The purpose is to examine all the circumstances surrounding the care and treatment provided and in each case to identify any errors or shortfalls in the quality of the service and to make recommendations for improvement as necessary. This investigation and report is in compliance with Department of Health "Guidance on the discharge of mentally disorded people and their care in the community" (HSG (94) 27).

1.2.2 The Independent Investigation Panel was required to address Terms of Reference agreed by NHS East Midlands and key stakeholders, set out in full in Section Two of this report.

1.3 Methodology

1.3.1 The independent investigation process was informed by interviews with:

- R
- R's mother
- Key staff involved in R's care, treatment and commissioning of care:
  - Consultant Psychiatrist W of Trust 1
  - The community based Consultant Forensic Psychiatrist of Trust 2
  - The Principal Accommodation and Commissioning Officer (PACO), Primary Care Trust (PCT)
- Relatives of the victim –sister, members of the extended family, daughter and her partner.

1.3.2 R gave signed consent to access his clinical and other relevant records, and to publication of relevant information.

1.3.3 Written statements had been made to the Internal Review Team by clinical staff of Trust 2 and a detailed response to the internal review report of Trust 2 by Consultant W and Trust 1 was also taken into account.

1.3.4 Extensive documentation was reviewed by the Independent Investigation Panel (details in Appendix One)

1.3.5 Northamptonshire Police did not cooperate with this independent investigation. In the absence of the police Statement of Case the Independent Investigation Panel were only able to account for the events leading to the homicide as contained in the sentencing transcript from the court's stenographer service.

1.3.6 The Panel utilised the Root Cause Analysis approach in carrying out this investigation

1.4 Summary of Contributory Factors and Findings

1.4.1 The contributory factors and findings are located in more detail at the end of the report. The following is an abbreviation of these:

1.4.2 Admission to the HSH for assessment and treatment was the correct decision as not only did R see the potential for the death of someone by his own hand, the assessing Consultant Forensic Psychiatrist concurred with this by stating that he would have posed a grave and immediate danger to the public should he have been released from direct supervision.

1.4.3 On admission to the HSH R experienced a different environment to that which he had anticipated. The option he had requested was personally challenging in having to begin to face his difficulties rather than being incarcerated in prison. Admission to this type of hospital demands a rejection of the ambivalence to treatment he went on to exhibit. Staff at all levels of care in Trust 1 and 2 were then faced with the complexity of dealing with R's personality disorder.

1.4.4 R's request to receive assistance was fleetingly insightful but unfortunately when in receipt of the help he requested he launched into criticism of his situation and wanted immediate results and rapid progress through the system. R had been advised that he may be detained for some five years in high security and possibly another two years in medium security. R spent a little over a third of this time in secure care. Simply put, had the original time scales told to R been adhered to (the Panel thought these appropriate and proportionate to R's presentation and identified needs); at the time of the homicide R would have still been in a HSH with his actions being challenged in a safe environment; consequently R would not have been able to commit the offence against V.

1.4.5 R caused disruption within the ward areas, was abusive to female nursing staff and bullied less able patients in both secure units and was intimidating. Even when in the firm structure of the DSPD Unit R continued this behaviour and needed seclusion on occasion for various reasons.

1.4.6 On a positive note R engaged in all psychological assessments offered and engaged well with the Clinical Forensic Psychologist and understood and cooperated in these processes. R attended education classes and entered these positively. R exhibited creativity in workshop facilities. It was R's behaviour in the ward environment which caused difficulties; a situation which was repeated in the MSU. Difficulties in his interpersonal relationships were played out in the HSH with R clearly demonstrating his controlling and threatening relationship with his partner, which resulted in monitoring R's telephone calls to her. There was no recorded evidence that R's difficult interpersonal relationships with family members and partners were explored in either secure setting.

1.4.7 Care Programme Approach (CPA) planning was thorough and well recorded and the analysis of R's clinical presentation was accurately observed. The decision to take the path of transfer to lesser security and the assumption that this was the appropriate course of action was never questioned. When R was not considered as fitting the then criteria used to determine DSPD status his return for longer term treatment to the Personality Disorder Unit Directorate was not considered, or not recorded, although it was requested by R as evidenced in his clinical notes. At all subsequent CPA meetings both in high and medium secure settings there was no dissent within the multidisciplinary teams, or from the Commissioners of services, as R was pushed towards discharge.

1.4.8 The CPA planning at all three levels of care in high secure, medium secure and community require comment as per the terms of reference. All were timely with the most thorough diagnostic analysis being undertaken within the high secure environment. This established the detail of R's personality and functioning. However the knowledge built up by investigation and observation appeared to dissipate when making sensible decisions on R's next phases of treatment and containment. Overall there was significant reliance on the support R had from his family. The CFT was more realistic in what they could achieve when R was not subject to detention.

1.4.9 There was much discussion concerning the offending behaviour of R and the truth around what he had said by way of embellishment of his violent actions in order to achieve admission to the HSH. There was no record of any attempt to corroborate these claims although R had received a lengthy prison sentence for five robberies. The details of these were described by the prosecution counsel at R's trial sentencing hearing for the manslaughter of his victim. The detail of these robberies could have been sought from the original sentencing crown court and would have confirmed his propensity for violence.

1.4.10 Having been assessed as not fitting the DSPD criteria the plan developed was to transfer R to the newly commissioned personality disorder unit at the MSU. Consultant W from the MSU attended review meetings and appropriately requested attendance of a clinical team who would offer aftercare on discharge from medium security. The commissioners attending did not arrange for this allocation to take place and no community based team from Trust 2 was identified until a few weeks before R's ultimate discharge. Commissioning members of staff from the PCT's Individual Packages of Care Team (IPC) had been in attendance at CPA review meetings at the high and medium secure hospitals. This team deal with requests to fund placements and assisted with locating and accessing suitable placements for individual patients. As such placements could be in a wide range of services, including the independent sector and out of county placements, local services were not invited to become involved until the placement was closer to agreement. The IPC team's stated view is that they were considering options with R, all of which he declined, and that the MSU made separate contact with the Borough Council of R's home area. This resulted in the allocation of temporary accommodation by the council under its homeless person's provisions. It then became appropriate to enlist the services of the CFT of Trust 2 once R's place of discharge had been decided upon by the MSU. The IPC view was that this was a poor choice of placement for R.

1.4.11 R's transfer to the HSH, close to his expected date of release from prison, was badly timed and this practice of transfer, close to the expected date of release, has now ceased as a consequence of a recent court case. The prison service knew R's behaviour well and until his transfer to secure hospital care the prison service had controlled the negative aspects by moving him around various prisons, thus preventing him establishing himself in one place. Access to the prison service's DSPD unit was available for referral early on into his prison sentence. Had R been assessed for and given treatment in such a unit he would have been eventually discharged from prison to supervision on license from the Probation Service with sanctions available should he not comply with the expectations of conditions imposed upon him during the life of the license period.

1.4.12 As it was, R's referral to HSH care resulted in a Transfer Direction under Section 47 of the Mental Health Act 1983. The Direction under Section 47 therefore had the same effect as a hospital order under Section 37 of the Act without restrictions under Section 47/49. Such Hospital Orders can be discharged by the patients Responsible Clinician or on appeal/review to Hospital Mental Health Act Managers. (Restricted patients can only be discharged conditionally or absolutely by a Mental Health Tribunal chaired by a Judge who would review arrangements made for transfer to conditions of lesser security or the community. Hospital Mental Health Act Managers cannot hear such cases. Conditional discharge of restricted patients includes regular reporting to the Mental Health Unit at the Ministry of Justice by the patient's social supervisor and supervising psychiatrist on their activities. Such conditions may last without limit of time. Should problems in supervision

or adherence to specific conditions cause concern the patient can be recalled to hospital). Once Consultant W discharged R's hospital order when he was discharged to the community the option of recall and monitoring by an external agency was not available.

1.4.13 In addition for all restricted patients there is clear guidance for the arrangements which need to be in place prior to discharge. These were available prior to R's discharge and despite him not being restricted they could have been referred to as good practice. They have been updated and published by the Ministry of Justice as 'Guidance for Social Supervisors' and 'Guidance for Clinical Supervisors', March 2009.

1.4.14 Annex B: 'Summary of Recommendations for good practice for staff of the discharging hospital' in the social supervisor's guidance gives nineteen points for consideration by the discharging hospital. These include transfer of comprehensive documentation to those who will take up supervision and responding helpfully to those requests for further information. In R's case there were reported difficulties made to the Panel in obtaining information requested by MAPPA (full details of the MAPPA process are in Appendix Four) and the supervising Community Forensic Team, in particular from the HSH. The Panel were however unable to locate correspondence seeking such. Points 9, 10 and 11 cover the issue of suitable accommodation and point 10 states, *"it is important to identify suitable accommodation and to specify which types of accommodation would not be appropriate for individual patients",* with point 11 adding, *"there should be no question of a patient going automatically to unsuitable accommodation simply because a place is available…"*

1.4.15 The temporary accommodation R was discharged to from the MSU was described to the Panel by R when interviewed in prison and by his mother. Two of the Panel members visited the accommodation and area in which it was located and to them it appeared to be unsuitable for a patient leaving a lengthy period of time in prison and intensive assessment, treatment and care in secure hospitals.

1.4.16 R described how he had to put a padlock on his door, there being no bed and the place being filthy and smelling of urine. Others in the accommodation were drunk, using drugs and shouting at night. R had to share a bathroom and toilet facilities with them. R found this depressing as he is clean, ordered and tidy and was finding the transition difficult enough. The description of the temporary accommodation was confirmed by R's mother. R had the additional problem that his benefits had not been established. The Panel concluded the accommodation R was discharged to was inappropriate. Arrangements eventually had to be made for R to obtain General Practitioner (GP) services by visiting the custody suite in a local police station.

1.4.17 The staff in the CFT in Trust 2 had to attempt to engage with R on his discharge on a voluntary basis and R could accept or reject their approaches to assist him on his own terms. The team coped with R's chaotic, demanding and intimidatory nature as he engaged and disengaged with them for a year before he killed his victim. R was considered

too high risk for staff to conduct lone visits and staff only met with him when in pairs. This team discharged their duties consistently and steadfastly to provide what aftercare they could for R.

1.4.18 The discharge of R from the HSH appeared to the Independent Investigation Panel to be precipitate (as evidenced from the proposed psychological treatment in the HSH which suggested a 5 year period of treatment, echoing the admitting RC's view) and that from the MSU even more so. Whilst R was judged as meeting the criteria of 'grave and immediate danger' on admission to the HSH (as evidenced by the admitting RC's statements to the Mental Health Review Tribunal (MHRT)); the panel agree that it was appropriate to attempt to manage him in a MSU. However, the MSU at that time did not have the availability of a psychologist to continue R's treatment and to allow what appeared to be the pace of his treatment in the MSU to be dictated by R through his negative behaviour was difficult to comprehend. That discharge was ill advised and should have been tempered with extreme caution.

1.4.19 When R's behaviour was difficult to tolerate in the medium secure service a return from trial leave to high secure care should have been requested to be considered.

1.4.20 A conversation was held on the 24th of June 2010 with the Responsible Medical Officer at the HSH who had agreed to transfer R to the MSU for a period of trial leave and had later agreed to the request from the MSU that they should take responsibility for him. The question was put to him what would the reaction have been if the HSH had been asked to take R back from trial leave. His answer was that this had been discussed and that if this happened the HSH would have taken him back without entering protracted discussion and would further reassess him without risk to others. Once the MSU had taken responsibility for R and his trial leave from the HSH was terminated the ease of return would have been subject to more rigorous assessment.

1.4.21 What R himself had predicted prior to his release from prison and was the main valid reason he sought psychiatric help indeed eventually happened with the death of an innocent victim who had no knowledge of R and who was visited by him because of his acquaintance with a young woman who R had set out, for his own reasons, to 'rescue' from this frail and elderly man.

1.4.22 R is now detained in prison on an indeterminate prison sentence, treated as if serving a life sentence. On reflection from R's point of view it may have been more helpful to have spent more years in high security care being helped further to face the dominant and unhealthy part of his personality.

1.4.23 The Independent Investigation Panel have concluded that R was not ready for discharge into the community from medium secure care. Once R continued to show behaviour he had displayed in high secure care in the medium secure hospital R should have had his trial

leave terminated and been returned to conditions of high security for further treatment. The ability to do this was impeded by the MSU service having terminated R's trial leave prematurely. The MSU should have taken the full advantage of the full trial leave period to fully understand R's risk and engage him more fully in the treatment process. The discharge of R was ill advised and poorly structured. R was in a new and secure purpose built unit designed to deal with the challenging behaviours he and other patients were exhibiting.

1.4.24 The Panel concluded that it was inappropriate of the MSU care team to decide that R should not be referred to the MAPPA manager. Given R's violent offences and the length of his sentence, referral to MAPPA was required. Once referred by Trust 2, the MAPPA process worked effectively, in that staff worked to inform R's new partner and protect her. It was however difficult for the Community Forensic Team (CFT) members of MAPPA to keep informed of R's behaviour given his intermittent engagement with the service.

1.4.25 The Panel considered that more effective coordination between the work of the CFT and Team 63 (the specialist Personality Disorder service of Trust 2) might have enhanced the care that the CFT were able to offer R, through assessment and guidance to the CFT when R was in the community.

1.4.26 The Independent Investigation Panel reviewed the internal review carried out by Trust 2. Overall, the Independent Investigation Panel considered that the internal report from Trust 2 was detailed and thorough, and that its findings are in line with those of this Independent Investigation report.

Recommendations

When commissioned to undertake this investigation the Panel members were required to look wider than just a review of the events under scrutiny. Part of this wider review was the reassurance of the public that the organisations involved have moved on in their service provision in their work with this challenging range of patients. For example Trust 2 has progressed in the area of risk assessments and published clear documentation on this. The following recommendations affecting Trusts 1 and 2 are made in pursuing the reassurance of the public and incorporate current government thinking and service direction.

1.5.1 Commissioners of services must ensure the early involvement of clinical teams with patients when the first steps of planning movement between services are proposed and to monitor attendance of the appropriate staff at any planning meetings. Early dissent on the appropriateness of moves should be aired and resolved. Commissioners must be cognisant of the time assessment of such patients takes and make budgetary adjustments to accommodate this.

1.5.2 Patients with a diagnosis of personality disorder admitted to secure units from HSH care on six months Section 17 leave should have this amount of time allowed to pass before

accepting the full legal responsibility for them. In the case of R, this was Trust 1

1.5.3 The Guidance for Social Supervisors and Guidance for Clinical Supervisors (Ministry of Justice, 2009) should inform good practice and be adopted by all clinical staff and operational managers in secure units when discharging all patients to community settings.

1.5.4 Trust 2 should undertake a review of services for offenders with a personality disorder. This should be conducted taking into consideration the policy guidance of the 'Consultation on the Offender Personality Disorder Pathway Implementation Plan' Department of Health and Ministry of Justice (NOMS), February 2011. The Trust, within this review, should work with other agencies to agree and describe improved pathways out of healthcare and prison units. Commissioners of such services and stakeholder agencies should form part of the review. In further consideration of the change the governments wish to make in forensic services, the review should include in their considerations the government's response to Lord Bradley's, 'Report on people with mental health problems or learning disabilities in the Criminal Justice System'.

1.5.5 Local MAPPA should be given as much notice as possible and information of returning offenders from secure care and recommend a minimum of six months prior to discharge is adopted in all cases.

