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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of Sam in Essex

FINAL

Report Advisory Notice

This report deals with difficult subjects relating to mental health conditions, care and treatment, and serious incidents. We have made efforts to write our report in a way which is not overly descriptive and limits the use of third-party and non-relevant personal information. However, there are instances where information is necessary, for example, where a psychiatrist or doctor's opinion has been quoted or a specific act has been documented that is relevant to the case. We advise caution for those who may be triggered by reading information that might be distressing, and ask that they are helped to read this report in a safe and supported way.

FINAL

Author: **Niche Health and Social Care Consulting**
Conveyed to: NHS England East of England Region and Midlands Region
On the: 13 November 2024

Dear Sir/Madam

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting healthcare providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Draft Report has been written in line with the Terms of Reference for the independent investigation into the care and treatment of Sam. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied on for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

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USE OF ITALICS IN THE TEXT OF THE REPORT

The use of italics in the text of this report reflects direct quotations or reported speech

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1 Executive summary

Incident summary

1.1 Sam had been under the care of Essex Partnership University NHS Foundation Trust (EPUT) Specialist Mental Health Chelmsford & Essex centre (SMHTC&E) since January 2017, after transferring from local child and adolescent mental health services (CAMHS).

1.2 It is recorded that when Sam was 16/17 he had established an online relationship with a 14/15-year-old girl from Canada in 2016. We now know this to be Laura. Information suggested that Sam would spend considerable amounts of time in his room talking to his 'girlfriend' Laura. Although there were arguments and times when they did not speak to each other, this online relationship continued up to her arrival in the UK in November 2021. Sam had many relationships over the period of care, including cohabiting with various partners.

1.3 In October 2021 Laura told her family she was going to the UK to spend time with Sam. Her family had misgivings and did not want her to leave, but they have described her as being determined. Her plan was to stay in the UK for up to six months, and after that Sam would return with her and spend a similar period in Canada.

1.4 Laura arrived in the UK on 14 November 2021 on a six-month tourist visa and moved in with Sam. She had contact with her family in November and December 2021 and did not share any worries. In January 2022 Laura told her family that Sam was very controlling and would not let her go out. She also said he had recently attempted suicide. Sam's mother and stepfather kept in touch with the couple, and they saw them regularly.

1.5 Sam had been admitted to Broomfield Hospital on 26 December 2021 after taking an overdose of medication in front of Laura. He was referred to mental health services and was detained under Section 5(2)[1] of the Mental Health Act (MHA) on 29 December 2021. His symptoms had decreased by 30 December 2021 and the Section was lifted.

1.6 Sam was discharged from Broomfield Hospital on 30 December 2021. It was recorded that he initially agreed to a referral to the EPUT mental health crisis response service, Home First. However, it was later noted that he would not answer the phone and had left the hospital without consenting to the referral. Home First decided there were no risk indicators that would justify a cold call, so the referral was closed.

1.7 On 30 January 2022 Laura made a video call to her family, appearing very upset. They offered to pay for her to return to Canada, but she later sent a message saying she would stay and work things out with Sam. However at her request, Laura's grandmother booked her on a flight to return home to Canada, which was to take place on 3 February 2022.

1.8 On 1 February 2022 a third party called the police to report a domestic incident at Sam's address. Police forced entry and found Laura deceased and Sam on the phone to his sister, explaining what he had done. An ambulance arrived at 4.27pm and Laura was pronounced dead at 4.33pm.

1.9 Sam was arrested and taken to hospital (Mid and South Essex NHS Foundation Trust) because he said he had taken an overdose of pregabalin[2] before his arrest. He was later remanded in custody.

1.10 In October 2022 Sam was convicted of murder and sentenced to life imprisonment.

Investigation

1.11 NHS England East of England Region and Midlands Region, commissioned Niche Health and Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and

[1] Section 5(2) of the MHA is the application to detain a patient already in hospital. https://www.legislation.gov.uk/ukpga/1983/20/section/5

[2] "*Pregabalin is used to treat epilepsy and anxiety*". https://www.nhs.uk/medicines/pregabalin/

treatment of mental health service user, Sam. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.12 The independent investigation follows the NHS England Serious Incident Framework (SIF, March 2015)[3] and the Department of Health guidance Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services.[4] The terms of reference for this investigation are given in full in Appendix A.

1.13 The main purpose of an independent investigation is to ensure that mental health care-related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services would help prevent similar incidents occurring.

1.14 The underlying aim is to identify common risks and opportunities to improve patient safety and to make recommendations for organisational and system learning.

1.15 This investigation was carried out alongside a domestic homicide review (DHR) which was commissioned by Safer Chelmsford Community Safety Partnership.

1.16 The lead author attended DHR panel meetings and had access to the chronologies and reports prepared as part of the DHR.

Relevant health history

1.17 Sam's involvement with mental health services began in late 2014 when he was 15 years old. He was referred to CAMHS by his GP following self-harm, violence and aggression at home. At the time he was attending a pupil referral unit because of his aggression towards teachers. While Sam waited for a CAMHS assessment, he was issued with a restraining order after a conviction for the harassment of a 15-year-old girl. He was also arrested for assaulting his mother and causing damage to the family home.

1.18 He was assessed by CAMHS and the youth offending team (YOT) for probation. The risks identified were the potential to cause harm to animals, anger outbursts and his negative attitude toward females.

1.19 He initially described hearing voices but was not thought to be psychotic after an assessment by the early intervention in psychosis team (EIPT). He was seen regularly for CAMHS psychiatry reviews and was allocated a key worker.

1.20 When Sam turned 18 in 2017, he was referred to EPUT Mid SMHTC&E, which is the adult secondary mental health service.[5] He continued to be aggressive to his mother and destructive in the home. In May 2017 his mother decided he could no longer live in the family home. Mental health services supported Sam in finding alternative accommodation, although he was seen as being potentially vulnerable to exploitation by other residents who were dealing drugs. During this time Sam was abusing cannabis and other street drugs.

1.21 From January 2017 Sam reported intrusive thoughts about harming a man from Basildon who had allegedly hurt his sister, and these were reported to the police. He continued to abuse drugs, including crack cocaine and cannabis, and did not always take his prescribed psychiatric medication. In 2017 Sam was diagnosed with emotionally unstable personality disorder (EUPD)[6]

[3] NHS England (March 2015) Serious Incident Framework. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

[4] Department of Health (2015) Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in mental Health Services. https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

[5] Secondary mental health services include hospitals, some psychological wellbeing services, community mental health teams (CMHTs), crisis resolution and home treatment teams (CRHTs).

[6] Borderline personality disorder https://www.nhs.uk/mental-health/conditions/borderline-personality-disorder/

and obsessive-compulsive disorder (OCD).[7] His medication at that time was sertraline[8] 100 mg daily, and aripiprazole[9] 400mg by depot injection[10] every four weeks.

1.22 It was noted that Sam had intrusive thoughts about harming and killing others and was damaging things in the home. He carried out rituals, such as handwashing, to manage his anxiety. He was offered access to psychological services in September 2017 but he did not respond when appointments were made.

1.23 There were further instances of aggression and drug abuse in 2018, and for a time Sam moved to a different part of Essex. In June 2018 Sam took an overdose of antidepressant and antipsychotic medication mixed with alcohol, heroin and crack cocaine. He was treated in the emergency department (ED). He received psychiatric reviews and care coordination from the EPUT SMHTC&E.

1.24 He committed further offences against his mother and he was remanded in custody for three months in July 2018. While in prison he was seen by primary care and mental health services.

1.25 His care was transferred back to the SMHTC&E after his release from prison in September 2018. Sam was abusing drugs with others in his accommodation. Following a breach of a restraining order in September 2018, he was remanded in custody until November 2018.

1.26 On his release he moved to Harlow. He was arrested in January 2019 for assaulting his then girlfriend, but not detained. His care was transferred to the local SMHTC&E. He admitted to using crack cocaine and was encouraged to access substance misuse services. Sam took two overdoses of medication in February 2019, around the time of the death of his father. He denied having suicidal thoughts and described taking extra medication for a "*buzz*".

1.27 Sam was arrested again in February 2019 for breaching a post-sentence order and was sent to prison until the end of March 2019. On his release he moved to Chelmsford and his care was transferred to the Mid-Essex (Mid) SMHTC&E. He had not engaged with mental health services since January 2019, but he now said he wanted to stop taking drugs and he asked for his medication to be restarted.

1.28 In August 2019 he went to the ED after taking an overdose. He described having paranoia, agitation and getting into altercations with others. It was agreed to admit Sam to the EPUT inpatient mental health inpatient unit at The Lakes, and he spent seven days waiting in an acute hospital ward for a bed. During this time he was arrested for threats to kill staff and for threats to kill a member of the public. After this arrest, he was returned to the hospital.

1.29 Sam was admitted informally to Gosfield Ward in The Lakes on 18 August 2019. However he discharged himself the following day after an argument about rules and expectations. He took further overdoses in August 2019. In September 2019 he admitted spending large amounts of money on crack cocaine and not taking his medication regularly. He made further threats to his mother in October 2019. He was living in temporary accommodation at this time, but later moved in with another girlfriend for a short period until that relationship broke down.

1.30 Psychological services were offered again in December 2019, but around that time he was arrested and remanded in custody for threatening and falsely imprisoning his partner. He remained in prison until March 2020. After his release he disclosed to the Mid SMHTC&E that he was having intrusive thoughts about harming children and he took another overdose. He was offered admission to a

[7] "*Obsessive compulsive disorder (OCD) is a mental health condition where a person has obsessive thoughts and compulsive behaviours*". https://www.nhs.uk/mental-health/conditions/obsessive-compulsive-disorder-ocd/overview/

[8] "*Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI)*". https://www.nhs.uk/medicines/sertraline/about-sertraline/

[9] Aripiprazole is an antipsychotic medication that helps with mental health conditions, such as psychosis or mood changes. https://www.nhs.uk/medicines/aripiprazole/about-aripiprazole/

[10] "*A depot injection is a slow-release form of medication. The injection uses a liquid that releases the medication slowly, so it lasts a lot longer. Depot injections can be used for various types of drug, including some antipsychotics*". https://www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics/depot-injections/

mental health hospital, which he refused. His stepfather wrote to the SMHTC&E about his concerns for Sam's safety, particularly about his drug misuse, but the service's response is not recorded.

1.31 In April 2020 Sam moved to his own flat in Chelmsford, where he remained until February 2022. He attended two psychology sessions in June 2020, then stopped going. There were further threats to his mother and further overdoses during 2020. He reported to the Mid SMHTC&E that he had stopped taking drugs in February 2021 and said he wanted to start going to psychology sessions again. Introductory group sessions were offered, and he attended one in August 2021.

1.32 He was discharged from care coordination in July 2021, after it was reported that his mental state had improved. However, his mother raised concerns with the Mid SMHTC&E in August 2021 because he had sent texts saying he felt suicidal. He denied this when the Mid SMHTC&E duty team contacted him, but he did agree to attend the psychology session in August 2021.

1.33 In November 2021 his mother again contacted the Mid SMHTC&E because Sam had sent several threatening messages to kill her, his sister and his neighbour. The SMHTC&E called Sam and he expressed anger towards his mother, although it was not clear why this was. He requested an outpatient appointment to review his medication and was seen on 3 December 2021.

1.34 At the medical review on 3 December 2021 the psychiatrist reviewed his medication history. It was noted that he had a long-standing diagnosis of OCD and felt anxious when he did not respond to his intrusive thoughts. He had been prescribed an antidepressant (duloxetine[11]) in April, but it had not helped so he stopped taking it. He had found aripiprazole had a calming effect. The psychiatrist prescribed the antidepressant escitalopram[12] 10mg once a day, to be increased to 20mg after two weeks, and aripiprazole 5mg once a day to increase to 10mg after two weeks. His prescription for pregabalin[13] was not changed. The psychiatrist noted that Sam denied taking any drugs for the "*last few years*". It was also noted that he was waiting for information from psychology, having attended the preliminary group sessions. He was to be seen again by the psychiatrist in two months' time.

1.35 On 26 December 2021 Sam was admitted to ED at Broomfield Hospital after a mixed overdose. He needed intubation[14] and reported visual hallucinations because of the overdose. On 27 December 2021 he was referred to the mental health liaison team (MHLT) from the intensive care unit. He refused a formal assessment by MHLT but did agree to be seen by the MHLT psychiatrist and the crisis team, Home First. However, Home First did not follow-up on the referral because it was reported that Sam had not given consent.

1.36 Sam was sent reminders that he needed to send in his self-referral to psychology, but he did not do it. Towards the end of January 2022, the SMHTC&E contacted Sam after his mother called them with concerns. Sam told the SMHTC&E duty team that he was living alone[15] and that he wanted a review of the medication he took for anxiety. Attempts were made to call him to arrange this, but he did not respond. Sam answered a call on 1 February 2022. He was described as responding rudely and said he did not want to talk; he just wanted a psychiatrist to do a medication review. A medical review request was made by the Mid SMHTC&E.

1.37 Sam was arrested in February 2022 after the homicide.

Conclusions

1.38 Sam had an extended period of care that was provided by EPUT. It was characterised by offending behaviours, including significant domestic abuse, threats to his family and others, and substance

[11] "Duloxetine is a type of antidepressant medicine known as a serotonin-noradrenaline reuptake inhibitor (SNRI)". https://www.nhs.uk/medicines/duloxetine/about-duloxetine/

[12] "*Escitalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI)*". https://www.nhs.uk/medicines/escitalopram/about-escitalopram/

[13] "*Pregabalin is used to treat epilepsy and anxiety*". https://www.nhs.uk/medicines/pregabalin/

[14] Intubation is when a breathing tube is placed in the windpipe. The tube keeps the airway open so air can get to the lungs.

[15] This was not true. S was living with L, but this was not known to the Mid SMHTC&E.

misuse. He had a troubled history from childhood and had been in contact with adult mental health services from the age of 18. Sam led a chaotic lifestyle that was interspersed with custodial sentences. His lifestyle, his frequent moves and the associated changes of GP practices made it challenging for care coordinators to maintain contact.

1.39 Although EPUT staff did liaise with police, there is no evidence that rigour was applied to trying to understand Sam's intrusive thoughts about harming others and his thoughts of sexually harming children. References are made to these being thoughts only, and there being no evidence that he may act on them. His risk to women (including those in his family) was not sufficiently explored and/or responded to in a meaningful way.

1.40 Treatment plans should have been underpinned by best practice guidance for the care and treatment of EUPD and OCD, and there should have been an expectation of engagement. There were missed opportunities for a forensic opinion, which could have informed a meaningful risk assessment.

1.41 If the multidisciplinary team (MDT) had agreed a formulation-based treatment plan that included the expectation of Sam's cooperation and engagement, there would have been an opportunity to consider if it was appropriate to continue to offer care under secondary mental health services. Because these two elements were absent, the approach was instead to react to crises, without having a longer-term plan.

1.42 Our findings focus on three main areas:

- care planning
- risk assessment
- family and service user involvement

1.43 The assessment of risk, including zoning,[16] fell well below expected standards and risks were not identified during the period of care. We make recommendations about risk assessment and the guidance on zoning.

1.44 It is for the DHR to consider whether there were warning signs of domestic abuse that professionals could have picked up. But there was clear evidence that Sam had abusive relationships with his mother and with his intimate partners. We found an absence of curiosity about this aspect of his presentation and the related risks were not assessed. Instead the risk assessment was inaccurate and incomplete.

1.45 Plans of care should have more obviously focused on an approach to the care and treatment of someone with a diagnosis of EUPD and OCD. Plans of care were reactive and responded to crises. They were hindered by Sam's lack of engagement and were mainly concerned with the medication he was prescribed for anxiety. No formulation was agreed. A formulation could have guided the focus of his treatment; and there was no long-term planning.

1.46 We have been given a draft of a new Trust service specification for a personality disorder and complex needs pathway. We hope that some of the learning identified in this report will be incorporated into these approaches.

1.47 Sam had a very supportive family who tried to advocate for him, despite the relationship difficulties, but there is little evidence of family involvement in care planning and risk assessment.

[16] Zoning is a risk assessment protocol that allows all the team to understand key information about service users at a glance. Mid Essex Specialist Community Recovery Service Operational Policy, 2015.

Recommendations

1.48 This independent investigation has made nine recommendations that will provide learning from the event.

EPUT recommendations

Recommendation 1: Recording of Mid SMHTC&E MDT meetings **Mid SMHTC&E MDT meeting notes did not routinely record who was present, what discussions took place and what actions were to be taken.** Mid SMHTC&E MDT meetings should record the practitioners present, the issues discussed and the decisions made. Subsequent meetings should discuss the actions taken to check on progress.
Recommendation 2: Changes to Care Programme Approach (CPA) status **Changes to CPA status were made without MDT discussion.** The Trust must ensure that there is a mechanism to ensure that the policy expectation of changes being made to CPA status only after a full MDT discussion is implemented and standards of practice are monitored.
Recommendation 3: Referrals to Home First **The Home First referral was closed without first obtaining accurate information.** If there is a question about consent for a referral to Home First, further information should be requested before the referral is closed. This should include attempts being made by the Home First team to establish consent.
Recommendation 4: Treatment for OCD **There was no evidence of psychoeducation about the OCD diagnosis or of low-intensity interventions being offered.** Care plans for individuals with a diagnosis of OCD should include the principles of care and treatment in the National Institute for Health and Care Excellence (NICE) guideline, Obsessive-Compulsive Disorder and Body Dysmorphic Disorder: Treatment.[17]
Recommendation 5: Pathway for individuals diagnosed with a personality disorder **There was no evidence of a multidisciplinary care plan that followed NICE guidance for EUPD.** Care plans for individuals with a diagnosis of EUPD should include the principles of care and treatment in the NICE guideline, Borderline Personality Disorder: Recognition and Management.[18]

[17] NICE (29 November 2005) Clinical Guideline [CG31] Obsessive-Compulsive Disorder and Body Dysmorphic Disorder: Treatment. https://www.nice.org.uk/Guidance/CG31

[18] NICE (28 January 2009) Clinical Guidance [CG78] Borderline Personality Disorder: Recognition and Management. https://www.nice.org.uk/guidance/CG78

Recommendation 6: Risk and zoning **The zoning system was not linked to risk assessment and management plans and did not provide guidance for practitioners about the type and levels of intervention needed to reduce risk.** The system of zoning should be revised to include expectations of the intervals between MDT meetings, MDT meeting membership, and the recording of discussions and actions. The zoning protocol should describe the frequency and levels of intervention, and the reviews needed at each stage. Any revisions to the protocol should be agreed at senior level and incorporated into the protocol, rather than decided locally.
Recommendation 7: Risk assessment and formulation **There was no agreed formulation or understanding of the nature and degree of risk to others or risk to self.** The Clinical Risk Assessment and Safety Management Policy should include the expectation that there is an MDT approach to developing a formulation-based understanding of risk, which includes guidance for community-based staff.
Recommendation 8: Domestic abuse **The indicators of domestic abuse were not incorporated into clinical risk assessment.** Domestic abuse must be part of the assessment of clinical risk and include reference to the guidance in the Trust safeguarding policy.
Recommendation 9: Service user and family/carer/partner involvement **There is little evidence of efforts having been made to involve the family or any of his partners in care planning or risk assessment.** The expectation of involving families and the service user in care planning and risk assessment is already established in policy. The Trust must ensure that there are mechanisms to ensure it takes place as required. The CPA policy refers to the involvement of "family or carer" and should also include the expectation of involvement of partners or significant others who are in a relationship with the service user.

2 Investigation

Incident

2.1 Sam fatally assaulted Laura in their flat in Chelmsford in February 2022. It was recorded that Sam had established an online relationship with a 14/15-year-old girl from Canada in 2016. We now know this to be Laura. Information suggested that Sam would spend considerable amounts of time in his room talking to his 'girlfriend' Laura.

2.2 Although there were arguments and times when they did not speak to each other, the relationship continued until 2022.

2.3 In October 2021 Laura told her family she was going to the UK to spend time with Sam. Her family had misgivings and did not want her to leave, but they have described her as being determined. Her plan was to stay in the UK for up to six months, after that Sam would return with her and spend a similar period in Canada.

2.4 Laura arrived in the UK on 14 November 2021 on a six-month tourist visa and moved in with Sam. She had contact with her family in November and December 2021 and did not share any worries. In January 2022 Laura told her family that Sam was very controlling and would not let her go out. She also said he had recently attempted suicide.

2.5 Sam had been admitted to Broomfield Hospital on 26 December 2021 after taking an overdose of medication in front of Laura. He was detained under Section 5(2) of the MHA and referred to the MHLT. His symptoms had decreased by 30 December 2021 and the Section was lifted.

2.6 Sam was discharged from Broomfield Hospital on 30 December 2021. It was recorded that he initially agreed to a referral to Home First. However there was a question about whether he had consented and it was later noted that he did not answer the phone and had left hospital without consenting to the referral.

2.7 On 30 January 2022 Laura made a video call to her family, appearing very upset. They offered to pay for her to return to Canada, but she later sent a message saying she would stay and work things out with Sam. However, at her request, Laura's grandmother booked her on a flight to return home to Canada, which was to take place on 3 February 2022.

2.8 On 1 February 2022 a third party called the police to report a domestic incident at Sam's address. Police forced entry and found Laura deceased. An ambulance arrived at 4.27pm and Laura was pronounced dead at 4.33pm.

2.9 Sam was arrested and taken to the ED because he said he had taken an overdose of pregabalin[19] before his arrest. He was later remanded in custody.

2.10 In October 2022 Sam was convicted of murder and sentenced to life imprisonment.

Approach to the investigation

2.11 NHS England, East of England Region and Midlands Region, commissioned Niche Health and Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of mental health service user, Sam. Niche is a consultancy company specialising in patient safety investigations and reviews.

2.12 The independent investigation follows the NHS England SIF (March 2015) and Department of Health guidance Article 2 of the European Convention on Human Rights and the Investigation of

[19] "*Pregabalin is used to treat epilepsy and anxiety*". https://www.nhs.uk/medicines/pregabalin/

Serious Incidents in Mental Health Services. The terms of reference for this investigation are given in full in Appendix A.

2.13 The main purpose of an independent investigation is to ensure that mental health care-related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services would help prevent similar incidents occurring.

2.14 The underlying aim is to identify common risks and opportunities to improve patient safety and to make recommendations for organisational and system learning.

2.15 This investigation was carried out alongside a DHR which was commissioned by Safer Chelmsford Community Safety Partnership.

2.16 The lead author attended DHR panel meetings and had access to the chronologies and reports prepared as part of this review.

Contact with victim's family

2.17 Laura's family in Canada asked for all contact about investigations to be managed through the DHR process. We offer them our sincere condolences.

2.18 Laura's mother was offered the opportunity to read the findings and recommendations of the report through a specialist advocate in October 2024. The findings were conveyed and the family did not wish to give any feedback.

Contact with perpetrator's family

2.19 The lead author and DHR chair met with Sam's mother and stepfather in June 2023. They described having many years of difficulties with Sam, during which they had tried to support him. His stepfather had attended many outpatient meetings with him and had written to his MP to try to get help for Sam.

2.20 His stepfather had written to the Mid SMHTC&E about his concerns several times and had not had a satisfactory response. His mother had called the Mid SMHTC&E many times about her concerns and to share risk issues, such as his threats to her and others. She was particularly concerned about his admission to Broomfield Hospital in December 2021 after his last overdose, when he was very physically unwell and described having hallucinations after the overdose. She felt he should have been detained for his own safety.

2.21 They both felt that Sam was let down by services and they would have liked to have seen a much more proactive approach to helping him. They did not feel involved in his care, and they believe they would have been able to contribute if they had been asked. In particular, they had a great deal of insight into the difficulties in the relationship between Laura and Sam and how they were living between November 2021 and February 2022.

2.22 They had the opportunity to read and comment on the draft report in June 2024. They reported feeling overwhelmed at the number of missed opportunities to assess the risk that Sam posed to women, including his mother and sister. They reiterated their hope that lessons would be learned and the system approach to risk such as in this case would be changed. They feel completely let down by the NHS system.

Contact with Sam

2.23 The lead author and DHR chair met with Sam in prison in August 2023. Sam did not think he had received the right help from services to manage his difficulties, particularly for his intrusive thoughts about harming people. He had not discussed his attitudes to women with any of the care coordinators or psychiatrists.

2.24 Sam said that when he took overdoses, he had sometimes wanted to die, especially in December 2021. He acknowledged he had been offered psychological help by mental health services and had not followed this up. Sam said he had not told services the level of his drug abuse and that he was also abusing prescription medication because he wanted the prescriptions to continue.

2.25 The report was shared with him in May 2024. Sam was concerned about the amount of detail in the report and did not wish for his medical information to be published.

