niche
HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of a mental health service user (Mr. Z) in West London

October 2020

Final report: October 2020

First published: **October 2020**

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

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

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. However, where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

This is a confidential Report and has been written for the purposes of NHS England alone under agreed framework terms. No other party may place any reliability whatsoever on this report as this report has not been written for their purpose. Different versions of this Report may exist in both hard copy and electronic formats and therefore only the final, approved version of this Report, the ‘Final Report’ should be regarded as definitive.

Niche Health and Social Care Consulting
Trafford House
Chester Rd
Old Trafford
Gtr Manchester
M32 0RS

Telephone: 0161 785 1000
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

Contents

Executive summary

1.1 NHS England, London commissioned Niche Health and Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr. Z. Niche is a consultancy company specialising in health care investigations and reviews.

1.2 This independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2] The terms of reference for this investigation are given in full in Appendix A.

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

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

Mental health history

1.5 Mr. Z's care and treatment was provided jointly by West London Mental Health NHS Trust (WLMHT or the Trust), Forensic Outreach Service (FOS) and London Cyrenians Housing (LCH) at Collette House. LCH is an organisation providing supported accommodation to people with severe and enduring mental health problems and Collette House is an accommodation-based support service funded under the Supporting People programme.[3] Collette House is commissioned by the London Borough of Ealing (LBE) who place individuals under a joint arrangement with NHS Ealing Clinical Commissioning Group.

1.6 Mr. Z had been conditionally discharged under Section 37/41 of the Mental Health Act 1983 (MHA)[4] to Collette House on 27 April 2015. Mr. Z first had

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

[2] Department of Health Guidance ECHR Article 2: investigations into mental health incidents https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

[3] Supporting People is a UK government programme helping vulnerable people in England and Wales live independently and help them to remain in their home. It is run by local government and provided by the voluntary sector. It was launched on 1 April 2003.

[4] Under Section 37 of the MHA, the court diverts an offender from a custodial sentence to a hospital for treatment. Section 41 is a restriction order, imposed by a court to protect the public from serious harm. The Ministry of Justice, rather than the responsible clinician, has to give permission for leave of absence, transfer between hospitals, and discharge. Mental Health Act (1983) http://www.legislation.gov.uk/ukpga/1983/20/section/37

contact with mental health services as an adolescent with the Earls Court child guidance clinic. The details of this are outside the scope of our investigation.

1.7 He first came to the attention of adult mental health services in 1986, at the age of 18 whilst in prison for attempted robbery with a 10-month sentence. However, at that time he was not considered to be mentally ill by the assessing psychiatrist.

1.8 Mr. Z has had 10 admissions to inpatient services from 1990 up to the time of the homicide. For two of these, he was granted a conditional discharge and was recalled in both instances; 19 March 2001 and 17 September 2009. During this time, he had displayed psychotic symptoms in the form of auditory hallucinations, paranoid delusions, passivity phenomena and thought disorder. He had also presented with negative symptoms in the form of self-neglect and decreased motivation.

1.9 He has been treated with a variety of anti-psychotic medications, including clozapine.[5] However this was stopped in 2010 due to a 'red result' from his blood test (a raised white cell count).

1.10 Mr. Z is also noted in his clinical records to display both dissocial and emotionally unstable personality traits. These manifest in the form of verbal and physical aggression, impulsiveness, poor anger control, threats of (and actual) self-harm, and the use of maladaptive coping strategies (such as using drugs).

1.11 His contact with mental health services includes many recorded instances of non-compliance with conditions, non-concordance with medication, violent and aggressive behaviour, illicit drug use, sexually inappropriate behaviour, absconding from services and numerous threats to disengage or not comply if he perceived he was being unfairly treated. This was most notably the case when he perceived staff were not facilitating visits to his girlfriend (called 'Y' throughout).

Offence

1.12 On 27 July 2015 the Forensic Outreach Service (FOS) was informed that a member of staff at Collette House, Jenny Foote, had died and the suspicion was that she may have been killed by a resident. Mr. Z had been reported missing at midday on 27 July and was subsequently arrested by police at 4.00 pm that day. He was later charged with murder and was remanded in custody.

Conclusions

1.13 This independent investigation has identified that there were failings within the care offered to Mr. Z, most notably in the communication between the housing provider LCH and the FOS, record keeping and scrutiny of Mr. Z's behaviour

[5] Clozapine is an antipsychotic medication prescribed for mental health problems. https://patient.info/medicine/clozapine-clozaril-denzapine-zaponex

by the FOS, and the lack of clear risk management plans and identification of thresholds for escalation and review of his care and placement.

Recommendations

1.14 We have made five recommendations for the Trust, and one for LCH and commissioners to address in order to further improve learning from this event.

Recommendation 1:
The Trust must ensure that discharge planning includes the following elements and develop a system to ensure standards are maintained.

- How legal conditions of discharge are interpreted.
- Provide a complete discharge summary and care plan which includes contingency management prior to discharge.
- Define who is responsible for delivery as well as what interventions are to occur and when.
- Must include carers, provider service staff and all relevant clinical personnel.

Recommendation 2:
The Trust must ensure that the agreed standardised risk assessment (including HCR-20) protocols, practice and documentation are monitored to reflect the outcomes from the Trust's internal action plan.

The focus of monitoring should be on communicating risk related information, reviewing of risk assessments and management plans considering additional information and the development of a risk formulation.

Recommendation 3:
The Trust must ensure that joint working practices with other organisations reflect developments in practice and protocol arising from this incident and the internal investigation action plan outcomes.

Specifically, that joint risk assessment and management plans, contingency plans and agreed protocols for discharge and recall are agreed in each individual case.

Recommendation 4:
The Trust must ensure that staff are appropriately skilled and competent to undertake the role of Social Supervisor.

Recommendation 5:
The Trust must ensure that it has a robust process for checking that all staff are appropriately registered with their professional body, and this should include ensuring that any agency staff employed are appropriately registered.

Recommendation 6:
In partnership with LCH, the commissioners of Collette House should clarify the role and nature of the Collette House service provision, including the limits of the service, and clear thresholds for raising and escalation of any concerns.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

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

2.3 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

2.4 The investigation was carried out by Tony McGranaghan for Niche Health & Social Care Consulting, and with expert peer review provided by Dr John McKenna, retired forensic consultant psychiatrist.

2.5 The investigation team will be referred to in the first-person plural in the report.

2.6 The report was also peer reviewed, edited and concluded by Nick Moor, Partner, Niche Health & Social Care Consulting.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[6]

2.8 We used information from WLMHT clinical records, police statements, LCH records and organisational policies.

2.9 A full list of all documents we referenced is at Appendix B.

2.10 We conducted group interviews with LCH and FOS staff, met with the social supervisor, and a further telephone interview with Mr. Z's Responsible Clinician/Clinical Supervisor, (RC/CS) took place.

2.11 A telephone meeting was undertaken with the NHS England case manager for WLMHT, NHS England WLMHT commissioner and the NHS England quality lead for commissioning in London. We have also had further follow on

[6] National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services.

meetings and communications with LCH and the FOS team to clarify additional points.

2.12 Relevant staff from LCH and Collette House also provided answers to written questions put to them which clarified key points.

2.13 We have adhered to the Salmon and Scott principles as outlined below:

"The Salmon Process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1966 Royal Commission on Tribunals of Inquiry. The Salmon Report set out general principles of an adversarial process for conducting an inquiry, similar, in essence, to what may be expected in a court of law. However, it was recognised by Lord Justice Scott, during his 1992 inquiry into the sale of arms to Iraq, that it is not practicable or appropriate in all cases to conduct an inquiry with a full adversarial process. Whilst recognising that it is proper that all witnesses must be able to adequately present their evidence, and have access to legal advice if required, it is not necessary to allow a full process of examination and cross-examination by legal counsel in order to achieve fairness in the course of proceedings. In many cases, the financial and logistical implications of such a process would have a significant detrimental impact on the ultimate aim of the inquiry; to reach conclusions on the issue under consideration."

2.14 The draft report was shared with NHS England, the Trust, London Cyrenians Housing and NHS Ealing Clinical Commissioning Group. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with the victim's family

2.15 The investigator met with Jenny Foote's family on 15 December 2016 at their home. The family have requested that she be referred to by her full name in this report. They were able to provide a detailed history of her career progress and personal development. Her brother has remained in contact and he has been updated by email and telephone on the progress/publishing of the report. At our initial interview with Jenny's parents and brother it was apparent that she was a motivated and conscientious young woman. Her family described how she was determined to live independently and lived alone in her own flat. She had studied graphic design originally and then qualified as a social worker in May 2015 and was awaiting placement.

2.16 Jenny was widely experienced in working with vulnerable adults and had worked as a support worker for London Cyrenians Housing (LCH) and one other company since August 2010. Her family described her as driven and friendly and a source of pride for her family. Her untimely death has had a devastating effect on her family.

2.17 She had attended 13 different training events whilst at London Cyrenians Housing (LCH), though not all were provided by LCH. This included personal safety training in August 2013. She was a well thought of member of staff.

2.18 We met with the family on 28 June 2018 and discussed the findings and recommendations and gave them a draft version of the report.

Contact with the perpetrator's family

2.19 The lead investigator and NHS England met with the perpetrator's family in December 2016.

2.20 We also met with the perpetrator's family in July 2018 and shared the main findings with them.

Contact with the perpetrator

2.21 Mr. Z was written to at the start of the investigation, explaining the purpose of the investigation and asking to meet him. We interviewed him with NHS England (London) at HMP Belmarsh on 16 December 2016.

2.22 We met with Mr. Z with NHS England (London) in August 2018 and shared the reports main findings with him.

Structure of the report

2.23 Section 3 provides a summary of Mr. Z's background and life up to the time of the incident.

2.24 Section 4 sets out the details of the care and treatment provided to Mr. Z.

2.25 Section 5 examines the issues arising from the care and treatment provided to Mr. Z and includes comment and analysis.

2.26 Section 6 provides a review of the joint internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.27 Section 7 sets out our overall analysis and recommendations.

3 Background of Mr. Z

Childhood and family background

3.1 Mr. Z is a 52-year-old man who is the eldest of three children, having two brothers.

3.2 Mr. Z was diagnosed with congenital hypothyroidism at the age of four months but had no other significant illnesses. He described one injury in 1989 when he burnt his leg whilst intoxicated with alcohol and required a skin graft at hospital.

3.3 At age 16, he was described by his mother as being more volatile. He left school with two 'O' levels. It is reported by his mother and in his clinical records that he had been unhappy at school and was often abusive to others. He had starting truanting.

3.4 When he left school, he gained employment as a trainee furniture repairer, but left after a year following a dispute with his employer.

3.5 His next job was as a lorry delivery assistant which he left after nearly a year. Apparently, this was due to his employer's dissatisfaction with his work.

3.6 Following another year working, this time laying pipes, he attended a City and Guilds bricklaying course, but had to give this up following his conviction and imprisonment for attempted robbery.

Relationships

3.7 Until the time of the incident Mr. Z, was in a relationship of almost 20 years with Y. She resides in supported accommodation with additional support from a care team. Y was acknowledged to be vulnerable and her own care team were concerned about this. Following an incident reported by Y in December 2014, all visits by Mr. Z to see Y were supervised. It was widely understood by many of the staff from the FOS and Collette House that visits to see Y were both a significant motivator and also a major cause of aggressive and threatening behaviour on behalf of Mr. Z if the visit was thwarted or prevented.

3.8 Mr. Z has said that he believed that Collette House staff were actively inhibiting his opportunity to meet with Y, despite explanations to the contrary.

3.9 On interview Mr. Z stated that he had had other relationships during this time. He reported to us that when he was living in Mosaic House, a registered care home in North Wembley, he had engaged in a sexual relationship with a woman. He had met this woman when out with her carer and had engaged in a consensual sexual relationship with her.

Forensic history

3.10 Mr. Z has been in contact with criminal justice services from the age of 18.

3.11 He has an extensive recorded history of offending dating back to 1986 when he was sentenced to 30-month youth custody following convictions for attempted robbery and theft. His criminal record shows convictions for 39 offences on at least 11 occasions between 8 June 1988 and 6 January 1993. From 1990 onwards he has also had convictions for violence. He has convictions for 41 acquisitive (stealing) offences, two drug related crimes, four assaults and one for affray. It is noted that drugs and alcohol exacerbate his threats and violence.

3.12 He was twice given a hospital order (meaning that the Court found he was suffering from a mental disorder at the time of sentencing and that detention in hospital for treatment was ordered as an alternative to a penal disposal), the first in May 1993 and the second for treatment following his conviction for common assault in August 1996.

3.13 This offence led to his conviction for common assault and then being detained under the provisions of Section 37 and 41 MHA - that is, a hospital order with a restriction order. The latter offence occurred when Mr. Z was already an inpatient in St Andrew's Hospital, Northampton, and led to him being originally arrested on suspicion of common assault and indecent assault.

3.14 The details of this offence are that according to records, shortly after 9.00 pm on 14 March 1996 Mr. Z entered the room of a female service user and assaulted her. A male nurse heard the screams of the woman and entered her room. He observed the female lying face down on the mattress with Mr. Z sitting astride her with his hand on her tracksuit waist band which had partially been pulled down.

3.15 In our interview with Mr. Z he claimed that he had not committed any sexual act and that a "big deal was made out of nothing".

4 Care and treatment of Mr. Z

1990 - 1993

4.1 Mr. Z first had contact with adult mental health services in 1986 whilst in detained in a Young Offender Institution (YOI) for attempted robbery of a building society using a toy gun and a balaclava. He was not considered to be mentally ill following an assessment by the psychiatrist and was given a 30-month prison sentence.

4.2 His first admission, in January 1990, followed a referral by his GP as Mr. Z had presented with depression and an attempt to kill himself by throwing himself over the banister at home. At the time he gave a history of drinking one and a half bottles of spirits a day. This was the first of 10 admissions to inpatient services, two of which resulted from recalls from conditional discharges.

4.3 His second admission occurred when he was admitted for detoxification from alcohol between 14 and 24 February 1990. However, due to having left the ward without notice on two occasions, he was discharged in his absence.

4.4 Following this he served a 13-month prison sentence for theft and deception. Two days after the end of the sentence he was admitted to a private hospital in Harrow due to uncontrolled drinking in April 1991.

4.5 Between 5 and 8 May 1991 he was admitted to Ellis ward at the John Connolly wing of Ealing Hospital as an emergency referral from his GP presenting with suicidal thoughts and low mood. He also reported that he was hearing voices commanding him to do things and felt he was being controlled by forces outside as well as reporting thought insertion and thought alienation.[7] These symptoms are reported to have subsided rapidly and he was discharged with a diagnosis of personality disorder, possible drug induced psychosis and alcohol problems.

4.6 Mr. Z was readmitted to Ellis ward on 17 May 1991 following an attempt to jump from a window. He described having recurrent thoughts to kill himself and that forces that were trying to control him had returned after his discharge. He had been consuming large amounts of alcohol. He was involved in numerous incidents of behaviour that indicated an increased risk, including drug and alcohol use, breaking ward rules, aggression to others and himself including attempts to run in front of traffic, jump off a bridge and attempting to strangle himself with a bed sheet. In August 1991 he is also reported to have tried to stab his mother on a home visit leaving a small mark on her chest. He was subsequently transferred to a locked ward and

[7] Thought insertion is defined as feeling as if one's thoughts are not one's own, but rather belong to someone else and have been inserted into one's mind. The person experiencing thought insertion will not necessarily know where the thought is coming from but is able to distinguish between their own thoughts and those inserted into their mind. Thought alienation is a symptom of psychosis in which patients feel that their own thoughts are in some way no longer within their control. It includes thought insertion, thought withdrawal, and thought broadcast.

continued to be disruptive with a fluctuating mental state. He was finally discharged on depot medication.[8] He is noted to have not engaged with follow up and was non-concordant with medication.

4.7 In early 1993 he was remanded in custody for offences of affray, common assault, deception theft and actual bodily harm. He was admitted in March 1993 to the locked ward at the John Connolly Wing of WLMHT forensic services from prison following an attempt to hang himself. He was described as demonstrating behaviours characteristic of schizophrenia. He was reported to have smoked cannabis and absconded several times. He was placed under Section 37 MHA and was discharged on 6 July 1993. He is noted to have then been homeless for a period.

4.8 Mr. Z was again remanded in custody 25 August 1993. On 12 November, he was admitted to St Bernard's wing, Ealing Hospital, under the provisions of Section 38 MHA. His records note that he was admitted on the grounds that he suffered a 'psychopathic disorder'.[9] On 30 November, he was returned to prison as this disorder was not deemed to be amenable to treatment.