1.5.6 Trust 1 should record the source of information regarding the detail of offences committed by patients, checking the detail of the offence(s).

1.5.7 Trust 1 should closely examine offences and offending behaviour described by the patient, making appropriate enquiries to verify the patient's account.

1.5.8 Trust 1 should consider peer review of patients with personality disorders who are to be discharged into the community without statutory supervision.

1.5.9 Trust 1 should always consider if a Community Treatment Order would be appropriate in all cases of patients being discharged from secure hospital care who are not subject to supervision on a restriction order.

1.5.10 Commissioners of forensic services should acknowledge the time-consuming nature of this work and plan to commission services accordingly. An audit of the time taken in planning for the support and assessing ongoing risk factors of patients returning to the community from secure psychiatric care should be undertaken to help demonstrate the complexity they pose and the re-evaluation of the allocation of resources and identification of gaps in provision.

1.5.11 Trust 1 and 2 should reacquaint themselves with the guidance 'Information Sharing and Mental Health', Department of Health, September, 2009.

2 Terms of Reference and Principles of Investigation.

2.1 Terms of Reference

Undertake a systematic review of the care and treatment provided to R by Trust 1 and Trust 2 to identify whether there was any aspect of care and management that could have altered or prevented the events of 11 September 2008.

The investigation team was asked to pay particular attention to the following:

- To review the quality of the health and social care provided by the Trusts and whether this adhered to their policies and procedures, including:
    - To identify whether the Care Programme Approach (CPA) had been followed by the Trusts with respect to R and establish if deficiencies were material in the case;
    - To identify whether the risk assessments of R were timely, appropriate and followed by appropriate action;
    - To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;
    - Application of the Mental Health Act
- To examine the referral and discharge process between the HSH and the MSU including the management of any trial leave during 2007
- To examine R's care and treatment whilst at a MSU and the management of the extended periods of leave he was granted during 2007
- To examine the referral and discharge process from the MSU to the Community Forensic Team in Trust 2 in September 2007
- To examine the role of the care coordinator and the interrelationship between the Community Forensic Team and the Personality Disorder Team (Team 63) in Trust 2 in providing care and supervision to R
- To examine the role of the various agencies involved including the Ministry of Justice and the collaboration between these agencies and both Trusts.
- To examine the effectiveness of the MAPPA process in the management of R.
- To establish whether the recommendations identified in the Trusts internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trusts in response these recommendations

- To identify any learning from this investigation through applying Root Cause Analysis (RCA) tools and techniques as applicable

- To report the findings of this investigation to East Midlands Strategic Health Authority.

2.2 Principles

2.2.1 **Approach.** The investigation was not to duplicate the earlier internal investigations; this work was commissioned to build upon the internal investigations.

2.2.2 **Publication.** East Midlands Strategic Health Authority will determine the nature and form of publication of the outcome of this review. The decision on publication will take into account the view of the Chair of the Investigation Panel, relatives and other interested parties.

2.2.3 **Data Protection.** The completed investigation report contains details of the clinical care and treatment the service user received and is therefore subject to the Data Protection Act and if made public could also breach the Human Rights Act. It is the responsibility of NHS East Midlands to ensure that there is a balance within the report that would protect the rights of those individuals involved in the incident whilst also discharging its duty to publish what is deemed to be in the public interest.

2.2.4 **NHS East Midlands Policy for Managing and Investigating the Most Serious Events in Mental Health Services.** This specific policy indicates that a key reason for commissioning an independent investigation is to ensure that lessons are learned, that the quality and effectiveness of services are continually improved and that the public and patients have confidence in its services. In achieving this objective the independent investigation team has to ensure that there is openness and transparency in the investigation process and that the public interest is served by this process. However the NHS has a duty to maintain and protect the rights of patients and their families to confidentiality. The independent investigation therefore needed to fully explore the relevant facts, documents and records without compromising those rights.

2.2.5 **Support to Victims, Perpetrator, Families and Carers.** When an incident leading to death or serious harm occurs, the needs of those affected need to be of primary concern to the Foundation Trust, Strategic Health Authority and the Independent Investigation Panel. This should be reflected through the principals of the National Patient Safety Agency (NPSA) guidance, which are:

- the principle of acknowledgement,
- principles of truthfulness, timeliness and clarity of communication,
- the principle of apology.

2.2.6 The families of the victim and perpetrator within this process were contacted and in this case where reasonable were offered a meeting with the Independent Investigation Panel. In general families wish to:

- know what happened
- know why it happened
- know how it happened
- know what can be done to stop it from happening to anyone else; and,
- tell their account of events.

2.2.7 It is important that the debate on the matters of public concern which arise from this case are grounded on an accurate and full account of the facts which may have hitherto been denied. It would be unfair to the public, relatives of the victim, relatives of the perpetrator and for the perpetrator himself for the debate to be concluded without knowledge of the facts.

2.2.8 Procedure. All inquiries have to consider what procedure is appropriate for the particular issues to be considered. The objectives must be to conduct an inquiry which as far as is practicable:

- investigates the matters within the terms of reference thoroughly;
- ensures objectivity;
- ensures all the relevant information is considered;
- is fair to those who are under scrutiny;
- recognises the position and interests of all those concerned with the events which led to the inquiry.

2.2.9 Principles. The Independent Investigation Panel believes that at the core of any mental health service delivered to people with a mental disorder there must be four principles:

- clarity in current diagnosis, objectives, needs, changing the diagnosis, needs and risk assessment and the strategies to clarify and deal with them;
- coordination of the delivery of service, sharing of information and action;
- checking on the outcome of service provision by regular review;
- changes in the diagnosis needs and risk assessments, and service provision in light of the review.

3 Methodology

3.1 Data Collection and Analysis

3.1.1 **Consent** was sought from and given by R to access relevant health and criminal justice records prior to these being seen by any member of the Panel. This included consent for relevant information from these sources to be included in the published report. R was sent information about the scope of the investigation and its terms of reference, details of the Independent Investigation Panel and how it would proceed. R agreed to be interviewed: this was carried out in prison by the Lead Investigator.

3.1.2 Information about the scope of investigation, its terms of reference and procedures, and information about the Panel members was sent to relatives of V, R's mother and staff who were invited to interview. The victim's relatives were contacted with the help of the staff of the local probation Trust as was R's nearest relative.

3.2.3 Staff invited to give evidence to the Panel were written to with similar information, although in addition the areas the Panel wished to explore with them were also contained in their individual letter. How the Panel were to proceed with witnesses was subject of a separate note. All staff witnesses were seen in a neutral venue away from their place of work. A verbatim transcript was made available to those who had attended and they were encouraged to add to or explain further any points they wished to expand or clarify.

3.2.4 All staff invited to be interviewed by the Panel did so voluntarily and were open and helpful in their contribution to this independent investigation and we thank them for their candid help. The administration and health records staff of Trust 1 were of enormous help.

3.2.5 Three key staff involved in R's assessments, treatment, and supervision and commissioning of his care were interviewed, including Consultant W of Trust 1; the community based Consultant Forensic Psychiatrist of Trust 2 (CFP) and the Principal Accommodation and Commissioning Officer, Commissioning Primary Care Trust (PACO).

3.2.6 The sister of the victim and members of the extended family were seen at their home by the medical member of the Panel. The daughter of the victim and her partner were seen by the Chair and Lead Investigator at their home. R's mother was also seen, by the Chair and Lead Investigator of the Panel.

3.2.7 The details of these key interviews are described in Appendices Four and Five.

3.2.8 Staff of the two Trusts and the Probation Trust were helpful and responded to all requests for information which was within their gift to do so, or directed us to those who could help. Written statements had been made to the Internal Review Team by clinical staff of Trust 2 and a detailed riposte to Trust 2's internal review report by the Consultant W and Trust 1 was also taken into account.

3.2.9 Requests for information were made to the criminal justice agencies involved with R, through the MAPPA joint chairs. The MAPPA Senior Management Board was positive in their initial response, wishing to support the Independent Investigation insofar as it was to consider the actions of their staff in connection with the mental health process, as long as this did not cover ground already considered by the criminal justice agencies own scrutiny of events prior to the incident. They were also concerned that some sensitive material was not to be disclosed specifically but only as generalisations.

3.2.10 Relevant MAPPA minutes, relating to R's management were eventually made available to the Independent Investigation Panel after protracted correspondence. Minutes of MAPPA meetings provided contained only action points; further information was gleaned from documents held by Trust 2.

3.2.11 However, after repeated requests, the local County Constabulary decided not to give the Panel access to the documentation prepared for the prosecution case. This statement of case helps give a clearer indication of the events of the homicide and the accuracy of what is recorded in reports and can confirm, or not, the patient/perpetrator's and others accounts. This information helps establish a base-line of the index offence and greatly aids or confirms the account of the patient and helps describe their particular pathology evident during the event. It also helps, in many instances, to clarify facts for victim's relatives.

3.2.12 In the light of no response from the MAPPA Manager to the request for help in obtaining the prosecution case papers, the Lead Investigator approached the Crown Prosecution Service (CPS). The CPS were responsive and would have obtained the relevant documentation, but a request for confirmation from them to the relevant police superintendent led to the information being withheld.

3.2.13 Eventually, seven months after the initial approach, the Independent Investigation Panel had to take the alternative route of purchasing the transcript of the sentencing proceedings in relation to R at further public expense. This information, whilst of significant assistance in providing an alternative version of events to that provided by R, did not provide the level of detail which would have been available in the prosecution case papers.

3.2.14 The Panel had hoped that its requests for unconditional help and cooperation embraced such areas of information held in determining the actions of R and the protection of the public pursuant to the information it held concerning him. Had it been made available

to the Panel, although not necessarily disclosed in its final report, it would have been of considerable help in describing the fuller factual detail of this homicide and the relationship between R, the young woman concerned and her father.

3.2.15 The Panel was disappointed by the overall response from the County Constabulary and was further perplexed as to why the documentation it requested was denied. R had, after all the efforts of the Panel, given permission for such information to be provided when he signed his consent form and the Independent Investigation Panel members are more than well versed in the issues of confidentiality, third party information and the expectations of the NHS East Midlands Strategic Health Authority concerning such.

3.2.16 In the absence of information from the prosecution case, the Panel was therefore unable to interview the woman who had been involved with the victim. This situation was unhelpful.

3.2.17 Overall, extensive documentation was reviewed by the Independent Investigation Panel (details in Appendix One)

3.1.18 Root Cause Analysis (RCA): RCA seeks to identify the origin of a problem. It uses a specific set of steps to find the primary cause of the incident or problem to determine what happened; determine why it happened and what to do to reduce the likelihood that it will happen again. RCA assumes that systems and events are interrelated. Basic types of causes are:

- **Human causes** – People did something wrong, or did not do something that was needed.
- **Organisational causes** – A system, process, or policy that people use to make decisions or do their work is faulty.

3.1.19 RCA helps discover specific actions that contributed to the incident under scrutiny. This often means that RCA reveals more than one root cause and helps identify what is the real reason the problem occurred.

3.1.20 The Panel utilised this approach in analysing the documentation and information from interviews. The Panel did not consider that, in this case, such fundamental underlying factors could be identified.

3.1.21 It is important that the debate on the matters of public concern which arise from this case are grounded on an accurate and full account of the facts which have hitherto been unavailable. On this basis the Panel has described the events post the offence as this gives a fuller picture of the man and his observed behaviour, and R's direct personal comments which enabled the Investigation Team to reach the conclusions. It is important to note the events following the unlawful killing were not available to the Trust when conducting their internal investigation.

3.2 Membership of the Independent Investigation Panel

3.2.1 The Panel consisted of three senior and experienced mental health professions, Dr Colin Dale, Mr Peter Green and Dr Michael Rosenberg. (Details in Appendix Two)

3.2.2 The Panel was advised by Dr Tony Fowles, a former Chair of the Lancashire Probation Board, on matters concerning the criminal justice services.

3.2.3 All three members of the Independent Investigation Panel and the criminal justice advisor are independent of any of the organisations involved with the homicide and have had no involvement in any of the previous investigations.

3.2.4 This Level 3 (independent) investigation was commissioned by NHS East Midlands from Caring Solutions UK Ltd. Planning the investigation commenced in December 2009, in line with Department of Health "Guidance on the discharge of mentally disordered people and their care in the community" (HSG (94) 27).

4 Introduction

4.1 Summary of the incident

4.1.1 Information in this section is taken from the transcript of sentencing proceedings purchased from the court.

4.1.2 V was an elderly man at the time of his death. He lived alone in a second floor flat. He had befriended a woman in her late twenties (Y) who lived in the same block of flats. There were conflicting concerns, both that she was vulnerable to exploitation; and that he was being exploited by her. There was no evidence presented that V had in fact been exploiting her in any way.

4.1.3 R had had a relationship with Y some years previously: he became aware of the friendship between her and V and convinced himself she was being (sexually) exploited by V. R took it upon himself to 'rescue' Y. Witnesses reported R had threatened to 'do the old man in'. On his way to V's flat R had an altercation with another party, assaulting this man. On arrival at the block of flats R shouted up the stairs, calling V a 'pervert'. When V emerged from his flat, R ran up the stairs and punched V who fell back to the floor. R then ran off and rode away on his bicycle. Two witnesses confirmed the details of the assault.

4.1.4 Emergency services were called who found V unconscious. V was transferred first to a general then to a specialist hospital and underwent neurosurgery to relieve intracranial pressure. V was certified dead in the early hours of the following morning.

4.1.5 R was arrested later the same day.

4.1.6 The post mortem revealed that V had died of severe head injury with subdural bleeding. The injuries were consistent with a punch to the left side of the jaw with further injuries caused when the right side of his head hit the ground.

4.1.7 R pleaded guilty to the manslaughter of V. In his summing up the Judge noted that R was dangerous and was of the opinion that R posed a significant risk to the public of serious harm. Consequently, R was sentenced to imprisonment for public protection, with a minimum term of 18 months before he would be eligible for consideration for release. R would only be released if it was considered safe to do so. The Judge also noted that R's version of events to a psychiatrist, that he had just pushed V away was untrue: R deliberately punched V hard in the face.

4.2 Background and Context: Early History

4.2.1 R spent his childhood and young teenage years living with his parents and older sister. R had no difficulties reaching developmental milestones, until the age of 9 or 10, at which point he became oppositional, violent and would frequently run away from home. R was frightened of his father who, according to R, was violent and cold towards him, whilst being close to R's sister. R's mother tried to compensate for his father's lack of affection towards him. R could be aggressive and stole from his father.

4.2.2 At about aged 8 R commenced using a variety of illegal drugs, later moving onto crack cocaine and amphetamines. He also started using alcohol at an early age, again having phases of heavy drinking, when he would drink in the morning to cope with his hangover.

4.2.3 R was disruptive at school and left without any qualifications. On leaving school R became an accomplished plasterer.

4.2.4 As an adult, R found it difficult to maintain relationships or friendships and has never had any close friends. R had a long-term relationship which was violent and abusive on both sides. R had a daughter from this relationship. In general R was suspicious of his girlfriends.

4.2.5 R was sentenced to prison when in his early twenties, having committed over 40 miscellaneous offences from the age of about 14. R was sentenced to a further 7 years imprisonment 3 years later, following conviction on 5 counts of robbery. **It is important to note that details of the very serious level of violence involved in these robberies was not known to the clinical teams responsible for R's care either as an in-patient or out-patient.** During R's 5 ½ years in prison he was moved 14 times on account of his difficult and disruptive behaviour

4.3.6 In spring 2002 R was charged with assaulting a police constable and resisting arrest. R later stole 2 shotguns, because his family was being harassed. R was arrested later the same night and showed the police where he had hidden the shotguns. At the time R was subject to a Community Rehabilitation Order. R was reluctant to engage with group-work during this order and met a Conditional Release Licence with resistance.

