PSYCHOLOGICAL APPROACHES CIC

AN INDEPENDENT REVIEW OF THE CARE AND TREATMENT OF MR X

March 2020

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CONDOLENCES

The panel would like to offer their condolences to the family and friends of the victim of this tragic event on the 12th May 2016.

The panel also acknowledges the impact that this incident has had on those staff who worked closely with the victim at the community hospital for so many years, seeing him as both a friend and a valued work colleague.

1 INTRODUCTION:

1.1 The incident:

1.1.1 On 12th May 2016 at approximately 14.30 hours, Mr X attacked and fatally stabbed the victim, a bank nurse who was semi-retired, in the nursing office at a community hospital using a knife, which he had obtained externally, sometime before the incident.

1.1.2 Despite best efforts by senior staff on scene and shortly thereafter, the ambulance services, aided by an Air Ambulance Team who responded very quickly, the victim was certified deceased at the scene.

1.1.3 Mr X was prosecuted and was subsequently convicted of Manslaughter on the grounds of diminished responsibility due to his mental ill health.

1.2 The background:

1.2.1 The victim had been employed at the hospital for many years and was well known to Mr X. Staff reported that he was well liked by colleagues and the patients alike. Staff were not aware of any specific difficulties that the victim had ever reported to have with Mr X.

1.2.2 Mr X who is a Black British man of African descent was 40 at the time of the incident and had a longstanding recorded history of mental illness, formally diagnosed as Paranoid Schizophrenia. Perhaps of note the victim was also black but of Caribbean descent.

1.2.3 Mr X was first referred to a Child Psychiatrist at the age of 15 years due to "odd and violent" behaviour.

1.2.4 At the age of 16 he was referred to social services by the Police following an allegation of assault against his mother

- 05/07/1992 - His mother claimed that he hit her about the face and body, possibly following an argument with his father about what TV programme to watch

1.2.5 After this incident, he was placed in foster care as his family was reluctant for him to live at home.

1.2.6 After a relatively short period in foster care, Mr X moved into a residential care home (Arun Lodge), where he resided until he was offered a tenancy in Boutflower Road, Battersea where he remained until his original index offence.

1.2.7 Whilst at Arun Lodge, he changed his name and instructed social workers not to disclose his new name and address to his parents.

1.2.8 During his tenancy at Boutflower Road there were three specific incidents of note.

- 18/08/1995 – Mr X is reported to have had a fight with his father, which resulted in him stabbing his father with a pair of scissors. His father sustained a punctured lung, but did not wish to press charges. It was reported that he had been drinking alcohol at the time of the incident.
- February 1997 – Mr X was charged with the rape of an ex-partner (who was also the mother of his daughter). The charges were however dropped in March 1997.
- Shortly after the allegation, Mr X is reported to have taken an overdose of paracetamol tablets, which, per records, did not require hospital treatment.

1.2.9 Mr X's original index offence was a conviction for Grievous Bodily Harm (GBH), following the stabbing of a mini cab driver on the 20/07/1998, who was parked in Mr X's street. During an interview by police at the time, Mr X claimed there was a large conspiracy against him and that his life was under threat.

1.2.10 Whilst attending court, he was interviewed by a psychiatrist for the Court Diversion Scheme who described him as guarded and a poor historian. He believed he was expressing paranoid delusions of people laughing and pointing at him in the street when being moved on by traffic wardens. He also stated others were laughing at him when he was at bus stops.

1.2.11 Mr X reported to the psychiatrist that he carried a knife for his own protection.

1.2.12 Whilst in prison, Mr X was assessed by two other psychiatrists, which led to his transfer to the Shaftesbury Clinic at South West London & St Georges NHS Trust (SWL&StG) on the 10th September 1998, initially under section 48/49 of the Mental Health Act 1983 (emergency prison transfer for treatment with restrictions).

1.2.13 On the 20th November 1998, following a court appearance Mr X became subject to a Section 38 MHA 1983 (Interim Hospital Order) and then on the 11th January 1999 this was converted to a Section 37/41 MHA1983 (Hospital Order with Restrictions)

1.2.14 Mr X was formally diagnosed as suffering from Paranoid Schizophrenia

1.2.15 Mr X was born in Lambeth and grew up in the Balham area of South West London. His personal and family history is not covered in detail by this report but is available in his medical notes.

1.2.16 Mr X's history of using alcohol and drugs is not covered in detail within this report, but this is available in his medical notes. It is noted that prior to the index offence in 1998, Mr X was drinking cider and vodka two to three times

per week. However, his alcohol use in later years, whilst at community hospital, was not perceived by his clinical team to be problematic.

1.2.17 Mr X was reported as having a history as a teenager of using cannabis, and experimenting with Ecstasy and LSD. This however, was not perceived to be an issue whilst at Southleigh, where he denied using drugs, which was supported up until 2015 by negative urine drug screens (UDS).

1.2.18 A detailed chronology of Mr X's psychiatric and medical history following his admission to the community hospital is provided as **Appendix (2)**

1.2.19 Reports indicate that during the initial phase of Mr X's care at the Shaftesbury Clinic, he remained guarded and his persecutory and paranoid beliefs continued. In response to this, he was treated with antipsychotic medication (Olanzapine). It is reported that he was initially non-compliant but eventually took the medication when he felt he had no choice. The addition of a further medication, Amitriptyline, an antidepressant medication, led to a reported improvement in his mood and mental state.

1.2.20 In September 2000, Mr X developed, what was thought to be, gynecomastia (an enlargement of breast tissue in males); a recognised side effect of medication he was taking. Thus, his medication was changed to oral Quetiapine (an atypical antipsychotic medication). The diagnosis of gynecomastia was later questioned by a plastic surgeon following an onward referral from an endocrinologist.

1.2.21 Between August 1998 and January 2002, Mr X made gradual and continual progress at the Shaftesbury Clinic, eventually engaging in various treatment groups and community programmes.

1.2.22 On the 18th January 2002, Mr X was conditionally discharged to St Georges House. At the time, he was prescribed Quetiapine orally twice a day. 200mgs morning, and 300mgs at night.

1.2.23 On the 29th April 2002 Mr X was readmitted informally to Springfield Hospital. His paranoid ideas had returned; he was refusing medication and had begun drinking alcohol. He was noted to be irritable with hostel staff and isolating himself. It is recorded that by June he had recommenced unescorted community leave, but was complaining of the reemergence of gynecomastia as a side effect of medication. He was discharged back to the hostel in July 2002.

1.2.24 On the 4th October 2002 Mr X requested readmission to hospital via repeated phone calls stating he was unhappy and isolated at the hostel. After reassessment by a forensic consultant psychiatrist, he was recalled to hospital under Section 37/41 MHA1983. He was noted to not be eating well, had lost weight, was isolating himself and remarked that staff were talking behind his back.

1.2.25 During this admission, it was reported in correspondence that Mr X did seem to realise the seriousness of his illness and the dangers of using alcohol or illicit substances. It was also stated that Mr X experienced "paranoid phenomena" evident in his unpredictably, aggressive and verbally threatening behaviour to members of staff.

1.2.26 On the 12th January 2004 Mr X was conditionally discharged; to York Road Hostel in Sutton. Initially he was settled but he remained isolated and it is reported he did not attend meetings with his key worker and other staff. Further, residents it is said found his guardedness intimidating.

1.2.27 On the 4th November 2004 Mr X complained about his treatment by staff at the hostel to his social worker. He requested a private meeting with the Care Standards Inspector as he believed others at the hostel were making complaints about him.

1.2.28 At the end of the meeting he was given feedback by the inspector and the project manager of the hostel, who expressed concern about his lack of engagement and that he was not benefitting as much as he could do from the hostel programme. It is reported that within two minutes of the meeting, Mr X went to the kitchen and was smashing piles of crockery and throwing pans around. In doing so, he broke windows and damaged plaster work.

1.2.29 Mr X was arrested and charged with criminal damage, this led to his recall to the Shaftesbury Clinic. The hostel chose not to press charges though Mr X was later cautioned by the police for his behaviour.

1.2.30 Following his return to Shaftesbury Clinic Mr X initially demonstrated a reluctance to engage, being uncooperative, but polite and calm. To begin with, Mr X refused medication. He was thought to be depressed so was prescribed Fluoxetine and his Risperidone was increased to 8 mgs daily. He eventually agreed to take the medication.

1.2.31 Over the following year Mr X settled into a pattern, gradually reengaging, taking part in some activities but reluctant to do others. His leave was gradually increased to unescorted and his medication was gradually increased.

1.2.32 He was assessed by HM1(a manger of a community hospital, part of private hospital group) and RC2 R on the 9th December 2005. He was described as cooperative however, guarded and minimalised his historical alcohol use, drug use and the incidents of assault including the index offence.

1.2.33 The assessment acknowledges the history of placements breaking down due to difficulties with staff, poor engagement with professionals and paranoid ideation. The question of his compliance with medication was also raised in the context of his cautious attitude and the difficulty in measuring his compliance. There was a question as to whether Clozapine (an atypical antipsychotic medication) had been "seriously explored?"

1.2.34 The report concluded that a placement would be offered.

1.2.35 A Mental Health Review Tribunal (MHRT) was held on the 16th December 2005 and a conditional discharge was granted, with a review date of the 3rd March 2006 to consider the implementation of the recommendations. Accordingly, Mr X was stepped down from medium secure care.

1.2.36 Mr X was conditionally discharged a community hospital on the 3rd May 2006

1.3 The Community Hospital

1.3.1 The CQC report of this hospital was published on the 13th May 2016, following an inspection on the 19th and 20th August 2015, stated the service was rated overall as good. The five specific domains were rated as follows: -

- Are services safe? - Good
- Are services effective? - Good
- Are services caring? - Outstanding
- Are services responsive - Good
- Are services well-led - Good

1.3.2 The report states: -

The community independent hospital provides care, treatment and rehabilitation for people with mental health problems. The service provides assertive rehabilitation for 25 male and female patients with complex mental health needs. The service consists of a ward (19 beds) and a small number of semi-independent flats (6 beds).

1.3.3 HM2, the Hospital Manager at the time of the incident, when interviewed as part of the investigation, described the patient population as broadly dividing into three groups, which he linked to their pathway through the service: -

- "Slow - treatment resistant with high levels of chronicity. Slow stream rehabilitation which does not respond well to treatment, generally a lengthy admission".
- "Medium - came in after a lengthy period on acute ward, commonly would stay for three to five years and typically would move onto supported accommodation".
- "Fast- respond well and move on to independent or semi-independent living".

1.3.4 During discussions with the Hospital Manager he described the flats as; small self-contained units with their own small furnished kitchenette including sharps. This environment was aimed at supporting rehabilitation for those patients who were considered as being suitable for future "step down" to independent or semi-independent living. He acknowledged that in May 2016

there were no formal processes in place to monitor sharps and other utensils in the flats but this changed post the incident.

1.3.5 The hospital manager informed the panel that at the time of the incident, the hospital had no emergency alarm system in-situ for staff to call for immediate assistance, this has subsequently been addressed and staff now carry a personal alarm. He did state that a simple hard wired "nurse call" system did exist in patient's bedrooms.

