VERITA

IMPROVEMENT THROUGH INVESTIGATION

An independent investigation into the care and treatment of Mr J

A report for
NHS England, London Region

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1. Introduction

1.1 Background to the independent investigation

Mr J, a 23-year-old man, stabbed and killed Mr V in a random attack on 24 April 2014. They did not know each other. They had been travelling on the same bus; when Mr V got off, Mr J followed him and attacked him in the street. At the time of the incident Mr J was under the care of South London and Maudsley NHS Foundation Trust's early intervention service.

Mr J was arrested and later charged with murder. Mr J pleaded guilty to manslaughter on the grounds of diminished responsibility at the Old Bailey in February 2015. He was sentenced to a hospital order with restrictions and detained at a high-secure unit.

NHS England, London Region, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr J.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation may not identify root causes or find aspects of the provision of healthcare that directly caused an incident, but often finds things that could have been done better.

1.2 Overview of the trust

South London and Maudsley NHS Foundation Trust provides mental health and substance misuse services for Lambeth, Southwark, Lewisham and Croydon.

1.3 Approach to the independent investigation

NHS England, London Region, commissioned the independent investigation.

The investigation team consisted of Kathryn Hyde-Bales, senior consultant/investigator and Emily Ewart, Verita associate. Dr Martin Lock provided expert advice and undertook a review of Mr J's clinical records. From now on the investigation team will be referred to as 'we'. Our biographies are in appendix A. Tariq Hussain, associate director, peer reviewed the report. Jackie Hardy, a member of the Verita mental health advisory group also reviewed the report.

We reviewed documentary evidence (see appendix B). This included:

- national guidance;
- trust policies and procedures;
- Mr J's clinical records; and
- the trust internal investigation report.

We interviewed the following staff:

- Mr J's care coordinator (care coordinator 1);
- honorary associate specialist 1;
- clinical service team lead for the home treatment team 1;
- trust investigation facilitator 1; and
- clinical service lead for early intervention in psychosis and OASIS 1.

We could not speak to the Croydon Outreach Assessment Support Team (COAST) locum consultant psychiatrist 1 because she had left the trust. We tried to contact her via the trust but received no response.

Mr J gave us permission to review his medical records. We offered to meet Mr J to discuss our investigation but he declined. We sent him a copy of our report to comment on before publication.

We contacted the police to request copies of details of Mr J's criminal record. They gave us a 'summary of bad character', which detailed incidents for which Mr J was charged, cautioned or convicted. We contacted Mr J's GP surgery and Mr J's GP records were sent in response.

We contacted Mr J's next of kin to ask if she wished to be involved in our investigation. Although she didn't reply to our first letter, we did meet with her at the end of our investigation to share the investigation report.

We spoke to Mr V's wife at the outset of our investigation to discuss the work we would be undertaking. We later provided an update on our investigation and our subsequent findings. We would like to thank her for the information she shared with us about her husband.

We also met with one of Mr V's daughters at the end of our investigation to share a copy of the investigation report.

This independent investigation report includes a chronology outlining the care and treatment of Mr J. Analysis appears in sections 6 to 13, where particular issues and themes are highlighted.

2. Terms of reference

The aim of the independent review is to assess whether there were any gaps or deficiencies in the care and treatment that the service user received which could have been predicted or prevented the incident from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring. Specifically,

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.

- Review the progress that the trust has made in implementing the action plan.

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.

- Compile a comprehensive chronology of events leading up to the homicide.

- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.

- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.

- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.

- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.

- Where relevant to involve the public services such as the police, probation, LA in contributing to the investigation

- To review and consider if Mr J's escalating violent behaviours were integrated into effective care planning and risk management plans

- To review and consider what plans were in place to manage and monitor Mr J's compliance medication and if that had any impact on his mother

- To consider the wider safeguarding issues in relation to Mr J's family unit after several assaults

- To review and consider the decision making process of Mr J being discharged from PICU and the CRHT referral process, including escalation

- Assess the capacity and capability issues and workload concerns in the EIS team as raised by the internal report

- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

- Consider if this incident was either predictable or preventable.

- Provide a written report to the investigation team that includes measurable and sustainable recommendations.

3. Executive summary and recommendations

3.1. Introduction

NHS England, London Region, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr J, a mental health service-user.

The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. The independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident but it might find things that could have been done better.

3.2. The incident

Mr J attacked Mr V with a knife on 24 April 2014. They had been travelling independently – they did not know each other – on the same bus near Mr V's home. Mr V got off, Mr J followed him and assaulted him in a random attack. Mr V died of multiple stab wounds. Mr J was arrested the same day and later told the police he had also committed a serious assault with a knife against a member of the public[1] a few days earlier.

Mr J pleaded guilty to manslaughter on the grounds of diminished responsibility at the Old Bailey in February 2015. He was sentenced to a hospital order with restrictions and detained at a high-secure unit.

3.3. Overview of care and treatment

Mr J was first referred to mental health services in 2011. His behaviour had become increasingly bizarre, including responding to auditory hallucinations - to the point that his family had fled their home because they were concerned for their safety. He was sectioned under the Mental Health Act on 1 April 2011 and admitted to Psychiatric intensive care unit 1 (PICU). He remained on the ward until early July when he was granted leave. He was discharged from his section in September.

Mr J was first referred to the COAST (early intervention service) during his first admission. The trust website[2] describes early intervention services as:

[1] We do not know any further information about this offence.
[2] http://www.mentalhealthcare.org.uk/early_intervention_services

> "Early intervention services are specialist services, available across England (and in many other countries) that were set up to provide treatment and support for young people who are experiencing symptoms of psychosis for the first time, and during the first three years following a first episode of psychosis.
>
> Early intervention services are run differently in different parts of the country, but all aim to give young people and their families a wide range of help, treatment and support – information to help them make sense of what's happening, for example, talking therapies like family therapy and cognitive behaviour therapy as well as medication. Early intervention teams also help people get back to, or continue to, work or study, and liaise with other services and agencies to sort out benefits and finances, and help solve any housing problems."

The home treatment team[1] saw him briefly after he was discharged from hospital and before he became part of the COAST caseload. He was routinely seen by care coordinator 1 and attended regular medical reviews. Mr J complained during his medical reviews about the side effects[2] of taking olanzapine[3]. In February 2012 his medication was gradually changed to aripiprazole[4]. Mr J began a medication-free trial period in May 2012.

Mr J's mother attended the COAST office on 22 August 2012 to say she was concerned that he was showing early signs of relapse. He had a medical review on 30 August 2012 and it was agreed that the medication-free trial should continue.

Care coordinator 1 noted that Mr J's personal care was deteriorating in early October 2012 although his mood was good and he showed no signs of psychotic symptoms.

Mr J was arrested on 21 October 2012 for assaulting a member of staff at a local supermarket in South London. He was detained under Section 2[5] of the Mental Health Act (MHA) and admitted to the PICU on 23 October 2012. After his admission staff learnt that Mr J had assaulted a neighbour and was reportedly seen by another neighbour carrying a knife. During his first few weeks on the PICU, Mr J was violent towards staff and other patients and he refused medication. He was transferred to an acute ward on 14 November 2012 and discharged on 29 November 2012.

Mr J was charged on 6 December 2012 with threatening a member of the public with a knife. Witnesses did not wish to pursue the matter and the police took no further action.

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[1] Home treatment teams offer support to patients being considered for an acute admission or who are being discharged from hospital. Support is intensive and offered for a brief amount of time (e.g. 1-2 days).
[2] In the interest of patient confidentiality we have excluded any detail about these side effects.
[3] An antipsychotic
[4] An antipsychotic
[5] Section 2 of the MHA is the process by which a patient is admitted to hospital for assessment because of concerns about his or her mental health and safety (http://www.legislation.gov.uk/ukpga/1983/20/section/2)

Mr J presented well in early 2013, showing a steady recovery from his previous relapse and showed partial insight into his illness.

Mr J was arrested on 27 July 2013 after an unprovoked attack on his sister. He later assaulted a custody officer and a police officer. Mr J was detained under Section 2 of the MHA on 30 July 2013 for treatment of an acute psychotic episode. He was violent towards staff and patients during the first few weeks of his admission and required 2:1[1] observation. Mr J's Section 2 expired on 26 August 2013 and he was found to be non-detainable which meant that staff had no legal recourse to keep him on the ward. Ward staff encouraged him to stay on as an informal patient, but Mr J declined and he was discharged on 27 August 2013 when he returned to his mother's home.

Mr J was seen regularly by care coordinator 1 and for medical review during the rest of 2013. He seemed well and appeared to be taking his medication.

Mr J's mother was seen for a carer's assessment on 8 January 2014. She said Mr J had recently appeared restless and she thought he might have finished his medication. She said he seemed preoccupied and did not seem to be sleeping as well as usual. Care coordinator 1 saw Mr J on 15 January 2014. He denied hearing voices and said he was taking his medication.

Mr J was seen on 5 February 2014 by honorary associate specialist 1 and care coordinator 1. He presented as well, denied experiencing psychotic symptoms or paranoia. He said he was taking his olanzapine but continued to experience side effects. No risks were identified during the interview.

Mr J's mother told care coordinator 1 on 6 March 2014 that he was taking his medication. She described him as well and sociable. Care coordinator 1 recorded in Mr J's notes that he would write to the Recovery team[2] with a view to beginning the discharge process from the COAST.

Care coordinator 1 saw Mr J on 7 March 2014. He denied experiencing any psychosis and was given a prescription for 28 days of olanzapine.

Mr J attacked a member of the public with a knife on 6 April 2014. Trust staff and the police were unaware of this incident until Mr J confessed to it to the police after he killed Mr V.

Mr J was seen at home by care coordinator 1 on 16 April 2014. He was given 28 days of olanzapine. Mr J said he had run out of medication three to four days before, if not earlier. He denied any symptoms of psychosis. His mother said he was sleeping well and both said that Mr J was not showing any signs of relapse. Care coordinator 1 agreed he would see Mr J in four weeks and that his mother would act as a liaison in the interim.

[1] 2:1 observation requires two staff closely observe and monitor one patient.

[2] Typically, patients are discharged from the trust EIS after three years. After this they may be discharged to another service that includes the Recovery team. This team offers continuing mental health support in the community to individuals with severe mental health problems.

Mr J attacked and killed Mr V, a stranger, eight days later on 24 April 2014.

3.4. Chronology summary

Mr J was allocated to the COAST caseload in 2011 after his first inpatient admission. He remained under its care until the index offence in April 2014. The exceptions to this were when he was an inpatient in 2012 and 2013. Mr J's care was predominantly managed by his care coordinator (care coordinator 1) but he was regularly seen for medical review with a consultant psychiatrist.

3.5. Themes arising

The following sections provide our comments on and analysis of the themes outlined in the terms of reference and those we identified as part of the investigation.

3.6. Risk assessment and risk management

We found six risk assessments in Mr J's notes. We also found six brief risk screens for 2011 (three), 2012 (two) and in 2013 (one).

We note however that the risk assessments did not include a risk management and/or crisis plan; specifically, what to do in the event of Mr J's mental state deteriorating and/or an increase in the risk of violence.

The only risk management plan we found for Mr J was created when he was on the ward in August 2013. It was completed by ward staff in response to his aggressive behaviour in the PICU. The plan looked at initial safety considerations, including observation levels on the ward, use of seclusion and prn[1] medication. The management plan elaborated on this and included the possibility of psychology and occupational therapy involvement. We note that the plan did not reflect the numerous episodes of violence in the early stages of Mr J's admission. These were logged as separate incidents. We believe that this does not reflect the sheer number of risk events that occurred in a relatively short period.

The electronic patient record (epjs), includes a risk alert section. In Mr J's case this detailed two incidents – an assault charge (no further details recorded) dated 22 October 2012 and that Mr J had been charged with threatening a member of the public with a knife on 6 December 2012. This information was repeatedly recorded in Mr J's notes.

The risk summary was updated on 24 April 2014, recording that Mr J had killed a stranger. No other risk events are listed and we question the effectiveness of a repeated but incomplete risk summary. We believe it would have been more useful to include a comprehensive risk event history, including triggers, outcomes and a risk management plan. A full risk assessment (and accompanying management plan)

[1] 'Pro re nata' – prescribe as needed

should have been completed whenever there was a significant change in circumstances – in line with trust policy – but we found no evidence of this routinely happening.

Risk assessments must always lead to a risk management plan. Risk management is central to keeping the patient and others safe. In this case, it was a serious failure to not have an adequate risk management plan in place, particularly in light of Mr J's assaulting behaviour that the COAST knew about.

Finding

Mr J's risk assessments were not completed in line with trust policy.

Mr J did not have an adequate risk management plan to effectively manage the risk of his mental health deteriorating or the risk of his violence increasing. This was a serious failure in his care.

3.7. CPA and care coordination

Mr J had an inpatient care plan during his admissions in 2011, 2012 and 2013. We found evidence that these care plans were regularly reviewed during his admissions.

By contrast, we found significantly less evidence of Mr J's community-based care plans or regular review. Mr J was on the caseload of the early intervention service. This service is for service users aged between 18 and 35 who are experiencing their first episode of psychosis. We were struck by the limited information recorded in Mr J's community care plan. We found no evidence of an assessment of health and social needs, nor reference to Mr J's family beyond the role of his mother in monitoring his compliance. The care plans did not link to his risk assessments or clearly signpost what was to happen if Mr J experienced a crisis. We found two crisis plans, dated 20 June 2011 and 9 August 2012, both of which said that Mr J should contact the COAST during office hours or visit A&E out of hours. Again, these crisis plans make no reference to the safeguarding of Mr J's mother or younger siblings or what to do in the event of their safety being compromised.

'Summaries of need' were completed annually for Mr J which gave more information about his broader needs. Two further summaries were completed in parallel with Mr J's CPA review. However, the summaries of need and CPA review were not clearly linked. We found one recovery and support plan dated 28 March 2014 but it contained little information and emphasised the role of Mr J's mother in his care. The sections about contingency and crisis planning were sparsely completed and did not adequately set out what to do in a crisis.

We were struck by the generally poor quality of the records in relation to Mr J's care planning. Mr J was seen regularly and his progress notes were regularly updated but this information was not incorporated into risk assessments or an effective care plan.

Finding

Mr J's community care plans did not adequately assess and manage his health and social needs. The care plans failed to set out an integrated approach to his care and management.

3.8. Discharge planning and aftercare

Mr J was transferred or discharged to another team five times during his care. We found evidence that healthcare professionals discussed Mr J's discharge from the ward to the community. However, these were not always documented. We found good evidence that Mr J's care coordinator was involved in each of his discharges from the ward into the community.

Mr J was detained under Section 2 of the MHA for just over a month in 2013. At the time of his discharge staff were reluctant for him to leave the ward but he was assessed to be non-detainable. Mr J was encouraged by staff to remain an informal patient – which he initially agreed to do – but no bed was available locally and he decided to leave. Crucially, because Mr J's section had expired, staff could not compel him to stay and continue treatment as an inpatient.

The home treatment team (HTT) declined to be involved in Mr J's discharge from the ward to the community because he was a PICU patient. This is not HTT policy and we found no clearer reasoning for this decision. We believe that the HTT should have been involved in Mr J's discharge from the PICU in 2013. Mr J was being discharged without a period of trial leave, despite the fact his sustained period of violence on the ward had ended only three weeks earlier. The team would have provided additional support to Mr J and his mother, who was reluctant to have him home straightaway. A patient cannot be detained under Section 3 unless the relevant criteria for detention are met. The decision that he was non-detainable under Section 3 appears to have been based on his presentation at the time. There is no evidence to show whether or not wider factors were taken into consideration. Based on Mr J's records, it appears that too much emphasis was placed on the fact that he wanted to go home and not enough planning beforehand to manage the situation safely.

