REPORT OF THE INDEPENDENT REVIEW INTO THE NHS CARE AND TREATMENT PROVIDED TO MR O

Confidential

Contract reference:	**Mr O**
Incident type:	**Homicide**
Date of Incident:	**24th December 2015**
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Date of report:	24th January 2018

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EXECUTIVE SUMMARY

1. Introduction

1.1. This is the report of an independent review commissioned by NHS England into the care and treatment provided to Mr O, who was a patient of Hertfordshire Partnership University NHS Foundation Trust (HPFT) when on 24th December 2015 he met and then killed Ms M.

1.2. This review was carried out alongside a multi-agency review which included Hertfordshire Partnership University NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, the National Probation Service, Avon and Somerset Constabulary, and the Hertfordshire Constabulary, under the auspices of the Hertfordshire Domestic Abuse Partnership.

1.3. This report will focus specifically on the NHS care given to Mr O and communication between services. The multi-agency review has both informed and been informed by this report, and identifies the multi-agency learning.

1.4. We would like to extend our sincere condolences to the family of Ms M for the terrible and tragic loss of a much loved daughter. We hope that the impetus and challenge within this and the multi-agency report will lead to changes in services and across agencies.

1.5. We would like to thank all the staff in the NHS, two Police constabularies, the Probation services, and the Hertfordshire Domestic Abuse Partnership for their support in this investigation. Our primary aim, as with all investigations into NHS treatment and care, is to learn lessons from this case and to help improve services, making them safer.

1.6. Appendix 1 of the report contains the Terms of Reference for the investigation. Appendix 2 contains details of the investigation team and Appendix 3 lists the documentation the team reviewed, which included NHS case notes, Trust policies, and copies of internal reviews carried out by the NHS, Police and Probation service. Appendix 4 lists the witnesses interviewed, and Appendix 5 gives a summary of chronology of the NHS care Mr O received. There are no significant inconsistencies across this information and the team has no reason to doubt its reliability.

2. Findings

2.1. Context of this review

2.1.1. Homicides by people in receipt of mental health services are extremely rare. Overall, of around 600 homicides per year, 11% or 50-60 per year are committed by people in contact with mental health services, a number that has been falling since 2008.[1] Whilst there would never be an excuse for failing to diagnose, assess or manage the risk of harm that might be presented by such individuals, individual clinicians will rarely see service users who pose so severe a threat, because their numbers are very low; this makes the management of risk to others especially challenging.

2.1.2. Mr O was diagnosed as having an Emotionally Unstable Personality Disorder (EUPD), with narcissistic and dissocial (psychopathic) traits. EUPD is a relatively uncommon condition (a prevalence rate of perhaps no more than one or two per cent) characterised by fluctuations in, and difficulty managing mood. A Dissocial Personality Disorder is characterised by disregard for the feelings of others and an inability to modify behaviour in response to adverse events; it may also feature a relatively low threshold for violence, a tendency to blame others and a wide range of interpersonal and social disturbance.

2.1.3. Mr O's behaviour was highly volatile, with rapidly changing mood, and he presented different challenges and risks. At times he was provocative towards staff from statutory agencies and he used implicit and explicit threats on occasions. However, he was intelligent and could also be socially very engaging.

2.1.4. With this range of behaviour it was likely that Mr O would come to the attention of the Police, Criminal Justice System and NHS organisations. It was therefore not a question of whether he presented a 'legal' problem or a 'health' problem, Mr O was likely to engage with and challenge all of the agencies, and they needed to find ways to work together to manage his behaviour.

2.1.5. NICE guidance, published to inform NHS Clinical Commissioning Groups about the care requirements for people with a Personality Disorder (PD) of this type, emphasizes the importance of inter-agency collaboration, multi-disciplinary care planning, risk assessment and management for what can be amongst the most challenging of all mental health conditions. [2]

[1] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016) Annual Report and twenty year review. http://research.bmh.manchester.ac.uk

[2] National Institute of Health and Care Excellence (2009) `Personality disorders: borderline and antisocial' www.nice.org.uk/guidance/cg77

2.2. Summary of the care and treatment provided to Mr O

2.2.1 Mr O was born in Enfield in 1989 the youngest of three brothers, and his family moved to Hertfordshire when he was 6 years old. He was reported to be successful both in sport and academically, going on to attend university and study at Masters Level.

2.2.2 Records indicate that Mr O had been identified at the University of Surrey as having harmed himself in 2009 and 2010 with a further episode in Wales in 2011. He first came to the attention of Hertfordshire Partnership University NHS Foundation Trust (HPFT) in July 2013 after an episode of self-harm led to attendance at an Accident and Emergency department, and he was referred to HPFT. He was supported by HPFT community services and was discharge from their care in October 2013.

2.2.3 There are no records suggesting that between the end of this episode of NHS care in 2013 and February 2015 Mr O received any input from mental health services.

2.2.4 In February 2015 following an episode of self-harm Mr O came under the care of the Intensive Support Team of Avon and Wiltshire Mental Health Partnership Trust (AWP) where he was living at that time with his girlfriend and her family. During this period of NHS care he disclosed violent fantasies of murdering women and raping them. On 20th March 2015 he reported specific thoughts of killing and raping his girlfriend's sister, and made a threat to kill an AWP Community Psychiatric Nurse. He was detained by police under Section 136 of the Mental Health Act, but following a Mental Health Act assessment he was determined not to be suffering from a mental disorder. Given the risk he posed he was immediately arrested for threats to kill and remanded in custody at HMP Bristol.

2.2.5 During March and April 2015 he remained in HMP Bristol. Some assessment work was carried out by the mental health prison in-reach service which was delivered by a group of health organisations including AWP; however due to his short stay no active treatment was commenced.

2.2.6 Having pleaded guilty to two threats to kill, in early May 2015 as a condition of bail, Mr O returned to his parents' home to await sentencing from Bristol Crown Court. Within two weeks he had called the police to request that he be sectioned under the Mental Health Act, had engaged in self harm which required his treatment at Accident and Emergency, and was re-referred to HPFT. He was initially seen by the crisis team, and referred to the Acute Day Treatment Unit. From there he was transferred to the care of the community team.

2.2.7 In mid-June 2015 Mr O was admitted to the Royal London Hospital after having self-harmed; his injuries were so serious that they warranted surgery and were life-threatening. He was then referred for inpatient care on Swift Ward at HPFT, and after three weeks he was discharged to community support.

2.2.8 At the end of July 2015 police were informed that Mr O had made a threat to kill his girlfriend's brother and, after threats and suicide attempts at the beginning of August, Mr O was readmitted to Swift ward. During his following 8 weeks in hospital there were concerns raised about sexual relationships with vulnerable female patients on the ward, such that he was moved to an all-male ward. Case notes suggest he posed a significant challenge to safe ward management, for example by setting fire to items in the garden area of the ward.

2.2.9 While he was under the care of community services prior to his August admission an assessment was requested from the Trust's Forensic services and this was carried out in early August by the consultant forensic psychiatrist FCP1.

2.2.10 Swift ward consultant CP1 and the forensic consultant FCP1 agreed that Mr O needed a detailed and comprehensive forensic assessment in a more structured environment, and that it might be possible to apply a Section 38 Interim Hospital Order when his case came to Bristol Crown Court. FCP1 therefore wrote to Bristol Crown Court suggesting this. No response was received. CP1 also recommended that Mr O be held under Section 3 of the Mental Health Act pending his attending court.

2.2.11 When he insisted he was going to leave the ward on 10th August, Mr O was held under Section 5 (2) of the Mental Health Act (MHA). This section allows a person who is currently an informal patient on a ward and who expresses the intention to leave to be held for up to 72 hours for a further assessment if clinicians believe they may pose a risk to themselves or others. On 11th August due to his behaviour Mr O was moved to Owl Ward within HPFT, an all-male ward with access and exit controlled, under the care of the ward consultant CP2.

2.2.12 A Mental Health Act Assessment was carried out on 12th August by two consultants and an Approved Mental Health Practitioner. In that assessment Mr O confirmed that he would stay on Owl Ward voluntarily, and be bound by a behavioural contract. In the light of the Mental Health Act guidance on using the least restrictive care setting possible, and on the basis that Mr O had agreed to stay voluntarily, the assessing team agreed Mr O did not require to be detained under the Mental Health Act at that time.

2.2.13 The Mental Health Act Assessment was carried out thoroughly, and reached its conclusion in the context of the information the assessors had at that point in time.

The assessing team were aware of the view of CP1 that Mr O should be held under Section 3 of the Mental Health Act, and of FCP1's proposal that the Court should direct an Interim Hospital Order, although FCP1's report was not completed so it was unavailable to the assessing team. These views were not reflected in the outcome of the assessment.

2.2.14 Following the assessment, CP1 met CP2 to discuss their different views on detaining Mr O, but did not reach a shared view. CP2 and FCP1 reviewed Mr O's care and, on an understanding that Mr O was responding to strict boundaries and compliant with his treatment plan, they reached a view that the risk of him actually carrying out the threats to kill and rape were low and an Interim Hospital Order was not required.