4.9 It was noted on this admission that he also used heroin and drank alcohol.

1994 - 2015

4.10 On 18 April 1994 Mr. Z was admitted from custody (Wormwood Scrubs) to the Henry Rollin Unit, Horton Hospital, under the provisions of Section 38 MHA[10] (for a second time). It is noted that during this admission Mr. Z presented the ward with numerous management problems including aggression, resulting in six periods of seclusion. In June 1994, he was transferred back to prison, on the grounds of borderline personality disorder that was not amenable to treatment. Mr. Z was sentenced to 30 months imprisonment on 5 July 1994.

4.11 On 15 December 1994, a day or two before his release date, Mr. Z was transferred to Ealing Hospital (Blair ward PICU) under the provisions of Section 47, MHA (subsequently remaining in hospital under a 'notional' section 37). He eventually was transferred to St Andrew's Hospital on 14 March 1995.

---

[8] Depot antipsychotics are administered by deep intramuscular injection at intervals of 1 to 4 weeks. Long-acting depot injections are used for maintenance therapy especially when compliance with oral treatment is unreliable.

[9] According to the Mental Health Act (1983) (amended 2007) "psychopathic disorder" means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. It is traditionally defined as a personality disorder characterised by persistent antisocial behaviour, impaired empathy and remorse, and bold, disinhibited, egotistical traits.

[10] Section 38 MHA is an interim hospital order, given by the courts, to a convicted person to undertake assessment and treatment as to whether a full hospital order is the right outcome. It will last a maximum of 12 weeks.

4.12 He was treated at St Andrew's with a range of anti-psychotic medication with little significant improvement in his mental state. There are reports of hostility, violence and inappropriate touching and approaches to female service users.

4.13 Later in 1995 Mr. Z agreed to take clozapine[11] with notable improvement in his behaviour. However, in August 1995 he again refused to take his oral medication due to perceived weight gain.

4.14 In March 1996 the offence of common assault occurred at St Andrew's, and he received a Section 37/41 hospital order in August 1996. Mr. Z agreed to recommence clozapine some months later. It is noted in the clinical records that this brought about an improvement in his mental state.

4.15 He was subsequently transferred to a low secure male only ward and then to an open ward in November 1998. He was eventually granted a deferred conditional discharge[12] on 21 February 2001 and conditionally discharged to Lyndhurst House registered care home in Finchley, provided by Care Homes UK on 19 March 2001. The conditions of discharge included taking prescribed medication, avoiding alcohol and illegal drugs and seeing members of the forensic community team. A conditional discharge means that the patient must comply with the conditions of the discharge, and that the Secretary of State has the power of recall to hospital and must be provided with regular progress reports. The conditions are "designed to operate for the protection of the [patient] and others and to enable the patient's safe management in the community. They are not measures for social control, nor even for crime prevention. Breach of conditions does not, in itself, justify recall to hospital, but it should act as a trigger for considering what action is necessary in response".[13]

4.16 Between the periods 2001 to 2009, Mr. Z managed well in the hostel setting with only minor infractions of rules. He continued to comply with his medication and kept the majority of appointments with his WLMHT clinical supervisor (CS).[14]

4.17 It is recorded that in 2006 he went to a woman's flat and smoked crack cocaine and injected heroin. During our interview with Mr. Z he stated this was a 'one off' event.

---

[11] Antipsychotic drug used as a sedative and in the treatment of schizophrenia

[12] A Mental Health Review Tribunal (MHRT) can order that a conditional discharge be deferred until the conditions can be met.

[13] para 7 of the Mental Health Casework Section guidance "Guidance for clinical supervisors", published by Ministry of Justice, March 2009.

[14] Ministry of Justice; Guidance for clinical supervisors': Section 7 – The role of the Clinical Supervisor; "The clinical supervisor is responsible for all matters relating to the mental health of the patient, including regular assessment of the patient's condition, monitoring any necessary medication and its effects and consideration of action in the event of deterioration in the patient's mental state." March 2009

4.18 However, in March and April 2009 some deterioration was noted. He was not independent in his self-care, and was disputing his medication, whilst also receiving a temazepam[15] prescription from his GP. This period of deterioration in behaviour culminated in an incident of 'going missing' from the hostel.

4.19 From the records and from Mr. Z's explanation on interview he had gone to Margate with a woman, whom he had met with her carer in a local cafe. He states that he paid for a hotel for three nights in Margate and engaged in unprotected sex. This woman was being sought by her care home staff and eventually, with the intercession of the police she returned to her care home.

4.20 The clinical records also describe how on 20 April 2009 he was recalled from Lyndhurst Hostel to Three Bridges medium secure unit (provided by WLMHT) as he was still under the Section 37/41 MHA restriction order. At his Care Programme Approach (CPA) review[16] on 5 May 2009 a number of issues arose. Mr. Z appeared unaware of the seriousness of his actions with the vulnerable female and said that it was 'fate'.

4.21 There were discussions around the legality of his recall as the social worker pointed out that a person cannot be recalled solely on the basis of breaking a condition.[17]

4.22 There was agreement by the clinical team that Mr. Z had been recalled due to the need for assessment including the use of drugs, and so that the risk to others and himself be ruled out.

4.23 It was agreed by the team that despite his mental state not deteriorating, he continued to require 24 hours support. The team agreed to look for an alternative placement and that they would be recommending a conditional discharge at tribunal.

4.24 At his discharge planning meeting on 15 September 2009, the main considerations for his transfer to Mosaic House registered care home were discussed. This was primarily due to the fact that Mr. Z had commenced new medication namely olanzapine,[18] so his mental state required close monitoring. Also, there were concerns raised about his sexually inappropriate behaviour, his vulnerability and personal care. There is a note of a potential

[15] Temazepam is used to treat insomnia. It is a benzodiazepine, and like other similar drugs can create dependence, and be abused.

[16] The Care Programme Approach (CPA) is a process for the assessment, planning and reviewing of someone's mental health care needs. CPA is for someone who has a diagnosis of severe mental disorder. There will normally be a care co-ordinator who co-ordinates the input of the multi-disciplinary team and the team will hold regular review meetings.

[17] In order for the Justice Secretary to recall there must be evidence of mental disorder of a nature or degree warranting detention (following Winterwerp v Netherlands (1979) as reflected in the Mental Health Act 1983). In order to justify recall and before recalling the Justice Secretary must have up to date medical evidence showing that these legal criteria for detention are met. For more information see: Ministry of Justice "The recall of conditionally discharged restricted patients" 4 February 2009.

[18] An antipsychotic medication that affects chemicals in the brain. Olanzapine is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder.

concern that due to previous verbal aggression related to other people's ethnicity, Mr. Z may encounter problems due to the ethnic diversity of the hostel residents.

4.25 It is noted that Mr. Z and his parents were in agreement with the care plan and were impressed by the hostel.

4.26 He met regularly with his keyworker (up to three or four times a day) for short interactions/catch ups throughout his stay at Mosaic House. His records show that he sporadically attended planned activities such as hostel-based groups and volunteer work at a dog's charity. They also show that when he didn't attend it was because he was often too distressed. His Social Supervisor,[19] acting in the capacity of care coordinator (CCO)[20] discussed Mr. Z's lack of activity at a meeting on 18 February 2010, with the bulk of the meeting related to Mr. Z's relationship with his girlfriend, Y. There had been an incident when Mr. Z had visited her with his parents and Mr. Z became very upset.

4.27 It is noted that the team agreed that Mr. Z should have no unsupervised visits with his girlfriend until this had been risk assessed by the respective teams. His keyworker reported that Mr. Z attended his girlfriend's care home on a supervised visit on the first Sunday of each month.

4.28 A number of concerns were raised about Mr. Z managing disappointments related to the relationship. He had made several threats to resume drinking and he threatened to go on hunger strike unless his demands to see her were met.

4.29 It was agreed at this meeting that Mr. Z required more structure to his week but at this stage there were no concerns regarding his compliance with rules or concordance with medication and behaviour at the hostel. At his CPA review meeting on 16 July 2010 it was concluded that Mr. Z's adherence to his medication regime had led to a significant improvement in his overall wellbeing. His parents reported that they were very happy with the care he was receiving. There were noted improvements in his self-care, behaviour and attendance at structured programmes. Mr. Z was also noted to have a sponsor from AA and that he had been attending Addaction weekly.[21]

4.30 Despite concerns raised by the earlier rapid deterioration in behaviour the professionals attending agreed that he should remain at the hostel as he continued to require on-going support and supervision.

---

[19] social supervisor refers to the professional involved in providing reports to the Ministry of Justice following a restricted service user being discharged from the hospital. The person discharged from the hospital is subject to Section 37/41 under the Mental Health Act (1983).

[20] Under the guidance for the Care Programme Approach, a care coordinator should; fully assess needs, write a care plan which shows how the NHS and other organisations will meet those needs, and regularly review the care plan with the service user and others to check progress.

[21] AA is Alcoholics Anonymous. Addaction is a leading voluntary sector organisation that supports adults, children, young people and families to make positive behaviour changes across England and Scotland.

4.31 On 13 May 2011 an urgent review was called when it was discovered during a routine health and safety check by staff, that Mr. Z had been stockpiling medication, obtaining a prescription of zolpidem[22] from his GP and drinking a half bottle of whiskey per day. This is noted to have occurred when his parents, social supervisor and hostel manager were away. It is not recorded if any further conditions were put in place to address the issue of stockpiling medication, outside of regular security and Health and Safety checks.

4.32 On 21 June 2011 Mr. Z met with his community nurse from FOS to discuss progress. They discussed his relationship with his girlfriend, and how this had affected his recent behaviour and general low mood. This was the only issue of concern to Mr. Z at the meeting and he was noted to be engaged and compliant with conditions.

4.33 At his CPA review on 6 July 2011 Mr. Z explained that he had planned to take an overdose (of stockpiled medication), but then had decided not to as he did not want his parents to return from holiday and 'find him gone'. It was noted that he continued to be settled in the hostel and continued with a work rehabilitation programme, however it was noted that he was no longer attending his volunteer work at a dog's charity. Mr. Z was also informed that he would be having a change in Responsible Clinician (RC),[23] and Mr. Z thanked his old RC for his help over the preceding years.

4.34 On 10 August 2011 a new consultant took over Mr. Z's care as his RC. Whilst it was acknowledged that Mr. Z still required a high level of input, he was regarded as settled.

4.35 On 9 January 2012 his CPA review concluded that he had shown good progress over the preceding six months.

4.36 On 15 May 2012 it is noted by his RC that over the past three months Mr. Z's mental health presentation had generally remained the same. However, the RC also noted increasing incidents of hostility towards hostel staff. This appears to be when they were encouraging him to engage in his structured activity programme.

4.37 It is noted on 18 October 2012 that Mr. Z had been attempting to obtain further medication from his GP. When asked by staff he said that he had done this with the intention of stockpiling medication because his plan to stay with his girlfriend over Christmas had been cancelled. This appears to have been his perception and not the intention of his clinical team.

4.38 At his CPA review on 7 January 2013 it was noted that Mr. Z's engagement and compliance had deteriorated, and an increase in aggression had occurred. Mr. Z stated that the only reason he was taking his prescribed

[22] Zolpidem is a sedative, also called a hypnotic is used to treat insomnia. It affects chemicals in the brain that may be unbalanced in people with sleep problems (insomnia).

[23] In the Mental Health Act (1983) a "Responsible clinician" is defined in s34 as the approved clinician with overall responsibility for the patient's case, where a patient is liable to be detained for admission for assessment or an application for admission for treatment.

medication (olanzapine) was because he remained subject to a restriction order.

4.39 In February 2013 Mr. Z underwent another change of RC which caused him some upset. He was reassured that the FOS input would remain in place.

4.40 At the request of his girlfriend's care home staff Mr. Z was seen by his new RC on 3 April 2013 following an incident where he consumed a bottle of whiskey. He also reported to this RC that he had had sex with a prostitute in Harrow.

4.41 In the period following this, Mr. Z was suspected of taking illicit substances. He eventually admitted to taking herbal/ 'legal highs' and said that "there was nothing the team could do" to 'stop him'.

4.42 In June 2013 Mr. Z behaved in a threatening manner towards the hostel staff. This related to requests to turn his music down. Mr. Z was verbally abusive and slammed the door on the staff member. He later came to the office to apologise, and when the staff member attempted to have a discussion with Mr. Z he became agitated and verbally abusive and went to headbutt him. Mr. Z grabbed and twisted the staff member's wrist to take the phone off him as he was calling for help. Mr. Z refused to give the phone back unless the staff member agreed not to call the police. He only agreed to give the phone back when another staff member entered the office, and the duty manager was then called to discuss this with Mr. Z.

4.43 There were also several incidents where he threatened not to comply with rules or treatment conditions unless specific needs were met. These were usually related to visits to his girlfriend.

4.44 In November 2013 at his CPA review meeting Mr. Z behaved in a hostile and threatening manner to towards the hostel manager and his Social supervisor. He also accused his parents of taking the side of the mental health team in not supporting his absolute discharge (in this instance, being fully discharged from his restriction order, rather than conditionally discharged).

4.45 On 2 December 2013 Mr. Z was urgently reviewed as he had made threats to stab his CCO and other staff. It is noted in his records on that date that he also assaulted a member of staff by punching them. During the review he was apologetic and explained that he tended to be hostile to his care givers, especially female, as he held some hostile feelings towards his mother. He remained at the hostel and need for ongoing monitoring required was discussed with him, for support and managing the risks to self and others.

4.46 The hostel staff contacted the Trust on 10 December 2013 to say that Mr. Z's mental state had deteriorated, and he had admitted to taking novel psychoactive substances.

4.47 Because of this he was reviewed on 16 December 2013 by his RC, social supervisor, and the hostel manager. During the subsequent review on 16 December 2013 Mr. Z was again reported as being hostile and threatening,

making threats to get ‘stoned’ and teach them a lesson. When reminded that making threats to harm others and being abusive to staff and carers was unhelpful and unacceptable, Mr. Z started using abusive language and calling names to his social supervisor and RC. He made threats to knife his then social supervisor, who he thought was responsible for his continued detention and restrictions. He also made threats to ‘sort out’ his RC. Mr. Z was becoming increasingly hostile and further discussion was proving to be unproductive, hence a decision was made to terminate the interview.

4.48 All the professionals were of the opinion, that Mr. Z was aroused, volatile and had a low threshold to discharge physical aggression. The conclusion was that the therapeutic relationship had broken down. Mr. Z was refusing to /adhere to the conditions of his discharge, in order to effectively and safely manage the risks. In the context of his aroused state, it was felt that use of alcohol and illicit substances would only increase the chances of Mr. Z acting out on his verbal threats. He was also considered to be at risk of accidental harm to self by overdosing on alcohol or illicit drugs as a result of reckless, impulsive behaviour and aroused state of mind.

4.49 It was decided by the clinical team to recall Mr. Z to hospital as it was felt the therapeutic relationship had broken down. He was returned to Solaris ward, an 18 bedded male low secure ward at St Bernard’s Hospital on 16 December 2013.

4.50 During this admission he was noted on three occasions to have been aggressive or violent to staff and other patients. He also engaged in family work sessions with his family whilst an in-patient. However, his parents cancelled these sessions on 26 September 2014 as they no longer wanted to attend sessions. This followed an incident where Mr. Z had attempted to withdraw extra money from his parents account.

4.51 He is also noted on this admission to have engaged with psychology to examine his anger. He had started to make arrangements to marry his girlfriend, although he perceived this was hampered by the clinical team as they wanted assurances about his girlfriend’s capacity to provide consent.

4.52 He is noted to have been accepted for Collette House on 16 December 2014.

4.53 On 29 December 2014 Mr. Z’s RC was contacted by Mr. Z’s girlfriend’s keyworker to say that there had been an incident at Christmas when Mr. Z and his girlfriend were at Mr. Z’s parent’s house. His girlfriend (Y) had reported that she had to ‘beat’ Mr. Z off as he had demanded sex. His RC was informed that a safeguarding process had started but that Y had not wanted to involve the police. This issue was discussed in a safeguarding forum coordinated by Y’s care team, resulting in agreement that they could see each other again on a supervised basis.

4.54 It was explained to Mr. Z on 31 December 2014 that his RC had reported this incident to the Ministry of Justice, and therefore whilst a response was awaited, he could not have leave. He became agitated and distressed, taking

his shirt and jacket off and imitating hanging himself. At this point he made threats to harm his RC.

