Psychological Approaches

# AN INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF Mr Y



May 2022

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## INTRODUCTION

1. The external investigation by Psychological Approaches into the care and treatment of Mr Y was commissioned by NHS England, London investigations team in December 2021. This report provides a summary of that investigation and its findings along with recommendations for the responsible NHS Trust.

2. Psychological Approaches would like to thank South London and Maudsley NHS Foundation Trust for facilitating this investigation.

### The person

3. Mr Y is a 38-year-old black British man who was born and brought up in South London with his mother and two siblings. Mr Y was guarded with professionals regarding personal matters; nevertheless, we know that his early childhood was spent in South London with his family who he remained in contact with throughout the time covered by this report. However, during adolescence, he began to associate with antisocial peers and to get involved in offending behaviour. Subsequent violence was associated with Mr Y becoming involved with antisocial peers and problematic use of illicit drugs. Mr Y had four children by a number of partners, and we know that they were important to him, and that he was concerned for their wellbeing. At the time of the incident, he was hoping to take up a course in music production. **Further details regarding contact with Mr Y's family and the victim's family are detailed in Appendix III of this report**.

### The incident

4. In the early afternoon of 4 January 2019, the victim was travelling with his 14-year-old son by train from Guildford to Waterloo when he got into an altercation with Mr Y, who was travelling on the same train. Following the altercation, the victim followed Mr Y as he moved into an adjacent carriage. There Mr Y stabbed the victim multiple times in the neck with a knife he had in his possession. The victim died at the scene. Mr Y left the train at the next station. A police search took place which led to two arrests in a flat in Farnham of Mr Y and a woman understood to be his girlfriend.

5. Mr Y was arrested for murder on 5 January 2019 and charged on 7 January with fatally stabbing the victim and possession of an offensive weapon. Mr Y was found guilty of murder at trial and was sentenced on 12 July 2019 to life imprisonment with a 28-year tariff.

## BACKGROUND TO Mr Y's CARE AND SUPPORT

6. For clarity the narrative summary of Mr Ys care and support is presented as four separate time periods. These are:

- 2007 – 2015; an overview of Mr Y's mental health care prior to his contact with South London and Maudsley NHS Foundation Trust (SLaM)
- March to November 2015; Mr Y's admission to SLaM medium secure hospital at River House
- 2017 – June 2018; Mr Y's care under the Lambeth forensic community team (LaCFT) following his release from prison
- July 2018 onwards; community-based care provided whilst Mr Y is living in Bognor Regis.

**7. More detail can be found in the Chronology (see Appendix I).**

8. For each time period, we comment on the following issues – all of which were highly pertinent to the support and care provided by SLaM – as well as highlighting points of good practice
   - Diagnostic issues
   - Care planning
   - Assessment and management of risk

9. **The commentary is based on our access to records and interviews conducted, details of which can be found in Appendix II to this report.**

**10.** The investigation has focused on areas of care and support provided to Mr Y that address the agreed Terms of Reference to this investigation. **These Terms of Reference are provided in Appendix III to this report.**

## 2007-2015

11. Mr Y was first referred by his GP to South London and Maudsley NHS Foundation Trust (SLaM) in September 2007 aged 24 years. At initial assessment, carried out over two appointments by a community mental health team (CMHT), he was described as hostile and aggressive and was requesting rehousing. He reported that he was living with a female friend and was carrying a knife in public. He complained of hearing voices in his head telling him to kill people who were going to harm him. The assessing team contacted the police and spoke to his solicitor who confirmed, as he had reported, that the police had warned him to leave his flat.

12. In April 2008 Mr Y was arrested in Crawley following a disturbance on a train and threatening another passenger, he was assessed and detained under section 2 of the Mental Health Act and admitted to a Psychiatric Intensive Care Unit. Admission is recorded as being for assessment of command auditory hallucinations, threatening and volatile behaviour and thought disorder. He was discharged from hospital in May 2008, failed to attend the planned seven day follow up post discharge and the decision was made, due to lack of information about his whereabouts to wait rather than offer further appointments.

13. Mr Y next contacted the CMHT in April 2009 when he attended two appointments saying that he had run out of prescribed medication (Olanzapine, an antipsychotic), that he wanted to be admitted to hospital and complaining of feeling paranoid.

14. In September 2009 Mr Y was assessed by the court diversion team at Magistrates Court before being remanded to HMP Brixton charged with wounding with intent, he was convicted in December 2009 with a sentence of 7.5 years.

15. In July 2010 Mr Y was transferred from HMP Brixton healthcare wing to a medium secure inpatient ward at River House under section 47/49 of the Mental Health Act for further assessment to inform future management. He remained an inpatient within the medium secure service until March 2011 when he was remitted to HMP Brixton.

16. Mr Y was next referred to the CMHT by his GP in February 2012 having been released from prison on parole in December 2011. On assessment he reported difficulties at his accommodation which was a probation hostel. He also reported being increasingly suspicious with daily auditory hallucinations. He said he was compliant with prescribed medication, which remained as Olanzapine and he also reported regular, daily, use of cannabis.

17. In October 2014 Mr Y was recalled to prison for breaching his conditions by living at an address that had not been approved and for violent and aggressive behaviour towards family members.

### *Diagnostic issues*

18. Mr Y's first formal ICD-10 diagnosis is recorded in May 2008 as acute transient psychotic disorder with secondary diagnoses of mental and behavioural disorder due to use of cannabinoids, dissocial personality disorder (PD) and paranoid PD. It is noted however that there remained the need for further assessment and symptoms were self-remitting often at times of crisis and the potential for malingering or feigning symptoms was also noted. By 2010 after admission to the medium secure inpatient service ICD-10 diagnosis is recorded as schizophrenia; this was revised to paranoid schizophrenia in March 2011. By the end of 2012 however this was revised again to mental and behavioural disorder due to use of cannabinoids. The clinical records report diagnosis as schizophrenia complicated by cannabis misuse and dissocial personality traits in a referral to the forensic team in October 2014 and in notes of a formulation meeting in March 2015 as paranoid schizophrenia and antisocial behaviour disorder.

### *Care planning*

19. Within the body of the contemporaneous clinical records, plans for care are summarized in brief at weekly ward reviews during inpatient admissions and following community contacts.

### *Assessment and management of risk*

20. Throughout this time the risk screening tool was completed intermittently, there are regular references made in the contemporaneous clinical records to the need for risk assessment and risk management in relation to risk of violence; there is clear evidence

that clinical staff were aware of Mr Y's risk to others and to himself inherent in the plans and actions.

21. Child need and risk screens in relation to Mr Y's children were completed during this period.

## March – November 2015

22. Mr Y was transferred from HMP Thameside to the SLaM medium secure inpatient service at River House again in March 2015 under section 47/49 of the Mental Health Act.

23. The rationale for transfer is outlined in the medical report for the Mental Health Review Tribunal (dated September 4th, 2015) as being as a result of Mr Y's continued poor insight despite compliance with treatment whilst in prison. The aim of the admission was for assessment and formulation of his mental disorder and to obtain a detailed assessment of his risk of violence towards others. This would also enable the organization of '*a robust and comprehensive aftercare package'.* Mr Y was awaiting an imminent parole board hearing at the time of transfer. Immediately prior to transfer a request was made by Lambeth community mental health team to transfer Mr Y's care to case management by the forensic services.

24. On admission to the medium secure ward Mr Y was noted as showing good insight into his illness: he was aware of his diagnosis which is noted as being paranoid schizophrenia, and of his medications.

25. In April 2015 Mr Y raised concerns about a fellow patient on the ward saying that the other patient was related to the victim (of his index offence) and that he felt unsafe on the ward and requested a move to a different ward. This was facilitated and he moved wards returning to his original ward after a few days.

26. In May 2015 the trainee psychologist in the team, under the supervision of a clinical psychologist completed an HCR-20 V3 Risk Assessment. This included the following within its formulation *'Mr Y demonstrates poor insight into his violent behaviour and mental health difficulties and has demonstrated poor supervision compliance. As a consequence of the above, Mr Y appears to have developed a belief system, including violent attitudes, which support violent behaviour. This is apparent in Mr Y's minimization and denial of previous violent incidences, as well as his consistent involvement in criminal activities'.* The assessment rated Mr Y's risk of serious physical harm as moderate and noted this could escalate to serious or life-threatening harm if in the community without appropriate supervision.

27. Mr Y is noted, by his Responsible Clinician (Psy.1) in May 2015, not to have exhibited any deterioration in his mental state and to not have engaged in therapeutic activities on the

ward; this led to discussion with Mr Y and his solicitor about a potential return to prison as he did not appear to be benefiting from being in hospital.

28. During admission Mr Y made a claim for Employment and Support Allowance although he was not entitled to this as a transferred prisoner. This was addressed by the team social worker once the team became aware.

29. Mr Y was offered the opportunity, but declined, to join the substance awareness group. Regular urine drug screens were taken as per plan and were positive for cannabis on several occasions. He was also suspected to be involved in bringing drugs onto the ward also on several occasions.

30. In May 2015 the multi-professional team noted that Mr Y was not exhibiting any signs or symptoms of psychosis and there was no evidence of an acute deterioration of his mental illness. As he was also not engaging in any meaningful therapeutic work the team began to consider returning Mr Y to prison. The team contacted Mr Y's probation officer who expressed concern about a return to prison as he felt that Mr Y needed treatment for his personality traits and that there was a risk that his mental health may not be managed in prison. In June 2015 it is noted that Mr Y asked about going to Waddon ward (specialist personality disorder service within River House). In July 2015 Psy. 1 referred him to Waddon ward for further assessment of his personality disorder and treatment, that being participation in the Violence Reduction Programme. Mr Y expressed some concerns about being in the programme along with offenders who had committed sexual offences. He is recorded as being of the view that he did not have a personality disorder but was open to discussion about this. He talked through the traits of antisocial personality disorder with the psychologist. Mr Y was transferred to Waddon ward in late August 2015 for assessment of his motivation to participate in the Violence Reduction Programme.

31. At ward review in early September Mr Y is noted as being unsuitable for the ward following a report from the psychologist. While he had a diagnosable personality disorder he was '*not in clear agreement with this diagnosis or sufficiently committed to treatment at this time'.* Mr Y was transferred back to the rehabilitation ward, at the end of September 2015 as he had said that he did not want to remain on the specialist ward. Remission to prison was discussed and agreed at Mr Y's Care Programme Approach (CPA) review meeting at the end of September 2015.