1.3.6 In relation to the nursing office where the incident took place, patients were not allowed "open" access. However, the hospital manager stated, that as the unit was a rehabilitation service, staff did not lock themselves away from patients. On the day of the incident the handover had just ended and staff had just left the office to go off duty leaving 2 members of staff in the office when the assailant walked in through the open door and attacked the victim.

1.3.7 In the aftermath of the incident the office door was replaced with a stable door arrangement, where the bottom half would slam lock. Custom and practice today is to keep the door locked.

1.3.8 During discussion with RC1 Mr X's Responsible Clinician (RC) at the time of the incident, she described the "core team" (senior staff group) at the hospital as being cohesive and working well together, this was echoed by others in the core team.

1.3.9 In terms of clinical information and handovers received from the team, occupational therapy, psychology and social work were considered to provide good reports. However, nursing reports could sometimes be "variable". Written information in these reports sometimes needed further qualifying in ward rounds by the RC.

1.3.10 The staffing levels of "direct delivery" staff (nurses and support workers on the ward) was generally five during the day and four at night. Two of these would normally be registered nurses. On occasions these numbers would be supplemented with agency nurses or support workers, (approximately 5% of the time). On the day of the incident there were no agency staff working.

1.3.11 During a discussion multi-disciplinary discussion group with staff from the hospital and the panel, there appeared to be a marked difference in levels of work satisfaction. The nurses described high levels of frustration. This related to areas such as staff induction, staff supervision and differential pay arrangements. The above was believed to impact on staff recruitment and retention.

1.3.12 The nurses stated that on occasion they felt vulnerable, but also acknowledged that the hospital would agree to increase staffing numbers if it

was considered as clinically indicated. They did, however, add that the process to gain agreement for additional staff was very time-consuming.

1.3.13 The nurses described feeling that there were a lot of administration tasks, which they had to undertake and only a limited number of computers, which made writing reports and completing audits etc. more difficult. It also reduced time available for direct patient care.

1.3.14 Finally, they described a new alarm system that had recently been installed, which required all staff to carry a personal alarm. However, no bag or belt arrangement was provided to carry them, resulting in staff walking around carrying keys and alarms or supplying their own bag.

1.3.15 The psychologist and OT described a more positive experience with the opportunity for space to review notes and to see patients although the psychologist did describe paying for her own clinical supervision externally, although managerial supervision was provided in- house.

1.4 First Response & Support

1.4.1 The incident occurred on Thursday the 12th May at approximately 14.30 hrs. Due to the time and it being a week day the hospital was well-staffed, including senior managers who were immediately called upon and attended the scene.

1.4.2 The alarm was immediately raised using a 999 call and police, ambulance and shortly after, an air ambulance team were quickly in attendance.

1.4.3 Within minutes of the assault, due to significant blood loss from several stab wounds, the victim had a cardiac arrest. Staff immediately administered Cardio Pulmonary Resuscitation (CPR) and had access to, and had been trained to use an automatic defibrillator (AED) that was available on site. The AED indicated “not to shock”, CPR was continued until the ambulance personnel came and took over.

1.4.4 The victim was pronounced deceased at the scene at approximately 15.30

2 PURPOSE OF REPORT:

2.1 NHS England have commissioned this independent investigation to unlock learning for the NHS, which can improve the delivery of mental healthcare services for individuals, such as Mr X, and those connected with them, thus reducing the risk to others.

2.2 The full terms of reference for the independent investigation into the care and treatment of Mr X provided by the private hospital group and SWL&StG can be seen at **Appendix (1)**

3 METHDOLOGY:

3.1 A comprehensive review of the medical files including previous reports, notes and related correspondence.

3.2 Interviews with key staff.

		Position
1	RC1	Responsible Clinician at time of incident. Employed by InMind
2	HM2	Manager of the hospital
3	NM1	Clinical Nurse Manager, of the hospital
4	SL1	Lead on SUI's, SWL&StG
5	MD1	Medical Director, SWL&StG
6	MR	Commissioning manager at Wandsworth CCG.
7	CC1	Care Coordinator at the time of the incident, SWL&StG
8	Staff group, Southleigh	5 staff from different disciplines representing the 'direct delivery' team at Southleigh
9	MD2	Contracted as Medical Director of the private hospital group

3.3 E-mail correspondence with DCI JM, Metropolitan Police, Homicide and Major Crime Command

3.4 E-mail correspondence with CO1, Safeguarding Manager at Croydon Council with regard to the delay in the MERLIN report of January 2016 being shared with the community hospital

3.5 Visits to the Community Hospital.

3.6 A review of correspondence relating to the ending Section 75 arrangements for social supervision between SWL&StG and the Wandsworth Council, specifically as they were taken back into council control.

3.7 A review of the internal report relating to the review of the incident under the chairmanship of MD2 who was interviewed, along with other panel members

3.8 As per Psychological Approaches Community Interest Company (CIC) internal protocols, a peer review of the report also took place.

3.9 A member of the panel met with the victim's daughter to discuss her experiences and that of the family, to clarify their expectations of the investigation and the report. During the meeting the daughter raised the following concerns: -

- That no one seems to have challenged or acted on Mr X's continued refusal to talk or engage.
- She found the term 'stable' in the case notes rather "*galling"* for someone who wasn't engaging and was in effect doing as he pleased with no monitoring.
- She felt unsure if anyone checked if he was taking his prescribed medication.
- She did not think the possibility he was using illicit drugs was explored rigorously enough.
- She was concerned the police did not report his attendance at the station, either in January, or on the day of the offence immediately
- She was concerned about why he could keep a sharp knife in his room, how he entered the office so easily and the lack of panic alarms
- Overall, she feels several of the measures intended to manage risk were either inadequate or absent.

3.10 The panel formally approached Mr X via his Responsible Clinician at Broadmoor Hospital, to invite him to meet with the panel and participate in the investigation process. His RC confirmed to the panel that he spoke with Mr X who declined this invitation.

To ensure that the structure and content of the report is comprehensive the Terms of Reference were reviewed and the concerns of the victim's family added. They were then condensed into the following eight broad categories.

1. The monitoring and escalation process of Mr X's engagement with staff, psychology, GP, drug screening test and his alcohol usage.

2. The quality of communication processes between SWL&StG, the community hospital, Wandsworth CCG and other agencies, including management responsibilities for the step down of Mr X's care and the impact on Mr X care and treatment without the input of a care coordinator.

3. The management, monitoring of compliance and escalation processes with regard to Mr X's conditional discharge, including frequency of monitoring and professional responsibilities through changes in the community mental health team's composition; in particular the management and provision of the social supervisor reports to the Ministry of Justice after September 2015.

4. To review the CCG's monitoring processes in relation to Mr X's length of stay.

5. Mr X's involvement with the police and subsequent communications on 22nd January, 9th May and the morning of the incident including the reason for delay of the MERLIN report being shared by Croydon Social Services.

6. To review if any previous concerns were noted between Mr X and the victim.

7. The quality and effectiveness of Mr X's clinical reviews by all professionals, including joint care plans and risk assessments, following concerns that he was relapsing prior to the incident.

8. Consideration of the effectiveness and timeliness of the originally commissioned investigation

3.11 **The Benefit of Hindsight** – The investigation panel fully accept that they are reviewing the services and care provided to Mr X, post the tragic incident of the 12th May 2016, giving them the benefit of hindsight. The panel's role therefore is to try to establish whether the incident was predictable and or preventable or to identify failings, missed opportunities or gaps in the care which Mr X was provided.

4 SUMMARY OF FINDINGS:

4.1. The monitoring and escalation process of Mr X engagement with staff, psychology, GP, drug screening test and his alcohol usage.

4.1.2 A repeated theme throughout Mr X's long periods in care has been the presentation of being guarded and not willing to engage with staff. This guardedness with, on occasion underlying hostility, according to the Nurse Manager led some staff to avoid or minimise interactions. This presentation also led to his peers expressing feelings of intimidation, as described in reports from York Road Hostel. At the community hospital, he generally spent little time with the other patients, tending to prefer his own company.

4.1.3 A review of the clinical history led the panel to consider whether the medication, as prescribed for Mr X, was consistently at an optimum level. Following his recall to the Shaftesbury Clinic on the 4th November 2004, he initially refused medication. After a period, as with other admissions, he did begin to reluctantly accept medication. On this occasion both Fluoxetine and Risperidone 8mgs, the latter was titrated up to 9mgs before being reduced back down prior to discharge. During the following year, he was described as

gradually reengaging and taking part in some activities, which may have been indicative of an improved mental state. It was from this admission that he was eventually conditionally discharged to the community hospital.

4.1.4 The panel recognises the challenge of monitoring prescribed anti-psychotic medication as being a consistent theme during Mr X's entire psychiatric history. In part, this has been due to the need to find the balance in his willingness to take medication, whilst developing a trusting therapeutic relationship, which acknowledges and tries to ameliorate the expressed side effects. With any oral preparation, medication compliance is more difficult to monitor.

4.1.5 Given Mr X's clinical presentation through his teenage years and up to his admission to the community hospital, accessing his "inner world" was essential to understanding and monitoring his risks. In this context, given his history, the panel were concerned that the internal move from the ward at the community hospital to one of the independent flats, after only five months, seemed precipitous, although at this time Mr X was engaging with staff.

4.1.6 In the first few months of 2007, only three months after he moved to the flats, Mr X had already begun to disengage with staff at the hospital and externally. He refused to cooperate with any psychological testing and stated "he would not do any psychology". He refused a breathalyser test, which led to the decision to reverting to daily room checks, which he was unhappy with. He began to miss sessions at Seagull Prints where he had been well known from the period that he was at the Shaftesbury Clinic through the transitional period as he moved back to the community hospital.

4.1.7 In view of the above the panel is of the view that the conditions set by the Mental Health Review Tribunal on the 6th December 2005, as detailed in the early reports, were already being tentatively challenged by Mr X. In summary, these were:-;

- To reside at the community hospital or other accommodation as approved by the Responsible Medical Officer (RMO), Care Coordinator (CC) and Social Supervisor (SS)
- To Cooperate with the RMO, CC and SS and comply with their directions, allow access and attend appointments, as instructed
- To take medication, as directed
- To submit to blood/urine testing, as required

4.1.8 The opportunity of establishing an early regime and setting of firm boundaries for Mr X in relation to his care at the hospital, as a conditionally discharged patient appears to have been passed over. It could be argued that this established a culture of limited or non-compliance, which made monitoring his mental state and risk considerably more difficult over the following years. However, it is also recognised that Mr X had a long history of non-compliance prior to his admission to the community hospital and so this history may have occurred in any event.