4.3.7 In mid-2002 R was sentenced to 4 ½ years. Two years later, R was assessed by a Forensic Psychiatrist from a MSU. R was considered not to be suffering from any mental illness, but presented with traits of 'dissocial personality disorder' and 'paranoid personality disorder'. These traits included an irresponsible attitude, inability to maintain enduring relationships, very low tolerance to frustration, proneness to blame others, sensitivity to setbacks, suspiciousness, including misconstruing neutral or friendly actions as hostile or contemptuous, and finally, suspicion without justification of

sexual partners or regarding sexual fidelity. R was not considered appropriate for transfer to secure hospital provision under the terms of the Mental Health Act 1983, but it was recommended that the prison psychological service attempt to provide help for his psychological difficulties.

4.3.8 In spring 2004, when R was due for release within a few months, R wrote to the Centre for Forensic Mental Health in Trust 1, requesting help for his personality problems. This letter was passed on to the Primary Care Trust (PCT) for R's home catchment area. The PCT referred him to a HSH and thereafter to the Centre for Forensic Mental Health in Trust 1, which had initially declined to consider him.

5 Chronology

5.1 Key events in R's life, relevant to his care and treatment provided by Trust 1 and Trust 2 are:

- **13 April 2005** Transferred to HSH provided by Trust 1 from prison, under the Mental Health Act 1983. R was scheduled for release from prison on 6 May 2005 and his probation supervision licence expired on 13 September 2005. R remained in this hospital for 22 months.

- **27 February 2007** Transferred from HSH, on trial leave, to a MSU also provided by Trust 1. R continued to be subject to detention under the Mental Health Act, and his Responsible Clinician continued to be the Consultant Forensic Psychiatrist at the HSH.

- **14 June 2007** Trial leave ended and R was formally transferred and continued as a detained patient in the MSU with Consultant W taking over as Responsible Medical Officer/Responsible Clinician.

- **25 September 2007** R was discharged from the MSU and from his detention under the Mental Health Act. R had been a patient in the MSU for 7 months. R's aftercare then became the responsibility of the Community Forensic Team (CFT) provided by Trust 2. R became an informal patient, able to accept or reject the services offered to him.

- **September 2008** R committed the homicide. R pleaded guilty to manslaughter and was given a sentence of imprisonment for public protection (IPP) with a minimum of 18 months before he could be considered for release. If released from prison, R will remain on licence for life.

5.2 Overall, the picture is one of R seeking help, requiring this to be at his own pace and then becoming angry and frustrated when treatment and care did not follow his wishes. For all services his level of engagement with treatment was sporadic, being particularly difficult to engage as an informal patient in the community. As an in-patient R was cruel to fellow patients, seeing himself as superior to them. On the other hand, whilst in secure care, R attended workshops and was reported to be an accomplished artist, skilled woodworker and focussed in education classes. R's relationships with family, partners, healthcare and criminal justice professionals were characterised primarily by paranoia and attempts to manipulate, with a resort to threats and intimidation. Although R could establish relationships, he found it difficult to maintain them because of this paranoia, and this seemed to particularly apply to girlfriends. R could be physically violent and aggressive towards them. R's mother was and continues to be

supportive of her son. The two following sections provide a much more detailed chronology and account of events, from the time R was referred to the HSH to the homicide.

5.2 Chronology – From referral to HSH to discharge from MSU

Date/Time	Event	Source of Information
2004		
2004	Referred to HSH	
22 November; 30 December	R interviewed in prison by a Consultant Forensic Psychiatrist (Consultant FP), concluded R suffered from a personality disorder of a sufficient nature and degree to warrant detention in hospital. This was followed by referral to HSH. The Consultant FP noted R has many of the features of Post Traumatic Stress Disorder, often associated with survivors of abuse. R also described in detail how he had tortured 3 people in the past. (R later withdrew this disclosure, saying he had fabricated them in order to assist his admission to hospital).	Clinical notes
2005		
2005	Seen by a Consultant FP from HSH: discussed at HSH Admissions Panel. The Consultant concluded there was enough evidence to support a diagnosis of, 'Dependence on Multiple Psychoactive Substances' (ICD10:F19.2) and described twenty disadvantageous personality characteristics meeting the diagnostic criteria for Paranoid (ICD10:F60.0), Dissocial (ICD10:F60.2), and Emotionally Unstable Personality Disorder, Borderline type (ICD10:F60.31). R's personality disorder had given rise to abnormally aggressive and seriously irresponsible conduct sufficient to meet the criteria for the legal classification of Psychopathic Disorder of a nature and degree to warrant treatment in hospital. Treatment in hospital was deemed likely to alleviate and prevent deterioration in this condition, and was necessary in the interests of protection of others.	Clinical notes
18 March	R seen for pre-admission psychology assessment report, R concerned over the possible 5 years he would have to stay in HSH.	Clinical notes
13 April	Home Office warrant directing transfer of R to HSH under Section 47(1) of the Mental Health Act 1983. There was no restriction imposed by the Home Office/Ministry of Justice.	Clinical notes
24 April	R transferred to HSH, and admitted initially to the Personality Disorder Directorate, then later to the DSPD unit. If R had remained in prison his expected date of release was 6 May 2005, with his probation supervision license scheduled to expire on 13 September 2005. R was disruptive and demanding to staff and patients, he was cruel to patients,	Clinical notes

	subversive and antagonistic. R was noticed to be menacing to his girlfriend during telephone calls, which were then monitored, despite R's significant complaints. However, R slowly began to comply with his care plan sporadically, and began to engage with occupational therapy, psychology, nursing staff and the clinical team.	
11 August	R appeared at a Mental Health Review Tribunal (MHRT), to which he had applied. Consultant FP report indicated R had difficulty in adjusting to hospital from prison, was still in the period of assessment and could only receive the treatment he needed in conditions of the utmost security. The independent psychiatric report, commissioned by R's solicitors, concluded that R required specialist treatment, but that this could be provided in a medium secure service, and that R did not require the level of security in the HSH. The decision of the Tribunal noted that R claimed he had fabricated the three incident of torture in order to access NHS treatment for his personality disorder. R was not to be discharged	Clinical notes Tribunal decision letter
September	Further assessment on the DSPD unit of HSH.	
10 November	R appealed to the Hospital Managers, who concluded that if his behaviour continued to be appropriate, and the clinical team agreed, R could be referred to the personality disorder unit at the MSU .	Clinical notes
15 December	Initial assessment by Consultant W from the MSU on the DSPD unit. Consultant W was concerned that this referral had been made only two months after R's transfer to the DSPD unit, when he was still considered to pose a 'grave and immediate' risk to the public and the diagnosis and risk assessment had not been completed. Consultant W response to the referral noted his requirement that thought be given to alternative placement for R should he disengage from treatment or become violent on the MSU. A CPA Care Coordinator should be appointed to avoid any dispute regarding responsibility for R when discharge from medium secure care became appropriate.	
December and January **2006**	Chartered Forensic Psychologist interviewed R over 5 1-hour sessions and administered a range of exhaustive psychometric tests for the International Personality Disorder Examination. R scored as meeting the criteria for a definite diagnosis of three personality disorders: Antisocial Personality Disorder; Borderline Personality Disorder; and Paranoid Personality Disorder. (Details in Appendix 5) R was also assessed using the Psychopathy Checklist – Revised (PCL-R, Hare 2003). This is designed to assess the clinical features of psychopathy. R's score was 25 which, in conjunction with his having a diagnosis of one or more personality disorders in addition to Antisocial Personality Disorder, meant that he met the criteria for the DSPD programme. R's score of 25 placed him at the time of the assessment at the lower end of the high risk bracket, suggesting a moderate-	Clinical notes

	high risk of repeating acts of violence if released into the community.	
8 February	Consultant W attended a CPA meeting. This meeting concluded that R did not appear to meet the DSPD criteria. The HSH was asked to explore the veracity and detail of the three 'torture' incidents described by R in his letter requesting admission for hospital treatment. The details of the five robberies which led to R's seven year sentence were available to other agencies but were not sought out by the HSH. Consultant W commented that R had problematic interactions with nurses, including confrontations and episodes of seclusion. The nursing report noted R's difficulty in accepting boundaries which he did not think were necessary, when he could become very angry. R could be threatening and abusive to female staff. R had managed to obtain heroin in the HSH: he was informed that the MSU had a 'zero tolerance' approach to illegal drugs. The purpose of a placement to the MSU would be to facilitate the pathway from high security to community support, and to help consolidate any progress he had made. Consultant W indicated the need for a clear pathway for R from the MSU. He further requested that representatives of the service commissioners and the community mental health team (CMHT) attended the next review.	Clinical notes
February	R's risk assessment using the HCR-20 tool was completed. R seemed to have increased insight into his aggressive behaviour and personality difficulties: but there remained concerns about his need to further develop awareness and to control his behaviour. This assessment concludes that, if remaining in a secure setting, his risk of committing further violent acts was moderate, but if released the risk would be moderate to high, particularly in the context of a relationship or if R returned to drug use or to consuming large amounts of alcohol. However, if he remained motivated to address some of the factors linked to his aggressive behaviour that would help him work to minimise risk, in either setting. R was also assessed using the 'Violence Risk Scale' (which addresses risk of violent recividism in institutionalised individuals returning to the community). R's readiness to change was identified as moving between 'having no awareness of the problem' to 'an awareness of the problem without observable changes in behaviour'. In summary, R was assessed as needing further work to minimize his risk of further violence. In addition, R's challenging, hostile and intimidating demeanour indicated that he would be difficult to place and that he would need further treatment before a suitable bed could be found.	Clinical notes
18 April	Clinical Management Meeting noted that R's relationship with his girlfriend had been terminated.	Clinical notes
16 August	CPA meeting held; no representation from the Commissioners or CMHT. The MSU wrote to R's Responsible Medical Officer (RMO) that they needed to plan moves for R beyond the MSU in order for them to cooperate.	Clinical notes

16 August	Multi-disciplinary team Treatment Needs Analysis Meeting. R was identified as not meeting the DSPD criteria and it was confirmed that he had been referred to the MSU with the support of the clinical team. There were no representative from the Commissioning PCT nor from the Community Mental Health Team who may have had ultimate responsibility for his care and treatment. Six goals for those taking over his care and treatment were provided in the psychology report. A five year treatment plan was described, appropriate for use in high security or in medium security and beyond.	Clinical notes
6 September	HSH DSPD unit's clinical team held full review of R's case.	Clinical notes
19 September	Treatment Needs Analysis Meeting, which did include attendance from the Commissioning PCT and the local authority. The Commissioner noted that R would not be expected to stay in the MSU for long; also noted his name should be placed on the housing waiting list as soon as possible.	Clinical notes
2007		
11 January	Reviewed by MHRT. Concluded R was ready for transfer to lesser security and that he should be transferred to the new unit at the MSU for personality disordered patients (due to open the following month) as soon as possible.	MHRT decision letter
24 January	A CPA/Section 117 meeting was attended by the PACO from the Commissioning PCT whose role was to monitor his progress and engage community facilities at an early stage. R would be transferred to the new 10-bed unit in the MSU, along with other patients from the HSH.	Clinical notes
27 February	R was transferred to the MSU on trial leave having spent 22 months in the HSH. During his stay in the HSH R set himself high standards when attending workshops. R was an accomplished artist and woodworker. R was focused in education classes, picking things up quickly and attending extra classes.	Clinical notes
28 February	R was seen by Consultant W – he informed R that he would have to deal with a degree of frustration before he could convince his clinical team that he was progressing.	Clinical notes
28 March	It was made clear to R that he could only be discharged by Consultant FP at HSH, whilst he was on trial leave. The review indicated some difficulties in his interpersonal style.	Clinical notes
28 March	Meeting of the MSU Mental Health Act Managers. R had been in the unit for only 5 weeks, and appeared to be repeating a pattern of seeking help, wanting it at his pace and not at the speed considered appropriate by those responsible for his care and treatment. The plan was to progress from escorted to unescorted leave over a six month period, whilst working with the local NHS Trust and housing provider to put together a package of after-care.	Clinical notes

	Consultant W's report noted that R's behaviour within the MSU continued to present extremely challenging behaviour, including being argumentative and belligerent to staff and bullying vulnerable patients. R continued to expect his needs to be immediately met. It went on to note that it was unlikely that an acceptable care package in the community could be put together within the coming 6 months, in addition to his continuing behavioural problems. The report goes on to suggest that R's main motivator is his desire to be in control of his placement and treatment but that he needs to face reality, accept that his deep-seated problems would require intensive work with the MSU multi-disciplinary team and appreciate he would survive in the community only with sufficient additional help and support. If R did not accept the progress he needs to make the alternatives were a return to HSH or for his RMO there to agree to discharge him. This RMO noted that progress to the community needed to be cautious given his history of substance misuse and impulsive behaviour.	
28 March	R appeared to have accepted a 12-18 month time frame for him to complete the required work and for a suitable package of care to be put together for him in the community.	Clinical notes
21 May	CPA meeting, attended by PACO, nurse and forensic clinical psychologist from HSH. The meeting focussed on whether R had made sufficient progress to progress to moving towards the community. Reports provided included reference to R's continued behavioural problems on the ward in relation to both patients and staff, although it was noted that he had not actually been violent in either the MSU or HSH. R engaged in art classes. Plan for the future was: • The importance of developing independence. • Live independently in the community. • Support network to work in conjunction with family support. • Drugs- key issue- work needs to continue. • Work- has capacity to hold down full time job – potential option with brother-in-law. • To register on the housing list immediately and register as homeless. R was told that while he had made some good progress it was patchy and significantly more would be expected of him if he expected to be discharged from the unit within the next six to nine months and to remain in the community. It was agreed that R's statutory supervision would be transferred from the RMO at the HSH to Consultant W and that consideration is given to R having local escorted leave from the unit to the community provided that he had a period of at least four weeks during which there are no incidents or any concerns as to his behaviour.	Clinical notes