3 Background of Sam

3.1 Sam was one of three children, born in 1999 and raised in Basildon. He has an older brother and sister. Shortly after his birth his parents separated. His father lived locally and died in February 2019. His mother's new husband is described by Sam as his stepfather.

3.2 From the age of 14, Sam knew that when his mother had become pregnant with him, his father had said he did not want another child and if she wanted to keep the baby, he would leave. His mother said that Sam's elder brother often mentioned it, saying if Sam had not been born, they would still be together.

3.3 Several referrals were made to children's social care from 1999, in Sam's first year, when his father alleged his mother was in a relationship with someone who should not be in contact with children. His father made another referral in 2003, alleging that his mother's new partner was violent to her and the children.

3.4 In 2009 his mother's then partner was murdered abroad. This was seen as a significant loss for Sam, who received some counselling.

3.5 Sam was moved from mainstream school to a pupil referral unit in 2014, because he was very disruptive and had thoughts of killing his teachers. Sam left school aged 15 with no qualifications. His father died in February 2019.

3.6 Sam has never been in paid employment; he received benefits and accommodation support.

3.7 In 2014 there were several incidents where Sam destroyed or damaged property, and one instance of him making an indecent photograph of a child. Most of his contacts with the police happened after 2015 and almost all involved violence or threats to females, including his mother.

3.8 Between 2017 and 2020, 10 domestic abuse or violence allegations were made involving Sam and his mother. They were for assault, criminal damage and malicious communications.

3.9 Four allegations of domestic abuse or violence involving Sam and his sister were made. They ranged from common assault and criminal damage to more serious assaults. One allegation of domestic abuse involving Sam and his stepfather was reported in 2020, for an offence of malicious communication.

3.10 There were reports of the domestic abuse of multiple partners between 2015 and 2021. The allegations included harassment, breach of harassment order, breach of non-molestation order, malicious communications, false imprisonment, threats to kill, assault, damage, stalking, and coercive and controlling behaviour.

4 NHS care and treatment

CAMHS 2007 – 2014 (aged 8 – 15)

4.1 In June 2007 Sam (aged 8) was referred by his school to a child and family consultation clinic for behaviour problems, anger management and outbursts.

4.2 In August 2012 (aged 13) he harmed himself with a knife and had problems managing his anger in school. In that same month he was seen by Essex Community CAMHS after he went to the ED at Basildon Hospital. He had cut himself, had smashed up rooms at home, and had been drinking and smoking cannabis.

4.3 Sam was seen by a school nurse in November 2012 because of his aggression in school, and his mother was said to be very concerned about him. Sam was referred for individual support with CAMHS after a few sessions with a counsellor.

4.4 There were concerns about his health and behaviour at school. It was agreed by children's services to offer a full health and common assessment framework assessment.[20]

4.5 The initial assessment was completed in March 2013. At that time Sam said that he had smoked cannabis and drunk alcohol regularly, but he had stopped using cannabis and occasionally used alcohol. He smoked up to 10 cigarettes a day.

~~4.6~~ In 2013 (aged 14) he was living with his mother and older sister. His older brother lived alone. Sam did not see his father regularly.

4.7 CAMHS staff attended a Team Around the Child meeting in June 2013. At this meeting CAMHS staff suggested that Sam had underdeveloped emotional and cognitive ability rather than a mental illness. It was agreed to carry out IQ tests through the council. The family were receiving support and his behaviour at home was improving. The family were moving to a cottage in rural Essex. This meant a planned change of school for Sam, and it was suggested this would be good because it would change his friendship group.

4.8 In January 2014 Essex CAMHS wrote to Sam's new school. They ended their involvement with Sam and suggested that he be assessed for autistic spectrum disorder. The family GP requested an assessment for autism from a community paediatrician in February 2014.

4.9 In March 2014 Sam cut his arms superficially, he was seen by his GP and referred to community paediatrics. He described being overwhelmed with emotion at the weekend because of an intense online relationship with a girl in Wales.

4.10 In October 2014 the community paediatrician reported that an assessment for autism had been completed and Sam did not meet the diagnostic criteria. It was noted his self-esteem was low, and it was suggested that his cognitive and learning ability should be formally assessed. At this time Sam had been excluded from school and was attending a pupil referral unit. He was said to find the support at the unit helpful, but the school told the GP that if Sam needed support for mental health issues, he should be referred to CAMHS services.

4.11 The GP made an urgent referral to the Chelmsford CAMHS Gateway in October 2014, after Sam's mother took him to the surgery because he was having angry outbursts at home. They were described as violent outbursts in which he threw furniture around the house and caused general damage and mayhem. It was noted he had a history of self-harm, was struggling with his schoolwork and was swearing at the teachers. He was taken into police custody on 7 October 2014 after a disturbance at home and was due to appear in court on 24 October 2014.

[20] "*The [common assessment framework] is a shared assessment and planning framework for use across all children's services and all local areas in England*". https://www.scie-socialcareonline.org.uk/the-common-assessment-framework-asset-and-onset-guidance-for-youth-justice-practitioners/r/a11G000000180S3IAI

4.12 The referral to Chelmsford CAMHS was triaged on 9 October 2014 and was passed to the Tier 2[21] community CAMHS team at North Essex Partnership University NHS Foundation Trust (NEPT).[22] After an initial assessment, in December 2014 Sam was offered individual therapeutic work with a community CAMHS practitioner. He was placed on a waiting list for treatment.

CAMHS 2015 – 2017 (aged 15 – 18)

4.13 Sam was seen by Chelmsford CAMHS (provided by NEPT) alongside the YOT and EIPT. At a review in February 2015 (aged 15) it was noted he was taking fluoxetine[23] 10mg as prescribed, although he continued to have "*distressing thoughts*". There was still conflict at home, especially with his sister.

4.14 At that time he was on a youth rehabilitation order[24] for breaking a restraining order, and the history of violence to his mother and sister was noted. He was seeing YOT three times a week. He was also a Child in Need[25] and he had an allocated social worker. After the family move, Sam had less access to cannabis. His early history of anxiety was noted. He had panic attacks and was particularly anxious in crowds, so he avoided these types of situation. He often woke in the night and texted his mother with worries about the house being invaded. He said he heard voices asking him to hurt his family. He described the voices as intrusive and did not want to act on them, although he had thoughts of stabbing his mother. The thoughts were stronger when he was alone. He described getting some relief from these thoughts by squashing the head of a kitten, but he then felt remorse for what he had done.

4.15 No signs of psychosis were found during his sessions with CAMHS. He said talking about his experiences had given him some relief, although he was embarrassed. His extensive cannabis use was noted, and it was agreed further investigations were required. The consultant psychiatrist prescribed fluoxetine 10mg to help reduce his anxiety and the intrusive thoughts. He was also given an anxiety management pack and given advice on distraction.

4.16 At the March 2015 review, Sam was still having distressing thoughts about hurting people, which he tried to resist. His sleep and appetite were poor, and he had some suicidal thoughts, but no plans to carry them out. Risperidone[26] 0.5mg was added to the prescription and the fluoxetine was increased to 20mg per day, to be reviewed in April 2015.

4.17 By the May 2015 review, his sleep had improved, although he often asked his mother for reassurance by texting her about his worries. Thoughts of worthlessness remained, and he was bored and not motivated to occupy himself or play sports. He said he had no plans to harm himself or others and he appeared less anxious. In June 2015 he said the thoughts of harming others were less intense. He was concerned about weight gain caused by his medication but he was less anxious.

4.18 In June 2015 Sam was seen and assessed by the NEPT Criminal Justice Mental Health team at Chelmsford Police Station after being arrested and detained for criminal damage. He was reported

[21] Tier 2 CAMHS is "*Targeted services such as youth offending teams, primary mental health workers, educational psychologists and school and voluntary/third sector providers counselling (including social care and education)*". https://www.england.nhs.uk/wp-content/uploads/2018/04/mod-camhs-tier-2-3-spec.pdf

[22] North Essex Partnership University NHS Foundation Trust is no longer functioning. Services were taken over by EPUT in April 2017.

[23] "*Fluoxetine is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI)*". https://www.nhs.uk/medicines/fluoxetine-prozac/about-fluoxetine/

[24] "*[A youth resolution order] is a community sentence within which a court may include one or more requirements designed to provide for punishment, protection of the public, reducing re-offending and reparation*". https://consult.justice.gov.uk/sentencing-council/sentencing-youths/user_uploads/youth-rehabilitation-orders.pdf-1

[25] Under Section 17 Children Act 1989, a child is considered 'in need' if they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the local authority; or their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the local authority; or if they have a disability. https://www.legislation.gov.uk/ukpga/1989/41/section/17

[26] Risperidone helps with symptoms of some mental health conditions, such as aggressive or agitated behaviour in children. https://www.nhs.uk/medicines/risperidone/

to have thrown items belonging to his mother and broken some ornaments. His actions were classed as a form of domestic violence. Sam was removed from the home because his mother said she was afraid of him and Children Act[27] proceedings made him a looked after child.[28] A few days later his mother agreed that he could return to the family home.

4.19 Further CAMHS medical reviews took place in July, August and September 2015, in conjunction with the youth offending service. By September 2015 his sleep and mood had improved. He reported having fewer intrusive thoughts and feeling more able to deal with them. His medication was risperidone 1mg at night, and sertraline[29] 150mg. His blood pressure was higher, and he was referred to the cardiology department at Broomfield Hospital. No medical concerns were found, and he was advised to stop smoking, cut down on salt and do more exercise.

4.20 In November 2015 he was seen by the CAMHS psychiatrist again because he had started to experience panic. He was avoiding social situations and was not taking the sertraline regularly. Sam said he became angry easily with family members. He agreed to continue taking the sertraline 150mg and risperidone 1mg.

4.21 However, by January 2016 he was not taking medication regularly and was reported by his mother as being less compliant with his medication, more aggressive and refusing to participate in family activities. The next appointment with the psychiatrist was brought forward because of the re-emergence of these symptoms. Sam was not taking his medication and was using cannabis. His appointments with YOT had ended. YOT suggested he start an apprenticeship, but Sam was reluctant. He agreed to restart the medication and reduce his use of cannabis.

4.22 A NEPT psychology report dated February 2016 stated that the main concerns were:

- Sam having thoughts of harming his mother and sister.
- Aggression towards his mother and sister.
- Poor emotional regulation, especially managing his anger appropriately.
- Poor problem-solving skills, particularly in relation to interpersonal relationships.
- Low stress tolerance and underdeveloped emotional and social intelligence and coping skills.

4.23 This report noted that, given his psychological profile, Sam would struggle to engage in individual therapy. It said the goals of any intervention should be to help Sam develop the necessary skills to manage himself more effectively. To achieve this it said Sam would need consistent and continuing support with well-trained staff. However, it was noted that Sam might only agree to interventions under the pressure of severe family disorder or legal problems.

4.24 In February 2016 a domestic incident was recorded: Sam had assaulted his mother after she refused to take him out for the evening. He grabbed her by the shoulders and shook her, and smashed items in the home.

4.25 In November 2015 the CAMHS in Essex changed to become Emotional wellbeing and mental health service (EWMHS) for children and young people (EWMHS). They are provided by North East London NHS Foundation Trust. Although the provider changed, the staff moved with the service and Sam continued to see the same psychiatrist in April 2016.

[27] "*An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes*". https://www.legislation.gov.uk/ukpga/1989/41/introduction

[28] "*A child who has been in the care of their local authority for more than 24 hours is known as a looked after child*". https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children

[29] "*Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI)*". https://www.nhs.uk/medicines/sertraline/about-sertraline/

4.26 In April 2016 (when Sam was aged 17) his GP signed a certificate stating that he was unable to work because of an anxiety disorder. At the psychiatric review in April 2016, Sam said relationships at home had improved significantly. His mood had also improved, although at times he still fixated on the worry that he might harm others. This was particularly noticeable after he watched violent films, and he was encouraged to limit this. He had cut himself a few times but was generally able to distract himself from thoughts of self-harm. He was keen to take medication that would help him sleep, and melatonin[30] 2mg at night was prescribed.

4.27 Sam had been prescribed sertraline 150mg and risperidone 1mg. The risperidone was increased to 2mg by May 2016. In June 2016 it was noted at the psychiatric review that he was still struggling to leave the house, but he felt better if it was a quiet and familiar place. He had been on holiday with his mother and sister and had stayed in the room most of the time. The psychiatrist increased the sertraline to 20 mg in June 2016, and arranged to see him for review in July 2016. At the July review the psychiatrist recorded that Sam said there had been a difficult few weeks after the family holiday. Sam had been less compliant with his medication and was smoking cannabis. He wanted to move out of the family home, and social care was contacted to support this process. Sam agreed to take his medication and try to maintain a healthier lifestyle.

4.28 The GP continued to sign Sam as unfit for work. In September 2016 the GP asked the psychiatrist to review his medication because his triglyceride[31] levels were raised.

4.29 The psychiatrist reviewed his medication in September 2016. It was noted that his triglyceride levels were raised but overall his cholesterol was within normal limits. Sam did not feel able to look for work. He was compliant with his medication. Sam had applied for supportive housing and was waiting for placement. There was a great deal of stress at home because his sister had recently been assaulted by someone known to the family. Sam presented as calm and cooperative and seemed more relaxed. His weight had increased however from 70kg to 100kg. He agreed to start an antipsychotic (aripiprazole).

4.30 Sam turned 18 in January 2017, and was referred from EWMHS to the adult mental health services; Mid SMHTC&E at EPUT in December 2016.

SMHT mid Essex, 2017 – 2018

4.31 On his referral to the Mid SMHTC&E, Sam's notes were reviewed before an assessment was arranged. There was a concern that he might be experiencing psychotic symptoms, and a call with the EWMHS consultant psychiatrist was requested to clarify the nature of Sam's difficulties. An initial assessment appointment was arranged on 10 January 2017, which he did not attend, and again on 19 January 2017, which he did not attend.

4.32 The Mid SMHTC&E duty line received a call from Sam's mother on 19 January 2017. She was very distressed and said he had "*trashed*" her kitchen and punched holes in the wall. She said he had not been physically aggressive towards her, but he had been verbally abusive, calling her derogatory names.

4.33 Sam was seen by a community psychiatric nurse (CPN) on 23 January 2017 for assessment by the Mid SMHTC&E and an urgent medication review was arranged with a psychiatrist for the following day. It was noted that Sam had been transferred from CAMHS and he had also been seen by the YOT and EIPT. We have not seen a record of the outcome of the EIPT assessment. He voiced thoughts of killing the person who allegedly had assaulted his sister, and this was reported to the police.

4.34 Sam had been prescribed sertraline and aripiprazole but had stopped taking aripiprazole in January 2017. At the appointment with the psychiatrist he described having thoughts of hurting other people,

[30] Melatonin is a hormone used to aid sleep problems. https://www.nhs.uk/medicines/melatonin/about-melatonin/

[31] Triglycerides are blood fats that when raised can indicate high cholesterol. https://www.nhs.uk/conditions/high-cholesterol/

which he found stressful. According to him he managed them by putting on music loudly to distract himself. He was clear that these thoughts were his own thoughts, and he did not want to have them. He had assaulted his mother and sister in the past but not recently, although he had current thoughts of harming his mother.

4.35 He told the psychiatrist in January 2017 that he had not used cannabis for three years. He used alcohol occasionally and smoked 20 to 25 cigarettes a day. He said he had no thoughts of self-harming, but he also said he sometimes felt he wanted to kill himself. At that time he was not having thoughts of killing himself very often and he had no intention or plan to act on them. Hurting other people and killing himself were fleeting thoughts. He did not appear to be responding to any kind of stimuli during the interview. He said aripiprazole helped to dampen his thoughts and he agreed to take this orally alongside the sertraline. He was prescribed sertraline 200mg and aripiprazole 5mg.

4.36 The plan made by the psychiatrist was for Sam to contact the crisis or duty teams in case of crisis and wait to be allocated a care coordinator (CCO). Sam was placed in the team 'red zone'. This meant there would be frequent input from the team, and it would be noted quickly if any risks escalated, at which point he would be referred to the crisis team or he would be admitted. A medical review was planned for 20 March 2017, or earlier if needed.

4.37 Sam was discussed in the weekly Mid SMHTC&E MDT meeting on 8 February 2017. It was noted that the CPA handover from EWMHS was planned for 20 February 2017, and would be attended by a CPN and psychiatrist from the Mid SMHTC&E. Sam did not attend this appointment, but it was an in-person handover from the EWMHS consultant to the Mid SMHTC&E psychiatrist.

4.38 On the same day Sam's mother called the Mid SMHTC&E duty desk in a very distressed state. Sam had had an argument with his sister, and his mother was concerned for the sister's safety. His mother was worried that he was going to act on his thoughts of killing people. He had applied for supported housing and was due to move out. He was in the red zone and it was noted that a care coordinator should be allocated as soon as possible.

4.39 Essex police completed a street triage form on 6 April 2017, after his mother called to report that Sam had been smashing items in the kitchen. He was seen by EPUT mental health street triage team. There were no psychotic symptoms and no self-harm or suicidal thoughts. He reported thoughts of killing someone who deserved it and was told that would be considered premeditated murder. Sam was not taking his prescribed medication and had been consuming energy drinks. A care coordinator (CCO1) had been allocated, and Sam was due to see them and the Mid SMHTC&E consultant psychiatrist the following day. No crisis intervention was needed, and the contact was handed over to CCO1.

4.40 Sam was seen by the Mid SMHTC&E as planned on 7 April 2017. There was a concern that he was preoccupied with taking the law into his own hands, for the assault on his sister. He described a male voice in his head telling him to do this. The aripiprazole was increased to 10mg. A referral was made to the South East Essex Forensic Psychiatry Service to review the risks involved and advise on risk management. No correspondence from the forensic service in response to the referral is available.

4.41 An urgent medical review was requested by CCO1 after reports that Sam presented a high risk of harm to others. The review took place with the Mid SMHTC&E psychiatrist on 28 April 2017. Sam described throwing a bowl of food at his sister in the previous week but said he had not assaulted his sister or mother since January 2017. He continued to express a desire to kill the person who had harmed his sister. He was able to describe what the consequences would be if he took the law into his own hands.

4.42 Sam said he had not taken his medication for five or six days, and asked if he could have a depot injection. It was agreed his request would be discussed with the consultant psychiatrist. Oral aripiprazole was restarted at a lower dose. The plan was:

- "*Sam would recommence his medication*

- *CCO to provide support in the community, increasing input to 'step-up care'*
- *CCO to make contact with police about his threats to harm an individual*
- *For consultant psychiatrist review in two months*"

4.43 On 2 May 2017 Sam was taken to ED by his sister, initially reporting suicidal thoughts. During the assessment Sam said he was not suicidal; he just wanted his medication changed from tablets to injections. He said he smashed things at home because he "*gets wound up*" and because he forgets to take his medication and gets up at different times, so having an injection would be better. The advice was to hand over to CCO1 who would request a medication review and continue with CCO support.

4.44 Sam did not respond to a follow-up phone call on 3 May 2017 by the Mid SMHTC&E duty team, and it was handed over to CCO1 to get in touch.

4.45 Sam's mother called the access and assessment team[32] on 28 May 2017 asking for him to be housed elsewhere. She said he had "*trashed*" her home and she could no longer cope with him living with her. It was not clear why his mother had not called the Mid SMHTC&E, and it was explained that mental health services would not be able to rehouse him, but a medical review could be arranged. It was handed over to CCO1 to follow up.

4.46 At a Mid SMHTC&E MDT meeting on 28 June 2017, it was noted that there had been approximately 20 police call outs by Sam's mother since January 2017. These had all been because he was damaging the family home. It was agreed that a psychological assessment would be helpful and should be arranged.

4.47 On 6 July 2017 it was agreed that a depot injection would be prescribed. Aripiprazole 400mg depot every four weeks was started. Sam phoned the Mid SMHTC&E duty team on 17 July 2017 to say he had been having difficulty sleeping since his depot injection had been prescribed. He was prescribed 14 days of promethazine[33] 50mg to help him sleep. He agreed to collect it from the Mid SMHTC&E.

4.48 Sam moved to a Sanctuary Supported Living[34] facility in Witham from 7 August 2017.

4.49 In August 2017 the psychology assessment took place. The clinical opinion was that Sam's presentation was consistent with a diagnosis of OCD. It was reported:

- "*Recurrent and persistent thoughts and images, which he experienced as intrusive and unwanted, and made him feel distressed and anxious. He said he has no intention of acting on these thoughts and they do not fit with his view of himself.*
- *He attempts to ignore or suppress these thoughts or 'neutralise' them with mental rituals, such as imagining them written on the walls.*
- *He engages in mental repetitive acts in order to 'neutralise' his anxious thoughts, needing to perform these acts with a degree of precision these acts are time consuming and aimed at reducing his anxieties*".

4.50 Sam also reported a degree of social anxiety: he often worried about what people thought of him and assumed people would judge him negatively. He described having suffered panic and anxiety attacks since the age of 14 and avoiding social situations. He also described being worried about the wellbeing of his sister after her assault and expressed anger at the perpetrator.

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[32] The access and assessment team is the single point of access to EPUT services for those experiencing moderate to severe mental health issues. https://eput.nhs.uk/our-services/adult-mental-health-teams-access-and-assessment-colchester/

[33] Promethazine is an antihistamine medicine that relieves the symptoms of allergies. It can cause drowsiness and can be prescribed for short-term sleep problems. https://www.nhs.uk/medicines/promethazine/

[34] Sanctuary Supported Living provide support, housing and assistive technology. https://www.sanctuary-supported-living.co.uk/

4.51 The psychology service opinion was he did not present a risk to others, and his thoughts could be seen as an expression of anger and a wish to see himself as a protector for the women in his family. He did not show any symptoms that indicated psychosis, delusions or paranoia. Further psychology service appointments were arranged to discuss his background and discuss options for treatment.

4.52 In August 2017 the Mid SMHTC&E consultant psychiatrist asked the GP to prescribe promethazine 50mg regularly to Sam, which he had been taking to help him sleep.

4.53 A psychology assessment was offered to Sam on 12 September 2017, but he did not attend this or follow-up appointments that were made. Because of this his name was taken off the psychology service caseload, in line with normal practice.

4.54 Sam was seen on 23 November 2017 for a medical and CPA review by a locum consultant psychiatrist. The diagnosis was listed as EUPD. His medication at that time was listed as sertraline 100mg daily and depot aripiprazole 400mg every four weeks. Sam described getting angry easily but had not harmed anyone. Although his mood was okay, he had felt anxious after not being able to access his sertraline prescription for a month. He had moved out of the area, so his GP had refused to issue a repeat prescription. Sam was given a sertraline prescription and was strongly recommended to register with a new GP. His sleep, appetite and concentration were okay. He was using cannabis every day but was not drinking alcohol and said he felt otherwise healthy. There were no delusional or perceptual abnormalities, no thought disorders and he was able to talk spontaneously.

4.55 Sam denied having any thoughts of self-harm or suicide. He was still saying he would harm the person who allegedly assaulted his sister, but they were in Basildon and he had no intention of going there. He was fully aware of what would happen if he assaulted them and the view of the psychiatrist was that Sam had capacity and was aware of his responsibility for his own actions.

4.56 When discussing treatment options the psychiatrist recommended Sam attend Open Road[35] for support with drug and alcohol use. Sam had mixed feelings about it, but it was agreed that CCO1 would make a referral and then Sam could decide. Sam was not experiencing any side effects from the aripiprazole. The plan sent to the GP was:

- "*GP to continue to prescribe sertraline until reregistered.*
- *CCO1 to continue to support Sam in the community to monitor his mental health, risk and possible side effects of medications.*
- *CCO1 to discuss threats to hurt an individual in Basildon with the police.*
- *CCO1 to make a referral to Open Road to address cannabis use.*
- *[Sam] is aware of emergency contact numbers.*
- *To be reviewed in the psychiatric outpatient clinic in three months, or earlier if needed*".

4.57 In December 2017 Sam restated his intention to kill the individual in Basildon to CCO1. CCO1 reported this to Essex Police. Sam was interviewed by police with CCO1 present.

4.58 In the MDT zoning meeting on 3 January 2018 Sam was moved from red to amber. The police had recently been to speak to him about threats to kill the person who had allegedly assaulted his sister.

4.59 His mother called the Mid SMHTC&E on 23 January 2018; Sam was being moved to accommodation in Brentwood as a priority because of an incident with another resident. He had reportedly spent the week with his terminally ill father in Basildon. He had then punched a wall at home because he was feeling unsettled, but this had not escalated.