4.55 Mr. Z requested a 1:1 meeting with his RC and apologised for his behaviour. On 5 January 2015, his leave was reinstated.

4.56 At a ward round on 27 January 2015 the clinical team are noted to have proposed couples' therapy for Mr. Z and his girlfriend, related to the difficulties around their differing perceptions of the relationship in particular Mr. Z's wish for sex. It was not known if his girlfriend's team had as yet pursued an independent capacity assessment regarding this. His clinical team felt that they should consider exploring safeguarding issues for his girlfriend as Mr. Z was possibly 'idealising the relationship'. There were concerns that Mr. Z would be more vulnerable to disappointment should his girlfriend not perceive the relationship as he did, and this would have a negative effect on his thinking and mood.

4.57 On 30 January 2015 Mr. Z gained permission from the Ministry of Justice for a transfer to Butler House, a 12 bedded 'step-down' ward which serves as a rehabilitation ward for patients in the forensic service.

4.58 On 2 February 2015 he was transferred to Butler House. Throughout this admission Mr. Z's behaviours challenged and concerned his care team. These behaviours included inappropriate sexual behaviour, non-compliance with rules and regulations and threats to disengage unless requests were met.

4.59 Following admission to Butler House he had a CPA review meeting on 3 February 2015. At this meeting, with reference to his response to his RC on 31 December 2014, Mr. Z stated he no longer wished to harm his RC. He was made aware that for now he could not have physical contact with Y whilst the allegation of pressuring his partner into having sex at his parents' house over Christmas was investigated.

4.60 Mr. Z underwent a change of social worker on 12 February 2015 with all information, including a recommendation for family therapy, handed over.

4.61 At the ward round of 17 February 2015, the team communicated that they would like Mr. Z to commence day visits to Collette House. It was noted in the ward round minutes of 17 March 2015 that the team were awaiting permission for overnight leave from the Ministry of Justice (MoJ).[24]

4.62 On 7 April 2015, Mr. Z was allocated a new social supervisor from the FOS team to begin the pre-discharge preparation. This person would also act in the role of care coordinator when he returned to the community. By this time permission from the MoJ had been received for Mr. Z to commence day leave

[24] Mr. Z was still under S37/41 MHA (1983). As patients approach the stage of their rehabilitation where they are close to discharge, it is common for responsible clinicians to ask for overnight leave. As with any application for leave, the Secretary of State will only consent to overnight leave if satisfied the proposal does not put the patient or others at risk.

but was unable to progress to overnight leave due to funding restrictions by the local authority.

4.63 On 14 April 2015 Mr. Z was informed by the clinical team that his discharge would still be supported. The First Tier Tribunal (mental health), formerly known as the Mental Health Review Tribunal, agreed a conditional discharge on 23 April 2015 with the following conditions. Mr. Z was to:

- reside at a 24-hour supported mental health hostel or other hostel deemed suitable by his treating team;
- comply with appointments and care management plans with his RC and social supervisor;
- cooperate with monitoring of illicit substances and alcohol, including herbal highs;
- remain totally abstinent from the use of illicit substances and alcohol, including herbal highs; and
- cooperate with geographical exclusion zones including allowing monitoring of contact with his long-term partner Y as is considered necessary.

4.64 Mr. Z's discharge meeting under CPA occurred on 27 April 2015. Whilst neither his parents nor hostel staff were present, his father was aware of the discharge plans as they had been discussed and agreed at the tribunal hearing a few days prior to this. Although his social supervisor did attend, it is noted that they were only in attendance for the latter part of the meeting related to completing the HCR-20 risk assessment document.[25] A discussion was had regarding his routine and it was agreed that he would attend hostel based activities on Tuesdays and Thursdays and a substance misuse group on Fridays.

4.65 Over the next month Mr. Z presented several challenges to his care team related to his management. He is noted to have not returned as agreed with his curfew on 29 April 2015 and did not attend a meeting with his social supervisor on 28 April 2015, although he did see her on 29 April 2015 following the incident of being missing. The reports from LCH describe how Mr. Z was often challenging from the point of admission but that these challenges were diminishing in frequency.

4.66 FOS team nursing notes report that on 3 June 2015 'other than pushing boundaries no acute concerns raised by hostel staff'. By 17 June 2015 it is noted by his social supervisor that 'hostel staff feedback appeared to be adhering to the rules and acting appropriately with staff'. The report to the MoJ completed by his social supervisor, dated 23 June 2015 states in section

[25] The HCR-20 is a comprehensive set of professional guidelines / risk assessment tool for the assessment and management of violence risk. It focuses on 20 factors: 10 historical (H), 5 clinical (C), 5 risk management (R)

5.1 ("Please give details of any evidence of physical or verbal aggression by the patient since the last report and any action taken") that there were "none reported by the staff or Mr. Z". His RC noted "no concerns by LCH" in a review on 17 June 2015.

4.67 The working practice document from LCH (in effect the plan for how to work with Mr. Z) dated 3 May and signed on 23 May 2015 identifies two occasions when female staff should approach Mr. Z in pairs. These were that female staff should work in pairs when supervising his medication, due to his inappropriate sexual comments, and also that with respect to noise, especially at night female working night staff should seek and co-opt the presence of the sleeping in member of staff. Together they were to demand access to his flat and insist that he opens the door and explain why they were there. This plan adds that it is useful to try and negotiate what volumes were acceptable, and that if Mr. Z still refused to reduce the noise, to return to the office, lock the door, report the incident and in all cases report back to his social supervisor.

4.68 The CPA review records from 21 May 2015 indicate that whilst there were some problems with his verbal hostility the clinical team were satisfied with his progress. There were no concerns raised about his mental state.

4.69 From this time until the day of the incident on 27 July 2015 there were 14 incidents of non-compliance with hostel rules, seven incidents of verbal aggression and one of sexually inappropriate behaviour. However, the notes record that since admission in April the frequency and intensity of these incidents was reducing. In May 2015 there were 10 records of aggressive outbursts and failure to comply with hostel rules, in June 2015 seven were recorded, and in July 2015 there were three.

4.70 He was seen by the WLMHT Drug & Alcohol Support Service (DASS) Senior Nurse who provide input into the FOS on 3 June 2015, and it was noted that hostel staff reported Mr. Z had been 'pushing boundaries' such as playing loud music late at night, but no acute concerns were expressed by hostel staff.

4.71 On 17 June 2015 he was seen by his social supervisor and was reported to have been acting appropriately with staff and adhering to the rules of the hostel. He was also seen by the DASS worker on 17 June, who reported that the hostel staff had no concerns about Mr. Z.

4.72 On 19 June 2015 he was seen by a member of the FOS who reported that hostel staff said he was accepting medication, complying with hostel rules but at times required prompting to maintain personal hygiene.

4.73 The social supervisor took him to see his girlfriend Y on 23 June 2015, without problems.

4.74 Mr. Z had expressed frustration to hostel staff many times about not being allowed out into the garden after 10.00 pm. A potentially serious incident occurred at the hostel on 30 June 2015. Mr. Z was observed on CCTV camera coming down the stairs shirtless. He was confronted by a female staff

member and reminded of house rules, he then barged past staff making his way out to the garden to the sundeck, where he sat down and lit a cigarette. He told hostel staff sternly that he was not going to be moving as he makes his own rules and was verbally abusive and swearing. Mr. Z then jumped out of his seat and tried to threaten staff by chasing her back into the lounge and telling her that he will do what he wants and show staff what he means. At 10.10 pm the staff member and the night staff went to the back garden to persuade him to put some clothes on. This time, Mr. Z jumped up again aggressively and threatened staff. The incident report from LCH states that he appeared "to have the stance of someone going to headbutt". This was also reported in the Trust internal investigation report. However, the witness evidence to this incident does not appear to describe Mr Z's stance as that of 'someone going to headbutt' but rather as someone acting in a very aggressive manner. He persisted to show his tattoos, which has writing on his arm about the law, and stood over staff in a threatening manner. At 10.45 pm staff went back out and Mr. Z said, "you are lucky my radio died", and although he took his time making his way back to his room he did eventually leave and returned to his flat by 10.55 pm.

4.75 An incident form had been completed at Collette House describing the garden incident, although there was no corresponding entry in the daily notes. The incident form (dated 30 June 2015, at 9.45 pm) included the note that the LCH duty bleep holder had been informed, and they advised LCH to call the police. The note states that police were not called because [Mr. Z] had left the back garden shortly after this advice was given. This incident form also contains a typed note: 'BBB confirms this was reported to social supervisor A from the Forensic Outreach Service'.

4.76 We found no evidence that this incident form was shared with anyone in the FOS team. The hostel staff at interview stated they reported to his social supervisor that his behaviour was unacceptable, threatening and abusive.

4.77 The social supervisor reported to us at interview that she had an email from the hostel manager stating that Mr. Z had broken some house rules, including playing loud music.

4.78 We have seen an email from LCH staff dated 1 July 2015 at 11.04 am, to the social supervisor, informing them that Mr. Z's behaviour had been 'unacceptable threatening and abusive when staff asked [Mr. Z] to dress appropriately when coming down to the communal areas, [Mr. Z] persisted in this behaviour towards female staff as a protest against house rules. An incident form has been completed.'

4.79 We have seen the incident report which details that when asked to put some clothes on Mr. Z 'jumped up again aggressively and threatened staff, [Mr. Z] appeared to have the stance of someone going to headbutt'.

4.80 We have also seen other reports concerning the 30 June incident and Mr. Z's behaviour. In one record from LCH staff this states that:

"**PM**. Mr. Z returned from Ealing Broadway late this evening. A knocked on his door to remind him of medication. When A and B supported him, he appeared confused of the timings of the day. It was unbearably hot in Mr. Z room to the point where he was dripping in sweat. Later after medication he was observed coming down to the deck with no clothes on - A immediately told Mr. Z he needs to put clothes on, to this he became very aggressive and upfront in a physical manner pretending like he would do something as staff inform him. EH went back out ten minutes after to remind him to go to his room to put clothes on once again Mr. Z started swearing and said he wasn't going to do so."

"**Night.** Mr. Z was seen in garden at the beginning of this shift, when it was around 10.25pm both sleep over staff and waking night went to him in garden to tell him to return to his flat because the lounge is going to be lock at 10.30pm but Mr. Z refuse and said he is not going back to his flat and we can't tell him for live he was so aggressive towards staff. Bleep holder was informed she said we should give him more 10min. after that if he refuses to return to his flat, we should call police; we also went back after l0min. to ask him to go back to his flat which he now complied."

4.81 This is the only mention that he had no clothes on, and it isn't clear if he was fully naked or was just without his shirt. We have since been told by LCH that Mr. Z had only removed his shirt.

4.82 RiO[26] notes record that Mr. Z was seen by his social supervisor in the presence of hostel staff on 2 July 2015, just before the social supervisor went on leave for three weeks. We have received conflicting information concerning the date of this meeting, since LCH diary records the visit as 3 July as 12.00 am. We have also seen an email from the new LCH manager dated 2 July, introducing themselves to the social supervisor, and saying that they were 'hoping to be here when you visit tomorrow' which would have been 3 July. We can find no explanation for the two different dates to have been recorded by LCH and the FOS team social supervisor. In our view it is more likely that the visit occurred on 3 July. However, we will refer to this visit as being on '2/3 July'. We also note that the entry in RiO made by the social supervisor concerning this visit was recorded as being made at 0900. In any event this would have been recorded before the visit at lunchtime on either the 2 July or 3 July. We have been unable to reconcile how this has been possible.

4.83 At this meeting (on 2 or 3 July) Mr. Z claimed that the new manager was now letting him into the garden at night to smoke. On this occasion the social supervisor spoke to the house manager who expressed concerns that there was no risk assessment in place regarding Mr. Z visiting his girlfriend. The social supervisor assured the manager that this had been put in place on discharge and that she would review the discharge notes. There is no record in the notes that this was done.

4.84 During their interview for the internal investigation, the social supervisor is recorded that they were aware that Mr. Z had been in the garden with his shirt

[26] RiO is the electronic record system used by the Trust for clinical records

off and had been playing his music loudly but was not aware that he had threatened to headbutt anybody. They said that if they had been, they would have recommended that LCH phone the police.

4.85 The new manager of LCH wrote a warning letter to Mr. Z dated the 30 June 2015. This letter warns Mr. Z to comply with house rules concerning playing music loudly and respecting other residents. It does not mention keeping clothes on, his demand to stay in the garden late at night, responding to reasonable requests from staff to come indoors so the building can be locked, and the threatening and abusive behaviour and the feigned headbutt .

4.86 We have seen evidence of regular and frequent contact between LCH and the FOS team over this period in the form of mobile and land line phone call records. However, we are not aware of the content of any of these phone calls and therefore are unable to determine the nature of these conversations and what exactly was said in terms of briefing the social supervisor about the incident in the garden.

4.87 On 10 July 2015 Mr. Z attended the weekly New Horizons psychology group run by the FOS team Clinical Psychologist to assist and prepare patients for the transitions to community living. This is offered to both inpatients and community patients and the notes record that he contributed well to the group discussion, reflecting on his own experiences of staying out in the community and the challenges he faces.

4.88 His RC visited him at the hostel after this, the date is not given but the entry is noted as a 'late entry' on 16 July 2015. The RC noted that hostel staff had reported back that Mr. Z was mentally and physically stable, complying with conditions, and accepting medication. However, Mr. Z was noted to have been stressed about the potential cancellation of a visit to his girlfriend. Mr. Z's RC fed back to hostel staff and reminded them of the care plan related to visits and the need to book contact with his girlfriend's service two weeks in advance.

4.89 The social supervisor's report to the MoJ ('Report on conditionally discharged restricted patient' 15 July 2015) was completed by the team manager in the social supervisors absence. The Team Manager had consulted with the clinical supervisor and hostel staff prior to submitting this report. This report includes the statement "there have been no concerns expressed about [Mr. Z's] mental state which has remained stable since his discharge from hospital". In the section on inappropriate sexual behaviour, the following statement is made: 'There have been minor concerns expressed about [Mr. Z's] attitudes to relationships, intimacy and boundaries. He has been reprimanded for showing staff member's pornographic material on his phone. He has also been observed to have little understanding of intimate boundaries with his girlfriend who is also a vulnerable adult. Because of this their contact is closely supervised at all times and there are strict arrangements for planning and organising visits with her'. This information had been fed back to the social supervisor by LCH staff.

4.90 There was an incident on 17 July 2015 where it is reported that staff received a telephone call from an unknown man. He stated that he had found Mr. Z's wallet on a train and wished to return it. Mr. Z was unable to provide an explanation as to how his wallet had ended up on a train.

4.91 It was arranged that Mr. Z was seen by his care manager from London Borough of Ealing on 21 July 2015 who noted that Mr. Z had settled in well at Collette House and was complying with his medication regime of olanzapine 20 mg and sodium valproate 800 mg twice daily. The plan was for him to continue with his current medication regime and to be supported to maintain contact with his family and girlfriend with his next review scheduled for 24 August 2015. He reported that his last visit to the girlfriend was about three weeks previously and they could not go to the cinema together as he had planned because the care home was short of staff. He reported that they instead went to a café and had a drink together. He was supported by social supervisor to travel to Watford to see her. His next visit with her was scheduled for 28 July 2015. It is noted that hostel staff reported no concerns about his management or the keeping of house rules.

4.92 Mr. Z attended Ealing Hospital A&E department following one episode of haematemesis (vomiting blood) on 24 July 2015 however this was viewed as minor and he was discharged back to the hostel.

4.93 The homicide occurred on 27 July 2015. Mr. Z had been playing his music loudly. Jenny had made attempts to get Mr. Z to turn down his music in response to the complaint made by a local resident/neighbour. Jenny had knocked on his door then moved away to the foot of a set of stairs. When he opened the door, she asked him to turn the music down. This request was complied with as the neighbour later reported the sound of the TV being turned off. There was no face to face contact at that time. There are no other reports of interaction with Mr. Z, or complaints about loud music, until three hours later when he came downstairs and killed Jenny who was alone in the office. It is reported in Mr. Z's notes that at 06:00 am a staff member from Collette House heard screaming from a downstairs office in Collette House. On attending the office, they saw what they thought was blood, and called the police. Mr. Z was seen leaving the building shortly after the police were called.

4.94 We have not been provided with further information about the offence (i.e. psychiatric reports, hearing transcript), but we have been provided with police witness statements concerning this case and are aware Mr. Z was convicted of Jenny's murder, rather than manslaughter by reason of diminished responsibility, in March 2016 and received a life sentence to serve at least 24 years.