	The next review was to be held in six months time (i.e. end October 2007).	
11 June	Formal recommendation to the RMO at HSH that R's period of trial leave should be terminated.	Clinical notes
11 June	R seen and informed his behaviour towards staff and patients would no longer be tolerated.	Clinical notes
14 June	Recommendation agreed. Consultant W became R's RMO.	Clinical notes
18 July	Letter from Consultant W to Forensic Commissioner of Joint Commissioning Team to update them on R's progress. R's behaviour within the MSU continued to be problematic. R was moved from a rehabilitation unit to a more structured ward, in order to challenge his bullying behaviour. However, escorted trips to the community had gone well and he is more settled when engaged in practical activities on the unit. Keeping him in a structured environment may lead to problems rather than being a solution. The plan remained to manage a gradual re-integration into the community over coming 4/5 months, looking for a discharge date by the end of the year. This timescale could be shortened if R did not engage with treatment or had a detrimental effect on the management of other patients. Consultant W requested assessment by the CFT, although oversight of his anti-psychotic medication could be provided by the CMHT. A copy of the CPA meeting minutes was sent to the Community FP at Trust 2.	Clinical notes
20 August	Consultant W wrote to the commissioners with copy to Community FP at Trust 2, confirming discharge date of 25 September 2007. He felt that continued detention in medium security was more of a hindrance than a help to R, and staff should not be expected to continue to tolerate his behaviour. R had been on unescorted leave to the local gym which he was using constructively and had been attending a local drug service. Drug monitoring had proved negative. Consultant W was not optimistic that local services would be any more successful than the MSU had been, but R would require psychiatric oversight as he was on psychotropic medication.	Clinical notes
14 September	1st assessment of R by the CFT when he was on home leave.	Clinical notes
21 September	Section 117 discharge planning meeting, when the following was agreed: • Follow-up by Trust 2's CFT – R would be in contact with the Psychiatrist and Care Coordinator alternately twice a week. • To continue on his current medication – especially as it helps alleviate some of his paranoid thinking. • Input from the locality Drug and Alcohol Service (CAN). • R would not require to be referred to MAPPA unless there are increasing concerns. The meeting was attended by the Community FP who understood that the main reason for discharging R was that of	Clinical notes

	his inability to engage and benefit from his current hospital treatment. He commented that if it was the view of the MSU team that R was untreatable then he would expect it to be clearly and explicitly documented in R's discharge summary and in the CPA review minutes.	
25 September	R was discharged from the MSU to the community, 7 months after his admission. At the same time, his detention under the Mental Health Act 1983 was also discharged. R was therefore an informal patient able to accept, or not, the services offered to him in the community.	Clinical notes
26 September	A letter was sent to the Community FP with a copy to the Community Forensic Psychiatric Nurse. Associated documentation was a discharge summary; minutes of R's Section 117 meeting. (There were concerns raised on the transfer of detailed reports and requests made by MAPPA and Trust 2 for such information to the HSH. In fairness to the HSH having trawled through the records of Trust 2 and MAPPA correspondence requesting such information could not be found. In the HSH records, which the Panel had unfettered access to , they did not have such correspondence requesting information contained within them)	Clinical notes

5.3 Chronology: From discharge from MSU to the homicide.

Date and Time	Event	Source
2007		
14 -30 September 14 September 21 September	Face to face contacts – 3 Text contacts – 1 Telephone Contacts – 6 Referrals made to CAN and contact made with department of social services in relation to housing and benefit needs (DLA) Assessed by CFT-CC1 and Community FP – R on home leave from RSU. R distressed by lack of any accommodation on discharge; R felt he needed long term input from the CFT and NDAS.	Statement to internal review

25 September 27 September	CPA/Section 117 meeting held at MSU. Discharged from MSU. R reviewed by Community FP; his accommodation was 'uninhabitable' and in an area well known for social problems and drug abuse. R reported increased craving for illicit drugs, triggered by his circumstances.	Statement to internal review
1 – 30 October 1 October 3 October 4 October 8 October 15, 18, 19 October	Face to Face contact –11 Text contact – 2 Telephone contact – 14 Numerous attempts made by Community Forensic Team (CFT) to process / hasten benefits being resolved. Referrals made to Benefits Agency and Job Centre Plus. R advised to register with GP as soon as possible. Community FP contacted carer. R's mother was concerned about his mental state and her perception that R had not been provided with an adequate after-care package. R seen, he stated he felt unsafe, with increased paranoia. Medication increased. Attended appointment at Council for Addictions Northants (CAN) Risks reviewed. R's situation deteriorating, increased paranoia; benefits stopped as he had been overpaid for two years. R refused to see Community FP because he felt it would be of no value.	Statement to internal review Statement to internal review
1 – 30 November 8 November	Face to Face Contact – 1 Text Contacts – 7 Telephone Contacts – 11	

21 November 23 November 26 November 27 November 28 November 29 November	Payment available from Job Centre Plus after difficulties in obtaining sick note due to not having a GP. R continued to refuse to see Community FP because he would not prescribe the increased levels of medication that R requested. Community FP advised CFT-CC1 to contact MAPPA , requesting a meeting; to contact assessment wards, the RRHTTT and out of hours service to alert them to the situation; and approach the Forensic Psychologist to offer further appointments and conduct a risk assessment (HCR-20). R complained that CAN worker had missed four scheduled appointments. MAPPA meeting called. Meeting held between CFT-CC1 , Community FP, CFT-CC2, and two staff from Team 63. Plan formulated to manage R , the Panel agreed that the plan gave sound advice and provided a comprehensive plan of action. CAN worker changed, CFT only advised once contact was made by CFT to discuss R 's appointment. Advice given to CAN that R should not be seen alone. Increase in risk noted, CAN were advised to contact police about abusive telephone call they received and copies of the risk assessment were sent to a CAN worker. CFT-CC1 also contacted police about his behaviour as well as the GP surgery. CAN worker arranged to meet R. CAN worker requested involvement in MAPPA meeting once arrangements were made.	Statement to internal review MAPPA minutes
1 – 31 December 3 December 5 December	Face to Face Contacts – 1 Text contacts – 1 Telephone contacts – 7 CFT-CC1 had not been able to make contact for a month: R refusing further contact said he was not taking any medication. Escalating risk and disengagement noted.	Statement to internal review

13 December 19 December 27 December 31 December	MAPPA meeting held. Arrangements made for R to see a Forensic Medical Examiner for GP services in a police station, R had been banned from surgeries because of his threatening and intimidating behaviour. R reported to be considering discharge from mental health services R did not attend his CPA review. He declined to see his new care coordinator (CFT-CC2) Self reported self harm R not accepting help or attending for appointments, decision made by CFT to contact Team 63 for advice about engaging R. MAPPA meeting scheduled for 13/02/08, this could be brought forward if necessary.	Statement to internal review
2008		
1 – 31 January 2 January 4 January 7 January 2008 9 January	Face to Face contacts – 13 (7 of these with Substance Misuse Worker (SMW)) Text contacts – 0 Telephone contacts – 3 Home visit conducted, R initially wanted an admission to hospital, although this changed when at the threshold of the unit. Admitted using crack cocaine, heroin and cannabis. Community FP saw R, R stated he had been allocated an unfurnished council flat and he would have to wait 3-4 weeks for a grant. R had a new girlfriend and reported paranoid ideas about her fidelity and that she might leave him. Expressed fear of being admitted to a secure facility. Assessed by SMW at Northamptonshire Drug and Alcohol Service (NDAS) clinic.	Statement to internal review

18 January 25 January	R failed to attend for his appointment with Forensic Psychologist. Reported having paranoid thoughts relating to his girlfriend to Community FP. Medication increased. Again reported having paranoid thoughts relating to his girlfriend to Community FP. Medication increased.	
1 – 29 February 2008 5 February 6 February 11 February 13 February 14 February 18 February 27 February 29 February	Face to Face contacts – 2 Text contacts – 0 Telephone contacts – 7 R failed to attend his appointment with Forensic Psychologist on three occasions now (20th Feb also). Team 63 contacted CFT to ascertain if input was still required after receiving letter to state that R's needs had changed. SMW reported disengagement with NDAS clinic. A warning letter was sent on 18th Feb. Due to his work commitments, R was transferred to evening appointments. First MAPPA meeting, R to be managed at Level 2. Information shared between agencies. CFT-CC2 attended MAPPA meeting, referral to be made to child protection regarding his young niece who is living with him. R admitted assaulting his girlfriend who had become his partner. She and their unborn child were already known to social services although no new risk was highlighted to social services on reporting of the incident. This would be discussed in MAPPA meeting. R's pregnant partner informed CFT that R had assaulted her. Plan to inform MAPPA and Children's services. Later Community FP saw R, informed him about referral to MAPPA.	MAPPA minutes Statement to internal review MAPPA minutes

	2nd MAPPA meeting, focus on welfare of R's partner & unborn child, and presence of R's niece in his flat. R received his first payment for his employment, reports he is managing well apart from ongoing situation with his pregnant ex-partner.	
1 – 31 March 6 March 12 March 23 March 25 March 28 March 31 March	Face to Face contacts – 3 Text contacts – 0 Telephone contacts – 6 During March R took an overdose of drugs and made superficial cuts to his arm, in the context of the breakdown of the relationship with his ex-partner. R's new Care Coordinator (CFT-CC2) received call from Child Protection to inform CFT that they are looking into the case. MAPPA meeting: focus on R's (now) ex-partner and unborn child, reported R had been harassing her. Risks reviewed in light of disengagement with CFT and NDAS clinic. Sister contacted CFT to express her concerns over R and his intention to harm her family after R lost his job with his brother in law (bad time-keeping). She was advised to contact police. Niece returned to her mother's home, after altercation at his flat. R asked Community FP and CFT-CC2 if he can go into hospital as he is not coping. Denies that he would act violently on his anger towards his sister. Paranoid about his family being against him. R was informed that he could not go into hospital as his mental state was stable, appointment given for following day.	Statement to internal review MAPPA minutes Statement to internal review

1 – 30 April 14 April 14 April 18 April 25 April 30 April	Face to Face Contacts – 6 Text contacts – 0 Telephone contacts – 3 CFT-CC2 makes home visits to R. R is given several appointments with SMW at NDAS clinic in April. R is angry about the involvement of child social services. Child Protection meeting: R's ex-partner was told to have no further contact with R and that he would have to proceed through solicitors if he wished to be in contact. R angry with the above outcome. Professionals meeting held with Team 63 input. Contingency plan to be made available for when he disengages with the service. R gave consent for his HSH medical records to be accessed by CFT – especially the therapy he had undertaken. Benefit suspended due to R not completing forms. Social Worker related concern that R is still in contact with his ex-partner. MAPPA meeting, attended by CFT-CC3 (Principal Social Worker (PSW) and Approved Social Worker (ASW)) and Community FP. R was deregistered from MAPPA level 2 to Level 1, there was no intelligence about him and he appeared to have settled. R continued to complain about his referral to MAPPA	Statement to internal review Statement to internal review
1 – 31 May	Face to Face contacts – 4 Text contacts – 0 Telephone contacts – ongoing R cancelled his appointment for 7 May but rearranged for 21 May. It is noted that his release information from HSH	

	has still not been received.	
1 – 30 June 2 June 4 June 10 June 11 June 13 June 25 June	Face to Face Contacts – 8 Text contacts – 0 Telephone contacts – 0 R reports feeling very low and depressed. Medication altered. Outpatient appointment with Community FP, discussed SMW's concerns about his failure to attend for appointments when R is on a high dose of Subutex (a replacement therapy for heroin). Agreed to a short informal hospital admission in a week's time. CFT-CC2 escorted R to mental health hospital unit, although he was sharing his anger at this solution. Later the same day R decided he wanted to leave hospital, he felt staff were hostile to him, he would not sleep in a cubicle arrangement with 5 other men. CFT-CC2 escorted him home. Social services and anger issues were discussed with R. Response letter sent to R in relation to his complaint about referral to MAPPA made by CFT-CC1 . MAPPA contacted by police who are concerned that R may be accessing a known crack dealer. R admitted using crack but asked that it was not discussed in the presence of his mother so a further appointment would be made. A team meeting shows that R made threats to kill but they were hearsay and staff could not recall these when interviewed. MAPPA meeting, this was a new referral at Level 2. R had been mixing with drug dealers, threatening them and taking their money from them. R placed on MAPPA level 2 but was not informed of this due to his reaction risk. Community FP uneasy about being unable to inform R. Request to be made again to HSH for R's medical records.	Statement to internal review Statement to internal review MAPPA minutes
1 – 31 July	Face to Face Contacts – 2	

23 July 25 July 28 July	Text Contacts – 2 Telephone contacts – 1 R is evasive in July 2008 missing planned home visits and having his phone go to answer phone or is off. The staff made numerous attempts to contact R. CFT-CC2 and SMW joint home visit and find R unkempt and he reports that he was arrested that morning on suspicion of burglary but released without charge. Drug tests were positive for heroin and cocaine Home visit by Community FP and CFT-CC2 finds R asleep and upon waking he does not wish to communicate. Appointment arranged for 1 August 2008. CFT meeting: Discussion regarding possible discharge of R from the service, noted difficulty of assessing risk as R would only engage on his terms. Community FP advised sharing information with MAPPA and between police and forensic service to ensure risk warnings were received and CFT could consider next steps. Noted R had not engaged in meaningful therapeutic activity or developed a working relationship with the team. Community FP would not consider discharge so that the team could demonstrate the extent of their attempts to manage R.	Statement to internal review
1 August 13.00	Community FP and CFT-CC2 called at R's home for joint visit, R was not in. CFT-CC2 records letter sent for appointment on 05.08.08 at 1 1am.	Clinical records
4 August	CFT meeting discussed R mental state noted as stable, risk unknown: agreed to monitor R. Failure to attend appointments discussed, weekly appointments still offered. To continue to try to engage. Criminal intelligence reported an increase in R's criminal behaviour.	Clinical records
5 August 9:30	CFT-CC2 received phone call from R requesting his medication, reminded him that they were visiting later so she would see him then, R said he had forgotten but would be in.	Clinical records
5 August 11:00	CFT-CPN and CFT-CC2 make joint visit at R's home. R a lot more composed, he said had reduced his drug use: he reported he is attending the gym regularly, helping out in return for free sessions and relating to better to people there. R also back in contact with sister and her husband. R informed prescription to be dropped round on following	Clinical records

	day and that he will be informed of next appointment (arranged with Dr1 for 12.08.08).	
6 August	MAPPA meeting attended by CFT-CC2. MAPPA meeting had been arranged due to new police intelligence. R's lack of engagement, drug taking and the risks were discussed. Risks felt to be elevated because of his drug taking, including risk of harm to people. The difficulties for the CFT discussed – R could be volatile and aggressive. To continue to manage at Level 2 and consider deregistering or discharging R at next meeting. CFT-CC2 was to contact HSH for R's documents on behalf of MAPPA, CFT to continue to work with R.	MAPPA minutes
11 August	CFT meeting - discussed R and noted mental state to be stable, risk as unknown but high risk and agreed action to monitor. Genuinely calmer, befriended gym owner, had cut down illicit drugs.	Clinical records
12 August 13:00	CFT-CC4 and Dr 1 home visit to R, no answer at door at first. Telephoned him and eventually replied and was guarded in tone. Said that he was not at home. R asked for another appointment later in the week. Dr 1 will see if he can arrange a joint visit with CFT-CC2 on Friday 15.08.08.	Clinical records
15 August 11:20	CFT-CC4 and Dr 1 visited R's home, not at home and his phone was temporarily not taking calls. Dr 1 left a note for R to call him.	Clinical records
18 August 14:20	CFT meeting: discussed R and noted mental state to be stable, risk as unknown and agreed action to monitor. DNA's discussed and continuing telephone calls to him. CFT-CC4 telephoned R to arrange an appointment for 12.30 Tuesday 19th August. Phone not obtainable, CFT-CC3 and colleague agree to visit and leave a note if he is not there**.** Letter sent to R with appointment at NDAS Clinic for 27 August.	Clinical records and Addiction Service notes
19 August 13:30	Joint visit with CFT-CC3 and CFT-CC5 at R's home to monitor. Initially R had appeared to be reasonable in mood, but became increasingly negative about himself and his development of a social network. R continued to stay with his mother and attends his own flat during the day. R no longer showing pride in his work to refurbish his flat, reported being increasingly lonely, felt he had negative reputation locally (his mental health history and his perceived reputation from the police) were an impossible barrier to developing a social network – consequently he was lonely. R felt that others could not cope with his behaviour (changes in mood, attitude, non-verbal signals) so developing friendships has not been possible. R was finding it difficult to divulge his recent past but could not cover this up because it would be dishonest. More positively he had developed a friendship with the gym owner, who had also had a previous stay in prison. R'S difficulties in developing a social life led to feeling that pressure is building within him, reporting thoughts of self-harm which he did not carry out to avoid distressing his mother whom he respected. R did not divulge any	Clinical records

