Psychological
Approaches

Independent Review

of the Care and Treatment of Mr X

January 2022

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INTRODUCTION

PURPOSE OF REPORT

NHS England has commissioned this independent review, in line with the NHS England Serious Incident Framework. The main purpose of this review is to ensure that learning has been properly and effectively identified, and subsequently embedded into practice. The underlying aim is to identify opportunities to improve patient safety, at the individual, team, organisation and system levels.

METHODOLOGY

Mr X was known to East London Foundation Trust (ELFT) at the time of the serious incident (January 2013), having recently been under their care. However, the incident did not come to the attention of the Trust until February 2017, with the internal investigation report being completed in June 2017. Given the time elapsed since the incident – and the changes to services that had occurred since that time – it was felt appropriate to focus the review on current service delivery, with a particular emphasis in two areas[1]:

- The internal ELFT investigation action plan, seeking evidence of lessons learnt and sustained change in any service or care delivery concerns identified. To this end, ELFT provided documentation as requested, and a number of interviews with key staff members were conducted. The findings are detailed in PART ONE of this report[2].
- Identifying any issues or concerns with pathways of care for individuals such as Mr X – that is, mental health service users with a diagnosis of personality disorder and a history of offending behaviour. To this end, a professionals' workshop and a service user focus group were conducted. The findings are detailed in PART TWO of this report.

PART ONE

THE INCIDENT

MR X first came into contact with ELFT services at the age of 10 years, when he was referred to child and adolescent mental health services (CAMHS) in 1999. He was subsequently involved with a number of ELFT services, including Newham CFCS (a multi-agency specialist

[1] Terms of Reference can be found in Appendix II of this report
[2] The Evidence Table can be found in Appendix IV of this report

service for young people with complex problems) in 2006, when he was 17 years old; the Millfields Unit (a medium secure personality disorder service) between 2008 and 2010; and supervision in the community by a Consultant Forensic Psychiatrist between 2010 and 2012. His last contact with ELFT services was in December 2012, when he was assessed in the A&E Department of a local general hospital by the psychiatric liaison team, including a junior psychiatrist. No further treatment was indicated at that time.

MR X was diagnosed with personality disorder, characterised by antisocial and borderline traits, and with features of Asperger's Syndrome. However, formal assessment indicated that he did not meet diagnostic criteria for an Autistic Spectrum Disorder.

MR X has a history of offending behaviour and has previous convictions for robbery, common assault, impersonating a police officer and possession of a loaded/unloaded air weapon in a public place. He was also strongly suspected of being involved in a number of incidents across ELFT sites during January 2011, where he is suspected of impersonating a nurse.

MR X was arrested in Rome on 3rd February 2013 on suspicion of the murder of one man and the attempted murder of another man. The murder was believed to have taken place on the night of 26/27th January 2013, and the attempted murder on 3rd February 2013. Mr X was convicted of both offences on 9th July 2014 and sentenced to imprisonment in Italy. In February 2017, he was extradited to the UK to stand trial for the murder of a 58 year old man in Northolt on the 7th January 2013. He was convicted of murder and arson in September 2017 and sentence to life imprisonment with a minimum tariff of 39 years.

A SUMMARY OF CONTACT WITH MENTAL HEALTH SERVICES

Mr X's contact with ELFT is summarised in the brief timeline below. The review concentrated on his more recent contact between 2008 and 2012.

Date	Event
15.12.99	**First contact with ELFT.** Assessed by Newham Child & Adolescent Mental Health Service (CAMHS)
10.03.06	Urgent CAMHS assessment
11.03.06	Urgent admission to inpatient unit
15.03.06	Discharge and readmission under S136
17.03.06	Detained under Section 2 Mental Health Act (MHA)
31.03.06	Forensic Psychiatric assessment

10.04.06	Discharged from inpatient unit
17.04.06	Admission to inpatient unit. Application for Section 2 MHA
29.04-01.05.06	Impersonated medical and nursing staff on at least three occasions in different ELFT sites
03.08.06	Transferred to adult services (Community Mental Health Team NW)
18.08.06	Remanded in custody. Trial date 13.11.06
06.12.07	Awaiting sentencing in HMP Chelmsford
11.06.08	Admitted to Millfields Unit under S45a MHA
16.01.09	S45a MHA expires; detained under notional S37 MHA
06.02.10	Failed to return from unescorted leave. Contacted Millfields Unit to say he was in Milan with boyfriend
16.02.10	Licence revoked and warrant issued for arrest
24.02.10	Notes indicate that recalled to prison (absent without leave - AWOL - for 16 days)
10.05.10	South London and Maudsley Behavioural Genetics Clinic assessment: does not meet criteria for Autistic Spectrum Disorder
27.05.10	Referred to CMHT by Mental Health Liaison Team (MHLT), HMP Brixton
27.08.10	Re-referred to CMHT by MHLT, HMP Brixton
07.10.10	First appointment with Consultant Forensic Psychiatrist
??.10.10	Forged Trust ID and impersonated psychiatric nurse Six month suspended sentence with condition to see Consultant Forensic Psychiatrist weekly
08.01.11	Impersonated psychiatric nurse
08.03.11	Suspended sentence supervision order with 12 month mental health treatment requirement
08.04.11	Arrested for impersonating an MI5 officer, stealing a radio and oyster card and using false documents. Remanded in custody.
16.08.11	Further suspended sentence with mental health treatment requirement and to reside in forensic hostel
19.08.11	Remanded in custody and then sentenced. Released 23.02.11
23.04.12	24 months suspected sentence with 100 hours unpaid work and 12 months supervision
10.05.12	Claimed collapse following court hearing on the 07.05.12. Discharge summary showed “concerns of a cancerous brain tumour”. Hospital had no record of attendance.
24.05.12	Discharged by Consultant Forensic Psychiatrist to GP (but not entered on RiO)
01.08.12	Referral from GP to CMHT asking for urgent assessment as refusing treatment for brain tumour.