Findings

Healthcare professionals involved in Mr J's care discussed and oversaw his discharge from an inpatient setting to the community in 2011, 2012 and 2013 but this was not always documented in line with trust policy.

Mr J's Section 2 expired in August 2013. He was assessed at this time and found to be well enough to go home, which is what he wanted. As a result, ward staff could not detain him, despite their documented intention that he transfer from the PICU to an acute ward as an informal patient.

Mr J's records do not show whether or not any wider factors about Mr J were taken into account when he was assessed.

The HTT should have engaged with Mr J when he was discharged from hospital in August 2013.

3.9. Forensic services and MAPPA

We note that Mr J's care coordinator (care coordinator 1) was proactive in seeking the opinion of forensic services twice in relation to managing Mr J in 2011 and 2012. The risk assessment undertaken in August 2011 concluded that Mr J did not qualify for follow-up by the forensic team because his historical risk factors (which included a lack of criminal convictions) were insufficient. Our clinical adviser said many perpetrators are not prosecuted despite allegations of significant violence or other criminal behaviour, and criminal convictions alone are an unreliable indicator of risk. Equally, we note that in the months leading to his admission in April 2011, Mr J had been convicted of battery, arrested for allegedly stealing, slapped a family friend, assaulted his sister and got into fights with his brother. As an inpatient, he regularly attacked and/or threatened ward staff and patients in the first three weeks of April. The forensic service should have given these events greater significance when deciding whether to be involved in supporting Mr J.

Our clinical adviser concluded:

> "After taking all the evidence into account I am of the opinion that the psychiatric professionals looking after Mr J underestimated his risk of violence to others. I am very concerned that they easily accepted Mr J's suggestions that he remained compliant with the treatment recommendations and they did not use every opportunity available to them to try and treat Mr J with depot antipsychotic medication."

We discuss Mr J's compliance further under medicines management and compliance.

The COAST did not refer Mr J to MAPPA[1]. We accept that Mr J did not meet the criteria for the service but we believe it would have helped to liaise with MAPPA and the police to see if any of Mr J's violent incidents had resulted in a criminal prosecution or if Mr J's psychiatric illness had contributed to a case against him being dropped.

Mr J was violent as an inpatient on many occasions and repeatedly attacked or tried to attack ward staff and patients. He was also violent and unpredictable in the community on a number of occasions and threatened people with a knife more than once. After his arrest in October 2012 he attacked a police officer and a custody officer. Charges were not pursued against him on any of these occasions. The only evidence of prosecution we could find was for battery in 2011, a public offence order in 2012, and fare evasion in 2013.

[1] Multi-agency public protection arrangements

Our clinical adviser said: “Having a psychiatric illness is not a defence to criminal behaviour. It might well be used in mitigation and will almost certainly be taken into account when sentencing a person convicted of a criminal offence but it does not excuse that behaviour completely.”

We conclude that continuing engagement with the police, MAPPA and probation services would have provided the COAST with a more accurate forensic history, which in turn would have led to the development of a more effective risk management plan and care plan.

Finding

The COAST did not engage with the police or probationary services to discuss the management of Mr J. Stronger links with these and forensic services may have facilitated better risk management and a more robust care plan for Mr J.

3.10. Medicines management and compliance

Mr J’s notes clearly documented that compliance with medication was a fundamental aspect of managing his risk. The clinicians involved in Mr J’s care placed significant trust in his complying with his medication. His notes often record whether he said if he was taking his medication, but record no proof (e.g. blood tests). The notes do not say how staff assured themselves that Mr J was taking his medication.

We found limited discussion in Mr J’s notes about exploring alternative forms of treatment for him. Mr J’s transfer paperwork (to the community) in 2011 suggested that a CTO[1] was to be used but this did not happen.

It is difficult to comment on why a CTO was not used after Mr J’s 2011 discharge, given that trust staff did not detail their rationale for this decision. We note that a CTO does not ensure compliance but it would have provided a process to work with Mr J on his medication regime more assertively. The advice of our expert forensic psychiatrist was that a CTO should have been used in this case as we set out in section 9 of the report under ‘medicine management and compliance’.

We were surprised that a medication-free trial was agreed in May 2012, given the importance the forensic team had placed on Mr J’s medication compliance. We note that care coordinator 1 knew that Mr J’s compliance was an issue and presented Mr J to the Forensic Forum where the use of CTO and depot[2] was discussed. However, this was largely dismissed because Mr J was not subject to a community order.

[1] A community treatment order (CTO) is a means by which patients sectioned under the Mental Health Act receive treatment in the community subject to adherence to the conditions set, e.g., that they receive their medication in injections. The patient is not discharged from the care of his or her responsible clinician and failure to meet the conditions can lead to a patient being recalled to hospital
[2] Depot medication is medication given by injection that is slowly released into the body over a number of weeks http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/depotmedication.aspx

This ties in with the lack of engagement by trust staff with the police and probationary service. It is reasonable to assume such engagement would have facilitated an open discussion in relation to the management of Mr J, particularly around prosecuting his criminal activity and the options this would have presented to clinical staff.

Findings

Clinical staff did not assure themselves adequately that Mr J was taking his antipsychotic medication.

Mr J's care coordinator (care coordinator 1) tried several times to explore different treatment options for Mr J but these were never implemented.

Collectively, clinical staff did not adequately explore alternative options to giving Mr J oral antipsychotic medication.

Clinical staff placed too much responsibility on Mr J's mother to monitor his compliance with antipsychotic medication.

At the time of Mr J's discharge from hospital in 2011, it would have been appropriate to put a CTO in place to try to help his compliance with treatment recommendations.

3.11. Safeguarding

Mr J had a history of violence that at times encroached into the family home, leading to at least one instance when the family fled the family home because they were worried for their safety. We found no evidence to suggest that the COAST ever considered Mr J's younger siblings to be at risk. Mr J's notes record that his younger siblings were not considered to be at risk but the rationale for this decision was not documented in the notes.

Fundamentally, we found no documented evidence of any discussion by the COAST with other agencies and/or teams in relation to the children's welfare. Similarly, we found no evidence to indicate that the COAST considered the risk that Mr J posed to his mother. We found no evidence of domestic violence but we believe that the team's risk assessment of this possibility was inadequate.

The failure to engage with other agencies and/or teams about the welfare of Mr J's family was a missed opportunity for the team to test its assessment of Mr J's risk to them.

The team placed too much responsibility on Mr J's mother, expecting her to accommodate him after inpatient stays and monitoring his compliance. This in turn could have created difficulties in their relationship. Despite this, we note that care coordinator 1 had a good relationship with Mr J's mother and provided support to her after the index offence.

Findings

The COAST did not undertake adequate safeguarding assessments of Mr J's siblings, which left them potentially at risk.

Healthcare professionals involved in Mr J's care underestimated the risk he posed to his family and others, which left them potentially vulnerable and at risk.

Care coordinator 1 proactively supported Mr J's mother during her son's care and after the index offence in April 2014.

3.12. Predictability and preventability

We consider the homicide would have been predictable if there had been evidence from Mr J's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time.

Mr J was seen by honorary associate specialist 1 or care coordinator 1 once a month between January and April 2014. In each appointment he was noted to be well and nothing untoward was recorded in his notes, though it was noted on 9 January and 16 April that he had run out of medication.

Care coordinator 1 last saw Mr J on 16 April. He said he had run out of medication 'three or four days ago' though it was probably before this. He denied any signs of psychosis and said he was sleeping well – which his mother confirmed. Care coordinator 1 wrote in the notes "No relapse signs evidence such as closing certain doors obsessively". Mr J was given a four-week prescription for olanzapine.

Mr J was seen by members of the COAST in 2014 and noted to be well. He had not voiced any explicit threats to others in the months leading to the incident, and there was no evidence that he had been violent towards others or destroyed property. Both the team and the police were unaware of the incident on 6 April 2014 when he had stabbed a member of the public.

He had a history of violence, the risk for which increased when he was unwell. A number of incidents occurred, with varying degrees of severity, before each of his inpatient admissions.

We conclude that it could reasonably have been predicted based on his history that Mr J might be violent at some time but the timing, the severity and the target of his violent behaviour were not predictable.

Effective risk assessment and risk management plans, robust care plans, using different treatment options and better engagement with other services such as the police might have reduced the risk of Mr J's violent behaviour. We cannot conclude though that this would have prevented the incident on 24 April 2014. The trust had

no knowledge at the time that he intended to cause harm to anyone, any indication of impending violence and therefore no legal reason to detain him.

Findings

We find that, although it could have been predicted that Mr J would be violent again, the timing, the severity and the target of his violent behaviour were not predictable.

We find that the death of Mr V could not have been prevented by healthcare professionals involved in Mr J's care but the risk may have been reduced.

3.13. The trust internal investigation report

The trust internal investigation used a root cause analysis (RCA) approach in line with trust policy and met its terms of reference. It highlighted areas of good practice and concerns around service delivery. However, we believe that restricting the scope of investigation (from August 2013 until the index offence) limited the exploration of some areas that would have been helpful to investigators in terms of both context and action (not) taken. We believe that the internal investigation could have explored some areas in more depth, including safeguarding and Mr J's forensic history. The investigation should have explored the implications of the mental health homicide and wider learning for the trust.

Finding

The trust internal investigation addressed its terms of reference but could have explored some areas in more depth. This might have helped identify broader lessons for trust staff.

3.14. The trust's progress against the internal investigation recommendations

The trust internal investigation identified three areas for improvement: resourcing of the COAST, medication compliance and carer's assessment. The trust action plan detailed four recommendations in response to these. The trust showed progress against these recommendations, including improved resourcing to the COAST. However, work is not complete and requires continuing monitoring.

Finding

The trust has made some progress completing the action plan but some work goes on, without a completion date.

3.15. Recommendations

The COAST service managers must undertake a case note audit to assure themselves that service user records are being completed in line with trust policy. This audit should assess risk assessment, and care planning.

Service managers must ensure that service user records are completed in line with the trust discharge policy.

The trust should assure itself that the correct systems are in place to enable staff to readily access advice from trust forensic services.

The trust should assure itself that guidance and information is available to frontline staff in relation to engaging with the police and probationary services.

The trust should assure itself that it has appropriate support and guidance in place for staff to explore treatment and management options for high risk service users.

The trust should assure itself that members of the COAST understand and can effectively implement the trust safeguarding policy as part of their assessment of patients, their families and/or carers.

4. Chronology of care and treatment

4.1. Background

Mr J was born in 1990, the third of seven children. Mr J has minimal contact with his father. Before his first admission in 2011 he lived with his mother and two of his siblings - a half-sister and a half-brother, both minors. The records indicate that Mr J described his childhood as ok with no history of domestic violence or abuse. His family had no known history of psychiatric or physical health problems.

Mr J attended college in London to study electronics though was later expelled.

4.2. 2011

Mr J's family noticed in January 2011 that he began to stay up late and could be heard apparently responding to voices in his room. He became preoccupied with checking and rechecking items, e.g. that the front door was locked. He became possessive of the family laptop and taped his bedroom windows shut. He pushed his wardrobe against his bed and kept kitchen knives[1] under his bed.

Mr J's family said that he had become increasingly aggressive, rude and argumentative over the same period. He was expelled from college the same month for fighting with another student. He was charged for the assault and in February[2] pleaded guilty to battery at Magistrates Court 1. He received a six-month community order and was fined £25.

Mr J's family contacted his GP on 30 March 2011 to report that he was displaying increasingly bizarre and aggressive behaviour. They said that slowly become unwell over several years, though more in recent months; the previous night they had fled to a neighbour's home because they feared for their safety. They said that he was responding to auditory hallucinations and showed signs of self-neglect. Mr J was said to have walked naked into the front room of the family home and slapped his mother's friend. He reportedly returned later "sniggering and laughing".

Mr J's GP sent an urgent referral to the community mental health team (CMHT). The GP outlined that Mr J's mother had serious concerns and had called the police but they could not attend without a risk assessment. She remained afraid to return to the family home, concerned that he would attack her. She had arranged for her younger children, aged four and ten, to stay with their aunt. The GP further outlined that Mr J had attacked another sister when she was pregnant, had punched his brother and recently shoplifted. These incidents were undated in the referral.

The GP concluded "it appears that [Mr J] is suffering from a psychosis which has probably gradually worsened over time and has now gotten to a point where he is seriously unwell and posing a risk to others."

[1] Later described as butter knives.
[2] In Mr J's 'summary of bad character' from the police, it is recorded that this incident happened on 24 November 2011.

Mr J's notes show that his GP had contacted the police who were willing to undertake a visit in accordance with the Mental Health Act. Arrangements were made to transfer Mr J to South London and Maudsley NHS Foundation Trust by ambulance for assessment. The police attended the assessment.

Mr J was admitted to the psychiatric intensive care unit 1 (PICU) at South London and Maudsley NHS Foundation Trust on 1 April 2011 under Section 2 of the MHA. This was his first admission. CT1 A wrote in Mr J's notes that apart from trying cannabis, his family did not think he abused drugs or alcohol, though he did later refuse to provide a urine sample for drug screening.

CT1 A noted during Mr J's mental state exam (MSE) on admission that "[Mr J] appeared to be suffering from a first presentation of a paranoid psychotic illness. This could turn out to be Schizophreniform in nature, although there is no objective evidence to exclude substance use as a causative factor. The evidence for a psychotic illness is largely collateral and based on a history of auditory hallucinations, persecutory beliefs, bizarre and aggression."

Mr J was violent, suspicious and paranoid during the admission. He attacked another patient and tried to attack staff. There were four instances on the ward in April when he was violent or tried to be violent towards staff or patients. He spent time in supervised confinement. He was started on olanzapine[1] and fluoxetine[2].

Mr J's Section 2 expired on 28 April 2011, when he was detained under Section 3[3] of the MHA. The clinicians who assessed him for this noted respectively, "He [Mr J] has said that he will stop all medication, rendering him vulnerable to relapse as such early days in his treatment regime" (manager 1) … "lacks insight into his health problems and the need for treatment" (consultant psychiatrist 2)… "he needs to be on Section 3 of MHA… to facilitate further treatment, as well as move on to an open ward, and he needs a proper care plan…"

Mr J was transferred from the PICU to an acute ward on 19 May 2011. His notes on 27 May 2011 say that staff should contact the police if Mr J was discharged from hospital: "This is according to the police a public order offence with crime reference…" The notes also say that the police had attended the ward that morning to discuss this. Mr J began taking periods of Section 17[4] leave on 31 May 2011.

Mr J appealed against his detention and a first-tier (mental health) tribunal was to be held on 18 August 2011. His care coordinator (care coordinator 2) highlighted in her report to the tribunal of 12[5] May 2011 that Mr J had said he probably would not take his medication after being discharged into the community. She wrote "I believe there

[1] An antipsychotic.
[2] An antidepressant.
[3] Section 3 of the MHA can be used after a Section 2 has expired. It can also be used if a patient is known to mental health services and does not need to be assessed for Section 2. A Section 3 is used when a patient is admitted to hospital for treatment (http://www.legislation.gov.uk/ukpga/1983/20/section/3)
[4] Section 17 leave is a leave of absence from hospital granted to a patient subject to Section under the MHA http://www.legislation.gov.uk/ukpga/1983/20/section/17
[5] The care coordinator resubmitted her report on 15 June after a meeting with Mr J's mother.

is a propensity for [Mr J] to disengage with services and default on his current medication, which could lead to further deterioration in his mental state" and concluded that Mr J required further detention in hospital under Section 3 of the MHA.