[35] Open Road is a drug and alcohol recovery service In Essex. https://www.openroad.org.uk/

4.60 He was zoned as red by the MDT meeting on 24 January 2018. CCO1 had spoken to Sam's mother. Sam had moved out of the area to Brentwood from the Sanctuary accommodation and was pleased with the new accommodation. The plan was to transfer him to the south team as soon as possible. He was called on 16 February 2018 to arrange a change to the time of his depot injection and his CPA review on 22 February 2018. He did not attend but called to apologise for oversleeping and the appointment was rearranged for 26 February, which he did not attend.

4.61 On 3 March 2018 it was noted at the MDT meeting that Sam was at risk of relapse. He had not been attending his depot appointments and he had been asked to go to the Mid SMHTC&E offices that day, but he did not. He stayed in the red zone. His depot injection was given late and only after a home visit was made to him on 22 March 2018. On 28 March 2018 his zone was changed from red to amber after it was noted he was doing okay in supported housing.

4.62 Sam began attending for his depot again from early April 2018. Sam told CCO1 on 4 April 2018 that he wanted to be moved to another supported accommodation property. He thought that it would be possible despite the difficulties being made clear to him along with the fact that there were no vacancies anywhere. He had difficulty accepting this. He said he would go and live in Basildon with his stepfather while at the same time acknowledging that they often clashed.

4.63 He attended for his depot on 5 April 2018, but he appeared subdued and tense. CCO1 asked Sam about him going back to live with his mother in Chelmsford, but he said his mother would not have him back living with her. He left without accepting the depot and was asked to come back the following day.

4.64 The same day his probation officer confirmed to CCO1 that Sam had appeared at Basildon Magistrates' Court on 23 March 2018 where he was convicted of harassment of his ex-partner. The offence involved Sam contacting her through social media – the first contact was within six minutes of his restraining order expiring. Sam had also breached the restraining order on previous occasions.

4.65 Having previously been known to youth offending services, Sam was now supervised by the National Probation Service because he was an adult. He was given a 12-month suspended sentence order[36] with 12 weeks custody, suspended. His conditions were to complete a 60-day rehabilitation activity requirement (RAR)[37] and also the Building Better Relationships programme.[38] This was a programme aimed at male perpetrators of domestic abuse that lasted for 27 weeks (one session per week). The 60-day RAR involved once-weekly supervision appointments with the probation officer, completing offence-focused work. His supervision would continue beyond this, until the expiry date of the order which was 21 March 2019.

4.66 At the zoning meeting on 11 April 2018, Sam was zoned from green to red. No records were available to explain when the change to green from amber (which was the zone recorded on 28 March) was made. It was reported that he was using cocaine. He had some side effects and was advised to go to ED. He was noted to be on probation for harassment.

4.67 Sam stayed in zone red at the MDT meeting on 2 May 2018. He was reported to have been very aggressive and abusive on the phone to CCO1. A planned meeting with the probation officer, Sam and his mother was to take place later that day.

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[36] "*A suspended sentence order is an order providing that a sentence of imprisonment or detention in a young offender institution in respect of an offence is not to take effect unless (a) an activation event occurs, and (b) a court having power to do so subsequently orders under paragraph 13 of Schedule 16 that the sentence is to take effect*". https://www.legislation.gov.uk/ukpga/2020/17/group/THIRD/part/10/chapter/5/crossheading/what-a-suspended-sentence-order-is/enacted

[37] "*The RAR is one of the requirements that can be included within a community order or suspended sentence order. The main purpose is to secure someone's rehabilitation, restoring service users to a purposeful life in which they do not reoffend*". https://www.gov.uk/government/publications/the-rehabilitation-activity-requirement-in-probation/rar-guidance

[38] "*Building Better Relationships … is a His Majesty's Prison and Probation (HMPPS) moderate-intensity cognitive-behavioural programme for adult men convicted of an Intimate Partner Violence offence*". https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1149864/evaluating-the-building-better-relationships-programme.pdf

4.68 Later on 2 May 2018 Sam and his mother attended a meeting with CCO1 and the probation officer. He apologised for being verbally abusive to CCO1. He had left the accommodation in Brentwood and had been living with his father in Basildon for three weeks. At some point he had contracted an infection, but he had been treated at ED and recovered. The depot aripiprazole was administered and was next due on 31 May 2018. His mother had accepted him back to live at her home and he was to be re-registered with the GP locally. He agreed to self-refer to Open Road because of his continuing use of cocaine and heroin, which he said he wanted to stop.

4.69 He was in arrears with his rent and was encouraged to write to withdraw from the tenancy and revoke his place. His accommodation had found evidence of drug dealing in his room, and he had taped up the doorway so there was no evidence of smoking. Sam and his mother agreed he had "*burnt his bridges*" with supported accommodation and the supported housing joint referral panel would not consider him for future placement. A new probation officer contact was shared with CCO1 on 1 June 2018.

4.70 On 6 June 2018 the MDT meeting changed his zone from red to amber. The only note made was that he "*is stable*".

4.71 Sam attended a CPA review in early June 2018. He said that since he had returned to his mother`s home in Chelmsford he was much more stable. He said he had stopped using crack cocaine and other substances. But he had not attended Open Road. He was attending the weekly Chelmsford probation appointment. However, the probation officer reported that Sam had told them he had taken crack cocaine on 15 June 2018. Probation also said that Sam was anxious about attending the Building Better Relationships group. He was reminded about attending for his depot injection on 27 June 2018.

4.72 Sam was assessed in police custody on 20 June 2018 by the EPUT Criminal Justice Liaison and Diversion team (CJLDT). He was under the influence of heroin at the time. Sam was released under investigation for criminal damage and breach of a probation order.

4.73 Sam was admitted to Broomfield Hospital ED on 23 June 2018 and assessed using the EPUT and Mid Essex Hospital Services NHS Trust joint adult mental health assessment protocol. He had taken an intentional overdose of pregabalin, sertraline, heroin and crack, with alcohol after feeling low. The assessment noted that he had support from his mother and a CCO. He was seen by medical staff on 24 June 2018. Sam and his mother saw the liaison mental health team. The risk assessment for suicide ideation included his historical risk as:

"*Reported that he took an overdose of his prescribed medication and some illicit drugs yesterday but had no intention of ending his life. He stated that he wanted some kind of help to deal with these bad thoughts. At the time of the assessment, [Sam] reported that he had no further thoughts of suicidal [sic] and will keep himself safe and has agreed with the proposed plan*".

4.74 The plan agreed was that Sam would be discharged home on 24 June 2018, CCO1 and the GP were to be notified, and Sam was advised to attend Open Road for support with his substance misuse.

4.75 On 30 June 2018 Sam was seen again by CJLDT at Chelmsford police station. He had been detained in custody accused of criminal damage. He had been identified as breaking a window to the office at Coverdale supported housing. No intervention was needed from CJLDT.

4.76 On 4 July 2018 Sam was remanded in custody after causing damage at his mother's address, to appear in court the following day. He said he would take an overdose after court, and the custody sergeant asked CJLDT to see him. He denied having any suicidal intent, but the custody sergeant was informed there would be a clinician in court if further assessment was needed.

HMP Chelmsford, July – September 2018

4.77 Sam was seen at the reception at HMP Chelmsford on 5 July 2018. The initial assessment was that there was no immediate risk, but the situation would need to be reviewed regularly. His history of receiving medication for mental health problems was noted.

4.78 Sam was noted to have a history of contact with mental health services, with a diagnosis of EUPD, and to be receiving a depot monthly. He had reported hearing voices in the past but not currently. He said he had taken an overdose a week before and he had a bandaged right arm, which he said he had injured after punching a window. He said he was due to see a doctor but could not because he was in custody. He reported daily use of heroin, cannabis and alcohol.

4.79 On 5 July 2018 Sam was seen by a doctor for screening. Sam said he had a diagnosis of personality disorder and was prescribed pregabalin and sertraline by his GP. A request to confirm the dosages was made to the GP. Sam told the doctor he was using benzodiazepines[39] and cocaine but denied current use. It is not clear whether he was tested for evidence of drug use. The plan was to re-dress his arm and refer him to the mental health team and to Phoenix Futures[40] for support with drug and alcohol recovery. He was placed on an Assessment, Care in Custody and Teamwork (ACCT) plan because of his recent overdose and suicidal thoughts.

4.80 On 6 July 2018 Sam was referred to Phoenix Futures who provided a mental health in-reach[41] and integrated drug treatment system (IDTS) in the prison. It was noted that he was known to the EPUT specialist mental health team, had a diagnosis of EUPD, and had taken an overdose of his prescribed medication. He said he was taking heroin daily and he was prescribed a depot injection, which he was currently up to date with.

4.81 On 8 July 2018 Sam took an overdose of antibiotics. He did not suffer any adverse symptoms, but he was low in mood. The ACCT remained in place because of his low mood

4.82 Healthcare staff attended the ACCT review on 13 July 2018. Sam was reported as not suicidal but he was experiencing some pain from the injured arm. His arm wound was cleaned and re-dressed. The ACCT was closed at this review because he seemed more settled and was happy with his cellmate.

4.83 On 15 July 2018 Sam was seen for a mental health review. Sam was willing to engage and reported that this was his first time in prison. He had been anxious for the first few days but now felt settled because he had a cellmate. He said that outside prison he saw his CCO twice a month and he had a depot injection every 28 days. Sam said he was pleased that he might be granted a home detention curfew (HDC).[42]

4.84 Sam agreed that CCO1 could be contacted. He was given his depot injection, which was aripiprazole 400mg every four weeks. His established diagnosis of EUPD was noted.

4.85 The contingency plan was:

- "*For [Sam] to present to the wing officer if he feels that he is at increased risk of self-harm or others are at risk from his behaviour. Wing officers will then gain contact with a member of the mental health team who will arrange to visit as soon as possible.*

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[39] "*Benzodiazepines are a type of sedative that may sometimes be used as a short-term treatment during a particularly severe period of anxiety*". https://www.nhs.uk/mental-health/conditions/generalised-anxiety-disorder/treatment/

[40] Phoenix Futures deliver alcohol and drug recovery programmes in prisons, https://www.phoenix-futures.org.uk/about-phoenix-futures/our-approach-to-recovery/our-models-of-treatment/justice-system-models/

[41] "*Prison inreach teams aim to provide the specialist mental health services to people in prison that are provided by community-based mental health teams for the population at large*". https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/short-changed.pdf

[42] "*The Home Detention Curfew (HDC) scheme provides a managed transition from prison to community for offenders serving short sentences*". https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1161231/home-detention-curfew-pf.pdf

- *He can be seen by Hotel 8*[43] *for assessment of presenting mental state in the absence of the care coordinator. Management plan to be agreed between [Sam], officers and Hotel 8.*
- *Consider use of ACCT document, consider transfer to health care if risks to self or to others are high due to deterioration in his mental state and can't be managed safely on the wing*".

4.86 On 18 July 2018 Sam was seen by the prison psychiatrist. His history of breaching a restraining order and criminal damage was noted. It was also noted that he was known to mental health services in the community, he had a diagnosis of EUPD with depression and anxiety and had a current CCO. Sam denied any bullying or debt in his cell.

4.87 Sam said he was doing well in prison. He reported he had tried to end his life three weeks before because he had felt unable to cope with the stress of prison and his dirty cell conditions, but he had later felt remorseful and guilty about the attempt. He said he had also tried to self-harm once before. This was when his ex-girlfriend "*kicked him out*" of her flat and he had taken multiple sertraline tablets. He reported having chronic symptoms of intrusive thoughts and said he would hear voices intermittently when under pressure or stressed. He acknowledged that these thoughts and voices were part of his personality and were not hallucinatory experiences.

4.88 He said he had been using drugs since November 2017 because he had been "*mixing with the wrong crowd*", and that he took crack cocaine, cannabis and heroin on a regular basis. He said he was trying to not get involved in such company and to abstain from drugs. He had recently had surgery on his right arm and was in pain, and it was agreed to prescribe him pain relief.

4.89 The prison psychiatrist considered that Sam's mood was a normal reaction to his circumstances, and that he was experiencing intermittent intrusive thoughts and voices (pseudo-hallucinatory in nature). Sam denied having any self-harm, suicidal or homicidal thoughts, plans or intentions.

4.90 The plan was:

- "*Continue medication as before, advised not take any drugs on the wing, for Regular [registered mental health nurse] RMN review.*
- *seen by RMN regularly, CPN [CCO1] is visiting on 2 August 2018 for CPA review*".

4.91 On 2 August 2018 a CPA review and post-release planning meeting was held, which CCO1 attended. The CPA review took place without Sam because the prison officers could not arrange for him to attend because of the prison regime at this time.

4.92 CCO1 reported that Sam was in prison for criminal damage because he had smashed his mother's property and her car. It had been reported that his mother might not be willing to take him back after his release, and it was unclear whether his father would be taking him instead. There was a possibility that he would be homeless after his release. If this were the case, he could make an application for emergency housing to the local council with a supporting letter from the prison mental health in-reach team.

4.93 The team discussed the post-release arrangements for administering his monthly depot aripiprazole. The date of the first dose after release was to be provided to the community team.

4.94 CCO1 reported that Sam had shown suicidal tendencies in the community caused by his illicit drug use. He had been reported as having taken overdoses on a few occasions. Sam had been advised to attend the Open Road service, but he had refused to engage with them to address his drug-related issues. Sam was on benefits. There was a history of him bullying and harassing his ex-girlfriend. It was not clear if he had a girlfriend at the time. His mother was very supportive but could not cope with him at home.

[43] Hotel 8 is a radio call sign for a nurse in prison.

4.95 After release Sam was to be seen by CCO1 every three to four weeks. A medical review would be carried out by the community psychiatrist, once every three months. He was to be given out-of-hours contact numbers to call in case he had a crisis, and he could contact his CCO during working hours.

4.96 The plan for after release was:

- "*Liaising with NACRO[44] for Housing*
- *Supporting letter for the housing by the Psychiatrist from the In-reach team*
- *Details of the Depot injection (next due date) will be provided to the Community team at the time of his release.*
- *Just been allocated a Probation Officer today*
- *Care Co-ordinator to review [Sam] as a 7 day follow up after his release and subsequently every 3-4 weeks.*
- *He will be reviewed by the Community Psychiatrist every 3 months.*
- *He will be encouraged to attend the 'Open Road' in Chelmsford. (Previously he registered with Open Road but did not attend his appointments).*
- *He will be followed up by the In-reach team until his release from the prison.*
- *The plan will be discussed with [Sam] later today as he could not attend the CPA and Post - Release plan*"

4.97 At the MDT zoning meeting on 15 August 2018 Sam was amber. It was noted he was in prison and was due to be released on 6 September 2018.

4.98 Prison mental health services gave Sam his aripiprazole depot 400mg on 24 August and noted it was next due on 21 September 2018. He was reported as being settled, eating and sleeping well, with no suicidal thoughts.

4.99 At the MDT zoning meeting on 5 September 2018, it was recorded that he was due to be released the following day. The current risk was noted as Sam being "*homeless*" when he was released. His restraining order meant he was unable to return to the family home.

4.100 Following his release on 6 September 2018, copies of his care plan were given to his mother to support his application for emergency housing. He was placed at emergency accommodation in Harlow.

4.101 However, the probation officer informed CCO1 on 11 September 2018 that, due to a physical altercation with another resident, he was evicted and moved to a B&B in Southend. Sam said he had been defending himself. There was no evidence to support this, but the matter was closed without police involvement. The probation officer gave the Mid SMHTC&E the contact details for the housing officer.

4.102 His zoning was changed from amber to red on 12 September 2018, based on information about the altercation (but no intervention was recorded).

4.103 CCO1 was told by the probation officer on 19 September 2018 that Sam was 'sofa surfing' with friends in Chelmsford instead of staying at the B&B accommodation provided. It was noted he had been detained at Harlow police station and was interviewed about a breach of his restraining order. He had been arrested at the request of South Wales Police, because the breach had been committed over social media. This was in relation to online harassment of a female in South Wales. The CJLDT had not been able to do an in-depth assessment with Sam when he was detained on 18

[44] National Association for the Care and Resettlement of Offenders. https://www.nacro.org.uk/

September because of time constraints, but he presented as stable and settled, although he showed some concern about the potential outcome of his court hearing. He was detained by police on 19 September 2018, to be interviewed about the breach of the restraining order in Wales. He was transferred by police to Wales to be interviewed but he was released the following day. Sam stayed at his mother's address for a short period but was also "*sofa surfing*". His mother called the Mid SMHTC&E on 19 September to check when his depot was due.

4.104 Sam was zoned amber on 26 September 2018, after the reports of him breaching the restraining order and being arrested. On 27 September 2018 Sam met with CCO1, along with his mother and stepfather, and received his depot injection.

HMP Chelmsford, October – December 2018

4.105 On 12 October 2018 Sam was back at HMP Chelmsford. He had been recalled because he had breached the terms of his licence. It was noted he had been released in September 2018, he was open to community specialist mental health services and had a diagnosis of EUPD.

4.106 At that time, he said he was prescribed sertraline 100mg, propranolol[45] 10mg and depot aripiprazole every four weeks, which was last administered on 26 September 2018 and was next due on 24 October 2018. Sam denied alcohol and illicit drug misuse. He complained of a cough and of being congested. His mental state appeared stable. Sam engaged well, had good rapport and eye contact, and interacted coherently and appropriately. No low mood was observed, and he denied having self-harm or suicidal thoughts. The plan was:

- "*… to refer to the GP for physical health.*
- *Refer to mental health referrals and allocations meeting, was on the waiting list for secondary health screen and smoking cessation*".

4.107 On 12 October 2018 Sam was seen by the IDTS team for assessment. They did not observe any deterioration in his mental state. Sam did not express any self-harm or suicidal thoughts. He said he occasionally used illicit substances with his peers. He had used heroin in the past but said it was not regular, it was only if he met a certain friend. He said he used cocaine every week and "*comes down*" with cannabis.

4.108 Sam said he had been drinking daily for the previous four or five months. That could be up to five bottles of wine a day, but that was not every day. He had referred himself to Open Road when he was in the community but he had not engaged with the service; he said he could not attend appointments because of his anxiety and OCD. Apart from anxiety, which he attributed to his mental health, he reported no other alcohol withdrawal symptoms. His last drink had been on 10 October, and no alcohol withdrawal symptoms were observed.

4.109 Sam told IDTS staff that he had been outside to the yard, but that he had needed encouragement from fellow inmates to do so. It was recorded that Sam reported experiencing high levels of anxiety. The IDTS plan was:

- "*No indications for medically assisted alcohol detoxification*
- *Referral to Full Circle[46] for psychosocial support and relapse prevention*
- *To remain under care of mental health*
- *Sleep hygiene behaviour education. Encouraged good diet and fluid intake. Alcohol screen completed*".

[45] Propranolol is a beta blocker that can help with anxiety and prevent migraines. https://www.nhs.uk/medicines/propranolol/

[46] Full Circle is a service delivered by Phoenix Futures "*to work with offenders with complex and additional needs*". https://www.phoenix-futures.org.uk/

4.110 On 16 October 2018 CCO1 was told the local housing panel had decided not to accept Sam's application for supported living. This was based on his history of criminal damage to property at a supported living house and his persistent abuse of illicit drugs at two previous residences in Brentwood. It was also noted that he still had not sought support or treatment from substance misuse services. CCO1 informed the probation service and his mother. At the MDT zoning meeting on 17 October 2018, Sam was zoned red. It was noted he was in prison and that no accommodation would be offered when he was released. He was disruptive wherever he went and was already open to probation.

4.111 On 24 October 2018 the Mid SMHTC&E MDT zoning was red. It was noted Sam would be in prison until 22 November 2018. His current diagnosis was EUPD, and it was queried if the depot was still appropriate. The plan was to arrange a professionals meeting with Sam's family and probation. CCO1 would discuss Sam's medication with medical staff and review him on his release from prison with a view to possibly discharging him from mental health services.

4.112 On 2 November 2018 Sam was seen by the prison psychiatrist, who noted it was his second time in prison. He strongly denied having any current thoughts of harming himself. He was happy with the depot injection, but he was not happy with his sertraline and he wanted to stop taking it. His main issue was not being able to sleep, and this made him anxious. After a long discussion, he declined a short-term prescription for zopiclone,[47] but a trial of promethazine[48] was negotiated, which could be stopped when he was released. The plan was to stop sertraline and start promethazine 50mg at night. This would be reviewed and the nurse would follow up.

4.113 In prison Sam was seen by his case manager for substance abuse and they discussed harm minimisation. Sam said before he was taken into custody, he had been smoking cannabis daily and was spending approximately £75 a week on it. He said he had smoked cannabis every day since the age of 16. Sam said he did not think cannabis was an issue, as all it did was "*mellow him out*". He also said that he smoked crack once or twice a week and could spend up to £150 each time on it. He said he had started smoking crack at the age of 18. He said when he had been released from HMP Chelmsford earlier in the year, he had started smoking heroin as well as crack and would spend around £250 each time on it.

4.114 At the Mid SMHTC&E MDT meeting on 7 November 2018, it was noted that a meeting was planned with Sam's family and professionals that afternoon. The meeting was to discuss if the team should continue to work with Sam because of his persistent drug use and his lack of engagement. There were issues with his drug taking and drug dealing. He was already under supervision from the probation service, and there had been no obvious changes to his behaviour. CCO1 was to discuss the appropriateness of continuing the depot with medical staff.

4.115 The meeting was held on 7 November 2018 with his mother, her partner, the probation officer and CCO1. It was noted Sam had exhausted all options with supported living because of his aggression and drug taking. The family wanted to challenge this decision and was given the details of where to make a complaint.

4.116 CCO1 made a second referral to the forensic service on 7 November 2018 by email. The request was for advice and CCO1 asked that this be given before Sam's planned release on 20 November 2018. CCO1 asked for advice about his ongoing management while he was in prison and for clarification about treatment options. Because of his age, the feeling was that services should explore all possible means of keeping him from becoming further involved in the criminal justice system.

4.117 Prison mental health services and the Mid SMHTC&E updated each other on 8 November 2018. Sam had told his mother he was keeping to himself to avoid drugs and was on "*suicide watch*".

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[47] Zopiclone is a type of sleeping pill that can be taken for short-term treatment of severe insomnia. https://www.nhs.uk/medicines/zopiclone/about-zopiclone/

[48] Promethazine is an antihistamine medicine that relieves the symptoms of allergies. It can cause drowsiness and can be prescribed for short-term sleep problems. https://www.nhs.uk/medicines/promethazine/

Prison health staff told CCO1 Sam was not on any special observations, and he was not on his own because he had a cellmate.

4.118 The prison forensic consultant advised that the depot should be stopped. However, this was apparently a misunderstanding and the depot was reinstated on 20 November 2018.

4.119 Sam was released on 20 November 2018. He went to the Mid SMHTC&E team base with his mother and was given the depot aripiprazole as prescribed. He told CCO1 that he wanted help for his substance misuse. He said he had seen the error of his ways and would try to curb his dependency on street drugs.

4.120 On 21 November 2018 the Mid SMHTC&E MDT meeting zoned him as amber. He was living at his mother's house "*unofficially*" because there was a restraining order in place stopping him living there. There is no record of this being discussed with the probation service or the police, or there having been a discussion with his mother about the potential risks. The 28 November 2018 Mid SMHTC&E MDT meeting zoned him as amber. Sam was still staying at his mother's and was hoping to be supported to find a private rental. The intervention was recorded as "*continue to support*".

4.121 Sam remained in the amber zone at the 5 December 2018 Mid SMHTC&E MDT meeting. A medical review was due that week, and his mother planned to attend it with him. He was still living at his mother's, and it was noted that he had not yet engaged with the substance misuse services. At the medical/CPA review on 7 December 2018, pregabalin 25mg was added because Sam was feeling very unsettled since coming out of prison on 28 November 2018.

4.122 On 12 December 2018 he remained in the amber zone and the update recorded was "*remains stable*".

SMHT North West, January – March 2019

4.123 On 2 January 2019 Sam was still in the amber zone, but it was noted he had not attended for his last depot on 19 December 2018. CCO1 was told by probation that Sam had moved to Harlow and the plan was to transfer him to the west community team.

4.124 On 3 January 2019 Sam registered with a new GP surgery at Addison House Surgery. CCO1 gave the new GP Sam's history on 3 January 2019, including that Sam was under probation and had been referred to Open Road.

4.125 A referral was sent to the EPUT North West SMHT on 4 January 2019 because Sam had moved to Harlow and registered with a Harlow GP. Sam had been told of the referral and said he was willing to engage.

4.126 Sam was seen on 7 Jan 2019 by his new GP and he asked for a prescription for pregabalin. The previous GP had prescribed pregabalin, but Sam was now requesting a higher dose. He was told his new GP could not review his medication history until his transfer had been finalised, but he could provide a copy of the psychiatrist's letter in the meantime.

4.127 The new GP carried out a medication review on 8 Jan 2019, and prescribed pregabalin[49] 25mg capsules for anxiety, to be taken three times a day.