4.1.9 In relation to the above, NM1 the nurse manager at hospital, who provided clinical supervision to the nurses, discussed with the panel her experience and knowledge of the relationship, which different staff had with Mr X. She indicated that he had several different primary nurses in the time that she worked at there, some who he engaged with reasonably well and others that he did not. When this occurred, it was put down to a personality clash. Of note, the victim was his associate nurse and seemed quite consistent in this role. The NM1 also described SW1, the hospital's social worker as someone else that seemed to have a positive relationship with Mr X

4.1.10 From early into Mr X admission to the community hospital there were indications of the ongoing use of alcohol; as indicated by the observation of him trying to dispose of tins, his own self-report, and occasional refusal of breathalyser tests, which is likely to be indicative of him knowing the test would have given a positive result. Later into his admission, he acknowledged drinking early in the morning, his preferred time to go shopping. In February 2016, when asked about his alcohol consumption he reported drinking two miniature bottles of whisky on two occasions during the preceding three days and more alcohol on the day of the ward-round. Despite this disclosure, the health care records indicate that urine drug screening and breathalyser testing appeared to have completely ceased in the preceding months. The panel was concerned by this finding as they considered that his previous history indicated the potential role of alcohol in destabilising his mental health, although this is different to the evidence from staff who considered there to be no perceived mental deterioration in Mr X.

4.1.11 In terms of illicit substances, historical reports indicate Mr X as having a history of using cocaine, LSD and ecstasy. Throughout his time at the community hospital his UDS were negative which supported his consistent denial of drug use.

4.1.12 At his first CPA following admission on the 16th June 2006 the relapse indicators were listed as:-

- Increasing suspiciousness i.e. paranoid thoughts
- Social isolation
- Angry outbursts
- Suspicious about medication
- Excessive alcohol abuse

4.1.13 In terms of indicators of relapse, a number of these, it could be argued, may have been triggered

4.1 Conclusions

- Within the first year of Mr X's admission to the community hospital, he was by his presenting behaviours, challenging some aspects of his conditional discharge. i.e. dismissive about alcohol usage, refusal to engage with psychology and showing increasing signs of isolating himself

- Despite the above, opportunities for higher levels of observation and supervision were conversely reduced.

- Reports indicate that a small number of the nursing team and the social worker did have a positive relationship with Mr X. These staff should have been supported with dedicated clinical supervision, perhaps by the psychologist, to seek to explore in a less formal way Mr X's "inner world" in areas such as; how he felt when he was out or whether he believed people in the street may have wanted to harm him?

- Checking for compliance with self-medication regimes was not clearly documented in the hospital policy, nor was clear guidance for periodic checks on apparently compliant patients.

- The panel acknowledge the positive change post the incident of a greater level of checks of the flats, including, the utensils in the kitchenettes which have been instigated. The process of such checks provides a helpful additional opportunity for engagement and ongoing assessment of patient's mental state.

- The addition of the emergency alarm call and changes to better secure the nursing office are recognised by the panel as positive environmental changes to provide greater security to staff working within the environment.

- Reports indicate that Urine Drug Screening and breathalyser testing ceased on 6th and the 18th August 2015 respectively. This is despite Mr X self-reporting of increased alcohol use and in early 2016, his attendance at Croydon Police Station expressing paranoid ideas.

- The panel concluded that throughout Mr X admission, there were opportunities by his presenting behaviour where recall to hospital could have been considered, as his compliance with his conditions of discharge were being challenged. However, it is acknowledged that multiple clinicians over a 10-year period considered his mental state to be stable, which would have been a substantial indicating factor for recall.

- Whilst accepting that Mr X consistently presented as a complex individual with an underlying encapsulated delusional and paranoid presentation, the panel considered evidence in the medical record indicates in the months

preceding the incident there had been an increase in his alcohol use, which was not being properly monitored.

- His general reluctance to consistently partake in psychology, physical health monitoring or activities at the hospital, also led the panel to speculate as to his reliability to take prescribed medication when he repeatedly questions its validity.

4.2 **The quality of communication processes between SWLSTG, the community hospital, Wandsworth CCG and other agencies, including management responsibilities for the step down of Mr X's care and the impact on Mr X's care and treatment without the input of a care coordinator.**

4.2.1 In the year preceding the incident the formal responsibilities of the parties involved in Mr X's care and supervision were broadly the following;

The community hospital was responsible for his day to day care and treatment. Through her direct employment with this hospital, RC1 was the Responsible Clinician and Clinical Supervisor in relation to the conditions of his Section 41 restriction order.

Between May-November 2015 SWL&StG was responsible for the provision of all social supervision under the terms of the Section 75 agreement. The London Borough of Wandsworth (LBW) then assumed this responsibility following the disaggregation of the Section 75. As part of the process of disaggregation, the Trust agreed to provide a list of individual patients who they were to handover. The panel has not been able to ascertain if this list, including the name of Mr X was in fact provided.

SWL&StG were responsible for the provision of a care coordinator through their community team.

The GP was responsible for overseeing Mr X's physical health care needs including offering annual health checks whilst at the hospital.

4.2.2 Whilst it is noted that Mr X attended the GP inconsistently and appeared reluctant to engage with the GP services, the panel found no relation to the provision of GP services and the incident.

4.2.3 The panel did contact two surgeries where Mr X and other patients from Southleigh were previously registered. We learnt that in 2017 Mr X was deregistered and they did not have any up to date health care records.

4.2.4 At the time of the incident on 12th May 2016 there should have been three

key professionals involved with Mr X; his RC/clinical supervisor, a care coordinator and a social supervisor.

4.2.5 The panel acknowledges the considerable efforts made by Mr X's care team at the community hospital in trying to establish who was allocated as his care coordinator and social supervisor in the months preceding the incident, as well as the inconsistency and gaps in provision of those throughout his time at Southleigh.

4.2.6 SWLStG and LBW worked closely planning the disaggregation of the Section 75 agreement with the preparation of a "joint shared approach" paper and a list of patients that would effectively 'lose' their social supervisor. There was a steering group that included other stakeholders such as the Wandsworth CCG.

4.2.7 It is worthy of note that the Ministry of Justice (MoJ) was not included in these meetings, nor copied into key correspondence which would have provided an early warning to the planned changes in social supervision responsibilities, from the Trust to the Local Authority.

4.2.8 The panel met with CM1 from Wandsworth CCG who was the commissioning manager at the CCG at the time of the incident. CM1 explained that following the Section 75 changes, there had been additional investment by the CCG in care coordinator roles at SWLStG.

4.2.9 The panel has been provided with the "South West London and St George's Mental Health NHS Trust and Department of Education and Social Services, Wandsworth Council Joint Operational Policy" which detailed the changes that came into effect in November 2015.

4.2.10 The panel has learnt that Mr X did not have an allocated social supervisor at the time of the incident (see table below). In addition, there had previously been frequent changes in the care coordinator provided by SWLStG, which had led to a lack of continuity.

4.2.11 The panel heard that the community hospital's MDT specifically scheduled a CPA for January 2016, to accommodate the diary commitments of the then care coordinator. Unfortunately, the individual left her role and the review was unable to go ahead and had to be rescheduled.

4.2.12 There was a 'virtual' CPA review recorded in RiO by CC1 on the 26th February 2016 where it states "Mr X remains under the care of the community secure hospital. I have been newly allocated to Mr X looking on previous documents previous plans were to refer Mr X to the Wandsworth Community Forensic Services.

> Plan: "follow up referral and book an appointment to meet Mr X in hospital". CC1 has confirmed with the panel that she never had face to face contact with Mr X and it was agreed practice at SWL&StG to hold 'virtual' CPA review meetings.

4.2.13 CC1 was new to the team and did not receive any formal handover. She informed the panel that the team used a traffic light system to manage and catagorise risk (red amber green). Mr X was placed in the 'Green Zone' as he was considered low risk as he was residing in a hospital setting.

4.2.14 CC1 did not receive any specific guidance on her responsibility for conditionally discharged patients. She told the panel that she questioned why high risk/forensic patients were open to her community team (despite SWLStG having a forensic team) and was told this was because the role of social supervisor had recently returned to LBW. She recalls being asked by the team manager to provide the names of all the 'forensic' patients but was not sure what this information was for.

4.2.15 When the panel met with MD1 the Medical Director, he stated that the role of care coordinator (as provided solely by SWLStG after 2nd November 2015) was difficult as they had to operate autonomously, liaise with the providers and LBW, and there was lack of clarity of their role given that Mr X was to all intent in 'hospital'.

4.2.16 MD1 expressed his concern that the current structure and provision of CPA for patients like Mr X, who are in hospital, being cared for day to day by a different organisation and are often out of area was "not suitable".

4.2.17 On the day of the incident, 12th May 2016. RC1 was Mr X RC/Clinical Supervisor, a role which she had been in since June 2015. His care coordinator was CC1, who had never met him since being allocated the role in January 2016 and there had not been a social supervisor in place since October 2015. As such, RC1 was left as the sole clinician carrying out the formal role of supervision, for a conditionally discharged patient. Ordinarily, it is required that a combination of at least two and often three, separate clinicians, each bringing their individual professional skills and training, as well as the views of their differing places in the health and social care network, carry out this function.

4.2.18 The panel established that the Ministry of Justice were working to investigate who his allocated Social Supervisor was following information received in December 2015, that SS1 his last social supervisor had left. The Trust informed the Ministry of Justice (MoJ) on the 15 December 2015, that future social supervisor reports would be provided by Wandsworth Local Authority (WLA).

4.2.19 Following an exchange of emails and telephone calls by the MoJ to SWL&StG between 17/2/2016 and 27/4/2016, the MoJ were informed that CC1, was employed as the care coordinator by SWL&StGs. They concluded, based on previous practice, that she was also to act as the social supervisor. The MoJ emailed CC1 on the 27/4/2016, requesting her report.

4.2.20 The MoJ appraised the panel of their practice to review reports whilst the information is still 'current' which relies on reports being sent within the preset time frames. However, they confirmed that unfortunately there are often

delays in reports being received and except for the routine administrative letters requesting reports and detailing expectations, they have no formal mechanism to chase late or missing reports. They also felt that their staffing resource does not allow for a more robust follow up procedure when time frames are not met. They were though reassured by the practice of many clinicians and community teams who provided an early alert to any serious concerns, directly by phone or email

4.2.21 In the event of a protracted period where reports have not been forthcoming, this would be brought to the attention of a senior manager who would pursue the RC with an approach to the Trust CEO (or responsible authority) as the final step.

4.2.22 In addition to these gaps in provision, in the preceding three years from August 2013, Mr X had been allocated a total of seven different care coordinators, five of whom had also carried the role of social supervisor. There was concern expressed by the Southleigh team that attendance by care coordinators at CPAs was sporadic.

4.2.23 Whilst it is difficult to determine exactly what impact this inconsistent and at times absent provision had on Mr X's care, both he and the MDT at the hospital, felt it was delaying a potential move on to the community. It is also clear that when Mr X contacted the police in distress, on three occasions, they expected that someone in his position would have an allocated social worker and Mr X told them correctly that he did not.

4.2.24 There is no guarantee that three separate professionals, all having relatively consistent engagement with Mr. X, would have gained any more knowledge or insight into Mr X's encapsulated delusional beliefs or potential clinical risks, but not having them is undoubtably a missed opportunity.

4.2.25 There appears to have been inconsistency in how various professionals understood Mr X's living arrangements and supervision levels. CC1 wrongly believed the community hospital was a low secure hospital and had never visited. Neither did she know that Mr X resided in an independent flat within the hospital. Nurses frequently noted in Mr X's clinical record at Southleigh that he lived independently.