32. In September 2015 Mr Y's ongoing care was transferred to the Lambeth community forensic team (LaCFT) with his community consultant forensic psychiatrist (Psy. 2) having also been his responsible clinician whilst on Waddon ward.

33. Mr Y was remitted to prison in November 2015. Prior to his return to prison healthcare staff from the prison attended a ward review and met with the ward team.

### *Diagnostic issues*

34. Ward review notes record Mr Y's diagnosis as paranoid schizophrenia throughout his 2015 admission. However, reference is clearly made in the contemporaneous record to anti-social personality disorder particularly in relation to the referral and short-term transfer to the specialist personality disorder ward. Formal ICD-10 primary diagnosis is recorded in September 2015 as paranoid schizophrenia and secondary as dissocial personality disorder[1]. The medical report for the first-tier mental health tribunal dated September 2015 records diagnosis as paranoid schizophrenia and antisocial personality disorder (ASPD). During handover to healthcare staff prior to remission to prison ASPD was noted as being Mr Y's '*predominant issue'.*

### *Care planning*

**35.** There are a range of care plans evident within the electronic care planning records for this period during which Mr Y was an inpatient, routine updates on plans are also summarised within contemporaneous clinical records.

### *Assessment and management of risk*

**36.** In May 2015, a specialist assessment of risk of violence, the HCR-20 was completed. From this point onwards the HCR-20 was reviewed during regular ward reviews and used as a guide for management of risk. Mr Y's risk of violence is articulated in the medical report for the first-tier tribunal as *'He has an extensive history of violent and non-violent offending (mainly underpinned by his personality disorder) associated with use of illicit substances and poor engagement with services'.*

### *Points of good practice.*

37. Mr Y's 2015 admission records evidence of the multi-disciplinary team adopting a psychologically informed approach to engaging with Mr Y and offering him a range of relevant interventions – including the option to transfer to a specialist ward with the secure hospital – that might have assisted him with addressing his problematic personality traits and risk-related behaviours.

38. We considered the HCR-20 and the Medical Report for the Tribunal to be of high quality.

## 2017-June 2018

39. Mr Y was released from prison in March 2017; prior to his release the Lambeth community forensic team (LaCFT) contacted his probation officer and clarified that he was MAPPA [2] level 1 and therefore would not be subject to multi-agency meetings.

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[1] Antisocial and dissocial are terms that relate to the same range of personality traits, and tend to be used interchangeably, although dissocial is the correct term for a formal diagnosis within the International Classification of Diseases (version 10) system.

[2] Multi Agency Public Protection Arrangements (MAPPA) outline the national system of managing sexual offenders and violent offenders. Level 1 requires ordinary agency management.

Contact between LaCFT and prison healthcare teams was maintained in the period between November 2015 and March 2017.

40. Mr Y moved into a hostel in Brixton, South London which specialises in providing supported accommodation for people with forensic mental health needs. His requests to be moved on began very soon after moving into the hostel, with him bidding for accommodation outside of London. He contacted Lambeth council, telling his care co-ordinator (CCO 1) that he had been told by the police previously that Brixton was not the right area for him to live. His complaints about various aspects of the hostel and life within it continued. He began to voice feeling paranoid and unsafe in April 2017. He was supported by his CCO1 with making applications for a change of accommodation and remained in regular contact with the team, although he did not always attend planned appointments. He made frequent demands - related particularly to his accommodation - often by telephone or email and became angry or upset, often shouting or swearing, or sending abusive emails or texts, when his needs were not met. He is reported however as having contacted the team in later April 2017 to say that he would not want to change team if he was given the opportunity to change location.

41. In August 2017 Mr Y was not engaging with the staff at the hostel accommodation and had an altercation with a contractor who was mending his toilet. As a result of this a meeting was arranged with him and his mental health advocate and CCO1. At the meeting Mr Y repeated that he had been told by the police that his life was in danger, he also complained of feeling very paranoid; he was described as ranting *'about how staff are not doing anything to sort out his accommodation'.*

42. In November 2017 his care co-ordinator changed to CCO 2[3] in order to provide locum cover. Over the subsequent months Mr Y continued to complain of paranoia and insomnia and remained pre-occupied with his accommodation. He communicated directly with the move on officer at Lambeth Borough Council about his requirements, specifying areas of London that he deemed safe alongside counties outside of London which would be acceptable to him. CCO 2 continued to offer support to Mr Y in his quest to find acceptable accommodation, in January 2018 rent arrears as well as anti-social behaviour towards staff and residents at the hostel led to the hostel providers planning to evict Mr Y.

43. His care co-ordinator also continued to encourage Mr Y to reduce his cannabis use and to consider a specialist substance misuse group available from SLaM services. However, in February 2018 Mr Y is noted to have increased his use of skunk and reported using throughout the day. He rejected the offer to refer him to the specialist group, on the grounds that he would not discuss his problems with others present.

[3] There were in fact five care coordinators assigned to Mr Y during this period in the community, of whom four provided locum cover. We refer to CCO 1, 2 and 3 as the care coordinators who provided the most consistent input to his care; CCO 2 and 3 were also interviewed for this investigation. Whilst in prison Mr Y was allocated a separate care co-ordinator in addition to the community care co-ordinator.

44. An incident at the hostel in February 2018 involving Mr Y shouting obscenities at staff and throwing a fire extinguisher down the stairs in response to his complaints about the cleanliness of the hostel, led to a verbal warning from the police. During February Mr Y sent abusive emails to the move on officer at Lambeth council leading to a warning from the move on officer that if he continued with his offensive communications his case may be closed. Mr Y later apologised by email. Clinical records held by the Trust include copies of emails between Mr Y and the council move on office and email liaison between hostel staff and CCO 2. Whilst there is no further record of meetings with housing, it is clear that housing requests were being managed by the housing team.

45. In March 2018 Mr Y is again noted to have presented with pressure of speech whilst listing complaints about his living arrangements and difficulties with finding an alternative. He also told CCO 2 that he had increased paranoid thoughts about feeling unsafe or about the hostel staff and resident's motivations. He talked about the increased occurrence of voices and referred to the possible use of skunk as a coping strategy. A planning meeting was held between Mr Y's hostel keyworker, CCO 2 and Mr Y following allegations that he had made threats towards another resident during an altercation.

46. Mr Y began looking for property in Bognor Regis in April 2018 and was supported by his care co-ordinator, CCO 2 who contacted West Sussex Housing options and the local forensic service on his behalf. His care co-ordinator agreed to directly support Mr Y in seeking to secure private rented accommodation in Bognor Regis including potentially supporting a joint visit to the area.

47. Just prior to the serious fire extinguisher incident in his hostel (see next paragraph), Mr Y had reported beliefs that staff were setting him up to be killed, his neighbours in the hostel were interfering with his food, talking about him, following him from room to room, etc. He reported feeling unsafe, and that he sometimes barricaded himself in his room at night.

*48.* At the end of April 2018 Mr Y was arrested by the police and removed from the hostel following an incident in which he reportedly chased and threatened hostel staff using a fire extinguisher to gain access to a staff office in which staff were present. During this incident Mr Y called CCO 2 telling him that he had confronted another resident whilst cooking food in the kitchen. He also described taking offence to comments by staff members and told CCO 2 *'I ain't letting him out of the office'.* He was assessed in custody by the liaison and diversion team and the assessment notes his risk to self and risk to others as high. The hostel refused to allow Mr Y to return on bail due to the risks to their staff. He was not able to use his mother's address as a bail address due to previous documented risks to his family. Whilst in custody Mr Y said that he had been wrongly charged and it was a police conspiracy, he also blamed his care co-ordinator, CCO 2, for his circumstances at the time. Mr Y was charged with a public order offence and bailed to his father's address in Croydon and was assessed by Psy. 2 when he was noted to present as calm and appropriate with good insight into his difficulties as someone with *'a paranoid personality'.*

49. Mr Y continued to receive support in his search for property in Sussex following his arrest, clarifying that he wanted to live in Sussex because he had a former girlfriend who lived there. He also informed his care co-ordinator that he had a current partner who he did not live with but who was about two months pregnant. In July Mr Y informed Psy. 2 about the significant personal event of a previous girlfriend.

50. In July 2018 temporary accommodation provided by Arun district council was confirmed for Mr Y in Bognor Regis.

### *Diagnostic issues*

*51.* There is limited evidence in clinical records throughout this period of any ongoing debate related to Mr Y's diagnosis. Mr Y is described in an email from his psychiatrist (Psy. 2) to the Arun Housing Officer as having a diagnosis of '……*paranoid schizophrenia. He has antisocial and paranoid personality disorders'*. In interviews, there was some discrepancy between team members as to how they conceptualised Mr Y's diagnosis. Although unclear from the notes we understand from staff members that auditory hallucinations were thought to be '*pseudo hallucinations'* because of the manner in which they were described. Nevertheless, he retained a formal diagnosis of paranoid schizophrenia in the clinical record throughout this time. Paranoid traits or symptoms are noted during this period of care.

*52.* On the day following the incident in March (paragraph 45), Mr Y was given a sedative, Promethazine 25-50 mg on an as required basis for two weeks. Psy. 2 recorded that he had no symptoms of psychosis but did not take into account Mr Y's chronic but possibly worsening presentation. This prescription was repeated on 12th September 2018, largely at Mr Y's own direction, because in the past when on this medication he reported feeling calmer, less depressed and slept better.

### *Care planning*

53. There is a partially completed Recovery and Support plan dated 21st March 2017 recorded in the care planning section of the clinical records which was completed with Mr Y; and there is a summary of the custody assessment carried out by the liaison and diversion consultant dated 24th April2018. There is also revised plan in the summary of the 24th April2018 risk screening tool however this did not significantly change the existing actions undertaken by the team.

**54.** A CPA review was held in December 2017 and noted that the next review was due to be held in December 2018; there is no record of this taking place.

55. There is limited evidence of joint team discussion about Mr Y during this period. LaCFT routinely discuss their caseload at multidisciplinary case management meetings. The clinical records evidence that Mr Y was discussed every 2-4 weeks, up to 28th June 2018, thereafter there is no recorded discussion. The first discussion of his case was on 13th July 2017 where the notes state *'Continuing challenging behaviours, abusing staff and refusing to engage with staff. Consider charging him for damage and threatening behaviour. To be reminded of house rules, and risk of eviction. Arrange a 3-way meeting'.*

*56.* The final discussion recorded is dated 28th June 2018; '*Still homeless. Private landlords have turned him down because of bad credit. He was supposed to meet with his CC for help to fill online form, but left without doing it. His CC said he has rejected every effort to engage. (See ePJS for full entry). CC to send letter supporting his housing needs and cc'd his RC'*

57. Nearly all the case management notes during this period related almost exclusively to accommodation issues and all bar one are very brief.