The clinician's report (dated 2 June 2011) to the tribunal described Mr J as suffering from a paranoid psychotic illness. It also highlighted Mr J's intention to not take medication in the community and the need for him to remain an inpatient.

He was seen for supported early discharge by the home treatment team (HTT) on 21 June 2011. Mr J was accepted for Section 17 leave under the HTT.

Mr J was seen by the HTT and early intervention psychosis team (COAST) on 30 June 2011. The HTT member of staff recorded in Mr J's notes "[Mr J] feels that reports in his noted [sic] that he heard voices and was noted to be talking to himself etc is not true…. Felt he didn't have mental health problems that it was unlikely to happen to him again and that he was better now". The teams wrote to Mr J's GP and said that Mr J was in the early stages of recovery after a first episode of psychosis. He was discharged from the HTT to COAST (and still under Section 17 leave) on 5 July 2011. He remained on fluoxetine and olanzapine.

COAST locum consultant psychiatrist 1 and care coordinator 3 saw Mr J for medical review on 25 July 2011. His mother was also present. Mr J presented as "guarded, suspicious and distrustful". The consultant noted that Mr J was compliant with medication and mental health services because he was subject to a MHA section. She added that a CTO[1] should be considered at the next review.

COAST locum consultant psychiatrist 1 saw Mr J again on 1 August 2011 for a medical review. He was noted to be well and compliant but the consultant attributed this as "clearly only due to Section 3".

COAST referred Mr J to forensic services in August 2011. Senior clinical psychologist 1 wrote in her report on behalf of the forensic service, dated 16 August 2011: "On consideration of the relevant risk factors it was decided that [Mr J] does not meet criteria for the forensic team due to relatively low number of historical risk factors". Mr J continued to be seen regularly in the community by the COAST.

Mr J's mental health tribunal took place on 18 August 2011. It concluded that Mr J should continue to be subject to detention so he was not discharged from the Section 3.

COAST locum consultant psychiatrist 1, AHMP 1 and care coordinator 1 saw Mr J for medical review on 12 September 2011. He appeared well and was told by COAST locum consultant psychiatrist 1 and care coordinator 1 that it was intended that his section would be rescinded. COAST locum consultant psychiatrist 1 wrote in

[1] A community treatment order (CTO) is a means by which patients sectioned under the Mental Health Act receive treatment in the community subject to adherence to the conditions set, e.g. that they receive their medication in injections. The patient is not discharged from the care of his or her responsible clinician and failure to meet the conditions can lead to a patient being recalled to hospital.

the notes that a CTO was not appropriate to manage Mr J at that time. We discuss this further in the report under 'medicine management and compliance'.

Mr J had a medical review on 23 September 2011. He was seen by COAST locum consultant psychiatrist 1 and AHMP 1. Mr J gave mixed messages, initially saying he would not take any more medication after he was discharged and would not attend appointments but later saying that if the tribunal recommended continuing treatment, he would prefer to engage in services voluntarily as opposed to being subject to legal compulsion. The consultant wrote in Mr J's plan that his medication would be reduced and his Section 3 rescinded if he was compliant.

Mr J attended another medical review on 11 October 2011. COAST locum consultant psychiatrist 1 noted that his mood was stable and no evidence of relapse but added that Mr J's compliance with medication needed to be closely monitored.

Mr J was seen again on 5 December 2011 by COAST locum consultant psychiatrist 1 and his care coordinator. He was well and compliant with his medication. He told the consultant he was experiencing side effects as a result of the medication. Consequently, the consultant made a plan to slowly change Mr J's medication to aripiprazole.

4.3. 2012

In January 2012 Mr J pleaded guilty at magistrate's court to using threatening, abusive, insulting behaviour with intent to cause fear. He was given a conditional discharge and charged £10 in costs.

Mr J was seen by COAST locum consultant psychiatrist 1 and care coordinator 1 on 2 February 2012. He seemed well and the consultant recorded: "Excellent recovery is ongoing. No risk to self or others evident. Compliant with medication and reviews."

Care coordinator 1 undertook an emergency visit[1] to see Mr J on 15 February 2012. He had been contacted by Mr J's housing support worker, who had concerns about Mr J's welfare. Mr J had told the support worker that he had dropped out of college and appeared to be neglecting his personal care. He seemed well, though his clothes were dirty. He appeared to be taking his medication as prescribed and said he was happy to finish his olanzapine supply before switching to aripiprazole.

Mr J was seen on 27 February 2012 by COAST locum consultant psychiatrist 1 and his care coordinator (care coordinator 1). He appeared well and compliant, though he was no longer at college[2]. Mr J said he continued to experience side effects with the olanzapine and that he preferred the aripiprazole, from which he did not experience side effects. The olanzapine dose was reduced to 5mg daily and the aripiprazole increased to 10mg po mane (orally in the morning).

[1] The COAST routinely undertook home visits to see Mr J while he was part of their caseload. These included some joint visits with the housing support worker.
[2] It is unclear when Mr J returned to college after being expelled in January 2011.

Mr J presented as well at the next medical review on 14 May 2012. The consultant wrote in the notes "Excellent recovery is ongoing but maintenance dose of antipsychotic stopped leaving him potentially at higher risk of relapse. No risk to self or others evident". A medication-free trial began.

Mr J failed to attend a medical review on 18 June 2012. COAST locum consultant psychiatrist 1 noted that Mr J's care coordinator (care coordinator 1) was trying to contact Mr J and his housing support officer but the team had not been alerted to any concerns/relapse indicators.

Mr J attended a medical review on 28 June 2012 with COAST locum consultant psychiatrist 1, care coordinator 1 and the housing support worker. Mr J was well – "Good recovery ongoing with no evidence of heightened risk for self or others".

Mr J appeared well during a home visit on 22 August 2012. However, his mother visited the COAST the same day without an appointment to say she was concerned he was showing early signs of relapse.

COAST locum consultant psychiatrist 1 noted that Mr J remained well at his medical review on 30 August 2012. COAST locum consultant psychiatrist 1 decided that Mr J's medication-free trial would continue. She noted that Mr J's care coordinator (care coordinator 1) would continue to monitor him for signs of relapse.

Mr J's care coordinator contacted his housing support officer on 1 October 2012. The housing support officer said Mr J's personal care was poor. Care coordinator 1 undertook a home visit the next day. Mr J's mood appeared good and he showed no signs of psychotic symptoms. A medical review was scheduled for 25 October 2012.

Mr J was arrested on 21 October 2012 for assaulting a member of staff at a supermarket in South London. He was referred to the AMHP (approved mental health practitioner) service the next day for assessment. Mr J was assessed in custody under the MHA and placed on Section 2. He assaulted a detention officer and a police officer while in custody.

His mother told staff that he went to her home the day before. He was unsociable and isolated himself. He did not eat and appeared restless. She later heard about the incident at the supermarket and told hospital staff that he had been arrested before his first admission in 2011.

Ability Housing[1] contacted the COAST on 22 October 2012 to give details about Mr J's arrest. Care coordinator 1 wrote in Mr J's notes that he had reportedly been involved in an incident over the weekend and it was alleged that Mr J had assaulted a neighbour and had been carrying a knife. Mr J had to be restrained and the police were called[2].

[1] Ability housing provides housing and support services to individuals with mental health needs, learning disabilities, physical or sensory impairments in London and South England (http://www.ability-housing.co.uk/about-us/)

[2] It was later reported that the police were unaware that a knife had been involved and the neighbour did not wish to press charges.

Mr J was admitted to PICU 2 at a hospital in Hertfordshire on 23 October 2012. Mr J was violent to other patients, ward staff at the hospital, and he refused medication.

Mr J's admission paperwork noted "Possibly has referential delusions and auditory hallucination to which he is responding, very poor insight".

Care coordinator 1 wrote to the forensic team while Mr J was in the PICU (the letter is undated). The letter said Mr J's brother had said Mr J's behaviour had become noticeably bizarre since January 2011 and outlined events leading to his first admission that April. The letter added: "My particular concern with working with [Mr J] is that his mental state is very difficult to assess. Prior to relapse I had seen [Mr J] but there were no obvious signs of psychosis". The letter goes on to note concerns from the housing officer in relation to cleanliness and says: "It is obvious now that there was [sic] subtle signs of deterioration in mental state prior to his recent relapse: disorganisation, poor hygiene, untidy, an angry outburst about changes in fees".

Care coordinator 1 concluded his letter by asking to present Mr J to the forensic team. He added that Mr J was trialling depot[1] medication (details below) and queried whether a CTO would be necessary given that Mr J had been compliant with his medication in the community before his psychiatrist agreed it could be stopped.

Mr J was treated with olanzapine as an inpatient. He refused oral medication on the PICU and was started on clopixol[2] depot 100mg, which was subsequently changed to 300mg weekly but this was stopped shortly after. His notes on 21 November say: "Had clopixol depot 300mg IM last on 13th Nov according to epjs[3] and was due on 20.11.12". An undated entry on his prescription chart says "Dose needs to be reviewed with pharmacy before being given due to concerns with tachycardia". It was agreed at a ward round on 22 November that the depot would be stopped.

Mr J was transferred from the PICU to an acute ward on 14 November 2012 and discharged on 29 November 2012. He left the ward the next day. He went to the HTT and subsequently COAST.

The Forensic Forum[4] was held on 20 November 2012. Care coordinator 1 attended. Consultant psychiatrist 3 wrote to care coordinator 1 on 5 December 2012. He noted that the services had exchanged correspondence about Mr J after his last admission. The letter outlined the forum discussion including Mr J's history, treatment options and issues related to his compliance, noting that Mr J was refusing to accept depot medication but agreed to remain on the ward informally. It said: "We agreed that were he to remain on oral antipsychotic medication, that this would likely need to be supervised in order to ensure compliance, and discussed whether his current accommodation could provide the necessary supervision or whether he might need to move to a higher supported and more closely supervised living arrangements". The letter further alluded to discussion around Mr J appearing in court in connection

[1] Depot medication is medication given by injection that is slowly released into the body over a number of weeks http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/depotmedication.aspx
[2] An injectable anti-psychotic.
[3] Electronic patient journey system.
[4] The Forensic Forum is a forum where staff can present patients to forensic services to discuss care and treatment options.

with an assault and the implications this might have for his treatment (e.g. compulsory hospital admission). No arrangements were made for the team to see Mr J.

Mr J was charged on 6 December 2012 after threatening a member of the public with a knife at a supermarket the day before. Witnesses did not wish to take the matter further and no further action was taken.

Mr J was seen for medical review on 10[1] December 2012 by COAST locum consultant psychiatrist 1. He presented as well and was happy to continue taking olanzapine. He attributed his recent relapses to alcohol abuse. Mr J admitted that he was afraid and aggressive when he was first admitted to hospital but did not recall hearing any voices, thought interference or further symptoms while an inpatient. COAST locum consultant psychiatrist 1 said the plan was for Mr J to continue on olanzapine, be subject to continuing medical review and regular monitoring.

4.4. 2013

COAST locum consultant psychiatrist 1 and care coordinator 1 saw Mr J for medical review on 7 February 2013 in the context of his CPA. His mother was present. Mr J was friendly and cooperative. He did not exhibit signs of psychosis and COAST locum consultant psychiatrist 1 noted that his recovery continued. Mr J remained on olanzapine, which he and his mother said he continued to take.

Mr J's next medical review took place on 30 April 2013. He was seen by honorary associate specialist 1 and care coordinator 1. Mr J seemed calm and cooperative. Honorary associate specialist 1 wrote in the notes "Steady recovery from his last relapse. He showed partial insight into the nature of his illness and the factors that predispose to relapse". Mr J agreed to continue taking olanzapine.

Mr J attended the COAST office unexpectedly on 10 June 2013 to request another prescription. He told care coordinator 1 that he had lost some of his medication. He denied any symptoms of psychosis. Mr J was given another prescription for olanzapine.

A further prescription was issued on 12 July 2013.

Mr J was seen for medical review on 17 July 2013 by honorary associate specialist 1. She wrote to Mr J's GP to say that Mr J remained asymptomatic and showed good insight into his illness. He denied experiencing psychotic symptoms and thought there was a small risk of relapse. Mr J said that he was taking olanzapine, though he was experiencing side effects. She suggested that Mr J might wish to explore with his GP pharmacological options to treat the side effects.

Mr J was arrested on 27 July 2013 for an unprovoked attack on his sister. He assaulted a custody officer and a police officer while he was in custody. The section 12 doctors who assessed Mr J noted: "Patient has established diagnosis of paranoid

[1] The letter to Mr J's GP was dated 11 December.

schizophrenia and has been stable until three days ago when his mental state deteriorated rapidly… he repeatedly assaulted medical staff and others unprovoked [sic] and during assessment he appears perplexed, distracted at times and admits to have [sic] command auditory hallucinations[1] and some derogatory in nature".

Mr J presented with command auditory hallucinations and there was some evidence of passivity phenomena[2].

The assessing doctors concluded that Mr J was unpredictable, a high risk to others and needed to be detained under Section 2 of the MHA for further assessment and management.

Mr J remained in custody for 72 hours before being admitted to the PICU at Hospital 1 in south London on 30 July 2013 for treatment of an acute psychotic episode. His notes say his risk to others was high.

Mr J hit or tried to hit members of staff on a number of occasions during his first two weeks on the ward and he required 2:1 observation. The notes say Mr J said he was responding to command voices. He improved around 16 August 2013 and said the voices he was hearing had disappeared. Mr J said on 23 August 2013 that he was experiencing side effects of his medication. He said that he had experienced this in the past and it was one reason he did not take his medication.

Mr J's Section 2 expired on 26 August 2013, when he could no longer be detained. Staff discussed the option of going to an open ward with Mr J but he declined and said he felt well enough to go home. Mr J was discharged on 27 August 2013 with TTOs ('to take out' medication) and CMHT follow up. His discharge paperwork noted that he had a historical risk of assault to members of the public, his family and health professionals when he was unwell. His risks reduced when he took his medication. It also noted that Mr J's mother would supervise his medication at home.

Care coordinator 1 contacted the ward on 28 August 2013 to say Mr J had been discharged without all his belongings or his medication. He went to the ward later that day to collect his belongings but his medication was not available. A member of the inpatient nursing staff wrote in the ward notes that Mr J had already received it. Mr J assured the nursing staff that he would check again and would contact his care coordinator if necessary.

Mr J attended a seven-day follow-up appointment with care coordinator 1 and honorary associate specialist 1 on 3 September 2013. He appeared well with no evidence of psychopathology and was bright in mood. His signs of relapse were checking things in response to paranoid ideas, poor sleep and irritability. Honorary associate specialist 1 agreed that Mr J would continue with olanzapine 10mg BD, be regularly monitored by his care coordinator (care coordinator 1) and reviewed again in a few months.

[1] Mr J later denied hearing command hallucinations.
[2] The belief of being under the control of others, either physically or emotionally

Mr J met his care coordinator (care coordinator 1) on 14 October 2013 to discuss his Employment and Support Allowance (ESA) appeal. Mr J appeared bright in mood and displayed no psychotic symptoms.

Mr J was seen for medical review by care coordinator 1 and honorary associate specialist 1 on 23[1] October 2013. Mr J presented as well and bright in mood. He denied experiencing paranoid delusions or perceptual abnormalities. Mr J appeared to have good insight into the nature of his illness and his treatment. He had been taking his medication even though he continued to experience side effects. He had not taken olanzapine for two days because his prescription had run out; he had occasionally missed the morning dose and taken two tablets at night. He was willing to continue with his current dose of 20mg a day. It was agreed that care coordinator 1 would continue to see Mr J regularly.