2.2.15 Mr O remained on Owl ward for 6 weeks, and showed similar challenging behaviours to those he had shown on Swift Ward. In this period of his care there was no evidence of a clear assessment of Mr O's risks, or a comprehensive, coherent care plan, leading to the delivery of a consistent care package. During his time on Owl Ward Mr O broke his behavioural contract, and may have broken his bail conditions as well. Routes were open to action under the Mental Health Act or the legal system, but these were not taken. This was arguably a missed opportunity for moving to a more structured environment where a more detailed assessment could have been undertaken.

2.2.16 As is noted above, FCP1 wrote to Bristol Crown Court on 10th August suggesting that the Court make an Interim Hospital Order and Mr O be admitted to a Low Secure forensic ward. There is no record of the receipt of this letter or any response from the Court to it. In addition to the letter send to the court by FCP1, two court reports were requested. One was provided by CP2, Mr O's consultant on Owl Ward at that time, the other by an independent consultant psychiatrist.

2.2.17 The independent psychiatrist took the view that Mr O did not suffer from a mental disorder that would make detention under the Mental Health Act appropriate. However, he considered that Mr O presented a significant risk of harm to himself, and that his level of risk fluctuated and would depend on situational factors. He felt it was almost impossible to give a reliable comment on the risk Mr O posed to others, due to limited information about him, but he was seriously concerned about his threats to kill.

2.2.18 He concluded that it was unlikely that any psychiatric treatment would alter Mr O's risk profile in the short to medium term, and that risk management should therefore rely on the criminal justice system and Probation services.

2.2.19 CP2 who wrote the second court report considered that Mr O's greatest risk related to himself; he had made several impulsive but very dangerous suicide attempts and

remained at high risk. He did not believe it was ever Mr O's intent to kill anybody, nor did he think he was ever likely to do so in the future. CP2 said that Mr O did not need ongoing hospital treatment, although might need brief admissions in times of crises, and suggested the Court direct a Mental Health Treatment Requirement (MHTR).

2.2.20 Three experienced senior consultants had reached different conclusions. This reflected the difficulties for experienced professionals to develop a coherent formulation of the challenges Mr O presented; how to assess his risk, and develop a coherent care plan to meet his needs with integrated risk management.

2.2.21 In September 2015 Mr O went on leave, to be supported by Community Mental Health Services. There was some confusion after he went on leave about whether and when he was due to return to hospital. On 2nd October Mr O was formally discharged from the Ward, and he saw his care coordinator on a routine basis. The lack of clarity about risk or plans to minimise risk may have left community staff vulnerable.

2.2.22 Having pleaded guilty of making two threats to kill in April, on 2nd December at Bristol Crown Court Mr O was sentenced to a Rehabilitation Activity Requirement and a MHTR, with a 9 month prison sentence suspended for two years.

2.2.23 A Probation Officer was appointed and completed the sentence plan with Mr O two days after the court hearing. However, this was not agreed or shared with Mr O's Community Psychiatrist or CPN, who were part of the HPFT community team, as the guidance indicates. There was an email exchange between the Probation Officer and the CPN on 14th December, the Community Psychiatric Nurse (CPN) reported that Mr O was settled and motivated, with no known current risks or concerns. This was the only contact between them before the homicide. There was no contact between the Probation Officer and the Community Psychiatrist CP3.

2.2.24 The imposition of a MHTR offered a final opportunity to create a single, comprehensive care plan including therapy input, and a fresh review of risk. However, there was no meeting to make a risk assessment or develop a coherent multi-agency plan.

2.2.25 In mid-December Mr O saw his GP for repeat medication, his final contact with a member of NHS staff prior to the homicide. At that point his mental state did not give cause for concern and the GP did not judge Mr O to present a threat.

2.2.26 On 23rd December Mr O met Ms M, with who he had been in contact through an internet dating site, and she was found dead on 24th December 2015.

2.3 Risk assessment, prediction and management

2.3.1 Risk assessment should always involve a thorough, up-to-date, comprehensive assessment of all the factors associated with the prediction of risk, and the consequences for the patient and other people. It should include information about the likely causes of risk; the triggers for risky behaviour, and information about the potential impact. The factors which are typically associated with risk include diagnosis, past behaviour, substance misuse, thoughts, intentions and/or mood.

2.3.2 Mr O's diagnosis of Emotionally Unstable Personality Disorder is associated with a 10% risk of death by suicide and Mr O's history was characterised by a pattern of significant self-harm. He threatened suicide several times and this is noted in the reports for the Court. The notes also record that Mr O had behaved in a threatening way towards vulnerable young women, one reason he had been moved to an all-male ward whilst he was under the care of HPFT. However, whilst HPFT completed risk screening assessment forms regularly for Mr O whilst he was in their care, the forms do not include explanations for the ratings of risk that were given and the plans for his care do not contain a clear statement about how risks could be mitigated.

2.3.3 Care Plans should always contain a comprehensive, integrated risk management/reduction plan. However, there is only limited evidence that action was taken to actively manage or minimise the risk that Mr O presented. Whilst there is one comment in the notes advising that he should be seen by two members of staff and never by an unaccompanied female, the notes do not contain a formulation of Mr O's problems or a statement of causes, triggers or possible impacts of risk. Furthermore, he did not have a final, agreed care plan when he was discharged from Owl Ward that was coordinated between the NHS and other agencies.

2.3.4 Exact predictions of risks for individuals are very difficult; for example, over a 10 year period, 3% of people with a mental health problem who have made threats to kill will go on to commit a homicide. Furthermore, such tragic events are statistically very rare. We cannot say with any confidence that the tragic death of Ms M could have been prevented. However, we can say that there were shortcomings in the way that Mr O's level of risk was assessed and managed.

2.4 Communication, within the NHS and between agencies

2.4.1 During our interviews and in the HPFT internal report it was clear that HPFT lack of information about Mr O's previous care was considered to have been one of the critical factors hindering appropriate risk assessment and management. There were three potential sources of information that might have been available to HPFT: AWP, the prison and Mr O's GP.

2.4.2 AWP considered that Mr O's episode of care from the Trust ended when he was detained by police, and they acted in a reasonable and timely manner in that within days of his discharge a comprehensive report was sent to Mr O's GP. Whilst Mr O was in prison the in-reach team carried out an assessment, but during his short stay no treatment plan was created, and on his release, there was no communication from the in-reach team to his GP.

2.4.3 GPs can act as a central point of communication about NHS patient care. However, when Mr O returned to Hertfordshire and presented once again to secondary care mental health services, the discharge report from AWP to the GP was not shared with HPFT even though the Trust routinely sent updates on his care to the GP. Mr O was consistently reluctant to share information about his previous episodes of care, but HPFT did not contact AWP directly, as policies suggest should have happened.

2.4.4 The lack of a single, coherent overall view of Mr O's history and care created a gap at the heart of care planning and risk assessment. It also hampered inter agency working.

2.5 A Talking therapy/Personality Disorder pathway.

2.5.1 Mr O made multiple requests for some type of talking therapy and the notes show that similar requests were made by those caring for him, in AWP and in HPFT. Medium to long term talking therapies are the treatment of choice for people with a personality disorder, although commitment and engagement by the patient is needed, and the evidence for their effectiveness is only moderate. No structured and ongoing talking therapy was ever delivered to Mr O during the period of his care with either AWP or HPFT.

2.6 Alcohol/substance abuse

2.6.1 Like the requests for talking therapy, references to the misuse of alcohol and illegal drugs appear in the clinical notes and police records, but Mr O's drug use does not seem to have been fully assessed. Considering that Mr O was noted to be impulsive and changeable, a full assessment of his alcohol and/or drug use would have supported the understanding of the challenges he posed.

3. Conclusions and recommendations

3.1 This is a report of a comprehensive investigation into the NHS care provided to Mr O prior to the tragic death of Ms M at his hand in December 2015. The work was undertaken alongside a multi-agency review by Hertfordshire Partnership University NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, the National Probation Service, Avon and Somerset Constabulary, and the Hertfordshire Constabulary.

3.2 The complexity of the challenge that Mr O presented, coupled with the relatively low probability in statistical terms that his threats would be followed through, made it difficult for those assessing him. On a number of occasions senior clinicians had different opinions about the level of risk he presented.

3.3 Whilst disagreement among professionals is not unusual, especially in such complex cases, it is essential that there is a mechanism to solicit expert opinion and discuss the implications within the multi-disciplinary team. In this way, a consensus can be reached about the steps that should be taken to mitigate risk and how to deliver care safely and effectively. Recommendations relating to this can be found in Section 4.4.2

3.4 The investigation team considered all the information gathered in the course of the review. While statistically people who self harm or threaten to kill pose a risk to themselves or to others there was no way for staff from any agency to determine whether Mr O was one of the 97% of people who only make threats or one of the 3% who carry threats through. Three experiences clinicians reached different views on the best course of treatment for Mr O, and the clinical records show that neither incarceration in Prison nor being held on a hospital ward with controlled access had an impact on Mr O's behaviour. We conclude therefore that the tragic death of Ms M could not have been predicted with the degree of certainty that would have made it possible to prevent.

4. Recommendations

In considering recommendations arising from the NHS care delivered to Mr O we have focussed on HPFT, they delivered the care of longest duration to Mr O, and he was in their care at the time of the homicide. There are no recommendations for the other NHS providers.