4.2.26 Mr X repeatedly expressed frustration with the slow progress in moving to a more independent setting. Over time, this became viewed by the community hospital's staff, care coordinators and social supervisors as a major contributory factor in his reluctance to engage with them. However, previously in his clinical history, such reluctance had been clearly identified by his care team at SWLStG as a symptom of poor mental health for Mr X.

4.2.27 Mr X had, himself, in fact refused some of the step-down options offered to him.

4.2 Conclusions

- Whilst acknowledging the "joint shared approach" in the planning for the disaggregation of the Section 75 agreement, the delivery of this appears to have failed. As no social supervisor was allocated and the care coordinator was unclear of the expectations in supporting Mr X at the hospital, the inclusion of the MoJ as an active (included in the membership of meetings) or passive (copy correspondence) stakeholder may have reduced the likelihood of this occurring.

- The panel is of the view that the practice of 'Virtual' CPA reviews, where a single clinician can review a patient as a paper exercise, is unsafe and does not properly affect the framework of MDT care as set out in the national standards. The attendance at the CPA meetings set up by the community hospital would clearly have met these standards.

- CC1 did not receive sufficient induction to the role of Care Coordinator which was new to her, neither did she receive a sufficient clinical handover to safely monitor and support a conditionally discharged patient living in semi-independent accommodation.

- The exact impact of inconsistent and, at times, absent provision of social supervision to Mr X, is difficult, with certainty, to establish but this additional external view and objectivity may have led to greater exploration of his encapsulated delusional beliefs and therefore potential associated risks.

- The inconsistency of understanding Mr X's living arrangements led to decisions about the potential risks posed by him being downplayed, either because it was thought he was in a secure hospital, or conversely because it was thought he was living independently in the flats and so must be low risk. Whilst at different ends of a spectrum, both views may have led to the importance of rigorous care coordination and social supervision not being fully understood.

- The panel are of the view that there was an overreliance on the delay in moving on to independent living being seen as the major cause of Mr X's disengagement and consequentially not enough emphasis on it being seen as a symptom of mental ill health

4.3 **The management, monitoring of compliance and escalation processes with regard to Mr X's conditional discharge, including frequency of monitoring and professional responsibilities through changes in the Community Mental Health Team's composition, in particular the management and provision of the social supervisor's reports to Ministry of Justice after September 2015.**

The Ministry of Justice, in its guidance for Social Supervisors says, 'The purpose of the formal supervision resulting from conditional discharge is to protect the public from further serious harm. There are two aspects to this.

- *The first is by assisting the patient's successful reintegration into the community after what may have been a long period of detention in hospital under conditions of security.*
- *The second is that the Secretary of State's ability to exercise his statutory powers to protect the public is dependent on the reports he receives from the supervisors about the patient's condition and behaviour in the community.*
- *Close monitoring of the patient's mental health and of any perceived increase in the risk of danger to the public enables timely steps to be taken to assist the patient and protect the public.*
- *Conditional discharge also allows a period of assessment of the patient in the community before a final decision is taken whether to remove the control imposed by the restriction order by means of an absolute discharge'.*

4.3.1 Mr X had been living at the community hospital for 10 years prior to the offence in May 2016. He had been conditionally discharged from the Shaftesbury Clinic on the 3rd May 2006 and, as previously noted, quickly moved into an independent flat at the hospital on the 30th September, as part of his anticipated further step down to a community placement.

4.3.2 Today, a first-tier tribunal would not normally consider a patient being conditionally discharged from a secure unit to a locked community rehabilitation hospital (as registered by the CQC). This follows the decision of the Supreme Court in *The Secretary of State for Justice v MM* [2018] UKSC 60 which was handed down on 28 November 2018. In such cases the use of Section 17 (3) MHA leave could be applied. For those patients lacking capacity a deprivation of liberty safeguard (DoLS) could be sought.

4.3.3 During his time at the community hospital Mr X had five different responsible clinicians and from August 2013 to May 2016, more than seven care coordinators (see table below). As perhaps expected, the panel noted through the review of his clinical file, differing styles in the medical management, with periods of his medication being raised to manage behavioural and mental state changes

Care Coordination and Social Supervision.
Mr X.

Date	Care Coordinator	Social Supervisor	S.S report completed.
August 2013 to January 2014	**CC2**	**CC2**	**August 2013** **October 2013**
February 2014 to Feb 2015	**CC3**	**CC3**	**February 2014** **May 2014** **August 2014**
March 2015 to May 2015	**CC4**	**CC4**	**March 2015**
June 2015 to July 2015	**CC5**	**CC5**	**June 2015**
August 2015 to October 2015	**CC6**	**CC6**	**September 2015**
October 2015 to	**CC7 (Nurse)**		
January 2016 to August 2016	**CC1 (Nurse)**		

4.3.4 From June 2015 to September 2016, RC1 was employed to provide six sessions (half days) per week of clinical care. These were split over 2.5 days (on site) with the final session allocated to providing on-call cover. Much of her first year had been focused on setting up systems and procedures to support the smooth running of the service. RC1 told the panel that the patients would be seen on rotation through the month.

4.3.5 Concurring with what HM2 had told the panel ward rounds were generally conducted on Wednesday, when approximately a third of the patients would be seen. On the fourth Wednesday of the month CPA reviews took place. RC1 indicated that there could be flexibility with this structure to fit around availability of attendees and, in addition, any urgent/risk issues.

4.3.6 RC1 provided leadership to the team. She also held RC responsibility for all except two female patients who were under the care of a forensic consultant from SWL&StGs. RC1 would chair the CPA reviews for all her patients and would see these patients on a minimum monthly basis.

4.3.7 Mr X was 'Conditionally discharged'; therefore the expectation was for the RC to complete quarterly reports to be submitted to the Ministry of Justice (MoJ) (later changed to the Mental Health Casework Section MHCS). RC1 completed a report in September 2015. Her final report to the MoJ prior to the incident was dated 6th May 2016.

4.3.8 Mr X was also expected to have a social supervisor, who would work closely with the RC, to monitor the placement and provide feedback to the MoJ (via quarterly reports) and help with 'move on' plans.

The Mental Health Act 1983 - Code of Practice

Chapter 22 – Patients concerned with criminal proceedings

Paragraph 22.79 states;

'Conditionally discharged restricted patients will, in most cases, be subject to community supervision and be monitored by a clinical supervisor and a social supervisor, both of whom are required to submit reports, generally quarterly to the Ministry of Justice, detailing the patient's progress, current presentation and any concerns. These reports should be comprehensive, including defining clearly any risks being presented by the patient, either to themselves or others. They should also record unusual occurrences such as interactions with the police and, where necessary, these events should be investigated further by the appropriate supervisor and information shared with other relevant parties. Although there is a requirement for regular reports if, at any time, clinical teams become concerned over a patient's behaviour or presentation, they should investigate those concerns and contact the Ministry of Justice straightaway. Similarly, these reports will be closely scrutinised by the Ministry of Justice and, where necessary, concerns will be raised with the relevant parties involved.

4.3.9 Until November 2015 the London Borough of Wandsworth (LBW) had a Section 75 agreement (National Health Service Act 2006) with SWL&StG whereby SWLStG would provide social supervision and care co-ordination. From 2nd November 2015 the social supervisor role was taken back under the management of the LBW.

4.3.10 As previously stated, it is recognised that SWL&StG and LBW worked closely planning the disaggregation of the Section 75 agreement with the preparation of a "joint shared approach" paper and a list of patients that would effectively 'lose' their social supervisor. There was a steering group that included other stakeholders such as the Wandsworth CCG.

4.3.11 Mr X was repeatedly noted as "difficult to engage" and "guarded" and the panel were concerned the team did not have enough information about his mental state and "inner world".

4.3.12 The investigation considered that the community hospital could only provide limited assurance regarding medication concordance, which relied upon his self-report attending to fill his dossette box and occasional checks as proxy measures for compliance. The panel do acknowledge the recording of some possible side effects i.e. gynaecomastia, involuntary tongue movement and the RC's position that such side effects would have been noticed.

4.3.13 In June 2010, following an assessment and referral by an endocrinologist. Mr X met with Dr2, a plastic surgeon, who questioned whether the breast

enlargement (gynaecomastia) was in fact not related to a raised prolactin from the anti-psychotic medication but due to obesity

4.3.14 A condition of his conditional discharge was to allow access; this would have included to his flat. The panel were of the view that staff should have been more assertive in this respect, although it is acknowledged that Mr X kept his flat clean and tidy with no overt signs of a deteriorating mental state.

4.3.15 CC6 was the last member of staff to hold the joint role of social supervisor and care coordinator. CC6 saw Mr X on the 19th August 2015 to prepare the MoJ report, this is an extract taken from SWLStG clinical records

> *"I was preparing to leave and was making an entry in the client's file when I met and had an impromptu discussion with the Director of the hospital HM2. We had a chat about Mr X care and he repeated the need for Mr X to move on. HM2 advised that Mr X has been referred to and accepted by Forensic Service at Wandsworth. He felt that this level of care should be the way forward considering Mr X risk profile. He deemed it as being quite high. Of this, he said that Mr X would require at least twelve months forensic supervision support in the community on his move from the community hospital. He added that main stream CMHT care would be unsuitable. HM2 said that Mr X does not want to move to Wandsworth Borough. He advised that Dr3 from Forensic Service is aware of the forensic referral acceptance and that CM2 at Wandsworth CCG also has knowledge of the case"*

4.3 Conclusions

- Considering the lack of any confirmed concordance with oral medication on balance, the panel concluded that as a conditionally discharged patient, whose proposed pathway was for onward independent living, a long acting depot medication was strongly indicated.

- The panel concluded that Mr X could have been considered to be in breach of the conditions of his conditional discharge. However, there was no evident consequence of this, which may have led to discussions as to whether recall should be considered.

- The panel found gaps in the provision of social supervision following the Section 75 changes in November 2015 and gaps in reports to the Ministry of Justice.

- Whilst the panel recognised this as a 'unique' situation with the changes in commissioning. The local authority needs to provide assurance that over the past three years practices have improved and further omissions are unlikely to occur.

- Unfortunately, the panel found themselves questioning the quality of the stated "organisational memory" for Mr X, due to multiple changes in staff. The panel recognises that the workforce will change over time, but all agencies need to ensure there are processes for safe clinical handover. This should also include a system to check that when actions are suggested they are completed (for example the failed referral to forensic services by CC6

- The CQC registration of the hospital and the flats as a single site, registered in its entirety as a hospital is confusing, as indicated by the CC1 who was not familiar with the hospital and unaware that Mr X was living in an independent flat.

4.4 **To review the CCG's monitoring processes in relation to Mr X's length of stay.**

4.4.1 The panel met with CM1 from Wandsworth CCG who was the commissioning manager at the CCG at the time of the incident. They explained that following the Section 75 changes there had been additional investment by the CCG in care coordinator roles at SWLStG.