Mr J was issued with prescriptions for olanzapine on 6 November and 3 December 2013. Mr J saw care coordinator 1 on 6[2] December 2013. The appointment was brief because Mr J wanted to leave but he said he remained happy with 20mg of olanzapine and showed no signs of psychosis.

4.5. 2014

Care coordinator 1 spoke to Mr J's mother on 2 January 2014. She said Mr J was well with no sign of relapse (e.g. awake at night or obsessively closely connecting doors in the house). She said he took his medication in front of her about three days a week.

Mr J was issued a prescription for olanzapine 20mg (for five weeks) on 8 January 2014.

Care coordinator 1 undertook a carer's assessment with Mr J's mother on 8 January 2014. She reported that Mr J had recently been restless and had probably finished his medication. The last time he had taken his medication in front of her was the previous week. She said that he had been talking to himself recently and did not seem to be getting to sleep as easily as usual; he seemed a bit preoccupied recently. They discussed whether Mr J might meet the criteria for Asperger's Syndrome. He seemed unconcerned that he had hit his sister before his previous admission and lacked awareness that he had upset her. Care coordinator 1 planned to discuss this with the COAST. Mr J's mother was given his prescription for five weeks medication.

Care coordinator 1 phoned Mr J on 9 January 2014. Mr J said that he had gone two days without medication – in between prescriptions – and had some trouble sleeping. He denied hearing voices or experiencing paranoid ideas. Mr J said he had not seen his GP about the side effects he was experiencing as a result of taking the olanzapine. They arranged to meet on 13 January 2014 and a medical review was scheduled for 28 January 2014.

[1] A letter was sent to Mr J's GP about this appointment on 11 February 2014.
[2] Mr J had attended the COAST office the previous week for an appointment but his care coordinator was on annual leave.

Mr J failed to attend the appointment on 13 January 2014. Care coordinator 1 contacted his mother on 15 January 2014. She said she did not think Mr J was experiencing mental state problems. Mr J could be heard in the background saying he thought the appointment was that day. He subsequently attended the appointment 90 minutes late. He appeared bright and engaging. He denied hearing voices and said that he was taking his medication. Care coordinator 1 discussed Asperger's Syndrome with Mr J who declined an assessment.

Mr J failed to attend a medical review on 29 January 2014.

Care coordinator 1 spoke to Mr J's mother on 31 January 2014. They discussed Mr J's debts. She said that she had seen Mr J take his medication three days ago but otherwise he had been sleeping or she was busy.

Honorary associate specialist 1 and care coordinator 1 saw Mr J for medical review on 5 February 2014. Mr J presented as well and denied experiencing psychotic symptoms or paranoia. He said that he had been taking the olanzapine, even though he continued to experience side effects. He said he had not missed any doses in the last month and felt that olanzapine was the right treatment for him. Mr J was happy to continue taking olanzapine. The notes say: "No acute psychotic symptoms noted. No risks identified during the interview. He [Mr J] is showing good insight into the illness and he is willing to continue with current treatment. The lack of structured activities is one of the main concerns at the moment". Honorary associate specialist 1 planned that Mr J would continue on 20mg olanzapine and be subject to regular monitoring of side effects of the medication and regular review with care coordinator 1.

Care coordinator 1 spoke to Mr J's mother on 6 March 2014. She said he was still taking his medication. She described him as well and sociable. Care coordinator 1 wrote in the notes that he would write to the Recovery Team to start the discharge process.

Care coordinator 1 wrote to Recovery team 1 on 6 March 2014 to say that Mr J had nearly completed his three years with COAST and requested that Mr J be transferred to Recovery team 1. Care coordinator 1 wrote that Mr J was compliant with his medication and he would require little input provided this continued. He added that Mr J had experienced relapses in the past and could become violent when he was ill so he needed continuing care coordinator input.

Mr J attended an appointment with care coordinator 1 on 7 March 2014. He was given a prescription for 28 days' olanzapine. He denied experiencing any psychosis.

Mr J attacked a member of the public with a knife on 6 April 2014. Clinical staff (and the police) were not aware of the incident until Mr J later admitted what he had done when he was detained for the index offence. He later pleaded guilty to attempted murder.

Care coordinator 1 undertook a home visit on 16 April 2014. He gave Mr J 28 days' olanzapine. Mr J said he had run out of medication three or four days earlier, if not

longer. He denied any symptoms of psychosis. Mr J and his mother confirmed that he was sleeping well. They said Mr J was showing no signs of relapse, such as closing the door obsessively. Care coordinator 1 decided that Mr J would be reviewed in four weeks and that his mother would act as liaison until then.

Mr J attacked and killed a stranger, Mr V, on 24 April 2014. They had been travelling on the same bus. Mr J followed Mr V when he got off and stabbed him repeatedly.

He did not present with psychotic symptoms when later assessed.

Mr J pleaded guilty to manslaughter on the grounds of diminished responsibility in February 2015. He was detained indefinitely under the Mental Health Act.

4.6. Themes arising

In the following sections of the report we provide our comments on and analysis of the themes outlined in the terms of reference and those that we have identified as part of our investigation.

The themes are:

- risk assessment and risk management;
- CPA and care coordination;
- discharge planning and aftercare;
- forensic services and MAPPA;
- medicines management and compliance;
- safeguarding; and
- predictability and preventability.

5. Risk assessment and risk management

This section examines Mr J's forensic history to ask whether it was appropriately taken into account in the risk assessment and risk management process. Mr J's risk is considered throughout this report, particularly under the section entitled 'safeguarding'.

National policy requires that risk assessment and risk management be at the heart of effective mental health practice. Risk management should be an integral aspect of CPA. The outcome of risk assessment should feed back into the overall clinical management.

National best practice guidance in managing risk in mental health services (Department of Health, 2007[1]) sets out three risk factor categories. These are:

1. static factors – these are unchangeable, e.g., a history of child abuse or suicide attempts;
2. dynamic factors – factors that change over time, e.g., misuse of drugs or alcohol; and
3. acute factors or triggers – these change rapidly and their influence on the level of risk may be short-lived.

The trust *Clinical risk assessment and management of harm* (2011[2]) policy defines clinical risk assessment as "the process of assessing whether or not, and in what circumstances, a person may harm themselves or others (or be harmed)."

The policy details a number of risk areas that should be taken into account. They include capacity, behaviour that causes concern, repetitive acts and the effect of delusions or hallucinations on daily life.

The policy defines clinical risk management as:

> "a multi-disciplinary process which normally includes service users and/or their carers. All involved collaborate to identify potential clinical risks, as well as service user's strengths, in order to agree, and then implement, a management action plan to manage the risks whilst optimising use of the service user's own strengths to promote his/her recovery."

The policy says patients subject to CPA should have a care coordinator who is responsible for ensuring that risk assessments are completed and contemporary. It says a full risk assessment should be undertaken:

- "where completion of the brief risk screen indicates that further more detailed assessment (full risk assessment is required);
- at the first and every subsequent CPA review;
- when there is a significant change in circumstances for example;
    - on admission

[1] There has been no new national guidance issued in relation to risk assessment after 2007
[2] The trust updated this policy in 2015.

    - when moving between services
    - when commencing shared care
    - when granting leave
    - on discharge
- at the request of another agency e.g. a day centre, or housing association;
- at times of known high-risk for example:
    - during the post discharge period following a depressive episode
    - when facing new personal or family responsibilities or challenges
    - following disclosure by the service user about something of concern (e.g. domestic violence or abuse)
    - whenever there are concerns."

It adds:

> "Risk management that is directly informed by the risk assessment should form part of the patient's care plans aiming to change the balance between risk and safety…"

It says a HCR-20 form should be used for:

> "All service users admitted to the medium secure unit in-patient wards under the care of the Behavioural and Developmental Psychiatry Clinical Academic Group should have a HCR20 risk assessment completed within three months of admission."

The policy further says:

> "Following an incident, the service user's care should be reviewed with the senior clinician/practitioner/manager and the service user's risk management plan and care plans revised accordingly."

5.1. Analysis

A HCR-20 is a 20-item checklist to assess the risk of future violent behaviour in criminal and psychiatric populations. It includes variables that capture relevant past, present and future considerations and should be regarded as an important first step in the risk assessment process. The manual provides information about how and when to conduct violence risk assessments, research on which the basic risk factors are based and key questions when making judgements about risk.

Senior clinical psychologist 1 and care coordinator 3 completed a HCR-20 for Mr J on 16 August 2011. Mr J was not present during the assessment. It identified his previous violence, first violence at a young age and major mental illness as historical items. Lack of insight and active symptoms of mental illness were highlighted under clinical items and risk management identified 'non-compliance with remediation attempts'. Under clinical factors/evidence around lack of insight, the assessment concluded that Mr J's insight was limited, adding, "previously he [Mr J] made it very clear that he did not believe himself to have mental health problems, either currently or historically. Within interviews he often presented as guarded and suspicious".

The HCR-20 highlighted that Mr J's explanations for his aggressive behaviour "suggest that he does not accept responsibility for his behaviour and that he views aggression as an acceptable strategy for dealing with frustration and conflict, for example, incidents in which he feels insulted, disrespected or victimised". Senior clinical psychologist 1 wrote that this should be explored further.

The HCR-20 also included strategies that could be implemented to manage Mr J's risk of violence. These included more exploration of triggers and coping strategies, anger management strategies and CBT[1] for psychosis. These treatment strategies were considered and documented as part of the assessment but were not implemented as part of a risk management plan or acted upon and reviewed to consider their effectiveness.

This was the only instance when a HCR-20 was completed, despite the recommendation that it be regularly reviewed and updated: "The HCR-20 should be reviewed at regular periods or in the event of deterioration in his mental state". However we note that senior clinical psychologist 1 did not say who should be responsible for reviewing the HCR-20 and the trust told us that its early intervention teams do not have specialist training in completing HCR-20 assessments. Specialist training can be made available (if needed) however the current process is that early intervention teams should refer to forensic services for input. With this in mind we would encourage the trust to assure itself that staff are clear who is responsible for ensuring that an HCR-20 assessment is updated.

No further psychological intervention took place in relation to Mr J's psychotic illness or his view that aggression was acceptable under certain conditions. The exception to this was a psychological assessment on 21 August 2013 during Mr J's third admission. The trust told us "individual psychotherapy and family therapy is regularly offered to our clients. These interventions are only possible if they agree". We found no evidence in the notes that Mr J was offered psychological input other than this occasion.

We found six risk assessments in Mr J's notes. We also found six brief risk screens for 2011 (three), 2012 (two) and in 2013 (one).

Care coordinator 1 undertook Mr J's first risk assessment on 20 June 2011. Another took place in September of the same year. Further risk assessments were undertaken in September and November (two) of 2012. Mr J's last risk assessment took place on 30 April 2013.

The April 2013 risk assessment included Mr J's own view on his current risk. It noted that risk to others was considered high and that Mr J's compliance with medication remained a problem. However, the risk assessment does not include a risk management and/or crisis plan - specifically what to do in the event of Mr J's mental state deteriorating and/or an increase in the risk of violence.

[1] Cognitive behavioural therapy

The only risk management plan we found for Mr J was created when he was on the ward in August 2013. It was completed by ward staff in response to his aggressive behaviour in the PICU. The plan looked at initial safety considerations, including observation levels on the ward, use of seclusion and prn (prescribed as needed) medication. The management plan elaborated on this and included the possibility of psychology and occupational therapy. The plan does not reflect the numerous episodes of violence in the early stages of Mr J's admission. These are logged separately. We believe that this fails to reflect the sheer number of risk events that occurred in a relatively short period.

A risk alert section was repeated on all epjs entries, most recently on 24 April 2014, reporting that Mr J had killed a stranger. Mr J's charge of threatening a member of the public with a knife on 6 December 2012 and an assault charge (no further details recorded) on 22 October 2012 were also recorded. No other risk events were listed and we question the effectiveness of a repeated but incomplete risk summary. We believe it would have been more useful to include a comprehensive risk event history, including triggers, outcomes and a risk management plan. A full risk assessment (and accompanying management plan) should have been completed whenever there was a significant change in circumstances – in line with trust policy – but we found no evidence that this happened routinely. Examples of when Mr J's risk assessment should have been fully reviewed include when he was violent in October and December 2012, when he assaulted his sister in July[1] 2013, his subsequent admission to hospital the same month, and when he was discharged in August 2013.

We explore under safeguarding (section 10) healthcare professionals' assessment of the level of risk Mr J posed to others.

Risk management is central to keeping the patient and others safe. In this case it was a serious failure by the COAST omitting to having an adequate risk management plan in place, particularly in light of Mr J's assaultive behaviour that the team was aware of.

5.2. Finding

Mr J's risk assessments were not completed in line with trust policy.

Mr J did not have an adequate risk management plan to effectively manage the risk of his mental health deteriorating or the risk of his violence increasing. This was a serious failure in his care.

5.3. Recommendation

The COAST service managers must undertake a case note audit to assure themselves that service user records are being completed in line with trust policy. This audit should assess risk assessment and care planning.

[1] A brief risk screen was completed on 30 July 2013.

6. CPA and care coordination

This section examines whether Mr J met the criteria for CPA and whether he was allocated a care coordinator. We also examine the effectiveness of Mr J's care plan and whether he and his family were involved in care planning.

Regulation 21 of the Health and Social Care Act 2008[1] (Regulated Activities) Regulations 2010[2] states:

> "(1) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of -
>
> a) an accurate record in response of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user…"

We asked the trust to provide us with a copy of the CPA policy in place at the time of Mr J's care. They gave us two versions of the policy, dated 2008 (due for review in 2011) and 2015. The trust confirmed that these were the only policies in force.

The trust policy (2008) sets out the criteria for patients being put on CPA (e.g. severe mental disorder, current or potential risk, current or significant history of severe distress). It also highlights the central role of the care coordinator in managing patients subject to CPA. The care coordinator is responsible for "ensuring all the appropriate assessments are completed and updated as necessary and entering them on EPJS".

The policy gives details of what should be considered as part of the care plan including a "thorough assessment of their [the patient's] health and social needs."

The policy outlines a number of aspects of the role of the care coordinator, including ensuring "crisis and contingency plans are clear and accessible for the clinical team". It further details what should be taken into consideration when making an assessment of a number of areas including mental state, psychiatric history and social function and family relationships. The policy also highlights:

- "Degree of risk and dangerous and safeguarding of children and adults
- Identification of any precipitating factors to breakdown"

The CPA policy emphasises the importance of risk assessment and notes:

- "consideration of risk to a child should [sic] if the service user is responsible for or in contact with children

[1] On 1 April 2015 the CQC essential standards of quality and safety were replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have referenced the 2010 regulation because it was in place at the time the trust was overseeing Mr J's care and treatment.
[2] http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf

- Where risk concerns are identified consideration must be given as to whether procedures for protecting children and the public should be triggered. Please refer to the trust MAPPA, child and adult protection procedures.
- Members of the MDT should be aware of the underlying risk factors for suicide/homicide…"

It further outlines a number of clinical indicators for assessing violence, including a history of violence, problems with controlling a temper, poor compliance and altercations with the police.

The policy notes that care plans should be subject to regular review and updated frequently:

> "Formal reviews, involving the service user and, if appropriate the carer(s), will continue to take place at regular intervals and should be agreed between the service user, care coordinator and other members of the team. The frequency will depend on the service user's needs and circumstances… At each review meeting the date of the next review should be set and recorded. There may be occasions in between formal reviews when more urgent action is needed…"

The COAST is an early intervention service designed to provide support to patients aged between 18 and 35 who are experiencing their first episode of psychosis.