5 Arising issues, comments, and analysis

Collette House/London Cyrenians Housing

5.1 At interview for this investigation, staff from WLMHT and LCH expressed differences in understanding about the role and function of Collette House. The FOS staff said that Collette House was a specialist service for challenging individuals. However, the contract with LCH states that it was "an Accommodation Based Support service funded under the Supporting People Regime with top up funding from NHS Ealing CCG".

5.2 The West London Housing Related Support Framework Agreement defines housing related support services as "services that aim to develop and sustain an individual's capacity to live independently in accommodation". These services are not general health, social care or other statutory personal care services. The services are described as supporting independent living arrangements.[27]

5.3 The qualifying criteria for admission are:

- over 18 years old;
- in need of high/medium support; and
- in need of housing related support to maintain independence and willing to work with a support worker to an outcome-based support plan.

5.4 The London Borough of Ealing approves Collette House as a suitable 24 hour supervised hostel for patients from the forensic service, including those subject to a restriction order, not just those who have been detained under civil sections. They had been managing complex forensic patients of varying degrees for many years prior to the incident in July 2015. At the time of the homicide, five of the nine residents were on a MoJ restriction order, one of these had a personality disorder, and some were noted to have anger management issues.

5.5 It was a condition of his discharge that Mr. Z must reside in a "24 hour supported mental health hostel or other hostel deemed suitable by his treating team".

Staffing and management

5.6 We note that many of the staff employed at a senior level by LCH hold a recognised health or social care qualification which helps inform their practice

[27] In R(H) 2/07, Commissioner (now Upper Tribunal Judge) Charles Turnbull used the term "supported accommodation" and summed it up as follows:
"[the landlord] provides supported accommodation throughout the country for people with learning difficulties. By "supported accommodation" is meant accommodation in which a measure of care, support or supervision is provided to assist the occupants to cope with the practicalities of day-to-day living."

and decisions. It was stressed however at interview that the staff are not employed in that capacity, but as managers or team leaders.

5.7 We also note that many of the staff at Collette House have received enhanced training in mental health and safety including breakaway techniques, managing violence and personal safety. All of the staff have received induction.

5.8 Many staff had years of experience of working with people with mental health and complex needs, including challenging behaviour, giving them practical skills to work with clients at Collette House. In fact, 59% of staff had over five years' experience of working in the sector and 48% of staff had over ten years' experience.

5.9 We were told that locum staff were also similarly experienced. There were ten agency/locum staff working at Collette House and had between six and 15 years' experience.

5.10 There were a range of supervision arrangements in place to monitor the performance of staff including:

- formal 1-1 supervision and informal support via mentoring from experienced and/or qualified staff;
- appraisal;
- waking night checklist;
- CCTV;
- customer feedback e.g. House meeting, My Say or as part of the appraisal process;
- induction and probationary period;
- staff meetings;
- deputy attending at night;
- handovers and spot checks, and;
- checking the diary and the communication book.

5.11 There was a system in place to ensure that staff, in particular locum staff, had familiarised themselves with the resident specific working practices and other relevant documents. This included:

- Local induction (staff and locums).
- Formal supervision (staff).
- Team meetings (staff and locums).
- Comprehensive daily handovers.
- Communication book.

- Hard copies of resident files – including:
    - Customer Information Sheet & Missing Persons
    - Risk Assessment & Working Practice
    - Support Plan & Key-working information
    - Physical Health/Physical Health Correspondence
    - Mental Health/CMHT/Care Team Correspondence
    - Benefits, Finances and Rent Statements
    - Referral/Referral related paperwork
    - Licence Agreement, House Rules, Housing Contract
    - Collette House Correspondence

5.12 In addition, the Manager of the service asked staff to read the documents as part of their induction.

5.13 All members of staff (permanent and locum) have access to a full set of information about the current clients in the project. A comprehensive lever arch file is maintained in the scheme office which contains a complete suite of up-to-date documentation for each customer. This file, which is available to all staff, contains the following information:

1. Customer Information Sheet & Missing Persons
2. Risk Assessment & Working Practice
3. Support Plan & Key-working information
4. Physical Health/Physical Health Correspondence
5. Mental Health/CMHT/Care Team Correspondence
6. Benefits, Finances and Rent Statements
7. Referral/Referral related paperwork
8. Licence Agreement, House Rules, Housing Contracts
9. Collette House Correspondence
10. Miscellaneous.

5.14 In addition to access to the above file, we were told that all staff (permanent and locum) receive a comprehensive handover briefing at the start of each shift. The briefing covers the following topics:

- Incidents that have occurred in the previous shift.
- An assessment of the customer's current status.
- Any matters that need to be dealt with during the new shift.
- Any matters of concern.

Management of Mr. Z's risk in Collette House

5.15 In the internal investigation, there are a number of references to Collette House staff and communication with FOS staff. Collette House staff stated on interview that they communicated information to FOS about Mr. Z's behaviour, but we were told at interview with FOS staff that they often received verbal handovers only. It appears to us that this communication cannot be triangulated and evidenced adequately, and it is accordingly impossible to gauge whether the communication always fully reflected the true nature of Mr. Z's behaviour. It is also acknowledged by the FOS that the Collette House records were not examined by FOS staff.

5.16 We were told that Collette House staff regularly updated the FOS about Mr. Z on very many occasions. On several of these, the communication was to report that Mr. Z had been challenging, verbally aggressive, not reducing the volume of loud music, reported concerns, incidents and house rule breaches to Mr. Z's social supervisor. We have seen phone records of calls from Collette House to the FOS. However, we do not know the content of these phone calls. We have not been able to find the written evidence in Mr. Z's Collette House records of these contacts. Some of these can be triangulated with records in the nursing and social supervisor notes (29 April and 14 May 2015). However, many cannot, and there are notes of telephone contact from Collette House to the FOS on different dates, reported in the FOS team notes, that Collette House have not reported.

5.17 There are four FOS team records that discuss Mr. Z being settled and compliant (dated 3 June, 17 June, 2/3 July, and 16 July 2015).

5.18 The latest risk assessment at Collette House was dated 1 June 2015, however it is noted that there were 11 incidents of verbal aggression or threats from this time until the incident on 27 July, which were not reflected in the risk assessment. It was usual practice to update these for any formal review or following an incident, but this did not take place.

5.19 We were told that in the event of an escalation of risk behaviours Collette House would follow the contingency plan outlined in the CPA care plan of 15 May 2015.

5.20 The risk assessment and management plan contained a series of interventions to address harm to himself and others, substance use, mental health and exploiting others. The interventions described provide details of what staff are meant to observe for but there is no formulation of the risks, little evidence of what was to be done to reduce risk and what was to be done in the event of an escalation of risk behaviours.

5.21 The Department of Health Best Practice guidelines on Risk Management[28] states that all risk management plans should include a summary of risks

[28] Department of Health: "Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services" March 2009. London.

identified, formulation of the situations in which identified risks may occur, and actions to be taken by practitioners and service users in the event of a crisis.

5.22 An incident form related to the incident of 30 June 2015 was completed by LCH. The incident report noted the following concerning the incident:

"Mr. Z was observed on CCTV camera coming down the stairs shirtless. A (member of staff) confronted him and reminded him of house rules, to which Mr. Z barged past staff making his way to the sundeck. A followed Mr. Z to the garden as Mr. Z lit a cigarette and remained seated. Mr. Z told staff sternly that he was not going to be moving as he makes his own rules, if B (another member of staff) doesn't like it they can go f*ck themselves. A stood there waiting for a change in response, to which Mr. Z jumped out of his seat and tried to threaten staff by chasing her back into the lounge and telling her that he will do what he wants and show staff what he means. At 10:10pm A and Night staff went to the back garden to persuade him to put some clothes on this times, Mr. Z jumped up again aggressively and threatened staff, Mr. Z appeared to have the stance of someone going to headbutt . He persisted to show C (different member of staff) his tattoo, which has writing on his arm about the law. A tried to calm Mr. Z down and slowly pulled him off C when he stood in a threatening manner. At 10:45 staff went back out and Mr. Z had said 'you are lucky my radio died' although he took his time making his way back to his room he did eventually leave and returned to his flat by 10:55pm."

5.23 It was reported by LCH that information about this incident was shared with the social supervisor/CCO at a visit on 2 July 2015 (recorded in the FOS team electronic record) or 3 July (according to LCH diary entry), and with the RC when he visited later in July. The incident form has an addendum which was added later for the purposes of the internal investigation which states that the social supervisor had been informed. We have been told that Collette House staff, including the project manager, shared the information about the incident 'in full'.

5.24 We have also seen the Client Support Summary for Mr. Z from Collette House, dated 30 June 2015. This records three contacts with Mr. Z. The latter two concern the incident in the garden. These record:

"**PM**. Mr. Z returned from Ealing Broadway late this evening. A knocked on his door to remind him of medication. When A and B supported him, he appeared confused of the timings of the day. It was unbearably hot in Mr. Z room to the point where he was dripping in sweat. Later after medication he was observed coming down to the deck with no clothes on - A immediately told Mr. Z he needs to put clothes on to this he became very aggressive and upfront in a physical manner pretending like he would do something as staff inform him. EH went back out ten minutes after to remind him to go to his room to put clothes on once again Mr. Z started swearing and said he wasn't going to do so."

"**Night**. Mr. Z was seen in garden at the beginning of this shift, when it was around 10.25pm both sleep over staff and waking night went to him in garden to tell him to return to his flat because the lounge is going to be lock at

10.30pm but Mr. Z refuse and said he is not going back to his flat and we can't tell him for live he was so aggressive towards staff. Bleep holder was informed she said we should give him more 10min. after that if he refuses to return to his flat, we should call police; we also went back after l0min. to ask him to go back to his flat which he now complied."

5.25 Both of these records in the Client Support Summary do not mention the feigned headbutt, or that a member of staff felt scared (which they later reported in a statement made to LCH management).

5.26 Although some aspects of the incident were communicated to the social supervisor (i.e. the noise issues and the warning letter sent to Mr. Z) we have not been able to find evidence that this incident form was shared in full with anyone in the FOS team, or that they had been made aware of the aggression from Mr. Z (e.g. the feigned headbutt and his needing to be pulled away from the care worker by another member of staff) and the perception of a member of the staff on duty (being scared).

5.27 We have seen a copy of the email sent to the social supervisor/CCO by the Project Manager from Collette House on Wednesday 1 July at 11.04 am which states "Regarding Mr. Z, just to inform you staff reported his behaviour to be unacceptable, threatening and abusive when staff asked Mr. Z to dress appropriately when coming down to the communal areas. Mr. Z persisted in this behaviour to female staff, as a protest against house rules. An incident form has been completed."

5.28 The social supervisor recalls an email letting her know that Mr. Z had broken some house rules including playing loud music. She saw him on 2 July 2015 at Collette House (or 3 July, as there is some uncertainty about the precise date, see above). The entry made by the social supervisor dated 2 July 2015 makes no reference to the severity of this incident (i.e. the feigned headbutt), although she describes discussing aspects of the conditions of his discharge in the notes:

"I sat with Mr. Z within the garden he spoke about everything going well within Collette House and happy that the new manager is allowing him to access the garden on an evening to have his smokes. He spoke about arranging another visit with Y, but the manager reported that she is unable to facilitate this. Mental state was observed to be stable, he was mentally alert, and his speech was fluent and cohesive. He did however become agitated when he spoke about the new manager not facilitating his visit to Y. He was observed to have the understanding and capacity around this. We both sat and spoke to her and I explained his conditions of discharge and what was agreed at his 117 meeting. She stated she was not aware of this but will look through his reports to find the discharge summary. Mr. Z reported to be happy with that decision and soon became less agitated taking himself back to the garden for a cigarette."

Forensic Outreach Service (FOS)

5.29 The FOS is a forensic community service providing care and treatment for people requiring specialist forensic community support on discharge from inpatient forensic services. The service provides 9-5 support, Monday to Friday for around 70 patients subject to MHA restrictions and those on a Community Treatment Order (CTO). The service is multidisciplinary and consists of a consultant psychiatrist, community mental health nurse, social worker, clinical psychology, family therapist for service users and their family, and vocational work. It also includes Care Coordinators who are responsible for advice, facilitating treatment and liaison with the clinical team. At the time of this incident community mental health nurses and social workers assumed the role of social supervisor and Care Coordinator.

5.30 The service operational policy states that, 'the building and maintenance of good communication and networks are vital to the service-user's recovery and the management of risk in the community'. And that 'collaborative working with other teams may include:

- Joint assessment with staff from other teams.
- Consultation and advice to other teams.

5.31 From our investigation process and after interview with both teams, we are of the opinion that the available evidence does not unequivocally demonstrate that Collette House always provided adequate detail about Mr. Z's changes in behaviour and risk. This was then further compromised by the FOS team not recording verbal handover details from Collette House. We would normally expect to see that when an incident like that of 30 June 2015 was being considered, its context (a pattern on non-compliance and verbally aggressive behaviour) should have been obvious from the health records. However, this is not the case concerning this incident, as little of what had been reported (before and after this incident) was recorded consistently.

5.32 This information has been obtained via interviews and through scrutiny of clinical records, emails, statements and incident reports. During our interviews with Collette House staff they reiterated their belief that they had communicated adequately with members of the FOS team when they visited. Whilst this fact is contended by the FOS social supervisor/ CCO and the RC, they also acknowledge that they had not read the Collette House records when visiting. We believe it is reasonable for the FOS team to receive verbal handovers, which should be based around a joint understanding of risk and care plans. We do not consider it is reasonable for FOS team members to read the notes at Collette House at every contact for every patient. However, MoJ guidance places the onus for liaison and information seeking on the clinical and social supervisors.[29]

[29] Ministry of Justice "Guidance for clinical supervisors", 18 March 2009 and "Guidance for social supervisors" 18 March 2009

Commissioning and oversight of services

5.33 The WLMHT FOS is commissioned by NHS England, through a joint funding panel that has responsibility across London. There are geographical divisions, with commissioning staff and local case managers having responsibility for individual Trusts. This applies to high, medium and low secure inpatient services, and some community forensic services.

5.34 Mr. Z met the threshold for case management by FOS, as a patient with complex needs. This care would be clinically led, that is the FOS care team had responsibility for his care, which was funded by NHS England. It would be expected that the FOS would pick up any concerns through the care coordinator and feedback any issues.

5.35 The structures for oversight of the commissioned service are that NHS England receive monthly quality information from WLMHT about all forensic services in the contract. A monthly review meeting examines detail, but this detail alternates between information from high, medium and low secure services. This information is based on high level quality measures that are taken from agreed standards, such as numbers of staff appraisals achieved, levels of CPA reviews completed, risk assessments in place etc. If the provider has not met the targets they would be followed up, but the system does not drill down into detail about specific services or individual cases.

5.36 Current senior managers reported that they have not had any historic indications of concern about the WLMHT FOS team. This incident however has highlighted that there was need for a more detailed quality focus on the WLMHT FOS.

5.37 The LCH placement for Mr. Z was funded through a joint arrangement between Ealing Council and NHS Ealing CCG. The oversight of these arrangements is not within the remit of this investigation.

5.38 However, we have visited Collette House. We note that entry is through a locked door with intercom, staff offices are locked to prevent residents walking in, many of the corridors have CCTV, there are wall alarms, and staff all carry personal alarms. This is of concern, given the nature and complexity of the residents, and we have made a recommendation concerning this aspect of service provision and regulation.

Patient factors

5.39 Mr. Z is a 52-year-old man with an extensive mental health and forensic history. He has a diagnosis of paranoid schizophrenia, personality disorder and substance misuse problems.

5.40 In the preceding 28 years he had 10 admissions to inpatient services, three supported housing placements and community treatment interventions. He was subject to recall from two of these placements due to non-compliance with conditions of discharge/non-concordance with treatment.

5.41 Mr. Z has a history of demonstrating psychotic symptoms in the form of auditory hallucinations and thought disorder. He was not noted to be displaying these symptoms shortly before the offence. His medication at the time of the offence was olanzapine 20 mg and sodium valproate 800 mg twice daily which appeared to alleviate his psychotic symptoms.

5.42 He was also known to display a number of negative symptoms of psychosis namely self-neglect and decreased motivation. These were regarded as indicators of deterioration in mental state and usually associated with concurrent low mood. There are many examples of self-neglect with personal and sleep hygiene and non-concordance with medication despite being supervised, most notable in previous community placements.