	possible self-harm behaviours. R then felt CFT-CC3 and CFT-CC5 were not engaging with him as he wished so politely asked for them to leave. R had gained weight following his gym activities, and use of a multi-gym which his brother-in-law has set up for him. R's aim is to be bigger and stronger. R admitted involvement in 2 or 3 local fights, and his use of telephone help-lines at evenings/week-ends. Noted that Community FP is his closest confidant in the team, R recognises his psychotherapy expertise. R was encouraged to be proactive in engaging with the team. Next appointment made for 22nd August at R's home address.	
22 August 11:00	Community FP records appointment at R's home and R not at home.	Clinical records
26 August 11:00	CFT-CC2 tried to contact R by phone, his new number was going to a female answer message and CFT-CC2 was unable to leave a message, also attempted to leave R a note regarding visit but was unable to as trade buzzer had gone off. Letter sent to R re appointment for 29.08.08.	Clinical records
27 August	SMW records that R did not attend appointment at NDAS Clinic re Subutex, further appointment arranged with Dr 2 for 11.09.08 for review and warning letter sent.	Clinical records and Addiction Service notes
28 August 11:00	Community FP records home visit with other professional. R not at home.	Clinical records
29 August 11:00	CFT-CC2 calls at R's home with a nursing student, R not at home, no reply. To send a letter with another appointment for next week.	Clinical records; interview
01 September 11:00	CFT meeting: discussed R and note mental state to be stable, risk as unknown and agreed action to monitor. CFT-CC2 received phone call from R and agreed to visit on 04.09.08 at 12 mid day. R reports he feels abandoned now that his sister has left the country.	Clinical records
02 September 9:00	CFT-CC2 received phone call from SMW at NDAS Clinic to inform her that R had missed his last appointment with them and now has one with them on the 11.09.08 at 12.30 with Dr 2 who will be seeing R over the next 3 months while SMW is away.	Clinical records
04 September 12:30	Text message received from R requesting the team visit half an hour later than planned as he was pricing a job. On arrival CFT-CC2 and CFT-CC3 found R was not there, phoned him and R apologised that the job was taking longer than expected but he needed to see them as he felt distressed at the moment due to his sister moving and his grand daughter has been	Clinical records

	taken into care, R also reported that he took an overdose earlier in the week. CFT-CC2 agreed to visit tomorrow at 11.30 with Community FP. As R has not been seen to complete his CPA review this was done in his absence. CFT-CC2 reviewed risk assessment, including: • increased drug use although engaging with NDAS Clinic on sporadic basis, • no evidence of self harm • dietary intake reduced as drug use increased • social contacts more limited to other users • mother continues to play important role in R's life • signs of anger and frustration and known personal trigger factors, • no contact with ex girlfriend- team not aware if baby had been born, • frustrated by his situation and inability to secure driving license until illicit drug free. R was aware he could be abusive when immediate needs were not met but becomes remorseful afterwards, one arrest for burglary but not charged. Also referred to MAPPA following police intelligence of an increase in his drug behaviour police report that their intelligence indicated that others were fearful of R. Remained on MAPPA level 2. R's engagement continued to be erratic - he would ask for assistance and promise to attend appointments then would not be available. Team to continue to actively encourage R to engage. Team had looked at ways of increasing his engagement and offered flexible appointments Use of Mental Health Act 1983 had been discussed but not felt to be necessary as R's conversations indicated he was looking for work and managing his affairs	
05 September	CFT-CC2 diary records appointment made for 5th, but there is no record of a visit taking place	Clinical records
08 September 11:50	CFT meeting: discussed R - mental state stable, risk unknown and action to monitor. R's failure to attend appointments discussed. No information from police. CFT-CC2 telephoned R as he had sent a text message on Friday apologising for not being there. R informed them his telephone and gas were about to be cut off and stated that if was their fault for not providing adequate after-care. R became angry at the suggestion that it would be easier to help him if he attended appointments. R hung up then switched his phone off.	Clinical records
10 September	CFT-CC2 and nursing student called to R's home no reply or on his phone, so they posted his prescription and sick	Clinical records,

11:00	certificate through his mother's door with an appointment for the following week with Community FP and CFT-CC2	interview
11 September	R arrested on suspicion of murder of elderly gentleman. ASW service contacted to provide appropriate adult service.	Clinical records
12 September	CFT contacted by ASW service who had been asked to provide an appropriate adult on previous night. Community FP examined R in police custody and stated he was fit to be interviewed	Clinical records
15 September	R charged with unlawful killing.	Clinical records

6 Findings and Contributory Factors

6.1 Introduction

6.1.1 The findings of this investigation are presented under the headings of the Terms of Reference. The overall objective of the investigation was to undertake a systematic review of the care and treatment provided to R by Nottinghamshire Healthcare NHS Trust and Northamptonshire Healthcare NHS Foundation Trust to identify whether there was any aspect of care and management that could have altered or prevented the events of autumn 2008.

6.1.2 What R himself had predicted indeed eventually happened when in the community resulting in the death of an innocent victim who had no knowledge of R but who was sought out by him because of his acquaintance with a young woman R had set out, for his own distorted reasons, to 'rescue' from this frail and elderly man.

6.2 To review the quality of the health and social care provided by the Trusts and whether this adhered to their policies and procedures, including:

6.2.1 To identify whether the Care Programme Approach (CPA) had been followed by the Trusts with respect to R and establish if deficiencies were material in the case

6.2.1.1 The CPA process and procedures were of a high quality at the HSH and to a lesser extent at the MSU. The Panel, from the records of CPA meetings, was unable to determine the level of debate and whether there was any dissent in the multi-disciplinary teams in the high and MSUs of Trust 1 concerning the care pathway being determined for R.

6.2.1.2 Professionals who should have attended in the main did, with the HSH Consultant FP and Chartered Forensic Psychologist attending CPA meetings at the MSU whilst R was initially on trial leave there. However, despite the appropriate request by Consultant W for the PACO and representative of the appropriate team of Trust 2 to attend the CPA meeting on 16 August 2006 when R's transfer to the MSU was to be discussed neither attended, although a representative of the PCT and of the local authority attended the meeting in September.

6.2.1.3 The Independent Investigation Panel was, however, left with an impression that alternative strategies were not considered once a course had been set to accommodate the complexities presented by R. For example there seemed to be little consideration of his return to the Personality Disorder Directorate's wards in HSH, or discussion at the MSU about his return there. There were not, in either service, detailed plans to

consider addressing his relationship difficulties with family and partners and the world around him.

6.2.1.4 Sections 6.4 and 6.6 also refer to this Term of Reference.

6.2.1.5 Had R been detained for a longer period of care and treatment in High Security and his eventual discharge from Medium Security been better planned over a reasonable length of time in order to establish more positive conditions within the community these may have improved his experience of discharge and made him more amenable to voluntary support. As it was R's experience of discharge resulted in a negative experience for him.

6.2.1.6 As far as the CPA processes were concerned, there were no deficiencies which were material to the case. However, the panel considered that decisions made in the light of the information available were flawed.

6.2.2 To identify whether the risk assessments of R were timely, appropriate and followed by appropriate action;

6.2.2.1 Whilst at the HSH R was assessed by the Chartered Forensic Psychologist over five one hour sessions in December 2005 – January 2006.

6.2.2.2 R was also assessed at the HSH with the PCL-R, an established and widely used tool for assessing the clinical features of psychopathy. In February 2006, the assessment was completed and indicated that R's risk of violence in a secure setting was low but if released into the community would increase to moderate - high, particularly in the context of a relationship or if R returned to drug or alcohol misuse.

6.2.2.3 R was also assessed using the 'Violence Risk Scale', which indicated that he needed to do further work to minimize his risk of violence.

6.2.2.4 All the above assessments were carried out in a timely, appropriate, thorough and detailed manner. In particular the HSH conducted a detailed HCR-20 Risk Assessment. The details of R's involvement in the 5 robberies were not thoroughly explored.

6.2.2.5 In August 2006 the Psychologist's report set out six goals for those taking over R's care and treatment. This included a 5-year treatment plan, to be delivered in high or medium security and beyond. Unfortunately, the Forensic Commissioner was not in attendance at this meeting; and on transfer to the MSU the psychology post was vacant and this treatment plan was therefore not implemented.

6.2.2.6 Consultant W suggested that it was counter-productive to continue to detain R in a secure setting. There was however no formal assessment of R's risk in a community setting, although staff reported that R's behaviour was more acceptable in this context. A considered assessment of R's risk in a community setting, particularly taking into account his poor impulse control would have been appropriate.

6.2.2.7 There were deficiencies in the risk assessment of R. Risk assessments were based on faulty information regarding R's previous violence offences, underestimation of R's propensity to violence when unsupervised and failure to investigate R's own accounts of his behaviour and his withdrawal of confession to involvement in violent offences. This in turn meant that clinical judgment regarding risk were questionable. However, since then, Trust 2 has issued improved and sound risk management guidance.

6.2.3 To examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;

6.2.3.1 The records available to the HSH, DSPD unit full case review, in September 2006 were of a high standard and the analysis was thorough and encompassed the observations of all professional groups involved with R. The reports were comprehensive and informative (Trust 1).

6.2.3.2 Of considerable importance and quality was the work undertaken by the Chartered Forensic Psychologist with R, whilst R was in the DSPD service of the HSH (Trust 1).

6.2.3.3 The Care Programme Approach at HSH was thorough and well recorded and the analysis of R's clinical presentation was accurately observed. The decision to take the path of transfer to lesser security and the assumption that this was the appropriate course of action was however never questioned. When R was not considered as fitting the then criteria used to determine DSPD status R's return for longer term treatment to the Personality Disorder Unit Directorate was not considered, or not recorded, although it was requested by R as evidenced in nursing running records. At all subsequent CPA meetings both in high and medium secure settings there was no dissent within the multidisciplinary teams or from the Commissioners of services as R was pushed towards discharge (Trust 1).

6.2.3.4 There was much discussion concerning the offending behaviour of R and the truth around what R had said in way of embellishment of his violent actions in order to achieve admission to the HSH. There was no record of any attempt to corroborate these claims although R had received a lengthy prison sentence for five robberies. The details of these were described by the prosecution counsel at R's trial sentencing hearing for the manslaughter of his victim. The detail of these robberies could have been sought from the original Crown Court and would have confirmed his propensity for violence (Trust 1).

6.2.3.5 Discharge planning from the MSU was poor, which meant that R was faced with multiple problems on discharge, including inadequate and inappropriate accommodation, welfare benefits not arranged and no GP identified.

6.2.3.5 It must be strongly emphasised that the staff in the Community Forensic Team in Trust 2 had to attempt to engage with R on his discharge on a voluntary basis and R could accept or reject their approaches to assist him on his own terms. The team coped with

his chaotic, demanding and intimidatory nature as he engaged and disengaged with them for a year before R killed his victim. This team discharged their duties consistently and steadfastly to provide aftercare for R.

6.2.4 Application of the Mental Health Act, 1983

6.2.4.1 R was transferred to the HSH very close to his expected date of release. This stored up difficulties for the Community Forensic Team who were eventually left to deal with him on a voluntary basis. The CFT had a statutory obligation to offer to provide a service following the discharge of his Hospital Order by the MSU - R could accept it or not.

6.2.4.2 The decision to conclude the trial leave and transfer responsibility for R from HSH's Consultant Forensic Psychiatrist to the MSU's Consultant W was hasty; however the process was appropriately carried out with documentation to confirm the decision.

6.2.4.3 The decision to discharge R from the MSU was also a decision to discharge his Hospital Order. It would have been possible for a referral to be made back to the HSH when R was on trial leave, but this decision was not made. Consultant W has expressed in interview that he considered there was a question about whether it would be legal to further detain R when in the community and did not consider referring him back to HSH. In addition R's behaviour towards other people was much improved when he was on leave and seemed to deteriorate within the confines and boundaries of the secure ward. The Panel considered that the primary responsibility of secure psychiatric hospitals is that of protection of the public and was surprised that as R was offensive to patients and staff that discharge was considered to be the appropriate action.

6.2.4.4 The growing public concerns about a small number of highly publicised dangerous patients was the impetus for further legislation by way of the Mental Health (Patients in the Community) Act 1995. The principal provision of this new Act was the Supervised Discharge Order (SDO: Section 25a), which aimed to ensure that patients discharged from Section 3 or Section 37 receive appropriate aftercare. A patient could be required to (a) live at a specified address, (b) allow access to the supervisor and other professionals and (c) to attend for specified treatment.

6.2.4.5 In a study in the South West of England Responsible Medical Officers (RMOs) commented on the time-consuming process of applying for a SDO and felt it had limited value because of the lack of sanctions. The RMOs expressed greatest optimism for success for those patients who are generally not compliant but were basically law abiding individuals who would cooperate when awed by the weight of law, even when no sanctions would be taken if they should break the requirements. However, the attitude of many of the psychiatrists interviewed was that "it was worth a try" and that there were potential benefits in tightening up on procedures that should be occurring anyway. A few psychiatrists expressed anxiety that, if these patients misbehaved or

things went wrong, more blame could be attached to them. There was concern that if the patient reoffended, readmission to hospital would be assumed rather than bringing charges against the individual.

6.2.4.6 The Mental Health Act Commission's (MHAC) 8th Biennial Report 1997-1999 (the first published following the introduction of Supervised Discharge) notes that there were few applications made - 318 in England in 1997/8 and 11 in Wales. Although this was half as much again as the previous year, it still fell far short of the 3000 patients estimated by the Department of Health (Dept. of Health, 1993) who would be suitable for the new power.

6.2.4.7 The MHAC suggest that one obstacle was the cumbersome and bureaucratic application procedures. Also they felt that it was perceived as powerless in that treatment cannot be enforced and there are practical difficulties in exercising the powers which do exist.

6.2.4.8 This approach was available to Consultant W when considering discharging R to the community but there is no evidence the use of Section 25a was considered. The Panel thought it should have been considered as the minimum possible in helping R establish himself into independent living, having been in custodial and restrictive environments for over a decade. As observed above the Panel thought it would have been 'worth a try' and it may have helped in some small way in aiding the community based forensic team in their support of R.

6.3 To examine the referral and discharge process between the HSH and the MSU including the management of any trial leave during 2007

6.3.1 Admission to high security care was the correct decision as not only did R see the potential for the death of someone by his own hand the assessing Consultant Forensic Psychiatrist acknowledged that R would have posed a grave and immediate danger to the public should he have been released from direct supervision. R's request to receive assistance was fleetingly insightful but unfortunately when in receipt of it R launched into criticism of his situation and wanted immediate results and rapid progress through the system. R had been advised that he may be detained for some five years in high security and possibly another two years in medium security. R spent a little over a third of this time in secure care.

6.3.2 R caused disruption within the ward areas, was abusive to female nursing staff and bullied less able patients in both levels of secure units. In the firm structure of the DSPD unit R maintained this behaviour and needed seclusion on occasion for various reasons.

6.3.3 On a positive note R engaged in all psychological assessments and treatments offered and positively engaged with the Clinical Forensic Psychologist and understood and cooperated in these processes. R attended education classes and entered these positively. R exhibited creativity in workshop facilities. It was R's behaviour in the ward environment which caused difficulties (a situation which was repeated in the MSU – although the MSU could not offer the scale of diversionary daytime activities available in high secure care which R enjoyed). Difficulties in R's interpersonal relationships were also played out in the HSH with R clearly demonstrating his controlling and threatening relationship with his partner, which resulted in monitoring R's telephone calls.