4.1 Risk assessment and management

We recommend that in the light of this report within 6 months current practice in HPFT for assessing risk be thoroughly reviewed and in the light of that a plan developed. Over the following 12 months training in risk assessment should be refreshed in line with current best practice and evidence concerning the most effective way to support staff to deliver a high standard of care.

	We consider that areas requiring strengthening include: • Taking a multifactorial history and case formulation • Risk assessment and risk reduction planning • How to integrate risk assessment and reduction as part of the overall Care Plan • Strengthening the audit process to assure the quality of risk assessment and care planning • Strengthening systems to ensure the multidisciplinary review of complex cases • Full implementation of the personality disorder care pathway

4.2 Communication

We recommend that in the next 6 months the in service training programme is reviewed, alongside staff access to HPFT policy documentation, to ensure that HPFT relevant policies relating to inter-agency communication are implemented fully such that:

	• Staff are aware of the relevant policy documents and existing national guidance and are enabled to use them at critical points in care. • Staff are aware of and understand issues relating to patient confidentiality, and when it can (or must) be breached. • There has already been a strengthening of capacity and increased awareness within HPFT of systems to gather information about individuals from other NHS organisations or agencies. This needs to be shared more widely across HPFT. • In conjunction with primary care HPFT develops a standard information sharing protocol with GPs.

4.3 Mental Health Treatment Requirement training

We recommend that in the next 6 months changes be made to the in service training programme so all staff are made aware of the use of Mental Health Treatment Requirements (MHTR) that may be applied by the Court and, given that MHTRs are not used frequently:

	• Over the next year HPFT and probation services develop resources and expertise to support staff when an MHTR is applied, and review the use of current guidance. • Ensure that when an MHTR is applied by a Court HPFT supports Probation services to draw together the immediate staff involved so they can develop a shared understanding of their roles and responsibilities in meeting requirements of the joint protocol.

4.4 Discharge process

We recommend that HPFT further strengthens its practice in relation to patient discharge to build on and extend good practice extant in HPFT to:

	• Ensure discharge meetings always occur • Ensure there is a full discharge CPA • Ensure a crisis team discharge to community team does not normally occur without a meeting with the care coordinator present • HPFT has focused on delivering 72 hour follow up, which is a higher standard than the national requirement of follow up at 7 days. We commend this and would urge continued support for 72 hour follow up.

FULL REPORT OF THE INDEPENDENT REVIEW INTO THE NHS CARE AND TREATMENT PROVIDED TO MR O

1 Introduction

1.1 This is the report of an investigation commissioned by NHS England into the care and treatment provided by the NHS to Mr O who was under the care of Hertfordshire Partnership University NHS Foundation Trust (HPFT) on 24th December 2015 when he met and then killed Ms M.

1.2 We would like to extend our sincere condolences to the family of Ms M for the terrible and tragic loss of a much loved daughter. We hope that this report will, at least in part, help the family to understand the background circumstances of the tragedy, and that the impetus and challenge in this report and the multi-agency findings will lead to change within services and across agencies. Our primary aim is to learn lessons and help to improve mental health services, making them safer for those who receive care and those who are affected by the care given.

1.3 In April 2013 NHS England became responsible for commissioning independent investigations into homicides by people in contact with mental health services. Guidance provided by NHS England for their conduct emphasizes the importance of rigour and independence stating that in addition to establishing what happened and making any necessary recommendations for learning and change that services must be open and transparent with families and patients.

1.4 We would like to thank all the NHS staff who participated in this investigation, and colleagues in the multi-agency review team including the two Police constabularies, Probation services, and the Hertfordshire Domestic Abuse Partnership for their support.

1.5 Core Terms of Reference form the basis for NHS investigations of this kind. Additional specific Terms of Reference were developed for the NHS investigation of this case, in addition to the terms of reference for the multi-agency Partnership Review. They can be found in Appendix 1.

1.6 Appendix 2 contains details of the investigation team who were appointed by NHS England. They were drawn from a group of independent `preferred providers' for investigations, all of whom have the appropriate level of seniority and relevant experience.

2 Methodology

2.1 An initial scoping discussion was held in February 2017 with the commissioner of the investigation (NHS England), and the terms of reference for the NHS review and the multi-agency review were agreed at the Partnership Review meeting on 20th March 2017.

2.2 An agreement was reached concerning the use of an approach based upon Root Cause Analysis to examine the facts of the case, identify ways in which care might have been altered or improved, and to understand how systems for delivering care and managing risk are currently functioning. Copies of the case notes were received in March 2017 and arrangements were then made to speak with key individuals. To minimise the repetition which families may face after such an incident all agencies contact with families was though the multi agency review process. Two approaches were made to Mr O's family in the hope of being able to meet with them, but they were too distressed to speak with us. A representative of the multi-agency group has met with Ms M's family.

2.3 In addition to reviewing the assessments and case notes written by the Trust about Mr O and his care, the team worked alongside the multi-agency review panel, and were able to review the Internal Management Reports produced by Hertfordshire Partnership University NHS Foundation Trust and Avon and Wiltshire Mental Health Partnership NHS Trust, the National Probation Service, Avon and Somerset Constabulary, and the Hertfordshire Constabulary and the two medical reports submitted to the court.

2.4 We would like to thank all those who gave us information about Mr O's circumstances and care in the period before Ms M's death. We are grateful for their willingness to help and for their honest and open approach to our team, despite significant levels of continuing distress as a result of these shocking events. There are no significant inconsistencies in the information provided and the team has no reason to doubt its reliability.

2.5 Copies of current policies used by the Trust were also examined. Appendix 3 contains a list of the documents and policies that were reviewed. Appendix 4 contains a list of all the individuals who were interviewed about the care and treatment provided for Mr O.

2.6 Adapted Salmon Principles were used for this non-judicial investigation, meaning that all those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference.[3] They were offered the opportunity to be accompanied to the interviews, if they wished. Face to face interviews were recorded and transcribed. Telephone conversations were summarised and checked back with participants. Written accounts of the interviews were verified for accuracy by each witness before being `signed off.' All witnesses were assured that their testimony would be confidential. Of course, a court of law may require witness statements to be submitted.

Context of this review

2.7 Homicides by people in receipt of mental health services are extremely rare. Overall, of around 600 homicides per year, 11% or 50-60 per year are committed by people in contact with mental health services, a number that has been falling since 2008.[4]

2.8 Whilst there would never be an excuse for failing to diagnose, assess or manage the risk of harm that might be presented by such individuals, it is also important to understand that because the numbers are so low an individual clinician will rarely see a service user who poses so severe a threat to others, because their numbers are very low: this makes the management of risk to others especially challenging.

2.9 Mr O was diagnosed as having an Emotionally Unstable Personality Disorder (EUPD), with narcissistic and dissocial (psychopathic) traits. EUPD is a relatively uncommon condition (a prevalence rate of perhaps no more than one or two per cent) characterised by fluctuations in, and difficulty managing mood. A Dissocial Personality Disorder is characterised by disregard for the feelings of others and an inability to modify behaviour in response to adverse events; it may also feature a relatively low threshold for violence, a tendency to blame others and a wide range of interpersonal and social disturbance.

2.10 Mr O's behaviour was highly volatile, with rapidly changing mood, and he presented different challenges and risks. At times he was provocative towards staff from statutory agencies and he used implicit and explicit threats on occasions. However at the same time, Mr O was intelligent and could be socially very engaging.

[3] The Salmon Principles are six requirements set out under the Tribunals and Inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations. Although the current investigation was not judicial (solicitors were not directly involved) the investigators ensured that all those being interviewed were informed and invited to participate; they were given the Terms Of Reference, and they were offered the opportunity to have someone accompany them.

[4] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report and 20-year Review' (2016).
http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf

2.11 With this range of behaviour it was likely that Mr O would come to the attention of the Police, Criminal Justice System and NHS organisations. It was therefore not a question of whether he presented a 'legal' problem or a 'health' problem, Mr O was likely to engage with and challenge all of the agencies, and they needed to find ways to work together to manage his behaviour.

2.12 NICE guidance is published to inform NHS Clinical Commissioning Groups about the care requirements for people with a Personality Disorder (PD). The guidance (www.nice.org.uk/guidance)[5] describes treatments, quality standards and an ideal care `pathway', but whilst the guidance recommends psychological therapies should be provided, it points out that evidence for the effectiveness of such treatment is limited. It emphasises the importance of treating co-morbid conditions such as anxiety, depression or psychotic symptoms which the patient with PD may present, and it identifies the importance of inter-agency collaboration, multi-disciplinary care planning, risk assessment and management for what can be amongst the most challenging of all mental health conditions.

3. Events leading up to the homicide

3.1 Appendix 5 contains a more detailed chronology of the events leading up to 24th December 2015. This is based upon a review of the case notes and the internal report from the HPFT and AWP, the Police and Probation services, and interviews with staff. To give structure to our findings there is a summary time line below, with the abbreviations for clinical staff in the text identified alongside events.