12.12.12	Assessed by junior liaison psychiatrist in general hospital. Verbal aggression and agitation. Prescribe PRN promethazine and staff advised to contact police if aggressive or threatening. **Last know contact with ELFT.**
07.01.13	Murder of 58 year-old man in Northolt, Middlesex
26/7.01.13	Murder of adult male in Rome, Italy
03.02.13	Attempted murder (victim escaped and Mr X arrested)
09.07.14	Convicted in Italy of murder and attempted murder
16.02.17	Extradited from Italy to UK
26.09.17	Following conviction for murder and arson, sentence to life imprisonment with minimum tariff of 39 years

INTERNAL INVESTIGATION FINDINGS

The Trust internal review team identified a number of examples of good practice. The standard of record keeping was excellent throughout all services. There was effective inter-team and inter-agency collaboration in the assessment and management of the risks MR X posed when he presented in crisis in 2006. The transition from CAMHS to adult forensic services was well-managed and the Millfieds Unit were able to engage with MR X for 22 months between 2008 and 2010, during which time he had the opportunity to engage with therapeutic activities. Some initial confusion regarding who should provide follow-up for MR X, following his release from prison in 2010, was rapidly resolved and the forensic team maintained a therapeutic relationship with him despite multiple offences and periods in custody.

The review team did not identify any care delivery problems. However, they did identify three service delivery problems.

1. When checked in 2012, it was incorrectly listed on MR X's electronic patient (RiO) record that he remained open to forensic services and that his care co-ordinator was his primary nurse on the Millfields Unit, despite having been discharged from the Unit in February 2010 and from all services in May 2012.

2. When staff became aware that MR X had been arrested for murder and attempted murder in Rome in March 2013, a Datix from was completed and a 48 hour report was requested. There was a review through the then serious incident process and scrutiny of some clinical notes and the incident was closed in March 2013. Although the new murder charge was not known at that time, it would have been easier to have undertaken a serious incident review in 2013, rather than in 2017, particularly in terms of contacting other agencies.

3. The review team were unable to obtain the case files or files from the locality CMHT and there was no audit trail for what could have happened to them.

All the actions that were identified following the internal review – including those that had already been implemented – are detailed in the first column of the Evidence Table, which is laid out in Appendix IV of this report.

ADDRESSING THE TERMS OF REFERENCE

Emerging clinical and risk information

This item relates to any information regarding the homicide conviction that emerged in 2017 as a result of the police investigation, and which might have raised new concerns regarding the care that Mr X received from ELFT in 2008-12. In interview, the Metropolitan Police provided details of the circumstances of the homicide offence and any other relevant information that had come to their attention at the time. It was clear that deception – impersonating a person in authority - was a central component of the offence, as it had been during previous convictions. However, the offence involved a prolonged and torturous assault on the victim that was extreme and out of keeping with prior offending. There was no information that suggested evidence for an escalation in behaviour over the months preceding the homicide offence, and nothing that might have been identified by mental health services at that time.

Please note that Mr X was invited by NHS England to participate in the Investigation and/or meet with the investigating team and NHS England, but declined to do so.

Review the action plan

- **The implementation of the Trust's internal investigation action plan.**

The action plan recommendations, updated evidence and assurances are detailed in the Evidence Table in Appendix IV.

Action 1:

- **Comment on the commissioners' monitoring of the action plan**

The Trust acknowledged that, although the forensic directorate owned the action plan, it was not checked for completion at six months as there had been confusion about ownership of the plan, and a change of personnel at the time. The ELFT Incidents & Complaints

Manager confirmed that the serious incident review report was submitted to the Commissioning Support Unit (CSU), which acts on behalf of the CCGs, on the 16th June 2017 and that they received feedback from them on the 5th July 2017. The CSU confirmed that the CCG had reviewed the report and recommended that it be closed. ELFT received a further communication from the CSU on the 18th July 2017 and the report was subsequently discussed at a bi-monthly serious incident panel meeting between ELFT and Newham CCG. The North East London Specialist Commissioning Case Manager reviewed the draft serious incident review report and recommend an independent review, as there may have been missed opportunities to intervene when MR X was seen by the ELFT psychiatric liaison team six weeks prior to the incident. Shortly afterwards the Case Manager moved to a new post; for a short time of organisational change there was not a full mental health team to review progress. There is now a system for tracking through the quality meeting so oversight is now in place.

Action 2: Verbal assurance was given that efforts were made to engage with the victim's family. However, they did not wish to engage and there has been no subsequent contact with them. The police requested that there be no contact with MR X until the completion of his trial.

Action 3: Procedures are now in place to ensure that all forensic outreach patients are managed by a care co-ordinator, who ensures that all patient episodes are opened and closed in a timely manner. Forensic personality disorder patient caseloads are reviewed in supervision and a recent audit confirmed that none of the forensic outreach cases which were open, but which met criteria for closure, were patients in the personality disorder service.

Action 4: Processes for identifying and managing serious incidents have been updated and Datix grading is now completed centrally by the Patient Safety Team and is overseen by the Trust Chief Medical Officer and Chief Nursing Officer.

Action 5: There has been complete transfer of medical notes to electronic records in ELFT and there have been no paper record incidents recorded in Newham since the serious incident review. Audit of records in the forensic directorate in 2018-2019 identified one paper record incident, which was rapidly resolved.

Embedding of learning

Terms of Reference items:

- **The embedding of learning across the Trust, and identify any other areas of learning for the trust and/or commissioner.**

- **The processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services in relation to those with a diagnosis of personality disorder and offending behaviour.**

Action 6: There have been robust efforts to ensure learning in relation to record keeping within the Trust, including a Trust-wide learning event in September 2017. Each Borough Directorate provides updates via monthly 'Learning Lessons' newsletters and regular seminars. The extent to which learning from incidents is embedded Trust-wide is less clearly evidenced, but we were assured that the Trust is well aware of this and it is the subject of a current Trust review.