5.43 Mr. Z has been treated with a variety of anti-psychotic medications. His response to these has been variable, however he was known to have responded well to clozapine but had stopped this of his own accord on two occasions due to his perception that he had gained weight. There are three occasions, discussed earlier, when it is known that Mr. Z sought medication from his GP whilst receiving prescribed anti-psychotic medication both as an inpatient and whilst in supported accommodation. The first of these was whilst in Lyndhurst residential care home in North Finchley. On this occasion he tried to persuade the FOS team to reduce his clozapine, claiming it was making him too drowsy, whilst at the same time secretly receiving temazepam from his GP on the basis that he was finding it difficult to sleep. The second was on 13th May 2011, following a report that Mr. Z had been stockpiling amitriptyline,[30] obtaining supplies of zolpidem from his GP without the knowledge of the psychiatric team and drinking half a bottle of whiskey per day. He was urgently reviewed by his then RC. This coincided with significant people, including his parents, social supervisor and hostel manager being away. On the third occasion, 18 October 2012, his then RC received a GP letter dated 17 October 2012 requesting advice on Mr. Z's care. It was reported that Mr. Z had attended a new GP surgery and registered with them in order to obtain zopiclone, which he obtained from the doctor. Hostel staff was alerted to this situation and Mr. Z's room at the hostel was searched. Mr. Z later admitted that he had done so in order to stockpile medication to take an overdose in case his request to spend one night over the Christmas period with his girlfriend was not allowed.

5.44 Whilst attending Community Activities Project Ealing (CAPE), a mental health day service set up to deliver meaningful daytime activities, he was reported by volunteers there to have been discovered seeking medication on the internet.

5.45 Mr. Z was also diagnosed as suffering from traits of both dissocial and emotionally unstable personality disorder. This manifested in verbal and physical aggression, poor anger control, impulsiveness, threats and actual self-harm, use of drugs and alcohol in attempts to cope and dishonesty. Whilst a number of psychological interventions took place to address his anger control, relationship behaviour and drug and alcohol use, there was little evidence of his ability to manage these traits when in both inpatient and

[30] Amitriptyline is an anti-depressant.

community placements. His care plans located in the 'Working Practice' document outlined a set of approaches to be used when responding to Mr. Z and aspects of his behaviour. In particular the approach to him not complying with house rules reminds staff:

- to be polite and tactful;
- to never argue or raise their voice;
- for him and staff to report the concern to the house manager;
- if concerned to report to police;
- for female staff at night to co-opt the sleeping in member of staff's help; and,
- if he refuses to comply/turn the volume own to retreat to the office, write an incident form out and report to his social supervisor.

5.46 However, other than report to his social supervisor, as in the FOS team documentation, there were no contingencies described in the event of an escalation in behaviour, such as thresholds for, or consideration of, clinical review and escalation.

5.47 Mr. Z has an extensive history of using alcohol to excess and the use of illicit drugs. He acknowledged on interview that he had continued to take 'legal highs' when in his community placements. There is repeated evidence of the occurrence of risk behaviours in the context of drug and alcohol use. The records from Collette House and FOS state that this was suspected but not proven. His father also reported that he suspected Mr. Z was taking illicit substances. However, the Urine Drug Screens (UDS) undertaken at reviews did not detect this, and LCH had no knowledge of him taking any drugs, Novel Psychoactive Substances (NPS)[31] or otherwise whilst at Collette House.

5.48 The FOS team, on interview for this investigation, believed that Mr. Z was free of substances when in Collette House. However, his self-report to us on interview challenges this. He alleges that he had taken novel psychoactive substances (legal highs) whilst at Collette House. These would not have shown up in the UDS. Although they would have appeared on a mouth swab test, the notes record one mouth swab being taken to test for 'Spice' (a novel psychoactive substance) whilst he was in Collette House, with negative results. Mr. Z saw a dual diagnosis worker on two occasions and attended both Addaction and Alcoholics Anonymous to address his difficulties. Mr. Z is also known to have made threats to recommence drug or alcohol use when his requests were not met. We were told that at no time during his stay in Collette House did Mr. Z report he was taking novel psychoactive substances, and on 16 July 2015 actively denied taking them.

5.49 We believe it is apparent from the actions taken in his previous community placements and at Collette House that there were several behaviours which, whilst highly indicative of the risk of violence, were not seen as obstacles to his remaining in the placement. These were specifically that Mr. Z engaged in

[31] Also known as 'legal highs'.

violence and aggression, threats to harm himself and others, non-concordance with medication and non-compliance with conditions of placement. Nevertheless, despite the aggressive and threatening outbursts, there is no record that Mr. Z had physically assaulted anyone whilst at Collette House, and the records reported a decreasing pattern of outbursts and challenging boundaries. When incidents did occur, they were discussed, but other than the two previous occasions when he was recalled, at no other time is it recorded that recall was ever considered. We have been told that Mr. Z was registered in the 'Amber zone'[32] for longer than the standard post month discharge period due to some reports of verbally challenging boundaries around smoking and the early incidents of showing pornography to a staff member. Decisions to place or keep people in amber at that time were reviewed in the weekly team meeting and this meant that he was considered at risk of recall. The guidance on recall for Conditionally Discharged patients' states:

"There is no need for the patient's mental health to have necessarily deteriorated in order to justify recall. If a patient has a mental disorder and is presenting an elevated risk linked to that disorder that warrants detention in hospital, then the patient can be recalled. In such a case the criteria for detention would be met because the disorder was of a nature (rather than degree) that warranted detention in hospital and this is necessary for the protection of other persons."

A decision was made to take him out of Amber zone on 23 June 2015.

5.50 A significant factor in his noncompliance and lack of engagement was his relationship of 20 years with a woman whom he met whilst they were inpatients in the Trust. There are over 50 references to incidences of aggression, threats of self-harm and non-concordance in relation to issues surrounding arrangements for seeing her. Efforts were made by WLMHT teams, including FOS, and supported by Collette House, to encourage the maintenance of these arrangements to visit his girlfriend as agreed in the care plan. On several occasions Mr. Z's behaviour and mental state prevented these visits.

5.51 It would appear that Mr. Z held an 'idealised' view of the relationship and whilst he said he wanted to marry her it appeared she was not as enthusiastic as he was about this. There were also concerns raised by her own care team as to her capacity to make an informed decision on sexual contact and marriage. Mr. Z stated that if they were to marry this would prevent him using alcohol or drugs and would stop him from losing his temper.

5.52 In December 2014, following a Christmas visit at his parents, his girlfriend made an allegation against him related to him pressuring her to have sex,[33] and his contact with her was suspended temporarily. This issue was

[32] a system of grading the risks a service user presents from Green - no risk, to Red - significant risk.

[33] Mr Z's parents refute that this incident could have happened, since they were always in close proximity to Mr Z and Y

discussed in a safeguarding meeting initiated by Y's care team resulting in agreement that they could see each other again but on a supervised basis.

5.53 It was recommended on a number of occasions that Mr. Z and his girlfriend engage in some joint therapy as a couple to examine their relationship. Whilst this did not occur, the rationale for suggesting this is questioned, given the fact that Y was a vulnerable adult and Mr. Z was known to have often made threats to disengage from treatment if his wishes were not met.

Discharge process

5.54 The discharge planning was initiated while Mr. Z was still on Solaris ward, a low secure ward within the St Bernard's hospital site, in October 2014. Collette House was assessed to be a suitable placement for management of his future care by the Solaris ward team and the London Borough of Ealing. Mr. Z was assessed by two experienced staff from LCH in December 2014. They were provided with the required information, which included his mental health condition, his being subject to a restriction order, his substance misuse problems, his history of violence, his other risk history and an assessment of his risk at that time and they assessed him as being suitable for placement at Collette House. His presentation was settled at the time and no concerns by the ward staff or the Collette House team were expressed following the assessment. The internal investigation into the incident contains statements by LCH staff which suggest that they knew Mr. Z would be challenging in his behaviours. The care plans related to his illness, his medication, substance use, conditions of stay, insight, recovery and his relationship. There was also a crisis plan in place should staff be unable to de-escalate Mr. Z's aggressive behaviour, and a contingency plan to address a deterioration in his mental state. The LC working practice document dated 3 May 2015 and signed by Mr. Z and his key worker on 23 May 2015 clearly identified the approach to be taken if Mr. Z breached house rules. This included the way to speak with Mr. Z, and for female staff on nights to approach him in pairs. It is noted that on all occasions any behaviours were to be reported back to his social supervisor.

5.55 Psychological therapies continued on transfer to Butler House and he completed the group work. He had also started attending the weekly New Horizons group in the community in January 2015. This is a group run by the Trust to assist and prepare patients for the transitions to community living. This is offered to both inpatients and community patients. Even after discharge Mr. Z continued to attend the New Horizons group regularly with positive feedback from the facilitators. One of the main facilitators also worked with the FOS and Butler House. He regularly updated the Butler House and FOS at weekly meetings about his progress. Mr. Z engaged very well and made good use of the group and made good contributions. There were no concerns raised by the facilitator while he was an inpatient or in the community. A Drug and Alcohol support worker, who continued to review him at the hostel at regular intervals, also attended FOS meetings. No concerns were raised by him.

5.56 On 14 December 2014, Mr. Z was interviewed by the management staff from Collette House and deemed to be suitable for placement there. The

assessment report by the management staff at LCH demonstrate that they had a good awareness of his risks and the potential challenges but state that these were not apparent during interview.

5.57 There were some issues with obtaining the decision for conditional discharge. The Tribunal panel agreed that Mr. Z should be transferred to Butler House for pre-discharge work, and his RC was therefore not recommending discharge at that point. We were informed at interview that the usual procedure for a discharge pathway is for discharge via Butler House.

5.58 When funding had been agreed Mr. Z commenced twice weekly visits to Collette House. An issue not in the control of LCH or WLMHT was that funding for overnight stays was not agreed by the local authority. These therefore could not be facilitated financially and so these did not happen. Nevertheless, Collette House and the FOS agreed that the conditional discharge could proceed despite no overnight leaves taking place. The funding for his placement was already in place before he was transferred to Butler House in February 2015. However, there was no funding agreed for overnight trial or familiarisation leaves as Ealing Council would not fund overnight leave while the individual is still an inpatient.

5.59 Butler House is a low secure pre-discharge unit. Patients on a medium or low secure forensic ward who are considered close to discharge are sometimes moved to Butler House in final preparation for placement in the community. This also provides the least restrictive option under such circumstances. The Butler House team works in close liaison with the FOS, which is eventually responsible for supervising forensic patients. Placement on Butler House facilitates a smoother transition and effective management of the risks.

5.60 Staff from Butler House including the RC, the social supervisor, the Psychologist and the Drug and Alcohol support workers also work with the FOS. Both Butler House inpatients and community patients are reviewed and discussed at a weekly meeting at South West House, another building where the FOS operates from, in order to coordinate discharge planning.

5.61 The RC for patients on Butler House would also be the RC for Mr. Z in the community upon discharge, the move to Butler House also facilitated the RC getting to know the patient well and coordinating his smooth transition into the community.

5.62 Staff on Butler House, being a pre-discharge unit, have considerable experience of working closely with the hostels, the families, Multi-Agency Public Protection Arrangements (MAPPA)[34] and other relevant agencies. This

[34] MAPPA stands for 'Multi-agency public protection arrangements. There are 3 categories of offender eligible for MAPPA.
Registered sexual offenders (Category 1). Sexual offenders who are required to notify the police of their name, address and other personal details and notify any changes subsequently.
Violent offenders (Category 2). Offenders sentenced to imprisonment/detention for 12 months or more or detained under hospital orders. This category also includes a small number of sexual offenders who do not qualify for registration and offenders disqualified from working with children.

close working has assisted in the safe and effective discharge of many complex and long stay inpatients within the West London Forensic services from various levels of security.

5.63 He was noted to be stable in mental state and behaviour and compliant with the transitional arrangements during his stay on Butler House. There were no physically aggressive and non-compliant behaviours while on Butler House.

5.64 A period of overnight leaves may have ideally been desirable, but this was not funded by the Local Authority at the time. However, given Mr. Z's progress these could not in the circumstances be considered essential. As a patient detained under Section 37/41, he was allowed substantial amounts of day leave from Butler House, a low secure pre-discharge unit, before his conditional discharge. These day leaves allowed the team to assess the patient's ability to independently manage his activities of daily living and adhere to the rules of Butler House and the hostel. Mr. Z coped without difficulty on being moved from a low secure ward to Butler House.

5.65 The Collette House manager had a meeting with the social supervisor on 21 April 2015 prior to the tribunal hearing and agreed that there was no need for trial overnight leaves. The internal investigation report noted that on "21st April he was seen at Collette House by the Social supervisor. Staff at the hostel

---

Other Dangerous Offenders (Category 3). Offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm, there is a link between the offending and the risk posed, and they require active multi-agency management.

There are three levels of MAPPA management:
Level 1: ordinary agency management.
Level 2: active multi-agency management, and
Level 3: active enhanced multi-agency management.

Level 1 cases
Ordinary agency management level 1 is where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or 3 MAPPA meeting.
Level 2 cases
Cases should be managed at level 2 where the offender:

- Is assessed as posing a high or very high risk of serious harm, or
- The risk level is lower, but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm, or
- The case has been previously managed at level 3 but no longer meets the criteria for level 3, or
- Multi-agency management adds value to the lead agency's management of the risk of serious harm posed.

Level 3 cases
Level 3 management should be used for cases that meet the criteria for level 2 but where it is determined that the management issues require senior representation from the Responsible Authority and Duty-to-Co-operate agencies. This may be when there is a perceived need to commit significant resources at short notice or where, although not assessed as high or very high risk of serious harm, there is a high likelihood of media scrutiny or public interest in the management of the case and there is a need to ensure that public confidence in the criminal justice system is maintained.

The Conditional Discharge report to the Mental Health Casework Section of the Ministry of Justice, dated 15 July 2015 records Mr. Z as being on Level 2 MAPPA

expressed no concerns. He had settled within Collette House and was getting on well with staff and service users. The manager stated that they did not feel it was necessary for him to have overnight leaves prior to discharge (a view, which was supported by the FOS team)."

5.66 The MoJ had approved the patient's overnight leaves and the Secretary of State had made a comment in the statement dated 21 April 2015. This states:

"The Secretary of State has read the report by [the RC] dated 13 April 2015 and the nurse report dated 23 March 2015. The Secretary of State acknowledges the consensus among the treating team that all of the measures are now in place to ensure Mr. Z's safe transition from hospital into supported accommodation. The Secretary of State would prefer to see Mr. Z tested at the proposed community accommodation on an overnight basis. However, he has considered that funding has not been made available".

5.67 The tribunal panel having heard the evidence presented were also satisfied that the discharge could take place without the need for overnight leaves. It is clear that if either the Butler House team, Collette House staff or the tribunal panel had considered trial overnight leaves were necessary at the time of the hearing, Mr. Z would not have been discharged.

5.68 Mr. Z was having six to eight hours of unescorted day visits two to three times a week to Collette House for nearly three months prior to the tribunal hearing. He engaged well but according to LCH he only spent two to three hours at Collette House. He was engaged in community programmes (New Horizons group, substance misuse) and compliant with the hostel staff, and even participated in Sunday meals there. He maintained regular contact with his family, who were pleased with his transition arrangements.

5.69 Some of the early disagreements Mr. Z had with the hostel staff e.g. about contributing of £12 towards service charges, would not have specifically come to light during overnight leaves. These became apparent only after he became a resident after discharge. These in the event were dealt with by the social supervisor during joint meetings with Mr. Z and the hostel staff.

5.70 His First Tier Tribunal (mental health) hearing was postponed in March 2015, and when it did take place on 23 April 2015 it was attended by his RC and social supervisor/CCO. The Tribunal agreed with the team's plans to discharge Mr. Z conditionally.

5.71 The internal investigation noted that the conditions of conditional discharge were appropriate. These were to:

- reside at a 24-hour supported mental health hostel or other hostel deemed suitable by his treating team;
- comply with appointments and care management plans with his RC and social supervisor;
- cooperate with monitoring of illicit substances and alcohol use including herbal highs;

- remain totally abstinent from the use of illicit substances and alcohol including herbal highs; and
- cooperate with geographical exclusion zones including allowing monitoring of contact with his long-term partner Z as is considered necessary.