The COAST Croydon Early Intervention in Psychosis Service operational policy (2013) describes its core aims as:

> "To provide a comprehensive and intensive needs led mental health service to the client group, which focuses on their emotional and developmental needs, particularly the impact of first onset psychosis on individuals and their families. The developmental needs of younger clients will be addressed through promoting age appropriate social contacts and reintegration into mainstream occupation, training, and education provision."

It adds:

> "COAST provides early ongoing support to the individual and the family of people who have experienced or are experiencing a first episode of psychosis. Uses integrated treatment interventions including:
>
> - Medical treatments
> - Cognitive Behavioral [sic] Therapy approaches
> - Problem-Solving techniques
> - Educational Material / Psycho education
> - Social Inclusion Group programme
> - Emphasis on engagement with a difficult to engage client population
> - Family interventions."

6.1. Analysis

Mr J met the criteria for CPA and had a care coordinator. Care coordinator 1 told us he was first asked to assess Mr J during his first admission in 2011. The initial assessment took place on 9 June 2011 after which Mr J was taken on to the team caseload. Mr J's care coordinator changed briefly during the summer of 2011 but care coordinator 1 was his substantive care coordinator after this time.

Mr J's first care plan was dated 1 April 2011, following his admission to the PICU on a Section 2. There is evidence in the notes that the care plan was reviewed regularly during this admission. We found further evidence of inpatient care plans when Mr J was admitted in 2012 and 2013.

By contrast, we found significantly less evidence of Mr J's community-based care plans or regular review. We found two care plans written when Mr J was in the community, dated 2 August 2011 and 30 November 2012. Care coordinator 3 completed the 2011 care plan. The care plan summary detailed that Mr J's mental state, risk and compliance should be monitored every two weeks. It also said that Mr J's mother would monitor his compliance with his medication. The care plan did not record a date for the next review. The 2012 care plan was completed as part of Mr J's discharge to the community. It set out the role of the HTT to visit Mr J daily and facilitate handover to the COAST. A date for review was not recorded.

We were struck by the limited information recorded in Mr J's community care plans. We found no evidence of an assessment of health and social needs, nor reference to Mr J's family beyond the role of his mother in monitoring his compliance. Care coordinator 1 told us that Mr J would not engage in any structured community activities (beyond college) and it was difficult to discuss this with him because he did not want to talk about it.

Mr J's care plans did not link to his risk assessments or clearly signpost what action should be taken in the event of Mr J experiencing a crisis. We found two crisis plans, dated 20 June 2011 and 9 August 2012, both of which said that Mr J should contact the COAST during office hours or visit A&E out of hours. Again, these crisis plans make no reference to the safeguarding of Mr J's mother or younger siblings and what to do in the event of their safety being compromised. We explore this further under 'safeguarding'.

We did however find that 'summaries of need' were completed annually – and twice (August 2011 and February 2012) in parallel with a CPA review. These gave more information about Mr J's broader needs. The summary of needs reflected Mr J's living arrangements, his family and history of violence, though again both summaries of need recorded 'no risk concerns' in relation to his family. Though the summaries of need were completed in parallel with the CPA review, a link between the two was not signposted in either set of documents.

Though not reflected in Mr J's care plans, we found evidence of care coordinator 1 and the local authority engaging in relation to Mr J's housing in 2012 (when he was not living with his mother). The progress notes show a dialogue between care coordinator 1 and the housing officer (e.g. she contacted him when she had

concerns about Mr J's welfare). The housing officer undertook home visits with care coordinator 1 and attended Mr J's medical review in June 2012.

We found one recovery and support plan dated 28 March 2014. It contained little information (e.g. "Trigger: stopping medication; Coping strategy: start medication again") and emphasised the role of Mr J's mother in his care. The sections in the form about contingency planning and crisis planning are sparsely completed and do not adequately set out plans (e.g. the section entitled 'what you can do in a crisis' is empty).

We were struck by the poor quality of the records in relation to Mr J's care planning. Mr J was seen regularly and his progress notes were regularly updated however this information was not incorporated into risk assessments or an effective care plan.

Care plans are central to mental health practice. Mr J had relatively high risk factors. Furthermore, a psychologist had suggested he needed psychological intervention and support. The COAST regularly visited Mr J and monitored his medication compliance. We believe that the early intervention service could have done more to help Mr J develop coping mechanisms and prevent mental deterioration. We found no evidence of an integrated treatment approach as set out in the team operational policy.

6.2. Finding

Mr J's community care plans did not adequately assess and manage his health and social needs. The care plans failed to set out an integrated approach to his care and management[1].

[1] See recommendation under 5.3

7. Discharge planning and aftercare

This section considers whether Mr J's three discharges from inpatient facilities into the community were appropriate and managed in line with trust policy.

We reviewed the trust discharge and transfer policy (2011) in place at the time of Mr J's care[1]. The policy outlines the roles of individual practitioners (e.g. consultant psychiatrist, care coordinator etc) in facilitating a patient's transfer or discharge. It goes on to distinguish the differences in the process according to whether the patient is under CPA or not, emphasising the role of the care coordinator in the case of the former.

The policy says that a pre-discharge meeting should take place before a patient is discharged, but notes that if the patient is being discharged from the ward to the HTT exceptions can be made:

> "The home treatment team (HTT) often accepts service users at short notice and the process is best considered as a 'modified discharge' in that it is often not possible to have arranged a pre-discharge meeting. This might then take place in the community prior to discharge from the HTT to the community team."

The policy says that for planned discharges:

> "a multi-disciplinary pre-discharge meeting should be held, which for service users detained under the relevant sections of the Mental Health Act will constitute a 117 after-care meeting. If on CPA, this will be a CPA review meeting."

The policy adds that a discharge care plan should be developed which includes details of how to notice and manage a relapse.

The policy further outlines tasks that should be undertaken in relation to community transfers (e.g. HTT to COAST). These include requesting a transfer in writing and holding a pre-transfer meeting.

The trust CPA policy (2008) also refers to discharge:

> "The period around discharge from hospital is a particularly high risk of suicide. This emphases the need for proper assessment prior to discharge and effective follow-up afterwards. Service users should be seen within seven days of discharge."

The HTT operational policy (2013) says:

> "The service will provide a short-term community based treatment and care package aimed at facilitating the recovery process for those people who have

[1] A new transfer and discharge policy was implemented September 2015.

been assessed to need hospital admission. This includes people assessed for formal detention in hospital."

It adds that the HTT will:

> "The service will facilitate early discharge from inpatient care, offering a community-based alternative to hospital treatment."

7.1. Analysis

Mr J was transferred or discharged[1] to another team on five[2] occasions during his care:

- April 2011, Mr J was referred by the CMHT to the COAST
- June 2011, Mr J was discharged (early) from the PICU by the HTT
- July 2011, Mr J discharged from the HTT to the COAST
- October/November 2012, Mr J was transferred from the PICU to an acute ward and subsequently discharged to the COAST
- August 2013, Mr J was discharged from the ward to the COAST

We found evidence of a discussion among healthcare professionals about Mr J's discharge from the ward in 2011. We found no ward discharge plan, though Mr J was granted Section 17 leave in June and remained on this until 12 September when he was discharged from his Section 3. He was under the care of the COAST at this stage and a risk assessment was conducted on 14 September.

We found no evidence of a pre-discharge meeting for Mr J in November 2012. However, we found a number of entries in his progress notes by different practitioners – medical, nursing and HTT - in relation to his discharge. Mr J's discharge was discussed at a multi-disciplinary team (MDT) ward round on 4 December 2012. We found no evidence of a risk assessment being undertaken in the community to coincide with Mr J's discharge, though care coordinator 1 completed a child need and risk screen on 6 December 2012.

Inpatient staff were reluctant for Mr J to leave the ward in 2013. The ward notes detail discussions between Mr J and the healthcare professionals in relation to his inpatient stay. During medical review on 23 August 2013 it was recorded:

> "Patient has expressed a wish to be detained in order to continue care under current clinical team. No grounds to continue to detain him under MHA… continue to assess over the bank holiday weekend. If there are any incidents that might indicate need for detention under the MHA then to call AMHP/S12 dr [sic] for assessment"

[1] The trust policy defines the 'transfer' of a patient as when they are moving community or inpatient teams; 'discharge' refers to moving from the ward to the community (or from the trust entirely, to another provider or primary care).

[2] In November 2012 there was another occasion when the HTT intervened in Mr J's care. Equally in March 2014 steps were being taken to transfer Mr J from the COAST to Recovery team 1. This transfer did not happen before the index offence.

On the morning of August 26 it was recorded in Mr J's notes:

> "[Mr J] will need a mental state assessment when his section expired [sic] if he refused to stay as an informal patient. Staff to contact duty doctor."

Staff were keen for Mr J to transfer from the PICU to an acute ward but his Section 2 had expired and he wanted to go home. He initially agreed to be transferred to an acute ward as an informal patient but the only available bed was out of the area and he did not want to go. Mr J wanted to leave the ward when his section expired at midnight on 26 August 2013 but ward staff decided it was inappropriate to discharge him from the PICU without a period of observation. ST1 A on call wrote in the notes at 7.45pm:

> "Hopefully he [Mr J] will be asleep and it won't be a problem but if the patient does demand to be discharged it will be necessary to sign a section5 (2) until he can be assessed tomorrow by his consultant."

The on-call duty doctor saw Mr J later that night. She wrote in the notes at 11pm:

> "Agrees to stay in hospital for a few weeks as mental state stabilises… patient has expressed a wish to be detained in order to continue care under current clinical team. No grounds though to continue to detain him under MHA. This should be kept under review."

ST1 A detailed Mr J's mental state exam (MSE) in the notes and added:

> "I discussed the above [Mr J's MSE] with [SpR on call] and we both felt it was advisable for him [Mr J] to remain on the ward to be reviewed by his team tomorrow. I explained my concerns with [Mr J] and that in the morning a clear plan could be put into place, the diazepam reducing regime put into place, consideration of HTT etc. and that was much more difficult to arrange out of hours. Initially he was happy with this plan, but then said he would actually prefer to go home."

Mr J agreed to spend the night on the ward but chose to leave the next day. A PICU discharge summary was completed in 27 August 2013.

Mr J's section had expired and staff could not compel him to stay on the ward and continue treatment as an inpatient. They had to let him leave.

Care coordinator 1 told us he had hoped that Mr J would remain on the ward where other treatment/management options could be considered. He had hoped Mr J would be placed on a Section 3. He thought that pressures on beds and the absence of the usual consultant (who was on leave) hampered the situation. He told us that he had hoped Mr J would at least have a discharge CPA and it was a shock that he was discharged so quickly:

> "There was talk of him going to a bed outside the trust, but then I think he pushed mum until mum said okay, I can take you back, but not on the ward, suddenly he's home, and that felt like a shock, back to square one, really."

Mr J's notes show that the HTT declined to be involved during the August discharge because he was a PICU patient. No further explanation was recorded in the notes. We found no reference in the HTT policy to PICU patients being an exception. We asked the clinical service team lead[1] of the HTT about this. She confirmed it is not – nor was it - policy for the HTT to refuse PICU patients though it was rare for a patient to be discharged straight from the PICU into the community. She added that it was possible that the team and the ward discussed this, even though it is not recorded in the notes.

The HTT should have been involved in Mr J's discharge from the PICU in 2013 given his risk and forensic history. HTTs are essentially an extension of hospital wards and this is particularly important given that Mr J was discharged from a PICU – an intensive care unit for psychiatric patients. The team would have provided additional support to Mr J's mother who was reluctant to have him home straight away. Mr J was being discharged without a period of trial leave, despite the fact his sustained period of violence on the ward had ended only three weeks earlier.

A patient cannot be detained under Section 3 unless the relevant criteria for detention are met. The decision that Mr J was not detainable under Section 3 appears to have been made based on his presentation at the time. There is no evidence to show whether or not any wider factors were taken into consideration. Clinicians involved in Mr J's discharge appear to have placed too much emphasis on the fact he wanted to go home and not enough planning beforehand to manage the situation safely.

There is good evidence in the notes that Mr J's care coordinator was involved in each of his discharges from the ward into the community.

Mr J's notes say that he told his care coordinator 1 on the day of his discharge that he did not have his medication. Care coordinator 1 checked this with Mr J's mother who did not know. He made arrangements for a prescription be made available to Mr J if he could not find his TTAs (the medication he was meant to take home from the ward).

The notes do not make clear whether or not Mr J was given his medication. The notes say:

> "[Mr J's care coordinator] called about 13:40pm about [Mr J] who was discharged yesterday. He stated that there was not TTa given to him and some of his personal belongings are still here, and he will send him back to collect the above. [Mr J] came about 15.20 and got his phone and red comb, but his TTa was really giving [sic] to him and he promised to check his bag properly and he will get back to us if he is unable to find it, his care coordinator will give him his daily medications".

Mr J's notes contain no further information about this.

[1] The clinical service team lead for the HTT spoke to us in the capacity of her role – she had not personally encountered Mr J when he was under the care of the trust.

7.2. Findings

Healthcare professionals involved in Mr J's care discussed and oversaw his discharge from an inpatient setting to the community in 2011, 2012 and 2013, but this was not always documented in line with trust policy.

Mr J's Section 2 expired in August 2013. He was assessed at this time and found to be well enough to go home, which is what he wanted. As a result, ward staff could not detain him, despite their documented intention that he transfer from the PICU to an acute ward as an informal patient.

The HTT should have engaged with Mr J when he was discharged from hospital in August 2013.

7.3. Recommendation

Service managers must ensure that service user records are completed in line with the trust discharge policy.

8. Forensic services and Multi-agency public protection arrangements (MAPPA)

This section examines whether the healthcare professionals responsible for Mr J considered and adequately explored the role of the trust forensic service and MAPPA in his care and management.

8.1. Forensic services

Community forensic team 1 aims "to provide assessment, treatment, rehabilitation and aftercare to those service users with a mental disorder and associated offending behaviour". The team protocol (2010) outlines the criteria for engaging with service-users, which includes service-users who have committed or have the potential to commit offences that include:

- homicide;
- attempted homicide;
- grievous bodily harm; and
- wounding with intent.

The protocol says service-users may be subject to a probation order, continuing judicial proceedings, MAPPA or multi-agency risk assessment conference (MARAC).

It says the team will not usually engage with service-users who have committed lesser offences, except when the offence indicates escalating risk.

The COAST asked community forensic team 1 to assess Mr J in August 2011. Senior clinical psychologist 1 met with care coordinator 3 twice to undertake a structured risk assessment using HCR-20 to assess whether Mr J met the team's criteria. Senior clinical psychologist 1 deemed that Mr J did not meet the criteria for the service because of his relatively low number of historical risk factors. The assessment noted a strong risk of Mr J becoming non-compliant with treatment recommendations.

Forensic services recommended that COAST use the HCR-20 to understand and monitor Mr J's risk. It advised that the HCR-20 should be reviewed regularly and in the event of Mr J's mental health deteriorating.

Care coordinator 1 presented Mr J's case to the Forensic Forum on 20 November 2012. His referral letter to the Forensic Forum he had said "My particular concern with working with [Mr J] is that his mental state is very difficult to assess. Prior to his relapse I had seen [Mr J] but there was no obvious signs of psychosis".

The forum noted the link between Mr J's psychotic symptoms and the risk of his assaulting others, including possibly using weapons. The forum highlighted the importance of Mr J taking antipsychotic medication as a means of managing his risk.