The CQC inspection report (2018) identified lessons learnt as being well managed by the forensic inpatients services. Learning is disseminated via 'Forensic Voice', emails and learning events.

Further recommendation for improvement as appropriate

Terms of reference item:

- **Make further recommendation for improvement as appropriate, and/or in light of any new information that may have emerged regarding clinical and risk concerns since the Trust's internal investigation was completed**.

The Trust did not consider that individuals with a diagnosis of personality disorder had featured particularly in relation to patient safety concerns over the past two years. They attributed this to having invested in

- The development of community PD treatment services
- Building the skills of staff working in community mental health services
- Managing acute admissions well for this group of service users in accordance with NICE guidelines (section 1.4, Borderline Personality Disorder: Recognition and Management, 2009 National Institute for Health & Care Excellence.)

The reviewers noted the proposed redesign for the community personality disorder service in Newham. Interviews with staff confirmed that developments were also underway in relation to multi-agency approaches to managing service users who presented to services on frequent occasions, and consideration of crisis interventions.

We noted two areas for further consideration that had been raised in the original investigation: transitions between teams within ELFT, and AWOLs (absent without leave).

Transitions
See also Part Two of this report, in relation to the professionals' workshop, including consideration of Terms of Reference item:

- **To review the current mental health pathways for patients with a diagnosis of personality disorder and offending behaviour, to include consideration of**
    - **Collaborative working between community and forensic teams**
    - **Management of referrals, transitions between services and follow up**

In ELFT, transitions seemed to be managed fairly well, and we were assured that problematic cases could be escalated. The Chief Medical Officer, who oversaw patient safety, did not consider individuals with a diagnosis of personality disorder to be over-represented in terms of incidents or complaints. The community teams identified that liaison meetings with the forensic outreach team could be very helpful in resolving concerns; similarly the forensic outreach team considered transfer of patients to the CMHT to be fairly straightforward.

However, the situation was less straightforward in relation to those with personality disorder and offending histories: the community forensic PD service (Changing Lanes) considered that there were difficulties in achieving shared care or handover of care in around 50% of cases, although they were also able to cite a number of examples of good practice. In contrast, the community teams said they rarely made use of the service and were under the impression that Changing Lanes was almost exclusively a step down service for the specialist personality disorder medium secure ward.

AWOLS
Mr X did not return from unescorted leave on 6th February 2010; his licence was subsequently revoked by the Ministry of Justice on 16th February 2010, and he was arrested approximately a week later and remitted to prison. No concerns were raised regarding this incident as a result of the internal investigation. Nevertheless, we reviewed the situation regarding AWOLs from the specialist personality disorder secure wards in ELFT, in line with the Terms of Reference (**To review the current practices and procedures for managing AWOL for patients with a diagnosis of personality disorder and offending behaviour**).

Since 2010, the service has enhanced its approach to security with the development of 'intelligence folders' in patient files, and the introduction of electronic monitoring of patients on leave (Missing and Absent Without Leave policy, June 2016; and the Electronic

Monitoring Protocol, March 2018). Intelligence folders are managed by the Social Work administrator and we were provided with evidence of the audit process. The Forensic Directorate now works in closer liaison with local police, who attend the service on a monthly basis. We were provided with details of all the three subsequent absconds, of which two were failed attempts to abscond (2015, 2016) and one abscond from escorted community leave.

The CQC inspection report (2018) found the forensic inpatient services to have improved in terms of safety, and specifically mentioned the individualized approach to the use of electronic monitoring to manage patient progression towards discharge. The Forensic Directorate have audited their use of community leave, as a result of the implementation of electronic monitoring, and were pleased to report that it had increased overall.

CONCLUSIONS TO PART ONE

We found ELFT to be very open and responsive to this review, and would like to extend our thanks to staff who ensured that documentation was shared and interviews conducted in a timely manner.

We concluded that the Trust had carried out the actions associated with the recommendations of the internal investigation report, and that there was evidence to suggest that sustained change had occurred in the areas identified. Some of these changes occurred as the result of trust-wide systems and processes, whilst others were specific to the delivery of specialist forensic services and/or mental health services in Newham. The lack of commissioner follow up in relation to the action plan was related to specific difficulties with changes in posts, and has subsequently been rectified with more robust tracking processes.

We noted good practice in terms of robust processes for ensuring patient security in the Forensic Directorate, and in terms of a Trust ethos of investment in community services for individuals with a diagnosis of personality disorder. We also noted efforts to develop innovation in terms of the multi-agency projects; however, we felt there was scope to improve protocols and practice for the shared care and transitions of care within the Trust for individuals with a primary diagnosis of personality disorder and histories of offending, as this is an area of potential risk in relation to patient safety.

RECOMMENDATION 1

The Trust should ensure that for those service users with a primary diagnosis of personality disorder (and offending histories), there is clarity and agreement between teams and

services within ELFT, including both formal and informal processes for resolving uncertainty and disagreement.

PART TWO

Part two relates to the delivery of a professionals workshop and a service user focus group. This covers items in the Terms of Reference under section 2. (see Appendix II).

SETTING THE SCENE

Mr X was primarily managed by the specialist forensic personality disorder service between 2008 and 2012, both as an inpatient and then an outpatient. This service was then part of the DSPD (Dangerous and Severe Personality Disorder) national provision for individuals with a primary diagnosis of personality disorder that was linked to a history of serious offending. In 2013, the DSPD provision was replaced by the OPD (Offender Personality Disorder) pathway strategy, with a range of services being delivered jointly by the NHS and HMPPS (Her Majesty's Prison and Probation Service). Over time, OPD services have become established across the country, including a triage system for identifying the cases held by probation that fall within the scope of the service and – more recently – the development of community teams to provide direct work with individuals who fall within the remit of the OPD provision.