4.128 On 8 January 2019 CCO1 had a telephone discussion with Sam and his probation officer on her mobile phone. The previous medical care plan containing his new pregabalin prescription had been posted to the Chelmsford GP instead of his new GP. The probation officer agreed to help with this. Sam said he would be asking for his dosage to be increased, that 25mg three times a day was not enough. This was to be discussed.

[49] "*Pregabalin is used to treat epilepsy and anxiety*". https://www.nhs.uk/medicines/pregabalin/

4.129 On 9 January 2019 Mid SMHTC&E still had Sam in the amber zone, noting he had been referred to the west team and was waiting to be allocated an CCO. He was allocated to CCO2 on 10 January 2019.

4.130 On 11 Jan 2019 his new GP noted Sam's history of "*long-term anxiety*" and agreed to increase the dose of pregabalin to 50mg three times a day. This was to be reviewed at the next psychiatric outpatient clinic.

4.131 On 14 January 2019 Sam was arrested for assaulting his then girlfriend, and her young child was also present.

4.132 On 29 January 2019 a joint visit from the mid Essex CCO (CCO1) and the new west CCO (CCO2) was made to Sam in his bedsit. A letter had been sent but Sam could not access his post box and so he was not expecting them. He told them since he has been in Harlow, he had been taking more illicit substances than he was before he went to prison. He had been taking £50 of heroin and £50 of crack each day. He was told it would be difficult for therapeutic work to make a difference while he was using drugs. He said he had an appointment with Open Road and a prescription for methadone.[50]

4.133 Sam was asked to consider if he wanted to work with mental health services and to let CCO2 know his decision. He was given the depot prescription, and a medical review was planned.

4.134 On 7 February 2019 his aripiprazole depot 300mg was administered at Sam's home address by an RMN from the North West SMHT. He did not have any concerns and was reported to be stable and planning ahead. He kept good eye contact throughout the engagement, and there were no signs of psychosis or depression. His next appointment was due on 7 March 2019.

4.135 On 13 February 2019 his mother called CCO2. She was concerned about Sam because he said he was struggling with his father's recent death. She thought he might be using drugs again because he had sent her a text saying he was useless. Apparently he only said "*nasty*" things like that when he was coming down from drugs. He had broken up with his girlfriend a week before. His mother said he had sent a photo of lots of pills saying he would not feel suicidal anymore "*if he takes all these*".

4.136 CCO2 went to see Sam at home with another member of staff the same day. Sam had abused pregabalin but was clear this was not a suicide attempt. He said he had been taking pregabalin to calm himself down. He was aware it was an overdose but he denied that it was any type of attempt to harm or kill himself. He said it was preferable to crack or heroin. He had used some crack in the week and wanted to get back to having a prescription for methadone.

4.137 Sam was encouraged to exercise, and they discussed the benefits of seeing friends. He had just broken up with a girlfriend but said he was not too bothered about this. He described her as a "*cheater*". He had made a fake social media account to see if she would engage and she had.

4.138 The North West SMHT staff talked to Sam about the benefits of spending time alone and how this could be beneficial to his mental health and to developing his own resources. There is no record of challenging the fake social media account.

4.139 It was documented that Sam had capacity to understand his abuse of pregabalin, and he understood there could be harmful effects of taking large doses. He was described as "*forward planning*" and although he had suicidal feelings, he said he did not have any plans to act on those feelings.

4.140 On 14 Feb 2019 Sam took an overdose of pregabalin and was seen in ED at the Princess Alexandra Hospital in Harlow. He described wanting a "*buzz*" and said he was not suicidal, but his mood had been low since his father's death and a recent relationship breakdown. He admitted to regular heroin and cocaine use. The liaison psychiatry team saw him. Their assessment was that he

[50] Methadone is a man-made opioid used to reduce the withdrawal symptoms of heroin. https://www.nhs.uk/medicines/methadone/

was not suicidal and had not intended to take his life. He was discharged to the care of the North West SMHT. CCO2 tried to contact him, but there was no response. The MDT meeting on 20 February 2019 noted that his girlfriend had moved to a refuge, and he had breached a probation order.

4.141 On 21 February 2019 an unscheduled home visit was made by CCO2 (they were accompanied by another staff member because of Sam's unpredictability). There was no answer at his flat. They contacted his family who told the team that Sam was staying with his grandparents. A professionals meeting was arranged by CCO2 for 1 March 2019 to discuss Sam's lack of engagement. The plan was to call Sam the following morning.

4.142 A medical review was arranged for 1 March 2019. Sam did not attend and he did not respond to CCO2's phone calls. The professionals meeting took place on 1 March 2019.

4.143 The North West SMHT consultant psychiatrist and CCO2 had a meeting to discuss Sam on 4 March 2019. It was acknowledged that Sam had not engaged with secondary mental health services and had continued to use illicit drugs to excess. It was agreed that his prescription for antipsychotic/psychotropic medications should be stopped because he was already using substances to excess, and the addition of psychotropic medication could be a risk to his physical health. He would be monitored, and if there was any deterioration in his mental state a different depot antipsychotic injection, with flexibility in how often it could be given, would be considered. CCO2 was to monitor him closely in the community and arrange a medical review if needed. However, Sam was remanded in custody shortly after this.

HMP Chelmsford, March 2019

4.144 Sam was seen in reception at HMP Chelmsford on 6 March 2019. He had received a 14-day sentence for criminal damage and breaching a restraining order. At the health screening he presented as calm and not suicidal. He told staff that his last overdose had been a year ago.[51]

4.145 A substance misuse assessment was carried out on 6 March 2019. He was positive for opiates and cocaine and said he was smoking £20-30 of heroin and £60 of crack per day. He said he had last used the substances on Saturday (four days earlier). He had been illicitly buying benzodiazepines from his friends. He mentioned that he had recently lost his father and had stopped engaging with the community mental health team.

4.146 Sam saw the prison GP and said he had been prescribed pregabalin 50mg three times a day for anxiety. He strongly denied having suicidal or homicidal thoughts. He was prescribed methadone and pregabalin and was to be followed up by the mental health and substance misuse team. The depot aripiprazole was also prescribed.

4.147 The referral was accepted by the in-reach mental health team on 7 March 2019, a key worker was allocated, and Sam was to be discussed in the MDT. He was noted to be calm and settled. After the MDT he was prescribed depot aripiprazole 400mg. CCO2 was emailed by the prison mental health team to inform them that Sam was in prison for two weeks and to give them his key worker contact details. He was to be seen by the prison consultant psychiatrist on 20 March 2019.

4.148 Sam's physical health was monitored daily as part of the drug withdrawal regime and he received regular methadone. He was prescribed 40ml of methadone.

4.149 He was seen by a mental health nurse/key worker on 9 March 2019. He reported having no concerns, and there was no concern about his mood, thoughts, sleep or appetite. He said that he had been using heroin in the community. He said he had been recalled to prison for breaching the terms of his probation licence. It was noted he was under the care of secondary mental health services with a diagnosis of EUPD. Because his earliest date of release[52] was 19 March 2019, the

[51] It was in fact 14 February 2019, see paragraph 4.138.

[52] The earliest date of release is the earliest date that a prisoner may be entitled to be released.

medical review was moved to 15 March 2019. Sam was given the prescribed depot injection on 11 March 2019.

4.150 It was noted by the prison in-reach team that he was under Harlow probation services. There was a child safeguarding concern. Sam had assaulted his ex-partner and she had fallen onto her three-month-old baby. Children's social services were involved. He had made threats to kill his ex-girlfriend in February 2019. He had been reported as having made numerous threatening calls to his mother, and of threatening behaviour towards a male who was accused of assaulting Sam's sister.

4.151 Sam was seen by the prison psychiatrist on 15 March 2019. He said he was struggling with anxiety, but that pregabalin helped to some extent. He was aware he was due to be released in a few days and felt he would be supported by mental health services and his CCO. He was cooperative and denied having any intention of harming himself, but he appeared anxious. The pregabalin was increased to 100mg twice a day.

4.152 Sam was released from prison on 19 March 2019. CCO2 called Sam on 22 March 2019, but there was no response.

SMHT West and Mid Essex, April 2019 – December 2019

4.153 On 8 April 2019 Sam, accompanied by this mother, attended a medical review with CCO2 and the consultant psychiatrist. Sam said that he had been "*clean*" for 31 days and would like to continue with his mental health treatment. He said the depot helped to stop his intrusive thoughts, but he sometimes had thoughts of harming others and it scared him. He did not elaborate further.

4.154 Sam spoke of having anxiety and appeared fidgety and with restless legs. He described finding public places difficult because he felt anxious around people, but he said the pregabalin helped to calm him down. The consultant negotiated with him, and they agreed that 300mg of pregabalin a day would be enough. The depot was discussed and it was explained that other less intrusive medications were available; a combination of sertraline and olanzapine[53] was agreed. Sam accepted that if he took illicit substances again this would break the agreement he had made with the team, which involved medication and therapeutic work.

4.155 Sam did not experience any suicidal thoughts at that time but he did have some anxiety. He had lost weight in prison and thought about attending a gym, but he was not sure how long he would be in Harlow. Social isolation was discussed, and ideas were suggested. He declined the offer of attending a relaxation group.

4.156 Sam accepted that the depot would not be prescribed. Six psychoeducation[54] sessions were planned, focusing on anxiety and stress, and looking at his intrusive thoughts. It was explained that, if he did not attend for two sessions, he would be discharged.

4.157 The plan agreed was:

- "*CCO2 to see [Sam] on 15 April 2019 at the team base.*
- *CCO2 to communicate plans to Open Road and probation.*
- *Sertraline and olanzapine to be started*".

4.158 CCO2 saw Sam at the team base on 15 April 2019. He was able to engage and talked about how he usually managed his anxiety, giving the example of going into a shop and fearing he would not have enough money and then being made to feel silly. He said when he was taking pregabalin he

[53] Olanzapine is an antipsychotic medication. https://www.nhs.uk/medicines/olanzapine/#:~:text=Olanzapine%20helps%20to%20manage%20symptoms,mania%20symptoms%20of%20bipolar%20disorder)

[54] "*Psychoeducation combines the elements of cognitive-behaviour therapy, group therapy, and education. The basic aim is to provide the patient and families knowledge about various facets of the illness and its treatment so that they can work together with mental health professionals for a better overall outcome*". https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7001357/

did not have those feelings and was fine, and sometimes he took more than was prescribed. He was encouraged not to do this, but instead to focus on managing without using drugs or medication.

4.159 CCO2 shared some information about EUPD with Sam. Sam said he did not know much about his diagnosis. They discussed mood dysregulation [55]and finding alternatives to unhelpful ways of managing emotions such as using drugs. Further psychosocial education about understanding and managing anxiety was shared, which CCO2 thought Sam was taking on board. Sam then said he intended to move to Chelmsford because he felt isolated from his family and friends and had paid the deposit on a flat.

4.160 It was planned that CCO2 would see Sam again on 25 April 2019, if he was still in Harlow. CCO2 made a referral to the Mid SMHTC&E on 29 April 2019, saying that his needs included support for OCD and personality disorder. Sam was seen by the Mid SMHTC&E on 10 May 2019, to discuss the transfer of his care, but he was told his care would not be transferred if he stayed registered with a Harlow GP.

4.161 In early May 2019 the Mid SMHTC&E tried to contact Sam several times by telephone to clarify whether he had changed his GP and let him know that if he had not done so, the transfer of care meeting arranged for 20 May 2019 would be cancelled and his case would be closed. On 3 June 2019 CCO2 called Sam to remind him to attend the transfer of care meeting for the following day.

4.162 On 4 June 2019 a meeting took place with CCO2, Sam and the duty worker for Mid SMHTC&E, in the absence of an allocated CCO, to arrange a transfer of care back to Chelmsford. Sam asked to go back on the depot. A family friend who accompanied him also asked if Sam could have depot medication again. CCO2 said they had seen Sam once every two weeks for mental health monitoring and for the start of anxiety management. Sam experienced social anxiety as part of his EUPD. CCO2 explained that their work together was cut short because he was moving back to Chelmsford. CCO2 spoke about Sam having a difficult time in Harlow because his father had passed away, which triggered difficult emotions for him. Sam acknowledged that he abused drugs as a way to cope with difficult emotions. He said that he no longer wanted to do this and said he wanted to find different ways of coping with distress.

4.163 Sam said he had stopped taking the olanzapine and sertraline two weeks earlier. This was because he had not registered at his local GP. He went to Harlow to get his prescription, but the pharmacist and the GP had not been notified of the medication changes and only had pregabalin on his prescription. Sam (accompanied by a friend) demanded an immediate medication review. It was explained by the duty worker that this would not be possible immediately but made a note that Sam would need a medication review.

4.164 There was a discussion about how details of the last medication review could be sent to his new GP, so the GP could write the prescription as soon as possible and Sam could restart his medication. Sam became visibly irritable and started to shout about people not doing their jobs, swearing at the duty worker. Sam punched his own knee in frustration. Staff diffused the situation and Sam later apologised for his behaviour. Sam was told that both workers felt unsafe, and Sam insisted this was because he was not on medication.

4.165 CCO2 agreed to review Sam's medication and send the information to his new GP at Beauchamp House Surgery in Chelmsford. CCO2 recommended that he should have a care coordinator for mental health monitoring and therapeutic intervention, and he should have a medication review.

4.166 Sam saw his new GP on 14 June 2019, he said he was on methadone and needed a new prescription. At that time the prescription was olanzapine 5mg, pregabalin 300mg and sertraline 50mg. The psychiatrist's letter stated Sam was not to take more than the recommended dose of

[55] Dysregulation, or emotional dysregulation, is an inability to control or regulate one's emotional responses, which can lead to significant mood swings, significant changes in mood, or emotional lability.

pregabalin. The GP noted that he had an appointment to see the Mid SMHTC&E psychiatrist within the month.

4.167 Sam saw the GP again on 19 July 2019, and said his anxiety was more stable and he had only taken cocaine once in the last few weeks. A letter from the substance misuse service was noted, which said he was no longer on methadone.

4.168 On 13 June 2019 Sam was discussed in the Mid SMHTC&E MDT meeting; it was noted he had been allocated to CCO3 and placed in the amber zone, and his depot should be restarted.

4.169 On 3 July 2019 he remained in the amber zone. The notes state CCO3 was to "*catch up with client*". On 10 July 2019 he was still zoned as amber; the notes of the Mid SMHTC&E MDT meeting said CCO3 was "*unable to contact last week, chasing up*". On 7 August 2019 he remained amber, CCO3 noted that Sam was not responding to messages, and that a letter for an outpatient appointment would be sent. The team were unsure where he was in Chelmsford.

4.170 On 8 August 2019 Sam was admitted to ED at Broomfield Hospital after taking an intentional overdose of pregabalin and sertraline. He was seen by the MHLT, with his girlfriend, and he reported a gradual deterioration in his mental health. He said he had experienced episodes of restlessness, aggression, agitation and intrusive violent thoughts towards himself and others. He was referred for assessment to the home treatment team (HTT) to assess whether admission was needed or if he could be safely treated at home by the HTT.

4.171 He was seen by HTT for a gatekeeping assessment on 10 August 2019. It was noted he had taken an overdose and then texted his girlfriend, telling her not to call an ambulance, but she did. The initial referral from MHLT had recommended a brief admission to a mental health unit. He was believed to have full mental capacity to agree to an informal admission, despite feeling paranoid and having intrusive thoughts. His mother and girlfriend also thought he should be admitted. Risk assessment found that a short, informal admission could help to stabilise his mental state and to restart him on his medications. His community care plan could also be reviewed.

4.172 He was assessed by the HTT again on Terling Ward at Broomfield Hospital on 12 August 2019. It had been agreed on 10 August 2019 that he should be admitted to an inpatient bed for mental health treatment, but he was still waiting for a bed. The HTT assessment confirmed that he still needed an inpatient bed. There had not been any management problems on Terling ward. Sam was seen by an MHLT psychiatrist on 15 August 2019 with his partner. Sam described having been irritable and throwing things and having difficulty sleeping. He asked for aripiprazole as he said this stabilised him. He was told he would also need medication for his OCD. Aripiprazole 10mg once daily was prescribed, with a possible prescription of an antidepressant (citalopram)[56] to start in one week, with monitoring for side effects. It was noted he was waiting for a mental health bed and could be re-referred to MHLT if needed. Sam called the police to the ward on 16 August 2019. He was threatening to kill staff and to kill the man in Basildon who assaulted his sister. He was removed from the ward by police, arrested and bailed to appear at Basildon police station on 5 September 2019. He was released from police custody and was advised to return to ED, which he did on 16 August 2019.

4.173 He was admitted to Gosfield Ward in the Lakes Mental Health Unit in Colchester on 17 August 2019 at 2.15am because of suicidal ideation, the risk he posed to himself and the deterioration in his mental state. He had to sleep in the Harbour Unit, which is the Section 136 MHA[57] suite, because no bed was available on the ward. The risks noted were violence and aggression, illicit substance use, suicidal ideation, anxiety, low mood, non-concordance with medication, dangerous and impulsive behaviours and decreased self-care. Admission paperwork was completed by the on-call doctor and he presented as calm, pleasant and polite, with no suicidal ideation. The plan was:

[56] "*Citalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI)*". https://www.nhs.uk/medicines/citalopram/about-citalopram/

[57] Section 136 MHA is the police power to remove a person without a warrant. https://www.legislation.gov.uk/ukpga/1983/20/section/136

- "*Nurse level 3 observations*[58] *whilst in Harbour suite*
- *Nursing observations on the ward to be decided by nurse in charge of the shift*
- *PRN [when required] Promethazine given to aid sleep*".

4.174 On the morning of 18 August 2019, Sam was shown around the ward, he socialised with other service users and had a visit from his girlfriend. He asked for leave to go to town with her. This was risk assessed and was agreed. The girlfriend's phone number was taken so she could be contacted if there was a problem while they were off the ward.

4.175 Sam had been prescribed medication to be given as required, to decrease his agitation. He was admitted to a bed on the ward that evening. He was initially reluctant to sleep on the ward after his night in the 136 suite and kept saying that he wanted private care. At the start of the night shift, he was caught smoking in the garden, and was defiant when staff asked for his smoking materials and explained the rules. The risk of Sam's becoming aggressive was noted.

4.176 Sam discharged himself from hospital on 19 August 2019, after becoming aggressive and hostile during a ward review. He walked out at about midday. He became agitated and hostile when he entered the reception and was overheard saying he would not return.

4.177 Sam presented himself at ED at Broomfield Hospital on 24 August 2019, and said he had been discharged a week earlier. He said he was feeling suicidal, paranoid and he wanted to hurt himself. He had taken crack and heroin the previous day. His girlfriend was present. He was seen by MHLT on 24 August 2019, and agreed to be discharged to the care of the Mid SMHTC&E. He said he had seen his CCO four days earlier and that the team were discussing his request to start clozapine,[59] and a medical review was being arranged. He agreed to a prescription for lorazepam[60] and to return home and be contacted by his CCO. Later he and his girlfriend refused to leave ED and insisted on being seen again. It was reiterated that there had been an assessment and the outcome was that he was not suicidal. He again agreed that his CCO would follow-up and had all their contact numbers. He was discharged to the care of the Mid SMHTC&E and to CCO3. Lorazepam was to be given as required. His girlfriend called the contact centre to complain multiple times, which had to be managed.

4.178 On 26 August 2019 Sam was admitted to ED at Broomfield Hospital after taking an overdose of his girlfriend's clozapine tablets. He denied taking any other drugs, but his urine test showed evidence of benzodiazepines and cocaine. His consciousness deteriorated and he was briefly admitted to the high dependency unit for intubation. He was assessed by the MHLT consultant psychiatrist on 28 August 2019. Sam was cooperative, but his eye contact was poor, and he appeared tired. He was preoccupied with not having access to medication after his self-discharge from the mental health ward. His speech was relevant and coherent, although he reported having paranoid thoughts and occasional auditory and visual hallucinations. He denied having any immediate thoughts of suicide or self-harm but said that he may impulsively hurt himself. His girlfriend said she had a safe and could be responsible for storing his medication safely. Sam described frequent bouts of uncontrollable anger with potential aggression. He denied any drug abuse but tested positive for illicit drugs (it is not clear whether he was challenged about this).

4.179 The MHLT plan agreed with him was:

- "*Start Aripiprazole 10mg OD [once daily], add clonazepam*[61] *0.5mg OD, add promethazine 25mg PRN (dose should not exceed 50mg at night)*

[58] To be observed within eyesight of staff, for patients who could, at any time, make an attempt to harm themselves or others.

[59] Clozapine is prescribed for schizophrenia in patients unresponsive to, or intolerant of, conventional antipsychotic drugs. https://bnf.nice.org.uk/drugs/clozapine/

[60] Lorazepam is a benzodiazepine that is used to treat anxiety and sleeping problems that are related to anxiety. https://www.nhs.uk/medicines/lorazepam/about-lorazepam/

[61] Clonazepam is a benzodiazepine that is used to treat anxiety. https://www.nhs.uk/medicines/clonazepam/about-clonazepam/

- *He will be provided with a two week prescription on discharge from HDU [high dependency unit] and GP to kindly provide repeat prescriptions*
- *To refer to HTT for brief support*
- *Trust line details and crisis numbers were provided he was advised to contact should help was needed*
- *He will contact his [community mental health team] CMHT to arrange a meeting with his CPN ASAP*
- *His partner will be in charge of his medication and will provide him with his daily dose*".

4.180 He was placed in the red zone at the Mid SMHTC&E MDT zoning meeting on 28 August 2019. It was noted that he had discharged himself from hospital against medical advice on 19 August and was aggressive and hostile when the seven-day follow-up review was carried out.

4.181 Sam was, at that time, under the care of Home First, and a once-weekly medication drop was done on 3 September 2019. Sam was at his partner's house. He accepted the medication and there were no concerns.

4.182 The Mid SMHTC&E MDT zoning meeting rated him as red on 4 September 2019, and it was noted by CCO3 that Sam was under the care of Home First at that time. A handover of care was to be arranged from Home First to the Mid SMHTC&E.

4.183 On 9 September 2019 Sam called the MHLT at Broomfield Hospital, saying he needed a medication review, and asking for advice about whether he should go to ED. He was told it would not be appropriate, and that he should call the Mid SMHTC&E to speak to his CCO. The interaction was noted and handed over to the Mid SMHTC&E duty team on 10 September 2019. Sam was zoned as amber on 2 October 2019, although it is not clear why his risk was thought to have decreased, because he had recently been on a two-day crack binge.

4.184 The zone was changed from amber to green on 27 November 2019, noting that his engagement had improved, and that he said he had not used drugs for six weeks.

4.185 Sam had a medical review on 3 December 2019, at which he said it was seven or eight weeks since he had last used drugs and relationships with his family were good. The working diagnosis was recorded as OCD, with intrusive thoughts of harming others. Risks documented were that he had been in prison for criminal damage and for not abiding by bail conditions or court orders. It was agreed a psychological assessment would be arranged.

4.186 At the Mid SMHTC&E MDT zoning meeting on 4 December 2019, Sam remained green. CCO3 requested a psychological assessment.

4.187 Sam was seen by MHLT in Broomfield Hospital ED on 9 November 2019. He had self-harmed, which was described as superficial cutting to his hands and torso. He said he had had a fight with his partner at home and she had called the police, who told him to go to ED. He said he was not currently taking any medication and had become unstable as a result – smashing things and becoming angry easily. He had not taken an overdose because he was worried that it would cause him physical disabilities. He said he had stopped taking drugs a month earlier because they made him feel worse. He was discharged to the care of Mid SMHTC&E and given crisis numbers.

4.188 In late December 2019 Sam was arrested after falsely imprisoning his partner and making threats to her. He was remanded in custody. He reported having taken an overdose of pregabalin and was taken from police custody to Broomfield Hospital ED on 30 December 2019. He was discharged back to police custody after being assessed on the same day.

HMP Chelmsford, January – March 2020

4.189 It was noted by prison healthcare staff on 1 January 2020 that Sam was on remand and due to attend court in February 2020. A new reception screening was completed. He was described as calm, with no thoughts of self-harm. He declined to give information about substance misuse. He said he had never been admitted to a mental health hospital and was fit to be housed in a normal prison location. A mental health team referral was made because of his history, and he was to see the prison GP.

4.190 The Mid SMHTC&E MDT zoning meeting on 8 January 2020 moved him from green to purple[62] noting that he had been remanded in custody.

4.191 At a mental health review on 2 January 2020, Sam was reported as being unhappy with his cellmate but he was otherwise calm and cooperative. He was well-kempt with no signs of self-neglect but was concerned that his cellmate might trigger his anxiety. He was to be discussed at the mental health team MDT and referred to the prison service Improving Access to Psychological Therapies (IAPT) service.

