VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr K

A report for
NHS England, Midlands and East Region

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Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

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1. Introduction

Mr K committed a homicide in 1985. He was convicted of manslaughter by reason of diminished responsibility and received a hospital order with restrictions without limit of time. He lived in the community from 2003 after treatment in a high secure hospital and a low secure rehabilitation ward. He was discharged from Mental Health Act restrictions in 2006. Mr K stabbed and killed Jane Edwards at her home on 14 December 2010. He was found guilty of murder and was sentenced to a minimum of 26 years in prison.

This independent investigation relates to the care and treatment the NHS, the local authority and other relevant agencies provided to Mr K from his first contact with services until the killing of Jane Edwards.

1.1. Background to the independent investigation

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

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

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

The Chief Executive of South Staffordshire and Shropshire Healthcare NHS Foundation Trust commissioned an internal trust investigation into the care and treatment of Mr K.

The trust investigation team made two recommendations and developed an action plan to realise them.

1.2. Overview of the Trust

The Trust provides mental health, learning disability and specialist community and inpatient services across South Staffordshire and mental health and learning disability services in Shropshire, Telford & Wrekin and Powys.

It has medium and low secure forensic treatment and rehabilitation centres for male patients and also provides an in-reach service[1] for local prisons. The Redwoods Centre was opened in September 2012 to replace the in-patient services originally provided at the Shelton Hospital mentioned in this report.

[1] The prison in-reach mental health team provides mental health services for those in prison.

2. Terms of reference

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with victim support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the commissioners that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post investigation evaluation.

This investigation will focus on the above issues and will examine the clinical pathways from high security forensic services to general adult community services. We examine how these services ensure their risk management plans are robust and keep clinical issues current and the circumstances that led to the patient's original involvement with forensic services.

3. Approach of the independent investigation

The investigation team referred to as “we”, comprised Chris Brougham, Verita Director, Geoff Brennan, Verita senior consultant, Dr Mostafa Mohanna, a general psychiatrist and Dr Martin Locke, a forensic psychiatrist.

We examined a range of national benchmarks of good practice, including National Institute for Health and Care Excellence (NICE) guidance and other good practice guidance. We also examined trust documents, including policies and procedures, the serious untoward incident investigation report and supplementary information relating to this case, including the action plan and records of meetings with staff.

NHS England contacted Mr K at the outset of the investigation to request access to his medical records and explain about this independent investigation. They did not receive a reply.

Mr K did not consent to our accessing his medical and other records, but the Caldicott Guardian[1] authorised their release in the public interest.

NHS England wrote to Jane Edwards’ family telling them about the independent investigation.

We met Jane Edwards’s brother at the beginning of the investigation to share our terms of reference. He gave us a list of questions that we included in our investigation. We address these in the main report and summarise them in Appendix C. We met him at the end of the investigation to share our findings and recommendations.

We interviewed staff when we found gaps in information or areas that required clarification or to find out about improvements in the trust since this incident.

We interviewed the following staff. The notation in brackets shows how we refer to them in the report.

- the lead of the trust investigation team (Lead Investigator 1);
- Mr K’s Link Nurse on discharge from Wroxeter ward and his Criminal Liaison Nurse at the time of the incident (Nurse 1);
- Mr K’s Care Coordinator at the time of the incident (Care Coordinator 3);
- a Consultant Forensic Psychiatrist who had assessed Mr K at various key points in his care in the trust (Consultant Psychiatrist 7);
- Mr K’s consultant at the time of the incident (Consultant Psychiatrist 11) ;
- the Company Secretary - with regard to service-user involvement (Company Secretary 1); and
- the Trust Service-User Involvement Coordinator for Shropshire (Service-User Involvement Coordinator 1) ;

[1] A senior member of staff in a healthcare organisation responsible for keeping patient data secure.

We also conducted a focus group with staff from the trust to discuss the following issues:

- The governance of service-user involvement.
- Integration between forensic services and generic community mental health services.

We developed a chronology of Mr K's care and treatment, analysed all the evidence received and developed our findings from this analysis. Our recommendations address these findings.

The report is divided into three sections each covering a distinct period:

a. Mr K's early life to admission to Ashworth Hospital. (See Appendix A)

b. Mr K's care and treatment at Ashworth Hospital. (See Appendix A)

c. Mr K's care and treatment at South Staffordshire and Shropshire Healthcare NHS Foundation Trust until the killing of Jane Edwards

The main recipients of this report are concerned with Mr K's care at South Staffordshire and Shropshire Healthcare NHS Foundation Trust, so we focused our investigation on this period.

Derek Mechen, a partner at Verita, peer-reviewed this report.

4. Executive summary and recommendations

4.1. The incident

Mr K committed a homicide in 1985. He was convicted of manslaughter by reason of diminished responsibility and received a hospital order with restrictions without limit of time. He was discharged from the high secure Ashworth Hospital in 2001 to the low secure Wroxeter ward at Shelton Hospital from where he was discharged to the community in 2003.