Around one third of the probation caseload has been identified as falling within the scope of the OPD pathway services; with greater clarity regarding the screening process and the inclusion criteria, it is likely that Mr X – if he were to present to services today as he did back in 2008 - would no longer meet criteria for the specialist service that he received back in 2008-12. OPD services are restricted to those who have committed serious interpersonal violence (physical or sexual) and who are under the supervision of the criminal justice system. Furthermore, prior to the serious incident, Mr X did not meet the criteria for management under MAPPA (Multi-agency Public Protection Arrangements) which is reserved for those with more serious sexual and violent offences. Mr X – along with the majority of the probation caseload, as well as those individuals who have completed their time on probation, and those who have offended but have not been convicted – would have been expected to access mainstream mental health services as required.

Since 2003, it has been accepted that personality disorder can no longer be considered a diagnosis of exclusion from mental health services[3]. However, it is still the case that mainstream mental health provision has been primarily designed to meet the needs of

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[3] NIMHE (2003). Personality Disorder: No Longer a Diagnosis of Exclusion.

those with mental illness rather than personality difficulties; services and the staff that deliver them do struggle at times to meet the needs of individuals with a diagnosis of personality disorder. This can lead to inadequate or inefficient service provision, uncertainty as to what interventions are most effective, service user experiences of rejection, and challenges in terms of communication between agencies and between teams. **The aim of the workshops – detailed below – was to focus on this group of individuals who have a primary diagnosis of personality disorder and who have a history of offending behaviour but who do not meet the fairly stringent criteria of the more recently developed OPD pathway services.**

PROFESSIONALS WORKSHOP

A workshop for professionals was held in London 24th June 2019.

Aim

The aim of the workshop was to bring together professionals from across London to:

- **a.** Consider – in the light of lessons learnt from serious incident investigations – health service delivery for individuals resident in London with a primary diagnosis of personality disorder and a history of offending behaviour who do not meet the threshold for specialist OPD pathway services.
- **b.** Consider developing a set of guiding principles for service delivery that could ensure a consistent multi-agency approach and good quality care across London for this particular client group.

Participants

The following professionals were invited to attend[4]:

- Senior clinical and operational representatives from all ten mental health trusts in London, including forensic and non-forensic care groups. Eight of the ten trusts were present at the meeting, including a range of senior staff (and two liaison psychiatrists).
- Commissioners, of which one NHS England and one Clinical Commissioning Group representative, attended.
- London Probation and Community Rehabilitation Company (CRC) leads.
- Chair of the SMB (Strategic MAPPA Board) and colleagues.
- Metropolitan police lead for mental health

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[4] The reviewers also met with the Mental Health Advisory subgroup of the Strategic MAPPA Board (SMB) for London

Methodology

The aims of the workshop were achieved by means of small group tasks relating to four case vignettes (fictitious but representative of service users commonly presenting to mental health services). Please see Appendix V for details on the four vignettes. Participants focused initially on their relevant pathways of care, as commissioned and laid out in local policies and procedures. Differences in practice between trusts were highlighted.

The groups subsequently discussed weaknesses in their pathways of care for this client group, as evidenced by issues and concerns raised by service users and carers, and highlighted in quality assurance processes related to safety, effectiveness and experience.

The group work exercises – and subsequent large group discussions – were particularly focused upon the Terms of Reference items:

- **To review the current effectiveness of and barriers to multiagency communication, with specific attention to communication between mental health services and MPS, NPS and other MAPPA agencies.**
- **To review the current practices and procedures for managing AWOL for patients with a diagnosis of personality disorder and offending behaviour.**
- **To review the current mental health pathways for patients with a diagnosis of personality disorder and offending behaviour, to include consideration of**
    - **Collaborative working between community and forensic teams**
    - **Management of referrals, transitions between services and follow up**

Emerging findings

There is no doubt that all trusts across London have services that individuals with a diagnosis of personality disorder can access and that are relevant to the difficulties associated with personality disorder. Some trusts have specialist personality disorder pathways that provide an enhanced service. However, the reality is that hard pressed teams struggle to meet the needs of individuals with personality disorder and it is by no means clear that every service user currently receives a consistent response from services across London, or even within individual trusts. Other agencies – such as the probation service – also report the same experience, in terms of never being entirely sure how to access the right mental health service at the right time for their offenders.

The workshop was exploratory in nature, but highlighted particular inconsistencies in the following areas[5]:

1. Trusts varied as to whether they offered a personality disorder-specific pathway of care and/or they had senior roles in the trust that championed services for individuals with personality disorder.
2. There was huge variability across and within trusts in the criteria of teams with the same title – that is crisis teams, community mental health teams (CMHT) and community forensic teams – with different thresholds for acceptance being used.
3. The treatment offer within trusts was strongly oriented towards those with a diagnosis of emotionally unstable personality disorder, and therefore tended to be oriented towards women service users (although not exclusively so). Those with other personality disorder characteristics – particularly antisocial traits (often male service users) – were particularly poorly served in terms of interventions.
4. Although policies may have been written in inclusive terminology, practice suggested that teams managed work pressure and anxieties by referring individuals on to other teams. That is, a poor fit with a service was responded to by trying to get another team to take on the case.
5. All participants acknowledged an uneven skill set and a need for training amongst their staff in relation to this service user group, particular in terms of enhanced engagement skills, and responding to behaviour that could be challenging.
6. Commissioning in some areas was fragmented, and this mirrored the potential for fragmentation and chaos in the service user group.

It is important to note that many of the trusts were able to evidence areas of good practice and exciting innovations in relation to the service user group. These included – but were not restricted to – multi-agency projects to manage crisis and care planning, particularly for those who were frequent repeat users of services. However, these areas of good practice were not replicated in all trusts, and their implementation was rather uneven.

SERVICE USER FOCUS GROUP

The following report is written by Dr Blazdell, and summarises the findings of a service user focus group held on 2nd July 2019.

Aim

The aim of the focus group was to build on the professional's workshop by developing an understanding of service user views regarding service provision in London for individuals with a diagnosis of personality disorder who had offending histories. The intention was to

[5] All these themes relate to individuals with a diagnosis of personality disorder and a history of offending behaviour

focus not just on forensic, but also experiences of mainstream mental health services both in the community and as inpatients.