A number of treatment options were discussed including the use of depot and the options potentially available to the COAST if Mr J was detained.

Mr J had a history of violence that included:

2011

- Punching a student – he was subsequently convicted of battery
- Slapping a family friend in the face
- Undated allegations of punching his brothers and slapping his sister
- Numerous attempts to attack staff and patients when an inpatient in April

2012

- Threatening and abusive behaviour
- Assaulting a member of staff at a supermarket
- Assaulting a neighbour with a knife
- Threatening a member of the public with a knife at a supermarket

2013

- Unprovoked attack against his sister
- Numerous attempts to assault patients and staff when an inpatient in August

8.2. Analysis

Mr J's care coordinators tried to seek the opinion of forensic services in relation to managing Mr J, in 2011 and in 2012. The risk assessment undertaken in August 2011 concluded that Mr J did not qualify for follow up by the forensic team because his historical risk factors, which included a lack of criminal convictions, were insufficient. Our clinical adviser said many perpetrators were not prosecuted despite allegations of significant violence or other criminal behaviour, and using criminal convictions as an indicator of risk could not be relied upon. In the months leading to his admission in April 2011, Mr J had been convicted of battery, arrested alleged theft, slapped a family friend, assaulted his sister and got into fights with his brother. As an inpatient he regularly attacked and/or threatened ward staff and patients in the first three weeks of April.

Our clinical adviser concluded:

> "After taking all the evidence into account I am of the opinion that the psychiatric professionals looking after Mr J underestimated his risk of violence to others. I am very concerned that they easily accepted Mr J's suggestions that he remained compliant (we discuss this further under medicines management and compliance) with the treatment recommendations and they did not use every opportunity available to them to try and treat Mr J with depot antipsychotic medication."

Care coordinator 1 told us he hoped the Forensic Forum would take Mr J onto its caseload in November 2012:

> "It was helpful, I guess, to talk about him, but frustrating that even if they're high risk, they don't take them until they're done something really bad, which is illogical almost".

Reading consultant psychiatrist 3's summary of the Forensic Forum, we were struck that it appeared to play down Mr J's risk. For example, Mr J attacked someone with a knife but the victim "incurred a superficial laceration to his hand only; Mr J was hoarding "items described as butter knives", though we accept that this may simply reflect author's writing style.

8.3. MAPPA

MAPPA manages the risk posed by the most serious sexual and violent offenders. The police, probation and prison services and other agencies are brought together to share information so that risk assessments and risk management plans can be put in place.

There are three categories[1] of offender under MAPPA criteria:

> "Category 1 – Registered sexual offender
>
> Category 2 – Murderer or an offender who has been convicted of an offence under Schedule 15 of the Criminal Justice Act and:
> - who has been sentenced to 12 months or more in custody; or
> - who has been sentenced to 12 months or more in custody and is transferred to hospital under s.47/s.49 of the Mental Health Act 1983 ("MHA 1983"); or
> - who is detained in hospital under s.37 of the MHA 1983 with or without a restriction order under s.41 of that Act.
>
> Category 3 – Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for an offence under Sch.15 of the CJA 2003."

8.4. Analysis

The COAST did not refer Mr J to MAPPA. We accept that he did not meet the criteria for MAPPA (though he had a history of violence which was known to the team) but we believe that this was a missed opportunity to discuss him with MAPPA professionals. It would have been useful for the team to liaise with MAPPA and the police to see if any of his violent incidents had resulted in a criminal prosecution or if Mr J's psychiatric illness had contributed to a case being dropped. Care coordinator 1 told us he had had minimal contact with the police and it was only since working in other teams that he had learnt about MARAC.

[1] http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

Mr J was an inpatient at the time of the Forensic Forum held in 2012. He had been admitted to the PICU in October after an alleged assault. He assaulted a police officer and custody officer at the time of his admission. His notes say he assaulted ward staff and patients while on the PICU. Mr J was violent and unpredictable on a number of occasions when he was admitted in July 2013 after assaulting his sister in an unprovoked attack. Charges were not pursued against him on any of these occasions. The only evidence of prosecution we could find was for battery in 2011, a public offence order in 2012, and fare evasion in 2013.

Our clinical adviser said: “Having a psychiatric illness is not defence to criminal behaviour. It might well be used in mitigation and will almost certainly be taken into account when sentencing a person convicted of a criminal offence but it does not excuse that behaviour completely”.

We conclude that continuing engagement with the police, MAPPA and probation services may have provided the COAST with a more accurate forensic history; which in turn would have led to the development of a more effective risk management plan and care plan.

8.5. Finding

The COAST did not engage with the police or probationary services to discuss the management of Mr J. Stronger links with these and forensic services may have facilitated better risk management and a more robust care plan for Mr J.

8.6. Recommendation

The trust should assure itself that the correct systems are in place to enable staff to readily access advice from trust forensic services.

The trust should assure itself that guidance and information is available to frontline staff in relation to engaging with the police and probationary services.

9. Medicine management and compliance

This section examines how trust staff managed Mr J's medication and ensured his compliance. We assess whether they adequately explored the different methods of monitoring and assuring compliance.

NICE (2009) guidance (CG82[1]) about the treatment and management of psychosis and schizophrenia outlines a number of factors that should be taken into consideration when reviewing treatment options and different medications (this guidance was updated in 2014[2]).

The trust has a medicine management policy (2010[3]). The appendices contain a section on compliance aids and include advice on how to improve concordance for example:

> "Ensure the client has been given information on their medication and understands why they have been prescribed it, when it should be taken and the importance of compliance."

Mr J's clinical notes make early reference (May 2011) that compliance with medication was a fundamental aspect of managing his risk. The chronology often notes his reluctance or refusal to take his medication on the ward and in the community. Clinicians in turn were aware of this and of a need to manage the risk.

Mr J gave clinicians mixed messages about whether he was prepared to take his medication in the community. He told COAST locum consultant psychiatrist 1 in September 2011 he would not take medication nor engage with mental health services after he was discharged but he also said that if his mental health tribunal recommended continuing treatment, he would prefer to engage voluntarily.

Mr J frequently complained that he experienced side effects when taking olanzapine and said this was why he stopped taking it. His clinician gradually changed his medication in early 2012 to accommodate this. Mr J began a medication-free trial in May 2012, though COAST locum consultant psychiatrist 1 noted that this placed him at higher risk of relapse. Mr J's mother raised concerns in late August 2012 that he was relapsing and he was later readmitted to the PICU on 23 October 2012.

Mr J was clear during some assessments that he did not wish to keep taking his medication because he did not believe he was mentally ill. In others, he would agree that olanzapine was the best treatment for him. His level of insight into his illness varied. Some clinicians described him during appointments as lacking insight whereas during others he was noted as having 'good insight'. A risk screen completed on 30 November 2012 noted: "… his [Mr J's] insight into his illness is very poor, he does not believe he has a psychotic illness."

[1] http://www.iris-initiative.org.uk/silo/files/updated-2009-nice-schizophrenia-guidance-cg-82.doc
[2] https://www.nice.org.uk/guidance/cg178
[3] The policy was updated in 2012 and 2014 but we have referred to the policy in place at the time of Mr J's first admission and his medication free trial period that began in Spring 2012.

Mr J was given a trial of clopixol depot during his inpatient admission in November 2012 as a result of his refusal to take oral medication. However, this was stopped the same month because of concerns that he was experiencing tachycardia (an abnormally high heart rate). Ward staff intended that Mr J would have an ECG[1] to explore this before the depot was continued. However a ward round took place on 22 November 2012 and SHO 1 recorded in the notes: "Informal and not consenting to depot yesterday…doesn't like the depots. Keen to stop them. Happy with tablets… Stop depot".

The clinical notes contain no further reference to the use of depot but the Forensic Forum explored prescribing options if Mr J was subject to a community order.

9.1. Analysis

The clinicians involved in Mr J's care placed significant trust in his compliance with his medication. The notes regularly noted whether Mr J said if he was taking his medication or not, though no concrete evidence (e.g. blood test) was recorded. Care coordinator 1 told us that Mr J refused to provide blood tests. Mr J had the capacity to refuse blood tests and there was no legal recourse available to care coordinator 1 to enforce a test.

The notes do not clarify how staff assured themselves that Mr J was taking his medication. They may have checked bottles or packets of medication to see whether the correct dose was being consumed. This would be no guarantee - patients can easily discard medication. Staff may have seen Mr J swallowing medication, though this again is not a guarantee of compliance. Care coordinator 1 told us that it was difficult to check Mr J's medication because he would often refuse checks.

COAST locum consultant psychiatrist 1 wrote to the GP on 11 October 2011 outlining a medical review she had undertaken with Mr J: "No evidence of relapse with ongoing recovery suggested but compliance needs to be closely monitored… he has little insight". The plan from the meeting was that Mr J be given a month's prescription and that care coordinator 1 continue to monitor his mental state and liaise with Mr J's mother. This fell short of a plan for monitoring compliance.

We found limited discussion in Mr J's notes about exploring alternative forms of treatment for him. Mr J's transfer paperwork in 2011 suggested that CTO was to be used but it was not. Mr J had been detained under Section 3 of the MHA therefore a CTO could be considered as a treatment option.

The HCR-20 completed by senior clinical psychologist 1 in August said "consider CTO for future management in the community". Medical reviews on 25 July, 1 August and 23 September of the same year each included a plan that a CTO would be considered. The reason for this postponement/lack of decision was not documented.

[1] Electrocardiogram – a means of measuring the muscular and electrical activity of the heart

COAST locum consultant psychiatrist 1 wrote to Mr J's GP on 13 September 2011 outlining a medical review with Mr J: "CTO not appropriate/needed to manage his care" but again, no reason was given.

Our clinical adviser commented:

> "I accept the care coordinator does appear to have seen Mr J on a very frequent basis but I fail to understand how the staff could have persuaded themselves that Mr J was as compliant with taking the medication as they believed he was."

Trust staff did not record why they did not use a CTO after Mr J was discharged in 2011 so it is difficult to comment on their decision. Nevertheless, we considered whether a CTO would have been an appropriate means of managing Mr J's compliance. A CTO does not ensure compliance but it would have provided a process to work more assertively with Mr J on his medication regime. Our clinical adviser said:

> "It is very difficult to know from the documentation available why a community treatment order was not used in Mr J's case. In my opinion one should have been used in order to see whether that might have helped with his compliance with treatment recommendations."

We were surprised that a medication-free trial was agreed in May 2012, given the importance the forensic team had placed on Mr J's medication compliance.

We acknowledge that care coordinator 1 was aware Mr J's compliance was an issue and presented him at the Forensic Forum in November 2012 but this appeared to be a largely academic exercise and no substantial assistance was offered. The forum briefly discussed the use of CTO and depot medication but this was largely dismissed because Mr J was not subject to a community order.

Care coordinator 1 wrote in Mr J's notes:

> "Forensic recommendations focused on [Mr J's] compliance with medication. Its [sic] possible that if he is prosecuted for his assault on the shop assistant at [supermarket] then Probation could work with his compliance with medication and us. His care team need to identify ways of monitoring compliance with medication; finding a tolerable medication (with min side effects); a placement with medication compliance support or a care package with compliance support needs to be considered. [Mr J] needs a lot of psychoeducation."

This ties in with the lack of engagement by trust staff with the police and probationary services in relation to Mr J's criminal behaviour. We cannot say what the outcome of such engagement would have been but we believe it is reasonable to assume that it would have facilitated open discussion in relation to the management of Mr J. In particular, around prosecuting his criminal activity and the options that this in turn would have presented to clinical staff e.g. insisting that Mr J took depot antipsychotic medication.

Care coordinator 1's clinical notes on Mr J and our interview with him left us with the impression that he had tried many times to treat Mr J in different ways (e.g. dosette box[1]), but he was left with few implementation options. He told us he had hoped the Forensic Forum would put Mr J on its caseload but despite the fact he was high risk, he was not deemed violent enough to meet its criteria. Care coordinator 1 had hoped that a CTO would be considered but it was not implemented.

Care coordinator 1 told us that Mr J was discussed at the team meetings and during supervision:

> "… we didn't come up with any other solutions other than the usual; monitor his mental state closely, make as much effort to support Mum in watching him, watching him take medication and monitoring his medication, look out for relapse signs. I obviously talked things through quite a bit with his doctor, [honorary associate specialist 1], but we didn't come up with any plans that I can remember alternative to the ones we had."

We note that Mr J's mother was asked to monitor his medication compliance. She had been asked to do this before - for example, during Mr J's medication free trial in May 2012. She was not always able to do it. Our clinical adviser said:

> "…it is not reasonable to expect family members to do that [monitor compliance]. It can result in tension between family members which may even lead on to physical aggression, and family members cannot be expected to ensure the medication is actually swallowed and not regurgitated."

Care coordinator 1 told us he would have preferred Mr J to be in a supported placement (not the family home) where his compliance could have been monitored more closely. However, he thought Mr J took his medication:

> "… he seemed to take medication, there seemed to be lots of indications he would take medication. He'd turn up for his script, he'd turn up on time, he'd tend to put on a bit of weight. His mum wouldn't see him taking medication at times, but medication stocks disappear, he'd say he was taking it, and that sort of thing."

Honorary associate specialist 1 told us she was confident that Mr J was taking his medication during the period she saw him (from July 2013) because he asked for new prescriptions, and complained about side effects. His mother was also assured he was taking his medication.

9.2. Findings

Clinical staff did not assure themselves adequately that Mr J was taking his antipsychotic medication.

[1] A container for medication that is divided into compartments by date and time.

Mr J's care coordinator tried several times to explore different treatment options for Mr J but these were never implemented.

Collectively, clinical staff did not adequately explore alternative options to giving Mr J oral antipsychotic medication.

Clinical staff placed too much responsibility on Mr J's mother to monitor his compliance with antipsychotic medication.

At the time of Mr J's discharge from hospital in 2011, it would have been appropriate to put a CTO in place to try to help his compliance with treatment recommendations.

9.3. Recommendation

The trust should assure itself that it has appropriate support and guidance in place for staff to explore treatment and management options for high risk service users.

10. Safeguarding

This section considers whether the healthcare professionals responsible for Mr J appropriately considered the welfare and wellbeing of his mother and family – particularly his younger siblings.

10.1. Mr J's younger siblings

The Government has produced guidance in relation to inter-agency working and safeguarding children. It has been reviewed a number of times and versions are available for 2010[1], 2013[2] and 2015[3]. We focus on the guidance in place at the time of Mr J's care. The 2010 guidance highlights the importance of inter-agency working:

> "Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm – depends on effective joint working between agencies and professionals that have different roles and expertise. Individual children, especially some of the most vulnerable children and those at greatest risk of suffering harm and social exclusion, will need co-ordinated help from health, education, early years, children's social care, the voluntary sector and other agencies, including youth justice services."

The guidance goes on:

> "For those children who are suffering, or likely to suffer, significant harm, joint working is essential to safeguard and promote their welfare and, where necessary, to help bring to justice the perpetrators of crimes against children. All agencies and professionals should:
>
> - be alert to potential indicators of abuse or neglect;
> - be alert to the risks of harm that individual abusers, or potential abusers, may pose to children;
> - share and help to analyse information so that an assessment can be made of whether the child is suffering or is likely to suffer harm, their needs and circumstances;
> - contribute to whatever actions are needed to safeguard and promote the child's welfare…"

The trust provided us with two versions of its safeguarding children policy, one dated 2008 (due for review 2011), the other dated 2015. The trust told us that the 2008 version was in place until 2015. The policy advises that all adult-focused staff:

[1] webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eorderingdownload/00305-2010dom-en.pdf
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417669/Archived-Working_together_to_safeguard_children.pdf
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

> "Routinely record details of the client's responsibilities in relation to children and consider the needs of children and parents in all aspects of their work. Currently this is via child need and risk screen in Patient Journey risk assessments and within (new) CPA."