4.4.2 To monitor placements such as Mr X's, the CCG employed Quality Assurance (QA) managers, these QA managers reported to CM1 and were responsible for oversight and support of placements but did not act as care co-ordinations. HW1 had attended several CPAs and was familiar with of the difficulties and frustration that the care team were experiencing in supporting Mr X to step down to supported accommodation.

4.4.3 Prior to any new placement being agreed, the referrer from the local mental health team would make an application to the placement panel, to discuss and agree. The QA managers would provide updates on cases to the panel and were expected to discuss progress and expected discharge dates. MR stated that over recent years this process had become "more refined". Decisions would be made between panel, Trust care coordinator and QA manager.

4.4.4 The investigation has been provided with the "South West London and St George's Mental Health NHS Trust and Department of Education and Social Services, Wandsworth Council Joint Operational Policy," which detailed the changes that came into effect in November 2015.

4.4.5 The panel has found that Mr X did not have a social supervisor at the time of the incident (see table below) and in addition there had been frequent changes in the care coordinator provided by SWLStG, which had meant a lack of continuity.

4.4.6 The panel were also informed by RC1 of variable practice for conditionally discharged patients placed at the community hospital at the time of the incident. With two patients being managed under the clinical care of the SWL&StGs Forensic Outreach Service, both had an RC and SS and Mr X and another patient were under the sole care of the RC at the hospital.

4.4 Conclusions

- The panel has heard that over the past 3 years WCCG has refined and improved the review of clinical placements. However, the panel felt that the CCG should have had greater oversight in the months leading up to the incident of the allocation of key staff (social supervisors and care coordinators) and also been more involved in facilitating the move-on plans for Mr X

4.5 **Mr X's involvement with the police and subsequent communications on 22nd January, 9th May and the morning of the incident, including the reason for delay of the MERLIN report being shared by Croydon Social Services.**

The MPS did provide information which signposted the panel to development of the Vulnerable Assessment Framework (VAF), an assessment tool to support officers when identifying vulnerable persons and the THRIVE+ model to help assess the appropriate police response to emergency calls. See Appendix 3

4.5.1 The first direct involvement of the police is recorded in police witness statements and a police MERLIN report. On 22nd January 2016, Mr X attended Croydon Police Station where he gave his full name and address and was seen by PO2. He showed them a letter expressing his concerns about staff at Southleigh, whom he believed were going to do him harm.

4.5.2 Also on 22nd January 2016 it is noted in Mr X's clinical record at Southleigh that a phone call was received from a police officer at 14:00hrs requesting Mr X's contact number. The record states 'To make sure confidentiality is maintained, the officer's contact number is given to Mr X'.

4.5.3 It is not clear from the police record of this incident, or the clinical record, whether it was PO2 who called, why they were calling or what information was exchanged. PO2, in their witness statement, remembers very little of the day's events on what was a busy shift.

4.5.4 There is no evidence that anyone at the hospital enquired more of the police, or explored with Mr X, why the police were contacting him and thus a possible

opportunity for a contemporaneous assessment of his presentation and current concerns was lost.

4.5.5 The following morning (23rd January 2016) a MERLIN report was faxed to Croydon Social Services department flagging this as an incident of concern. The MERLIN report was not immediately acted upon by Croydon Social Services. However, it is noted that in the initial response from Croydon Council they did not receive the report for some 24 hours later than it was sent by the police. This was because it was initially sent to Croydon Young People's Service, which forms part of the South London & Maudsley NHS (SLaM) Foundation Trust, who immediately forwarded it to Croydon Council. This initial delay was due to a misunderstanding of the paperwork by the police that all concerns are covered by the safeguarding children teams.

4.5.6 On 1st February 2016, a phone call was received by the secretarial staff at Southleigh seeking information on Mr X. The hospital's clinical nurse manager NM1 returned the call to Croydon Social services and spoke to Senior Community Practitioner CP1. (At the time of the incident Croydon Council had a Section 75 agreement with SLaM. The panel have been unable to clarify whether CP1 was employed by SLaM as part of this agreement, or was an employee of the council. NM1 was made aware that a MERLIN report had been received; she informed CP1 that there had been no recent concerns regarding Mr X's mental state and asked for the report to be sent to the community hospital.

4.5.7 CP1 did not send the MERLIN report to the hospital, but contacted Mr X's care coordinator CC1 and subsequently faxed the MERLIN report to her, saying they had been reluctant to share the information with the community hospital and were deferring to CC1 as the care coordinator to decide whether it should be shared with them.

4.5.8 CC1 then faxed the MERLIN report to Southleigh on 2nd February 2016.

4.5.9 It remains unclear why there was a ten-day delay between the police sending the MERLIN report to Croydon Social Services and the report being processed and passed onto the community hospital.

4.5.10 On 9th May 2016, Mr X telephoned 999 out of hours. The police transcript of the call shows he told the operator he was worried he was going to be abducted by staff and fellow residents at the private hospital in Croydon where he lives. He stated he had not been sleeping for two nights and that he "will do something". He gives his full name and the address of the hospital.

4.5.11 Mr X asked police to tell the hospital staff that they (the police) know about the plot. In response, he is told the police will not do that but, if he is attacked, he should call the police and they will attend.

4.5.12 He is advised to discuss things with his social worker or care coordinator but says he hasn't got one so is advised to speak to the hospital manager. He says he has previously reported incidents to the police but cannot give the

reference number, so is advised to find the reference number and call back. Mr X asks to speak to a supervisor, but this is refused. He is told it will be reported to the police in his local area and he is given a CAD number (4080 9/5/16) and advised to call 101 to check that it has been passed to local police.

4.5.13 On the 12th May 2016 on the morning of the attack, Mr X attended Croydon, Park Lane, Police station and spoke to PO3, saying that everyone at the hospital was plotting against him and he was going to be trafficked abroad.

4.5.14 He was observed to be clean and healthy looking and advised to speak to staff or his social worker. Mr X said he does not have a social worker but agreed he would talk to the hostel manager about his concerns. The police officer noted that he had previously attended the station with similar concerns and raised a MERLIN report, partly as he thought this may flag up concerns to the appropriate authorities, considering the lack of a named social worker who he can contact.

4.5.15 PO3 noted he was aware of the hospital and its function as a community mental health hospital that he had previously attended and recalled it being locked at night. Regrettably, the fatal attack took place before the MERLIN report could be acted upon.

4.5.16 There does not appear to be any mechanism to flag up to the police when a contact is the subject of a restriction order in the community. Officers can request a name check against the police national computer data base but are required to have grounds to justify this

4.5.17 Croydon Social Services have said that both MERLIN reports were sent initially to young people's services at SLaM by the police and that they received the first report on 24th January and the 2nd on or after 12th May.

4.5.18 Additionally, there is a record in Mr X's personal notes, which were found in his room after the incident, that he contacted Croydon Police on 4th March 2013 at 8am and spoke to PO4; this was a complaint about victimisation that "NHS nurses are trying to kill me."

4.5 Conclusions

- When the police called the hospital on 22nd January 2016 the appropriate response from staff, considering Mr X status as a conditionally discharged patient, would have been to make efforts to understand what the contact related to and if it had any bearing on his mental state or risk. It was ***inappropriate*** to view it as a "private matter".

- Staff at the hospital did not record, in any detail, contact from the police, which amounted to a failure in understanding how to balance the

requirements of confidentiality with their duty of care to the patient and with risk management.

- The way Mr X presented at the police station on both the 22nd January and the 12th May gave no indication that this was an immediately dangerous situation and the decision on both occasions to raise a MERLIN report was both appropriate and helpful.

- Whether an officer should have made supplementary telephone contact with the hospital in the panel's view was a judgement call made by officers on the day working in a busy police station. As such, and bearing in mind his presentation, calling could have been helpful but equally not calling and relying on the MERLIN report was also a reasonable judgement.

- The ten-day delay in January 2016 between the police sending the MERLIN report and the hospital receiving it was very unfortunate and undoubtedly led to a missed opportunity for a contemporaneous assessment of Mr X's presentation, mental state and current concerns.

- Croydon Council have offered assurance that new processes are in place which mean such delays could not occur today. This includes the replacement of the Central Duty Team by the "Front Door Team" who interfaces daily with the MET as required. In addition, in preparation for the implementation of the General Data Protection Regulation (GDPR) in May 2018 Council staff attended mandatory training in appropriate data protection and data sharing.

4.6 **To review if any previous concerns were noted between Mr X and the victim.**

4.6.1 Throughout the investigation process there has been no indication of a specific relationship difficulty between the victim and Mr X.

4.6.2 In discussion with NM1 the nurse manager at the hospital she described difficulties in relationships that Mr X had with some staff but that the victim had consistently been his associate nurse.

4.6.3 She went on to describe the victim as someone that would look for opportunities to see Mr X in his flat, i.e. taking his post.

4.6.4 In the MERLIN report from the Police, Mr X cited African staff as a group who he feared were invested in doing him harm. The victim was of Caribbean descent, which Mr X was aware of.

4.6.5 Post the incident, following a search of Mr X's flat, multiple notes were found expressing delusional and paranoid ideation which, in some cases, are dated back as far as 2000.

4.6.6 HM2 with NM1were the people who searched his flat and she described;

> "We also found lots of bits of paper with his thoughts written on them. I remember noting they were quite paranoid and he had named some staff in things he'd written but I cannot remember if the victim's name figured, mine HM2's, S1's and S2's were there, I remembered that they had a paranoid flavour but not specifically what they said".

4.6.7 Having reviewed the statements from staff which were given to the police post the incident, the one of specific note regarding the victim's relationships was provided by a support worker. She noted that Mr X would try to avoid talking to people who were in a role of providing care, preferring to talk with cleaning staff and such like. She went on to say that of all the nurses, the victim had the best relationship with Mr X.

4.6 Conclusions

- It remains unclear as to why the victim was targeted and is contrary to the original index offence when a taxi driver was the victim, whom Mr X believed was a direct threat.

- The victim was not identified within the various notes etc. that were found in Mr X's flat when examined the day after the incident.

- Less specific at the time of the original offence, was the more generalised belief that "people" were laughing at him at bus stops etc.

- It may, therefore, be in this context that the victim happened to be on duty when Mr X's paranoid beliefs were suddenly acted upon in such an uncontrolled way, driven by contributory factors, such as paranoid fear, lack of sleep, alcohol (although this was not noted in police statements at the point of arrest)

4.7 **The quality and effectiveness of Mr X's clinical reviews by all professionals, including joint care plans and risk assessments, following concerns that he was relapsing prior to the incident.**

4.7.1 The pro-forma used for risk assessment by the community hospital requires the same actions for both historical risk and current risks. This seems to downplay the need for review of care plans in the light of emerging or re-emerging risks

4.7.2 The risk assessment was amended following the hospital being made aware of Mr X's visit to the police on 22nd January. However, the risk section which was escalated for Mr X was the section covering Abuse / Exploitation and Vulnerability from others, his risk of violence and aggression was not increased and recorded - "This is not currently an issue in this environment" although there was a clear description of his index offence in 1998 in the risk assessment and it described the context of paranoid ideas held by Mr X at the time.

4.7.3 The panel are of the view that recording the new information under vulnerability created a confusing message as Mr X was not in fact more vulnerable to abuse neglect and exploitation following his contact with the police, but was more likely to be suffering clearly paranoid beliefs which may have increased his risk of violence to others.