Participants

Two organisations – London Pathway Partnership's Service User Forum and Women in Prison – were approached to access service users. Eleven people took part in the focus group (nine men and two women). All had been diagnosed with a personality disorder and had significant offending histories.

Methodology

The focus group was run as an open group discussion over two hours, guided by Dr Blazdell. The first part of the group focused on participants' experiences of accessing services in the community, and the second part of the group focused those aspects of services that can help.

Emerging findings

Services in the community

Although participants had widespread experience of using specialist forensic services, it was striking how few generic community services were mentioned by the group. Most mentioned seeing their GP, although their experiences were varied. One person spoke of how understanding and knowledgeable his GP was around personality difficulties, even going on to assign him a counsellor which he continues to see weekly; however, many of the other participants highlighted how little their GP knew and the scarcity of help that was on offer. Significantly, one woman spoke movingly about how she had tried to access help from her GP when she was feeling suicidal only to be told to come back in two weeks' time. For her, there was a clear link between her mental health issues, her substance use and her offending, but it was a link which the GP failed to recognise or act upon.

Other community-based organisations participants mentioned included Narcotics Anonymous, Alcoholics Anonymous and other third sector organisations. Significantly, engagement with NA and AA had begun whilst in custody and continued on release. Although not primarily 'personality disorder' services, there was something about the structure of the organisations and the support that they offer that people found helpful. Similarly, participants spoke highly of the support they received from third sector organisations, stressing the important role of advocacy, the critical importance of developing relationships and the need for continuity and consistency (see 'Things that can help' below).

Things that get in the way of accessing help

Participants felt that both their diagnosis of personality disorder and the fact of their offending history got in the way of them accessing the help that they needed. Many participants represented graphically the sheer amount of paperwork that existed about them, however they felt that this acted as a barrier, rather than an enabler, to accessing services. Many felt that "knowing you on paper" served as an alternative to getting to know the person in the present and was often used as an impediment to the development of therapeutic relationships with professionals.

One participant spoke of how he had been given the diagnosis: how the professional had been unable to "look me in the face" and had failed to discuss what the diagnosis meant. Instead, the participant was left to source information leaflets on personality disorder from the MIND website.

Lengthy waiting times were also cited as a systemic obstacle for accessing help. Both of the women who attended the focus group had received court orders to complete CBT programmes. However, on trying to access these courses, found that the waiting time was six to nine months. They went on to speak strongly about their mistrust in systems and how systems "set you up to fail".

Things that can help

Living in a peaceful and secure environment was highlighted as being of fundamental importance. Whether in supported accommodation or living independently, participants expressed the significance of housing with one man speaking movingly about how his housing security had been jeopardised when his keyworker was heard talking about the man's offence outside the hostel where he lived.

Relationships were also highlighted as being of critical importance. Participants expressed the need for continuity, speaking of how important 'through the gate' services can be and the negative impact that constant changes in staff can have on mental well-being and feelings of trust, safety and security.

Alongside the need for continuity in relationships with professionals, participants also spoke about the importance of consistency: of "people doing what they say they'll do", rather than offering "false promises" (for example, leaving a message and being told that someone will get back to you and that failing to happen). Furthermore, participants highlighted the quality of relationships they value. One participant spoke profoundly about an interview at the job centre when his key worker had reassured him that "he was on my side"; whilst others spoke about working with professionals who "genuinely believe in me" and who "fight my corner". For these participants, having someone who could act as an advocate; someone who they could trust, was essential.

Although participants spoke about wanting support, for many, having a say about what type of support was needed and when – a level of choice - was important. Throughout the focus group, participants spoke about how "disempowered" they felt, both as people with offending histories and people with a diagnosis of personality disorder. They spoke of how, when "things go wrong", it always feels as if it is they who are seen to be in the wrong, rather than any failure in the system. Having an advocate who can be trusted, having some choice about the level of support and the type of support they receive, were seen as steps towards empowerment.

Finally, participants highlighted the important role that Peer Support Workers can have. Examples were given from both sides of the relationship, with many speaking about how they had benefited from having been assigned a Peer Support Worker, and one man talking about his experience of being a Mentor. For this man, being a Mentor had given him real "purpose" and a sense of being valued. However, when the project was ended due to risk management fears, he was left feeling "deeply aggrieved".

Other members of the group also recognised the role that they could potentially play in "filling the gaps" in the system. The women expressed a desire to set up a peer support group for women who had had their children taken into care; whilst one man spoke of the dearth of services for pensioners being released from prison and the need to set up support services for an aging offender population.

PART TWO : CONCLUSIONS & RECOMMENDATIONS

Summary

In brief, the Terms of Reference were addressed within the workshops, and the findings can be summarised as follows:

- **To review the current effectiveness of and barriers to multiagency communication, with specific attention to communication between mental health services and MPS, NPS and other MAPPA agencies.**

No concerns were raised in relation to the communication of risk concerns from health services to other agencies. The primary area of difficulty related to non-health agencies knowing how to access relevant health services, being unsure as to which health services might be relevant; and confusion regarding the different service provision across Trusts. Attempts to seek help were often rejected. This was a frustrating situation for other agencies, and raised concerns regarding the inconsistent management of risk in individuals whose help-seeking behaviour can be challenging.

- **To review the current practices and procedures for managing AWOL for patients with a diagnosis of personality disorder and offending behaviour.**

The professionals' workshop discussed AWOL and serious incidents across the Trusts, but the participants reported that service users with a personality disorder were not over represented in terms of serious incidents. Given the evidence base that suggests that individuals with a diagnosis of personality disorder may be at higher risk of harm to self and to others, this anecdotal finding is slightly surprising. We suggest it may be possible that the difficulty that many individuals (and professionals) encountered in trying to access health services, meant that few were under the care of health services for any sustained period of time.