6.3.4 Having been re-assessed as not fitting the DSPD criteria in HSH, the plan developed to transfer R to the newly commissioned personality disorder unit at the MSU. Consultant W from the MSU attended review meetings at HSH and appropriately requested attendance of a clinical team who would offer aftercare on discharge from medium security. The commissioners attending did not require or arrange for this allocation to take place and no community based team from Trust 2 was identified until weeks before R's ultimate discharge (Trust 1, Trust 2).

6.3.5 The discharge of R from the HSH appeared to the Independent Investigation Panel to be precipitate. To allow what appeared to be the pace of R's treatment to be dictated by R through his negative behaviour was difficult to comprehend and that transfer was ill advised and should have been tempered with extreme caution.

6.3.6 R is now detained in prison on an indeterminate prison sentence, treated as if serving a life sentence. On reflection from R's point of view it may have been more helpful to have spent more years in high security care being helped further to face the dominant and unhealthy part of his personality, with the hospital order placing limits on his discharge.

6.4 To examine R's care and treatment whilst at a MSU and the management of the extended periods of leave R was granted during 2007

6.4.1 The Chartered Forensic Psychologist from the HSH attended the CPA at the MSU. There was no discernable input thereafter from psychology due to the need to recruit a replacement psychologist at the unit, and reservations on the part of Consultant W about the effectiveness of the proposed intervention. There did not appear to be any further therapeutic interventions directed towards R's difficulties with interpersonal relationships, particularly with women. The Panel felt that the unit rejected him in a sense because of his behaviour rather than confront it and if necessary recall him to higher levels of security.

6.4.2 The Independent Investigation Panel considered that granting leave was not the way to treat R who was not in control of himself and needed more time to explore his

behaviours in a controlled environment.

6.4.3 Because R did not fit in with staff and continued to abuse patients and staff he was given greater freedoms. It is this and his subsequent discharge the Independent Investigation Panel do not support.

6.5 To examine the referral and discharge process from the MSU to the Community Forensic Team in Trust 2 in September 2007.

6.5.1 The key component of the referral and discharge process was the Section 117 Discharge Planning meeting held in September 2007. There were four issues which in the view of the Independent Investigation Panel were not dealt with adequately. These were:

6.5.1.1 Appropriate accommodation had not been identified. R was discharged to temporary accommodation and even B&B had been mooted on one occasion. This accommodation was to cause R considerable stress and could have been avoided had the local Commissioners of Services and Accommodation Officers been given more time in securing reasonable accommodation once the decision had been made for a community discharge. The discharge summary had recorded that R's accommodation, *"was a long standing and particular concern as it was felt that if he became homeless or placed in inappropriate conditions it could precipitate drug misuse. Fortunately before his discharge local housing authorities had been able to locate a temporary self-contained flat for him".* The temporary accommodation R was discharged to was described to the Panel by R when interviewed in prison and by his mother. Two of the Panel members visited the accommodation and area in which it was located and to them it appeared to be unsuitable for a patient leaving a lengthy period of time in prison and intensive assessment, treatment and care in secure hospitals. It was highly inappropriate to meet R's needs and did little to support him in resettlement. When visited in prison R described the accommodation, which he had been told would just need a lick of paint by the unit's social worker. R had to put a padlock on his door, there was no bed and the place was filthy and smelt of urine. Others in the accommodation were drunk, using drugs and shouting at night. R had to share a bathroom and toilet facilities with them. R found this depressing as he is clean, ordered and tidy and was finding the transition difficult enough. R had the additional problem that his benefits had not been established. The Panel concluded the accommodation R was discharged to was inappropriate. Had an early referral been made to his hometown MAPPA, and more time given to Commissioners to engage appropriate resources and personnel the issue of housing may have resulted in his transitional move to this accommodation being avoided. Arrangements eventually had to be made for R to obtain GP services by visiting the custody suite in a local police station (Trust 2).

6.5.1.2 R's benefits were not established for his discharge which resulted in the MSU's social worker having to travel to R's home town to deliver his benefit payments. Eventually R was informed he had been overpaid resulting in a reduction in benefit.

6.5.1.3 Referral to MAPPA was not made at this stage. The local MAPPA manager should have known about and been kept informed of the passage of R through the forensic services. MAPPA through its component parts could have had an overview or offered direct help on accommodation issues. MAPPA should have formally been made aware that R, who was a habitual offender, was to return to their area. In addition, the MSU was required to notify the MAPPA manager for the locality that R was being discharged into the community. Given R's previous offences, the MSU had no discretion in this matter but the MSU did not make this referral. It would have been the responsibility of R's MSU Care Coordinator at the time.

6.5.1.4 R was also a Schedule 1 Offender (for assault occasioning actual bodily harm when he was a schoolboy on another boy). Schedule 1 offenders are persons convicted of an offence listed in the first schedule of the Children and Young Persons Act 1993. Such offences are not considered spent under the Rehabilitation of Offenders Act 1974. Prisons (and secure hospitals) must notify the Local Authority Social Services when a Schedule 1 offender is released or discharged. Local Authority Social Services then have a duty under requirements of Home Office Circular 54/1994 to identify, for example:

> 'When a child is found to be living in a household, or is frequently visited by, a person who is known to have inflicted abuse on another child, or is acting in a caring capacity and has a record of which includes offences of violence such as to cause concern for the child's safety…'.

R later on had his 15 year old niece living with him.

6.5.2 The discharge of R from the MSU appeared to the Independent Investigation Panel to be even more precipitate than his transfer from HSH to the MSU. Again, allowing what appeared to be the pace of his treatment to be dictated by R through his negative behaviour was difficult to comprehend. Discharge was ill advised. Consultant W responded that he did not agree with this finding, on the grounds that he considered 'there was no evidence that R had benefitted from any of the interventions offered to him whilst in hospital.'

6.5.3 There is clear guidance in respect of restricted patients for the arrangements which need to be in place prior to discharge. These guidelines were available prior to R's discharge and, although he was not restricted they could have been referred to as good practice. These guidelines have been recently updated and published by the Ministry of Justice as 'Guidance for social supervisors' and 'Guidance for clinical supervisors', March 2009.

6.5.4 Annex B: 'Summary of recommendations for good practice for staff of the discharging hospital' in the social supervisor's guidance gives nineteen points for consideration by the discharging hospital. These include transfer of comprehensive documentation to those who will take up supervision and responding helpfully to those requests for further information. In R's case there were difficulties in obtaining information requested by MAPPA, in particular from the HSH. Points 9, 10 and 11 cover the issue of suitable accommodation and point 10 states, "it is important to identify suitable accommodation and to specify which types of accommodation would not be appropriate for individual patients", with point 11 adding, "there should be no question of a patient going automatically to unsuitable accommodation simply because a place is available…"

6.5.5 When R's behaviour was difficult to contain in the medium secure service a return from trial leave to High Secure care should have occurred. The Independent Investigation Panel held a conversation in June 2010 with the Responsible Medical Officer who agreed to transfer R's care to the MSU, at their request, and the question was put to him what would the reaction have been if HSH had been asked to take R back from trial leave. His answer was that this had been discussed and that if it happened where patients were failing the HSH would take such patients back without entering into protracted discussion and would further reassess them without risk to others.

6.5.6 The above is described with the benefit of hindsight and in a paper dated the 19th of June 2009 produced by Consultant W he observed, "At the heart of this issue therefore is a dilemma. Services can either be empowered to exercise sanctions (and to possibly reduce risk) but at the cost of substantially reducing the population that it can serve by only taking those on some form of license or they can be more flexible in their provision by taking on some individuals over which they will have limited or no control but at the cost of exposure to greater risk. As in most life, one can not have it both ways. As a service provider, I think we need a firm steer from those in authority as to where the balance ought to be struck".

6.5.7 The External Review Panel had some sympathy with this argument, but felt it is best played out and recognised within community based services. Secure services invariably know the potential of the patient they are responsible for and that patients within their care are detained and are not informal.

6.5.8 The Panel having considered the above and the detail which is contained in the main body of the report have concluded that R was not ready for discharge into the community from medium secure care and indeed high secure care in which R should have remained. Once R continued to show behaviour he had displayed in high secure care in the medium secure hospital he should have had R's trial leave terminated and been returned to conditions of high security for further treatment to alleviate his condition.

6.6 To examine the role of the care coordinator and the interrelationship between the Community Forensic Team and the Personality Disorder Team (Team 63) in Trust 2 in providing care and supervision to R.

6.6.1 Number 63: Service for People with Personality Disorders

6.6.1.1 This service operates to a Service Specification Contract and is envisaged as delivering the agenda contained in 'Personality Disorder: No longer a diagnosis of exclusion – Policy implementation guidance for the development of services for people with a personality disorder" (NIMHE, January 2003) and, 'Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework' (NIMHE, November 2003).

6.6.1.2 The service also contributes to the implementation of the following policy guidance, 'Recognising complexity: Commissioning guidance for personality disorder services' (DOH 2009) and 'Borderline Personality Disorder, Treatment and Management', Clinical Guideline 78 (NICE, 2009), published after the homicide.

6.6.1.3 This translates into a series of principles and aims and objectives and outcomes of the service. The team offers a consultation and referral service to all Trust teams for individuals with significant problems related to their personality function with referrals reflecting the complexity of the client work, the way in which this can impact on the professionals or teams involved and includes those who have contact within the Trust and are a concern but may have not received coordinated intervention The service model aims to develop and sustain the capability of the Trust's workforce and is delivered by 5.5 whole time equivalent staff of differing professional backgrounds and was established in 2005.

6.6.1.4 The service is able to sustain a range of relevant training and respond to changing need and expectations concerning knowledge and skill development and met Commissioners expectation in delivering the local roll-out of the national Department of Health /Ministry of Justice: Personality Disorder, Knowledge and Understanding Framework training programme.

6.6.1.5 The model currently adopted enables a small specialist team to be deployed in relation to the very large level of need. A records audit in December 2009 identified more than four hundred people with a personality disorder diagnosis. The team is involved in the care of around 90-100 people at any one time, with about 25% of these receiving direct therapeutic work.

6.6.1.6 In relation to R, he was offered practical day to day support and 'supervision' from the CFT. A referral was made to Team 63 by the Community Forensic Team; two staff

consultation meetings were held and recommendations communicated to the CFT. Further consultation was offered by Team 63 but not taken up. The work of Team 63 could have been harnessed for assessment of R prior to discharge from the MSU (and even the HSH) to describe a plan for R when in the community and to describe how Team 63 would dovetail with the CFT.

6.6.1.7 This lack of a 'joined up' service between the two teams has been recognised, but has not changed since the homicide.

6.6.1.8 R did not respond to a number of Care Coordinators from the CFT and in particular would not engage with male staff. The whole team in effect acted as his Care Coordinator over the one year period. The team took responsibility as a whole to fulfill the role of Care Coordinator, given the complexity of working with R in a new service.

6.6.2 'Briefing Paper for Service Re-Design'

6.6.2.1 The Independent Investigation Panel was presented with this document when they met with the past and current managers of the service in November 2010.

6.6.2.2 The paper describes the strengths and the development needs which could be considered. The main service development points pertinent to this investigation are:

- There has been insufficient attention to the care pathway development in that Team 63 has not historically had a role either in assessment and recommendation in relation to referral or gate keeping, monitoring the effectiveness of placements, or in supporting transitional arrangements and step-down care
- Consultation is only able to be provided to Trust staff and the team is not resourced or commissioned to offer consultation or support to other key agencies, e.g. primary care or external to the NHS – the Probation Service
- There is a lack of clarity and joined-up working with the forensic service in respect of areas of overlap

6.6.2.3 The above are some of the challenges which are complex and need a whole system approach from all stakeholders. A specific recommendation is made concerning this service.

6.7 To examine the role of the various agencies involved including the Ministry of Justice and the collaboration between these agencies and both Trusts.

6.7.1 The DSPD unit at Her Majesty's Prison (HMP) Whitemoor was, by April 2002, beginning to function and had assessed over 60 prisoners of whom approximately half were considered to meet the criteria for admission. R was sentenced to his four and a half

years in July 2002 and was due to be released on the 6th of May 2005. R's disruptive behaviour resulted in him being 'ghosted' around different prisons. It appears that R was not considered or assessed for treatment at HMP Whitemoor, which would have been available to him within the time frame of his sentence. (Following his sentencing for the homicide having served his tariff of three years it has been reported to the Panel via R's mother that he is being told that he will now go to one of the two prisons based DSPD Units).

6.7.2 R's transfer to the HSH, close to his expected date of release from prison, was badly timed. The prison service knew this prisoner well and coped with him by moving him around the wider prison estate. Access to the prison based DSPD Unit was available for referral. Had R been assessed and possibly given treatment in such a unit R would have been eventually discharged from prison to supervision on license from the Probation Service, with sanctions available should R not comply with the expectations of conditions imposed upon him during the time of the license.

6.7.3 As it was R's referral to HSH care resulted in his Transfer Direction under Section 47 of the Mental Health Act. The direction under Section 47 therefore had the same effect as a hospital order under Section 37 of the Act without restrictions under Section 41. Such Hospital Orders can be discharged by the patients Responsible Medical Officer/Responsible Clinician or on appeal/review to Hospital Mental Health Act Managers. Restricted patients can only be discharged conditionally or absolutely by a Mental Health Tribunal chaired, in the case of a restricted patient, by a Judge or senior barrister who would review arrangements made for transfer to conditions of lesser security or the community. Hospital Mental Health Act Managers cannot hear such cases. Conditional discharge includes regular reporting to the Home Office by the patient's Social Supervisor and Supervising Psychiatrist on their activities. Such conditions may last without limit of time. Should problems in supervision or adherence to specific conditions cause concern the patient can be recalled to hospital. Once the Consultant W discharged R's hospital order when he discharged R to the community the option of recall and monitoring by an external agency was not available. It would have made a significant difference to the community team attempting to support and treat R in the community had they had available to them the additional levers that a restriction order would have afforded them.

6.8 To examine the effectiveness of the MAPPA process in the management of R

6.8.1 The informing of the MAPPA Manager prior to discharge from medium security is now a matter of routine some six months prior to anticipated discharge. What eventually made planning difficult for this monitoring group was absence of prior knowledge of discharge and following R's discharge was absence of good intelligence of R's activities.

6.8.2 Had MAPPA been informed in a reasonable time-span prior to discharge it is probable that the interim and unsatisfactory temporary accommodation arrangements could have been avoided as local authority housing is part of MAPPA.

6.8.3 MAPPA took steps to inform and protect the new partner of R who was pregnant by him and had been subject of an alleged assault. R's mother reported on several occasions when she was visiting her son she would call and in R's mother's words she was pestering her son.

6.8.4 The CFT had difficulty in monitoring R's actions with any certainty as R dictated how, when and if he would be seen and who would see him and where. It was therefore difficult for the CFT membership of MAPPA to provide an accurate account of R. On one occasion when a CFT community nurse gained access to R's new flat it was noted that the contents within it were of a quality far above that which R's benefits would have enabled him to purchase. MAPPA intelligence indicated that R was attempting to set himself up as a 'minder' to local drug dealers. R's mother had furnished his flat for him and had saved and stored furniture for his eventual release from prison and later his discharge from hospital. R's mother also reported that he was a victim of drug dealers and that she has spent a significant amount of money paying R's drug debts.