### *Assessment and management of risk*

58. The Trust risk screening tool was reviewed and updated by Mr Y's care co-ordinator, CCO 2, during this episode of care on seven occasions. The risk tool completed in August 2017 (Mr Y was released from prison in March 2017) still included the summary of risk completed by the inpatient team during his 2015 admission to medium security, suggesting that this had not been fully and thoroughly reviewed and completed. However, the risk tool completed following violent incidents in the hostel in April 2018 included more thorough and up to date summaries of risk. The summary of risk dated 24th April2018 records risk to others as '*high*' as does the record of his assessment in Brixton Custody following arrest. There is no documented evidence that this was shared or discussed in detail with the wider multi-disciplinary team. There is no evidence of the specialist HCR–20 being reviewed throughout this episode of care.

59. Mr Y's contact with his children is also noted within the 2018 risk assessment screening records.

### *Points of good practice.*

60. The team persisted in their offer of care, despite challenges particularly with regard to Mr Y's unrelenting demands related to his accommodation and limited engagement or participation in his own treatment, where many teams might have considered discharging the patient.

61. The care co-ordinator (CCO 2) worked extremely hard to engage with Mr Y whilst providing a positive role model; we found his clinical record keeping being of a high standard, and he followed through on plans reliably. His persistence in supporting housing efforts was exemplary.

## July 2018- 3rd January 2019

62. Mr Y was placed by the local housing office in Bognor Regis in temporary accommodation in July 2018. He continued to receive support from LaCFT and his care co-ordination was handed over to a new worker (CCO 3) within the team in September 2018. By the middle of August 2018, there is evidence of complaints from Mr Y about his Sussex accommodation particularly about the noise from the flat above his which was

disturbing his sleep and, he alleged that he could hear the neighbours '*talking about me*'. They were so noisy that this had '*taken over his life*', such that he found being in the flat '*horrible*'. He said that the children cried at all kinds of hours, disturbing his sleep. He said they were 'f*ollowing him from room to room … if he was in the bathroom, he could hear them there, and if he went to the bedroom they went there too*'. He could hear them talking about him, and believed they were dropping things on the floor deliberately to antagonise him. He heard the woman say '*you are not even supposed to be here'*, and this caused Mr Y to wonder if the male voice was a '*paedophile or other bad person*'. This fed into his anxiety. He said he was taking his medication to help him sleep, but the noise drove him to stay at "*other people's*". He said that usually he asked them to pick him up rather than use public transport, because he was too scared to go out.

63. The clinical team offered him potential solutions and advised that he reduce his cannabis use. No visits were made by the team to his flat. Mr Y was reluctant to say where he spent his time and the contradictory information provided by him is noted in the clinical record. His care coordinator, CCO 2 encouraged him to cut down on his use of cannabis. He also proposed to commission a 'personal assistant' to provide emotional support.

64. On 6th September 2018 having talked to his new care co-ordinator, CCO 3 by phone and having requested, in the morning, that he see his psychiatrist, Psy. 2 to discuss his accommodation, Mr Y was arrested by British Transport Police for allegedly masturbating in a public place. He was assessed in custody at Islington Police station and released pending investigation. A review was offered the following day with his psychiatrist, and he was eventually seen eight days later. He reported hearing voices more frequently over the previous two months which were making him feel more paranoid, increased by using skunk. He was reported to be angry about his recent arrest.

65. Mr Y continued to complain about his accommodation and the community team remained in contact with the housing officer at Arun council who expressed concern and asked for advice from the team in early October2018; she noted that Mr Y's support network was in London rather than Bognor Regis. Mr Y was reviewed by his psychiatrist on 11th October 2018 who noted that Mr Y showed him photos of his 3–4-week-old baby with his girlfriend (who was living with her parents), he also noted that the recent significant personal event involved the young woman who drove him to the appointment.

66. In November 2018 Mr Y's care co-ordinator, CCO 3, called him to check on his welfare however ended the call early when Mr Y became aroused and shouted at her.

67. On 3rd January 2019 Mr Y was reviewed in person by both his psychiatrist Psy. 2 and his care co-ordinator, CCO 3. He was noted to be pressured in speech but pleasant on approach. He showed pictures of his baby son but refused to disclose the baby's mother's name and he expressed concern about his older son's cannabis use. He reported that he had a court case due in January 2019 relating to the violent incident in the hostel back in April 2018.

68. The serious incident took place on 4th January 2019. On 7th January 2019 at the request of the Forensic Services Clinical Director, Psy. 2 made an additional retrospective entry into the clinical record. This entry highlighted the 3rd January 2019 discussion with Mr Y being about the help he felt he needed in developing more structured day time activities and training. Mr Y said that he wanted to do a course in music production. He also discussed his accommodation and described an incident where he had been racially abused by a member of the public which he had reported to the police. Mr Y is described as having remained concerned about his sons and was advised to seek the help of their GP. He continued to use cannabis regularly and said that although it sometimes made him more suspicious or aroused it mainly helped him to relax. Psy. 2 noted that Mr Y was not presenting with overt psychotic symptoms, and he was more relaxed than previously and the Psy. 2 had no concerns that he presented risk to himself or others.

### *Diagnostic issues*

69. Mr Y's diagnosis needed to be viewed in a historical context. The diagnoses of paranoid schizophrenia and co-morbid antisocial personality disorder were made in 2015, after a nine-month period of inpatient assessment precisely for the purpose of clarifying matters. Half-way through that admission, he was commenced on depot medication because of previous concerns about his compliance in the community.

***70.*** This diagnosis is acknowledged in some places (e.g., the psychiatrist Psy. 2*'s* email to provide information to Arun Housing Services dated 13th July 2018), but not in others (e.g., psychiatrist entry to the clinical record on 26th April 2018, 'No symptoms of psychosis. Presented as calm and appropriate in our interactions. Presents mainly as a paranoid personality'). No detailed systematic mental state examinations are recorded. The reasons why he was 'too scared to go out', even in Bognor, were not explored beyond what Mr Y volunteered; these beliefs appeared to be transferred to his new neighbours from similar beliefs expressed at the previous hostel.

### *Care planning*

71. A community care plan dated 15th September 2018 is included in the care plan section of the clinical records for this period and there is also evidence of planning around specific actions; for example, the plan for applying for funding for a personal assistant to provide support for Mr Y within the contemporaneous clinical notes. A care plan approach (CPA) review meeting was due to be held on 6th December 2018 (as noted in previous CPA review notes) however there is no evidence that this took place.

72. While finding a personal assistant to provide Mr Y with emotional support is suggested, there is no evidence that this was acted upon. It is difficult to see what a (probably) relatively untrained person might have added to the care of such a complex, high-risk individual characterised by paranoia, antisocial behaviour, serious violence, and difficulties with engagement.

### *Assessment and management of risk*

73. There is one review of Mr Y's risk screening during this period in September 2018 (when a child need and risk screen is also recorded) which appears to align with the handover

of care co-ordination and in which his risk to others is recorded as '*moderate'*. This followed the incident of indecent exposure (masturbating in public) although the incident itself is not entered into the record.

74. The clinical records for the review on 11th October 2018 record a comment related to the information shared by Mr Y about visiting his new baby suggesting that consideration should be given regarding informing local children and families social services and noting that further information was needed before a decision was made. There is no evidence of any further discussion or that any further information was sought.

75. Given the very high, potentially fatal risk to members of the public and fellow residents noted in the 2015 HCR-20, the risk factor of reported derogatory auditory hallucinations was not explored.

***Points of good practice.***

76. The care co-ordinator, CCO 2 and psychiatrist, Psy.2, managed to preserve as good a working relationship with Mr Y as his difficulties would allow. Both staff members made considerable efforts to stay in touch and to encourage him to cut down on his use of cannabis.

## ANALYSIS IN RELATION TO THE TERMS OF REFERENCE

## To review the care planning and risk assessment between agencies prior to his release from prison in March 2017.

### *Care planning*

77. The LaCFT liaison (out of area team) worker was allocated the case and first made contact in February 2016, over one year before Mr Y's release date, and then again in April 2016. Her initial request was for a clinical update and CPA meeting date.

78. In June 2016, she attended a review for Mr Y in HMP Highdown, jointly with his care coordinator from the Mental Health In-Reach Team (MHIRT). Mr Y had been turned down for early release at a parole hearing the previous week. His progress was noted as follows:
    - He was due to start initial assessments with psychology department on 13th June 2016.
    - His MHIRT care coordinator was seeing him weekly.
    - His mental state was stable and there were no incidents.
    - Random urine drug screens were all negative.
    - He was happy to stay with his previous GP and attend outpatient appointments with the LaCFT.
    - He agreed to a referral to the SLaM forensic services Behavioural Treatment for Substance Abuse group.

79. In November 2016, the liaison worker attended a joint clinical review with the Clinical Team Leader HMP Coldingley MHIRT, in preparation for Mr Y's release and to confirm the aftercare arrangements. The update confirmed that Mr Y remained stable, had been involved in no incidents, and was taking oral antipsychotic medication (Olanzapine 20 mg od). He was anxious about his future accommodation. However, In December 2016 the LaCFT liaison worker was informed that Mr Y had been moved to HMP Wandsworth and was being managed in the close supervision unit (CSU): he was refusing to move to ordinary location as he felt unsafe.

80. The liaison between LaCFT and prison healthcare was of a reasonable standard. However, we found no evidence of a Section 117 meeting – or similar - being held which would have enabled the community team to plan carefully for Mr Y's release. It may have also been helpful to discuss why Mr Y had been placed in segregation prior to his release. The lack of the standard process of a documented section 117 pre-discharge planning meeting may indicate a lack of effective leadership and oversight in the team at the time.

### *Risk assessment*

81. The electronic patient record was updated in terms of a Risk Screen on the system on 23rd November 2016. The information is reasonably detailed, and the existing (specialist assessment of risk of violence) HCR-20 dated May 2015 had been viewed prior to

completion. No further HCR-20 was completed as this was not team practice. The full Risk Assessment Tool in the clinical notes was updated on 26th August 2017 – five months after release - but the summary of risk within that document relates to when Mr Y was an inpatient in 2015, rather than reflecting an updated review of risk by LaCFT. Furthermore, the Trust policy for Clinical Risk Assessment and Management of Harm in use in 2017 stated that a risk assessment should be updated within 14 days of a transfer; in this case the transfer was from prison to the community.