- **To review the current mental health pathways for patients with a diagnosis of personality disorder and offending behaviour, to include consideration of**
    - **Collaborative working between community and forensic teams**
    - **Management of referrals, transitions between services and follow up**

The workshops focused on those individuals who do not meet the criteria for specialist OPD pathway services, and clearly identified concerns in this area. Although all trusts have policies and protocols in relation to both referral criteria and transitions between services and teams, probing via the case vignette exercises revealed that there are a great number of discrepancies between trusts; and tensions between teams in terms of the safe and appropriate flow of patients with personality disorder and offending histories into and through health services. These tensions raise concerns regarding the safe risk management of individuals whose life experiences means that they often struggle with problematic attachment patterns, are highly sensitive to perceived rejection and may struggle with trusting those in authority. We were not fully assured that these boundary disputes were settled in a timely fashion, and in a way that best met the needs of the service user. Transitions across provider boundaries are particularly challenging to navigate.

It was clear that many of the trusts did not offer the range of intervention options that were identified as helpful by the service user focus group; that is, the service offer was sometimes dominated by a relatively sophisticated psychological therapies service that was primarily oriented towards those with emotionally unstable traits. We were also not fully assured that there was equal engagement with both men and women (with offending histories) to provide them access to existing services for those with a diagnosis of personality disorder.

Next steps

There was an appetite in both workshops for the development of a London-wide protocol or framework for the provision of mental health services for individuals with a diagnosis of personality disorder and offending histories. There was understandable caution from the professional group in terms of resource implications and problems associated with over

specifying what should be delivered and how. Nevertheless, both workshops agreed that setting out expectations in order to achieve consistency was key.

It is clear that the service user focus group were able to provide a perspective on 'what good might look like' in terms of their focus on the quality of relationships, their needs at times of crisis, and their emphasis on the role of support staff and peer mentors.

Recommendation 2:

NHS England should ensure that a pan-London 'task and finish' group is set up with key provider and commissioner stakeholders. **The aim of this work is to focus on health service provision for individuals with a primary diagnosis of personality disorder and a history of offending behaviour that does not meet the threshold for OPD pathway specialist services; and to address the issues of inconsistency that are raised in this report. The goal is to ensure that concerns regarding risk, leadership and the efficiency of service delivery – together with greater clarity regarding the model of care - are resolved.** It is likely that there is learning from the implementation of the OPD pathway that could be incorporated into any recommendations for the wider personality disorder service delivery.

We suggest that a 'task and finish' group could comprise a mix of senior professionals, commissioners and service users from across London, in order to develop a protocol that sets out expectations for the accessibility and suitability of mental health services for this group of individuals. Such a protocol should:

- Be based on the current evidence base for effective management of individuals with personality disorder and offending histories
- Draw on senior mental health experience of service elements that have maximum beneficial impact
- Ensure a range of accessible and personality disorder-relevant offers are available for service users
- Emphasise those aspects of service user experience that are most closely linked to 'services that can be helpful'
- Develop a protocol that is resource neutral
- Provide commissioners with clear guidance as to 'what good looks like' in this area of work.
- Incorporate areas of good practice or innovation that can be replicated across trusts.
- Recommend a mechanism by which pan-London boundary disputes (geographical and inter-service) can be resolved in a timely manner in order to facilitate access to services.

- Ensure that the work considers the need for an interface with new developments in the OPD pathway, Provider Collaboratives, and the new Integrated Care Partnerships.

APPENDIX I : Psychological Approaches CIC

Psychological Approaches is a community interest company delivering a range of consultancy in collaboration with mental health and criminal justice agencies; our focus is on the public and voluntary sector, enabling services to develop a workforce that is confident and competent in supporting individuals with complex mental health and behaviour (often offending) that challenges services. We have a stable team of six serious incident investigators, and offer a whole team approach to each investigation, regardless of the specific individual or panel chosen to lead on the investigation. Our ethos is one of collaborative solution-seeking, with a focus on achieving recommendations that are demonstrably lean – that is, achieving the maximum impact by means of the efficient deployment of limited resources.

Lead investigator

Dr Jackie Craissati MBE is a Director of Psychological Approaches, and Consultant Clinical & Forensic Psychologist with 30 years experience of leading in forensic mental health services. She was Clinical Director of a large service for five years, with responsibility for quality and governance. She is now a Trustee with Samaritans, chairing the service and quality committee and with responsibility for safeguarding; and a non-executive Director for a mental health trust, chairing the quality committee and responsibility for 'mortality'.

Dr Craissati has considerable expertise and a national role in developing services for offenders with a diagnosis of personality disorder, particularly those with offending histories; she has published widely in relation to the evaluation of effective and high quality services in this area of work.

Co-investigator

Dr Colin Campbell is a Consultant Forensic Psychiatrist with expertise in personality disordered offenders, and working within the South London and Maudsley Trust. He is lead clinician for the offender personality disorder pathway in south-west London, providing services in the community, into the treatment unit in HMP Brixton, and as Responsible Clinician on the specialist personality disorder ward at the Bethlem Hospital.

Focus group lead

Dr Julia Blazdell is a lived experience consultant with over 20 years experience in academia and mental health services. She has former management board experience with Emergence, and has led a range of co-production projects with mental health trusts.

Extensive experience of designing and delivering training for staff working in secure settings; module lead for the MSc and BSc Knowledge and Understanding Framework for Personality Disorders; Co-president of the British and Irish Group for the Study of 'Personality Disorder'.

APPENDIX II: Terms of Reference

Terms of Reference

Independent Review of the Trust's internal investigation in regard to the care and treatment of Mr X provided by East London NHS Foundation Trust

1. Purpose of the Review

To independently review:

- The Trust's current practice considering emerging clinical and risk information
- To review the implementation of the Trust's internal investigation action plan
- To work closely with Metropolitan Police Service (MPS), National Probation Service (NPS), Clinical Commissioning Groups and NHS England Specialised Commissioning in quality assuring the wider system across London to reduce potential future risks.