6.8.5 Prior to the homicide there is a MAPPA minute which indicates there was some form of covert monitoring of R being undertaken by the police: the independent investigation team have no further information on this.

6.9 To establish whether the recommendations identified in the Trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response to these recommendations.

6.9.1 The review team considered a report produced by Trust 1 dated 14th of February 2011. This review was conducted by a Consultant Forensic Psychiatrist and made no recommendations. There were a number of problems with this report. It took almost two years for it to be produced by a single individual. This investigation should have followed a standard procedure and involved a multi-disciplinary panel with clear terms of reference as was the case in Trust 2. The independent investigation identified a number of recommendations for Trust 1 and finds it difficult to understand how the internal review was unable to identify and areas for implementation.

6.9.2 The Trust 2 review was conducted by a Consultant Psychiatrist, Associate Medical Director, the Suicide Prevention Co-ordinator, Director of Mental Health and the Associate Director of Nursing. The resulting report was reviewed by the Corporate Risk Manager.

6.9.3 They confirmed the main contact for Trust 2's monitoring of progress, and the link for planning R's future care and treatment beyond secure facilities was the forensic commissioner who attended the CPA reviews in this capacity. It was clear from the records that he and his colleagues were involved in planning R's care from April 2007.

6.9.4 R was assessed for the first time by the forensic service eleven days before his discharge from the MSU and the internal review team noted that there was no use of the Mental Health Act (1983) considered for the aftercare arrangements of R i.e. Section 25a or extended Section 17 leave.

6.9.5 The report produced by the internal review team undertook to determine a critical timeline. Their report further analysed the contact history of the forensic and drug dependency service with R by face to face and telephone contacts, including reviews with other agencies.

6.9.6 Risk assessments were reviewed appropriately by the Care Coordinators and undertaken using Trust 2's format on the 19th of October 2007; 26th of March 2008 and the 4th of September 2008.

6.9.7 Risk markers were noted to be:

- Verbalising paranoid ideation regarding behaviour or motivation of others; disengaging from the forensic team and irrational fears regarding the fidelity of his partner;
- Social Isolation; disengaging from the support of family members; disproportionate anger or aggression; increased anxiety and verbalised vulnerability.

6.9.8 Risk factors were identified as:

- Drug and/or alcohol use;
- Engaging in offending behaviour;
- Unstable circumstances including housing, benefits and future employment;

6.9.9 Likely risk situations or factors that could increase risk were identified as:

- Rejection – particularly by women (romantically or family members);
- Sensitivity to frustrating or conflicting interpersonal relationships;
- Unstable social circumstances that may lead to feelings of powerlessness, vulnerability and anger;
- Criminality;
- Drug abuse- in situations where using drugs it was recognised risk of recidivism was high.

6.9.10 A key issue for the community forensic team was determined as not being able to build an optimal therapeutic relationship with R prior to his discharge from medium security and

had been given only two week's notice confirming R's discharge when he was already on periods of home leave. There should have been the opportunity to build up a relationship prior to discharge at an early stage. This would also have enabled a clearer view to have been formed of what the team could achieve and what interventions they could use to support R. This finding in the internal review report is not fair to the Consultant W as he had flagged up the presence of R in the system for some two years to Commissioners pre R's discharge and had made invitations to the Trust to attend care planning meetings (see 1.4.10 ante).

6.9.11 R was identified as having no mental illness but had a diagnosis of Personality Disorder. R had previously been detained under Section 47 and Section 37 of the Mental Health Act 1983, and received treatment in a DSPD unit. It was acknowledged at the Section 117 meeting that due to R's previous behaviour and forensic history a community mental health team would not have managed him and with the requirements of Section 117 aftercare the Community Forensic team was felt to be most appropriate.

6.9.12 The plans and purpose of the team's interactions with R were to engage and offer support around housing, finance and drug misuse and monitoring of mental health. This was recognised as being something that would take some time to achieve. The team pursued and attempted to engage with R; they considered use of the Mental Health Act when necessary, and it had to be noted that R was not subject to any statutory restrictions. Given the above, including R's diagnosis, the Panel felt that the service offered to R was more than adequate.

6.9.13 There was evidence of regular discussion of the case.

6.9.14 The team pursued engagement with R and the Consultant appropriately reinforced the need for this. There were difficulties in engaging R and the team managed this by pursuing contact with him although at times would not get a response.

6.9.15 When disengaging R would still text and phone members of the team. R was texting the Care Coordinator prior to the incident. None of the content of these texts or phone calls caused any concern of risks to others. They raised risks known at the time related to R's lack of engagement and drug activity and the team were aware a police operation was in progress.

6.9.16 Differences of opinion had been discussed within the team on what further involvement was required, although the team remained committed to pursuing engagement on discussion with the team Consultant.

6.9.17 The Internal Review Team concluded that, "discharge arrangements were poorly thought through and inadequate which caused high levels of stress for R and complicated an already difficult situation in engaging him with the Community Forensic Services, with the Community Forensic Team only receiving two weeks notice of his discharge".

6.9.18 "The role of the PCT Commissioner for Secure Services was to ensure the necessary and essential sharing of information between the MSU and the Community Forensic Team. These arrangements were insufficient".

6.9.19 The Independent Investigation Panel reviewed the recommendations made by Trust 2's internal report. The Panel considered that these recommendations were appropriate and followed from the findings of the internal review team. Minor administrative changes were recommended and evidence was provided of their implementation. Two key recommendations requiring change are noted below and commented on by the Panel.

6.9.20 *"The Community Forensic Team should use Trust 2's Personality Disorder Team (team Number 63) more proactively with service users with personality disorder, such as supervision of cases, case management facilitated team discussion and problem solving."*

6.9.21 **Comment:** The work of team Number 63 and training has been considered more fully in Section 6.7 as it forms a specific Recommendation from a Term of Reference.

6.9.22 "*The Primary Care Trust should ensure that funding is made available where case workers can monitor the progress of out of area patients in secure accommodation and be responsible to manage the effective transfer of care of those patients returning to Trust 2's local services."*

6.9.23 **Comment:** Agreement is now in force with the Commissioners for in-reach to be provided six months prior to discharge of patients from secure facilities. There has also been an extension in the CFT tracking, providing Tribunal reports (mainly local facility reports) and attending external CPA reviews of Trust 2's patients in secure hospitals and intensive psychiatric rehabilitation placements. This work is carried out in discussion and conjunction with regional and local Commissioners of such services. The local health forensic commissioner is now embedded in the Community Forensic Team and regularly attends its meetings.

6.9.24 The MSU was criticised in their handling of the discharge of R by Trust 2. The report was systematically reviewed and commented on by Consultant W and a detailed response was prepared and shared with Trust 2. Some of these observations are contained in the section above describing R's time within this unit and are commented on in Section 6.5 of this report.

6.9.25 Overall, the Independent Investigation Panel considered that the internal report from Trust 2 was detailed and thorough, and that its findings are in line with those of this Independent Investigation report.

7. Main Findings and Recommendations

7.1 Main Findings

The Panel were required to determine if the actions taken by Trust 1 and Trust 2 could have been discharged differently, thus avoiding the homicide of V. The Panel found that Trust 2 made all attempts to engage with and support R when in the community on a voluntary basis. However, the discharge from high and medium secure care was precipitate and the thoroughness of arrangements for continuing supportive care for R's condition on discharge from the MSU, expected with such challenging patients, was poorly arranged. R's transfer to the community was accelerated. Simply put, had the original time scales told to R been adhered to (the Panel thought these appropriate and proportionate to R's presentation and identified needs); at the time of the homicide R would have still been in a HSH with his actions being challenged in a safe environment; consequently R would not have been able to commit the offence against V.

The failure by Trust 1 to establish the details of the offending history of R meant that his risk of harm to others was underestimated. R was able to minimise perceptions of his risk and construct a more benign history.

Through his behaviour R was able to dictate the pace of his journey through high and medium secure health services and his premature discharge into the community.

The community placement of R was poor and exposed him unnecessarily to known destabilisers (most notably drugs) and placed unnecessary stress on what was already a complex transition.

The absence of any legal framework for R's management in the community meant that the community forensic team[1] was more limited in their assertive management of R and R was able to dictate what to engage with.

7.2 Recommendations

When commissioned to undertake this independent investigation the Panel members were required to look wider than just a review of the events under scrutiny. Part of this wider review is the reassurance of the public that the organizations involved have moved on in their service provision in their work with this challenging range of patients. For example, since this incident, Trust 2 has progressed in the area of Risk Assessments and has published clear documentation on this (Cf para 6.2.2.7). The following recommendations affecting Trust 1 and 2 relates to

[1] A thorough review of the working relationship between Trust 2 and local MAPPA is being undertaken.

outstanding issues and are made in pursuing the reassurance of the public and incorporates current government thinking and service direction.

7.2.1 Commissioners of services must ensure the early introduction of clinical teams to patients when the first steps of planning movement between services are proposed and to monitor attendance of the appropriate staff at these. Dissent on the appropriateness of moves should be aired and resolved. Commissioners must be cognisant to the time assessment of such individual patients takes and make budgetary adjustments to accommodate this need.

7.2.2 Patients admitted to secure units from High Security care on six months Section 17 leave should have this amount of time allowed to pass before accepting full legal responsibility for them from the referring unit – in the case of R, this was Trust 1.

7.2.3 The 'Guidance for Social Supervisors and Guidance for Clinical Supervisors', Ministry of Justice, 2009 should inform practice and be adopted by all clinical staff and operational managers in secure units when discharging patients to community settings.

7.2.4 Trust 2 should undertake a review of services for offenders with a personality disorder. This should be conducted taking into consideration the policy guidance the 'Consultation on the Offender Personality Disorder Pathway Implementation Plan' Department of Health and Ministry of Justice (NOMS), February 2011. The Trust, within this review, should work with other agencies to agree and describe improved pathways out of healthcare and prison units. Commissioners of such services and stakeholder agencies should form part of the review. In further consideration of the change the governments wish to make in forensic services, the review should include in their considerations the government's response to Lord Bradley's, 'Report on people with mental health problems or learning disabilities in the Criminal Justice System'.

7.2.5 Local MAPPA should be given as much notice and information of returning offenders from secure care as possible: a minimum of six months prior to discharge in all cases.

7.2.6 Trust 1 should record the source of information regarding the detail of offences committed by patients, checking the detail of the offence(s).

7.2.7 Trust 1 should closely examine offences and offending behaviour described by the patient, making appropriate enquiries to verify the patient's account.

7.2.8 Trust 1 should consider peer review of patients with personality disorders who are to be discharged into the community without statutory supervision.

7.2.9 Trust 1 should always consider if a Community Treatment Order would be appropriate in all cases of patients discharged from secure hospital care who are not subject to supervision on a restriction order.

7.2.10 Commissioners of forensic services should acknowledge the time-consuming nature of

forensic work and its cost and plan to commission services accordingly. The commissioners of such services should be involved in the strategic review recommended that Trust 2 are recommended to undertake

7.2.11 Trusts 1 and 2 should agree a protocol on the handling of detailed confidential information when patients are transferred from the secure services of Trust 1 to Trust2 and vice versa.

7.2.12 Commissioners of forensic services should conduct an audit of the time taken in planning for the support and assessing ongoing risk factors of patients returning to the community from secure psychiatric care. This should be undertaken to help demonstrate the complexity posed and the re-evaluation of the allocation of resources and identification of gaps in provision.

7.2.13 Trusts 1 and 2 should reacquaint themselves with the guidance 'Information Sharing and Mental Health', Department of Health, September, 2009.

Appendices

Appendix One: People Interviewed and Documents Reviewed.

The investigation was assisted by interviews with the following:

R was interviewed in prison by the Lead Investigator and his signed consent was given to access his clinical and other relevant records.

Three key staff involved in R's assessments, treatment, and supervision and commissioning of his care were interviewed; they were:

- Consultant W of Trust 1
- The community based Consultant Forensic Psychiatrist of Trust 2.
- The Principal Accommodation and Commissioning Officer, Commissioning Primary Care Trust
- Members of Team 63
- The Governance Manager, Trust 2
- The Clinical Director of the MSU, Trust 1

The sister of the victim and members of the extended family were seen at their home by the medical member of the Independent Investigation Team. The daughter of the victim and her partner were seen by the Chair and Lead Investigator of the Independent Investigation Team at their home.

The details of these key interviews are described in Appendices Four and Five

Written statements had been made to the Internal Review Team by clinical staff of Trust 2 and a detailed riposte to the internal review report of Trust 2 by Consultant W and Trust 1 was also taken into account.

The following key documents were read:

'The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation', National Patient Safety Agency.

'Review into the Care and Treatment of R', STEIS No 2008/7751, Trust 2, 15 May 2009.

HSH's, 'Structured Clinical Judgment: Risk – Multidisciplinary Assessment of Risk' pertaining to R –2nd of August 2006.

Neuropsychology Report – 8th of February 2006 for CPA

Treatment Needs – Psychology Report – 15th of August 2006

Initial correspondence from the Consultant W from the MSU to the Responsible Medical Officer of the DSPD Unit in the HSH.

Psychiatric Assessment Report following referral to the Personality Disorder Unit at the HSH and associated documents provided to the Admission Panel dated the 7th of March 2005.

Pre-admission Psychology Assessment Report (Personality Disorder Directorate) - 18th of March 2005.

Initial referral letter from a Consultant Forensic Psychiatrist to the Personality Disorder Directorate dated 20th of July 2005.

Independent Psychiatric Report prepared for the Mental Health Review Tribunal following R's appeal against his continuing detention dated 30th of July 2005.

Minutes of a CPA meeting help on the 21st of May 2007 at the MSU.

Psychiatric Report dated 17th of February 2004 and associated documents.

Report to the Mental Health Act Managers Meeting at the MSU, 28th of March 2007.

Pre-Sentence Reports for Burglary of Dwellings produced on 16th of May 2002 and 2nd of July 2002.

Post-mortem Examination Report (FP0972), 21st of May 2010

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National Institute for Mental Health in England (2003) Personality Disorder: No longer a diagnosis of exclusion – Policy implementation guidance for the development of services for people with a personality disorder

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Appendix Two: Members of the Independent Investigation Panel

Dr. Colin Dale has been an Executive Nurse in three mental health NHS Trusts and has worked as a professional adviser to the Royal College of Nursing (RCN), National Institute for Mental Health in England (NIME), National Patient Safety Agency (NPSA) and the Dept of Health. He is currently the Vice Chairman of a NHS Mental Health Foundation Trust, a member of the Mental Health Review Tribunal and has functioned as an executive Director of Nursing with three previous NHS Trusts for a period spanning 11 years. He continues to work on a freelance basis as an independent Nurse Consultant and expert witness, combining this work with research and writing. He has worked on several previous mental health inquiries.

Dr Michael Rosenberg was previously the Consultant Psychiatrist, Inpatient Triage, South Downs Health NHS Trust (a new post involving the assessment and care of newly admitted patients for the first seven days of their care episode). Between 2003 – 2006 he was the Chief Executive and Honorary Consultant Psychiatrist South Downs Health NHS Trust; a Trust where he had previously been the Medical Director between 1998 – 2003. He was responsible for the Psychiatric Intensive Care Unit at Mill View Hospital from 1999 to 2005 (a modern 10-bedded unit caring for acutely mentally ill patients, requiring short-term intensive treatment). He is approved under Section 12(2) of the Mental Health Act 1983. He has extensive experience of the investigation of critical incidents and advised on the management of complaints. He was the lead Director for the Trust Patients' Advisory Forum and responsible for developing the Trust's Strategy for Patient and Public Involvement.