4.192 At the prison in-reach MDT meeting on 9 Jan 2020 Sam's previous mental health history in prison and the community was noted, and the name of the Mid SMHTC&E team and CCO3 was made available. Weekly mental health nurse follow-up was agreed on, along with the referral to IAPT and to Phoenix Futures. An appointment with the prison psychiatrist was arranged for 3 March 2020.

4.193 Sam's medication was prescribed and provided, which at the time was quetiapine[63] 100mg and fluoxetine 20mg. He requested an increase in quetiapine to help him sleep and said he needed pregabalin. He was told he would need to see the GP and psychiatrist to discuss these. His mental state was described as stable. Pregabalin was started on 1 February 2020 and Sam told nursing staff that this helped, but he still wanted the quetiapine to be increased.

4.194 He was seen for a mental health nurse review on 6 and 11 February 2020. He denied having any thoughts to harm himself and said his mood was stable.

4.195 The psychiatrist's review was moved forward from early March to 13 February 2020, and at that time Sam was described as being irritable and having intrusive thoughts of harming his cellmate. Quetiapine 50mg was added as a morning dose. It was noted he was waiting for an assessment by IAPT and was to be reviewed in four to six weeks if he was still in prison.

4.196 On 21 February 2020 Sam told prison mental health staff that he was coping okay, but he would become stressed if the trial did not go his way. He described some intrusive thoughts of harming his cellmate, but he was managing this with distraction techniques and talking to wing staff. Sam was released as planned on 2 March 2020 and healthcare discharge letters were sent to his GP and Mid SMHTC&E.

SMHT Mid Essex March – December 2020

4.197 Sam lived with his sister after his release. His stepfather contacted the Mid SMHTC&E to report that Sam had spent £600 on drugs in one week. He was also concerned because Sam had sent inappropriate texts to his sister. The Mid SMHTC&E tried to contact him to screen him for Home First support. He had apparently been released to temporary accommodation but had not arrived there. They were unable to contact his mother and a decision was made to report him to the police as a missing person on 21 March 2020. He was allocated to CCO4 on release from prison.

4.198 Sam was seen face to face by CCO4 on 4 March 2020. He reported that things were going okay, he appeared bright in mood, and was looking forward to moving in with his brother while he awaited to be allocated a place of his own by the council. He said he still wanted to see his ex-girlfriend but

[62] Purple was used to denote that he was in prison. Purple does not in fact exist in the zoning guidance.

[63] Quetiapine is an antipsychotic medication. https://www.nhs.uk/medicines/quetiapine/about-quetiapine/

was told to keep to the terms of the restraining order. He said he did not need any support to stop using drugs and was aware of Open Road if he changed his mind. He was starting driving lessons and was advised against drug driving. Relations with the family seemed to be okay at that time. Sam agreed to have fortnightly meetings with CCO4.

4.199 On 20 March 2020, Sam was taken to Southend Hospital ED by ambulance. He had drunk a bottle of wine and cut his neck and stomach. The cuts were described as superficial. He said he was of no fixed abode and he had been offered emergency accommodation. Transport was arranged when he was discharged. It later became known that he was in fact staying in a B&B in Stansted. He had been sending threatening messages to his family and had hacked his partner's email and social media accounts. He said he intended to kill himself and would hurt himself again if he did not "*get help*". He was seen by MHLT who helped him return to Harlow, to be followed up by Mid SMHTC&E.

4.200 CCO4 telephoned Sam on 2 April 2020. He presented as not being overly concerned about lockdown and he was social distancing. His mother was managing his money to help him avoid the temptation of spending it on drugs. He denied taking any drugs and said he was trying to save money to move into a flat of his own.

4.201 On 8 April 2020 he was zoned red. The Mid SMHTC&E MDT meeting notes record that he was going out despite having Covid-19 symptoms and had been calling the ambulance service inappropriately. He was moved from red to amber on 20 May 2020 because the risk was "*decreasing*". The discussion recorded that CCO4 felt Sam was still chaotic, but he was engaging with services.

4.202 In early June 2020 Sam requested an urgent appointment with the Mid SMHTC&E. He said that he had been seeing a private psychologist for an assessment, because he was concerned about the waiting times with EPUT. He described a chaotic approach to this. He had contacted several people he had found online and had had some very intense assessments by video or phone, which he found quite distressing. He had been taking crack to cope with this, which he agreed was not the answer, and again spoke of asking his mother to manage his money. He described OCD rituals of washing for over an hour, which he found distressing. It was planned to discuss psychological assessment at the next Mid SMHTC&E MDT meeting the following week.

4.203 At the Mid SMHTC&E MDT zoning meeting on 10 June 2020, he stayed as amber. CCO4 reported that he was very chaotic and difficult to engage with. Private cognitive behaviour therapy (CBT) practitioners had declined to work with him because of issues with managing risk. His risks were documented as persistent intrusive thoughts involving minors and slitting throats, which were very distressing for him. He was vocal about his intrusive thoughts when he had them, which could make those around him anxious. It was noted that he had never acted on the thoughts to harm others but he had harmed himself quite significantly. His forensic history was seen as unrelated to the intrusive thoughts. It was planned that CCO4 would meet with the psychology service to discuss their possible input.

4.204 On 10 June 2020 Sam was noted to engage well with a call from the Mid SMHTC&E, talking more openly about his OCD checking behaviours and rituals. He described washing for long periods, which he found distressing, and having distressing intrusive thoughts about sexual acts with children. Distraction and coping skills were discussed, and he was encouraged to prepare for his outpatients appointment the following day. Clomipramine[64] 50mg once daily and quetiapine 25mg once a day were prescribed at the medical review on 11 June 2020.

4.205 On 24 June 2020 Sam attended Broomfield Hospital ED for an accidental cut on his thumb which he got while he was cooking. He was discharged after having it dressed, with GP follow-up. Family members had been in contact with CCO4 expressing their concerns about his intrusive thoughts. CCO4 said Sam was okay, he was just expressing his thoughts in a way that made other people

[64] Clomipramine is an antidepressant. https://bnf.nice.org.uk/drugs/clomipramine-hydrochloride/#indications-and-dose

anxious, but he continued not to act on the thoughts. The zoning meeting on 24 June agreed he should remain amber.

4.206 A joint face to face appointment with CCO4 and a psychological clinician (principal clinical psychologist) took place on 24 June 2020. He appeared very anxious to 'get help' for his OCD but seemed to struggle to fully understand how he needed to be part of the process of psychological treatment. His intrusive thoughts and cleaning rituals were discussed, and his difficulties in relationships. Sam expressed anxiety in relationships and having a “short fuse”, getting angry if things were out of place. A genogram was started but not completed. There was discussion about how things seemed polarised so that they were either 'in control vs out of control' or in relationships were 'perfect and adoring vs paranoid and angry'. Sam was described as ambivalent about further sessions and was unsure what was required of him to engage in psychology sessions. Further joint sessions were planned.

4.207 At the Mid SMHTC&E MDT zoning meeting on 8 July 2020 he remained at amber. An appointment with CCO4 and the psychology service was planned to take place that day. Sam had reported that cleaning rituals were taking over his life now that he had his own flat, to the extent that his hands were raw from cleaning materials.

4.208 A joint face-to-face assessment was carried out by the psychology service and CCO4 on 8 July 2020. Sam was 20 minutes late, explaining he found it difficult to keep times because of his cleaning rituals. He said that he had some intrusive thoughts to harm himself and wanted some respite from the intrusive thoughts he experienced. He denied having any intention of acting on his thoughts. Sam said that he had been finding it particularly hard to concentrate and had been spending money impulsively. He also shared that he had been engaging in some impulsive behaviour in his sexual relationships with females. Sam was reminded there had been previous discussions about the extremes of being ‘in control versus out of control’ or in an ‘adoring versus paranoid/angry’ place in relationships and they tried to discuss how he could slow things down to be caring to himself and his mental health.

4.209 Sam seemed to struggle to take on board the potential difficulties of the impulsive acts and moved the conversation to his new kitten. How he planned to care for the kitten was explored, but his getting the kitten seemed to have been an impulsive act and minimal thought had been given to what was involved. Sam said he was keen to meet again. They reiterated that he needed to try to engage with the sessions on time and to think about what he wanted to gain from the sessions and from further therapeutic work. Further sessions were to be arranged.

4.210 CCO4 saw Sam at home on 14 July 2020. Sam struggled to concentrate and was easily distracted. He said he was in trouble with some people and wanted to move again. He eventually said he just did not feel comfortable in the area and wanted to move. Housing needed a letter of support from mental health services. He was encouraged to think about his strategy of moving when there was a problem, instead of working through the anxiety. However, Sam continued to say that everything would be solved if he moved. He said his relationship with his mother was getting worse and he wanted to kill her and her partner. This was discussed and it became clear that he felt rejected by his mother and felt she had chosen a partner over Sam. He said he was finding the psychology sessions useful and wanted to continue going to them. At the Mid SMHTC&E MDT zoning meeting on 15 July, he stayed in the amber zone. It was noted he was still anxious and agitated, but he was finding the psychology sessions helpful. He talked about having intrusive thoughts about stabbing his mother and his mother’s partner.

4.211 Sam was seen face to face at home on 21 July 2020 by CCO4. He was bright and engaged well. He said he was doing okay, but he was struggling with anxiety. He was told that a letter of support for housing had been arranged, and further psychology sessions were planned with him. He said he was having ongoing issues with his family, but there were no major issues. At the Mid SMHTC&E MDT zoning meeting on 22 July 2020 he remained at amber. It was noted that he was up and down and wanted to move accommodation.

4.212 Sam did not attend a video appointment that had been arranged with CCO4 on 27 July. At the Mid SMHTC&E MDT zoning meeting on 29 July 2020, he was moved from amber to green because the risk had decreased (although there are no details to support this assertion). It was noted he had missed his psychology service appointment, but he was very apologetic and said that overall he was okay.

4.213 On 4 August 2020 Sam was seen face to face by CCO4. He appeared distracted and talked about developing another relationship. His new girlfriend was staying with him, so he was reluctant to talk. He was encouraged to try to not repeat patterns of developing relationships quickly.

4.214 Sam did not attend the planned video call with the psychologist arranged for 12 August 2020. At the SMHTC&E MDT meeting on 19 August 2020 this was noted, and it was agreed a discussion needed to be had regarding any further appointments to be offered.

4.215 On 2 September 2020 Sam was seen by the street triage team, who sent a letter to his GP about his possible risk of overdose and his low mood. Sam did not overdose at the time, but he felt very low. He had not had a review with the psychiatrist since June 2020, and had not been taking the clomipramine because it made him feel unwell (but it had been ordered weekly). He asked for a medication review and he was advised to call his CCO, who had been trying to contact him.

4.216 CCO4 saw Sam at home on 9 September 2020. He was well-kempt and engaged well. He had some swelling and bleeding to his right cheek, but he said this was from the laser removal of a tattoo. He said he was doing okay. He asked straight away about when he would have another psychology service appointment and said he was worried that he had been "*written off*" and he really did not want that to be the case. CCO4 spoke to Sam about him having missed two psychology service appointments and the need for him to fully invest in and engage with the sessions, which he acknowledged. They discussed whether Sam was finding the process too difficult or if he thought it was too much. He immediately denied this and said he thought it was "*definitely the right thing*" for him and was something he was finding helpful. He admitted to starting to take heroin again about two months previously, but he said he had been clean for about a month. He was due to attend Crown Court in September for the breach of the restraining order. He denied having any recent issues with the police. He said he had been with his current girlfriend for seven weeks and things were going great. He had stopped taking the quetiapine because he felt it was not working. He was told about interactions between medications and street drugs. There were no further psychology appointments offered, but the reasons for this are not recorded.

4.217 On 14 October 2020 Sam was admitted to Broomfield Hospital ED by ambulance after taking an overdose of pregabalin. He was drowsy and unable to say exactly how much he had taken. The ambulance service reported that there had been a domestic argument and they had seen a suicide note when they arrived. Sam denied both these things. He was seen in ED, and opted not to be assessed by the MHLT, saying he felt safe to go home. He said he had an upcoming psychology service appointment and was happy to be seen by them instead. At the MHLT MDT meeting on 16 October 2020, it was noted that Sam had left before having an assessment and was due for a medical review that day with the Mid SMHTC&E, therefore there was no further action for the MHLT.

4.218 A medical review was conducted on 16 October 2020. Sam said he had stopped taking clomipramine and quetiapine but he was taking the prescribed pregabalin twice a day. He was started on duloxetine 600mg to take in the morning and olanzapine 5mg at night. The pregabalin continued at 300mg twice a day.

4.219 CCO4 made an unannounced home call on 11 November 2020, after being unable to contact Sam. When CCO4 arrived Sam was sitting in the hall with a woman and there was a strong smell of cannabis. Sam had a black eye and was reluctant to engage. His mobile number was checked as current. He had no concerns, and an appointment was made for two weeks' time.

4.220 CCO4 spoke to Sam by phone on 17 November 2020. He appeared very settled and was much more engaged in the conversation. He said his girlfriend was living with him now, but he was not

finding it stressful, and his relationship with his family had improved. He described some impulsive angry feelings and said he had smashed his phone. They discussed how he could manage his emotions and his tolerance to distress. Sam said he would like a face-to-face meeting next, and this was arranged for early December.

4.221 At the 18 November 2020 Mid SMHTC&E MDT zoning meeting he remained in the green zone. It was noted that his mother had called with concerns, but when he had been approached Sam said he was fine.

4.222 At the 25 November 2020 Mid SMHTC&E MDT zoning meeting he was moved to amber from green because the risks had increased. This was because although Sam was reported to be engaging well, there was a safeguarding issue with his girlfriend, who had recently taken an overdose of his medication. There was a suggestion that his medication had been stockpiled. The woman had also reported violence by Sam. CCO4 was to find out more information.

4.223 Sam told CCO4 on 2 December that he had some promethazine that his girlfriend had taken to overdose with. He acknowledged that there was some abuse in the relationship, but he denied being violent. He said he had called the police because of her violence towards him and that he had felt overwhelmed by the relationship. He said the relationship had now finished because he felt it was not healthy. He now felt much better and did not want a relationship. A discussion was had about the intensity and all-or-nothing approach he had to relationships, which he seemed able to reflect on. Sam wanted to restart psychological treatment, but he was advised that before he did this it would be beneficial if he had a period of stability.

4.224 At the 2 December 2020 Mid SMHTC&E MDT meeting, he was moved from amber to green.

4.225 CCO4 spoke to him on 15 December 2020 by phone at his request. Sam said he had "*cut his family off*". He was challenged about this decision, because he had received a lot of support from his family. He was encouraged to think about this pattern of "*all or nothing*" but he struggled to understand the issue and he said he was better off without them. He had asked for the call because he had strong urges to use heroin, but he was able to describe distraction techniques and a plan to prevent himself from using. He had a planned appointment for the following day, which he wanted to have by phone rather than as a face-to-face appointment. He had no concerns and cut the call short to go online gaming.

4.226 CCO4 spoke to Sam by phone on 22 December 2020. Sam again spoke about wanting to cut himself off from his family. He was encouraged to consider this and to reflect before making an impulsive decision. He engaged well and showed some ability to reflect. The next meeting was set for 6 January 2021.

4.227 On 31 Dec 2020 Sam's GP carried out a telephone medication review. Sam said he was feeling well, sleeping and eating, feeling happy and was trying to keep busy.

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4.228 Sam was seen at home by CCO4 on 7 January 2021 to discuss his care plan. He was distracted and he only engaged with CCO4 superficially, but he confirmed he was happy with the care plan. He was given a copy and the next contact was planned for two weeks' time.

4.229 Sam and CCO4 had a telephone appointment on 2 February 2021. During the discussion Sam talked about having moved in with a girlfriend for nine days. He said the relationship had developed very quickly, but he had then felt overwhelmed and finished it. He also talked about wanting to move again. He was encouraged to recognise this as a pattern of going backwards and forwards. CCO4 spoke about the need for him to make small changes before returning to psychological therapy. Sam said he was proud because he had turned down the offer of drugs recently. The next appointment was for three weeks' time.

4.230 A telephone appointment took place on 9 March 2021. Sam described seeing a girl for a short period. He then contacted an ex-girlfriend again, but then cut her off. He was encouraged by CCO4 to reflect on the pattern of sudden changes, and the need to try to reduce these changes.

4.231 In April 2021 Sam told CCO4 that he felt he was doing well and that he had not been taking any drugs. He had stopped taking the olanzapine because he said it was not helping and was causing negative side effects. CCO4 encouraged him to reconsider this decision. He said he felt ready to start psychological treatment and it was agreed this would be discussed. Appointments between CCO4 and Sam every two weeks were to continue.

4.232 Sam was discussed at the psychology service meeting on 24 May 2021. His diagnosis of EUPD and OCD was noted. At that time his presenting issue was his OCD symptoms. The challenge of his anxiety preventing him attending appointments was acknowledged, but it was also that he had the motivation to work on this. It was recognised that he had made positive progress:

- "*6 months no drug use; 6 months no suicide/self-harm; 6 months no prison.*
- *Risk of therapy de-stabilising him; he has high expectations of therapy sorting out other areas of his life. He has motivation [to] get better.*
- *Psychology had done a risk assessment as he was presenting as threatening to kill people – the aim of this assessment was for risk management, compared to therapy.*
- *[Sam] wants to be able to get on with his life. He wants to start to have normal patterns of behaviour and boundaries*".

4.233 The plan agreed was to offer Sam a place on the Psychology Education Programme (PEP).

4.234 In May 2021 Sam was offered a place on the PEP. A letter was sent to him on 25 May 2021 explaining the process and making it clear the PEP was the first step towards being considered for individual psychology sessions or psychotherapy assessment. This was a group (face-to-face) programme, with an appointment every week for three weeks, of an hour and a half. He did not respond to the texts and letters and in June 2021 he was sent a letter telling him he would lose the place if he did not respond.

4.235 On 21 June 2021 the Mid SMHTC&E duty team tried to call back in response to a call from Sam. The call would not connect, so the Mid SMHTC&E contacted his mother who confirmed that his number had changed. She reported that Sam had cut himself on his abdomen and said he intended to kill himself. The duty team called him on the new number. Sam denied having any intention to kill himself but said he had had an argument with his sister and was upset. He said he was feeling okay now and might go the hospital with his mother. There is no record that he attended hospital at this time.

4.236 Sam did not attend the first PEP appointment in July 2021, and had not responded to any of the contacts. At the Mid SMHTC&E MDT meeting on 7 July 2021, he was zoned as green. Sam also missed the second PEP appointment and was sent an opt-in letter. At the Mid SMHTC&E MDT meeting on 14 July, he was zoned green.

4.237 On 19 July 2021 CCO4 talked to Sam about having missed the PEP appointments. CCO4 explained the structure and purpose of the course again, and Sam agreed to attend. He was told that CCO4 was due to leave the team and they discussed the next steps in his care planning. Sam said he had improved significantly and agreed he did not need a care coordinator at that time. He agreed that the PEP and therapy were good next steps. He also agreed to contact the Mid SMHTC&E duty service if he had any worries or needed more support. He was to remain under the care of outpatients during the PEP.

4.238 CCO4 called Sam on 28 July 2021 to plan his future care and to discuss his non-attendance at the PEP. He was noted to be settled and bright. He said he was still unsure about the PEP, but he kept repeating that the next step for him was one-to-one therapy. It was reinforced that the PEP was the

pathway into this and Sam acknowledged this and confirmed he would do it. Sam again acknowledged he was doing very well and was much more settled and his mood was stable. He reported having no suicidal thoughts or intent. He said that his ongoing goals were to pass his theory driving test and start getting out into the community more. Sam confirmed he would contact the Mid SMHTC&E duty team if he needed, and he said he had no care needs apart from the therapy they had discussed.

4.239 He attended the group PEP session on 9 August 2021 on time and participated in one part of the exercises. Sam emailed after the session saying he had found it useful and wanted to continue. The next session was due on 23 August 2021.

4.240 Sam called NHS111 on 18 August 2021 because he ran out of pregabalin, this was re-prescribed at 400mg. He spoke to the out-of-hours GP service and described worsening anxiety, although said he had no thoughts of harming himself.

4.241 He was rated green at the Mid SMHTC&E MDT meeting on 1 September 2021, it was noted that he had not attended the most recent PEP session in September 2021, but he had called to rebook.

4.242 The Mid SMHTC&E duty team tried to call Sam on 3 November 2021 but there was no answer. His mother called the duty team to report that Sam had been sending threatening texts to her and his sister, saying that he would stab them all and kill himself. She said that Sam also threatened to harm his neighbour and appeared to be very paranoid. She had asked the police to carry out a welfare check. They subsequently did this, but no further action was taken.

4.243 The Mid SMHTC&E duty worker assured Sam's mother they would call him. Sam was phoned the same day. He sounded relatively calm with a normal tone to his speech and no signs of thought disorder. He said he did not like where he was living and denied threatening his neighbour. He asked for a medical review because he felt the medication was not working. He also asked for support to send the psychology team his new email address. He denied having any thoughts, plans or intentions to harm himself or anyone else.

4.244 The duty worker phoned Sam's mother to tell her that he seemed okay. His mother thanked the duty worker for calling her back. The plan was to request a medical review, which was done by email, and to cascade Sam's request that his email address be noted by the psychology team.

4.245 The psychology service sent a letter to Sam on 24 November 2021 thanking him for attending the PEP programme. He was invited to complete and send self-referral forms if he wanted to continue receiving psychological treatment. This was followed up by text.

4.246 Sam was seen for a medical review in the outpatients department on 3 December 2021. The Mid SMHTC&E psychiatrist reviewed his medication history. It was noted that Sam had a long-standing diagnosis of OCD and he felt anxious when he resisted responding to his intrusive thoughts. He had been prescribed duloxetine as an antidepressant previously, but it did not help so he did not take it. He had found aripiprazole had a calming effect. The psychiatrist prescribed escitalopram 10mg once a day, to be increased to 20mg after two weeks, and aripiprazole 5mg once a day to increase to 10mg after two weeks. The pregabalin was not changed. The psychiatrist noted that Sam said he had not taken any drugs for the "*last few years*" and considers taking drugs to be "*the worst thing he has ever done*". It was recorded that Sam was waiting for information from the psychology service, having attended the preliminary three sessions. He was to be seen again by the psychiatrist in two months' time.

4.247 The psychology service sent a reminder letter to Sam on 22 December 2021, noting that they had not received his self-referral form, and therefore assumed he no longer wanted to continue with psychological treatment. He was told he could be referred again if he wanted but he would be asked to repeat the PEP before he could receive any individual therapy.

4.248 On 26 December 2021 Sam was admitted to Broomfield Hospital after an overdose of lorazepam, aripiprazole, pregabalin and duloxetine. When he arrived at ED his Glasgow Coma Scale[65] score was 7 out of 15 and he was admitted to the intensive therapy unit where he was sedated and intubated. When the intubation and sedation were stopped, he was noted to be "*mildly confused/delirious*".

4.249 On 27 December 2021 Sam was referred to the MHLT by the intensive care unit. The context was that had taken an overdose of a mixture of tablets after an argument with his partner.,. who had witnessed the overdose.[66] On 27 December the initial MHLT contact recorded that he was unable to talk. He was "*stepped down*" to a medical ward, Tiptree Ward, on 28 December to wait to be reviewed by the MHLT.

4.250 On 29 December 2021 Sam was reviewed by the MHLT on Tiptree Ward.

4.251 The MHLT documented his medication at that time as pregabalin 200mg twice a day and escitalopram 10mg once a day, to be increased to 20mg after two weeks. Aripiprazole was started at 5mg once a day with plans to increase the dose to 10mg once a day. This prescription had been started on 3 December, so by 29 December Sam should have been on the higher doses of both escitalopram and aripiprazole. The MHLT psychiatrist recorded that he had gone to hospital because he overdosed on a mixture of his prescribed medications. During his stay in the hospital his level of consciousness fluctuated, and he was having hallucinations. Before going to the ward, MHLT was told that Sam had two security staff with him. Overnight he had assaulted a private security guard, seemingly without being provoked, by grabbing his neck and punching him. It was not clear whether he punched the security staff while holding his neck. After the assault, he said he had no recollection of it. He was detained on Section 5(2)[67] of the MHA on 29 December 2021. The Section 5(2) records that the assault was without warning. Sam's mood and behaviour had been incongruent and there was a possible psychosis. It was thought his mental state was such that he did not have capacity to make the decision to stay in hospital voluntarily.

4.252 Sam told MHLT staff he had taken the overdose impulsively because he had "*lost it*" after breaking a glass. He explained that this impulsivity was normal for him and that he was "*fine now*". He declined a full assessment but was happy to engage in conversation with MHLT staff, which enabled them to assess risk. He denied having any plans or intentions to end his life and described the overdose as an impulsive act.