[5] NICE guidance published to inform NHS Clinical Commissioning Groups about the care requirements for people with a Personality Disorder (PD). (www.nice.org.uk/guidance)

3.2 Summary time line

Date	Hertfordshire Partnership University NHS Foundation Trust (HPFT) July to October 2013	Key staff involved
12th July 2013	Seen in Queen Elizabeth 2nd Hospital Welwyn Garden City Accident and Emergency department following an episode of self harm, referred to HPFT Community Mental Health Services (CMHS).	
July/September 2013	Seen by staff from the Trust Crisis Assessment and Treatment Team (CATT) and CMHS over this period, and was stabilised.	
10th October 2013	Discharged from Community Mental Health Services.	
	Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) February to March 2015	
27th February 2015	Presented at Bristol Royal Infirmary following self-harm, and was referred to AWP.	
1st and 3rd March 2015	Mr O reported ongoing risk of self-harm, non-specific threats to kill, and intrusive aggressive and violent thoughts.	
4th March	Avon and Somerset Police were informed of the non-specific threats Mr O had made, and logged the call.	
20th March 2015	In telephone call with Crisis Team Mr O stated that he intended to kill and then rape his girlfriend's sister, and in a further call threatened to kill the Community Psychiatric Nurse (CPN).	
20th March 2015	Detained by police, the Doctor carrying out S136 assessment concluded that Mr O should not be detained under the Mental Health Act, and advised that Mr O 'does pose a risk to others but there is no further role for ...mental health services....' and should follow the criminal justice route.	
20th March 2015	Remanded in custody charged with making threats to kill.	
24th March 2015	Discharged from the care of AWP and a summary of his care was sent to his GP.	
	HMP Bristol 22nd March 2015 to 1st May 2015	
22nd March 2015	Detained on remand in prison	
15th April 2015	Pleaded guilty to making two threats to kill.	
1st May 2015	Formally discharged from HMP Bristol on bail to the family home awaiting sentencing.	
	Hertfordshire Partnership University NHS Foundation Trust (HPFT) 7th May 2015 to 24th December 2015	
7th May 2015	Princes Alexandra Hospital requested a bed for Mr O following episode of self-harm. Mr O was assessed by	

	community services and referred by them to the intensive mental health day unit.	
11th May 2015	First attendance at the Acute Day Treatment Unit.	
26th May 2015	Discharged from intensive day unit, to be seen by Community Mental Health Services.	
23nd June 2015	Referral from Royal London Hospital after a very serious suicide attempt. Admitted to Swift Ward.	Swift Ward Consultant CP1
6th July 2015	Discharged to the care of CATT and CMHS	
27th July 2015	Report that Mr O had threatened a service user's brother and police informed.	
1st August 2015	Following a threat by Mr O to jump from a window at home he was readmitted to Swift Ward.	Swift Ward Consultant CP1
5th August 2015	Forensic consultation with Mr O.	Forensic Consultant FCP 1
11th August 2015	Moved to Owl Ward, Mental Health Act Assessment carried out, decision not to detain him under the Mental Health Act.	Owl Ward Consultant CP2
20th August 20I5	Meeting between Owl Ward and Forensic Consultant Psychiatrists, agreed that at that time transfer to a Low Secure Unit was not warranted.	FCP1 and CP2
17th September 2015	Altercation with staff over restricting his visits female patients on other ward. Placed on a Section 5(2). ''When I leave or am discharged, I will kill someone – document that. I will kill someone when I leave, you must document that." Threat was reported to the police.	
18th September 2015	Community Consultant Psychiatrist agreed to be a probation psychiatric supervisor if Bristol Crown Court agrees to probation and imposes a Mental Health Treatment Requirement (MHTR) on Mr O.	Community Consultant CP3
20th September 2015	Discharged on weekend leave, but some confusion and he remained on leave after the weekend.	
21st September to 2nd October 2015	Technically Mr O was still an inpatient in this period but was supported by community services.	
2nd October to 24th December	Ongoing support from community services.	
2nd December 2015	Sentenced in Bristol Crown Court to a Rehabilitation Activity Requirement and a MHTR, with a 9 month prison sentence suspended for two years	
Mid December 2015	Appointment with GP for repeat medication, no concerns over his mental state	GP

3.3 In its internal review the Trust identified six critical factors/events in the course of Mr O's care and treatment, and we have reviewed them and other elements of care we think were critical under the relevant terms of reference.

4. Background and Findings

4.1 We have structured our findings against the terms of reference which are in Annex 1

Terms of Reference 1. Investigating and examining the NHS contribution to the care and treatment of the service user from 2013 up until the date of the incident;

- Forensic assessment,
- Mental Health Act Assessment
- Court reports
- Mr O's behaviour on Owl Ward
- Mr O's discharge from Owl Ward

Terms of Reference 2. Examining the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user;

- Follow up of Mr O's Mental Health Treatment Requirement following his sentence in December 2015
- Communication, within the NHS and between agencies

Terms of Reference 3. Reviewing and assessing compliance with local policies, national guidance and relevant statutory obligation;

Terms of Reference 4. Examining the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family;

and

Terms of reference 5 - to review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway;

- Risk assessment and management
- Availability of a talking therapy/Personality Disorder pathway
- Exploration of possible alcohol/substance abuse

4.2 **Terms of reference 1** - Investigating and examining the NHS contribution to the care and treatment of the service user from 2013 up until the date of the incident

4.2.1 The first records stating that Mr O had harmed himself are in 2009 and 2010, while he was at the University of Surrey, and in Wales in 2011, He first came to the attention of Hertfordshire Partnership University NHS Foundation Trust (HPFT) in July 2013 after an episode of self-harm led to attendance at an Accident and Emergency department, and he was referred to HPFT. He was

supported by both the HPFT crisis team and the community team over that period and was discharged in October 2013.

4.2.2 There are no records suggesting that between the end of this episode of NHS care in 2013 and February 2015 Mr O received any input from mental health services. However, his behaviour brought Mr O to the attention of various police forces. He was cautioned for the possession of cannabis, and interviewed by police with respect to threats he made to a girlfriend, an assault on his brother, and allegations made by Mr O with respect to a theft from him. None led to further legal action.

4.2.3 In February 2015 following an episode of self-harm Mr O was taken on by the Intensive Support Team of Avon and Wiltshire Mental Health Partnership Trust (AWP) where he was living with a girlfriend and her family. During this period of NHS care he disclosed violent fantasies of murdering women and raping them. On 20th March 2015 he disclosed specific thoughts of killing and raping his girlfriend's sister, and made a specific threat to kill an AWP Community Psychiatric Nurse. He was detained by police under section 136 of the Mental Health Act, where he was determined not to be suffering from a mental disorder. Given the risk he posed, he was immediately arrested for threats to kill and remanded in custody to HMP Bristol.

4.2.4 During March and April 2015, he was held in HMP Bristol. Some assessment work was carried out by the mental health prison in-reach service. However, due to his short stay no active treatment was commenced. On 15th April he pleaded guilty to making two threats to kill.

Care in Hertfordshire Partnership University NHS Foundation Trust, 2015

4.2.5 In early May 2015 as a condition of bail from HMP Bristol while awaiting sentencing from Bristol Crown Court Mr O returned to his parents' home. Within two weeks he had called the police to request that he be sectioned, and had engaged in self-harm which required treatment at the Accident and Emergency Department. He was re-referred to HPFT, initially seen by the crisis team, and subsequently he was referred to the Acute Day Treatment Unit (ADTU). From there he was transferred to the care of the community team.

4.2.6 In mid-June 2015 Mr O was admitted to the Royal London Hospital after having self-harmed; his injuries were so serious that they warranted surgery and were life threatening. He was referred from there for inpatient care at HPFT, and after three weeks on Swift Ward he was discharged to community support.

4.2.7 At the end of July 2015 police were informed that Mr O had made a threat to kill his girlfriend's brother, and after a further suicide attempt at the beginning of August Mr O was readmitted to HPFT. Mr O spent the first 10 days on Swift Ward, where his behaviour was complex and challenging. It included threats to harm himself, fire setting in the Ward garden, and insistent requests for PRN medication. PRN medication is prescribed by the doctor and may be given as required up to a limit. He also behaved towards female patients on the ward in an over-familiar way, and there was an allegation of inappropriate sexual activity with one female patient.

4.2.8 Finally, when he insisted he was going to leave the ward on 10th August Mr O was held under Section 5 (2) of the Mental Health Act. This Section allows a person who is currently an informal patient on a ward and who expresses the intention to leave to be held for up to 72 hours for a further assessment if clinicians believe they may pose a risk to themselves or others if they left.

Forensic assessment

4.2.9 While he was under the care of community services prior to his August admission an assessment was requested from the Trust's Forensic services and this was carried out in early August by the Forensic Consultant Psychiatrist FCP1. The Swift ward Consultant CP1 and the Forensic Consultant concluded that Mr O needed a detailed and comprehensive forensic assessment in a more structured environment, and they shared a view that there was the potential to request that a Section 38 Interim Hospital Order be imposed by Bristol Crown Court.

4.2.10 This view was supported in a Secure Service referral meeting where it was agreed that, in principle, Mr O's behaviour reached the threshold for an assessment for admission to the Forensic Unit. FCP1 wrote to Bristol Crown Court suggesting that when his case was heard, the Court should consider making an Interim Hospital Order and permit Mr O to be admitted to a Low Secure Forensic ward.