4.7.4 The community hospitals' H&S risk assessments say that all staff should be aware of the triggers likely to lead to violence for each individual patient and that these can be found on the risk assessments. This was not the case for Mr X and his care plans.

4.7.5 The team at the hospital and several of Mr X's care coordinators, developed a view that his disengagement with staff and activities related to his frustration in the delay to him moving on to more independent accommodation. Whilst this clearly may have been a contributing factor, it is highly likely to have also been indicative of an underlying deterioration of his mental state.

4.7.6 The environmental checks of patients living in the flats at the community hospital were the same irrespective if the patient was a restricted patient with a serious history of offending or not. There is also an impression, given in the clinical record, that nurses were satisfied that things were okay if they had sight of Mr X in the communal area, or smoking outside his flat during their shift and this would often be documented as a proxy for carrying out checks on his welfare, including checking his flat. It is noted that such checks were immediately imposed following the incident on 12th May.

4.7.7 The staffing structure at the hospital did not reflect and differentiate between those patients in the ward and those living independently in the flats. The panel discussed whether structuring the staffing differently each shift and providing a dedicated role to those patients in the flats, would provide for a greater level support, supervision and monitoring

4.7 Conclusions

- The pro-forma for risk reviews did not promote a review of care plans for re-emerging risks. Furthermore, whilst it did record Mr X's attendance at the police station in January, this was recoded and adjudged as an increase

in vulnerability which may have hindered staff reading the plan and understanding that there was a clear link between paranoid ideation and previous violence.

- Whilst lacking at the time of the incident Southleigh now have in place rigorous periodical checks of the environment in the flats.

4.8 Consideration of the effectiveness and timeliness of the originally commissioned investigation

4.8.1 The original investigation team was formed in June 2016 and reported back in January 2018. During this time the panel met between four and six times and experienced changes to the membership due to perceived conflicts of interests and changes in role.

4.8.2 Some meetings were held remotely as panel members came from different parts of the country and much of the final report was developed via e-mail.

4.8.3 It is understood that initially there were discussions between the stakeholder organisations about seeking an external party to assist with the investigation for the purposes of aiding objectivity. However, following this initial discussion, consensus was obtained and contributors came from within the stakeholder organisations. The Chair, although not directly employed, was previously known to InMind, having provided them with training. Today he acts as the organisations Medical Director and Responsible Officer.

4.8.4 The scope and purpose of the investigation was set out and it is understood agreed with NHS England.

4.8.5 The key deliverables were discussed and agreed as:-

- Joint investigation report
- Recommendations
- Report back to;
    - Wandsworth CCG
    - NHS England
    - Care Quality Commission & Clinical Therapy Review group

4.8.6 The methodological approach was described as “a comprehensive investigation undertaken by a multi-agency investigation panel using a Root Cause Analysis tools to establish contributory factors and lessons learned”.

4.8.7 The panel were surprised to learn that senior personnel from the multi-disciplinary team looking after Mr X, were not interviewed as part of the process and did view this as a missed opportunity for clarification. The rational given for their omission was that that the hospital had hired external psychologists for post incident support. Therefore, to interview them at that time was considered but not acted upon as it would be "re-traumatising".

4.8.8 The MDT also raised concerns that some participants on the internal investigation panel had also been the recipients of letters of complaint regarding lack of support in being able to facilitate Mr X's move on from the community hospital.

4.8.9 During meetings that the panel has held with members of the MDT, it is evident that the team felt marginalised and angry at not having been included in the process. They have held information which they believed to be relevant to the enquiry, which has been shared but not included, such as the large number of handwritten notes found in Mr X's flat post incident, which further provide evidence of longstanding delusions ideas.

4.8.10 The panel noted within the internal enquiry the reference to the importance of cultural factors as highlighted by the Francis enquiry into Mid Staffs Hospital. The internal enquiry concluded that they found no evidence to support cultural failings in areas such as:-

- Systems which supported business and not that of patients
- Systems which ascribed more weight to positive information about the service than to information capable of implying concern
- Standards and methods of measuring compliance did not focus on the effect of service on patients

4.8.11 Whilst the panel would concur that they did not find systemic cultural failings, they did hear from staff at both a senior level and those on the ground that there appeared to be a lack positive communication between the hospital and the wider management team of the group.

4.8 Conclusions

- The panel interviewed half of those involved in the internal enquiry. These participants felt the enquiry took longer than was desirable.

- Whilst acknowledging the complexities of this investigation with multiple agency involvement, a clear project plan with built in timescales and administrative support to hold the panel to account, may have achieved a timelier response.

- The panel would also support the view held by some participants that a completely independent investigator, or investigators, would have greatly assisted the inquisitorial nature of the investigation and its findings

- The panel concur with the view held by the senior team that they had a valuable contribution to make with their detailed knowledge and experience of providing care to Mr X. Not meeting with them was therefore a missed opportunity.

- Similarly, not visiting the site and speaking with staff that directly provided care was a missed opportunity to investigate, in more detail, issues such as capacity and staffing levels. The panel heard from the staff who provide direct care on a daily basis and heard that they feel stretched, undervalued and on occasion vulnerable. Therefore, a review of the staffing levels and benchmarking these against other services would be useful.

5 CONCLUSION & RECOMMENDATIONS

In examining the delivery of care and associated contributing factors surrounding Mr X culminating in the tragic event of the 12th May 2016, the investigation team has found no single element which, in isolation, could be described as a root-cause.

The team, as previously acknowledged, has had the benefit of hindsight when examining this case. Thus, in considering the contributing elements prior to the incident have considered whether any actions or omissions could be viewed as missed opportunities or gaps in the care which Mr X was provided. However, this does not mean that the homicide could have been either predicted or prevented.

5.1 RECOMMENDATION (1)

The Community Hospital - To undertake a review using a methodology such as 'Quality Improvement' to ensure that the vision, purpose and day to day operation of the hospital and flats is integrated and well understood by all who work there, in particular ward based nurses, this should include:-

- Dynamic risk assessment
- Patient confidentiality and its limitations
- Accurate record keeping
- Patient engagement skills
- Physical, Procedural and Relational Security
- The management and support of patients who are self-medicating

Organisationally, to support this the Groups senior management team should review the staffing levels, induction and implementation of training to provide an assurance framework that the above is delivered.

5.2 RECOMMENDATION (2)

Multi-agency working communication - A time limited multi-agency working group of senior officers is established including;

- The private hospital groups SMT
- SWL&StG
- Wandsworth Local Authority
- Police
- Wandsworth CCG
- Croydon Council

To undertake a review led by Croydon Council to ensure that all agencies interact and communicate effectively to support mental health patients living at the private hospital's services (and other similar services) in the patch. This should include:-

- Familiarisation with the community hospital services
- Lines of communication for safeguarding concerns
- Review of existing or, if necessary, development of information sharing policies
- Supporting timely step down for patients into community services

5.3 RECOMMENDATION (3)

The review of effective multi-agency management of conditionally discharged forensic patients that may pose or present chronic risks.

The legal framework exists to support those patients conditionally discharged from hospital and now living in the community. Within this case the principal responsibilities lay with the following organisations;

1. The community hospital for the provision of Responsible Clinician.

2. Wandsworth Local Authority for the provision of Social Supervisor.

3. SWL&StG for the provision of Care Coordinator.

In addition, Mr X was registered under MAPPA

- Metropolitan Police

The panel recommend an inter-agency approach facilitated by Wandsworth CCG with representation from all agencies is held with a view to supporting individuals such as Mr X;

The expected outputs should include:-

- Develop a quality improvement programme to include:
  - Produce, implement and monitor an agreed protocol for interagency working
  - Analysis of systemic factors impeding joint working and address these
  - Focus on risk management and information sharing
  - Ongoing monitoring and reporting to ensure progress is maintained

6 GLOSSARY OF TERMS

	Abbreviation	
1	GBH	Grievous Bodily Harm
2	SWL&StG	South West London & St Georges NHS Trust
3	Section 48/49	Emergency prison transfer for treatment with restrictions, Mental Health Act (MHA) 1983
4	Section 38	Interim Hospital Order - MHA 1983
5	Section 37/41	Hospital Order with Restrictions - MHA1983
6	UDS	Urine drug screening to indicate illicit substance misuse
7	Amitriptyline	Antidepressant medication
8	Gynecomastia	An enlargement of breast tissue in males
9	Quetiapine	Atypical, (or 2nd generation) antipsychotic medication
10	Conditionally discharged	The requirement to meet conditions in the community set by a tribunal. Failure to do so may lead to recall to hospital
11	Clozapine	Atypical, (or 2nd generation) antipsychotic medication
12	CQC	Care Quality Commission – The independent regulator for health & social care in England
13	RC	Responsible Clinician
14	AED	Automatic defibrillator
15	CC	Care Coordinator
16	Section 75 arrangements	Agreed arrangements for pooling resources and delegating certain NHS and local health-authority functions
17	CCG	Clinical Commissioning Group
18	MoJ	Ministry of Justice

19	SS	Social supervisor
20	MERLIN report	A data base and reporting system which holds information on vulnerable adults that come to the notice of the police
21	Fluoxetine	Antidepressant medication
22	Risperidone	Atypical antipsychotic medication
23	Mental Health Review Tribunal	An independent quasi-judicial body established to safeguard the rights of person's subject to the Mental Health Act
24	RMO	Responsible Medical Officer
25	CPA	Care Programme Approach
26	RC	Responsible Clinician (Clinical Supervisor)
27	LBW	London Borough Wandsworth
28	MDT	Multi-Disciplinary Team
29	Rio	Electronic patient clinical records system
30	SLaM	South London & Maudsley NHS Foundation Trust
31	CAD number	Computer aided dispatch, used to track police enquiries and resources
32	Francis enquiry	Review into the failures of care at Mid Staffs NHS Foundation Trust. Conducted by Sir Robert Francis QC
33	VAF	Vulnerable Assessment Framework (see appendix 3)
34	THRIVE+	MPS tool to assess Threat, Harm, Risk, Investigation, Vulnerability and Engagement (see appendix 3)
35	First-tier tribunal	Previously known as a mental health tribunal, now referred to as a First-tier tribunal. A second-tier tribunal is available for handling appeals against the First-tier tribunal
36	DoLS	Deprivation of liberty safeguarding – (Part of the Mental Capacity Act 2005). The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom

7 APPENDICES

Appendix (1)

Terms of Reference for Independent Investigation into the Care and Treatment of Mr X provided by InMind Health Care Group (Southleigh) and South West London and St George's NHS Trust.

- To review the monitoring and escalation process of Mr X's engagement with staff, psychology, GP for health check assessments, drug screening test and his alcohol usage.

- To review the quality of communication process between SWL&STG, Southleigh, GP and other agencies as appropriate.

- To review the monitoring and escalation processes in regards to Mr X's conditional discharge and clarify the level and frequency at which they were to be monitored.

- To explore the processes, management and responsibilities of SWL&StG, Southleigh and Wandsworth CCG for the step down of Mr X's care.