82. The Lambeth team leader's written response to the accommodation concerns raised by Mr Y's solicitor (dated 25th September 2017) makes reference to '*We have not been able to get any verified information about the threats he describes and we have informed him that the more appropriate agency for dealing with threats are the police'*. However, the clinical notes do not indicate what attempts were made to obtain verified information about the threats from others to Mr Y, nor why the community team did not consider contacting the police themselves.
83. There is evidence of appropriate clarification from the team regarding Mr Y's [4]MAPPA status prior to release. Prior to his sentence end he was registered as a Category 2 offender. On release (when his sentence ended) he would not have fallen under the remit of MAPPA unless an agency chose to refer him under Category 3.[5] Furthermore, there had clearly been appropriate communication in January 2017 between LaCFT and probation regarding licence restrictions such as exclusion zones, in order to inform the task of seeking supported accommodation.
84. **Overall, we considered the care planning and risk assessment between agencies prior to Mr Y's release from prison in March 2017 to have been reasonable. However, we would have expected a Section 117 meeting, or equivalent clinical review to have taken place around the time of release, and this should have prompted a thorough review of risk and care, and the development of a shared team view, supported by effective leadership, as to how to proceed.**

## To review the risk management of escalating risk/stress factors and actions taken, with reference to the following;

- Charges for indecent exposure
- Accommodation
- Intimidation to female staff (fire extinguisher and offensive weapon)
- Girlfriends' significant personal event
- Risk from others

[4] MAPPA category 2 is used for management of an offender who has been convicted of an offence and sentenced to 12 months or more in custody or 12 months or more in custody and is transferred to hospital under s47/49 of the Mental Health Act 1983.

[5] MAPPA category 3 is used for management of a dangerous offender who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management.

We have commented on the above in the order in which they occurred, in order to maintain narrative consistency.

### *Intimidation to female staff (fire extinguisher and offensive weapon)*

85. There are three recorded events of relevance on the SLaM risk screen: 26th February 2018, 23rd March 2018 and 23rd April 2018; these relate to incidents that took place at the 24/7 supported mental health hostel where Mr Y had been residing since his release.
86. The Liaison & Diversion Assessment in Brixton Custody Suite took place on 24th April 2018, the day following Mr Y's attack on the hostel staff with a fire extinguisher and his threats to kill a staff member. The assessment was to a good standard and concluded with an appropriate plan: rereferral to the team if Mr Y continued to raise concern, and attendance at Camberwell Green Magistrates Court on 25th April 2018. However, the clinical notes for the LaCFT – although identifying the risk to hostel staff as high on that day - focus purely on trying to find alternative accommodation for Mr Y. No mention is made of the long knife found in his bedroom by the police, nor is there mention of supporting the hostel staff. There is no indication of a discussion regarding the gender of victims in the documentation available, and no indication from the investigation interviews that this was an issue considered or explored by LaCFT at any point.
87. We note that there is mention on 3rd January 2019 (the day before the serious incident under investigation) that Mr Y had a court case pending in relation to one of the incidents that occurred at the hostel back in 2018; however no more detail is provided. It is not clear whether the team were aware of an impending prosecution or whether they had concerns about its potential impact on Mr Y and his risk.
88. In our view, given Mr Y's history including the serious attack on a previous fellow hostel resident, the problems that emerged at the hostel could have been anticipated. We found no evidence that he particularly targeted females for verbal abuse and threats. The LaCFT had one strategy – finding alternative accommodation for Mr Y – which was a reasonable but reactive response to a difficult situation. Given the team's confidence that Mr Y was not mentally unwell at the time of the incidents, it would have been appropriate to:

    - Have a clear approach that was understood by hostel staff and by Mr Y regarding the response to acts of aggression.
    - Set boundaries and expectations with Mr Y in relation to limits on behaviour that could be tolerated.
    - In our view, there was an opportunity to consider referring Mr Y to MAPPA at this point in time as a potential Category 3 referral[6] enabling multi-agency management of the risk Mr Y presented of violence or serious harm; at the very least, we would have expected the team to discuss this possibility as an option.

[6] MAPPA category 3 is used for management of a dangerous offender who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management.

### *Accommodation*

89. As discussed, problems in shared accommodation could have been anticipated at the outset, given Mr Y's history and his ongoing irritability and paranoia. However, it is fair to say that the first few months at the hostel were manageable. It is also the case that the care co-ordinator, CCO 2, made strenuous efforts to find alternative accommodation over a period of several months, offering support that went above and beyond.
90. There appeared from both clinical documentation and investigation interviews to be little discussion of the risk that Mr Y posed to other residents in his shared accommodation or consideration by LaCFT that this might be an issue to explore; this included very little attention paid to his history of concealing weapons in his bedroom. This is particularly salient given the previous offence of grievous bodily harm with intent, the victim being a hostel resident.
91. However, in the absence of a clear formulation that enabled the LaCFT to have a consistent approach to managing Mr Y's problematic personality traits and/or paranoid symptoms, there was a lack of limit setting evident in relation to the issue of accommodation. The team appeared to accept his self-report regarding threats to his safety and continued to seek solutions even after Mr Y had turned down several options. Further investigation may have enabled the team to differentiate between what were paranoid beliefs and reality. There were instances of good practice when they insisted that Mr Y apologise to housing officers for his rudeness for example, but at no point did the team appear to suggest that Mr Y needed to take greater responsibility for resolving the housing situation.

### *Risk from others*

92. The nature of the risk from others – as reported by Mr Y - seemed to vary in terms of who he was at risk from and in what location. Variously, it appeared to comprise peers with whom he had previously offended, or friends/relatives of the victim of his index offence. LaCFT had consulted with probation and understood that there may previously have been a threat to Mr Y in Southwark; a later report by Mr Y that Scotland Yard had spoken to him about potential threats appears to have been taken at face value. It appeared from interviews with the team that no attempt was made to seek clarification from the police regarding the nature or extent of the potential threat because this did not occur to them as an option for a way forward.
93. In our view, it would have been reasonable to approach the police – either in terms of local MAPPA or with the Trust's local liaison officer – to seek clarification about the nature of the threat to Mr Y. This would have assisted the team in setting limits to the approach to finding accommodation, and team leadership in supporting the setting of those limits.

### *Girlfriend's significant personal event*

94. The significant personal event occurred in early June 2018 and Mr Y attended the funeral at the end of June 2018. It later emerged that Mr Y was involved with two women at the same time, and one of whom gave birth to his child in the few months before the serious incident. The team reported a mixed picture when Mr Y talked about

the significant event, with little indication of sustained distress. When seen the day before the serious incident (3rd January 2019), he shared a picture of his newborn child (with a different partner) and expressed feelings of joy to CCO 3 and Psy 2.

95. In our view, the team made reasonable efforts to disentangle Mr Y's account of his intimate relationships and his children; he was guarded when questioned closely. Although understandably upset in the weeks that followed the personal event, there was no reason for the team to think that Mr Y was concealing considerable distress during the weeks prior to the serious incident.

### *Charges for indecent exposure*

96. Mr Y was arrested on 6th September 2018 following an allegation that he had been masturbating on a train. The incident was reported as a Risk Event, and the Risk Assessment Tool in the electronic record was updated on 14th September 2018. However, no changes were made to the risk assessment because, as the team reported during investigation interviews, the police did not pursue the incident. Therefore, the Risk Summary contains no reference to sexually inappropriate behaviour; there is also no mention of the historical allegations of rape and grooming an underage child. This meant that the team did not link the incident on the train with the historical incident in their discussions.
97. No charge was pursued by the police. The CCO 3 and Psy 2 reported at interview that they attempted to address the incident with Mr Y who was dismissive and said it was a mistake; however, the clinical record does not indicate that Mr Y was challenged about his account, or that risk concerns were raised. Both staff members agreed that the behaviour was out of character for Mr Y and a potential indicator that his mental state was disturbed. An entry in the clinical notes on 14th September 2018 indicates that Mr Y reported a greater frequency of auditory hallucinations over the past two months and increased paranoia due to ingesting Skunk.
98. We accept that Mr Y's defensiveness when questioned about this incident would have made it difficult to be sure exactly what happened. However, the absence of a robust risk management approach meant that the LaCFT failed to make a connection between this incident – almost certainly an indication that Mr Y was at the very least intoxicated but also possibly mentally disturbed at the time – and the previous allegations against him regarding an alleged offence of rape and grooming an underage child. We would have expected the formal risk assessment to have been updated fully and reviewed, and for there to be evidence of a team discussion about sexual risk. It would have offered a good opportunity for the team to approach MAPPA or the Trust's police liaison officer to request more information regarding the historical events. Social Services may well have held historical information, and this could have been accessed via MAPPA.

## To review the effectiveness of the joint working relationship Lambeth Community Forensic Team (LaCFT) and accommodation staff and other relevant agencies involved

99. Mr Y was supported by three different housing providers during the time that he was on the LaCFT caseload; Penrose hostel staff, Lambeth housing team and Arun housing. For Mr Y accommodation was a priority, a pre-occupation that was raised at almost every meeting he had with mental health community staff.

*100.* Mr Y presented housing officers with extremely specific, somewhat uncompromising, demands about where and what he would accept as placement. Failure to achieve these onerous demands then led to abuse from Mr Y. Whilst Mr Y's care co-ordinator (CCO 2) certainly attempted to address Mr Y's behaviour regarding his housing situation this was not done in conjunction with the housing teams in the main.

101. There is good evidence of the responsiveness and creativity of Mr Y's care co-ordinator (CCO 2) to his demands about his housing, there is also evidence of the same care co-ordinator, with whom Mr Y had a good relationship, discussing and attempting to address Mr Y's behaviour with him in relation to his abusive communications. There is however a lack of evidence of effective, collaborative and informed joint working.

102. It is of note that Mr Y was not visited at his flat in Bognor Regis by any members of the team. We comment further on this period of his care in the Terms of Reference section focused on this period of time below.

## To review the management of documented history of risk of serious harm to others and use of weapons in both community and hospital environments (with specific reference to the Tribunal in 2015 and HCR-20)

103. The HCR-20 (completed 11th May 2015 while Mr Y was on Effra rehabilitation ward) was comprehensive and provided a good quality analysis of risk. Serious previous offending, weapon use and the potential for high harm in the community was all identified, as was the history of mental disorder and the negative impact of cannabis use on his mental health and his risk.