The outcome of this review will be managed through governance structures in the commissioner and the provider's formal Board sub-committees and with Police and Probation services. The Commissioner will provide assurance to NHS England of completion of any actions/outcomes from the completed report.

2. Terms of Reference

2.1 Review system changes and current practices for the care and treatment of individuals with a diagnosis of personality disorder and associated offending behaviour within mental health services across London, since the care and treatment of Mr X in 2012, in particular: -

- To review the current effectiveness of and barriers to multiagency communication, with specific attention to communication between mental health services and MPS, NPS and other MAPPA agencies
- To review the current practices and procedures for managing AWOL for patients with a diagnosis of personality disorder and offending behaviour.
- To review the current mental health pathways for patients with a diagnosis of personality disorder and offending behaviour, to include consideration of
    - Collaborative working between community and forensic teams
    - Management of referrals, transitions between services and follow up

2.2 To independently review:

- The implementation of the Trust's internal investigation action plan.

- The embedding of learning across the trust and identify any other areas of learning for the trust and/or commissioner.

- The processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services in relation to those with a diagnosis of personality disorder and offending behaviour.

- Comment on the commissioners monitoring of the action plan.

- Make further recommendation for improvement as appropriate, and/or in light of any new information that may have emerged regarding clinical and risk concerns since the trust's internal investigation was completed.

3. Timescale

The review process starts when the investigator receives the Trust documents and the review should be completed within 6 months thereafter.

4. Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the review process and understand how they can be involved including influencing the terms of reference.
- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this review.

5. Outputs

5.1 A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations given specific consideration to the implementation locally, regionally and nationally, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

5.2 At the end of the review, to share the report with the Trust, and other services involved within the scope of the review and meet the victim and perpetrator families to explain the

findings of the review and engage the clinical commissioning group with these meetings where appropriate.

5.3 A final presentation of the review to NHS England, Clinical Commissioning Group, Police, Probation service and provider Board and to staff involved in the incident as required.

5.4 We will require monthly updates and where required, these to be shared with families, CCGs and all relevant Providers.

5.5 The investigator will deliver learning events/workshops for the Trust, staff and commissioners if appropriate.

APPENDIX III: Documentations and interviews

List of interviewees

Name	Role	Date of interview
Mr H	Incidents & Complaints Manager, ELFT	4th April 2019
Dr G	Chief Medical Officer, ELFT	23rd April 2019
Mr N	Head of Nursing and Associate Director of Safety and Security, Forensic Services, ELFT	26th April 2019
Dr T	Lead Clinician & Head of Service, Millfields Unit (PD unit, John Howard Centre, ELFT	26th April 2019
Ms W	Service Director, Newham, ELFT	26th April 2019
Mr G	Team Manager, Changing Lanes (community offender PD team, Forensic Services, ELFT)	26th April 2019
Dr D	Clinical Director, Newham Adult Mental Health Directorate, ELFT	26th April 2019
Dr S	Consultant Forensic Psychiatrist, Wolfson House and Waltham Forest Forensic Outreach Service, ELFT	20th June 2019
DC S	Detective Inspector, Metropolitan Police	17th July 2019
Ms T	Former NE London Specialist Commissioning Case Manager	Email correspondence

Documents reviewed

1. Internal investigation Serious Incident Review Report (STEIS: 2017/6122)
2. Copies of ELFT patient records for Mr X from 2008 to 2012, including copies of care plans, ward round notes, CPA meetings, community leave plans, and email correspondence between his care team and the probation service.
3. East London Forensic Outreach Service Operational Policy**.** ELFT June 2017
4. Discharge Summary for Mr X by Dr HG, Millfields Unit, 24th February 2010
5. Psychiatric Report for the Court on Mr X by Dr T. 26th January 2011
6. Addendum Psychiatric Report for the Court on Mr X by Dr T. 20th July 2011
7. Addendum Psychiatric Report for the Court on Mr X by Dr T, 10th July 2011
8. Addendum Psychiatric Report for the Court on Mr X by Dr T. 4th November 2011
9. Letter to Dr. K regarding Mr X from Dr. Celia Taylor. 24th may 2012
10. Examples of Patient Intelligence Files. ELFT.

11. Forensic Directorate Escape, Abscond & Non return from leave (> 4 hours). July 2016 to May 2019.
12. Changing Lanes – transfer of care, multi-agency working review. ELFT
13. Changing Lanes Intensive Intervention & Risk Management Service Forensic Operational Policy, April 2019.
14. Changing Lanes MAPA Database Protocol (undated)
15. Incident – SI Escalation Process. ELFT
16. Missing and absent without leave policy. ELFT June 2016.
17. Protocol for the use of electronic monitoring. ELFT March 2018.
18. Millfields AWOL Data as of April 2019 – includes all cases since first admission in 2005. ELFT April 2019.
19. How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS) – East London NHS Foundation Trust. NHS Improvement September 2017.
20. How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS) – East London NHS Foundation Trust. NHS Improvement March 2018.
21. How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS) – East London NHS Foundation Trust. NHS Improvement September 2018.
22. Outcome of Incident Grading Meeting 17 08 18. ELFT August 2018.
23. Missing record incident details, 5th September 2018
24. Monthly Learning Lessons newsletters for Newham, ELFT (11 months)
25. Learning lessons seminar agendas (23.3.18, 6.12.18)
26. Newham Secondary Care Psychological Services Personality Disorder Service Redesign Proposal, January 2019.
27. East London Forensic Outreach Service Operational Policy, June 2017.