5.72 Whilst these conditions are relatively generic and not unusual in such cases generalised and without specific focus on the details of Mr. Z's individual needs, support and supervision, they do require him to 'comply with appointments and care management plans'. The MoJ conditional discharge application form, Annex A[35] does specifically include the option of specifying compliance with hostel rules, expressed as "Reside at [specify address] [24 hour supported/supported/residential accommodation as directed by the RC and Social Supervisor] [and abide by any rules of the accommodation], and obtain the prior agreement of the responsible clinician and social supervisor for any stay of one or more nights at a different address''. It would have, in our opinion, been helpful to have at least considered being more specific about the requirement for compliance with house rules, given his history of challenging boundaries and threatening or non-compliant behaviour.

5.73 We consider that more specific conditions would have been expected. Arguably, it would have been a helpful condition to specify for a patient with Mr. Z's history exactly what behaviours would be tolerated and what (for example playing loud music late at night, persistent breaches of house rules, threatening and violent behaviour) would not. It seems to us that this would have made it more likely that the 30 June 2015 incident was clearly communicated to the health team (and then by them to the MoJ), as this would certainly have been a breach of such a condition. He was on his first warning for breaching house rules, but these related to noise at night and not respecting fellow residents, not aggressive and threatening outbursts.

5.74 Mr. Z was recorded as being on MAPPA Level 2 in the Conditional Discharge report to the Mental Health Casework Section of the Ministry of Justice, dated 15 July 2015.[36] A MAPPA notification should have been made prior to the commencement of authorised unescorted community leave, and at discharge. Subsequently MAPPA is updated at regular intervals. In Mr. Z's case MAPPA were updated on his transfer from Solaris to Butler House in February 2015. However, it does not appear that a MAPPA notification was made at the time of his discharge. The internal investigation concludes that this would not have had a bearing on the outcome. We agree with this, as it is difficult to see what difference the notification would have made, as the plan was for single agency working, which was what happened.

[35] Annex A - Examples of 'standard' conditions suggested by the First-Tier Tribunal, conditional discharge application form. https://www.gov.uk/government/publications/submit-a-conditional-discharge-request-for-restricted-patients

[36] Category 2: Violent Offender who has been sentenced to detention in hospital (e.g. section 37 hospital order)

5.75 Mr. Z's father was present at the tribunal hearings on 23 March and 23 April 2015. The RC on Butler House had met his family several times whilst the patient was in the community, prior to his recall in December 2013. His father was aware of the discharge meeting but could not attend and was aware of the discharge plans as they had been discussed and agreed at the tribunal hearing a few days prior to the discharge. His father was pleased that there was going to be continuity with the same RC upon Mr. Z's eventual discharge into the community.

5.76 Mr. Z's father was aware of his son's mental disorder, difficulties with his son keeping to limits set, and with his drug and alcohol use. His father's wish was for his son to have the best quality of life as possible under the circumstances. He took a humane and caring approach towards his son's wellbeing and supported his relationship with his long-term girlfriend, who was also under the care of mental health services.

5.77 Mr. Z's father had articulated his views favouring the patient co-cohabiting with his girlfriend to the Judge at the tribunal hearing in April 2015. However, his father was aware of the enduring fluctuating capacity issues with both Mr. Z and his girlfriend that made it challenging for the services to safely facilitate co-habiting.

5.78 Collette House informed the Butler House team that they were satisfied that the patient was suitable for Collette House when discharged as they were not only familiar with his case management, restriction order, risk of violence to others and follow up plans, but also had experience of managing him during his prolonged unescorted visits to the hostel two to three times a week for three months. The social supervisor and ward staff escorted him to the hostel on the day of discharge in a hospital vehicle and met with the Collette House team to hand over information about his care, including confirming follow up arrangements.

5.79 As commented earlier, the internal investigation report noted that the social supervisor had met with the Collette House manager and Mr. Z on the 21 April 2015. It was made clear by the manager that he considered there was no need for trial overnight leaves and that the patient, given his progress, would be offered permanent accommodation on discharge.

5.80 The only specification made by the manager of Collette House to the social supervisor was that they would accept admission only on Mondays. If the patient was not discharged on Monday 27 April, then it would not be possible to discharge him until May 11 as the following Monday May 4th was a bank holiday. This was discussed at the tribunal hearing and a decision was made to facilitate discharge as soon as possible. A pre-discharge meeting was held on 27 April 2015. Present were his clinical supervisor and social supervisor, his GP, and several health care professionals.

5.81 We found no evidence that either Mr. Z's parents, or LCH staff/Collette House staff had been invited.

5.82 Given Mr. Z's history, and in particular the fact that two previous community placements had 'failed' (in the sense that recall to hospital had been required), we consider that more specific conditions might usefully have been considered. Arguably, it could have been helpful if a condition had more clearly pointed to certain behavioural requirements or expectations, e.g. compliance with 'house rules'. We would expect that there would be a joining up and agreement of conditions and interventions in the community to successfully address Mr. Z's needs and the legal conditions set out as part of his discharge.

5.83 With specific regard to his risks, there was no joint formulation, descriptions of risk or plans for what was to happen in the event of a crisis. There was no description of any thresholds for recall or for the option of a prompt clinical review of the suitability of (or need to amend) existing care arrangements, including placement. There was no agreement (or apparent discussion) about what sorts of behaviours and issues should be immediately reported to FOS and when. We have made a recommendation specifically related to this.

5.84 Mr. Z was regarded as cooperating with the treatment interventions and complying with the care plan. There were no significant concerns from the members of staff who visited him in July 2015; the RC, social supervisor, Drug and Alcohol support Service (DASS) worker and Care Manager of the London Borough of Ealing who visited him at the hostel, and the psychologist facilitating the New Horizons group.

5.85 Mr. Z was a regular attendee at the weekly New Horizons psychology group after conditional discharge from the hospital. His RC, DASS worker and Care Manager saw him at least once a month. Initially his social supervisor saw him at least once a week, some of which were joint meetings with the hostel staff to address any concerns that were raised by the patient or the hostel staff, although this tapered off to every two to three weeks. The social supervisor had met with both managers of Collette House.

5.86 Mr. Z was regarded as generally compliant with interventions put in place by the social supervisor and the hostel staff. He occasionally deviated from agreed rules within the hostel, and this was accepted as not unusual in the client group at Collette House. No major concerns were raised by the staff that made the FOS team consider requesting a review of the suitability of his placement with the Care Manager or contacting the MoJ.

5.87 The FOS discussed the case during weekly meetings of the service and patients are placed on a traffic light system which denotes concerns the FOS have about the patient. The colours are Green, Amber and Red. All discharged patients are placed on Amber until the first CPA meeting and re-graded depending on how much input is needed or any concerns raised. Mr. Z was on 'Green' at the time of the offence and for many weeks prior to that, indicating that the FOS team were satisfied that the risks were effectively managed, and that the patient was complying with the management plans in the community.

5.88 The CPA/117 meeting should have included everyone in the care of Mr. Z and incorporated their views in the final checking of discharge plans. The care plan should have been clear on the MoJ conditions and the management of Mr. Z regarding these conditions. This would have been enhanced by an up to date record of historical, current and clinical risk issues. The HCR 20 along with the Trust's comprehensive risk assessment tools were considered by the FOS RC to have addressed all the risks and scenarios. These tools were reinforced during face-to-face contact with the hostel staff and the patient at regular meetings with the social supervisor and other members of the FOS who visited the hostel.

5.89 However, we consider that the crisis plan should have clearly set out the actions in the context of a change in behaviour/relapse indicators and what actions/interventions should have occurred, and that strenuous efforts should be made to ensure that all involved in the Mr. Z's care attend the CPA meeting, or have the opportunity to provide their input and receive feedback.

The role of the social supervisor/Care Coordinator

5.90 The role of the social supervisor is described as the professional involved in providing reports to the MoJ following a restricted service user being discharged from the hospital. The person discharged from the hospital is subject to Section 37/41 under Mental Health Act. The social supervisor works alongside the clinical supervisor.

The clinical supervisor is responsible for all matters relating to the mental health of the patient, including regular assessment of the patient's condition, monitoring any necessary medication and its effects and consideration of action in the event of deterioration in the patient's mental state. The clinical supervisor should be directly involved in the treatment and rehabilitation of the patient and should offer support for the patient's progress in the community, rather than simply checking that the patient is free from symptoms. The clinical supervisor should be prepared to work with other professionals involved in the patient's care, including the social supervisor and possibly the general practitioner, community psychiatric nurse and hostel staff.

5.91 We were informed that the person who was the social supervisor was also his care coordinator. They were qualified as a social worker and registered nurse. They were a temporary member of staff provided by an agency.

5.92 The role of the Care Coordinator (CCO) under CPA is the professional who takes a proactive and co-ordinated approach in identifying the most complex and vulnerable people with mental health problems, and then co-ordinating and managing their care in partnership with the individual and their carers.

5.93 We are concerned about the nature of communication between FOS and Collette House staff. From our interviews we are aware that there is a differing interpretation of the quality and extent of the communication about Mr. Z's behaviour, in particular the nature of the incident in the garden on 30 June 2015, which could have been an opportunity to comprehensively review his case.

5.94 The HCR-20 was not updated in line with the CPA process and raises further questions about the paucity of information in the risk management plans and discharge arrangements.

5.95 We were told that the social supervisor's contract with WLMHT had been terminated as they had carried out some nursing duties while not being registered with the Nursing and Midwifery Council.

5.96 Following discussion of this issue with WLMHT we received the following information from the service director of low secure and community forensic services:

- All requests for temporary staff are via the temporary staffing team who are the sole point of contact for agency and recruiting managers. They deal directly with agencies and liaise with managers accordingly.
- Temporary staffing only deals with agencies on an approved framework and this group is limited to a manageable group.
- It is the responsibility of the registered staff member to ensure that they are registered in the professions in which they have applied, and it is the responsibility of the agency to check this.

5.97 In the case of the social supervisor/CCO in this incident and prior to the above procedures being in place, a request for temporary staff was made by the Trust (they had a contract with a staffing agency called PULSE)[37].The agency replied, confirmed registration as both a nurse and social worker, and sent out details and CV to the Trust. They were then interviewed informally, and a start date was agreed with the Trust and temporary staffing, in the role of social supervisor.

5.98 They had been asked to carry out some nursing duties in the giving of medication to FOS team patients (not to Mr. Z). It later transpired that her nursing registration had lapsed, and an investigation ensued.

5.99 The CCO received 13 episodes of managerial and clinical supervision between March 2015 and May 2016 and is noted to have been provided with informal support and coaching outside of this. They also attended regular practice discussions within the nursing group and FOS team.

5.100 Currently each practitioner has their own caseload, but these cases are shared by the clinical team. Therefore, each patient will have a social supervisor, community psychiatric nurse, and a responsible clinician. This means that if any member of staff is on leave or absent then there is another to take over responsibility.

5.101 This was not the case in July 2015 when there was only an RC/ clinical supervisor and either a nurse or social worker allocated in a dual role of care

[37]PULSE agency. https://www.pulsejobs.com/

coordinator and social supervisor. The average caseload for the team was 15 but Mr. Z's social supervisor had a caseload of eight.

5.102 In our interview with the social supervisor they maintained that they had not had any specific training for the role and were initially working under the supervision of the FOS team manager.

Risk Assessment and risk management plans

5.103 His CPA Care Plan/Crisis Plan dated 21 May 2015 identifies the following warning signs:

- Alcohol or substance misuse
- Increased agitation
- Non-compliance with treatment and rules
- Paranoid or thought/beliefs
- Delusional ideas
- Preoccupation with intimate relationships
- Concern reported from mother or father.

This plan then identifies the steps to be taken in the event of a crisis as follows:

- Contact MDT as soon as possible, urgent assessment to be arranged.
- Mental state to be reviewed.
- Medication to be reviewed.
- If there are any signs of drug and alcohol abuse immediate drug screen to be completed.
- If Mr. Z becomes verbally abusive or threatening and the situation is unable to be de-escalated hostel staff to contact the police and MDT
- Hostel to implement emergency procedures i.e. contact police, out of hours mental health service where appropriate. All contact details are available to hostel staff.
- Liaise with, and support family where appropriate.

The contingency plan identifies the following seven steps to be taken:

1. Admission to hospital if deterioration in mental state. Unscheduled CPA if concerns are raised.
2. Reassessment by Forensic Outreach Service.
3. Placement review if concerns persisted.
4. Hostel staff to provide weekly key work to monitor risks.
5. Supervision by WLFS (West London Forensic Service).
6. Engagement with structured weekly activities.
7. Discussion about threshold for recall to hospital.

5.104 Unfortunately, the threshold for recall to hospital was not made clear during this planning process or at the Tribunal. There was room for more detailed and specific discussion about the particular behaviours, or persistence of behaviours, that would be expected to trigger a discussion of recall (N.B. not necessarily triggering recall itself). We believe that this should have been considered given his two previous recalls from community support providers and his high propensity for violence, and that thresholds for recall should have been considered by his clinical team.

5.105 Although the components of Mr. Z's risks were well known to those who worked with him, including Collette House staff who had identified his risks 'on paper' on assessment, we believe that the HCR-20 was significantly lacking in detail about these components. The HCR-20 is dated 18 February 2015 and noted to have been updated on 27 July 2015 by his RC after the homicide. The only section updated is section 4, 'Determining Case Prioritization', which relates to his recent transfer to custody.

5.106 It was well known by many of the FOS (including his RC, and previous social supervisor), New Horizons staff and LCH staff caring for Mr. Z that a particular trigger or flashpoint for aggression was any perception on his part that visits to see his girlfriend, Y, were being thwarted. In fact, although it was well known and recorded that Mr. Z would push boundaries and be verbally threatening and aggressive, potential thwarting of a visit to see his girlfriend was not given any significance despite it being a previous trigger for recall in 2013. In this instance he had threatened violence and to knife his then CCO because a visit to his girlfriend was stopped due to his taking legal highs. One statement from a key worker in Collette House acknowledges the significance of the need to manage visits to Y, and that these were organised by the social supervisor, Collette House were not always kept in the loop and that "arrangements were not hammered out properly".

5.107 There is insufficient evidence in the descriptions of his behaviour of the factors which increase his risks, what has been done to mitigate against risk other than restricted movements and what works with Mr. Z. There is no evidence that his HCR-20 was updated following the potentially serious incident of 30 June 2015.

5.108 The HCR-20 is a form of risk assessment and management planning based on ten historical, five clinical and five risk management factors. It is an example of what is known in the risk assessment literature as a structured clinical judgement process. When all information is gathered and allocated to the specific factor then the clinical team is expected to develop a formulation of risk for violence. The next sections describe the clinical team's views on what scenarios of violence could occur including the severity, imminence and frequency of behaviour. The clinical team then uses the guidance in the document to develop management strategies including details of risk enhancing factors, risk protective factors, monitoring, supervision and victim safety planning. From these details clinicians then develop care and risk management plans.

5.109 It is based around three core areas:

- **H factors** - history of violence.
- **C factors** - clinical factors that would influence the consideration of risk, such as mental disorders.
- **R factors** - the risk management factors.

History Factors

5.110 There is no information on previous history of violence from 1994 onwards despite many incidents of violence since that time. There is insufficient information on Mr. Z's history of substance use and refers to his last episode of alcohol intake as being in 2011. It is also noted that 'H 10' (Prior supervision failure) does not contain details of his second recall to hospital or other admissions related to his non-compliance with treatment interventions when in the community, and his aggression when he felt his visits with his girlfriend were being thwarted.

Clinical Factors

5.111 The clinical factors do not appear to acknowledge behaviours after 2013. We are aware of further incidents related to clinical factors including lack of insight, negative attitudes, impulsivity and unresponsive to treatment could have been included in this section. It does however contain an extra clinical factor, although this is limited in that it states that Mr. Z requires a substantial amount of support from the care team, hospital staff and family, but does not include any further details.

Risk management factors

5.112 The risk management factors, whilst containing relevant information related to these dynamic (changeable) factors, do not reflect up to date information nor are they extensive. This is likely to have influenced the amount of detail available to Collette House when developing their own risk management plans. Despite a specific section on 'Lack of personal support' there is a further risk factor identified relating to his dependence on his elderly parents, which should have been included in the appropriate section.

Scenario planning and developing management strategies

5.113 The scenario plans include one for violence leading to 'moderate to severe' injury and fire setting. There are general statements related to the imminence of violence such as deterioration of mental state but no idiopathic (related to Mr. Z's personal presentation of illness) details. It is not possible to ascertain what would happen in the event that Mr. Z's mental state deteriorates.

5.114 The origins of the fire setting scenario may relate to previous fire setting in 1994, however the first reference to fire setting is in the scenario. There is no reference to fire setting in the H, C or R factor details within the HCR-20. It is noted that the interventions in monitoring, supervision and victim safety planning are exactly the same as those for violence.