4.253 Sam said he wanted the Mid SMHTC&E to help him complete his self-referral forms for the psychology service. He said he was keen to engage in psychology sessions. He hoped they would help him understand his thoughts and behaviours, so he could then learn how to manage them. He was discharged back to the care of the Mid SMHTC&E or community follow-up. After this review Sam appeared to show some evidence of "*tactile hallucinations*".[68] Because of this, it was decided to keep him in overnight for review by a psychiatrist the following day. By the time of the review on 30 December 2021 the hallucinations had stopped and he was feeling better. His Section 5(2) was therefore lifted.

4.254 Sam was seen by the MHLT psychiatrist on 30 December 2021 in the presence of his partner (Laura). She confirmed she had seen Sam hallucinating the previous day and added that it was not the first time she had witnessed him hallucinating after an overdose. The nature and fluctuations of his hallucinatory behaviour were seen as what would be expected by them being drug-induced. No drug screen had been carried out on his admission to hospital.

4.255 At the MHLT assessment Sam was described as conscious and aware of time, place and people. He sat in his bed and engaged well with the conversation. He said he could not remember any of

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[65] Glasgow Coma Scale is an assessment of coma and impaired consciousness. https://www.glasgowcomascale.org/what-is-gcs/

[66] Although it was not known at the time, this partner was AW.

[67] Section 5(2) of the MHA is the application to detain a patient already in hospital. https://www.legislation.gov.uk/ukpga/1983/20/section/5

[68] A tactile hallucination is the feeling of being touched or of movement on the skin or inside the body that is not real.

the hallucinations or the behaviour described. Sam said he felt better in his mood and was optimistic about the future because he was planning to move to a new house.

4.256 The MHLT assessment described his partner (Laura) and his family as supportive. His partner removed all his stored medications and his sister offered to stay with them for a few days to help take care of him. He said he had used drugs only once in the past six months and denied having any current thoughts of suicide or self-harm. The plan agreed was:

- "*He prefers his pregabalin to be divided on 3 doses rather than two doses: please update prescription to pregabalin 150mg [three times a day] TDS*
- *Rest of medication remain the same*
- *He agreed on referral to for short term follow up*
- *His partner is arranging support via the church*
- *Responsible clinician to rescind the section 5(2)*".

4.257 He was discharged from Broomfield Hospital on 30 December 2021. The medication prescribed on discharge was aripiprazole 10mg, duloxetine 90mg, olanzapine 7.5mg, pregabalin 150mg three times a day and escitalopram 20mg.

4.258 On 31 December 2021 Sam was referred to Home First. It was noted by Home First that he had not given consent to be referred to Home First, and there were no risk indicators for a cold call, so the referral was closed, and he remained under the care of the Mid SMHTC&E.

4.259 Three discharge letters were sent to the GP from Broomfield Hospital ED, Broomfield Hospital medical ward and by the MHLT.

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4.260 Sam contacted the Mid SMHTC&E on 4 January 2022, asking for a letter to support his housing request. This was written and printed for him to collect on 5 January 2022.

4.261 A message was sent to Sam on 12 January 2022 reminding him that he had not returned the self-referral form for the PEP. He was asked to return the form by 26 January 2022 if he wanted treatment from the psychology service.

4.262 On 13 and 17 January 2022 the GP surgery wrote to Sam asking him to make contact, because the GP was trying to get in touch with him to discuss the discharge letter from the overdose in December 2021.

4.263 On 24 January 2022 Sam called the Mid SMHTC&E duty team to ask for a medication review. A request was made for an outpatient appointment. He called again on 27 January 2022 asking for an urgent call with a psychiatrist. On 28 January 2022 the duty team tried to call Sam on three different telephone numbers, with no response. A text message was sent asking him to contact the Mid SMHTC&E during office hours or NHS 111 out of hours.

4.264 The GP surgery wrote to Sam again on 27 and 28 January 2022, asking him to make contact. Sam called the GP on 28 January 2022, and a telephone review took place based on the discharge letter from December 2021. The GP recorded that Sam said he was okay. He had support from his mother and he was due to see the mental health team the following week.

4.265 On 28 January 2022, he was discussed at the Mid SMHTC&E MDT meeting. Sam's mother had contacted NHS 111 with concerns about his mental state. She said he had had no follow-up after a serious overdose. The Mid SMHTC&E received a request from the NHS 111 team leader to contact Sam, because his mother had raised concerns about his mental state. She said he was suicidal and wanted to hang himself. A message was left on the first attempt to contact him, then on the second call he answered. He said his medication did not seem as effective as it used to be, and he wanted

a medication review. He said whenever he took the medication, his anxiety seemed to get worse. He said he had previously been prescribed clonazepam and he had found it helpful, but this was later changed to pregabalin, which was making things worse for him. He denied having any active thoughts of self-harm or suicidal ideation, and he said he could keep himself safe and just wanted the medication to be reviewed.

4.266 Sam was described as sounding calm and he engaged well during the telephone conversation. He was coherent and his speech rate, tone and volume were normal. He was also aware of time, place and people. He said his appetite was good and he was eating and drinking okay, but he found it hard to fall asleep at times. No thought disorder or any psychotic symptoms were in evidence, and no abnormal perception was reported or noted. He appeared to have capacity and good insight into his current stressors and the effects of these on his mental health. He was able to weigh and retain the information that was discussed with him and to make choices about his mental health needs. He said he would try to keep himself safe and he was very grateful for the support offered.

4.267 The plan agreed with him was:

- "*To inform C-Specialist mental health team of patient contact with CRS[69] and C-Specialist team to make contact with patient as soon as possible to discuss his medication.*
- *Patient declined a referral to Sanctuary[70] for emotional support, he said he was fine and he can talk to his therapist if there is a need.*
- *Advised to contact CRS via NHS 111 option 2 should he be experiencing mental health crisis. MDT OUTCOME: no change*".

4.268 The Mid SMHTC&E duty team attempted to call Sam on 31 January 2022. They used all three different numbers on record for Sam. There was no answer from any of the numbers, and a text message was sent asking him to call back.

4.269 On 1 Feb 2022 the Mid SMHTC&E duty team called Sam to check on his wellbeing. He was described as responding rudely and said he did not want to talk; he just wanted a psychiatrist to do a medication review. Sam requested another medical review.

4.270 On 2 Feb 2022 Sam was seen by CJLDT. He had been arrested for the alleged murder of Laura and was referred to CJLDT for an assessment of his mental state while he was in custody. He reported having low mood and recently having self-harm/suicidal thoughts, but he had no current intent.

[69] South Crisis Response service

[70] Sanctuary Supported Living provide support, housing and assistive technology. https://www.sanctuary-supported-living.co.uk/

5 Discussion and analysis of care and treatment

5.1 This section of the report examines the issues in the care and treatment provided to Sam and includes commentary and analysis in line with the terms of reference agreed with NHS England.

5.2 This analysis includes:

"Review of the contact with mental health services from the transfer from CAMHS to adult services in 2017.

The referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.

Compliance with local policies, national guidance and relevant statutory obligation".

5.3 Care planning includes the issues of adherence to the CPA policy, transfers of care, diagnosis and medical reviews and best practice guidance. Risk assessment and management includes the issues of adherence to policy, zoning, risk to others and risk to self. The involvement of Sam and his family includes each of their perspectives.

5.4 Each section is concluded with summary findings.

5.5 Liaison with affected family and Sam was carried out with the DHR Chair.

Care planning

5.6 Terms of reference:

"*Examine the effectiveness of the service user's **care plan** and risk assessment, including the involvement of the service user and their family.*

Review the appropriateness of the treatment of the service user in light of any identified health needs/treatment pathway".

CPA policy guidance

5.7 The EPUT CPA Policy[71] states that:

"*Following the initial assessment, service users will be placed on either CPA or Non-CPA. The decision to provide care under CPA or Non-CPA is a clinical decision.*

- *CPA: An individual deemed to have complex needs, a higher risk profile and/or requiring multi-agency input should be placed on CPA.*
- *Non-CPA: An individual with more straightforward needs, one agency input or no problems with access to other agencies/support and lower risks should be placed on non-CPA*".

5.8 The policy expectation is that care needs across a range of different functions will be assessed, and the outcome of the assessment should include a summary of what happens next. A person-centred care plan should be developed by:

"… *listening to the patient and finding out what he/she wants and needs. It is about helping patients to think and plan what they want from their life now and in the future, and to enable friends, family and professionals to work together with the person to achieve these goals*".(CPA Policy July 2017)

5.9 Care plans should have an assessment of needs, including goals and outcomes. There should also be a detailed assessment of risk, and contingency and crisis plans should be developed for any of the risks that have been identified. The patient and their carers should be involved in agreeing goals

[71] CLP30 – CPA Policy July 2017

and developing plans. Copies of the plan should be provided to them both. Reviews should take place no less than every six months.

5.10 Electronic care records detail that Sam was managed under CPA/non-CPA as shown in Table 1.

Table 1: CPA/non-CPA

CPA		Non-CPA	
06/02/2015 – 22/01/2017	EWMHS	23/01/2017 – 09/08/2019	EPUT Mid SMHTC&E
10/08/2019 – 28/12/2020	EPUT Mid SMHTC&E	29/12/2020 – 01/01/2021	EPUT Mid SMHTC&E
02/01/2021 – 09/08/2021	EPUT Mid SMHTC&E	10/08/21	EPUT Mid SMHTC&E

5.11 Providing care under CPA was appropriate when Sam's care was provided by EWMHS, because he met the Trust CPA criteria. However we question his care being changed to non-CPA from 5 February 2019 to 9 August 2019. The records of this period and the period of "*non-CPA*" from 29 December 2020 to 1 January 2021 appear to be recording errors. It is clear from the records that he was allocated a care coordinator throughout his care at EPUT from March 2017 until July 2021. However meetings are not clearly recorded as CPA reviews, making the tracking of decisions and plans difficult to follow.

5.12 The Mid SMHTC&E MDT met to discuss concerns and risk issues and to provide an opportunity to discuss individual patients. The notes from these meetings are sparse and often just one line, for example, noting that the CCO was to "*maintain contact*". Decisions were also made about "*zoning*", which is discussed in Risk Assessment and Management (from paragraph 5.94).

5.13 It was stated that the CCO would see him regularly in the community to monitor his mental state from March 2017, but the frequency of this contact is not specified, and there are no regular entries that record contact or care plan updates.

5.14 His first Mid SMHTC&E care plan was written on 27 April 2017. The "needs" identified were recurrent thoughts of harming his sister and recurring intrusive thoughts of causing harm to others. These are not in fact needs, they are risks. He had been physically aggressive to his mother and sister and damaged property at home. The interventions were to monitor his mental state, encourage Sam to take his medication and to "*minimise risk*".

5.15 The contingency/risk plan was to "monitor mental state, liaise with mother as appropriate and request urgent medical review". The crisis plan only included relapse indicators of "increased agitation and distress tolerance". It stated that in a crisis the risks to take into consideration were "physically assaultive behaviour to family". After an incident of violence at home, it was agreed on 8 May 2017 that he be on "step-up care". No policy description of "step-up care" was made available to this review, and it is not possible to discern from the notes what, if any, increased support was provided.

5.16 Sam had many issues with housing, which the CCO supported him with. In May 2017 his mother made the decision that he could no longer live in the family home, and a move to supported accommodation was facilitated by mental health services. However, there were difficulties with his drug use and his vulnerability to exploitation by other residents. He was moved to another facility which also ended after four months because of his drug use and suspected drug dealing.

5.17 At a care plan review on 4 June 2017, it was noted that medication seemed to be having some effect on reducing his aggression towards his mother, and there had been no recent arrests, but he

remained aggressive and argumentative towards his sister. There is no description of what support the Mid SMHTC&E would provide, apart from monitoring and medical reviews.

5.18 Between April 2018 and April 2020 Sam moved accommodation 13 times. In October 2018 he was supported by mental health services to have his case presented to the Supported Housing Joint Referral Panel, although this was not successful. In November 2018 he was known to be living with his mother in breach of a restraining order, with no change to plans.

5.19 At the meeting to arrange transfer to the North West SMHT in January 2019, Sam said he had been taking more illicit substances, using £50 of heroin and £50 of crack each day. He was told that it would be difficult for therapeutic work to make a difference while he was using drugs, but the SMHT service would remain available to him to access. But care plans written by North West SMHT in February 2019 showed that Sam said he had initially engaged with substance misuse services, had started taking subutex[72] and had stopped using illicit drugs.

5.20 Interventions by the CCO in 2019 centred on psychoeducation, improving Sam's tolerance to distress, helping him to manage his thoughts and supporting him with his relationship with his family.

5.21 The care plans during his short admission to a mental health unit in August 2019 focused on stabilising his mental state, stabilising him on medication and reviewing the community care plan.

5.22 Following this admission, he was difficult to engage with. When he could be located for follow-up he was hostile and said he did not want to engage with mental health services because it had not been helpful in the past.

5.23 The care plan developed in January 2021 indicated that he would be seen by the CCO fortnightly. They were to oversee his care and provide psychoeducation about anxiety, social isolation and intrusive thoughts. The interventions were to "*continue to work with care coordinator around managing emotions, impulse control and managing his distressing thoughts. [Sam] to continue to try to implement suggestions and small changes. Once [Sam] is more settled in presentation and able to engage and concentrate more, then referral to psychology to be discussed with the team again. [Sam] to develop more positive coping strategies*".

5.24 Arrangements changed in July 2021, and on 19 July 2021 Sam was told that CCO4 was leaving the team. It is recorded that Sam agreed that he no longer needed the support of a care coordinator, particularly as he was attending the PEP programme. However there is no record of any MDT team discussion about this, and no lead professional was identified. Sam was to "*remain under the team under outpatients*".

5.25 The final CPA care plan was written on 5 August 2021, and there was a discussion with Sam about him not following up with the psychology service after attending the PEP sessions. He maintained that he wanted one-to-one therapy, and he was encouraged to follow the pathway open to him, which was to attend the PEP and then self-refer. He had presented as much more stable and settled. After this call it was agreed that he would remain under the Mid SMHTC&E team as an outpatient, he would rebook and engage with the PEP and then self-refer for therapy. He would contact the Mid SMHTC&E duty team if needed.

5.26 The CPA procedure states:

"*The patient and all relevant members of the multidisciplinary team are involved in the planning of any transition*".

5.27 Although no specific procedure is identified for managing the transition to non-CPA status, it is reasonable to expect that this should be discussed at MDT meetings and that plans would be

[72] Subutex or buprenorphine is a semi-synthetic opioid used as a heroin substitute. https://cks.nice.org.uk/topics/opioid-dependence/prescribing-information/buprenorphine/

agreed. There is no recorded discussion about this potential change at the preceding two MDT meetings in July 2021.

5.28 The plan recorded in August 2021 was for Sam to have outpatient appointments with the team psychiatrist, the GP was to provide repeat prescriptions, and Sam was to contact the team if he had any concerns about his medication. It is noted that this plan was agreed with Sam. There is no record of any MDT involvement in this decision or in any plans made after this.

5.29 The Mid SMHTC&E had contact with Sam through medical outpatient reviews and the duty team contacts. Further care plan reviews and updates were provided by outpatient letters to the GP.

5.30 Care plans were not completed in line with Trust policy expectations. It is not possible to track the sequence of CPA review meetings and the subsequent decisions and plans made. Care plans were largely responsive and lacked any underpinning formulation or long-term goals.

Transfers of care

5.31 Although Sam was under the care of EPUT from January 2017, there were eight transfers of care between teams during 2017 and 2022, and Sam had four CCOs. The CPA policy expectation is that transfers of care should be coordinated by the CCO. The patient and all relevant team members should be involved in the transition, clear plans should be agreed and shared with the relevant people, and handovers of care should be clearly documented.

Table 2: Transfers of care

Date	Service
January 2017	EWMHS to Mid SMHTC&E
July 2018	Mid SMHTC&E to HMP Chelmsford
November 2018	HMP Chelmsford to Mid SMHTC&E
January 2019	Mid SMHTC&E to North West SMHT
March 2019	North West SMHT to HMP Chelmsford
April 2019	HMP Chelmsford to North West SMHT
June 2019	North West SMHT to Mid SMHTC&E
January 2020	Mid SMHTC&E to HMP Chelmsford
March 2020	HMP Chelmsford to Mid SMHTC&E

5.32 The referral to adult mental health services was made in December 2016 and information was sent to the Mid SMHTC&E. This was followed up by the Mid SMHTC&E with a call to the psychiatrist to gather more clinical details, which was good practice.

5.33 When Sam did not respond to the initial offer of an assessment appointment in January 2017, he was offered further appointments and was eventually seen on 23 January 2017, and an urgent medical review was arranged for the following day. It was identified that there may be risks to self and others, particularly as he had damaged his mother's house that week and been verbally aggressive.

5.34 His care was discussed at the weekly Mid SMHTC&E MDT meeting, while waiting for the CPA handover to a Mid SMHTC&E CCO. He was placed in the red zone to increase the amount of input from the team and so they could quickly tell if his risks escalated, at which point he could be referred to the crisis team or admitted.

5.35 The CPA handover took place on 20 February 2017, attended by the EWMHS psychiatrist, Mid SMHTC&E psychiatrist and a community mental health nurse. Sam was invited to the meeting, but he did not attend. He later said there was a problem with buses.

5.36 He was allocated a care coordinator (CCO1). Although it is not clear exactly when this started, the notes indicate that CCO1 had been allocated by the end of March 2017.

5.37 Following assessment at the reception at HMP Chelmsford in July 2018, Sam's history of contact with mental health services was noted and the Mid SMHTC&E was contacted. His medication prescription was shared and was continued during his time in prison. CCO1 was invited to CPA review meetings and was kept informed of his progress during his times in prison, from July to September and again from October to November 2018. CCO1 was invited to discharge planning meetings. This was appropriate and it enabled care plans to continue.

5.38 The transfer to the west team in January 2019 was managed with Sam, arranging face-to-face meetings with both CCOs. When he was moving back to Chelmsford in June 2019, the transfer between the teams was managed through the Mid SMHTC&E duty team because a new CCO had not been allocated. He was supported to arrange changing his GP from Harlow to Chelmsford to enable prescriptions to be restarted.

5.39 The referral to Home First in December 2021 was not followed up because it was noted that he had left the hospital without his consent for the referral having been formally recorded, even though the medical assessment recorded he had given verbal consent to the referral. The records made by Home First indicate that Sam had refused to speak to the MHLT, which was not correct.

5.40 After a team discussion, Home First decided there were no risk indicators that would justify a cold call, so the referral was regarded as inappropriate. The Mental Health 24/7 Crisis Response and Home First Service Operational Policy[73] describes Home First as:

> "… *intensive home treatment as an alternative to inpatient admission for all adults 18+. The primary function is to undertake a comprehensive assessment of needs, whilst providing intensive intervention/treatment and stabilisation, thus enabling a quicker recovery and resolution for people who do or do not require a longer-term care package*".

5.41 The operational policy does not include the absence of recorded consent as an exclusion criterion. In fact, it takes self-referrals and referrals through NHS 111. Although there is reference to a team discussion in support of this decision, it would be reasonable, given his recent history of serious overdoses, to contact the referrer or the Mid SMHTC&E to discuss his risks before rejecting the referral.

Diagnosis and medical reviews

5.42 Sam had three psychiatric diagnoses from 2017:

- EUPD (ICD10[74] code F60.31)
- Differential diagnosis: mental and behavioural disorder caused by the use of cannabis, abstinent at the time (ICD10 code F12)
- OCD (ICD10 code F42)

5.43 Sam told CCO1 on 7 April 2017 that he wanted to hurt his family and a man who lived in Basildon. He was seen on 28 April 2017 for an urgent medical review, when he spoke about harming the man in Basildon. He claimed to hear a male voice in his head which he heard when he was very angry or under a lot of stress. He described his subjective mood as "*alright*" and, objectively he was described as stable. There was no formal thought disorder, no passivity or delusions were

[73] Mental Health 24/7 Crisis Response and Home First Service Operational Policy, March 2020.

[74] International Classification of Diseases 10 (ICD10) is the reference website designed for all current American diagnoses. https://www.icd10data.com/

observed, and he did not appear to be responding to any kind of stimuli. There were no suicidal thoughts or thoughts of self-harm. He denied any current illicit drug use.

5.44 At this time, he was being prescribed aripiprazole 10mg once a day and sertraline 200mg once a day, which he said he had not been taking regularly. He asked if he could have depot injections, which was to be discussed with the consultant, meanwhile the aripiprazole was increased to 10mg a day for seven days. It was noted that CCO1 was to provide "*step-up*" care. There is no definition of what "*step-up care*" means, either in the Mid Essex Specialist Community Recovery Service Operational Policy[75] or the CPA policy.[76]

5.45 The diagnosis of OCD was made in August 2017 after Sam became concerned that he posed a high risk of harm to others.

5.46 In July 2017 aripiprazole was prescribed as a depot injection (400mg monthly) at his request. At a medical review in November 2017 treatment options were discussed with Sam. He was told he may benefit from attending the Open Road service, when he spoke about his frequent cannabis use. Sam had mixed feelings about it, but it was agreed that CCO1 would make a referral. He was happy with the depot injection and had no side effects. His medication at that time was listed as sertraline 100mg daily and aripiprazole depot 400mg every four weeks.

5.47 At a medical/CPA review on 7 December 2018, pregabalin 25mg was added because Sam was feeling very unsettled since coming out of prison on 28 November 2018. He said he was feeling anxious and said he lacked any routine, although he denied any drug use. The role of aripiprazole depot injection was explained, and he said he felt that the depot helped him in managing his aggression and agitation. However, he agreed to consider reducing and stopping the depot once he started feeling better with pregabalin. Over the next year changes were made to the antidepressant and antipsychotic medication (fluoxetine and olanzapine) with occasional additions of promethazine to aid sleep.

5.48 The depot injection was stopped in April 2019, although it was agreed to continue with pregabalin 300mg once a day. The role of depot antipsychotic medication was explained to him and his mother, and he agreed to start sertraline[77] 50mg daily and olanzapine[78] 5mg at night. CCO2 would support and monitor, and it was planned to have a medical review after three months.

5.49 Medical reviews continued every three to four months, and requests for urgent review were responded to rapidly. Regular updates were sent to Sam's GP, as were with requests for prescriptions.

5.50 In December 2019 it was noted Sam had stopped taking the antidepressant medication and clonazepam[79] had been introduced. During 2020 further changes were made to Sam's antidepressant and an antipsychotic prescription. But in April 2021 Sam said he found the combination of antipsychotic quetiapine[80] and antidepressant clomipramine[81] helped his mood and

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[75] Version 2, April 2015.

[76] Version 1.6, July 2017.

[77] "*Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI)*". https://www.nhs.uk/medicines/sertraline/about-sertraline/

[78] Olanzapine is an antipsychotic medication. https://www.nhs.uk/medicines/olanzapine/#:~:text=Olanzapine%20helps%20to%20manage%20symptoms,mania%20symptoms%20of%20bipolar%20disorder)

[79] Clonazepam is a benzodiazepine that is used to treat anxiety. https://www.nhs.uk/medicines/clonazepam/about-clonazepam/

[80] Quetiapine is an antipsychotic medication. https://www.nhs.uk/medicines/quetiapine/about-quetiapine/

[81] Clomipramine is an antidepressant. https://bnf.nice.org.uk/drugs/clomipramine-hydrochloride/#indications-and-dose

made his thoughts more manageable. However, in December 2021 he had stopped taking clomipramine and was started on escitalopram[82] 10mg and aripiprazole[83] 5mg.

5.51 The last Mid SMHTC&E medical review on 3 December 2021 noted that he was waiting for information from the psychology service, having attended the preliminary three sessions, and it was thought that psychological therapy would be beneficial. Medication at this time was escitalopram 10mg once a day, to be increased to 20mg after two weeks, and aripiprazole 5mg to increase to 10mg after two weeks. The pregabalin prescription was not changed, and he was due another medical review in two months (in February 2022).

5.52 We have been told that Sam's stepfather attended many of his outpatient meetings, but this is not clearly recorded.

Best practice guidance

5.53 Sam had a diagnosis of EUPD and OCD and treatment should have been guided by the relevant NICE guidance:

5.54 The NICE guideline Obsessive-Compulsive Disorder and Body Dysmorphic Disorder: Treatment,[84] recommends people are offered the choice of low-intensity treatments or a course of selective serotonin reuptake inhibitor (SSRI) antidepressants. Low-intensity treatments include brief CBT using structured self-help material, brief phone CBT or group CBT.