4.2.11 CP1 wrote a recommendation that Mr O be held under Section 3 of the Mental Health Act pending his attendance at Court; and agreeing with the Forensic Psychiatrist that he should be held under a section 38 Interim Hospital Order.

4.2.12 With hindsight, it is not clear whether an inpatient forensic assessment would have produced a clearer formulation of Mr O's problems, causation, triggers

and possible consequences, or delivered a comprehensive risk assessment. However, an inpatient forensic assessment would have offered a framework for consideration of how to deal with this complex man, and how to structure and direct his care.

Mental Health Act Assessment

4.2.13 On 11th August due to his behaviour, Mr O was moved to Owl Ward, which was exclusively for male patients and where access and exit was controlled, under the care of consultant CP2.

4.2.14 A full Mental Health Act Assessment was carried out by two consultants and an Approved Mental Health Practitioner. In the course of that assessment Mr O confirmed that he would stay on Owl Ward voluntarily, and when the assessors outlined the behaviours expected of Mr O while on the ward he agreed to comply, and agreed to be bound by a behavioural contract.

4.2.15 In light of the Mental Health Act guidance on using the least restrictive care setting possible, and on the basis that Mr O had agreed to stay voluntarily and be bound by the behavioural contract, the assessing team agreed that Mr O did not require to be detained under the Mental Health Act at this time.

4.2.16 The Mental Health Act Assessment (MHAA) was carried out thoroughly, and reached a clear conclusion in the context of the information the assessors had at that point in time. The assessing team were aware of the views of CP1 that Mr O should be held under Section 3 of the Mental Health Act, and aware of FCP1's proposal that the Court should direct an Interim Hospital Order. However, FCP1's report was not completed and was therefore not available to the assessing team, and these views were not reflected in the outcome of the assessment.

4.2.17 Over the next few days there were individual discussions between the consultants. CP1 met CP2 to discuss their different views on detaining Mr O, but did not reach a shared view.

4.2.18 CP2 and FCP1 reviewed Mr O's care. On the understanding that Mr O was responding to strict boundaries and was compliant with his treatment plan they agreed that the risk of him actually carrying out the threats to kill and rape were low, and agreed that the use of the Mental Health Act was not warranted.

4.2.19 While the Mental Health Act assessment was carried out thoroughly it did not draw on the full range of views about Mr O's care expressed by the consultants or members of the multi-disciplinary clinical team, and there was no mechanism for testing, challenging and reaching consensus. Furthermore,

there was no indication of how any breaches by Mr O of the behavioural contract should be managed.

Mr O's behaviour on Owl Ward

4.2.20 Mr O remained on Owl ward for 6 weeks, and showed similar challenging behaviours to those he displayed on Swift Ward. For example, he frequently requested his PRN medication; asked for additional prescriptions; he contacted the police to express concern for his girlfriend; he made a complaint about another patient's behaviour; made written complaints to ward staff; interfered with the care of other service users; visited female patients on other wards; and questioned clinical decisions. He was detained under a Section 5(2) on 17th September after a threat to leave the ward, making an explicit threat that 'When I leave or am discharged, I will kill someone - document that'.

4.2.21 Despite Mr O breaking his behavioural contract, CP2's view was that there was little to be gained by detaining him in hospital under the Mental Health Act at this point. Mr O was physically present on the ward and was not able to leave without staff being aware; the only alternative would be to move him to a forensic inpatient unit and in CP2's view this was not required.

4.2.22 In this period of his care, we do not see evidence of a clear formulation of Mr O's problems, a comprehensive, coherent care plan leading to the delivery of a consistent care package, or a comprehensive risk assessment. During his time on Owl Ward Mr O broke his behavioural contract, and may have broken his bail conditions as well. Routes were open to take action under the Mental Health Act or the legal system, but these routes were not followed. These were missed opportunities for moving to a more structured environment and enabling a more detailed assessment.

Court reports

4.2.23 As is noted above, the FCP1 wrote to Bristol Crown Court on 10th August suggesting that the Court make an Interim Hospital Order and require Mr O to be admitted to a Low Secure forensic ward. There is no record of the receipt or any response from the Court to this letter. Two reports were requested by the Court. One was provided by CP2, Mr O's consultant on Owl Ward, the other by an independent Consultant Psychiatrist.

4.2.24 The independent psychiatrist took the view that Mr O did not suffer from a mental disorder that would make his detention under the Mental Health Act

appropriate. In his view, Mr O presented a significant risk of harm to himself, with fluctuating risk depending on situational factors.

4.2.25 However the independent psychiatrist felt it was almost impossible to comment on the risk Mr O posed to others, due to the limited information he had about him. It was not clear whether Mr O's threats to kill were simply a reckless way of getting attention and support from psychiatric services, or a demonstration of an intent to commit serious violence. However the psychiatrist was seriously concerned about those threats and could not reassure the Court the Mr O did not pose a risk to the public.

4.2.26 He concluded that it was unlikely that any psychiatric treatment would alter Mr O's risk profile in the short to medium term. On that basis, he thought risk management should be through the criminal justice system and Probation services.

4.2.27 CP2 who wrote the second Court report had not seen the independent psychiatrist's report until after he had submitted his own; he did not have full details of the indictment, and saw little paperwork. He considered that Mr O's greatest risk was to himself as Mr O had made several impulsive but very dangerous suicide attempts and, in his view, remained at high risk of self-harm. The consultant did not believe it was ever Mr O's intention to kill anybody; nor did he think Mr O was likely to do so in the future. He did not believe that Mr O posed a risk significantly greater than many young men in the community who seek serial partners.

4.2.28 CP2 did not think Mr O needed ongoing hospital treatment, although he thought he might need brief admissions in times of crises, and he suggested the use of a Mental Health Treatment Requirement (MHTR). His report contained elements of a care plan, including that Mr O should be offered a talking therapy; it identified Dialectic Behaviour Therapy (DBT), family therapy sessions, and input from CGL Spectrum around the use of drugs/alcohol.

4.2.29 The range of views expressed between the Forensic Psychiatrist's letter to the Court and the two Court Reports show the difficulties in developing a coherent formulation of the challenges Mr O created, assessing his risk and in creating a coherent care plan to meet his needs with integral risk management.

4.2.30 Three senior consultants had reached very different conclusions, FCP1 proposed Mr O be held under a Section 38 of the Mental Health Act with an Interim Hospital Order; the independent psychiatrist felt it very hard to quantify the risk but did not believe it was appropriate to detain Mr O under the Mental

Health Act, and CP2 saw the main area of risk being of Mr O harming himself, and that he could be managed in community services.

Mr O's discharge from Owl Ward

4.2.31 In the days prior to discharge Mr O made a further threat to kill and after refusing to remain on the ward informally, he was held on a Section 5(2) of the Mental Health Act. On 18th September a pre discharge meeting was held which included his parents and the Community Consultant Psychiatrist (CP3). At this meeting CP3 agreed to be Mr O's Probation Psychiatric Supervisor if Mr O was given a MHTR by Bristol Crown Court.

4.2.32 In September 2015 Mr O went on leave to be supported by the Community Mental Health Service. The notes then indicate that there was some confusion on the ward about whether and when he was due to return to hospital. However from the start of his leave the Crisis team were very active in working with him; he had a care coordinator whom he saw routinely and the team were in contact almost every other day. On 2nd October Mr O was formally discharged.

4.2.33 On 2nd December at Bristol Crown Court a Rehabilitation Activity Requirement and a Mental Health Treatment Requirement were imposed on Mr O, with a 9 month prison sentence suspended for two years.

4.2.34 It was good practice to include the family and community psychiatrist in the pre-discharge meeting. However the notes of the meeting do not reflect a clear formulation of Mr O's problems; their causation, triggers and the possible consequences of a failure to manage risk. There was no comprehensive, coherent care plan, no comprehensive risk assessment or risk management/reduction plan, or any plan for active sharing of a care plan across all partners.

4.2.35 Post discharge the Community Psychiatrist did not meet and assess Mr O, and this potentially left other team members working in a vulnerable situation.

4.3 **Terms of Reference 2** to examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user

Follow up of Mr O's Mental Health Treatment Requirement following his sentence in December 2015.

4.3.1 As part of his suspended sentence a Mental Health Treatment Requirement was imposed with an activity requirement for 15 days which would focus on victim empathy, sexual thoughts and feelings. A Probation Officer was appointed, and on 14th December there was an e-mail exchange between the Probation Officer and Mr O's Community Psychiatric Nurse (CPN). The CPN reported that Mr O was settled and motivated, with no known current risks or concerns; this was the only contact between them before the homicide.

4.3.2 There is guidance on Mental Health Treatment Requirements for psychiatrists and probation officers, produced jointly by Hertfordshire Probation Trust and Hertfordshire Partnership NHS Trust. Little account appears to have been taken of this guidance. The Court report was not produced by practitioner(s) in a position to offer any treatment, although the Community Consultant who was to be the supervisor attended the pre-discharge meeting; there was no evidence of liaison with those who would be responsible for the delivery of treatment before the report was written, and no shared understanding of the report's proposals or specific requirements. The Probation Officer, Community Psychiatrist and the CPN were all unfamiliar with MHTRs.