- To understand the impact on Mr X's care and treatment without the input of a care coordinator.

- To engage in the investigation process of all relevant agencies such as, GP, Croydon Social Care, police and Ministry of Justice, to understand any gaps in communication to support future learning.

- To review the CCG's monitoring processes in relation to Mr X's length of stay.

- To explore Mr X's first presentation at the police station on the morning of the incident to understand the reason for his attendance and to gain better understanding of his presentation before and after his attendance.

- To review if any previous concerns were noted between JJ and the victim.

- To explore the role and responsibilities of Mr X's community psychiatric nurse, following changes in the Community Mental Health Team's composition, in particular the management and provision of the social supervisor's reports to the Ministry of Justice after September 2015.

- To review the processes for management and monitoring of compliance with Mr X's conditions of Conditional Discharge.

- To understand the quality and effectiveness of Mr X's clinical reviews by all professionals.

- To understand what joint care plans were in place to manage Mr X, following concerns that he was relapsing prior to the index offence.

London Region

- To review the reason for delay of the Merlin Report being shared by Croydon Social Services with Southleigh Community Hospital and what actions have been taken to mitigate this risk of reoccurrence.

- To consider the effectiveness and timeliness of the originally commissioned investigation

Appendix (2)

Chronology of extracts from Mr X care and treatment at the community hospital

8.3.1 In a report prepared for the Home Office by Mr X Responsible Medical Officer (RMO), RC2 on the 31st July 2006 as routine feedback for a conditionally discharged patient summarised. Mr X's mental state remained stable and he has no problems with his new accommodation and has made friends with other residents and was friendly towards staff. He had successfully used unescorted leave and followed guidance. He also continued to attend Seagull Prints, a work-based project in Tooting, that he had commenced prior to his discharge from the Shaftesbury Clinic.

8.3.2 The same report also cited that Mr X was reluctant to give private information about himself and although complying with his prescribed medication, he was requesting that it be reduced.

8.3.3 The report concluded by proposing that Mr X was given trial leave in the independent flats.

8.3.4 Mr X moved into an independent flat on the 30th September 2006.

8.3.5 In November 2006, RC3 took over from RC2 and became Mr X Responsible Clinician (RC).

8.3.6 A level 2 Multi Agency Public Protection Panel (MAPPA) held on 1st December 2006 discussed Mr X's progress, concluding amongst other issues, that the 2-hourly observation of Mr X at night could be discontinued

8.3.7 Reports prepared for Mr X's Care Programme Approach (CPA) meeting in November 2007 indicated concern at the relationship between cannabis and alcohol and the assaults on his parents in 1992 and 1995.

8.3.8 It was agreed that a minimum level of monthly urine/drug screening and random breathalysers would be offered

8.3.9 In January 2007 Mr X refused to undertake psychometric testing and said that he would not engage with psychology. Staff also noted that he had not been regularly attending Seagull Prints. He responded to this by saying he had reached his optimum there.

8.3.10 In July 2007 the team and Mr X were informed that Dr3 had been allocated as Mr X's community forensic psychiatrist. This was discussed with Mr X by SS2.

8.3.11 In September 2007 Mr X commenced a two-year plumbing course for one day per week. On returning from the course on the 25th September, he went to his flat, but then immediately returned to the nursing office and was very angry, asking who had been into his flat. When the staff member did not indicate straight away who it was, Mr X left the room, banging the door. The hospital manager HM2 later met with him and explained that a health and safety check had been carried out. From this meeting, it emerged that Mr X was in the habit of inserting paper into his door, which would fall out if opened. This was considered to be a clinical indication of ongoing paranoia.

8.3.12 The consensus amongst the team was that whilst there were no clear signs of deterioration in his mental state, there was an ongoing level of stable paranoia present. The team agreed to try to explore with Mr X the difference between "healthy caution and paranoid thinking". He was also offered a small increase in his antipsychotic medication (Risperidone) which he was not keen to accept. It was, therefore, decided not to progress to self-medicating'

8.3.13 The report acknowledged that "ultimately Mr X's successful supervision in the community would be dependent upon security and the development of therapeutic relationships". These would be required to gain his trust and freer communication.

8.3.14 The nursing report covering the period June – December 2008 reports an incident in one of the regular community meetings in which staff were raising issues relating to patients' self-care and substance misuse. Mr X became verbally hostile in the meeting, resulting in it being ended early. Mr X returned to his flat before a few minutes later appearing at the nursing office in a threatening and hostile manner, saying that he would crush anyone who crossed him.

8.3.15 Following this incident his RC reviewed Mr X medication and a further anti-psychotic medication was added, Olanzapine 5 mgs daily

8.3.16 This report also noted that Mr X had, on occasion, been taking alcohol. He openly acknowledged drinking in the early morning on two occasions as he returned from leave to the local shops.

8.3.17 His clinical team again broached the subject of undertaking some psychological work and he was asked to complete the HCR 20 risk assessment. He initially agreed, but later refused when he was approached.

8.3.18 At a CPA meeting on the 30th November 2008 attended by his community psychiatrist, solicitors, social supervisor and the hospital's MDT, Mr X continued to demonstrate limited engagement and an ongoing level of paranoia. He refused to sign documents, such as his risk assessment and care plan, stating he did not agree with them. He also continued to refuse all physical checks, such as blood pressure basic observations and ECG. The social worker reported that Mr X did not like her approaching charitable

organisations for financial support for his training and that the three monthly contacts with his family were too much.

8.3.19 Mr X began to raise with the team his desire to move on and requested that he be discharged from the hospital as he felt restricted. The team considered this request premature and felt he needed longer at the hospital

8.3.20 Mr X's mental state continued to be regarded as stable, although the clinical team remained concerned that he showed little insight into his mental illness and continued to refuse to engage in areas such as psychology and physical health assessment by his GP

8.3.21 During a meeting with his social supervisor in January 2009 Mr X stated that he was drinking daily, in the morning, which was driven by boredom. He also said that he was continuing to take his prescribed medication although he did not think it helped him.

8.3.22 In April 2009 staff observed Mr X to be discarding several tins of lager in the rubbish from his flat. This this led to him being counselled regarding safe drinking levels.

8.3.23 At a multi-professionals meeting, held on the 24th April 2009, the issue of move-on was discussed as a potential place in Tooting had been identified. The team also spoke with him about the self-medicating protocol with a view to him taking responsibility for his own medication, which would be a requirement if he were to step down to independent living. However, he declined.

8.3.22 In July 2009 Mr X refused to meet with the Wandsworth community team who could help facilitate his move on to a placement in Tooting. This was later discussed with SS3, his new social supervisor, where he indicated he was happy to move on but did not know how to achieve this.

8.3.23 In August 2009 the social supervisor discussed contacting Mr X's father. He responded by saying that "things will go downhill" if the social supervisor did not respect his wishes. He then terminated the meeting.

8.3.24 During a meeting with his RC3, on the 9th April 2010, where she explored with him his gynecomastia and how this may not necessarily be linked to his medication, Mr X again expressed a desire to stop, or reduce his medication. As there had been no recent notable deterioration in his mental state, this resulted in the Olanzapine being stopped and the Risperidone being increased to 8mgs daily.

8.3.25 On the 18th June 2010, Mr X met with Dr2, a plastic surgeon, to explore the findings from the endocrinologist regarding his gynecomastia. It was reported that Mr X did not want to discuss the letters from the endocrinologist which indicated that the most likely contributing factor of his gynecomastia was obesity and not medication. Dr2 did not want this surgery

to be indicated as he considered the outcome may be poor, with the risk of considerable scarring.

8.3.26 It is reported that Mr X did not agree with the findings and continued to attribute the gynecomastia to side effects of medication.

8.3.27 In December the issue of Mr X self-medicating was raised. On this occasion, he accepted that this would be positive and agreed to read through the protocol as preparation for going self-medicating. **(**the hospital's Medications Management Policy - Pages 147 – 179 of the MPS evidence bundle).

8.3.28 In a ward round on the 7th January 2011, his mental state was again reviewed and it was considered that there was a no evidence of a depressive element to his presentation, so the Fluoxetine was stopped.

8.3.28 At the ward round on the 8th February, those present considered Mr X's mental state to have remained stable so he began the process of moving towards self-medicating on 9th February 2010.

8.3.29 Over the following months Mr X began to engage with psychology, which the team viewed as extremely positive.

8.3.30 During 2012 Mr X's behaviour remained very consistent. He would indicate a willingness to engage with psychology but then gradually withdraw. There were occasions when he was noted to be drinking, which RC3 indicated she would have to report when writing to the Home Office. Another opportunity for a placement was found in a new scheme, Burntwood Villas, which was on the periphery of Springfield Hospital. Mr X declined this and other placements and indicated he did not wish to return to Wandsworth.

8.3.31 RC3 remained concerned at his lack of insight and engagement in structured activities or psychological work. She believed that it would be via this engagement that he may gain insight into his illness.

8.3.32 In January 2014, RC4 took over temporary responsibility for Mr X's care, following the departure of RC3. In his first ward round his past history was presented by the team. HM2, the Hospital Manager described Mr X as demonstrating fluctuating hostility, and also that there was no insight into Mr X's internal world as he refuses to engage in conversations.

8.3.33 SW1, the unit's Social Worker, did appear to have a better relationship and indicated that she did not experience hostility from Mr X. It was also cited that there were two support workers and a Nurse (later to become the victim) who he also got on well with Mr X.

8.3.34 During the ward round the challenges around his moving on were discussed. When Mr X joined the meeting and discussing this issue, he said that he had previously lived in Surrey and found it to be more "laid back". He also

indicated that Wandsworth was where the offence took place. When given the opportunity to expand on this he said, “He didn’t want to go there”

8.3.35 When asked about his lack of engagement with staff, he said that he felt he had been sold a lie as he was told he would only be at the hospital for a year but he still has not left.

8.3.36 His use of drugs and alcohol was discussed. He said that he did not take cannabis anymore and was happy to be tested. He had taken alcohol and on occasion he was breathalysed every day and had felt harassed. RC4 explained that he was more concerned about cannabis due to the effect sometimes of paranoia.

8.3.37 NM1, the nurse manager, informed the meeting that there had been little change in his presentation in three years. The meeting concluded that there was no evidence of psychosis or mood disorder. He demonstrated some insight into areas such as the effects of cannabis and was prepared to continue to take medication.

8.3.38 Mr X was introduced to his new care coordinator who spoke with him about his desire for accommodation and its location.

8.3.39 In August 2014 RC5 took over the role of Responsible Clinician.

8.3.40 RC5’s report prepared for the CPA meeting in December 2014 noted Mr X’s mental state remained stable, with no evidence of psychosis or affective symptoms. There had been no inappropriate behaviour, self-harm or incidents of violence or aggression. The wider MDT reported no change and that he continued to be disengaged, disinterested and subtly irritable at times.

8.3.41 In presenting the background to the new RC, she noted that the “institutional memory” from the team, reported that previously (2006-2008) he engaged with occupational therapy, psychology and the active care plans but has become progressively disillusioned. The report also cites regular changes with social supervisor (SS) and care coordinators (CC) as not helpful. Whilst reports do demonstrate regular changes in SS and CC, there is little evidence in earlier reports of positive and regular engagement with clinicians.