5.55 NICE guideline Borderline Personality Disorder: Recognition and Management,[85] recommends the development of trusting relationships and a team approach that develops:

- "… *comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the person). The care plan should:*
  - *identify clearly the roles and responsibilities of all health and social care professionals involved*
  - *identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them*
  - *identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term treatment aims*
  - *develop a crisis plan that identifies potential triggers that could lead to a crisis, specifies self-management strategies likely to be effective and establishes how to access services (including a list of support numbers for out-of-hours teams and crisis teams) when self-management strategies alone are not enough*
  - *be shared with the GP and the service user*".

5.56 A referral for psychological assessment was made by CCO1, which took place in August 2017. The assessment by the consultant clinical psychologist concluded that Sam's presentation was consistent with a diagnosis of OCD. Sam reported having intrusive thoughts about harming others, which he found distressing, and which he had experienced since the age of 15. He had a series of mental "*rituals*" which he used to suppress them. He also reported having symptoms of social

[82] "*Escitalopram is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI)*". https://www.nhs.uk/medicines/escitalopram/about-escitalopram/

[83] Aripiprazole is an antipsychotic medication that helps with mental health conditions, such as psychosis or mood changes. https://www.nhs.uk/medicines/aripiprazole/about-aripiprazole/

[84] NICE (29 November 2005) Clinical Guideline [CG31] Obsessive-Compulsive Disorder and Body Dysmorphic Disorder: Treatment. https://www.nice.org.uk/Guidance/CG31

[85] NICE (28 January 2009) Clinical Guidance [CG78] Borderline Personality Disorder: Recognition and Management https://www.nice.org.uk/guidance/CG78

anxiety, he worried about what people thought of him and assumed people would judge him negatively. He described feeling worried and anxious about everyday things, but especially the wellbeing of his family and in particular his sister.

5.57 He showed no symptoms of psychosis and denied having any intention or plan to harm himself or take his own life. He was not seen as being a risk to others at this assessment. The view was his thoughts were most likely an expression of anger and a wish to see himself as the protector of the family. The plan was to see him again in September 2017 to explore his background further and discuss options for treatment, however, he did not respond to follow-up communication and was taken off the psychology service caseload.

5.58 At the Mid SMHTC&E MDT meeting on 4 December 2019, it was agreed that a psychological assessment would be arranged and a referral was made. However, he was arrested later in December 2019 and remained in prison until March 2020.

5.59 In June 2020 Sam told CCO4 that he had had a consultation with a private psychologist because he was concerned about waiting times with EPUT. He was using drugs and he appeared more chaotic. He said his washing rituals had increased. A psychological assessment was arranged for 8 July 2020. It was carried out by the psychology service and CCO4 and Sam was keen to engage. However, he did not attend follow-up sessions and by September 2020 he had missed two psychology service appointments and no further appointments were offered.

5.60 In April 2021 Sam told CCO4 that he felt well, had not been taking any drugs and felt ready to start psychological treatment. He was discussed at the psychology meeting in May 2021, and it was agreed he should be offered a place on the PEP. The records do not explain the rationale for this approach at this time, however it was explained to Sam that attendance at the three PEP psychoeducation session were required before he would be considered for one-to-one treatment. Sam missed the first two sessions but attended the third after a discussion with CCO4.

5.61 Sam participated in the PEP session and said he had found it useful. He was then invited by letter to self-refer to psychological treatment, which had to be done within a specified period after the PEP. This invitation was followed up by text. A reminder letter was sent on 22 December 2021 telling him that because he had not self-referred it was assumed he no longer wanted psychological treatment. He could be referred again if he wanted but would be asked to repeat the PEP before he could receive any individual therapy.

5.62 This review has not been provided with any policy or practice guidance that explains why the three sessions of PEP had to be completed before any individual work could be agreed.

Care planning findings

5.63 **CPA policy guidance**

After each routine or urgent medical review, a letter, described as a care plan review, was sent to Sam's GP. These letters gave an update on his mental state, presentation, the agreed medication regime, a risk assessment and a summary of future plans. This is good practice.
Care plans in 2017 and 2018 lacked detail about interventions beyond support and monitoring.
Care plans developed by successive CCOs from 2019 to 2021 became focused on supporting Sam to manage his thoughts, tolerate distress and develop positive coping strategies. This is in line with expected practice.
Moving from CPA to non-CPA without a care coordinator in July 2021, was not managed in line with policy guidance. There was no evidence of MDT involvement, or of a planned discussion with Sam or any of his family members.

5.64 **Transfers of care**

The transfer of care from EWMHS to the Mid SMHTC&E was carried out in a planned way, with good communication of his history. Sam was invited to the transfer meeting but did not attend. There was a face-to-face meeting between the psychiatrists involved, and a CCO was allocated shortly afterward.
Transfers of care between prison health care at HMP Chelmsford and the Mid SMHTC&E were managed in line with expected practice. Both agencies communicated well. Care plans and medication prescriptions were continued, and plans were agreed before discharge.
The transfer to Mid SMHTC&E and North West SMHT when Sam moved back to Chelmsford from Harlow was managed well. Both agencies communicated well and Sam was involved in the plan. He was supported to register with a GP and find accommodation.
The Home First referral in December 2021 was rejected because they did not have Sam's consent. This decision was not based on accurate information and was not completed in line with Trust policy.

5.65 **Diagnosis and medical reviews**

Medical reviews were carried out regularly, in conjunction with the CCOs. Clear plans were sent to the GP for prescriptions. This was in line with expected practice.
Changes to medication were discussed with Sam in response to his requests, and attempts were made to encourage him to take his prescribed medication regularly.
The presence of family members at meetings was not clearly recorded.

5.66 **Best practice guidance**

Sam was assessed by the psychology service in 2017 after concerns were raised about his obsessive rituals. He was given a diagnosis and was offered access to psychological treatments in September 2017 and September 2020. However, he was unable to engage with the service either time.
In May 2021 Sam was given a place on the PEP, which was an introduction to psychological work. There was no evidence that the policy supported this approach. Although he did not engage fully, he said he would like to continue psychological work. However, he did not follow up on the service that was offered, despite reminders and prompts.
Sam was prescribed antidepressant medication but there is no evidence of him being offered psychoeducation about his OCD diagnosis or of low-intensity interventions being offered.
Accepting that Sam was at times chaotic and inconsistent in his engagement, it is not possible to evidence a multidisciplinary care plan that followed NICE guidance for EUPD. His treatment pathway was not in line with expected practice.
Crisis plans were particularly weak. There was no constructive input beyond advice that he should attend the ED.

Risk assessment and management

5.67 Terms of reference:

"*Examine the effectiveness of the service user's care plan and* ***risk assessment****, including the involvement of the service user and their family*".

5.68 The Healthcare Quality Improvement Partnership (2018)[86] says a good risk assessment combines "*consideration of psychological (e.g. current mental health) and social factors (e.g. relationship problems, employment status) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people*".

5.69 A comprehensive risk assessment will take into consideration the patient's needs, history, social and psychological factors, and any negative behaviours (e.g. drug use).

5.70 Risk management planning is defined as a cycle that begins with risk assessment and risk formulation. This leads to a risk management plan which is subject to monitoring and review.

5.71 The Department of Health (2009)[87] identifies 16 best practice points for effective risk management which include:

"… *a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis*"

And:

"*Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach*".

Best practice in managing risk is based on clinical information and structured clinical judgement. It involves the practitioner making a judgement about risk based on the combination of:

- an assessment of clearly defined factors derived from research (historical risk factors)
- clinical experience and knowledge of the service user, including the experience of any carer's
- the service user's own view of their experience

5.72 The EPUT Clinical Risk Assessment and Safety Management policy[88] states that

"*Clinical risk assessment and safety management is part of the CPA process; however the principles apply to those under 'non CPA'. All patients' risks should be assessed. This involves identifying specific interventions based on an individual's support needs, taking into account safety and risk issues.*

A CPA care plan is drawn up, preferably with the patient/carer to meet the patient's needs. This forms the recorded safety management plan and should include the following:

- *A summary of all risks identified;*
- *Identify and document any unmet needs;*
- *Actions to be taken to manage risk in a safety plan by practitioners, patients and/or carers*".

Clinical risk assessment policy guidance

5.73 The EPUT Clinical Risk Assessment and Safety Management Procedure[89] is intended to provide guidance to practitioners based on best practice. The expectation is that practitioners will:

[86] National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (October 2018) The Assessment of Clinical Risk in Mental Health Services. https://www.hqip.org.uk/resource/assessment-of-clinical-risk-in-mental-health-service-an-ncish-report/

[87] Department of Health (March 2009) Best Practice in Managing Risk. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

[88] Version 3.5, July 2017.

[89] EPUT CLPG28, July 2017.

- "*Identify and understand the risks for and from each individual;*
- *Evaluate and manage those risks within an agreed framework to the highest professional standards as informed by NICE Guidance;*
- *Plan for contingencies and share that plan with patient, carers and all relevant colleagues;*
- *Clear and concise documentation relating to risks and share appropriately.*
- *Evaluate and manage those risks within an agreed framework to the highest professional standards as informed by NICE Guidance*".

5.74 A formulation of the risks is described as an essential element before any of these actions can be achieved. However there is no place in the risk assessment template for a formulation to be developed and recorded.

5.75 Risk formulation is based on a thorough assessment, and should bring together an understanding of personality, mental state, environment, potential causes and protective factors, or changes in any of these.[90]

5.76 The EPUT policy for clinical guidelines for the management of deliberate self-harm[91] refers to the NICE guideline, Self-Harm: Assessment, Management and Preventing Recurrence.[92] The expectation of the policy is that a trusting, supportive and engaged relationship is developed. The individual is involved in the decision-making. Self-harm is reduced by using this collaborative approach and by the promotion of the safety of the care environment, which includes reducing access to the means of harm.

5.77 For those who present a significant risk of self-harm:

"… *a specific care plan or safety plan, must be developed covering the immediate and long-term risks. The plan should be developed with the person, helping them to consider the difficulties they are experiencing and the resources available to help keep them safe and also therapeutic strategies which may be available and appropriate*".

5.78 The links between Sam's mood, his thoughts of self-harm and his taking of illicit drugs were recognised, and he was encouraged to self-refer to substance misuse services both in the community and in prison. However, he did not engage for long with any substance misuse service.

5.79 Sam regularly said his intrusive thoughts about harming others triggered his self-harm thoughts. The clinical guidelines for the management of deliberate self-harm emphasise the need to assess the person's situational stress, specific risk and protective factors, including any significant relationships that may be either supportive or that could increase risk.

5.80 It is clear from the records that efforts were made by successive CCOs in 2020 and 2021 to develop an honest and supportive relationship with Sam. This should have helped in understanding and assessing his risk. The intrusive thoughts were a significant stressor for Sam, but there was no agreed formulation. A formulation could have helped the practitioners better understand the intrusive thoughts and assess the risks.

5.81 Risk formulation brings together an understanding of personality, history, mental state, environment, potential causes and protective factors, or changes in any of these. It should aim to answer the following questions:

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[90] Royal College of Psychiatrists (May 2017) Rethinking Risk to Others in Mental Health Services. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr201.pdf?sfvrsn=2b83d227_4

[91] EPUT CG71, August 2017.

[92] NICE (September 2022) NICE Guideline [NG225] Self-Harm: Assessment, Management and Preventing Recurrence. www.nice.org.uk/guidance/ng225

- How serious is the risk?
- How immediate is the risk?
- Is the risk specific or general?
- How volatile is the risk?
- What are the signs of increasing risk?
- Which specific treatment, and which management plan, can best reduce the risk?

5.82 If there had been a more in-depth exploration of the risks posed by Sam, particularly to women, this could have led to more focussed care plans and interventions, aimed at reducing risk.

5.83 It is also clear that SMHT practitioners suspected that Sam was not always honest about his drug abuse and the extent of the impact it had on his mental state, but he was still given opportunities to engage in individual problem-solving and, later, in psychological work.

Risk assessments

5.84 It was clear there were concerns about potential risk at Sam's first referral to adult services in 2017. At an outpatient appointment on 20 April 2017, it was noted that Sam kept an action figure in his pocket which represented his aggression towards others, particularly the man in Basildon who had allegedly hurt his sister. He intended to bring this action figure if he attacked the man. There were concerns about his intrusive thoughts of harming others, especially when it was seen in the context of his history of violence and aggression. Sam agreed to an assessment by the EPUT forensic psychiatry service during which a thorough risk assessment would have been completed. Although there is a record of the referral being made, there is no evidence that it was followed by a forensic assessment. This was a missed opportunity.

5.85 Another referral to the forensic service was recorded in November 2018, but this was a request from CCO1 to the prison forensic psychiatrist for advice on medication and was not followed up as a formal referral for an assessment.

5.86 There was a list of successive risk incidents in the risk assessments from April 2017. These included the risk of aggression towards others, including his family, damage to property, self-harm/self-injurious behaviour, vulnerability and hazards because of his drug abuse.

5.87 The Trust policy expectation is that risk assessment will be reviewed after significant changes in a person's life, including their mental state, their social situation (for example, homelessness), a relationship breakdown, them having significant contact with the police or criminal justice agencies, or when the practitioner delivering most of the care changes. In addition:

"*Clinical risk must be reassessed/reviewed routinely (but at intervals not greater than 6 months for community mental health/learning disability services, two weekly for secure services patients and weekly ward-round for inpatients)*".

5.88 Risk assessment is referred to in separate parts of the clinical record and they are not always easily cross-referenced:

- each medical review/care plan update letter to the GP has a section on risk assessment
- the electronic record has a section on risk assessment which includes a structured summary
- the MDT zoning meeting makes reference to an allocated zone

5.89 In the electronic record when a new risk assessment is started, the previous risk incidents are also shown. This is good practice.

5.90 From January 2017 to December 2021 there were 15 risk assessments recorded in the structured electronic record. They include sections on suicidal ideation/intent, ideas of self-harm/self-injurious behaviour, violence and aggressive behaviour, evidence of neglect/vulnerability, safeguarding children and adults, physical health issues and hazards. There is an expectation that a management strategy will be developed for each risk identified.

Table 3: Risk assessments

Date	Trigger event
23.01.2017	Initial referral
22.12.2017	Update
17.01.2018	Vulnerable to exploitation by other drug users
20.06.2018	Probation order breach, likely to be arrested
04.07.2018	Overdose
05.09.2018	Prison release
01.03.2019	Safeguarding issue – he assaulted his partner and she fell on her young child
04.06.2019	Recording of team discussion: risk of potential death by misadventure due to drug abuse
16.08.2019	Overdose
17.08.2019	Prior to Gosfield ward admission
19.08.2019	Gosfield ward self-discharge
04.10.2019	Low mood and drug binge
15.10.2020	Overdose
29.12.2021	Overdose

5.91 While some of these relate to risk incidents, there was no systematic approach to reviewing the risk assessment after each risk incident – such as looking at previously documented acts of self-harm; threats and aggression made to his mother, sister and girlfriends; domestic abuse, which included coercive control; malicious communications; physical aggression; and drug abuse.

5.92 Also the risk assessments were not routinely updated following transfers of care, as set out in the policy. It is significant that the only formal risk assessment completed in 2020 was by a MHLT practitioner following an overdose.

5.93 While risks were reviewed at each outpatient review, they did use the same detailed structure and did not always follow the same format.

5.94 The medical review letters to the GP refer to a risk management plan. The plan includes the expectation that Sam would comply with his treatment, that he would be supported by the CCO and that he could contact the Mid SMHTC&E duty team for mental health concerns. From 2019 onwards it was stated in MDT meetings that his criminal behaviour should be managed by the criminal justice system.

5.95 The records show two main risk elements: risk to himself and risk to others. The Clinical Risk Assessment and Safety Management Procedure[93] tells practitioners who work with patients to manage the risk of harm by gathering information to assess and then manage risk.

5.96 The expectation is that this leads to three elements:

- "*Formulation: The application of clinical knowledge in predicting risks, identifying cues and interviewing, to bring together a formulation of risk.*
- *Measurement: The use of an appropriate tool that helps predict the likelihood of a risk occurring.*
- *Safety Plan: A safety plan is a prioritised written list of coping strategies and sources of support that patients can use during or preceding crises. The intent of safety planning is to provide a predetermined list of potential coping strategies as well as a list of individuals or agencies that patients can contact in order to help them lower their imminent risk*".

5.97 There was no evidence of a team approach having been taken to developing a formulation to understand Sam's risks, and no measurements were recorded.

5.98 There is a risk plan and management strategy listed for some of the risks identified in the safety plans included in each risk assessment. These lack detail and include phrases such as "*monitor mental state and increase frequency of contact accordingly*". There was clear evidence of his risk to others, but this was downgraded quickly and was not addressed. There was little by way of a risk management plan in relation to his threats to his mother, sister and girlfriends.

Zoning

5.99 The Mid Essex Specialist Community Recovery Service Operational Policy refers to zoning as:

"*Central to the whole team approach is the concept of Zoning. This identifies those who are at the highest risk and enables team resources to be targeted most effectively to reduce risk and work effectively towards discharge*".

5.100 Service users are zoned using a traffic light system:

- "*Red – for service users who need the highest levels of intervention*
- *Amber – where service users have high levels of need but present with no immediate risk factors at the current time*
- *Green – where service users are more stable and making a good recovery*".

5.101 Purple is used for Sam in 2020 while he was in prison, however there is no mention of the use of purple in the protocol.

5.102 The operational policy does not specify how frequently zoning for individual patients should be discussed at meetings, or what should trigger a zoning discussion. It does not specify the frequency of contact or what interventions might be needed to move someone from red or amber to green. There is no guidance about what risks should be considered, or how they should be quantified.

5.103 There are records of zoning decisions for Sam being made at Mid SMHTC&E MDT meetings. Accepting that these are a snapshot of how the MDT considered risk at the time, the zoning decisions made were frequently not supported by evidence. For example, a change from green to amber could be made based on feedback given in a phone call. The notes are brief, as would be expected if the template was being used (Figure 1). However, they were frequently only one line, with no explanation and few action points.

[93] CLPG, 28 July 2017.

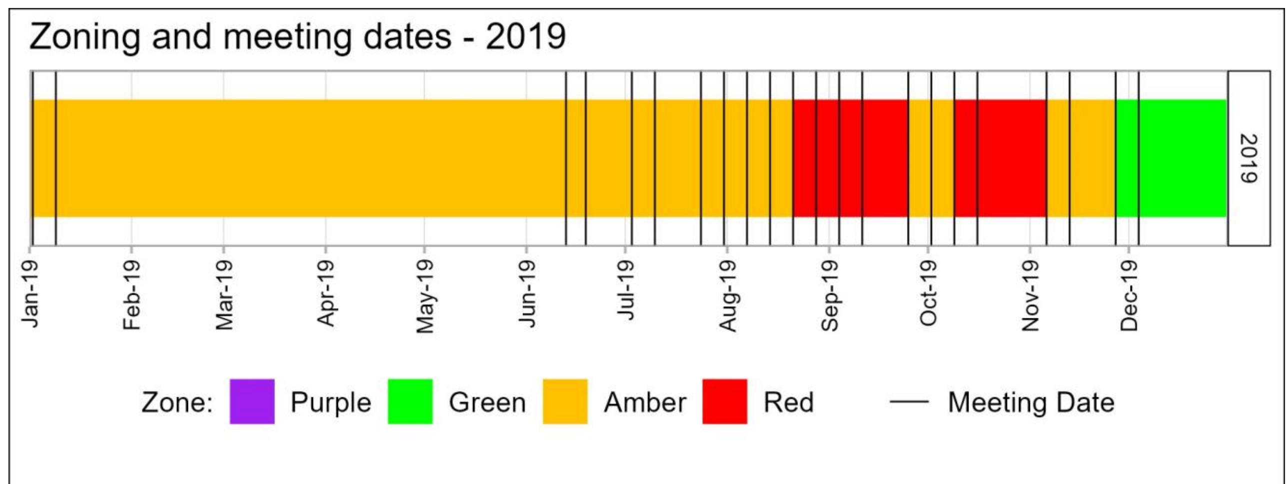
Figure 1: Zoning meeting template

	MDT ZONING MEETING
Name / Paris Number	
RAG Rating & Current Risk	
Discussion / Update	
Action Point	

5.104 There are times when Sam was zoned at red, but there was no introduction of an obvious change to the care plan, his risk assessment or the level of intervention. For example, in January 2019 he was arrested for assaulting his then partner, and was arrested again in February 2019 for breaching a post-sentence order and was sent to prison, but his zoning risk stayed at amber.

5.105 We have reviewed three years of zoning meeting records to analyse the decisions made. We referred to the recorded risk events and to the guidance in the zoning protocol. The diagrams below illustrate the zones applied to Sam during 2019, 2020 and 2021. The black lines in the diagrams represent the zoning meetings, when the decision was recorded. The MDT meetings either did not take place consistently or were not recorded consistently. There are long gaps between recorded meetings from January 2019 to June 2019 (see Figure 2), and August 2020 and November 2020 (see Figure 3). In 2021 there were only five recorded meetings of the MDT to discuss zoning (see Figure 4).

Figure 2: Sam zoning 2019



5.106 There are no zoning meetings recorded between January and June 2019, despite the amber rating, which suggests a heightened level of team oversight and intervention. A decision was made that home visits should be conducted in pairs in February 2019 due to the "*risks around lone working*". The risks were not explained and they are not mentioned in the zoning decisions. Sam was zoned red after he discharged himself from Gosfield Ward in August 2019. He was seen by Home First and a medical review was planned.

5.107 Sam was zoned as amber on 2 October 2019, although it is not clear why his risk was thought to have decreased, because he had recently been on a two-day crack binge

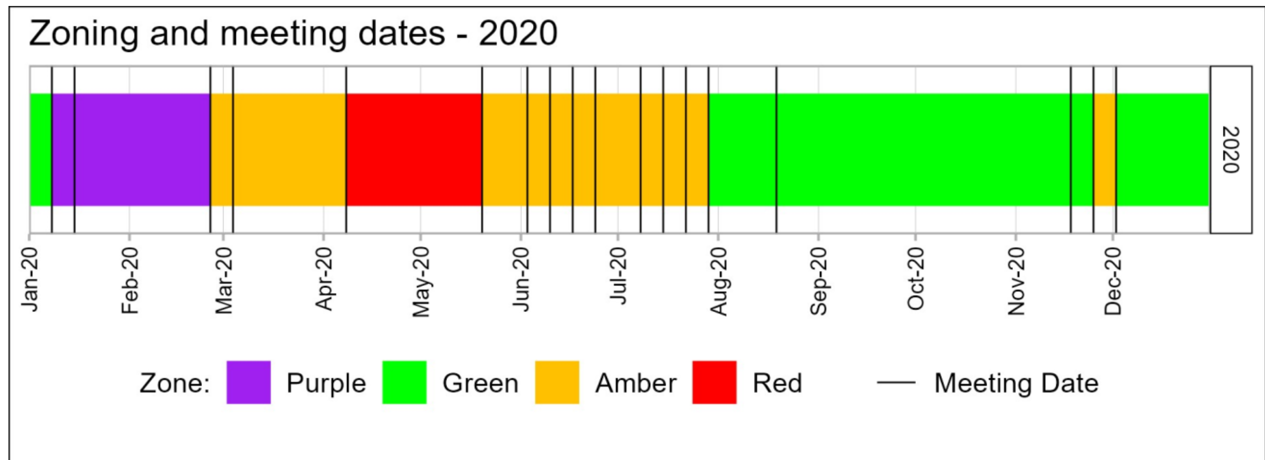
5.108 The red rating was applied again on 9 October 2019, it was noted that Sam was not engaging, was using crack more regularly and was making threats to harm family members. It was recorded that these were "*not mental health issues, more a behavioural issue*". On this date the meeting notes that no actions were discussed.

5.109 In early November 2019 Sam was moved from red to amber. CCO2 reported that his risk was associated with his crack binges: he was bingeing when he received his money each month then he

stayed off drugs until the next month. There was no evidence that his risk was decreasing, and it is not clear what risks were considered.

5.110 An ED attendance on 9 November 2019 when Sam cut himself after a fight with his girlfriend is not mentioned in the zoning meetings. The amber rating was applied on 13 November 2019. There was no discussion about a reduction in risk, or there having been a change to visiting practices. On 27 November the rating was changed to green, and in December 2019, Sam was arrested after threatening and falsely imprisoning his partner. He was remanded in custody, but this was not reflected in the zoning decisions.