The policy sets out what signs staff should look for in relation to child safeguarding and what to do if they have concerns.

Mr J did not always live in the family home but he was there in 2011 before his first admission. He maintained regular contact with his family when he was not living with them.

Six child and risk screens were completed between 2011 and 2013 (one in 2011, four[1] in 2012 and one in 2013). A child needs and risk screen was completed on 28 November 2012. It recorded no concerns in relation to the children's (Mr J's younger siblings) needs being met. A risk assessment on 30 November 2012 noted that Mr J would be staying with his mother and younger siblings when he left the ward: "Mother does not feel that the family are at risk but this will need to be closely monitored by HTT".

A HTT practitioner noted on 4 December 2012:

> "Spoke with c/co [care coordinator] following ward round plan: gain information re: safeguarding children issues in the past – in contact with younger siblings… Discussed if any previous concerns re: younger siblings as currently [Mr J] staying at mother [sic] house where siblings reside. C/co reported that there have not been any concerns in this current presentation."

An updated child needs and risk screen dated 6 December 2012 found no concerns and no need to make a referral to children's social care ("No risks identifiable to warrant a referral").

10.2. Analysis

Mr J had an extensive violent history that at times encroached into the family home, leading to at least one instance in which his family fled the home because they were worried for their safety. We found no evidence that the COAST ever considered Mr J's younger siblings at risk. Mr J's care coordinator told us he did not think he met Mr J's siblings – they were usually at school or in another room when he visited. The notes say on several occasions that they were not considered to be at risk, though the reason for this conclusion is not recorded. This conflicts with the actions of the HTT, who arranged to see Mr J only in pairs. This was not HTT policy but the clinical service team lead told us that a number of factors were taken into consideration (e.g. time of day, gender of staff) and that some staff preferred to visit in pairs. She added

[1] Two were completed two days apart in November 2012 and there is no obvious difference between them.

that the staff changed quite frequently, which could be unsettling for patients. This was another reason why staff might choose to go in pairs.

The trust told us it had no contact with children's services about Mr J's younger siblings. Our investigation focuses on the care and treatment of Mr J and we do not explore this further but we believe it further illustrates the extent to which Mr J's risk to others was underestimated – particularly in relation to his family.

We found no evidence of any discussion by the COAST with other agencies and/or teams in relation to the children's welfare. We believe this was a missed opportunity.

10.3. Mr J's mother

Department of Health Guidance[1] (2005) recommends health care professionals undertake:

> "Routine enquiry and providing information involve asking all women if they are experiencing domestic abuse, whether or not they show signs of it. An appropriate time to do so would occur as you take a social history, when you are asking about other factors that have a negative impact on a women's health."

The trust gave us a copy of its trust-wide *Safeguarding adults* policy (2008) and *Safeguarding adults at risk* policy (2014). The trust told us that the former was the safeguarding policy used until it was replaced in 2015. The policy says:

> "It is important to consider carers, families and friends who provide personal assistance and care to adults on an unpaid basis and who may be subject to abuse, this includes children as carers."

It adds:

> "Where an adult at risk lives in a family setting, all other members of the family need to be considered within the risk assessment process."

Mr J's mother was significantly involved in his care. She was his primary carer when he became unwell and regularly attended his appointments and engaged with his care coordinator.

10.4. Analysis

We found no evidence that Mr J's mother was subject to domestic violence, but nothing in the notes to suggest that this was ever explored with her. The notes say

[1] Responding to domestic abuse: a handbook for health professionals (2005).

she once left home because she was so frightened of her son. His older sister alleged that he had attacked her in an unprovoked attack[1].

We asked care coordinator 1 whether he considered Mr J's mother to be at risk:

> "No, obviously I had to consider the children as well. I suppose she was at risk, but there was never any evidence he had been aggressive to her. He wanted to be with her, he was gravitating towards her, she was the one who could help him with things in his life, and had more insight about what was going on for him, but she had her [academic] course and she had other children".

The trust internal investigation noted that health care professionals were wrong to rely on Mr J's mother in relation to his compliance with medication. We believe the healthcare professionals responsible for Mr J possibly placed too much reliance on his mother in general in relation to his care, particularly in accommodating him after his inpatient stays. Mr J was not permitted to return to his lodging after his inpatient stay in 2012, because he had assaulted a neighbour. His care coordinator tried without success to find him alternative accommodation. As a result he contacted Mr J's mother. The notes say she was at first reluctant to have him back but this was updated to say he was welcome for a short period.

We accept that it was reasonable to assume he could stay with his mother, as he had in the past but we found no evidence that this was regularly explored with her in terms of the risks to her and the younger children. We believe this shows that the healthcare professionals involved in Mr J's care underestimated the risk he presented to others. Our clinical adviser said:

> "I am of the opinion that the psychiatric professionals looking after Mr J underestimated his risk of violence to others."

Care coordinator 1 told us that he did not see how the family got on together because Mr J usually tried to get him to leave the home after their meetings. He knew that Mr J put pressure on his mother, particularly at the time of his 2013 discharge, to let him come home. Care coordinator 1 said that on this occasion she felt she was particularly wary because she needed more time and to be reassured that he was well. He told us that he felt powerless to stop the discharge home.

We found a carer need screening assessment dated 20 June 2011 and a carer needs assessment and plans dated 8 January 2014. Under 'assessment of support issues', the subsection of 'dealing with verbal abuse, aggression or violence' was scored as occurring sometimes (2) with a difficulty rating of 'too much difficulty' (4). These were the only documents we found in relation to carer need assessments and neither contained detail about managing Mr J's risks. The trust internal investigation praised the work of the care coordinator but noted the carer's assessment and CPA to be lacking.

[1] The police 'summary of bad character' notes that Mr J's sister was unable to substantiate her allegation and as a result no further action was taken.

Care coordinator 1 supported Mr J's mother in a number of ways, providing letters for her in relation to her college course, her financial problems and an application to move house. The notes say she would contact him independently if she had concerns about Mr J. For example, in August 2012 she contacted care coordinator 1 to say she thought Mr J was relapsing. The trust internal investigation found that he regularly offered support to Mr J's mother after the index offence in April 2014 and maintained contact with her despite having moved teams.

10.5. Findings

The COAST did not undertake adequate safeguarding assessments of Mr J's siblings, which left them potentially at risk.

Healthcare professionals involved in Mr J's care underestimated the risk he posed to his family and others, which left them potentially vulnerable and at risk.

Care coordinator 1 proactively supported Mr J's mother during her son's care and after the index offence in April 2014.

10.6. Recommendation

The trust should assure itself that members of the COAST understand and can effectively implement the trust safeguarding policy as part of their assessment of patients, their families and/or carers.

11. Predictability and preventability

We set out below the standards against which we assessed Mr J's care.

11.1. Predictability

We consider the homicide would have been predictable[1] if there had been evidence from Mr J's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

The COAST notes detailing its contact with Mr J in the weeks before the incident on 24 April 2014 contained 14 entries, a number of which detailed phone calls (including those with his mother) and prescriptions as opposed to actual meetings.

Mr J was seen once a month by care coordinator 1 or honorary associate specialist 1 between January and April 2014. He seemed on each occasion to be well and the notes record nothing untoward, though it was noted on 9 January and 16 April 2014 that he had run out of medication.

Care coordinator 1 saw Mr J on 16 April 2014. Mr J said he had run out of medication. Care coordinator 1 wrote in the notes "[Mr J] said he had run out 'three or four days ago' but probably it would have been a lot longer". Mr J denied any signs of psychosis and reported he was sleeping well – which his mother confirmed. Care coordinator 1 noted: "No relapse signs evident such as closing certain doors obsessively". Mr J was given a four-week prescription for olanzapine. This was the last time that care coordinator 1 saw Mr J.

Mr J had a history of violence, the risk for which was known to increase when he became unwell. A number of incidents occurred in 2011, 2012 and 2013, of varying degrees of severity. In 2012, he assaulted a neighbour with a knife. He was restrained before he could inflict serious harm. He also threatened a member of public with a knife. Each time he was an inpatient he assaulted or tried to assault staff and patients on numerous occasions and required 2:1 observation in 2012.

Members of the COAST saw Mr J in 2014 and noted he was well. Mr J had made no known explicit threats towards others in the months leading to the incident and there was no evidence that he had been violent towards others or destroyed property.

Crucially the team and the police were unaware of the serious assault Mr J had carried out against a member of the public on 6 April 2014 because Mr J did not admit to carrying out the assault until he was arrested for the killing of Mr V.

We conclude that it could reasonably have been predicted that he might be violent at some time but not when, how severely or against whom.

[1] Our definition was developed with Verita associate Lucy Scott-Moncrieff (former chair of the Law society) and Capsticks LLP

11.2. Finding

We find that, though it could have been predicted that Mr J would be violent again, the timing, the severity and the target of his violent behaviour were not predictable.

11.3. Preventability

We consider that the homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

Members of the COAST saw Mr J between 15 January and 16 April 2014. On each occasion he presented as well and told staff twice that he had run out of medication. The COAST team took this as evidence that he was taking it and gave him new prescriptions. Mr J's mother said he was well and compliant with medication during this period.

Whilst effective risk assessment and risk management plans, robust care plans, using different treatment options and better engagement with other services such as the police might have reduced Mr J's violent behaviour, we cannot say that this would have prevented the incident on 24 April 2014.

We found no actions available to healthcare professionals at the time that could have prevented the incident on 24 April 2014. They did not know he intended to cause harm to another. They had no legal reason to detain him or any indication of impending violence that they could prevent.

11.4. Findings

We find that the death of Mr V could not have been prevented by healthcare professionals involved in Mr J's care but the risk may have been reduced.

12. Trust internal investigation

The terms of reference for this investigation include assessing the quality of the internal investigation and reviewing the trust's progress in implementing the action plan.

This section examines the national guidance and the trust's incident policy to determine whether the investigation into the care and treatment of Mr J met their requirements.

12.1. National guidance

The NPSA good practice guidance *Independent investigation of serious patient safety incidents in mental health services*[1] (2008) outlines three steps in the independent investigation process, two of which are the responsibility of the trust. These are to undertake an initial service review within 72 hours of the incident coming to light and to complete an internal investigation using root cause analysis (RCA).

The NPSA produced *Root cause analysis investigation tools – Three levels of RCA guidance* (2008). It lists three levels of RCA and states that a level 2 (comprehensive investigation) should be:

> "Commonly conducted for actual or potential 'severe harm or death' outcomes from incidents, claims, complaints or concerns";

that the investigation should use:

> "Appropriate analytical tools (e.g. tabular timeline, contributory factors framework, change analysis, barrier analysis)";

and that it is:

> "Normally conducted by a multidisciplinary team, or involves experts/expert opinion/independent advice or specialist investigator(s). Conducted by staff not involved in the incident, locality or directorate in which it occurred".

12.2. Trust policy

The trust has a 'policy for the investigation of incidents, complaints and claims' (2011[2]). The investigation was categorised as level 2 – homicides and inpatient suicides. The policy requires that investigations at a severity level of A or B (Mr J was level A) must be completed within 60 working days.

[1] http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60156

[2] The policy was due for review in 2013 but we were told it was the policy in place at the time of the incident. The policy was reviewed in 2014 but this occurred after the incident therefore we have not referred to the latest version.

12.3. Detection of the incident

Mr J's notes say:

> "24/04/2014: Harm to Others – Killed a stranger on 24th April – reportedly pleading guilty whilst in custody; did not present as psychotic the day after the apparent murder."

The police contacted the trust on 25 April 2014 to ask for clinical information about Mr J.

The trust told us that the above statement was all the information it held in relation to the index offence.

12.4. Trust internal investigation

The trust commissioned an *Investigation into the events leading to the arrest of Mr A [Mr J] on April 2014 on a charge of murder* on 13 May 2014. The investigation team consisted of:

- a trust investigation facilitator (report author);
- a clinical director, Addictions CAG (clinical advisory group); and
- a head of nursing, psychological medicine CAG.

The internal investigation focused on the last time that Mr J was discharged from hospital in August 2013 until the index offence. The terms of reference for the investigation focused on a review of Mr J's care and treatment, including risk assessment and management; communication; discharge planning; engagement with Mr J's family; and liaison with other agencies.

The internal investigation team reviewed Mr J's clinical notes, trust policies and procedures and interviewed a number of staff involved in his care. The panel noted that the investigation could not fully meet its duty of candour because the trust could not make contact with the victim's family while criminal proceedings against Mr J were active. The trust was unable to disclose confidential information about Mr J to the victim's family. The investigation wrote that it had checked that the victim's family were being supported.

The internal investigation concluded that duty of candour was met in relation to Mr J's mother. She declined to be involved in the internal investigation. Mr J's care coordinator provided her with continuing support.

The report contained a chronology and explored a number of areas, including notable practice, contributory factors and root causes and lesson learned. It made four recommendations.

12.5. Analysis

The trust internal investigation used an RCA approach as guided by trust policy. It highlights areas of good practice and concerns around service delivery. However, we believe that restricting the scope of investigation (27 August 2013 until the incident) limited the exploration of areas that would have been helpful, in terms of both the wider context of Mr J's clinical and forensic history, and action (not) taken. Mr J's previous inpatient admissions are referred to in the internal report, though not in depth. The events leading to each admission are not clearly documented.

The investigation cautioned:

> "This case has yet to be heard in court and the investigators have not been provided with any information about how it is alleged that he obtained a weapon, motive and opportunity therefore they were unable to reach any definitive conclusion regarding causation."

We accept that the investigation was undertaken while criminal proceedings against Mr J were active but this should not have impeded the investigation.

- Liaison with external agencies including police and probation and the GP

The internal investigation notes that the COAST team referred Mr J to forensic services and sought its advice. However, the Community forensic team 1 is part of the trust and not an external agency.

The internal investigation should have further explored engagement with third parties, though we acknowledge that it could not get records from the police or Mr J's GP. Despite this, the absence in Mr J's notes of a substantial dialogue with other agencies should have been reflected in the internal report as evidence of a lack of engagement.

The trust internal investigation facilitator 1 told us that the panel explored this with the COAST. She felt there was a lack of curiosity on the part of the COAST in exploring (sometimes unsubstantiated) information it received about Mr J. She believed the team should have sought a police disclosure about Mr J. She felt staff were reluctant to contact the police based on their assumption that they would not engage with the team. She noted that the trust had a security manager (in post since 2011) who had worked hard to build the relationship between the trust and the police. We found no evidence to suggest that the COAST contacted the security manager about Mr J.

- Safeguarding

The internal investigation does not explore the safeguarding of Mr J's younger siblings, both of whom were minors. It notes that the team was up to date with level 3 mandatory safeguarding children training but the report does not investigate safeguarding any further.

The internal investigation criticised the level of support offered to Mr J's family at the time of his discharge in 2013 and the fact that they were persuaded to have him at home. It noted that the carer's needs assessment did not significantly change between 2011 and 2014 and that a child risk screen had been completed but never updated.

- Compliance with medication

The internal investigation noted that the team should have had a more systematic approach to monitoring Mr J's compliance with his medication. It highlighted that the team relied too heavily on Mr J's mother for this. However, we believe that the internal investigation placed too much emphasis on staff ensuring that patients took their oral medication as opposed to the need to explore other options. For example, exploring whether patients with histories like Mr J's could be treated with injectable antipsychotics would have been helpful.