Risk Summary

5.115 The risk summary completed as part of the CPA process relies on information from the HCR-20. It was completed eight months previously (as opposed to the expected six-month review process) however it contains little further information and some sections have not been updated. It also states that there has been no further evidence of risk behaviours, but we are aware that there were incidents of aggression when in Butler House. The risk summary has a section for describing the formulation, but this appears to be no more than a historical record and no analysis of risks, what causes them to occur and what should happen to mitigate risks.

5.116 The risk assessment information at Collette House is basic in its description of violence, what factors specifically influence an increase in risk to others and how these manifest. It includes interventions required to contain risk behaviours but does not include a comprehensive formulation. It is noted from statements and interviews that Collette House staff were furnished with information on the components of Mr. Z's risks, but these do not seem to be reflected in the documents. The HCR-20 Risk Assessment was shared with Collette House, but other than noting some previous historical incidents (including the circumstances regarding previous recall) it provided little information on his risks and how to manage them. The risk assessments do not reflect the crisis and contingency planning detailed in the FOS care plans for Mr. Z whilst resident at Collette House. The social supervisor confirmed at interview that she had not seen the Collette House care and risk management plans, however Collette House staff maintain that all relevant FOS staff had. We have not been able to reconcile whether the FOS team had seen and reviewed the Collette House care and risk management plans. However, as the statutory agency responsible, it is more important that the FOS team care and risk management plans are clear, describe thresholds for review and escalation, and are shared with key stakeholders, especially Collette House.

5.117 The interventions described relate to what staff need to do when risk behaviours occur but provides little information on what is the threshold for escalation. There are however details in the working practice document (an outline of daily interventions when working with customers) that staff should contact police if they perceive the risk of violence to be escalating.

5.118 We noted that these risk assessments were not completed until 1 June 2015, five weeks after admission. There do not appear to have been any standards in place related to how soon these should have occurred. It is also noted that the risk assessments in Collette House had not been updated from this time until the time of the homicide, despite 11 incidents of aggression and threats occurring. We have been told the risk assessments had been reviewed, but no change required. Because of this the risk assessments had not been updated.

5.119 There are now conditions in place which ensure that clinical teams are able to sign to confirm that they have read and contributed to these documents as contained in the new Safety and Risk management manual from LCH. This was informed by consultation with qualified health care practitioners and

Health and Safety specialists following reflection on further improvements to manage risk.[38]

5.120 It was apparent from interview with Collette House staff that they believed that the risk assessment and management interventions were adequate. It has been confirmed by members of the FOS team that they did not see the Collette House risk assessments. In order for care and risks to be jointly managed, it is important that both the FOS team and Collette House share risk assessments and management plans to arrive at a shared and understood view of how to manage risks, and how, when and why to escalate following any changes to conditions or behaviours.

5.121 The statements from the managers at Collette House in relation to the pre-admission interview suggest that they were well aware of the nature and severity of Mr. Z's risk, but this was not reflected in his risk plans. As stated before, the crisis and contingency plans from the FOS were not reflected in the risk management plans despite these relating to his care and management at Collette House. However, the working practice document of 3 May 2015 does describe the approaches to be taken with regard to sexually inappropriate behaviour, breaches of house rules, supervision of medication and requests to reduce noise, especially at night (by waking the sleep-in night staff).

5.122 The discharge summary does not appear to exist and there was no defined threshold for 'risky' behaviour, (i.e. at what stage does his behaviour become unacceptable or unmanageable) and what events would trigger a review of care arrangements, including recall to hospital.

5.123 The internal investigation report notes that they found the care plans from WLMHT to be adequate. We agree that they contain information on the expectations for and from Mr. Z in each of the care plans. However, these refer to his day to day responsive management and do not define or indicate a threshold for recall or indicate which behaviours might trigger a formal review of the current management more broadly. Secondly the care and risk management plans had not been regularly reviewed in response to behaviours and therefore did not accurately reflect current risk. This may have been exacerbated by an inadequate HCR-20 and the FOS team member's lack of awareness of the nature and frequency of Mr. Z's behaviour at Collette House.

5.124 The social supervisor told us that there was no elaboration on risk factors as part of the discharge process and therefore there was little structure in place to monitor increases in risk. As the responsible service with expertise in risk assessment and management, WLMHT care plans in this area would take precedence and should be accurately reflected in Collette House care plans.

[38] Cyrenians Safety and Risk Management manual 2016.

5.125 While we accept that rule breaches are common in a forensic sample, this view has to be tempered by the fact that Mr. Z had a history of previous noncompliance, aggression and two previous failed conditional discharges.

5.126 We have concluded that if the documentation is reflective of practice, then the FOS team had not shared and agreed with Collette House the most appropriate or effective interventions, and as such would not have been able to monitor Mr. Z's progress or deterioration adequately. Ultimately Mr. Z remained under the care of the FOS and so management of his risks remained their responsibility.

Communication, coordination, and contingency planning

5.127 The process of communication and coordination of information raises a number of questions.

5.128 The lack of discharge summary, the generalised nature of the conditions for discharge, and the inadequacy of available risk assessments at the time of admission to Collette House have in our opinion, inhibited the ability of both FOS and Collette House staff to make decisions on thresholds for behaviour and recall to hospital.

5.129 Indications from paper records and interviews with staff indicate that from the early stages of admission and throughout Mr. Z's stay at Collette House there was ample evidence of engagement in risk-relevant behaviours, including aggression, non-compliance with rules and regulations, sporadic attendance at activities and neglecting his responsibilities with regard to payments of fees and keeping his accommodation in an acceptable state. Mr. Z was a known quantity in respect of potential risk to others and the factors likely to be relevant for exacerbating such risks.

5.130 We believe that the reporting to the FOS team of the incident on 30 June 2015 by LCH staff did not reflect the severity of the behaviour, or at least its potential relevance given the wider context (of a conditionally discharged patient who had repeatedly tested boundaries and who was regarded as a potential risk to female staff at least). It is noted that at no stage was there a joint re-evaluation of his risks, his placement nor his risk assessment despite 18 different incidents related to non-compliance or violence and aggression, nine of which related to his risk behaviour. When interviewed the social supervisor stated that she was unable to recall why this had not occurred.

5.131 The adequacy of the assessments was undoubtedly affected by the level of communication between the two teams and potentially hindered by Collette House staff not attending the discharge CPA, and the FOS not being aware of the contents of the risk assessments/management plans in place at Collette House. It was confirmed by the social supervisor that the reason she did not check the Collette House documentation and accepted an incomplete discharge process was that she was a locum social worker and thought that this was the normal practice for this team.

Collette House staffing

5.132 At the time of the incident at Collette House the facilities in place to protect staff were as follows:

- A secondary means of escape from the office;
- the on-call sleepover room was above the office;
- staff had portable panic alarms;
- interconnecting telephones from the sleepover room and the office;
- emergency numbers speed dial facility;
- a solid door with wide peephole;
- door entry prevention by a code released metal bar;
- code system entry to the building;
- staff toilet entry by code only; and
- procedures and policies.

5.133 Since the incident the changes made in addition to the above include:

- closer adherence to risk assessments and management interventions;
- new procedures for the Floating Advance Support Team (FAST) including a waking night FAST worker, established in the Summer 2016 to go to new services which are underperforming to raise quality standards;
- the FAST now employs a real time advice and support to night staff to provide;
- support and guidance to raise standards;
- reminders and prompts to ensure service and customer familiarity;
- support and reminders of key policies and procedures;
- there is now an escalation protocol included as part of the Risk and Safety manual;
- LCH have now employed the services of a health and safety consultancy (McCormack Benson) to undertake a comprehensive Risk Assessment in each owned and managed service including Collette House;
- training programme including a new dedicated training suite;
- the introduction of an awareness scheme for new staff to familiarise themselves with customers;
- a peer mentorship scheme for new staff to contact experienced staff for informal advice and support;
- a new version control procedures for key documents;

- the introduction of lay inspections whose purpose is to take a snapshot of a service on the day and report back findings and recommendations; and

- paperwork review, the purpose of which is to review clients statutory risk assessment and shared management strategies.

5.134 At the time of the incident there were nine residents in Collette House with diagnoses of either personality disorder, depression and anxiety, psychosis or a combination of these. They were a mixed ethnic group of three white British, three Asian, two black British and one mixed race, all of whom were male. Five of these had MoJ restrictions.

5.135 LCH informed us that there were five models of night cover used across London which included their model of one waking staff and one sleep over staff. This is above the average staff to customer ratio as stated in local authority tenders for accommodation-based support.

6 Internal investigation and action plan

6.1 The internal investigation team comprised of:

- Chair (Consultant Forensic psychiatrist and Clinical Director, Specialist Services, Barnet, Enfield and Haringey Mental Health Trust).
- External Service Director (Sussex Partnership NHS Foundation Trust).
- External Nurse Consultant (Sussex Partnership NHS Foundation Trust).
- Chief Executive of the London Cyrenians Housing.
- The review administrator.

6.2 The report was dated 22 January 2016 and was signed off by the:

- Patient Safety and Complaints lead.
- Executive Director of High Secure and Forensic Services.
- Clinical Director of West London Forensic services.

6.3 We note that one member of the internal review panel was employed by LCH. However, we note all other members of the investigation team were all independent of the services being investigated. Whilst this approach can be useful for such a serious multi-service incident and ought to promote shared understanding and problem solving, the seniority of the LCH investigation team member also has the potential to be seen as that aspect of the investigation lacking independence.

6.4 The report took 93 days to complete and it is stated on the report that this was due to 'waiting for statements from Cyrenians employees'. In response to this the Executive Director for LCH states that LCH staff were originally asked if they would be available to take part in the NHS level 2 investigation[39] in September 2015. As this ran alongside the police investigation and Mr. Z's plea of not guilty, LCH trustees had asked if staff could submit written questions and answers and this was agreed. The questions were sent by email on 3 December 2015 with a timescale to respond by 18 December which was met. We have also seen that the Metropolitan Police Senior Investigating Officer (SIO) for the homicide of Jenny wrote to members of the internal investigation panel asking "In order not to prejudice any aspect of the trial it is essential that any reports concerning the tragic death of Jenny are not published and in public circulation until after the conclusion of the trial. Can you please bring this request to the attention of other panel members/staff?"

[39] According to the NHS Serious Incident Framework, a Level 2 investigation is "suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable" https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

6.5 The internal investigation team met with the family of the victim on 22 October 2015, and the family were given a copy of the internal investigation report and have been offered the chance to discuss this. The victim's brother has maintained close links with services and our investigation. Currently the victim's mother is also receiving further support provided by the Trust. The internal investigation team also met with Mr. Z's parents and has kept in touch with them through the investigation process.

6.6 We concur with the findings of the internal investigation that the practice of risk assessment, communication, adequate and relevant report completion, completion of discharge summaries and the involvement of carers fell short of required standards as outlined in FOS and Trust policy and accepted best practice within a forensic service.

6.7 The internal investigation made seven recommendations based on their findings. We agree that the process of risk assessment to risk management (identifying risks, evaluating these risks, developing a formulation and managing the components of risk) requires substantial review in order to ensure joint risk assessments map on to one another. We also concur with the internal investigation panel that communication on risk must be adequate and relevant, and that all necessary reports fall within expected guidance.

6.8 However, there is no evidence of Root Cause Analysis techniques (e.g. Fishbone analysis or any other formal investigatory analysis) being used.

6.9 The recommendations are not SMART (Specific, Measurable, Appropriate, Relevant and Time limited) in that whilst they give clear instruction on what should be done there is no indication of how, when and who is responsible, and how improvement will be measured. The recommendations relate to the findings from their investigation but are worded in such a way that they appear to be conclusions or findings and provide little direction on what actions needs to occur, and what outcomes should result from the changes to practice.

6.10 The internal investigation report states that Mr. Z received appropriate treatment for his mental illness and personality difficulties when he was in hospital and the community. Whilst we agree that his treatment up to discharge from Solaris ward was appropriate, we believe that his care and treatment whilst in Collette House lacked adequate risk assessment, contingency planning and communication, and this was the responsibility of the FOS team but required full communication and support from Collette House.

6.11 We agree with the internal investigation's conclusion that he was receiving ongoing intervention for his behavioural difficulties in the form of drug and alcohol therapy, the 'mind over matter' (substance misuse) group, understanding relationships and intimacy group, aggression management group and individual psychology. However, we question the timing of these groups in so much as they occurred near to discharge and that one group on relationship issues did not occur. We note that Mr. Z underwent a relationships programme in 2011, however the issues leading to his participation in the group in 2011 were still present in 2015.

6.12 We agree with the internal investigation that this should have commenced whilst in hospital and therefore do not believe, given his relationship difficulties and sexually inappropriate behaviour, that he received all the treatment interventions relevant to his risk and safe management in the community.

The internal action plan outcomes

6.13 The internal investigation made seven recommendations. As stated earlier these were not clear on how when and by whom they were to be completed. We have received reassurance in the form of the WLMHT action plan that provides information that all the actions were completed between June and August 2016, as well as which key personnel were responsible for implementation. Latterly we have received the evidence of oversight and implementation via a series of documents provided by the Head of Governance at WLMHT. This does not in all cases provide the evidence of assurance as claimed. The validity and relevance of these documents is considered in this section.

6.14 There are two joint agency recommendations, four FOS practice related recommendations and one LCH specific recommendation.

Joint agency outcomes

6.15 WLMHT and LCH have agreed to share the same risk assessment for users of their respective services and have agreed that a joint risk management plan will occur for all future referrals. LCH has provided minutes of the Senior Tier Screening panel meeting and the minutes from a meeting in response to recommendations from the internal investigation report. These minutes provide details of the intentions of the team to clarify and agree what should happen with regard to 'escalation processes' and risk assessments and shared paperwork. However, they do not provide detail as to how and when this has happened. We have not seen a copy of the new format.

6.16 The FOS team leader has ensured that on all occasions all staff will now receive feedback from hostel staff verbally and from the documentation, prior to meeting with the service user. They will also include feedback following their meeting as part of this process. This is included in the updated FOS Operational policy dated 1 April 2016.

FOS outcomes

6.17 The FOS team has identified a lead on family contact and carer practice.

6.18 There is evidence in the new FOS Operational policy about the key responsibilities in record keeping. To ensure that all reports are completed in a timely fashion, a communication has been sent out by the Executive Director and Clinical Director advising of expectations around the timeliness of reports in concordance with operational and CPA policy. There is an audit proposal form available to us which outlines an examination of the reporting of psychological interventions on to RiO (Electronic Record system). We also have a copy of the letter sent to RC's and Clinical Directors. However, we

view this as reassurance and not evidence of assurance since we have seen limited evidence of positive changes to practice.

6.19 According to the action plan outcomes document an audit of HCR-20 practice has been completed, and training/practice development has been adjusted accordingly. However, we have only been furnished with the audit report and not the changes to practice. The report had found that the HCR-20's were not updated following an incident in most of the cases with one example of 108 days between a serious incident and an update of the HCR-20. There is also an audit proposal available which addresses the recording of psychological interventions on RiO but as stated before there are no outcomes noted. Significantly the HCR-20 audit report has a section on post audit action plan which contains no information.

6.20 A communication has been sent to all RCs regarding the need to ensure that all discharge summaries are completed for all patients discharged from the service regardless of whether the person is to be followed up by a WLMHT service. We have been supplied with this letter, an audit proposal related to examining which patients have a full discharge summary and the new protocol for final discharge for the FOS. Again, we do not have the results of the audit, although we have been reassured that this issue is now addressed in the relevant protocols but have no evidence of implementation.

Collette House

6.21 LCH, the service provider for Collette House, has adapted its processes of handover of information to clinical teams to ensure that relevant information is communicated fully, and that a shared response to issues of concern from both services is agreed and understood. This is contained in the LCH Safety and Risk Management Manual which we understand was due to be reviewed after this investigation was complete.

6.22 In addition to this, as a result of the internal investigation we have also been informed that there are a number of additional elements included in the LCH 'Work Plan' for 2017-2018'[40] specifically related to outcomes of the initial incident investigation.

6.23 These map on to the recommendations from the internal review and include; More targeted attention to sleep hygiene; the introduction of a joint risk assessment for those individuals with long term partners/significant others in services; a reminder to all staff to request overnight leaves for service users subject to Section 37/41 restrictions; a reminder to staff to include parents/ carers in house activities, meetings and feedback sessions where possible; assurances that all clinical teams are able to sign to confirm that they have read/contributed to in house documents and; sending a letter to WLMHT to advocate for specified drug screening for novel psychoactive substances ('legal highs') as well as LCH training on these.