APPENDIX IV : EVIDENCE TABLE

	Recommendation	Trust stated position	Evidence	Additional supplementary assurance
1	Action plan to be checked in 6 months time	Acknowledgement that although the Forensic Directorate owned the action plan, checking had not taken place as there had been confusion over this (and a change of personnel at the time).	No minutes available. Email confirmation from ELFT Patient Safety Manager and former NE London Specialist Commissioning Case Manager.	ELFT submitted the SI report to the Commissioning Support Unit (CSU) who act on behalf of the CCGs on 16/6/17 & they received feedback fro them on 5/7/17 confirming that the CCG had reviewed the SI report & recommended it for closure. ELFT subsequently received a further comment from the CSU on 18/7/17 & the report was subsequently discussed at a bi-month SI Panel meeting between ELFT & NHS E. NE London Specialist Commissioning Case Manager (2017) reviewed the draft investigation report and recommended an independent review, as there may have been missed opportunities when Mr X was seen by the psychiatric liaison service six weeks prior to incident.
2	Check that feedback has been given to family, patient, and other	Efforts were made to engage with victim's family, but there was no engagement. Police requested no contact		Verbal assurance provided. There has been no subsequent contact with families.

	agencies by 10 days following sign off.	with Mr X, as trial not yet completed.		
3	All forensic community patients to be managed by the care co-ordinator to ensure referrals/cases are opened and closed in a timely way.	Confirmation by Lead Nurse that email communication was sent to the forensic service staff.	Audit 2017 results: 58 (96%) of all cases closed & letter to referrer. Remedial action required in 3 (4%) cases. Current audit of 52 open forensic cases (requiring closure) reveals none relate to the PD service.	Current procedures confirm that forensic PD caseloads are checked in supervision, & the administrator keeps records up to date.
4	A robust process for identifying and managing serious incidents including changes to Datix and the minuting of grading meetings.	Powerpoint presentation of serious incident management shared.		Confirmation from the Trust Medical Director and Incidents Manager that Datix grading is completed centrally by the Patient Safety team, overseen by Trust Medical Director & Chief Nurse.
5	Final assurance that the processes around record keeping in the Newham Directorate are robust, and there are no incidents regarding missing notes.	Newham remains confident this was an isolated incident. With the complete transfer to electronic records, no paper record incidents noted, although a small medical files archive remains.	April 2018-19 audit of Forensic Directorate incidents relating to loss of paper records revealed one incident related to an internal transfer, notes found a week later.	See footnote[6]

[6] In the course of reviewing the medical records for Mr X, it emerged that the paper files for his time in the community (2010-12) were missing from the forensic directorate; nevertheless we were able to obtain copies of email correspondence and reports.

6	Record keeping will be the focus of the next Trust-wide learning event (November 2017).	A learning event was held on 29/9/17. The MD shares uncertainty regarding the effectiveness of embedding trust wide learning from incidents, and this is the subject of a current Trust review.	Screen shot confirmation of the learning event was provided.	The annual learning events agenda was shared, as were eleven monthly Learning Lessons newsletters.

APPENDIX V : Workshop Vignettes

ALICE

Alice is a 21 year old woman, presenting to A & E, with bruising to her face, a length-wise deep cut in her forearm (self harm) and expressing suicidal ideas. She has presented before, and reports a history of self harm that has been escalating over the past couple of years.

Alice has a conviction for child neglect, and indeed her toddler is now in care. The violence in her relationship is concerning, as it seems to be fuelled by binge drinking by both her and her boyfriend, and they are both involved in the violence (although her boyfriend inflicts more serious harm).

She has no employment history other than sporadic sex working. She was sexually and emotionally abused as a child, and has been diagnosed as presenting with traits of both emotionally unstable and antisocial PD.

BILL

Bill has come to the attention of mental health services for the first time, aged 30. He lives with his parents, and his mother became depressed and went to her GP where she revealed the difficulties with Bill. The GP liaised with him, and he agreed to a referral to the CMHT.

Bill collects Nazi memorabilia and antique weaponry, as well as pursuing an interest in martial arts. His behaviour is becoming more difficult for his parents, as he responds increasingly aggressively to their attempts to interact with him, and they are frightened of him. He seems very isolated except for some links with others (a far right chat room) via the internet.

At school Bill was bullied and suffered from stomach upsets. There was one prior incident of concern when a cat went missing and it was thought that he might have harmed it. He was also admitted to an adolescent ward for 2 weeks aged 15 when he became suicidal and erratic in his manner. The unit thought that Bill probably presented with traits of autistic spectrum disorder or emerging PD of a schizoid or schizotypal type. However, a neurodevelopmental specialist was clear that he did not meet the criteria for a formal diagnosis of ASD.

CHARLIE

Charlie is 45 and has recently gone to his GP reporting weight loss, poor sleep and a lack of motivation to continue working (unskilled work with a friend). The trigger for what appears to be depression is his relationship breakdown after many years, when his wife left him to have a relationship with one of his friends.

Charlie has a long history of antisocial behaviour in the past, commencing with thefts at the age of 15, and escalating to involvement with a criminal peer group, and more serious crime. He served a long sentence throughout his 30s for armed robberies, and has been out of prison for five years, and has recently completed his period on probation licence.

The CMHT offer Charlie an appointment with a psychologist, but on being offered talking therapies, he storms out of the room, picks up a chair in the waiting area and breaks a window before rushing out of the building. The team refuses to offer a further appointment, and Charlie submits a complaint.

DAVE

Dave is 25 and well known to both the probation service and the local mental health service. He has had three admissions to an acute psychiatric ward in the past two years, on each occasion his apparent psychotic state is resolved within a few days. However he becomes verbally threatening towards staff, and on the last occasion physically assaulted the ward manager; triggers are usually linked to attempts to enforce basic ward rules. Dave has been offered one follow up appointment in the community each time, but having failed to attend, is discharged. The case is closed but he presents on a section 136 a month later.

The police have refused to prosecute following the aggression on the wards, as they view Dave as having mental health problems; the probation service have also shown great tolerance and patience during his licence, as they view him to have unmet health needs, and he only has 3 weeks left on his licence.

Dave has a childhood diagnosis of ADHD, and truanted at school; more recently he has been diagnosed with antisocial and emotionally unstable PD. He became involved in substance misuse as a teenager, and his heavy class A drug use may trigger the brief psychotic episodes. His offending relates to property damage, possession of drugs, and fairly ‘minor’ robberies that involve stealing mobile phones and similar impulsive offences.