104. At that point in time, there was no attempt to seek clarification from social services or the police regarding the following historical concerns as this was not a particular concern of the ward team at the time: an early allegation of rape; safeguarding concerns regarding his children and his mother and siblings; and the nature and extent of any threat to Mr Y's safety from criminal peers. A 2009 reference to a report that Mr Y might have '*been grooming a 14-year-old girl and having sex with her*' was not referenced in the HCR-20. However, on balance, it is fair to conclude that clarifying these uncertainties was not a priority at that point in time but would have become relevant as Mr Y approached his release from prison on 7th March 2017.

105. The medical report to the Tribunal (dated 4th September 2015) is detailed and of good quality; the risk assessment is in line with the HCR-20 (dated May 2015) conclusions, and the recommendations for longer term risk management were reasonable and achievable. Both the HCR-20 and the subsequent medical report to the

Tribunal accurately record the risk of use of weapons - specifically the risk of assault using a knife - and this being potentially fatal.

106. The HCR-20 was referenced in the brief risk screen prior to Mr Y's release from prison. Thereafter, there was no evidence of any reference to the HCR-20 and it was not LaCFT policy to use this specialist tool. We have already commented that the risk assessment should have been reviewed at the time of discharge (see paragraph 82). Risk events were reliably recorded as they occurred, but the trust risk assessment tool was not always updated in a thorough and timely manner, and the analysis of risk in the Risk Summary section was limited. In particular we note the failure to note potential sexual risk in the risk assessment updated on 14th September 2018, one week after his arrest for indecent exposure.

107. The Trust Clinical Risk Assessment and Management Policy clearly lays out the expectations for risk assessment standards. Of particular relevance is:

- the guidance for information-gathering for risk assessment (paragraph 5.4) citing the importance of significant others and criminal justice agencies;
- the guidance for compiling a summary of risk with details of triggering and protective factors as well as estimating the severity, timescale and changes of risk (paragraph 6.3.4);
- the emphasis in the policy on the risk management plan as the '*main point*' of the risk assessment (paragraph 6.3.5).

**108. In our view the quality of the documented risk assessment by the LaCFT was not of the standard that we might expect from a specialist forensic service. Some of this related to the failure to seek clarification regarding outstanding matters such as the early allegation of sexual assault or the risk to Mr Y from others. However, perhaps more concerning was the lack of high-quality risk analysis evident in the Risk Assessment Summary; and the failure to make any significant adjustments to the risk plan in response to the serious risk events that occurred.**

**109. The failure as outlined in 108 above meant that risk management lacked breadth and was insufficiently robust; this was due to lack of clarity in the formulation as to what was driving the risks. There was a failure to link care plans sufficiently closely to the risk assessment and an excessive focus on supporting accommodation needs, from interview and review of documentation it appears that this was not discussed or considered to be required by the team**

## To review the management of Mr Y's substance misuse and anger issues and consideration of referral to appropriate services.

110. Mr Y had a long history of cannabis misuse, usually preferring high strength skunk. He has no convictions in this area, but his paranoid/psychotic symptoms were frequently linked to substance misuse since 2008, aged 25. He self-reported that it helped him to relax but the clinical teams in prison and the community were clear that substances triggered an exacerbation of psychotic symptoms. He was offered an evidence-based group intervention to address substance misuse; this was an appropriate service offer

but was not acceptable to Mr Y due to his paranoid traits and unwillingness to talk in front of other patients. The team did not offer any alternatives, such as individual work., as they were aware that Mr Y did not participate in groups and had not routinely actively engaged in 1:1 talking based therapies previously. Although LaCFT, and CCO2, did raise the need for Mr Y to reduce his cannabis use at times, but **we found no evidence of a rigorous assessment of substance misuse or a robust plan to address the concerns**.

111. In terms of anger issues, the 2015 HCR-20 refers to Mr Y's tendency towards emotional instability, in that he could become quite frustrated and verbally aggressive when challenged over breaching boundaries. There was evidence for this following his release from prison in 2017, with evidence of persistent irritability, several episodes of anger and verbal abuse, particularly in relation to accommodation issues. In our view, LaCFT focused on soothing Mr Y when he was agitated, rather than addressing the anger issues proactively or considering whether this was an indication of psychosis. An anger management intervention was not considered and although we accept that he may well not have welcomed or benefited from such an intervention, the team should have considered it at a review meeting. There appeared to be little or no discussion of whether irritability and anger may have been an indication of underlying psychotic illness and therefore whether a review of medication might have been appropriate to consider. **In summary, the lack of a shared team view about Mr Y's presentation and symptoms hindered effective management of the anger issues.**

**112. The elevated risk of violence posed by individuals suffering from paranoid symptoms and exhibiting significant anger does not seem to have been fully recognised by LaCFT as a current and significant risk concern. This was particularly notable given the additional evidence that cannabis use exacerbated Mr Y's paranoid state of mind and his level of agitation[7].**

## To explore the effectiveness of the care planning and management of risk specifically to others when residing in Bognor Regis

113. Mr Y moved to Bognor Regis in August 2018, placed in temporary accommodation by Arun Council. Immediately there were indications of paranoid thinking in relation to the upstairs tenants, as well as the keyworker from Arun Council. Within a few weeks the community team were uncertain as to whether he was staying in Bognor, spending time with a relative in Croydon, or with a girlfriend.

114. In interviews, both the CCO 2 and Psy 2 stated that they decided to maintain responsibility for Mr Y's care during his time in Bognor Regis because he was placed in temporary accommodation only, and because they anticipated that he might not settle there. There was no detailed discussion about the risk of harm that Mr Y might pose to

[7] See for example Beaudoin, M., Potvin, S., Giguere, C., Discepola, S., & Dumais, A. (2020). Persistent cannabis use as an independent risk factor for violent behaviors in patients with schizophrenia. Schizophrenia; and Witt, K., van Dorn, R., & Fazel, S. (2013). Risk factors for violence in psychosis: systematic review and meta-regression analysis of 110 studies. PLoS One, 8, https://doi.org/10.1371/journal.pone.0055942.

other tenants or to staff entering his property, nor was there any indication that they communicated the potential for Mr Y to keep weapons at his property.

115. **In our view, it was reasonable for the LaCFT to retain responsibility for Mr Y during the first few months of his time in Bognor Regis.** There was a good level of communication between the CCO 2and Arun Council; however, we were not assured that the nature of the risk to others was sufficiently clear to ensure that tenants and the key worker were safe. This includes the concern that Mr Y may have concealed a weapon in his room.

**116.** Best practice would suggest that the local community forensic team or community mental health team should have been involved in the handover, with a professionals meeting arranged. However, whilst the team had contacted the local service to identify housing options they did not consider any further contact as they were not planning to transfer Mr Y's care. **At the very least, we would have expected LaCFT to communicate with the relevant service in Bognor Regis, to alert them to Mr Y's presence in their catchment area.**

## To explore and understand the management and actions taken following safeguarding concerns.

117. The investigation team has not received any documented evidence of any actual risk incidents involving Mr Y and any of his children after his release from prison in 2017.

118. Throughout Mr Y's contact with the Trust services, he is noted to have regularly discussed his children, who they lived with and his level of contact with them. Latterly in May 2018 he told LaCFT about a previous partners significant personal event, it later transpired that this was a partner who he continued to visit and who supported him to attend outpatient appointments. Later in 2018 he showed Psy. 2 photographs of his new baby daughter by a girlfriend who was living with her parents.

119. There are nine child risk and need screens completed and filed in Mr Y's records and there are regular references in the contemporaneous clinical records to clinical staff concerns. On each occasion, the teams involved responded '*No*' to the question '*are there concerns whether the child (ren)'s needs are being met*?'. A positive response to this question prompts further action within the Trust template.

120. During 2018 Mr Y's care co-ordinator (CCO 2) and psychiatrist (Psy. 2) both describe having been given selective or contradictory information by Mr Y about current relationships. Mr Y was guarded on this topic generally, seemingly avoiding providing details (including the names of baby's mothers) which would enable further exploration. Mr Y told the team about both a new baby and at similar time about a significant personal event. Psy. 2 says that he did not have any concerns about Mr Y's risk to these women and the baby however in his clinical record of 11th October 2018 he suggests that a decision needs to be made about whether Children and Families services should be informed. There is no further reference in the records to a team discussion about this decision. CCO 2 however completed five child risk and need screens during 2018 and it is of note that of which none identified a need to take further action. CCO 2 however does describe Mr Y as being avoidant of sharing information with the team which he ascribes to Mr Y knowing that the team would have to share this information. Both CCO 2 and

CCO 3 reflected on the situation in interview saying that they should have shared the limited information that they had with the child safeguarding team. The team did not discuss this with the Trust child safeguarding lead for advice as they did not consider that they held sufficient factual information to enable effective action to take place.

**121. It is evident that throughout Mr Y's contact with the Trust the teams working with him had an awareness of the potential risk that Mr Y posed to his own children. There is also evidence of consideration as to the need to share information with child safeguarding teams. Trust policy was followed regarding completion of the appropriate screening tools however at a point where sharing information with these teams may have been required this was not done as it was not considered necessary by the team at the time.**

**122. Further action from the team at the time might have included a conversation with the Trust child safeguarding lead, social services or to have considered as part of a referral to MAPPA. If the team had fully reviewed this case and developed a shared formulation at regular case management meetings and with effective clinical leadership support, we would have expected for such action to have been advised.**

## TRUST INVESTIGATION (drawn from the standard NHS England Terms of Reference)

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

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

123. Overall, the Trust investigation was reasonably thorough and arrived at several understandable conclusions. A number of these are replicated in our own investigation.

124. However, we feel that the Trust investigation fails to emphasise sufficiently two particular areas of concern:

- Although Mr Y's psychiatrist (Psy 2) in LaCFT knew Mr Y from his 2015 inpatient stay, there was a missed opportunity for the wider LaCFT to develop a longer-term plan for Mr Y's care in the community at the point he was an inpatient at River House. This would then have enabled them to update such a plan at regular intervals over the next two years until he was released from prison having held a Section 117 meeting.
- The negative impact of the LaCFT's failure to develop a shared view of how best to manage Mr Y's risk in light of his personality and symptoms, with the result that a narrow focus was adopted, with a lack of clinical leadership evident.

125. We have examined the action plan and the evidence provided to demonstrate completion and have the following views on each of the actions outlined in the plan (see headings below):

**Ensure the process for transfer of care is underpinned by the forensic mapping and ELT pathway.**

- The forensic mapping is good – as described in a diagram - and we heard strong evidence for the efficacy of the pathways liaison role linking the ward to the community.