4.3.3 The Probation Officer completed the sentence plan with Mr O two days after the Court hearing. However, this was not discussed, shared or agreed with Mr O's Community Psychiatrist or CPN as the guidance suggests. The nominated medical supervisor who had been identified to Bristol Crown Court was never contacted between the Court hearing and the homicide.

4.3.4 Mr O's last contact with a member of NHS staff was with his GP in mid-December. He attended for a repeat prescription of his medication. The GP who was meeting him for the first time, described him as not appearing depressed or anxious, and his mental state did not give rise to concern. She did not find him threatening but she found him quite difficult and felt that he liked to unsettle people.

4.3.5 The imposition of a MHTR created a final opportunity to create a single, comprehensive care plan including therapy input, and a fresh review of risk.

However, there was no meeting to develop a multiagency plan, formulation of Mr O's problems, comprehensive, coherent care plan, or comprehensive risk assessment.

4.4 **Terms of Reference** 3 - to review and assess compliance with local policies, national guidance and relevant statutory obligation

4.4.1 There are a number of Trust policies relevant to the care provided for Mr O, these are identified below with comments on the extent to which they were followed.

4.4.2 **Care co-ordination policy** – this states that for people moving between Trusts 'the current care coordinator is responsible for sharing information as necessary....' It also says that 'in all cases there needs to be a final judgment by the relevant consultant and/or care coordinator as to whether there may be sufficiently strong grounds for overruling the request of a service user who has asked that information should not be shared....' public interest outweighs the duty of confidentiality. Issues of safety...may take priority.'
'It is important that all staff... clearly and openly debate issues involved in needs agreement and assessments of risk.'

4.4.3 **Comment** – The policy makes it clear that there is a process and criteria for breaking confidentiality when the need arises; it would therefore have supported staff to contact AWP for further clinical information about Mr O. It also describes the need for staff to openly debate issues in the assessment of risk. However, neither aspect of this procedural guidance was followed in relation to Mr O's care. Furthermore, whilst a limited amount of information about Mr O was shared, it was not shared across all relevant teams and services.

4.4.4 **Adult Mental Health Community Services Operational Policy** – This policy document was ratified on 1st July 2014 and issued on 1st May 2015. It includes a detailed description of the community services for people with a personality disorder. It emphasises the importance for specialist personality disorder clinicians to consult with respect to unplanned admissions.

4.4.5 **Comment –** Mr O is recorded in the notes on multiple occasions as asking for a talking therapy, psychology, psychotherapy, CBT or DBT. However, Mr O did not receive any structured therapy.

4.4.6 **Mental Health Treatment Requirements Guidance for Psychiatrists and Probation officers, July 2012. Produced by Hertfordshire Probation Trust and Hertfordshire Partnership NHS Trust** –

- This guidance developed in Hertfordshire states that 'In cases where a court report is commissioned from a Consultant Psychiatrist....the report would ideally be prepared by a practitioner in a position to offer the treatment incorporated in the MHTR.

- Where a psychiatric report is requested, probation officer/criminal justice liaison practitioner (CJMHP) should liaise and share an understanding of the intended proposals, specific requirements, respective responsibilities and focus.

- When an MHTR is imposed the Offender Manager should arrange an initial meeting (service users, offender manager, psychiatrist, mental health care coordinator....)'

4.4.7 **Comment –** The guidance is simple and clear although the Probation Officer, the community psychiatrist and the CPN were not familiar with it, or with MHTRs. Furthermore, the Court report was not produced by the practitioner in a position to offer the treatment incorporated in the MHTR, although the community consultant who was to be the supervisor was invited to and attended the pre-discharge meeting.

4.4.8 We have no evidence of liaison with other staff before the psychiatrist's report was written, or of any attempt to develop a shared understanding of the meaning of the proposals it contained. The specific requirements responsibilities and focus of the MHTR were not discussed and no initial meeting was arranged.

4.5 Terms of Reference 4 - to examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family;

and

Terms of reference 5 - to review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway;

4.5.1 Risk assessment, prediction and management

4.5.2 Risk assessment should always involve a thorough, up-to-date, comprehensive assessment of all the factors associated with the prediction of risk, and the consequences for the patient and other people. It should include information about the likely causes of risk; the triggers for risky behaviour, and information about the potential impact. The factors which are typically associated with risk include diagnosis, past behaviour, substance misuse, thoughts, intentions and/or mood.

4.5.3 Mr O's diagnosis of Emotionally Unstable Personality Disorder is associated with a 10% risk of death by suicide and Mr O's history was characterised by a pattern of significant self-harm. He threatened suicide several times and this is noted in the reports for the Court. The notes also record that Mr O had behaved in a threatening way towards vulnerable young women, one reason he had been moved to an all-male ward whilst he was under the care of HPFT. However, whilst HPFT completed risk screening assessment forms regularly for Mr O whilst he was in their care, the forms do not include explanations for the ratings of risk that were given and the plans for his care do not contain a clear statement about how risks could be mitigated.

4.5.4 Care Plans should always contain a comprehensive, integrated risk management/reduction plan. However, there is only limited evidence that action was taken to actively manage or minimise the risk that Mr O presented. Whilst there is one comment in the notes advising that he should be seen by two members of staff and never by an unaccompanied female, the notes do not contain a formulation of Mr O's problems or a statement of causes, triggers or possible impacts of risk. Furthermore, he did not have a final, agreed care plan when he was discharged from Owl Ward that was coordinated between the NHS and other agencies.

4.5.5 Exact predictions of risks for individuals are very difficult; for example, over a 10 year period 3% of people with a mental health problem who have made threats to kill will go on to commit a homicide. Furthermore, such tragic events are statistically very rare. Therefore, we cannot say with any confidence that the tragic death of Ms M could have been prevented. However, we can say that there were shortcomings in the way that Mr O's level of risk was assessed and managed.

4.6 Communication, within the NHS and between agencies

4.6.1 During our interviews and in the internal report it was clear that HPFT perceived the lack of information about Mr O's previous care to have been one of the critical factors hindering appropriate risk assessment and management. There were three potential sources of information that might have been available to HPFT: information from AWP, HMP Bristol prison and Mr O's GP.

4.6.2 AWP considered that Mr O's care from the Trust and his CPA ended when he was detained by police, and they acted in a reasonable and timely manner in that within days of his discharge a comprehensive report was sent to Mr O's GP. Whilst Mr O was in prison the in-reach team carried out an assessment, but during his short stay no treatment plan was developed, and on his release, there was no communication with his GP.

4.6.3 GPs can act as a central point of communication about NHS patient care. However, when Mr O returned to Hertfordshire and presented once again to secondary care mental health services, the discharge report from AWP to the GP was not shared with HPFT. Over this period the HPFT routinely sent updates on his care to the GP, and while they offered to share the information they had with the GP they did not request any information the GP held on him. Mr O was consistently reluctant to share information about his previous episodes of care, but HPFT did not contact AWP directly, as policies suggest should have happened.

4.6.4 The lack of a single, coherent overall view of Mr O's history and care created a gap at the heart of care planning and risk assessment. It also hampered inter-agency working.

4.7 A Talking therapy/Personality Disorder pathway.

4.7.1 Mr O made multiple requests for some type of talking therapy and the notes show that similar requests were made by those caring for him in AWP and HPFT. Medium to long term talking therapies are the treatment of choice for people with a personality disorder, although commitment and engagement by the patient is needed, and the evidence for their effectiveness is only moderate. No structured and ongoing talking therapy was ever delivered to Mr O during the period of his care with either AWP or HPFT.

4.8 Alcohol/substance abuse

Like the requests for talking therapy, references to the misuse of alcohol and illegal drugs appear in the clinical notes, but Mr O's drug use does not seem to have been fully assessed. Considering that Mr O was noted to be impulsive and changeable, a full assessment of his alcohol and/or drug use would have supported the understanding of the challenges he posed.

5 Conclusions and recommendations

5.1.1 This is a report of a comprehensive investigation into the NHS care provided for Mr O prior to the tragic death of Ms M at his hand in December 2015. The work was undertaken alongside a multi-agency review by Hertfordshire Partnership University NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, the National Probation Service, Avon and Somerset Constabulary, and the Hertfordshire Constabulary.

5.1.2 The complexity of the challenge that Mr O presented, coupled with the relatively low probability in statistical terms that his threats would be followed through, made it difficult for those assessing him. On a number of occasions senior clinicians had different opinions about the level of risk he presented. Whilst disagreement among professionals is not unusual, especially in such complex cases, it is essential that there is a mechanism to solicit expert opinion and discuss the implications within the multi-disciplinary team. In this way, a consensus can be reached about the steps that should be taken to mitigate risk and how to deliver care safely and effectively. Recommendations relating to this can be found in Section 5.2

5.1.3 The investigation team considered all the information gathered in the course of the review. While statistically people who self-harm or threaten to kill pose a risk to themselves or to others there was no way for staff from any agency to determine whether Mr O was one of the 97% of people who only make threats or one of the 3% who carry threats through. Three experiences clinicians reached different views on the best course of treatment for Mr O, and the clinical records show that neither incarceration in prison nor being held on a hospital ward with controlled access had an impact on Mr O's behaviour. We conclude therefore that the tragic death of Ms M could not have been predicted with the degree of certainty that would have made it possible to prevent.