[40] This is the LCH plan for improvement and development throughout 2017/18.

7 Overall analysis and recommendations

Care and Service Delivery problems

7.1 We have identified several care and service delivery problems. These are summarised below.

7.2 The problem statement is:

"Mr. Z was discharged into Supported Housing accommodation, Collette House, without proportionate risk management and contingency plans in place to monitor and respond to his presenting risks."[41]

Contributory Factors	Analysis
Patient Factors	Mr. Z had a long-standing involvement with mental health services and the Criminal Justice system. He presented several related behaviours which were well known to all stakeholders in his care and treatment. His risks were a known quantity and he demonstrated increased likelihood of aggression, substance use, sexually inappropriate behaviours, and non-concordance with treatment and variable compliance with conditions of engagement. Mr. Z is known to have been presenting challenging behaviour from the point of transfer with one serious incident three weeks prior to the incident.
Individual Factors	A discharge plan was not completed. His HCR-20 was incomplete and not updated until after the offence. His Collette House risk assessments had not been completed or altered to reflect noncompliance with rules and aggressive incidents. The actions of the CCO in the areas of communication, reporting and advising Collette House and the FOS clinical team fell far short of expected practice. The CCO/social supervisor was not registered with the Nursing & Midwifery Council (NMC.) Collette House staff did not adequately communicate their concerns or the facts of Mr. Z's challenging behaviour. FOS staff did not read Collette House records and relied on Collette House staff communications. There were no contingency plans in place in the event of an escalation in behaviour, nor were there any details of recall thresholds.
Task Factors	As with above, incomplete/not reviewed risk assessments. Risk management plans did not include all stakeholders.

[41] A problem statement is a clear concise description of the issue(s) that need(s) to be addressed by a problem-solving team. It is used in Root Cause Analysis investigations to define the issue to be investigated.

	Risk Management plans did not reflect known risks. CPA and Risk policies not adhered to. Mr. Z discharged without a discharge plan reflecting conditions of discharge. Psychological therapy not reflected in treatment interventions following discharge.
Communication Factors	Collette House staff did not accurately communicate incidence or effect of challenging behaviours. No means to bring to the attention of the FOS team pertinent issues within the Collette House records. The CCO on interview could acknowledge inadequate communication but was unable to recall why. Not all stakeholders included in planning process.
Team Factors	Limited inclusion of all stakeholders in decision to and process of discharge. CPA processes not followed accurately. Supervision did not identify inadequate communication practices, lack of formal review of risk management and care plans or inadequate discharge planning. Team configuration, at the time, did not provide adequate cover/monitoring of contact.
Education and Training Factors	Apparent lack of compliance with policy and guidance.
Equipment and Resource Factors	None identified.
Working conditions Factors	Lone female working practice. Working practice document in Collette House described need to wake sleep in night staff if two staff required to attend to Mr. Z.
Organisation and Strategic Factors	Trust checks on validation/registration and qualification not appropriate. Collette House communication practice inadequate. Joint working conditions not reflected in practice, specifically communication and adaptation of risk related information.

Conclusions

7.3 We are of the view that the communication of information from FOS to LCH via the discharge processes, and during Mr. Z's stay in Collette House did not fully reflect the nature and severity of risks. The LCH risk management plan did not reflect the potential severity of risks nor what was to be done in the case of an escalation of risk.

7.4 The discharge conditions should have been expanded upon by the FOS to include the specific details of what interventions were required to ensure that conditional discharge criteria were met, and the requirement to adhere to

accommodation rules. This would include reference to the options, and thresholds, for a prompt review of clinical care arrangements, including the potential for recall to hospital.

7.5 The assessment of his appropriateness for transfer to Collette House might have been better informed if he had been able to engage in overnight stays. The working practice document of 3 May 2015 details that female staff at night were to wake the sleeping staff and to approach Mr. Z in pairs, which implies there was an understanding of the potential risks posed to female staff working alone at night by Mr. Z. More trial overnight stays may have altered Collette House's acceptance of Mr. Z, or at least their approach to him.

7.6 The completion of risk assessments, including the HCR-20, should have been of a standard that made it clear what was to be done, by whom and how.

7.7 We were told that Collette House staff regularly updated the FOS about Mr. Z. We have been informed by LCH of 18 occasions when this happened. On several of these, the communication was to report that Mr. Z had been challenging, verbally aggressive, not reducing the volume of loud music, reported concerns, incidents and house rule breaches to Mr. Z's social supervisor. We have also been provided with a log of frequent telephone calls from Collette House to the FOS. We are not privy to the contents of these calls. Alongside this, we have not seen the written evidence in Mr. Z's Collette House records of these contacts. Some of these can be triangulated with records in the nursing and social supervisor notes (e.g. 29 April and 14 May 2015). However, many can not, and there are notes of telephone contact from Collette House to the FOS on different dates, reported in the FOS team notes, that Collette House have not reported.

7.8 There are four FOS team records that discuss Mr. Z being settled and compliant (dated 3 June, 17 June, 2/3 July, and 16 July).

7.9 Our conclusion is that there is no evidence in the FOS records that the several occasions when Mr. Z challenged boundaries, breached rules and played music loudly, including the incident on 30 June, were ever clearly communicated in detail, noted and considered. We believe that the health record lacks the detailed recording we would normally have expected to see. The context (a pattern of non-compliance and verbally aggressive behaviour) is not obvious from the health records, as little of what had been reported (before and after this incident) was recorded.

Predictability and preventability

7.10 Predictability is 'the quality of being regarded as likely to happen, as behaviour or an event'.[42] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been

[42] https://www.dictionary.com/browse/predictability

predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[43]

7.11 We conclude that the homicide of Jenny was not predictable. However, the potential for Mr. Z in future to perpetrate inter-personal aggression was real, rather than irrelevant, and was recognised as such (e.g. at the point of discharge, and based on his past history and clinical features, the care team had agreed that a conditional, rather than an absolute discharge was appropriate). There were then several incidents of non-compliance and aggressive confrontation between Mr. Z and LCH staff, including in particular the incident of 30 June 2015 and during previous community placements, where recall had twice been required. Whilst there was no actual physical violence during the incident on 30 June, the threat of violence was recorded, and the incident was considered sufficiently serious for consideration being given to calling the police. While the gravity of this incident may be disputed, it is clear that in any event it led to LCH contacting their duty bleep holder and being advised to inform the police, to the social supervisor being e-mailed, and to the LCH manager issuing Mr. Z with a written warning. These developments indicate that active risk assessment and management to try and reduce the frequency or severity of non-compliance and aggression remained a continuing clinical requirement. Furthermore, the relevance of Mr. Z's wish to maintain a relationship with Y, and of his attitude to staff oversight and restrictions of the practicalities around this, had also remained clear. As already noted, in December 2014, Y's allegation that she had had to beat Mr. Z off when he demanded sex was reported by the RC to the MoJ. On 2 July 2015, the social supervisor noted that Mr. Z became 'agitated' when the LCH manager spoke about not being able to facilitate a visit to Y. On 16 July, Mr. Z was noted to have been stressed about the potential cancellation of a visit to Y (due on 28 July). Whilst we accept that between 30 June and the incident in July aggressive outbursts from Mr Z were reducing in frequency, we believe that because of the nature of the circumstances surrounding his previous recalls, and the known 'trigger' for aggressive confrontation concerning cancellation of visits to his girlfriend, a longer term view of his potential for violence was required. Against this total background, there was a risk of some incident of future aggression, including violence.

7.12 Prevention[44] means to 'stop or hinder something from happening, especially by advance planning or action' and implies 'anticipatory counteraction'; therefore, for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

7.13 The CPA Care Plan of 21 May 2015 identified that in the case of increased agitation and/or non-compliance with treatment and rules, the contingency plan identified the following seven steps to be taken:

[43] Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120
[44] http://www.thefreedictionary.com/prevent

1. Admission to hospital if deterioration in mental state. Unscheduled CPA if concerns are raised.
2. Reassessment by forensic outreach service.
3. Placement review if concerns persisted.
4. Hostel staff to provide weekly key work to monitor risks.
5. Supervision by WLFS (West London Forensic Service).
6. Engagement with structured weekly activities.
7. Discussion about threshold for recall to hospital.

7.14 Although there was no evidence of active symptoms of mental illness during the period of Mr. Z's conditional discharge (up to and including the time around the homicide), we believe that the 30 June incident should have triggered a documented discussion or consideration (involving the relevant clinicians) around whether or not it was appropriate to initiate a formal review of his care arrangements (including placement suitability), as indicated in his CPA plan above.

7.15 Mr. Z was conditionally discharged from his Section 37/41 by the First Tier Tribunal. The conditions of his discharge were:

1. To reside at a 24-hour supported mental health hostel or other hostel deemed suitable by his treating team.
2. To comply with appointments and care management plans with his RC and social supervisor.
3. To cooperate with monitoring of illicit substances and alcohol use including herbal highs.
4. To remain totally abstinent from the use of illicit substances and alcohol including herbal highs.
5. To cooperate with geographical exclusion zones including allowing monitoring of contact with his long-term partner 'Y' as is considered necessary.

7.16 The frequency and severity of his behaviour should have, as a minimum, resulted in the consideration of a joint review by FOS and LCH of the match between the patient and the placement, and whether (and how) the clinical and risk issues presented could be effectively managed in that placement, or whether an alternative placement should be considered. Mr. Z was a conditionally discharged patient. The guidance states that conditions are:

"designed to operate for the protection of the [patient] and others and to enable the patient's safe management in the community … Breach of conditions does not, in itself, justify recall to hospital, but it should act as a trigger for considering what action is necessary in response".

7.17 We cannot conclude that Mr. Z should have been recalled, or indeed that he would have been recalled had some form of formal discussion or review taken place. However, given the historical and clinical features, as well as the then current context, we do conclude that as a matter of good practice the 30 June incident should have been followed by some kind of evaluation or review of the existing risk management arrangements. Whilst the outcome of any such

discussion cannot be known, this could have involved deciding to take no further action or initiating a formal review (in line with the CPA). Again, such a CPA review might have led to no changes being made to the current management, or to considering whether different service responses to key behaviours (including non-compliance and rule breaking) might be appropriate, such as providing information to Mr. Z about these contingencies or specifying formal conditions relating to his tenancy. This could have included consideration of service responses to key behaviours, non-compliance or rule breaking, up to and including specified formal conditions relating to his tenancy and placement (and including how Mr. Z was apprised of such issues). It is entirely possible that had this opportunity for such a discussion been taken, there could then have been some differences in how care was delivered, and risk managed. More generally, where such discussions do not take place within teams or between agencies, there is a greater risk overall that care plans (including risk management plans) may become less robust, more dated, and less comprehensively informed. In this particular case however, and in particular because of the significant time gap between this incident and the homicide, we cannot conclude that the homicide was predictable or that it would have been prevented by any such review.

Recommendations

7.18 We have made six recommendations to improve practice:

Recommendation 1:

The Trust must ensure that discharge planning includes the following elements and develop a system to ensure standards are maintained.

- How legal conditions of discharge are interpreted
- Provide a complete discharge summary and care plan which includes contingency management prior to discharge.
- Define who is responsible for delivery as well as what interventions are to occur and when.
- Must include carers, provider service staff and all relevant clinical personnel.

Recommendation 2:

The Trust must ensure that the agreed standardised risk assessment (including HCR-20) protocols, practice and documentation are monitored to reflect the outcomes from the Trust's internal action plan.

The focus of monitoring should be on communicating risk related information, reviewing of risk assessments and management plans considering additional information and the development of a risk formulation.

Recommendation 3:

The Trust must ensure that joint working practices with other organisations reflect developments in practice and protocol arising from this incident and the internal investigation action plan outcomes.

Specifically, that joint risk assessment and management plans, contingency plans and agreed protocols for discharge and recall are agreed in each individual case.

Recommendation 4:

The Trust must ensure that staff are appropriately skilled and competent to undertake the role of Social Supervisor.

Recommendation 5:

The Trust must ensure that it has a robust process for checking that all staff are appropriately registered with their professional body, and this should include ensuring that any agency staff employed are appropriately registered.

Recommendation 6:

In partnership with LCH, the commissioners of Collette House should clarify the role and nature of the Collette House service provision, including the limits of the service, and clear thresholds for raising and escalation of any concerns.

Appendix A – Terms of reference

Core terms of reference

- 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 Mr. Z's first contact with services to the time of his offence.
- Review the appropriateness of the treatment of Mr. Z 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 Mr. Z harming himself or others.
- Examine the effectiveness of the Mr. Z'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.
- 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.
- Assist NHS England in undertaking a brief post investigation evaluation.

Outputs

- A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.
- A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.
- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proofread and shared and agreed with participating organisations and families (NHS England style guide to be followed).

- Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference.

- Independent panel to involve police (including Family Liaison Officers) within the review process.

- At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation.

- A concise and easy to follow presentation for families.

- A final presentation of the investigation to NHS England, Clinical Commissioning Groups, provider Board and to staff involved in the incident as required.

- NHS England will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public.

- NHS England will require monthly updates and where required, these to be shared with families.

Specific terms of reference

- To review the rationale for the decision making of the placement and care level in the community and to explore the partnership working between WLMHT, FOS and Collette House staff.

- To review the commissioners risk assessment, assessment of suitability of placement and ongoing responsibility.

- To review the assessment completed by the management of Collette House when accepting the referral of Mr. Z in respect of the resources available at the time.

- To review if any changes have been introduced in Collette House to safeguard staff and service users since the 27th July 2015 and the basis/criteria that informed such changes.

- To review and understand if the Trust Internal report investigation panel experienced any challenges which resulted in the Trust Report not meeting the required Serious Incident Framework (2015) standards.

- To review the service users risk assessment and care planning with particular attention to joint working between FOS and Collette House and escalation planning.

- To explore the level and adequacy of discussions between the WLMHT FOS staff and Collette house pertaining to proactive management of the patient's escalating behaviour, risk triggers in particular signs of deteriorating behaviours.

- To explore current and historic risk factors pertaining to other residents and staff at Collette house and the escalation process in place for managing these.

- To understand if Mr. Z had a relationship with the victim prior to the 27th July 2015 and if so, how was this managed and what was the level of knowledge the victim had over the risks and triggers associated with Mr. Z. To also understand the relationship and knowledge that other members of staff, particularly locums, had over Mr. Z.

- To review and understand the responsibilities over the supervision of service users and any protection plans, including any MoJ restrictions and compliance.

- To understand the FOS consultant and team responsibilities and their impact on individual care plans

- To review the training levels and competence of staff with a particular emphasis on the use of locums and relevant procedures.

Appendix B – Documents reviewed

London Cyrenians Housing (LCH)

- Safety and Risk management manual.
- Service user records, risk management plans and care plans.
- Work plan 2017-2018.
- Email responses to queries from investigator.
- Victim's personal training record and shift details

West London Mental Health NHS Foundation Trust (WLMHT)

- Serious Untoward Incident report.
- Meeting notes from 25 April 2016, addressing WLMHT recommendations.
- Senior Tier steering panel minutes for 24 January 2017.
- Internal review report WLMHT.
- Action plan from internal review, WLMHT and LCH.
- Forensic Outreach Service (FOS) operational policy undated.
- FOS patient information sheet.
- FOS protocol for final discharge check.
- FOS CPA Guidance undated.
- FOS protocol for managing amber/red alerts.
- FOS Recall and Crisis Guidance October 2016.
- FOS protocol for arranging cover for clinical and Social Supervisors.
- WLMHT Audit proposal form Discharge summaries record.
- WLMHT email response to investigator queries.

Ministry of Justice

- Guidance for Social Supervisors 18 March 2009.
- Guidance for Clinical Supervisors 18 March 2009.
- The recall of conditionally discharged patients 4 February 2009.

Metropolitan police

- 145 witness statements concerning the investigation into the homicide of Jenny Foote.

Appendix C – Staff interviewed

West London Mental Health NHS Foundation Trust
Service Director
Team Manager, Forensic Outreach Service
Consultant Clinical Psychologist
Consultant
Ward Manager
Community Psychiatric Nurse
Sector Manager, Ealing East Recovery Team
Social Supervisor

London Cyrenians Housing
Collette House (CH) Manager
Area Manager London Cyrenians Housing
Support Worker CH
Support Worker CH
Support Worker CH
Executive Director, London Cyrenians Housing