Peter Green is a qualified psychiatric social worker and general manager with significant experience as a senior executive in local government, the National Health Service, the Mental Health Act Commission and latterly independent psychiatric hospital provision and consultancy. He was the principal social worker at St. James's University Teaching Hospital, Leeds and has worked in all three HSHs, as a senior practitioner at Rampton Hospital, the Head of Social Work Services at Broadmoor Hospital and the Director of Rehabilitation and General Manager at Ashworth Hospital. He has considerable expertise in the assessment of mentally disordered offenders and evaluation of service delivery. He has aided the administration of two public inquiries.

The Panel was advised by Dr Tony Fowles, a former Chair of the Lancashire Probation Board, on matters concerning the criminal justice services.

All three members of the investigation team and the criminal justice advisor are independent of any of the organisations involved with the homicide and have had no involvement in any of the investigations to date.

Appendix Three: Care Programme Approach

One of the Terms of Reference was to consider this cornerstone of practice within mental health services.

The Care Programme Approach (CPA) was introduced in 1990 as the framework of care for people with mental health needs, originally intended to be implemented by April, 1991 and to run in parallel with the Local Authority Care Management system.

The CPA was revised and integrated with Care Management in 1999 to be used by health and social care in all settings, including inpatient care.

Two tiers of CPA were established: Standard and Enhanced.

Standard was described as being for those people whose needs could be met by one agency or professional worker.

People on Enhanced CPA have multiple needs which are more likely to be met by inter-agency co-ordination and co-operation. There is likely to be a higher element of risk and disengagement from services. A Care Plan was to be developed to address those needs. A key worker or Care Coordinator was to be appointed and regular review was to take place making changes to the plan to reflect changing need.

A new system for conducting CPA was implemented in October, 2008. Although this was not within the time frame of R, it restated that the role of the Care Coordinator was vital.

Appendix Four: Background to Criminal Justice Issues

1 MAPPA

Multi-Agency Public Protection Arrangements are a set of arrangements established by police, probation and the prison service (known as the Responsible Authority) to assess and manage the risk posed by sexual and violent offenders. Other agencies that co-operate in MAPPA include youth offending teams, Jobcentre Plus, local education authorities, registered social landlords, social services, strategic health authorities, NHS Trusts and electronic monitoring providers.

The principles that govern MAPPA are simple:

- Identify who may pose a risk of harm.
- Share relevant information about them.
- Assess the nature and extent of that risk.
- Find ways to manage that risk effectively, protecting victims and reducing further harm.

Central to all risk management is the need to consider the protection of previous and possible future victims. As part of any risk management strategy it may be considered necessary for information to be disclosed directly to others by the police in order to prevent harm, such as new partners, landlords, and other agencies.

A Strategic Management Board monitors and reviews how these arrangements are working in each local area. Chaired by a senior representative of the police, probation or prison service, the Board includes senior representatives of other agencies. Each Board has two members of the public appointed by the Secretary of State, to act as lay advisers in the review and monitoring of the arrangements and to help improve links with communities.

Revised guidance issued by the Home Office and National Probation Service relating to sections 325-327 of the Criminal Justice Act 2003, resulted in guidance which identified the following features of good practice crucial to the effectiveness of public protection.

- Defensible decision making in the assessment and management of risk.
- Rigorous risk assessment and the importance of the victim focus of MAPPA work.
- Robust risk management in coordinating the work of each agency and integrating work to promote the offenders' self management.

Guidance identifies three categories of offenders who are subject to the MAPPA process, and emphasizes the importance of identifying them promptly and accurately:

- Category 1 – Registered sex offenders who have been convicted or cautioned since September 1997 of certain sexual offences and are required to register personal and

other relevant details with the police in order to be monitored effectively. The police have primary responsibility for identifying category 1 offenders.

- Category 2 – Violent and other sex offenders receiving a custodial sentence of 12 months or more, since April 2001, a hospital or guardianship order, or disqualification from working with children. All these offenders are subject to statutory supervision by the National Probation Service and consequently probation is responsible for identifying Category 2 offenders.

- Category 3 – Other offenders who are considered by the Responsible Authority to pose a "risk of serious harm to the public". Identification is largely determined by the judgment of the Responsible Authority, based on two considerations:

The offender must have a conviction that indicates that he is capable of causing serious harm to the public.

The Responsible Authority must reasonably consider that the offender may cause harm to the public. The responsibility of identification lies with the agency that deals initially with the offender.

Below these categories an operational structure was created to ensure offenders were managed according to their assessed risk and risk management needs. In brief the structure is:

- Level 1 (Ordinary risk management) – Where the agency responsible for the offender can manage risk without the significant involvement of other agencies – only appropriate for Category 1 and 2 offenders who are assessed as presenting low or medium risk.

- Level 2 (Local inter-agency risk management) - Where there is "active involvement" of more than one agency in risk management plans, either because of a higher level of risk, or because of the complexity of managing the offender. The essential feature of Level 2 arrangements is that their permanent membership should comprise those local agencies which have an active role to play in risk.

- Level 3. Those offenders defined as the "critical few" who pose a high or very high risk. Level 3 cases can be 'referred down' to Level 2 when risk of harm deflates.

The quality of both risk assessments and the risk management plan are heavily determined by the effectiveness of information sharing arrangements. The Responsible Authority also has a clear duty to share relevant risk assessment information and that the risk identified is managed robustly. This means that the Responsible Authority must seek to ensure that strategies to address that risk are identified and plans developed, implemented and reviewed on a regular basis. Those plans must include action to monitor the behaviour and attitudes of the offender and to intervene in their life in order to control and minimise the risk of harm.

However the ability of the Responsible Authority to ensure robust management is thought to depend on a number of factors. Case specific detail such as the nature and severity of risk posed and the factors that may trigger reoffending behaviour, the attitude of the offender and whether any statutory powers exist to modify or contain behaviour are all highly relevant in determining what risk management options are appropriate. So too is the engagement of the range of agencies that are able to make a specific contribution to the development of appropriate strategies and to directly manage elements of the risk management plan. It is believed that the strongest examples of MAPPA development reflect the ability of the Responsible Authority to engage other agencies.

The Guidance states that key to the effectiveness of Level 2 and 3 arrangements are the multi-agency representation and involvement. In determining the level of the representation and the nature of that involvement three factors must be considered. First, the representatives must have the authority to make decisions committing their agency's involvement. If decisions are deferred then the effectiveness of the multi-agency operation is weakened. Secondly, they require relevant experience of risk/needs assessment, management and the analytical and team playing skills to inform deliberations. Thirdly, the effectiveness of Level 2 and Level 3 arrangements depend in a large part upon establishing continuity. Multi-agency work is often complex and benefits greatly from the continuity of personnel and their professional engagement.

2 Indeterminate Prison Sentence

The Criminal Justice Act 2003 created two new indeterminate prison sentences: the sentence of indeterminate detention for public protection (IPP) for adults, and a parallel sentence of detention for public protection (DPP) for children and young people under 18. They were to be imposed on those who committed specified, 'serious violent and sexual offences' and who were deemed to pose as 'significant risk of serious harm' in the future. The sentence became operative in April 2005.

The scope of these sentences was very wide. The offence in question could be one of 95 different offences, from manslaughter to robbery. Moreover, in the case of adults, the fact of having previously committed any of the 153 offences specified in the schedule to the Act created a presumption that the threshold of significant risk of serious harm had been reached. That presumption could only be displaced if the court was presented with material about the offence or offender which made the imposition of an IPP unreasonable. Once sentenced, offenders were given a 'tariff' (the minimum period of imprisonment required for punishment and deterrence) but would only be released after that point if they could show the Parole Board that they had reduced their risk to the public. Given the wide range of offences and the presumptive nature of the legislation, many tariffs were short: averaging 30 months at first (the equivalent of a five year sentence), with one as low as 28days.

Prisoners, once released, would be subject to license supervision and possibly recall to prison for at least ten years and possibly for life. As this process was the same as that for life-sentenced prisoners, the National Offenders Management Service (NOMS) decided that they should be managed in the same way as lifers.

Appendix Five: Personality Disorder and Services

1 Dangerous Severe Personality Disorder (DSPD) Programme

Proposals for the DSPD Programme were set out in a governmental consultation document in 1999. They were intended to address perceived failures in the penal and psychiatric systems in protecting the public from dangerous offenders.

Three main elements were proposed:

- New powers to enable the indeterminate detention of DSPD individuals.
- Removing or amending the treatability requirement in the mental health legislation.
- Providing 300 high-secure places in specialist DSPD units.

Defining criteria were to be threefold:

- Severe personality disorder.
- High risk of future serious and harmful offending.
- Connection between the personality disorder and risk of offending.

New legislative powers of detention specifically for DSPD individuals were not in fact introduced. The DSPD units operated under existing mental health legislation in two of the HSHs and generic criminal sentencing powers for the two prison units. The introduction of extended and indeterminate sentencing under sections 225 and 227 of the Criminal Justice Act 2003 provided additional powers that were important for the prison based units.

2 Personality Disorders

R was assessed in the HSH as meeting the criteria for three personality disorders. These were:

Antisocial Personality Disorder: this includes a pervasive pattern of violation of the rights of others that begins in childhood or early adolescence and continues into adulthood. Individuals with such a disorder are probably selfish, show little regard for others or the opinions of society around them. They tend to lack remorse or empathy for their victims and are likely to take advantage of others with little sense of loyalty, even to those who are close to them. An individual with this particular disorder would be expected to place little emphasis on his social role responsibilities (e.g. fatherhood), and their behaviour is likely to be reckless, involving risks that are potentially dangerous to them and those around them. A history of conduct disorder during adolescence and involvement in antisocial behaviour and illegal occupations is also likely.

Borderline Personality Disorder: The essential feature of this disorder is the pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning in early childhood. The perception of impending rejection or separation or loss of

external structure can lead to profound changes in self-image. They display impulsivity which is potentially self-damaging.

Paranoid Personality Disorder: The essential features relate to a pattern of pervasive distrust and suspiciousness of others such that their intentions are often seen as hostile threatening or demeaning. These beliefs are steadfastly maintained in the absence of any real supporting evidence; however these beliefs are rarely of delusional proportions.

Appendix Six: Interviews with Trust 1 and 2's Professional Staff.

The views of Consultant W were similar to those expressed in the main body of this report which has been quoted in detail. He confirmed that R was contemptuous and insulting who became a different man when granted leave. He further confirmed that he did not consider R's return to conditions of high security. He established a specific discharge date to galvanise people into action.

The Principal Accommodation and Commissioning Officer indicated that he and his colleagues' view was that the patient was, *"calling the shots"* and wanted to be, *"in charge of his own destiny"*. R declined the offer of being considered for a staffed local authority hostel, independent homes and rehabilitation wards of Trust 2. He felt this case in his experience was a *"one off"* and that the whole case was unusual starting with his transfer from prison close to his release date. His discharge *"happened very quickly"* and that he and his colleagues were, *"trying to do it properly"* and that they, *"could see trouble was looming."*

The community based Forensic Psychiatrist impressed the Independent Investigation Panel. He decided early on that he would do his best along with his team to offer the best they could to R. The fact that they stuck with him despite his voluntary relationship with them was laudable.

Appendix Seven: Cooperation with the Independent Investigation.

A letter was sent to the joint Chairs of MAPPA, dated 9th February, 2010.

A response to this letter dated 12th of February, 2010 was received from the Joint Chairs of the MAPPA Senior Management Board which laid out their rules for co-operation.

This letter is reproduced in some detail as follows:

"With regard to your review, we are more than happy to support and help in any way we can. We both feel that the Strategic Health Authority to commission such a review is healthy and, in the long term, will be beneficial to partnership working in the county…whilst we are happy to help and support you there are some points that we would like to make clear from the outset."

- *"We are supportive of any process which seeks to clarify lessons that can be learnt and agree to members of our staff being interviewed in that context. However, we are not supportive of our staff being re-interviewed in relation to the original matters that are not connected to the mental health process, as in our opinion this process has already been undertaken and our staff have been scrutinized regarding their actions".*

- *Secondly, we consider some of the more sensitive material you will have access to is not suitable for public consumption purely because of the sensitive nature of the work involved in managing people….therefore whilst we are happy for you to be sighted on documents, e.g. MAPPA minutes, we do not expect these to be disclosed and any reference to them should be made as a generalization rather than a specific".*

"Our previous reviews have rightly identified failings in our systems and processes and, as agencies, we have made every effort to learn from these mistakes and to improve our internal processes in order that they are fit for purpose. Some of the cases you are reviewing in MAPPA terms took place during the inception of these schemes and there has been considerable progress and changes since then and we now consider the system to be more robust."

"We would therefore be grateful if you can ensure that any changes that we have made and any strengths you now see within the current system could be recorded accordingly in your report."

Finally the letter states, *"…we are happy to support your review and to this end we would like to nominate the MAPPA manager…he will provide you with any assistance you may require".*

The Panel gave reassurances we did not wish to interview any police personnel and were helped by the Probation Trust staff in locating and contacting the victim's relatives.

After protracted one-sided correspondence and telephone calls the minutes of R's MAPPA meetings were received by the Panel on the 17th of May, 2010; some five months later.

On examination there were eight sets on Excel generated minutes provided dating from the 31st of October 2007 to the 6th of August 2008. These minutes only described action plans which had little background information attached to them and were therefore relatively unhelpful to our investigation. Eventually the Independent Investigation Team discovered, in a bundle of documents held by Trust 2, some of these background minutes, but not all of them.

An e-mail dated the 29th of June, 2010 was sent to the MAPPA manager reviewing the numerous requests for help in pursuing information of the statement of case prepared by the police for the CPS. This e-mail finally posed the question, *"is there a need to discuss with others in your service, or do you feel I need to make my request elsewhere, e.g. the CPS?"* Consent had been given by R to approach such agencies for help.

The Panel had hoped that its requests for unconditional help and cooperation embraced such areas of information held in determining the actions of R. Had it been made available to the Panel, although not necessarily disclosed in its final report, it would have been of considerable help in understanding and describing the fuller factual detail of this homicide.

No response was received and subsequently on the 12th of July the CPS was contacted to enlist their help. They were extremely responsive and were prepared to obtain all archived records for information for the Panel to peruse. As a courtesy they contacted the police Superintendent Joint Chair of MAPPA in the Public Protection Department, Protective Services Command, for a view on release of information.

The CPS wrote to the Panel on the 20th of July, 2010 stating that this officer said it should withhold the information. Finally, after seven months of asking, a decision had been made. The police view was simple, *"if this is a review of the actions of the health authority and partnership working then I am struggling to see why a copy of the tape recorded interview is required."* This was not what had been requested.

The Panel finally wrote to the police on the 19th of October 2010 informing them they would now need to pursue accessing this information through another avenue, as the lack of response had jeapordised progress of this investigation within the time frame required by the NHS East Midlands. The Panel therefore finally resorted to purchasing, at further public expense, as a minimum, the transcript of the sentencing proceedings for R. These are public records and are not subject to veto. When obtained these were not as informative of the events of the offence which would have been held by the police, but they were of significant assistance in providing an alternative version of events than that put forward by R.

The Panel was therefore unable to interview the woman involved with the victim, her father or read her statement. This situation was unhelpful.