8.3.42 The report notes that in the context of the team judging him the team viewed his mental state as stable “for years” and the risk he posed to self and others remained low.

8.3.43 With regard to his medication, he remained self-medicating taking 6mgs Risperidone daily. During interview, the doctor observed involuntary movements of Mr X’s tongue which is a recognised side-effect which she viewed as highly suggestive of compliance.

8.3.44 He continued to indicate that he was not taking cannabis or other illicit substances, which appeared to be supported by on-going negative urine drug screens. With regard to alcohol, he reported drinking a pint once every couple of weeks. There had been no recent evidence to suggest differently.

8.3.45 The report acknowledged that he was known to the Croydon MAPPA but was now managed at level 1

8.3.46 The ward round on the 27th January 2015 noted Mr X's presentation remained settled, with minimal interaction with staff. His refusal to have weekly physical observation was raised, which he agreed to have monthly. It was noted that he was not attending groups or community meetings and he had not met with his CC recently. His alcohol consumption was noted to be a pint or can of beer two or three times a week. RC5 also prescribed Hyoscine Hydrobromide at night as he complained of night time dribbling.

8.3.47 In March 2015 RC4 again took over temporary responsibility for Mr X's care. When RC4 asked Mr X how things were, he responded that 'everything was the same, but that wasn't a good thing'. The lack of his move on was discussed but he felt nothing suitable had been offered.

8.3.48 RC4 gave Mr X "some positive feedback about his mental health" and the management plan remained unchanged.

8.3.49 On the 11th June 2015, RC1 took over clinical responsibility for Mr X's care. During the handover meeting in which RC1was introduced, RC4 explored with Mr X how he was progressing. When discussing medication, he confirmed he was still self-medicating, filling up his dosette box weekly. He said that he had no side effects and he thought the medication helped by making him feel more calm and relaxed.

8.3.50 Mr X confirmed that he had met with his new care coordinator who had asked him to fill in a report. The issue of a move on was discussed. He continued to express a desire to go to Surrey, saying that he 'didn't want to live in Wandsworth or Croydon'. RC4 reassured Mr X that the care team were supporting his desire to move on, but they had no control over the funding panels and it was always difficult to arrange out of area placements.

8.3.51 When asked how he would spend his day if he were to move on, he said that 'it was difficult to say but would like to be self-employed'. He had been looking at the possibility of becoming a loans broker: he could set up a website and write blogs to help market it.

8.3.52 His urine drug screen and breathalysers were reported as negative.

8.3.53 The medical report prepared for the CPA meeting of the 6th October 2015, repeated much of the information from the previous CPA in December 2014. It concluded that his mental state remained stable and there had been no evidence of psychotic symptoms in recent months. His UDS were negative and he was compliant with his medication. It did note that Mr X continued to

isolate himself with minimal interaction with other residents, or members of the MDT.

8.3.54 The nursing report prepared for the same meeting noted; 'he has no wish to contact his family and is not keen on talking about this topic when explored.'

8.3.55 The report noted that Mr X was not compliant and adhering to his responsibilities regarding his rehabilitation and treatment plan. He does not avail himself for 1:1 sessions with his primary nurse, he is not engaging with any individual or group therapeutic sessions either with the OT, or the psychologist. He also refused to engage with the Recovery Star review.

8.3.56 With regard to actions, which had been prescribed at the last ward round, regarding blood test, physical health observations and prolactin levels, his. primary nurse states, 'it has not been possible for the nursing staff to follow up with this plan due to his uncooperativeness.'

8.3.57 In relation to medication, she reported, 'Attempts have been made for Mr X to complete a side effect monitoring scale form with no luck. He, however, tells the MDT he is happy with his current medication.'

8.3.58 In the ward round of the 5th January 2016, it was reported that Mr X was settled in mood and maintains a stable mental state. It appears that urine drug screening and a breathalyser test had not been conducted since August or September 2015. The meeting also recorded that Mr X indicated that he had spoken to his mother over the Christmas period to offer season's greetings, but otherwise had no friends.

8.3.59 **First Appearance at Croydon Police Station -** The ward round of the 5th February 2016 noted that Mr X's mood and behaviour continued to appear settled. However, the hospital had received a phone call from the police stating, 'Mr X had attended the Croydon Police Station and handed them a letter. The content of the letter expressed high levels of paranoia that staff were colluding against him'.

- Nurses have threatened to report his mental health to the authorities
- There is a ploy to get him extradited from the UK
- He believed he was being victimised and persecuted by African immigrant nurses working for the NHS
- Nurses were making false accusations against him to the police of a sexual nature
- He believed he was a sitting and lame duck and that his life was in danger

8.3.60 When his RC and other members of the MDT tried to explore the content of the letter, which had been written on the 23rd January Mr X became angry and refused to answer questions.

8.3.61 When asked if he felt he needed to act on his thoughts by harming someone, Mr X said it had not got him anywhere in the past and so he does not want to address his concerns.

8.3.62 When asked about his index offence he said that he accepted that stabbing someone was not the way to deal with things.

8.3.63 The ward round went on to explore whether he had been drinking more Mr X stated that he had drunk two miniature bottles of whiskey the previous Tuesday and Thursday and had also had two drinks that morning. He reported that the drinking made him feel better. He said he had not taken any drugs.

8.3.64 His RC advised Mr X to speak with the psychologist about his thoughts and concerns and advised that he should get a solicitor to help write a letter of complaint to his care coordinator as he had not had help to move on.

8.3.65 His risk assessment profile (section – Abuse, Exploitation, Vulnerability from others) noted the content of the letter but the rating remained unchanged.

8.3.66 The ward round of the 1st March 2016 makes no reference to Mr X's previous attendance at the police station. It would also appear that no UDR or breathalysers had been taken

8.3.67 The ward round of the 6th April 2016 was very similar in content. Mr X was settled with no changes in behaviour. He is only seen "when in a rush going through the unit". Avoids contact with staff or peers and had not attended his 1:1 session with his primary nurse.

8.3.68 Still no UDR or breathalysers recorded since August 2015.

8.3.69 Mr X was informed that the team had received a response to a letter of complaint regarding the lack of support in finding a suitable move on placement for him and that new placements were being looked for.

8.3.70 The ward round on the 4th May 2016 noted in the update/discussion the following:

- Mr X attended the ward round. He reported nothing new and denied any thoughts to go to the police.
- He said he was sleeping well
- He denied any coughs, no chest pains. He questioned why he was asked this. The RC stated it was because he refused to have any physical checks
- He was evasive when asked about how many cigarettes he smoked and said it was because he smoked roll-ups and said he was fed up with the questions
- He confirmed that he drinks alcohol but said that he did not get drunk
- He denied feeling paranoid and had no plans to contact the police again

Metropolitan Police Service note

9.1 In 2013 the MPS collaborated with the University of Lancashire to develop a tool that officers could use to identify vulnerabilities in people that they came into contact with, in everyday policing. This risk assessment tool was called the Vulnerability Assessment Framework (VAF) and used the key headings of Appearance, Behaviour, Communication, Danger and Environment for officers to categorise identifying factors that may be unusual or give concern.

9.2 If three or more factors are identified then officers are required to complete a report on the 'Merlin Adult Coming to Notice' report. Officers must also complete a Merlin (at any stage of any encounter or investigation) if they use Mental Health Legislation or have concerns regarding a person mental health. This approach ensures that no matter how a person with vulnerabilities presents to the MPS there is a consistent and corporate approach to how we record our interaction. This is regardless of whether a crime is being alleged, or substantiated, or merely a concern about that individual.

9.3 Once the MERLIN report is completed by an officer, a level of research is conducted on each report using all police indices for any relevant history by teams in the local Multi Agency and Safeguarding Hub (MASH). Appropriate information is then shared with Adult Social Services to enable effective signposting for support services, appropriate intervention such as mental health assessment or any relevant safeguarding assessment to take place.

9.4 In 2018 the MPS introduced the model THRIVE+ to assess the appropriate police response to an emergency call. It is based on: Threat, Harm, Risk, Investigation, Vulnerability and Engagement. THRIVE+ is a framework that enables officers and staff to undertake structured and more consistent decisions on cases from the initial call at the first point of contact, through the lifecycle of an incident or investigation. Call handlers will still be able to resolve calls without deployment of officers, for example if there is a more appropriate agency to signpost the caller to. Key to THRIVE+ are the principles that staff and officers should feel empowered to use their professional judgement and discretion in decision-making.

10 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.

PANEL MEMBERS

9.1 Mr John Enser – (RMN/RGN – DiP in Management / MSc in Health Services Management)

John is a registered mental health and general nurse. He has 40 years' experience; initially in clinical practice, before moving into middle and senior management roles. For 10 years, he was an executive member of the Forensic Psychiatric Nurses Association (FPNA). John has designed and developed many new services including; In-patient services, prison mental health and primary care, police and court liaison services and community. Inevitably, this has involved working with multiple agencies and reviewing incidents when things have gone wrong as part of the governance and assurance framework. Independently and as a Director for Psychological Approaches, he has carried out reviews of other services which were experiencing difficulties and led on "deaths in custody" reviews. He is an Honorary Lecturer at Canterbury Christchurch University and has an MSc in Health Services Management.

9.2 Dr Jonathan West

Dr Jonathan West is currently employed as a consultant psychiatrist by Oxleas NHS Foundation Trust in South East London. He has been with the Trust for 15 years. During this time, he has worked as Clinical Director and was involved in the early years of CQUIN and delivering the Darzi 'quality agenda' in addition to leading on several large-scale service redesign projects. Jonathan has primarily worked within 'recovery' or psychosis teams. At present Jonathan works in a busy Early Intervention in Psychosis team in Greenwich. The team is audited annually and Oxleas is seen as leading the field in relation to early Intervention services. Jonathan is especially interested in the physical health and wellbeing of his patients and believes that it is important to get this right at an early age.

Jonathan is the Chair for the London Early Intervention in Psychosis Clinical Reference Group which has been overseeing the 'waiting time and access standard' for EIP which came into force in April 2016. As the London Regional EIP lead he has also supported NHS England and NHSI with a series of London workshops looking at how services have fared with the implementation of the standard.

9.3 Ms Lisa Dakin

Lisa is a Registered Nurse in both Mental Health and Learning Disability and has over 25 years' experience working as a nurse leader with offenders who have mental health needs or learning disabilities.

Lisa has an MSc in Multi-Disciplinary Forensic Mental Health and a Post Graduate Diploma in Leading, Managing & Partnership working. Lisa has a proven track record of providing high quality care in a number of senior positions across a range of health organisations including setting up new projects and implementing significant change in services. She has a particular interest in what we can learn from incidents, both in terms of when things go seriously wrong, or learning from trends for lower level incidents within health services.

Lisa has led on many investigations into serious untoward incidents within inpatient services, prisons and local mental health and primary care services. Lisa currently works in a substantive role as Head of Nursing & Associate Clinical Director for Forensic & Prison services in a large NHS Trust, working on an ad hoc basis for Psychological Approaches.