**HCR-20 in the community should be completed using Trust risk tool protocol agreed by South London Partnership (SLP)**

- The HCR-20 process in the community was written as a protocol in September 2020. The protocol is sensible, defensible, and proportionate. However, we have not seen any audit of implementation of the protocol which – on the action plan – is scheduled for 12 months post implementation. The Trust has informed us that the audits in the 4 teams were not consistently implemented. In 2021 two of the four teams completed an audit.

- We also believe that the Trust's proposal '…..*to reduce caseload sizes to enable rapid community response and offer access to more therapeutic interventions*' included in the '*Transformation of community forensic services*' business plan that has been

shared with us will serve to support the completion of specialist but essential assessments such as the HCR-20 risk assessment at the point of transfer into the team.

- We understand that the team reviewed the relevant protocols in December 2021 and January 2022 and there is now a shared understanding of the type of incident which would trigger a full review of an existing HCR-20.

- The primary risk tool in the team remains the Trust standard risk assessment tool with a minimum expectation of review annually.

**Implement trust risk tool protocol for community completion of HCR-20 MDT risk triage process**

- See above. This action appears to be almost a duplicate of the previous action.

**Strategic review to ensure that psychology provision is adequate to the scale of needs of the LaCFT service.**

- As referred to above we note the undated document titled '*Transformation of the community forensic services'* business plan that has been shared with us and which we understand is going through internal Trust governance processes for approval. This outlines remodelling of the forensic community team establishments including addressing the psychology provision. However, given the action above was meant to be implemented by December 2020 and this has yet to be completed, this now requires further action. We note that the Trust cycle of business may have been affected by the global pandemic. We also note information shared with us from the Trust that the business plan was discussed by the Trust in November 2021 with the following outcome '…….*confirmed that majority of the transformation work has already taken place in forensics, however there's still a gap in local interface……. Decision was made that Forensics improvement project can remain in the Right Care Programme and can report quarterly to the Right Care Programme Board'.* We consider however that this action requires expansion to address the significant individual caseloads held by the members of LaCFT and evidence of lack of leadership that we identified and noted throughout this investigation. We note that average caseloads at the time of the incident in 2019 were 24-26 per worker and in January 2022 they remain at 24 per worker on average.

- Implementation of the proposals within the Transformation document would serve to address these issues. We note particularly that one of the objectives of the programme is to '*Increase staffing levels and recruit specialist staff in order to reduce caseload sizes to enable rapid community response and offer access to more therapeutic interventions'*. We support this principle.

## QUESTIONS FROM VICTIM'S FAMILY

***Police in Farnham didn't check him – shouldn't they check his history and mental health when he was acting anti-socially?***

126. Mr Y was not managed under Multi-agency Public Protection Arrangements (MAPPA) and therefore there was not a mechanism in place for informing the police about him in any routine way. When he came into contact with the police - for example when he was arrested for alleged indecent exposure - the police communicated with mental health services.

***He wasn't living in Bognor Regis but in Farnham, shouldn't he report of his change of address?***

127. As above, as Mr Y was not managed under MAPPA and there was no formal obligation for him to report his whereabouts to any agency.

***Why police called to Farnham address didn't check on him or if they did, could they not take him in for and assessment. He is a mental health patient after all.***

128. Our understanding is that Mr Y's formal address was in Bognor Regis and it was in fact only after the serious incident in January 2019 that he was found at his girlfriend's address in Farnham. It is clear that Mr Y had been unwilling to reveal details, such as addresses, about girlfriends to the mental health team. As Mr Y is an adult who had capacity and who was being managed as an informal patient, the team had no right to insist that he shared such details.

***There is a poor communication between mental health department and police.***

129. As above, as Mr Y was not managed under MAPPA we have concluded in our investigation that whilst there may have been some missed opportunities to ask for further information from the police about others who may have been threatening to harm Mr Y, generally information was shared when required such as at point of arrest.

## SUMMARY

130. Mr Y had a settled early life until becoming involved with an antisocial peer group at secondary school which led to the start of his offending during adolescence. His first violent offence was related to his misuse of substances and associated paranoid traits and symptoms.

131. Concerns about Mr Y's mental health emerged in 2007, the view being that he may be experiencing a developing psychotic illness, and that his substance misuse aggravated symptoms, leading to evidence of mental distress and hearing voices. The lengthy custodial sentence that he received in 2010 for a serious violent offence led to him spending a year in hospital in a secure inpatient unit in 2015 before being returned to prison. Mr Y was subsequently accepted onto the caseload of the Lambeth Community Forensic team; the community team managed him after release from prison in 2017 on an informal basis as he had previously been recalled to prison and had served his full sentence.

132. Although we have identified a number of learning points from this investigation, we note that the care and support provided to Mr Y during his inpatient stay at River House was of a good standard, as was the liaison between the Lambeth Community Forensic Team (LaCFT) and the prison mental health in-reach team. The learning points identified relate to the care and support provided by LaCFT during the two years post release from prison.

133. We will not reiterate our conclusions to the questions posed by the Terms of Reference here, as they are laid out in full in the previous section. However, there are two important themes that emerged as a result of our investigation and our reflections on the learning:

- First, we acknowledge that Mr Y was at times intensely distressed by the way in which his life was progressing and by his mental health difficulties. Nevertheless, we have no doubt that he posed considerable challenges to the LaCFT in terms of the support and supervision that they may have wished ideally to offer him. These challenges were of a degree that any team would have struggled to manage. They included Mr Y's repeated rejection of the therapeutic interventions offered, his mixed feelings about his diagnosis (and whether in fact he wanted help at all), and his intimidating presentation at times of agitation. He chose to engage with the team exclusively on his own terms, and the nature of his paranoid thoughts and feelings was such that he was always guarded and selective about revealing details regarding his social network and daily activities. It is therefore fair to say that although we raise a number of learning points for LaCFT and the Trust, we are by no means confident that by attending to these issues, the team would have significantly reduced the potential risk of violence that Mr Y posed to others; we acknowledge that Mr Y might have disengaged from the team as a result.

- Nevertheless, our second observation relates to an overarching theme of concern that we raise in relation to the team's management of Mr Y. This could be

summarised – in our view – as the lack of a stable, cohesive, well-led and nurturing multi-disciplinary team structure which could facilitate the development of excellent care planning and risk management. This left the management of a complex individual who posed challenges to the delivery of care, to be carried out in an environment that felt unsafe. As a consequence, we felt that there was:

- A notable absence of team reflection over a two-year period, leading to a lack of robust review around medication, care planning and risk management.
- A reactive rather than proactive approach to managing Mr Y, including the failure to set out clearly in advance the boundaries to acceptable behaviour and the limits to support.
- A failure to protect staff from the psychological impact of behaviour that could be intimidating, and which could, at times, inhibit the care provided or the effective risk management that might otherwise have taken place.

## NEXT STEPS (Recommendations)

134. We have one recommendation to make with the aim of addressing our comments in paragraph 136 above. That is, we recommend that the trust develop a stable, cohesive, well-led and nurturing multi-disciplinary team within LaCFT, addressing three areas:

- Staffing profile.
- Performance.
- Cultural ethos.

It is a matter for the Trust to provide a detailed action plan for us to approve. We suggest – given our support for the Transformation of Community Forensic Services document – that the Trust use this as a baseline on which to build.

This recommendation has been developed collaboratively with the Trust and has their agreement.

## APPENDIX I: CHRONOLOGY

Sources: Clinical records provided by NHS Trust internal SUI report.

| Date | Event |
|---|---|
| March 1983 | **Date of Birth** |
| | **1999-2003** |
| 1999 - 2008 | PNC printout (from SI report).<br>11.06.99 – Balham Youth Court – Burglary and theft (dwelling); 12 hours attendance centre.<br>22.10.99 – Southwark Juvenile Court – Destroy or damage property; fine £15 costs £10.<br>01.11.99 – Balham Youth Court – Burglary and theft (dwelling); 2 years supervision order.<br>15.12.99 – Lambeth Juvenile Court – ABH; 80 hours community service order. Failing to surrender to bail; fine £10.<br>10.04.02 – Croydon Magistrates Court – Possessing a bladed article (on 26.03.02); fine £100 costs £55.<br>10.04.02 – Balham Youth Court – Possessing a bladed article (on 25.12.00); fine £100 costs £55.<br>01.10.02 – Plymouth Magistrates Court – Damage property; community rehabilitation order 12 months, compensation £250 costs £55.<br>13.02.04 – Leicester Crown Court – Possessing a small firearm, possessing ammunition without a certificate, obtaining pecuniary advantage by deception, using a vehicle while uninsured; sentenced to a total of 2 years and 6 months imprisonment in a young offender institute. |
| | **2003 – Age 20 years** |
| 2003 | First contact with mental health services HMP YOI Leicester |
| 09.10.2003 | Sussex (north) Magistrates Court –disorderly behaviour or threatening/ abusive/insulting words likely to cause harassment alarm or distress; fine £100 |
| 13.02.2004 | **2004 – Age 21 years** |
| | Leicester Crown Court – Possessing a small firearm, possessing ammunition without a certificate, obtaining pecuniary |
| | **2007 – Age 24 years** |
| 09.2007 | Referral to Mental Health services (SLAM). Recorded as hostile and aggressive, concerned with accommodation issues. Talked about carrying a knife in public. Complained of hearing voices telling him to kill people he thought were going to harm him. |
| | **2008 – Age 25 years** |
| 30.04.2008 | Arrested at Crawley train station by British Transport police for an altercation involving threatening another passenger on a train. Admitted to PICU on S. 2 MHA. Initial impression was that symptoms were as the result of cannabis use. |