Figure 3: Sam zoning 2020



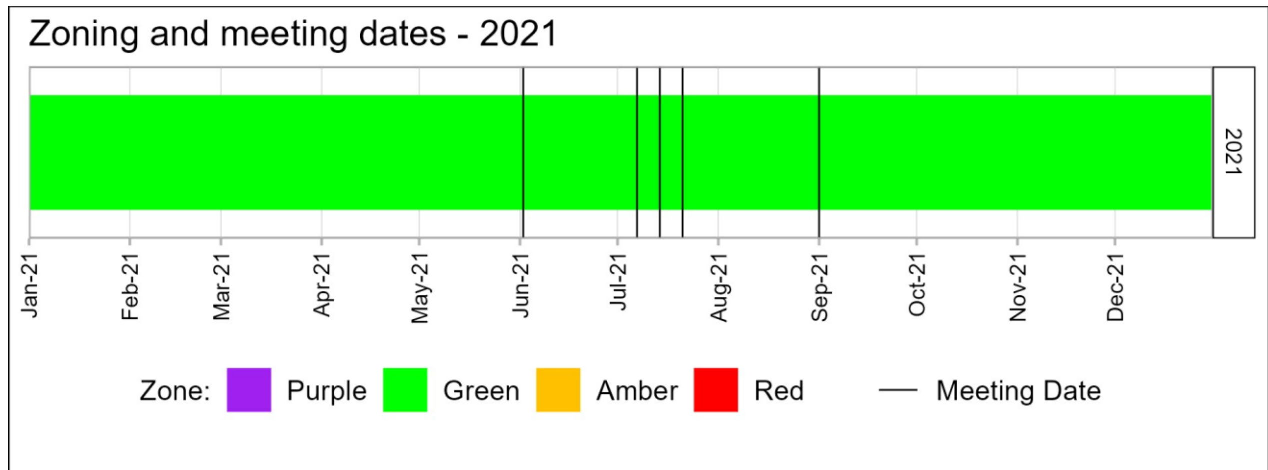
5.111 Purple was used to denote that Sam was in prison, however purple is not included in the zoning guidance. There was no guidance about how the team should approach care while a patient was in prison.

5.112 The red zone reflects MDT concerns in April 2020 that Sam was calling the ambulance service inappropriately and was going out while positive for Covid-19. The risk was seen as decreased in May 2020, so he was moved to amber, but there was no description of why or supporting evidence.

5.113 Sam and his family raised concerns in early June 2020 about his intrusive thoughts of harming others, including children, which he found distressing. However it was stated that he had never acted on these thoughts of harming others and was just expressing his thoughts. He remained in the amber zone. His forensic history was regarded as "*unrelated to the intrusive thoughts*", again there was no supporting evidence for this assertion. A discussion with the psychology service about this was planned.

5.114 The amber rating in December 2020 related to a safeguarding issue, as his girlfriend at the time had taken an overdose of his medication and was vulnerable.

Figure 4: Sam zoning 2021



5.115 Five zoning meetings were recorded to have taken place during 2021. Although Sam does appear to have been less chaotic in his presentation, there is no obvious reason why his zoning and risk were not discussed.

5.116 Sam reported in June 2021 that made a cut on his abdomen, and the change from care coordinator-led care in July 2021 was a significant event. In November 2021 his mother reported that he had been sending her texts threatening to kill the family and then himself. His mother called the Mid SMHTC&E duty team and a medical review was arranged – although Sam denied being any risk.

5.117 The ED attendance in late December 2021 was for a significant overdose, which does not appear to have been discussed in zoning meetings.

5.118 Sam remained under the care of EPUT until the homicide in February 2022. He was discussed at the Mid SMHTC&E MDT meeting on 28 January 2022, but there were no recorded zoning meetings in January or February 2022.

5.119 The Mid SMHTC&E approach to zoning appears uncoordinated and confusing, and added little or nothing to effective risk management. There was clear evidence that Sam posed a risk to himself and to others (especially females). Decisions to change zones were made without recording any discussion which showed how risks were weighed or measured. He was zoned to green without any substantial or sustained evidence of improvement in his mental state or social functioning.

Risk to others

5.120 There is no evidence of rigour having been applied to trying to understand Sam's intrusive thoughts about harming others and of his thoughts about sexually harming children. Reference was made to them being thoughts only and there being no evidence that he may act on them. They are described as threats. It was not believed that there was any intent to the threats and it was thought they were possibly "*behavioural*". It was stated that his risk to others was not related to his mental state and that any offences should have been managed through the criminal justice system.

5.121 There is no evidence that a considered MDT discussion about his risk of harming others took place. So these statements seem to have been made without discussion and without a considered review of his history. No formulation was developed, and a formulation could have helped practitioners understand the potential risks. Also forensic assessments were not completed, despite referrals being made in 2017 and 2018.

5.122 The most significant risk Sam posed to others was for domestic abuse, both with family members and with intimate partners. Sam had an extensive history of stalking, harassment and coercive control in intimate relationships, from the age of 15. There is at least one example of his physical aggression against a partner when a baby was present in February 2019.

5.123 It was also clear from his history that being convicted and given a restraining order made no difference to his behaviour. This information was not included in the risk assessment or management plans and it was not used to help develop a formulation.

5.124 Aggression in the home was well documented in the EWMHS history before his transfer to EPUT. Threats and aggression directed at his mother and sister are well documented in the following years, but there is no evidence of detailed history-taking or of attempts being made to understand his behaviour. When it became known that he was staying at his mother's house in breach of a restraining order, no action was taken. Threats to his mother and other family members continued, and there is no evidence that the team tried to support them or signpost them to other services.

5.125 There was no exploration of his attitude to females and the degree of risk he may have posed.

Risk to self

5.126 There are many documented instances of Sam's harming himself; most of these are overdoses, with some instances of cutting.

Table 4: Risk to self

Date	Event
23.06.2018	Overdose
08.07.2018	Overdose
14.02.2019	Overdose
08.08.2019	Overdose
26.08.2019	Overdose
20.03.2020	Overdose of alcohol and cuts to neck and abdomen
14.10.2020	Overdose
21.06.2021	Reported cut to abdomen
26.12.2021	Overdose

5.127 It was noted in March 2019 that Sam was at risk of accidental death by misadventure, because he was abusing heroin, crack and cannabis and was starting to show signs of addiction to pregabalin, which he was also buying off the street. He was not seen as actively suicidal but at risk of overdose and making unwise choices in drug taking.

5.128 The plan was for professionals to check his capacity, particularly around unwise decisions; for CCO3 to have fortnightly appointments with him; to refer him to the HTT or crisis team as needed; and for him to have regular medical reviews. This risk assessment was reviewed and updated in June 2019. Sam denied any suicidal ideation and it was noted that he had been selling household items to fund his drug use, and his flat was nearly empty. There was no recorded discussion about capacity.

5.129 In August 2019 Sam said he wanted to end his life and had thought about going to the train station or jumping off a building. He took an overdose of clozapine, and his girlfriend called an ambulance even though he had asked her not to. He told the assessing staff he could not cope with the intrusive thoughts and compulsions to harm himself and others. The assessment at that time recommended a brief admission to an inpatient mental health unit.

5.130 A voluntary admission was arranged, but Sam left after a day after becoming angry that he was expected to follow ward rules about smoking and leave. It is clear from this intervention that the risk he posed to himself was taken seriously. He was offered an admission so he could have a period of stability and so he could be assessed in a safe environment. Sam was unable to take advantage of this opportunity because of his impulsivity.

5.131 Capacity is not referred to again in the assessments of self-harm in 2020 or 2021, either in zoning meetings or CCO contacts.

Risk assessment findings

The 2017 forensic referral was not followed up and the 2018 discussions about a forensic opinion were not followed through. They were missed opportunities to make a thorough assessment of his risks.
There was a lack of consistency in the recording of MDT discussions and the timing of zoning decisions. However, Trust policy does not provide clear guidance about the practice and quantifying of zoning.
The zoning system was not linked to risk assessment and management plans and it did not provide practitioners with guidance about the type and levels of intervention that could be used to reduce risk.
There was no agreed formulation or understanding of the nature and degree of risk Sam posed to others or himself. Risk assessment was not undertaken in line with Trust policy.
Admission was arranged in 2019 to provide an opportunity for a mental state assessment and medication review, but Sam was unable to take advantage of this opportunity.
Evidence of domestic abuse was not included in risk assessment and management plans.
Sam's continued substance misuse restricted the impact of the supportive interventions delivered by the Mid SMHTC&E.

Service user and family involvement in care planning

5.132 Terms of reference:

"Examine the effectiveness of the service user's care plan and risk assessment, including the **involvement of the service user and their family**.

5.133 The CPA policy expects family/carers to be involved in care planning, as these examples show:

"*… in collaboration with carers and ensure information, advice or signposting to services is given*"

"*… work with the person, their families and carers to identify measures to be taken to prevent a crisis developing and develop a personal crisis and contingency plan*"

"*… work with the patient and their families/carers during times of crisis, ensuring crisis situations are responded to timely, effectively and safely*"

"*… risks assessment will be review [sic] on receipt of concerns from family and/or carers and shared with the MDT or with a senior member of the clinical team for discussion*".

Family perspective

5.134 Sam had an extensive history of threatening and aggressive behaviour towards his mother, his sister and his stepfather. Although there was no physical aggression after he moved out of the family home at his mother's request in 2017, he continued to send verbally abusive messages and to make threats to his mother's and his sister's safety and to make threats to his stepfather. At other times Sam described feeling supported by his family, especially his mother.

5.135 The SMHTC&E were aware of this and encouraged Sam to stop taking an "all-or-nothing" approach to his relationships with his family and to engage positively where possible.

5.136 The care plan template in the clinical records has a section for involving family in the process. The questions included in the section are:

"*Have you included the adult's family/partner/carer as part of the process?*" Yes/No

This was not answered in Sam's care plans for 2018, 2019, 2020 or 2021.

"*Will the Adult or Carer experience substantial difficulty engaging in this process in your view?*" Yes/No

5.137 These were all ticked "No" in Sam's care plans.

5.138 The family engagement section of the care plan template asks the author whether they have included the adult's family as part of the process. In the final care plan for Sam, written on 5 August 2021, this section is blank. Subsequent questions about whether the family needs support to engage are also blank. There is no evidence that Sam's family were asked to be involved or that their involvement was discussed with Sam.

5.139 There is a section to record whether a carer's assessment has been offered to the carer and whether the offer has been accepted. Where it was recorded that the assessment had been offered or accepted, no details were included.

5.140 Sam's mother made many calls to services telling them about threats made to her or other family members or asking for help for Sam when he appeared to be in crisis, and/or was not responding to her.

5.141 When we met in 2023, his mother and stepfather shared letters they had written to his care coordinators over the years, and a letter they sent to the local MP to try to engage her in getting help for Sam.

5.142 Sam's stepfather wrote to the West SMHT C&E in July 2021 about his concern that Sam was unstable and needed help. He asked who the care coordinator was since CCO4 had left. This shows that the family were not involved in the decision to move Sam to non-CPA support. These letters are not logged as having been received in the clinical records and we found no recorded responses.

5.143 We were told by the family that Sam's stepfather went to many outpatient reviews with Sam. This was not consistently recorded.

5.144 Sam's mother and stepfather showed a great deal of care and concern for Sam, despite the history of aggression and threats. They wanted to be involved in plans for his care and they do not believe the Mid SMHTC&E made efforts to either involve the family or to assess the risk Sam posed to them. This was not in line with the practice expected by policy.

5.145 Sam's mother and stepfather were very involved in supporting Sam in the period before the homicide, particularly after his overdose in December 2021. They had information that may have highlighted the stresses and tensions that were developing in his relationship with Laura.

Partner/girlfriend perspectives

5.146 There is no evidence that efforts were made to explore the perspectives of the various partners that lived with Sam during his care at EPUT. While it is clear that Sam was not open with staff about details of his various relationships, it was known that he was cohabiting for long periods. It was also known that he had committed various offences against female partners such as coercive control, threats, social media harassment and physical assaults.

5.147 Successive CCOs were aware that he was cohabiting at times, and there were instances recorded of him attending MHLT assessments and care review meetings with a partner.

5.148 While he was under probation during 2018 and 2019 it was known that the offences were committed against either his mother or successive partners. Joint meetings were held with probation to discuss

plans, but there was no mention of the need to gather the perspectives of those with whom he was in a relationship.

5.149 There was one opportunity to engage with Laura and gain her perspective, which was during the MHLT assessment in late December 2021. It was known that he had taken the overdose in front of her, but there is no evidence of any enquiry into her perspective or feelings about this, or the effect this may have had on her.

5.150 It was noted that she said she would remove all his stored medications and arrange some support through her church. There was no enquiry into how the couple were living their lives.

5.151 His history of risk to females was very well documented, but the assessment focussed only on potential risks to himself. The presence of Laura was regarded as a protective factor, and potential risks to her were not considered at this stage.

5.152 The CPA policy reference to family and carer involvement in care planning does not include reference to partners or relationships with significant others. It is arguable that a partner or cohabiting girlfriend does not fit within the definition of “family” or “carer”. We have made a recommendation about making the aspect of family/carer involvement more inclusive.

Individual perspective

5.153 Sam told us that the greatest concern to him was his intrusive thoughts, and he was at times very distressed by his thoughts of harming others, particularly children. He told us that he had thoughts about killing a CAMHS staff member. He said this was not addressed, instead the worker was just changed. We have been unable to substantiate this claim.

5.154 He did not think he had enough support to help him manage his intrusive thoughts, although he was able to recognise the support he had been offered: care coordinator time, access to substance misuse services and input from psychological services.

5.155 Sam admitted he was not always honest with services, particularly about his drug abuse, and agreed he had been given many opportunities to be truthful about his situation. He said he had been driven by wanting more medication, especially pregabalin, and he was supplementing his prescription by buying more on the street.

5.156 Sam said he had wanted to die when he took the overdose in December 2021, because he wanted to escape the situation he was in. He was able to describe how challenging the situation was while he was living with Laura. He was using cannabis to excess and was staying indoors with her constantly. He did not reveal any details of their difficulties during the assessment at Broomfield Hospital.

5.157 It must be acknowledged that his mother and stepfather made great efforts to support them both and to give them guidance. This was not always accepted by Sam.

Service user and family involvement findings

There is little evidence of efforts being made to involve the family in care planning or risk assessment, despite the family sending letters and requesting meetings. The family did not feel involved.
Sam would have liked more direct intervention to help him with his intrusive thoughts but he acknowledged that there were offers of therapeutic input that he did not always accept.

6 Trust contribution to the domestic homicide review

6.1 The Trust completed an initial report after being told that Sam had been arrested for the homicide. The Trust was an early adopter of the new Patient Safety Incident Response Framework (PSIRF),[94] and the agreed process was to use the initial decision monitoring tool which would make a decision about the next steps.

6.2 The decision monitoring form gives a chronology of recent events and identifies the most recent care plan and risk assessments. It was agreed that an investigation was needed, but this was paused (known as 'stop clocked') on 17 February 2022 pending the police investigation.

6.3 It was later agreed there would not be an internal patient safety investigation because it was clear there would be a statutory review in the form of a DHR and a mental health homicide investigation commissioned by NHS England.

6.4 An internal management review was submitted to the DHR panel and it was shared with this NHS England investigation.

6.5 The terms of reference for the Trust's internal management review were set by the DHR and included a review of the Trust's contacts with Sam. The scope of the DHR was from January 2015 to February 2022.

6.6 The report provides a chronology of key events, Sam's engagement with services, risk events and concerns raised by his mother during that time.

6.7 The analysis of Sam's care and treatment concluded that information sharing between EPUT, probation services and the police was good during 2017 and 2018.

6.8 It was found that from 2019 to 2021 there were several instances where Trust staff should have shared information with police.

6.9 The opportunities offered to Sam and the challenge of his lack of engagement are noted, particularly in relation to the input from the psychology service and his approach to medication compliance. The report also noted that the change from CPA to non-CPA was not discussed by the MDT, and that a case with these complexities needed more consistent support than it was possible to provide through the Mid SMHTC&E duty team. It was noted that the Home First referral, after the overdose in December 2021, was not accepted because it was not clear that consent had been given.

6.10 The report made four recommendations:

1. "For discharge and pathway plans for complex cases to be discussed with the wider MDT.
2. To develop a rationale for use by the Home First team to decide whether to accept or reject a referral. This rationale should acknowledge presenting risks. Where consent has not been established before the referral, attempts should be made to seek consent.
3. To adopt a consistent approach when offering psychological services, and psychology to determine whether one-to-one or group-based treatment is best suited to service users' needs.
4. To improve communication between community mental health support and external agencies to enable better exchange of information".

6.11 We support these recommendations, although note that the fourth recommendation is very broad and would be challenging to implement and quantify. However we suggest that the issues of

[94] The PSIRF is the "*NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety*". It will replace the SIF (2015). Early adopters tested the introductory framework and their feedback informed the development of the final version of the PSIRF. https://www.england.nhs.uk/patient-safety/incident-response-framework/

consistent risk assessment and care planning that fully involve the patient and family should also be acknowledged, and we have made recommendations accordingly.

7 Conclusions

7.1 Sam had an extended period of care provided by EPUT. It was characterised by offending behaviours, including significant domestic abuse, threats to his family and others, and substance misuse. He had a troubled history from childhood and had been in contact with adult mental health services from the age of 18. Sam led a chaotic lifestyle that was interspersed with custodial sentences. His lifestyle, his frequent moves and the associated changes of GP practices made it challenging for care coordinators to maintain contact.

7.2 There is no evidence that rigour was applied to trying to understand Sam's intrusive thoughts about harming others and his thoughts of sexually harming children. References are made to these being thoughts only, and there being no evidence that he may act on them. His risk to women (including those in his family) was not sufficiently explored and/or responded to in a meaningful manner.

7.3 Treatment plans should have been underpinned by best practice guidance for the care and treatment of EUPD and OCD, and there should have been an expectation of engagement. There were missed opportunities for a forensic opinion, which could have informed a meaningful risk assessment.

7.4 If the MDT had agreed a formulation-based treatment plan that included the expectation of Sam's cooperation and engagement, there would have been an opportunity to consider if it was appropriate to continue to offer care under secondary mental health services. Because these two elements were absent, the approach was instead to react to crises, without having a longer-term plan.

7.5 Our findings focus on three main areas:

- care planning
- risk assessment
- family and service user involvement

7.6 The assessment of risk, including zoning, fell well below expected standards and risks were not identified during the period of care. We make recommendations about risk assessment and the guidance on zoning.

7.7 It is for the DHR to consider whether there were warning signs of domestic abuse that professionals could have picked up. But there was clear evidence that Sam had abusive relationships with his mother and with his intimate partners. We found an absence of curiosity about this aspect of his presentation and the related risks were not assessed. Instead the risk assessment was inaccurate and incomplete.

7.8 Plans of care should have more obviously focused on an approach to the care and treatment of someone with a diagnosis of EUPD and OCD. Plans of care were reactive and responded to crises. They were hindered by Sam's lack of engagement and were mainly concerned with the medication he was prescribed for anxiety. No formulation was agreed. A formulation could have guided the focus of his treatment; and there was no long-term planning.

7.9 We have been given a draft of a new Trust service specification for a personality disorder and complex needs pathway. We hope that some of the learning identified in this report will be incorporated into these approaches.

7.10 Sam had a very supportive family who tried to advocate for him, despite the relationship difficulties, but there is little evidence of family involvement in care planning and risk assessment.

7.11 Sam was at times very difficult to engage with and actively resisted contact. A summary of the findings is listed below:

Care planning

After each routine or urgent medical review, a letter, described as a care plan review, was sent to Sam's GP. These letters gave an update on his mental state, presentation, the agreed medication regime, a risk assessment and a summary of future plans. This is good practice.
Care plans in 2017 and 2018 lacked detail about interventions beyond support and monitoring.
Care plans developed by successive CCOs from 2019 to 2021 became focused on supporting Sam to manage his thoughts, tolerate distress and develop positive coping strategies. This is line with expected practice.
Moving from CPA to non-CPA without a care coordinator in July 2021, was not managed in line with policy guidance. There was no evidence of MDT involvement, or of a planned discussion with Sam or any of his family members.
The transfer of care from EWMHS to the Mid SMHTC&E was carried out in a planned way, with good communication of his history. Sam was invited to the transfer meeting but did not attend. There was a face-to-face meeting between the psychiatrists involved, and a CCO was allocated shortly afterward.
Transfers of care between prison health care at HMP Chelmsford and the Mid SMHTC&E were managed in line with expected practice. Both agencies communicated well. Care plans and medication prescriptions were continued, and plans were agreed before discharge.
The transfer to Mid SMHTC&E from North West SMHT when Sam moved back to Chelmsford from Harlow was managed well. Both agencies communicated well and Sam was involved in the plan. He was supported to register with a GP and find accommodation.
The Home First referral in December 2021 was rejected because they did not have Sam's consent. This decision was not based on accurate information and was not completed in line with Trust policy.
Medical reviews were carried out regularly, in conjunction with the CCOs. Clear plans were sent to the GP for prescriptions. This was in line with expected practice.
Changes to medication were discussed with Sam in response to his requests, and attempts were made to encourage him to take his prescribed medication regularly.
The presence of family members at meetings was not clearly recorded.
Sam was assessed by the psychology service in 2017 after concerns raised about his obsessive rituals. He was given a diagnosis and was offered access to psychological treatments in September 2017 and September 2020; however he was unable to engage with the service either time.
In May 2021 Sam was given a place on the PEP, which was an introduction to psychological work. There was no evidence that the policy supported this approach. Although he did not engage fully, he said he would like to continue psychological work. However, he did not follow up on the service that was offered, despite reminders and prompts.
Sam was prescribed antidepressant medication but there is no evidence of him being offered psychoeducation about his OCD diagnosis or of low-intensity interventions being offered.

Accepting that Sam was at times chaotic and inconsistent in engagement, it is not possible to evidence a multidisciplinary care plan that followed NICE guidance for EUPD. His treatment was not in line with expected practice.
Crisis plans were particularly weak. There was no constructive input beyond advice that he should attend the ED.

Risk assessment and management

The 2017 forensic referral was not followed up and the 2018 discussions about a forensic opinion were not followed through. They were missed opportunities to make a thorough assessment of his risks.
There was a lack of consistency in the recording of MDT discussions and the timing of zoning decisions. However, Trust policy does not provide clear guidance about the practice and quantifying of zoning.
The zoning system was not linked to risk assessment and management plans and it did not provide practitioners with guidance about the type and levels of intervention that could be used to reduce risk.
There was no agreed formulation or understanding of the nature and degree of risk Sam posed to others or himself. Risk assessment was not undertaken in line with Trust policy.
Admission was arranged in 2019 to provide an opportunity for a mental state assessment and medication review, but Sam was unable to take advantage of this opportunity.
Evidence of domestic abuse was not included in risk assessment and management plans.
Sam's continued substance misuse restricted the impact of supportive interventions delivered by the Mid SMHTC&E.

Service user and family involvement

There is little evidence of efforts being made to involve the family in care planning or risk assessment, despite the family sending letters and requesting meetings. The family did not feel involved.
Sam would have liked more direct intervention to help him with his intrusive thoughts but he acknowledged that there were offers of therapeutic input that he did not always accept.

Appendix A – Terms of reference

Terms of reference

The investigation is to be conducted in partnership with the DHR.

The investigation will:

1. Examine the NHS contribution to the care and treatment of the service user, from their first contact with specialist mental health services to the date of the incident.
2. Critically examine and quality assure the NHS contributions to the DHR.
3. Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.
4. Review and assess compliance with local policies, national guidance and relevant statutory obligation.
5. Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and their family.
6. Review the appropriateness of the treatment of the service user, in light of any identified health needs/treatment pathway.
7. To work alongside the DHR panel and chair to complete the review and liaise with affected families.
8. To provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or to stand alone.
9. To develop a learning document for wider circulation.

Appendix B – Glossary

ACCT	Assessment, Care in Custody and Teamwork
BMI	body mass index
CAMHS	child and adolescent mental health service
CBT	cognitive behaviour therapy
CCO	care coordinator
CJLDT	criminal justice liaison and diversion team
CPA	Care Programme Approach
CPN	community psychiatric nurse
CRS	crisis response service
DHR	domestic homicide review
ED	emergency department
EIPT	early intervention in psychosis team
EPUT	Essex Partnership University NHS Foundation Trust
EUPD	emotionally unstable personality disorder
EWMHS	Emotional Wellbeing and Mental Health Service
HDC	home detention curfew
HTT	home treatment team
IAPT	Improving Access to Psychological Therapies
IDTS	integrated drug treatment system
Mid SMHTC&E	Mid Essex Specialist mental health team, Chelmsford and Essex
MDT	multidisciplinary team
NICE	National Institute for Health and Care Excellence
OCD	obsessive compulsive disorder
PEP	Psychology Education Programme
PRN	when required ('pro re nata')
PSIRF	Patient Safety Incident Response Framework

RAR	rehabilitation activity requirement
RMN	registered mental health nurse
SMHT	Specialist mental health team
SIF	Serious Incident Framework
SSRI	selective serotonin reuptake inhibitor
TDS	three times a day
YOT	youth offending team

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