Trust progress against internal report recommendations

5.1.4 Our team identified steps taken by HPFT to implement the recommendations that were made in the internal report that was prepared in the months immediately after the tragic death of Ms M. While a policy was in place for delivering a personality disorder care pathway at the time Mr O was in contact with HPFT he was not placed on it. The acute care pathway for personality disorders has now been revised and work to develop approaches to psychiatric formulation of patients with PD is ongoing.

5.1.5 In some of our interviews we heard about significant work which has occurred in inpatient services to ensure that previous NHS health care records are accessed when required and that a full CPA meeting occurs prior to any discharge. It also appears that steps have been taken to strengthen arrangements for 72 hour follow-up post discharge. We also heard about a programme to increase staff skills in understanding and assessing risk in a holistic way, and to ensure that the risk reduction plans flow from and into care plans

5.1.6 There is a new safeguarding team in place with more staff, and following staff training there is improved awareness among staff of safeguarding.

5.1.7 Our preliminary information suggests that progress is being made; we suggest that the following recommendations be implemented to strengthen services further.

5.2 Recommendations

In considering recommendations arising from the NHS care delivered to Mr O we have focussed on HPFT, they delivered the care of longest duration to Mr O, and he was in their care at the time of the homicide. There are no recommendations for the other providers.

5.2.1 Risk assessment and management

We recommend that in the light of this report within 6 months current practice in HPFT for assessing risk be thoroughly reviewed and in the light of that a plan be developed. Over the following 12 months training in risk assessment should be refreshed in line with current best practice and evidence concerning the most effective way to support staff to deliver a high standard of care.

	We consider that areas requiring strengthening include: • Taking a multifactorial history and case formulation • Risk assessment and risk reduction planning • How to integrate risk assessment and reduction as part of the overall Care Plan • Strengthening the audit process to assure the quality of risk assessment and care planning • Strengthening systems to ensure the multidisciplinary review of complex cases • Full implementation of the personality disorder care pathway

5.2.2 Communication

We recommend that in the next 6 months the in service training programme is reviewed, alongside staff access to HPFT policy documentation, to ensure that HPFT relevant policies relating to inter-agency communication are implemented fully such that:

	• Staff are aware of the relevant policy documents and existing national guidance and are enabled to use them at critical points in care. • Staff are aware of and understand issues relating to patient confidentiality, and when it can (or must) be breached. • There has already been a strengthening of capacity and increased awareness within HPFT of systems to gather information about individuals from other NHS organisations or agencies. This needs to be shared more widely across HPFT. • In conjunction with primary care HPFT develops a standard information sharing protocol with GPs.

5.2.3 Mental Health Treatment Requirement training

We recommend that in the next 6 months changes be made to the in service training programme so all staff are made aware of the use of Mental Health Treatment Requirements (MHTR) that may be applied by the Court and, given that MHTRs are not used frequently:

	• Over the next year HPFT and probation services develop resources and expertise to support staff when an MHTR is applied, and review the use of current guidance. • Ensure that when an MHTR is applied by a Court HPFT supports Probation services to draw together the immediate staff involved so they can develop a shared understanding of their roles and responsibilities in meeting requirements of the joint protocol.

5.2.4 Discharge process

We recommend that HPFT further strengthens its practice in relation to patient discharge to build on and extend good practice extant in HPFT to:

	• Ensure discharge meetings always occur • Ensure there is a full discharge CPA • Ensure a crisis team discharge to community team does not normally occur without a meeting with the care coordinator present • HPFT has focused on delivering 72 hour follow up, which is a higher standard than the national requirement of follow up at 7 days. We commend this and would urge continued support for 72 hour follow up.

APPENDIX 1

Terms of Reference for the NHS investigation

Purpose of the Review (NHS England)

To identify whether there were any gaps or deficiencies in the care and treatment that Mr O received which were relevant to the prediction and/or prevention of the incident of 24th December 2015. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could prevent similar incidents from occurring.

The outcome of this investigation will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

Terms of reference

1. to investigate and examine the NHS contribution to the care and treatment of the service user from 2013 up until the date of the incident;

2. to examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user;

3. to review and assess compliance with local policies, national guidance and relevant statutory obligation;

4. to examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and his family;

5. to review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway;

6. to work alongside the multi-agency review panel and Chair to complete the review and liaise with affected families; and

7. to provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or separately.

The terms of reference for multiagency Partnership Review (all agencies):

(1) to establish, within the period 1 July 2013 to 24 December 2015, the circumstances leading to the murder of Ms M;

(2) to establish whether there are lessons are to be learned regarding the manner in which agencies and relevant professional officers worked, either individually or collectively;

(3) where changes in policies and procedures are identified as a result of lessons learned, to make appropriate recommendations, establish timescales for their implementation and identify what is likely to change as a result;
(4) to consider any published or available reports from participating agencies;

(5) to consider whether any information known by individuals and/or agencies could or should have been shared with others;

(6) to consider whether any family, friends or associates of Ms M and Mr O should be invited to participate in the review;

(7) to consider whether any changes in policies and procedures identified in (3) above should be shared with agencies not involved in the review process;

(8) to consider whether the conclusions and recommendations of this review should be published or otherwise made available, and if so, within what timeframe; and

(9) to conduct the review in co-ordination with other review processes and in particular that of NHS England.

APPENDIX 2

The investigation team

Anne Richardson Consulting Ltd (ARC) is a group of senior professionals, including people with lived experience of mental ill health and of providing care (lay members) who come together with a unique combination of knowledge, skill, and experience in delivering investigations under HSG (94) 27 and other related work. We share a passion about the quality and safety of mental health services; about supporting staff constructively, and about the importance of involving families and carers who often feel very excluded from the investigatory process.

Anne Richardson, Director of ARC, is a clinical psychologist by training. Specialising in work with adults with severe mental ill health and long-term needs, she is an experienced clinician, trainer and communicator. As head of mental health policy at the Department of Health, she was instrumental in the development of the National Service Framework for Mental Health and for the development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008). Anne has worked on a number of investigations into the quality of NHS care and treatment provided for people who lost their lives unexpectedly, or for those who were themselves responsible for a death whilst in contact with services.

Lawrence Moulin has over 30 years' experience working in the NHS and at the Department of Health. His most recent post in the NHS was as the West Midlands Strategic Health Authority Lead for mental health and learning disabilities, with oversight of homicides and suicides, safety and service performance. Prior to this he worked as a clinical psychologist, a service manager and, in London, as a commissioner of services for people with mental health problems and/or with a learning disability. In addition, he worked on the delivery of national policy with the National Institute for Mental Health in England, in the Department of Health and more recently with the Care Quality Commission as a Specialist Advisor.

Hugh Griffiths is a former consultant psychiatrist in the North-East of England where he carried responsibility for in-patient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework.

Lisa Haywood (a lay member of the team) has worked as a Mental Health Act Tribunal Member since 2006. She also has a formal role as an appraiser within the tribunal service. Lisa has lived experience of mental health services and extensive experience in the field of service user and carer involvement and services. She has worked on a number of serious incident inquiries and for the Health and Social Care Advisory Service. Lisa was Vice Chair of national MIND for 12 years and has held roles with several local Service User Networks. Lisa supports the team to bring an independent voice and challenge to our methodology and findings.

APPENDIX 3

Documents review in the course of this work
Reports:
1. HPFT Trust internal report and HPFT Trust internal report executive summary
2. AWP Trust internal Report
3. Avon and Somerset Police internal management review
4. Hertfordshire Police internal management review
5. Hertfordshire probation overview Annex E and overview Annex H chronology
6. Court report from private psychiatrist and court report from HPFT psychiatrist
7. Paper copy of HPFT electronic patient records • Risk assessments/ care plans/needs agreement • Case notes • Legal documents • Correspondence • Clinical investigations • Monitoring and observation charts • Prescription charts
Policy background
NOMS Mental Health Treatment Requirements
NOMS Rehabilitation Activity Requirements
HPFT Policies
1) Care Coordination Policy Incorporating the Care Programme Approach & Sharing Information Guidance
2) Clinical Risk Assessment and Management Policy For Individual Service Users
3) Crisis Assessment and Treatment Teams Operational Policy
4) Discharge and Transfer of Service Users within the Care Planning Process Policy and Procedures
(Incorporating 7 day Follow-up and Delayed Transfers of Care)
5) Operational Policy for Community Mental Health Services
6) Lone Working Policy
7) Delivery of Care – Policy and Procedures (Incorporating the Care Programme Approach)
8) Clinical Risk Assessment and Management Policy for Individual Service Users
9) Crisis Assessment and Treatment Teams Operational Policy
10) Transfer and Discharge Policy
11) Adult Mental Health Community Services Operational Policy
12) Lone Working Policy
13) Acute Day Treatment Units Operational Policy
14) Supervision Policy
15) Criminal Justice and Forensic Mental Health Service Operational Policy
16) Safeguarding Adults from Abuse Policy and Procedures
17) Carer Practice Policy – Information for front line staff on the correct ways to support carers within HPFT
Additional reports
Homicide Investigation Report into the death of a child - Executive Summary Sept 2014
An independent investigation into the care and treatment of P in the West Midlands, NICHE, 2017
An independent thematic review of investigations into the care and treatment provided to service users who committed a homicide and to a victim of homicide by Sussex Partnership NHS Foundation Trust. Oct 2016
Threats to kill: a follow-up study L Warren, P Mullen, S Thomas, 2007
Managing Suicidality in Patients With Borderline Personality Disorder, J Paris, 2006
Chronic Suicidality Among Patients With Borderline Personality Disorder, 2002, J Paris