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| **1.05.2008** | Contact from the police made to the ward requesting that they be informed of discharge in order that they be able to follow up on incident that he was arrested for. Wanted by 3 other forces at point of arrest. |
| **20.05.08** | Discharged to live at mothers home, referred to community mental health team for 7 day follow up. |
| **ICD -10 Diagnosis 20.5.2008** | Primary – F.23 Acute transient psychotic disorder<br>Secondary 1 – F.12. Mental & behavioural disorder due to use of cannabinoids.<br>Secondary 2 – Dissocial Personality Disorder (PD)<br>Secondary 3 – F.60 Paranoid PD<br>*'These diagnoses need further assessment over a several month period to determine their stability. However, there are clear longstanding features of an antisocial PD with complicating paranoid PD traits. The transient psychotic features are very brief lasting only hours or days. They are self-remitting and Mr Y only reports them at times of crisis. He quickly denies symptoms afterwards. It is not possible to outrule malingering/feigning symptoms in the context of secondary gain such as supporting a case for housing, avoiding incarceration, or accepting responsibility for his violence'.* |
| **06.2008** | Referred to in ePJS 04.09.2009 record – Seen by court diversion in Brighton following arrest in Brighton. |
| **13.06.2008** | Sussex (central) Magistrates Court – Destroy or damage property; fine £65. |
| **18.08.2008** | Croydon Magistrates Court – Burglary and theft (dwelling); 4 weeks imprisonment. |
| **09.08.2008** | Leicester Crown Court – Facilitate the acquisition/possess criminal property, intimidating a witness; 12 months imprisonment. |
| | **2009 – Age 26 years** |
| **14.04.2009** | Record that MAPPA not holding case – 'level one'. Also reference to report that Mr Y might have 'been grooming 14-year-old girl and having sex with her' |
| **07.05.2009** | Seen by Care co-ordinator (CC) at CMHT – talking about being paranoid and having 'knives all over the flat' |
| **07.07.2009** | Index Offence: Mr Y got into an argument with the victim on returning to his hostel accommodation from his warehouse nightshift job. He was carrying his work tools, including a cutting implement used to cut straps. According to Mr Y, the victim asked him for money owed to him by Mr Y. The man allegedly hit Mr Y who retaliated by stabbing him in the neck, severing his carotid artery and requiring extensive emergency surgery. Mr Y reportedly evaded capture for a few months before he was apprehended by the police. |
| | **2010 – Age 27 years** |
| **18.02.10** | Inner London Crown Court – Convicted of wounding with intent GBH (index offence); 7 ½ years (4 ½ years custodial with an extension period of 3 years). |
| **06.07.2010** | Transferred from HMP Brixton to River House MSU s.47/49 plan to fully assess and plan future management. |

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| **ICD 10 Diagnosis 11.08.2010** | Primary F20 Schizophrenia |
| | **2011/12 – Age 28/29 years** |
| **04.03.2011** | Transferred back to HMP Brixton. |
| **ICD 10 – Diagnosis 4.3.2011** | Primary F20.0 – Paranoid Schizophrenia |
| **12.2011 – 2.2012** | GP referral back to community mental health services. |
| **ICD 10 Diagnosis 17.09.2012 (2)** | Primary – F12.5 – Mental & behavioural disorder due to use of cannabinoids. |
| | **2013- Age 30 years** |
| **18.3.2013** | Referred to forensic team for advice. |
| **14.11.2013** | GP alerted team that Mr Y had informed him that he (Mr Y) was in danger of killing himself or others. MHA assessment attempted. |
| | **2014 – Age 31 years** |
| **14.04.2014** | Referral made to forensic team to request professionals meeting to re-evaluate risk and plan care. |
| **01.10.2014** | Referred to forensic service for care management and intervention. |
| **16.10.2014** | Recalled to prison after he breached his parole conditions. Information from his probation officer stated that the reasons included that he was at an address that had not been approved and that there was violent and aggressive behaviour towards family members. |
| | **2015 – Age 32 years** |
| **09.03.15** | Transfer from HMP Thameside under Section 47/49 to Thames [Acute] ward at River House MSU |
| **20.03.2015** | Ward review. Apart from some initial anxiety since his transfer from the prison, Mr Y was settled in terms his mental state. He became confrontational and agitated if requests not met immediately. He attended the gym regularly and some of the ward organizational meetings. Mr Y asked to move to Brook rehabilitation ward where he had been an inpatient during 2010-2011. |
| **03.04.2015** | Concern that he was not feeling safe on the ward because of another patient. According to him, the patient was a cousin of the victim of Mr Y's index offence and had made threats against him. |
| **06.04.2015** | Returned back to Thames ward when the other patient moved to Norbury ward [PICU]. He presented as unsettled on return to Thames. |
| **07.04.2015** | Argument with another patient which escalated to the point where staff had to call the Response Team to diffuse the situation and prevent a physical altercation. |
| **08.04.2015** | Ward round. Mr Y not engaging in any therapeutic groups / activities. He was preoccupied with his safety on the ward and requesting to be moved to another ward. |

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| **15.04.2015** | Altercation between Mr Y and another patient who threatened to kill him. Transferred within the MSU to Effra ward, rehabilitation ward |
| **20.04.2015** | Ward round. Mr Y reported that he was paranoid in prison because he was in a confined space. He also reported that he had been depressed following the ending of his relationship with ex-girlfriend and hearing voices with a derogatory content. He said that his mental state improved with medication. He denied using illicit substances and became irritable and aroused when this challenged. |
| **22.04.2015** | Professionals Meeting. Community RC and CC attended. Diagnosis discussed. Inpatient consultant recommended that Mr Y should remain in hospital to continue treatment, and be discharged via the hospital route, following a Parole Board Hearing. This would facilitate his engagement in aftercare and placement |
| **05.05.2015** | Ward Round - unsettled, demanding and challenging at times. Suspected of smoking and trading contraband with a patient on Thames ward. Compliant with medication and OT groups. At interview he presented as relaxed and interacted well. He was somewhat irritable and dismissive regarding the team's concerns about trading and security breaches. |
| **10.05.2015** | Concerned raised about possession of contraband. Response Team searched Mr Y's room. During the process he was very loud, resistive, threatening, and abusive towards the team. Contraband found and Y became aroused and threatening He was offered PRN Promethazine 50mg which he accepted and became more settled |
| **19.05.2015** | Ward round. Discussion about whether behaviour was driven by his anti-social personality. Not engaging in any meaningful therapeutic work. The team discussed option of returning him to prison. |
| **23.07.2015** | Effra ward RC made referral to Personality Disorder Service (Forensic Intensive Psychological Treatment Service; FIPTS) on Waddon ward, as it was felt that specific treatment of his personality disorder was required, in the form of a violence reduction programme, as his presentation was dominated by concerns related to his behaviour and risk. Mr Y was aware and agreed to referral. |
| **19.08.2015** | Mr Y attended meeting to discuss Waddon ward referral. Expressed that he would be interested in going to Waddon but had some concerns about discharge as he had applied for a tribunal and if this was successful he intended to apply for a parole hearing. |
| **20.08.2015** | Transferred from Effra to Waddon ward, for assessment regarding suitability for the Violence Reduction Programme. |
| **ICD 10 – Diagnosis 04.09.2015** | Primary F20.0 Paranoid Schizophrenia<br>Secondary F60.2 Dissocial PD. |
| **8.9.2015** | Ward review – Professional's discussion. Assessed as presently unsuitable for Waddon Ward. Appeared to have a diagnosable PD, but noted to not be in clear agreement with diagnosis or sufficiently committed to treatment at time. |
| **22.9.2015** | Transferred from Waddon ward to Effra ward |

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| **28.09.2015** | CPA review recommended return to prison, to continue his sentence and be released from there via parole board |
| **06.10.2015** | Letter from Mr Y's solicitor stating that Mr Y wanted to remain in hospital as was willing to engage with Waddon programme and asked for a second chance to engage |
| **06.11.2015** | Transferred to HMP Highdown |
| | **2016 – Age 33 years** |
| **09.06.2016** | Lambeth community forensic team (LaCFT) worker attended CPA review at HMP Highdown jointly with his care coordinator from the In-reach mental health team, Mr Y had a parole meeting previous week, turned down for early release. No further paroles until the end of sentence on 20/03/2017. The HMP Healthcare team had reviewed his case and had not supported a referral to personality disorder services. Aftercare arrangements discussed and Mr Y agreed to referral to Focus project for supported accommodation. |
| **03.08.2016** | Referral to River House MSU from Highdown for a Gatekeeping Assessment relating to an urgent admission to a Medium Secure Forensic Inpatient Unit. Reported to be experiencing a relapse in his psychosis, in the context of Paranoid Schizophrenia reported that he was hearing voices. Symptoms not being treated with his current olanzapine prescription. Also experiencing low mood, not treated (by?) Mirtazapine. |
| **15.08.2016** | Pre-admission assessment at HMP Highdown Objectively appeared in low in mood and clearly described symptoms consistent with his working diagnosis of Paranoid Schizophrenia |
| **19.08.2016** | Referral/assessment discussed in the MSU pathways meeting. Decision taken not to accept referral because *"It appears his recent deterioration in mental state was precipitated by him having access to and taking illicit substance's*. Inreach team informed, and referral closed. |
| **17.1.2016** | Joint review of progress between Lambeth Community Forensic team liaison worker and healthcare staff at HMP Coldingley where Mr Y had been transferred. Mr Y expressed anxiety about his future, in particular accommodation arrangements. |
| | **2017 – Age 34 years** |
| **09.01.2017** | Lambeth community team contacted probation officer as part of setting up aftercare (post release) arrangements. Requesting information related to restrictions / exclusion zones and MAPPA level. Probation officer confirmed that Mr Y was level 1 MAPPA and not subject to multi agency meetings. |
| **01.02.2017** | Alert noted that Mr Y was a registered category 1, level 1 MAPPA. |
| **07.03.2017**<br>**20.03.2017** | Mr Y was released from prison<br>Moved into Penrose Hostel at Leander Road. |
| **04.08.2017** | Discussed at Lambeth Community Forensic Team (LaFCT) team meeting. Not engaging well with staff at accommodation. Had an altercation with the contractor fixing his toilet. He did not attend appointment with his CC, and MH Advocate. |
| **09.2017** | Correspondence with Mr Y's solicitor re: his concerns that his safety was under threat from associates of the victim of his index offence. |