- Forensic history

The internal report does not provide a clear chronology of Mr J's forensic history so it is not possible to know if the investigation team's assessments were based on such a history. For example, the report contains no reference to Mr J's fare evasion, which his care coordinator had written to the court to appeal the charge on behalf of Mr J.

The trust investigation facilitator 1 told us about Mr J's referral to forensic services in 2012. She noted that the Forensic Forum is only for an opinion and not a referral for assessment. This would have required a separate referral. She added that Mr J did not meet the criteria for forensic services. She reflected on the team's lack of curiosity about Mr J's criminal activity and the failure to engage with the police – though we note that this was not documented in the internal report.

- General comments

Overall, we found the internal investigation a difficult report to use. The investigation addressed its terms of reference but its findings are not set out clearly and do not link clearly with lessons learned and subsequent recommendations. We agree with the lessons learned and recommendations but it is not clear how the investigation weighted these in contrast to other areas of concern (e.g. "Risk assessments were not updated in relation to changing circumstances; No evidence of communication with the GP in the patient record") that did not become lessons learned or recommendations.

The report narrative is relatively short and relies heavily on a table detailing areas of concern divided into patient factors, individual/staff factors and task factors. Some of these points could usefully have been expanded to make the report easier for a wider audience to read. For example, a 'task factor' entry said: "The carer's

assessment was incomplete and not annually reviewed" but the report does not give a reason given for this. Record keeping for a variety of assessments (risk, child) was poor or incomplete but the internal investigation did not explore why.

The trust did not contact the victim's family whilst criminal proceedings against Mr J were taking place. The victim's wife told us that the trust had attempted to contact her after the trial, but she had received a number of letters from different agencies which was confusing and unhelpful during such a distressing and difficult time. The trust told us that it was currently reviewing how it contacts and engages with families and we would encourage it to reflect on its engagement with the victim's family in this instance as part of this process.

Tragic events like the index offence in April 2014 require a robust approach from the trust to examine in depth all the lessons that can be learnt and shared across a service. As previously noted, the internal investigation met its terms of reference and it details how the lessons identified were to be shared (e.g. presented at a strategy meeting). However, we feel the investigation would have been a more useful way to draw out themes and wider learning for trust staff if it had explored more thoroughly the areas we identify above.

12.6. Finding

The trust internal investigation addressed its terms of reference but could have explored some areas in more depth. This might have helped identify broader lessons for trust staff.

13. Progress on implementing the trust's action plan

This section looks at the trust's progress in implementing the action plan developed in response to its internal investigation report.

The report identified three key areas for improvement (which is described as 'lessons learned'):

- resourcing of the COAST team;
- medication compliance; and
- carer's assessment.

The action plan sets out four recommendations. We reproduce these below under the relevant headings.

We reviewed the documents the trust submitted as evidence of completion and/or progress with the action plan.

13.1. Resourcing of the COAST team

The trust internal report described the COAST team as poorly resourced in comparison with other early intervention teams in the trust. It said:

> "It is recommended that the psychosis CAG [clinical advisory group] seeks to negotiate funding for the COAST team that is more consistent with the service they seek to provide. In addition consideration is given to funding a trainee doctor, full time psychologist and vocational worker to enable the team to work more consistently within the Early Intervention Model and that the team is resourced to the same level as other EIS teams across the trust."

The action plan said a business case had been made to CCG 1 in the context of *"Achieving Better Access to Mental Health Service by 2020"* with a view to meeting NICE standards (2015) by April 2016 and bringing the CAG in line with other trust early intervention services. The plan recorded that the recommendation had been fully implemented but it says that the CAG was awaiting the outcome of the bid.

The clinical service lead for the early intervention service 1 told us about resourcing. He said more money had been agreed in September 2015 and three new care coordinators would join in January 2016. He added a borough-wide recruitment drive continued to try to fill other posts, including psychology and family intervention workers.

The internal report also said the client caseload ratio was 26:1 - higher than the Department of Health recommendation of 15:1. The clinical service lead told us that the caseload had reduced to 22/23 and would fall to 18 in January 2016. He added that the London caseload average was 23.

13.2. Monitoring compliance

The internal report said the team could have had a more systematic approach to monitoring medication compliance. It cautioned that the demands on an under-resourced team made it understandable that they relied on Mr J's mother to monitor his mental state and tell his care coordinator she was worried. The trust investigation facilitator 1 told us that it was later learnt that these monitoring arrangements were not in any case robust because she did not always see Mr J take his medication. The internal investigation recommended:

> "Prescribing guidance for care pathway, which is currently under review, should incorporate guidance on medication monitoring for the EI teams including the importance of taking an assertive approach to medication compliance where there is reason to believe that it is an issue and checking medication levels by blood test as part of the annual physical healthcare check."

The action plan noted that work in relation to this recommendation continued. It said that recent pathway prescribing guidance (October 2014) included the use of target blood level and different methods for improved compliance (e.g. depot). However, further guidance in relation to medication concordance monitoring remained in development. This guidance is being developed in collaboration with the Promoting Recovery pathway. Preparations are underway for a pilot of new solutions for improved monitoring of compliance with oral medication that excludes carers. The action plan does not detail when this will happen. It adds that the use of global routine plasma monitoring had been discussed but was unlikely to be taken forward because of the risks it presented to service-users.

The trust provided us with minutes from the 'Early Intervention – Managers/consultants' meeting dated 11 November 2014. Medicine compliance was discussed during this meeting in relation to texting individuals (or their carers) reminders to take their medication. Annual blood tests and plasma levels were also discussed.

The minutes the trust provided are over a year old. We asked for the most up-to-date action plan and details of any progress made. We assume that this recommendation around monitoring compliance remains in progress.

13.3. Carer's assessment

The internal investigation noted the dedicated work of the care coordinator in supporting Mr J's mother but it also noted some flaws in practice. In particular, the carer's needs assessment and CPA were not fully used and there was no evidence to suggest Mr J's mother was offered psychological support. It recommended:

> "The trust stresses the importance of carer's need assessment, to collect comprehensive information as one component of care planning and care provided. The director for social care will be asked to commission a review of the carer's assessment electronic form with a view to improving its utility."

The action plan recorded this recommendation as ‘action in progress’ (2). It was scheduled for completion in April 2015.

The action plan outlined that the director of social care had contacted the directors of social care for Borough 1, Borough 2, Borough 3 and Borough 4 with a view to working together to align efficiency and consistency across the boroughs. A working group was to be established to ensure new ways of working were in line with the Care Act that came into effect on 1 April 2014.

An update in the action plan dated July 2015 said work continued to update the electronic assessment form. It said that the current carer’s form could not be made compliant with the Care Act 2014. In the interim staff were being told to use the SLaM (the trust) carer’s assessment form as an engagement tool. We saw an email dated 1 April 2014 that was sent to all staff asking them to use the form as an initial assessment form. It provided contact details of the relevant individuals for each borough if it was felt that a patient needed further support.

The care group were scheduled to meet in August 2015 to discuss progress with the form and developing it into guidance.

The action plan further recommended:

> “A Blue Light Bulletin on Police Disclosure to be compiled by the patient safety team and the SMS. The bulletin will be circulated to local services via clinical service leads and associate clinical directors.”

The trust action plan recorded this as complete (3). It detailed an update in July 2015 that said a Blue Light bulletin had been completed and sent to the CAGs and shared across teams. It added that awareness-raising was carried out between January and March and that a bulletin would be put in the SLaM news and on the trust intranet.

It said the bulletin would be put in a ‘lessons learned’ report for quarter 1 that would be taken to the ‘Safer’ themed Quality Sub Committee (QSC) in August 2015.

We saw a copy of the Blue Light bulletin – learning from serious incidents, dated July 2015. It details how to request police disclosures to inform risk assessments. The trust list this action as complete (3) though we saw no evidence that the bulletin had been circulated.

The clinical service lead for the early intervention service 1 told us positive steps had been taken to develop the service’s relationship with the police but that the relationship with the probation service was still developing.

13.4. Finding

The trust has made some progress completing the action plan but some work goes on, without a completion date having been set.

14. Overall analysis

Mr J first engaged with mental health services in early 2011 when he presented with paranoid psychosis. Mr J was sectioned under the Mental Health Act on 1 April 2011 and was sectioned again in 2012 and in 2013.

Mr J's behaviour became increasingly aggressive and violent in the weeks preceding each admission. He had a history of violence, including a criminal conviction for battery. However, he was not prosecuted for his actions – including assaults against the police and inpatient staff.

Ensuring Mr J's compliance with medication was a fundamental aspect of managing his risk. The forensic team emphasised this in its assessments of him in 2011 and 2012. However, the extent to which the COAST could monitor his compliance was limited. Mr J was not subject to a community order so the team's primary means of monitoring was through asking Mr J and his mother whether he was taking his medication. It was inappropriate to rely so heavily on Mr J's mother to oversee his care and monitor his compliance. The COAST underestimated the risk Mr J posed to others, particularly his mother and younger siblings, and failed to adequately risk assess and safeguard against this.

Rather than relying on Mr J's mother, the COAST should have explored ways to monitor his compliance, though we acknowledge that their options were limited without a criminal conviction or detention under the MHA. Care coordinator 1 considered a number of options to manage Mr J (e.g. presenting him to the Forensic Forum) but no substantive action was ever taken (e.g. he was not accepted onto the forensic caseload). As a result, Mr J's care plan centred on monitoring his mental health and checking for signs of relapse.

The team should have engaged more readily with the police and probation services with a view to encouraging the prosecution of Mr J's violent behaviour. As it was, it appears that his behaviour was largely attributed to his mental illness, so there was a reluctance to prosecute. Different ways to monitor compliance would have been available to the team if legal action had been taken.

We considered the evidence and information available to the COAST in early 2014 and conclude that the team could not have predicted or prevented the incident on 24 April 2014. Mr J had not voiced any intention to harm others; neither had he displayed unusual or destructive behaviour. Crucially the team was unaware of the incident on 6 April when he had stabbed a member of the public. This only came to light after Mr J had been arrested for the index offence.

It could reasonably have been predicted that Mr J would be aggressive or violent, - particularly in view of his history – but the team could not have foreseen when his violence might recur or to what extent. Mr J's mental state was settled between January and April 2014 and the COAST had no grounds to use the Mental Health Act to detain him and therefore no opportunity to prevent the incident.

We nevertheless conclude that Mr J's potential for violence might have been reduced if effective risk assessment and risk management plans, robust care plans, using different treatment options (e.g. a CTO) and better engagement with other services such as the police had taken place.

Appendix A

Team biographies

Kathryn Hyde-Bales

Kathryn is a senior consultant at Verita with a background in investigations and regulation. She previously worked at the Care Quality Commission (CQC) where she managed the provision of analytical support to standalone projects and regional teams covering the NHS, independent and social care sectors. At Verita she has worked on numerous mental health homicides, reviews of safety at homes providing care for the elderly and on clearing a backlog of complaints at a Midlands trust.

Specialist areas

- Research methods and data analysis
- Regulation, inspection and compliance
- Mental health services
- Older people services

Emily Ewart

Emily is a registered mental health nurse and a cognitive behavioural therapist. She is currently employed in Central London as a CPN and also carries a CBT caseload. During her career she has worked in a range of acute wards and community based positions including work as a Care Coordinator. Emily has gained considerable experience in the identification of patient risks and has been involved in the creation of programs for trainee therapists. In her roles she has taken a proactive involvement in the development of procedures to ensure patients conditions are meet with the correct levels of care and experience. Emily has gained a number of Graduate and Postgraduate professional qualifications.

Dr Martin Lock

Dr Lock is a consultant forensic psychiatrist in private practice with extensive experience in adult general and forensic psychiatry. He has worked in all levels of secure psychiatric care, in HMP Wormwood Scrubs, ran a court diversion scheme, worked in a drug dependency clinic, an alcohol clinic and a mother and baby unit.

Since joining the Mental Health Review Tribunal as a medical member in 2003 Dr Lock has sat on almost a thousand tribunals. In addition to this he sat on hundreds of cases during his time on the Parole Board of England and Wales.

Throughout his career Dr Lock has assessed thousands of adults in mental health, criminal, childcare, family, immigration, personal injury and other civil cases, and sat on numerous inquiries into suicides and untoward incidents in secure psychiatric units.

Tariq Hussain

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations, grievance and abuse inquiries and reviews of team working in various acute care specialties.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Tariq retired from Verita in September 2015. He continues to undertake a small number of assignments as an associate.

Jackie Hardy

Jackie has worked in the field of mental health since the 1980s. For a number of years she worked alongside academics researching psychosocial tools and methods for alleviating depression. Jackie went on to work at a women's health centre where she established a volunteer programme aimed at helping women with mental health illnesses find employment.

Leading on from Jackie's own lived experiences with mental health illnesses, she established herself as an independent mental health consultant and has worked on projects for the London Borough of Newham and Social Care Institute for Excellence. Through these projects Jackie has gained experience working alongside service users and carers.

Jackie was an active member of SAFE Advisory Group (Advocacy for Mental Health Service Users in the District of Epping Forest) and MIME (Making Involvement Matter in Essex). Through MIME she trained as a facilitator and undertook training to be a peer researcher.

Appendix B

Documents reviewed

Medical records

- Mr J's medical records

Policies and procedures

- Safeguarding children policy and procedures, June 2008
- CPA policy, September 2008
- Community forensic team 1 protocol, July 2010
- Policy for the investigation of incidents, complaints and claims, September 2011
- Incident policy including management and reporting processes for incidents and near misses, September 2011
- Policy for clinical risk assessment and management of harm, October 2011
- Discharge and transfer policy, November 2011
- Medicines management policy, June 2012
- Community forensic team 1 operational policy, 2013
- COAST operational policy, April 2013
- Home treatment team operational policy, October 2013
- Safeguarding adults at risk policy, February 2014
- Trust medicines policy, July 2014
- Policy for the investigation of incidents, complaints and claims, October 2014
- Incident policy including management and reporting processes for incidents and near misses, December 2014
- COAST operational policy induction pack, 2015
- CPA policy, April 2015
- Safeguarding adults at risk policy, May 2015
- Home treatment team operational policy, July 2015
- Policy for clinical risk assessment and management of harm, August 2015
- Safeguarding children policy, principles and procedures, August 2015
- Discharge and transfer policy, September 2015

Internal report

- SI investigation report, May 2014
- SI action plan, updated November 2015

Other

- Metropolitan Police summary of bad character – Mr J
- Court transcript
- National policies and best practice documentation

Appendix C

Statement from the victim's family

We would like to express our views about the independent investigation report.

This report summarises Mr J's violent history plus a whole series of events which were missed opportunities to protect Mr J and the public at large. These include failures in risk assessment and management, care planning and medication management.

Whilst we understand that the report has been written to cover the circumstances and history of Mr J, it is really important that readers understand the impact and consequences that his actions have on the innocent victims family. A father was taken from 3 daughters and there is nothing that can be done to replace Mr V and the emotional stress and upset that this has caused.

We believe that the people involved in Mr J's care and treatment should be held to account. We believe that given Mr J's history it was only a matter of time before he committed further acts of violence. We also think if individual members of staff had done their job effectively Mr V would have most likely been alive today.

The authors of the independent investigation team have noted that the trust has made some progress on the recommendations from their own trust internal investigation report but that but some work goes on, without a completion date. We think this is unacceptable that there are still some improvements that need putting in place given it is now two years after the event.

Mr V's daughters were omitted from any discussions with the trust about the internal investigation and the findings from the report were not shared. Mr V's daughters only found out about this when a representative from NHS England got in contact in early 2016.