APPENDIX 4

Witnesses interviewed

Consultant Psychiatrist CP1 (Swift Ward)

Consultant Psychiatrist CP2 (Owl Ward)

Consultant Psychiatrist FCP1 (Forensic services)

Consultant Psychiatrist CP3 (Community team)

Approved Mental Health Practitioner (AMHP)

Ward Psychologist (PS)

General Medical Practitioner (GP)

Manager Criminal Justice Liaison, Bristol HMP

Associate Director Statutory Delivery, Avon and Wiltshire Partnership Trust

Mr O (the patient)

APPENDIX 5

Summary of NHS and related contact

Date	Hertfordshire Partnership University NHS Foundation Trust July to October 2013
12th July 2013	Seen in Queen Elizabeth 2nd Hospital Welwyn Garden City Accident and Emergency department following an episode of self harm, and was referred to Hertfordshire Partnership University NHS Foundation Trust Community Mental Health Services (CMHS).
19th July 2013	Further episode of self harm leading to a two days admission to Chase Farm Hospital
July/August 2013	Seen by staff from the Trust Crisis Assessment and Treatment Team (CATT) over this period, and was perceived to have stabilised
August/September 2013	Passed on the CMHS. Mr O asked for direction towards counseling. He was perceived to have further stabilised.
10th October 2013	Discharged from Community Mental Health Services, and a covering letter was sent to GP
	Avon and Wiltshire Mental Health Partnership NHS Trust February to March 2015
27th February 2015	Presented at Bristol Royal Infirmary following an episode of self harm, and was referred to the Avon and Wiltshire Mental Health Partnership NHS Trust Intensive Support Team (IST).
1st and 3rd March 2015	Mr O very distresses, in discussions with staff he reported ongoing risk of self harm, non specific threats to kill, and intrusive aggressive and violent thoughts.
4th March	Avon and Somerset Police were informed of the threats Mr O had made, and logged the call.
4th March to 19th March 2015	Series of face to face and telephone contacts, interspersed with attempts to make phone contact and messages left by IST staff. Mr O repeated the themes of thoughts of hurting others.
20th March 2015	In a telephone call with the Crisis Team CPN Mr O states that he intends to kill and then rape his girlfriend's sister, and in a further call threatens to cut the CPN's throat.
20th March 2015	Mr O was detained by police, where during a 136 assessment he made the same threats to kill, rape, and around sexual arousal. The Doctor carrying out the assessment concluded that Mr O should not be detained under the Mental Health Act, and advised that Mr O 'does pose a risk to others but there is no further role for ...mental health services....' and should follow the criminal justice route.
20th March 2015	Mr O was remanded in custody charged with making threats to kill.
24th March 2015	Mr O was discharged from the care of the IST and a summary of his care was sent to his GP.

	HMP Bristol 20th March 2015 to 1st May 2015
	During his period on remand in HMP Bristol Mr O met the prison in reach mental health team. They carried out assessment but due to the short duration of his stay no overall plan was created before discharge.
15th April 2015	Mr O pleads guilty to making two threats to kill
1st May 2015	Formally released from HMP Bristol
	Hertfordshire Partnership University NHS Foundation Trust
7th May 2015	Princes Alexandra Hospital requests bed for Mr O following episode of self harm. Mr O was assessed CATT and referred on by them to the Acute Day Treatment Unit.
11th May 2015	Mr O had his first attendance at the intensive day unit; he initially attended daily but became inconsistent and within 3 weeks stopped attendance.
26th May 2015	Discharged from intensive day unit in his absence, to be seen by the Community Mental Health Service (CMHS).
23nd June 2015	Referral from Royal London Hospital, after very serious suicide attempt. Admitted to Swift Ward. Reports note his forming close relationships with a number of the female patients on the ward.
6th July 2015	Discharged to the care of CATT and CMHS
July 2015	Regular meeting with CATT and on 28th July care transferred to CMHS, seemed generally stable.
27th July 2015	Report that Mr O had threatened a service user's brother and that police will be informed.
1st August 2015	Following a threat by Mr O to jump from a window at home he was readmitted to Swift Ward.
2nd August 2015	Mr O asked to leave the ward, but due to some unusual behaviour (climbing on a shed roof), vagueness about why he wanted to go out and who he might meet, threats to use a razor and saying 'he might do something tonight' he was detained under a section 5(2).
3rd August 2015	Discharged from Section 5(2). On the afternoon of 3rd August a bin in the garden next to Mr O was observed to be on fire, with Mr O fuelling it. A second fire in a bush was also observed. He was felt to be quite threatening when being reprimand about the fires being started. Mr O's case was allocated to a Forensic Psychiatrist for assessment
5th August 2015	Forensic consultation with Mr O. There was a view that 'There may be a case for section 38 interim Hospital Order and Mr O may be suitable for a PD low secure unit, given the nature of his offences and his clinical presentation.'
7th August 2015	Allegation Mr O had sexual contact with another patient. 'Police will be called and asked to interview Mr O'

10th August 2015	Ward reports that Mr O had had sex with fellow patient the previous week, and was involved with another ex patient in the past few days. The notes state 'Has had a number of relationships with other patients he has met on the ward. Mr O was placed on Section 5(2) but the details of this are not clear. The Consultant on Swift Ward recommended that Mr O be placed under Section 3 of the Mental Health Act and asked for a Mental Health Act Assessment. Mr O was then transferred to Owl Ward.
11th August 2015	Wanted to leave the ward but held under Section 5(4). Awaiting Mental Health Act Assessment he became threatening to staff on the ward.
12th August 2015	Mental Health Act Assessment carried out, with a decision not to detain Mr O. He agreed to make a behavioural contract.
19th August 2015	Case presentation at forensic psychiatry meeting, but it was unclear whether the Owl Ward psychiatrist was still supporting transfer to Low Secure Unit. It was agreed to discuss how to take it forward.
20th August 20I5	Meeting with Forensic Consultant Psychiatrist where it was agreed that at that time transfer to LSU is not warranted
26th August	Mr O reported friend has said she was suicidal and Mr O had called the police, later a police officer visited the ward to get more information.
3rd September 2015	Mr O had an altercation with another patient and reported it to the police, who phoned the ward.
4th September 2015	Mr O reported he had permission to remove his tag,
8th September 2015	Consultant was completing his report for Bristol Crown Court, and made a request to the court to ask for release of a previous report from a private consultant.
17th September 2015	Altercation with staff over restricting his visits female patients on other ward. Placed on a Section 5(2). ''When I leave or am discharged, I will kill someone – document that (name of nurse). I will kill someone when I leave, you must document that.' This threat was reported to the police.
18th September 2015	Increasing leave to parents. CMHS Consultant Psychiatrist agreed to be a probation psychiatric supervisor if Bristol Crown Court agrees to probation for Mr O
20th September 2015	Discharged on weekend leave, initially under the care of the CATT, then the CMHS

21st September 2015	Summary of notes from file Acute Care Pathway Assessment (CATT, RAID, ADTU) • History reviewed and recorded • Medication: o Venlafaxin XL 300 mg mane o Promethazine 50 mg nocte o Quetiapine 150 mg nocte • Well presented, appropriate throughout, subjectively low, objectively normal • No evidence or report of perceptual disturbances • Insight appears good • Risk: o History of severe risk to self (June 2015) by cutting arm o Risk of harm to self by impulsive overdose o History of harm to others (charged with battery following assault on ex-girlfriend 2009) o History of verbal abuse and hostility towards others o History of damage to property o History of threats to kill others o History of sexually inappropriate/manipulative behaviour towards vulnerable females o History of accusations against others Impression/Diagnosis: 26 year old man with ? past diagnoses of Psychopathy Current diagnoses of Emotionally Unstable Personality Disorder Recent admission following serious episode of self-harm Plan: • Discharge • Avoid misinterpretation • Short term support from CATT to facilitate safety • To be seen by 2 staff members at a time • No female staff to see Mr O unaccompanied
21st September to 2nd October 2015	Technically Mr O was still an inpatient in this period but was picked up but the CATT.
2nd October to 12th October	Ongoing support from CATT, handover to CMHS on 12th October.
12th October to 24th December	Ongoing support from the CMHS. One E Mail exchange with Mr O's Probation Officer.
2nd December 2015	Mr O sentenced to a Rehabilitation Activity Requirement and a MHTR, with a 9 month prison sentence suspended for two years
Mid December 2015	Appointment with GP for repeat medication, no concerns over his mental state