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| **10 / 11.2017** | Intermittent engagement with care coordinator, complaints and uncooperative with hostel |
| **7.12.2017** | CPA Review Update from Penrose: Behavioural problems continued not allowing staff to carry out Health and Safety checks and necessary requirements in his area. Warning letter completed but staff decided not to give him because of his threatening presentation. He had declined all five-placement offered. Team's view was that his behaviours were not due to mental illness, but personality. Penrose hostel to follow eviction process, and to hand him warning letter at CPA |
| | **2018 – Age 35 years** |
| **6.1.2018** | Seen by RC at his request complaining of poor sleep and increasingly paranoid about everything. Started shouting in OP reception where he was complaining that the reception staff were rude to him and had failed to open door when he rang bell. Complained about not getting the flat he was confident he would get. |
| **26.02.2018** | Reported that Mr Y came down the stairs shouting obscenities at a male and female support staff (Penrose). Then shouted that the house was dirty, complained that there were faeces on the toilet, on the tap and on the floor which prevented him from using the shower room. Male support staff told him the cleaners were coming and, in his presence, immediately called the Team leader in the office to find out how long it would take for the cleaners to arrive. Mr Y ran upstairs and then threw fire extinguisher downstairs, shouting threats. |
| **12+23/03/2018** | Resident at hostel reported Y had been threatening to him |
| **23.04.2018** | Staff at hostel reported that Y was verbally abusive and physically aggressive to staff. He was making threats to kill and bashing the office door with the fire extinguisher. Mr Y had gone into his room and returned with what looked like a knife still yelling that he was going to kill the member of staff. Police called and Y was arrested. Later evicted from hostel and bailed to live with his uncle in Croydon. |
| **24.04.2018** | Assessed by Consultant Forensic Psychiatrist in Brixton Custody suite following arrest for incident at Hostel, alleged offence recorded as Murder theat. During time in custody made racist remarks and threats to numerous custody staff. Risk summary includes Risk to others as *'High'* |
| **26.04.2018** | Medical review in OPD . Angry at events leading to charge of threats to kill. Feeling under stress and had not sleep well since the arrest. Bailed to father's address. |
| **27.05.2018** | Email from Mr Y to CCO1 confirming girlfriends significant personal event. |
| **12.07.2018** | Medical review OPA with Responsible Clinician Psy.2 and CCO. Y reported feeling depressed despite taking Mirtazapine 45 mg. Worried about eldest son who appears depressed [has ADHD and takes cannabis regularly]. Advised to get referral for him from GP to local CMHT. Discussed previous conversation with ARUN housing officer as classified by them as vulnerable person who is street homeless, They will look for self-contained flat equivalent because of history. |

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| **24.07.2018** | email from Arun Council confirming Ps move into Bognor Regis, West Sussex. |
| **16.08.2018** | New care co-ordinator CCO3 allocated to Mr Y |
| **17.08.2018** | Telephone call from Mr Y to CCO 1 Pressured speech during this call and could not tolerate interruptions for about 10 minutes. As the conversation progressed, he was able to tolerate longer responses and appeared calmer as the conversation continued. Themes of frustrations: Arun Council + temporary accommodation + noisy neighbours. Reported that he overhears the neighbours "*talking about me*." Believed the neighbours drop things on the floor to deliberately antagonise him Taking medication to help him sleep but the noise makes it unbearable to stay in; stays at "other peoples" [reluctant to confirm if this is his girlfriend or uncle's place] at such times but ends up asking them to pick him up rather than use public transport because he is too anxious outside. Attempted to stop using Cannabis at the start of July but had restarted as it helped to calm him but acknowledged it's contribution to paranoia-like symptoms |
| **06.09.2018** | Telephone call between Y and CCO3 Contact from Police and Court Liaison. Mr Y arrested after an allegation was made that he had been masturbating on a train. |
| **14.09.2018** | Attended OPA with Psy.2 CCO 3 and advocate. Hearing voices more frequently over the previous 2 months giving a running commentary and make him feel paranoid increased by using Skunk. Wanted to reduce or stop mirtazapine. Planned not to take skunk. Had been promised alternative accommodation and was bidding. Accommodation at time was a flat in Bognor Regis but upstairs neighbour very noisy. In regular contact with mother, worried about 18 yr old son who was taking drugs and lacking in ambition. Angry at recent arrest and denied masturbating in public. |
| | **2019 – Age 36 years** |
| **03.01.2019** | Attended medical review with Psy.2 and CC3 RC - After discussion about Mirtazapine plan to break tablet into 2 and take half for following 2 weeks.<br>Plan was to support him with information about First Step. Will research Raw sounds. Felt that he was unlikely to get accommodation he needed so would consider another borough e.g. Bromley not Lambeth or Croydon. Noted that the RC would try and review in further 2 weeks. Care coordinator noted that he appeared neatly kempt, pressured in speech, somewhat easily excited but pleasant on approach had started driving lessons and was made aware DVLA regulations in line of his mental health needs, said he was aware and knew what to do when he gets the license. said awaiting surgery secondary to shoulder injury showed (RC and CC) pictures of his 4-month-old son. Refused to disclose baby mother's name. Reported older sons relatively ok and still lived with his mum, 16-year-old continues to use cannabis advised to seek GP support and behavioural problems complained about upstairs neighbours noisy and that he was recently called racist remarks in Bognor Regis by another black lady. showed (Psy.2 and CCO3) pictures of his very clean flat which he said he |

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| | liked but only had issues with neighbour. It was noted that he seemed to think they made noise just to wind him up. Noted that he had a court case on 18th January following an incident when at Leander Road with staff and trashing a police cell when detained. Said Medication ok but prefers Olanzipine velotabs Psy.2 was to email GP to amend prescription. |
| **05.01.2019** | Mr Y was arrested and charged with murder and possessing an offensive weapon, following the stabbing of a man on a train travelling between Guildford and London Waterloo on 4 January 2019. |

## APPENDIX II: TERMS OF REFERENCE

Psychological Approaches

To review the care planning and risk assessment between agencies prior to his release from prison in March 2017.

To review the risk management of escalating risk/stress factors and actions taken, with reference to the following;

- Charges for indecent exposure
- Accommodation
- Intimidation to female staff (fire extinguisher and offensive weapon)
- Girlfriends' significant personal event.
- Risk from others

To review the effectiveness of the joint working relationship Lambeth Community Forensic Team (LaCFT) and accommodation staff and other relevant agencies involved.

To review the management of documented history of risk of serious harm to others and use of weapons in both community and hospital environments (with specific reference to the tribunal in 2015 and HCR-20) · To review the management of Mr Y's substance misuse and anger issues and consideration of referral to appropriate services.

To explore the effectiveness of the care planning and management of risk specifically to others when residing in Bognor Regis

To explore and understand the management and actions taken following safeguarding concerns.

## APPENDIX III – DOCUMENTATION READ AND INTERVIEWS HELD

### Documentation

South London and Maudsley NHS Foundation Trust's internal investigation report (dated 8th October 2020) titled '2019 368 WEB81802 report to CCG (Trust report)

South London and Maudsley Clinical Records Mr Y (2007 – 2021) as follows:

- ePJS – Events and clinical notes full summary
- ePJS – Care plans and CPA reviews
- ePJS – Third party and sensitive information
- ePJS – Outcome files
- ePJS – MHA, MCA and DOLS file.
- ePJS – Core information summary and client information sheet
- ePJS – Movement summary
- ePJS – Risk records

South London and Maudsley Clinical Policies as follows:

- Safeguarding Adults Policy V.2.3 (2016)
- Safeguarding Adults Policy V.3 (2020)
- Policy for Clinical Risk Assessment and Management of Harm V.2.3 (2015)
- Policy for Clinical Risk Assessment and Management of Harm V.3 (2020)
- MAPPA Protecting Children and the Public, Working with Multi-agency Public Protection. V.3 (2017)
- MAPPA Protecting Children and the Public, Working with Multi-agency Public Protection V.4.1 (2021)
- Safeguarding Children Policy, Principles and Procedures. V.5 (2015)
- Safeguarding Children Policy, Principles and Practice. V.6 (2020)

Trust internal SI Action plan and evidence
Medical Report for the First Tier Tribunal (Mental Health) Dated 4.09.2015
HCR-20 V3 Risk Assessment Dated 11.05.2015

Transformation of the community forensic services document (undated)

Minutes: Right Care Programme Board - South London and Maudsley
Dated Tuesday 16th November 2021

### Interviews

- CCO 2: LaCFT community psychiatric nurse (also provided a supplementary fact checking interview)
- CCO 3: LaCFT community psychiatric nurse
- Psy 1: Consultant Psychiatrist and Responsible Clinician, Effra ward

- Ward manager, Effra Ward (current)
- Psy 2: Consultant Forensic Psychiatrist LaCFT and Responsible Clinician, Waddon ward.
- Deputy director, Croydon services and forensic services.

**Interview requested:**

- Arun Housing Office (no response)
- Team Leader at time of incident (unavailable)

*Note: All staff interviewed were given the opportunity to review the report and send in factual accuracy corrections prior to this report being shared with NHS England.*

## Contact with interested parties

### *Contact with Mr Y*

Mr Y was invited to take part in the investigation but he did not wish to be involved at the start of the investigation; he was able to raise questions at any point.

### *Contact with the victim's family*

The family of the victim in this case met with representatives of NHS England and asked questions that they wanted to be considered as part of the investigation. The investigation response to these can be seen at paragraph 126-129.

### *Contact with Mr Y's family*

Members of the investigation team spoke to Mr Y's family by telephone as part of this investigation.

All interested parties are thanked for their responses to requests made to them as part of this investigation.

## APPENDIX IV: PSYCHOLOGICAL APPROACHES CIC

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

### Lead investigator

**Rebecca Hills, Associate, and Registered Occupational Therapist**

Rebecca has worked in mental health, primarily forensic mental health, since 1987 and held a range of senior leadership and management posts. Most recently she was operational director for an NHS forensic mental health service in Southeast England. She has experience of working in and managing prison mental health services. She has also held posts as both deputy and assistant chief operating officer in a large mental health Trust.

### Co-investigator

**Dr Jackie Craissati, Consultant Clinical & Forensic Psychologist, and Director of Psychological Approaches**

Dr Craissati has 30 year's experience in working in forensic and prisons directorates and was previously Clinical Director of such a service. Of particular relevance to this investigation is that she is national consultant advisor to the offender personality disorder pathway and specialises in the community management of individuals with serious offending histories and personality difficulties. She currently chairs the board of a mental health trust and was previously chair of the quality committee of the trust; she therefore has a detailed knowledge of matters pertaining to patient safety.

### Psychiatric advisor to the panel

**Dr Celia Taylor, Consultant Forensic Psychiatrist and associate.**

Dr Taylor trained at the Institute of Psychiatry, and then worked at Broadmoor Hospital before establishing a private medium secure specialist service for people with personality disorder. For the past 17 years she has developed and run the specialist personality disorder MSU in East London as well as working collaboratively with the probation service in London and delivering specialist OPD pathway services in prison.

## APPENDIX V – GLOSSARY OF STAFF ROLES

Psy. 1 Consultant Psychiatrist and Responsible Clinician, MSU
Psy. 2 Consultant Forensic Psychiatrist, LaCFT
CCO1 Care co-ordinator 1
CCO2 Care co-ordinator2
CCO3 Care co-ordinator3