He was fully discharged from sections 37 and 41 of the Mental Health Act after a tribunal in 2006.

Mr K stabbed and killed Jane Edwards at her home on 14 December 2010. He was found guilty of murder and sentenced to a minimum of 26 years in prison. This report relates to the care and treatment of Mr K from 1986 until the killing of Jane Edwards.

4.2. Jane Edwards

Jane Edwards was a volunteer at the trust and was involved in work with Shropshire Mental Health Services, which later became South Staffordshire and Shropshire NHS Foundation Trust. Her work involved providing a non-professional opinion to a number of work streams.

Much of her work took place in the department of psychological therapies and included working with management steering groups and sitting on interview panels.

Staff interviewed who had worked with Jane described her as capable and able to speak her mind.

Jane met Mr K through this work. They met regularly as members of a clinical governance/management group in the department of psychological therapies.

4.3. Overview of the care and treatment of Mr K

Mr K was diagnosed with paranoid psychosis after the homicide in 1985.

He received a hospital order with restrictions without limit of time and was sent to Broadmoor in 1986 under sections 37 and 41[1] of the Mental Health Act. This placed restrictions on Mr K and his care team. One of these restrictions was that the Home Office was to monitor his care.

[1]A section 37 is a hospital order that is an alternative to a prison sentence. The subject is sent to hospital instead of prison. A crown court judge can add a section 41 restriction order to this, making the section a 37/41, if they think a person is high risk and is worried about public safety. The additional restriction order means there are restrictions on both the person and the "Responsible Clinician" (i.e. the consultant psychiatrist in charge of the person's care). For example, the consultant needs to report on the subject's progress to the Secretary of State for Justice at the Home Office and needs permission from the Home Office before granting leave.

Mr K was transferred to Ashworth Hospital the same year because of overcrowding at Broadmoor. Both Broadmoor and Ashworth are high secure hospitals.

Mr K spent 16 years under the care of Ashworth Hospital. For most of this time he was treated in wards for patients with personality disorders.

Mr K had two trial periods in regional medium secure units. This meant a leave of absence from Ashworth Hospital to the units. In 1995 he had a leave of absence from July to October. His second leave of absence was from July 1998 until February 1999. Both these trials failed when Mr K became unhappy with his treatment and asked to be returned to Ashworth.

Mr K's psychiatrist prescribed him anti-psychotic medication for short periods during these leaves of absence. This was to protect Mr K from possible psychotic symptoms, stress and anxiety.

He neither exhibited nor reported actual psychotic symptoms while under the care of Ashworth Hospital. Including during his short stays in the two regional medium secure units. Despite this he was discharged with a diagnosis of paranoid schizophrenia and was prescribed a low dose of anti-psychotic medication.

Mr K was granted leave of absence from Ashworth Hospital again in January 2000 and was transferred to Wroxeter ward at Shelton Hospital. The ward was a low secure rehabilitation unit in South Staffordshire and Shropshire Healthcare NHS Foundation Trust. He settled on the ward and became a patient representative[1].

He did not suffer from or report psychotic symptoms while he was a patient on Wroxeter ward. He was fully compliant with his medication and all treatment.

Mr K appealed to the Home Office for a conditional discharge in 2002. They granted this so he moved to a supported accommodation flat in the community. During this time he was supported by the mental health team and attended outpatient appointments with a consultant psychiatrist.

The Wroxeter ward team followed Mr K up after discharge. His care was transferred in June 2003 to the South Shrewsbury community mental health team.

From 2003 Mr K reported occasional deteriorations in his mental health state to the care team. He also described hallucinations in the form of commands to harm himself and others. Mr K told staff that he would not act on these commands and that he recognised they were hallucinations. During these times Mr K's consultant psychiatrist increased Mr K's medication.

Mr K moved from supported accommodation to independent living in June 2004.

Mr K was well and engaged in a variety of social activities for most of the time after discharge. These included various service-user representation activities. He also had

[1] In this context, a patient representative is a patient who is receiving care on an inpatient ward who provides an opinion to services from the patient perspective.

weekly support with social activities from a worker from the mental health charity "Together".

Mr K appealed to the Home Office for an absolute discharge from sections 37 and 41 of the Mental Health Act in 2006. This was granted in August 2006.

During this time Mr K's care team continued to visit regularly and updated Mr K's care plans and risk assessments.

His Care Coordinator and Consultant Psychiatrist were changed between 2009 and 2010. Mr K continued to attend his appointments.

Mr K attended an outpatient appointment with his new Consultant Psychiatrist on 17 November 2010, who assessed that Mr K was well. Mr K's Care Coordinator also visited Mr K at home for a routine visit on 1 December 2010.

Mr K killed Jane Edwards on 14 December 2010.

When in custody Mr K was assessed under the Mental Health Act on 15 December 2010. He was not found to be mentally ill.

On 20 December 2010 Mr K was again assessed to determine if he should be transferred to the trust regional medium secure unit. The assessment concluded he was showing signs of disorganised and delusional thinking but not hallucinations.

4.4. Findings

Mr K's presentation satisfied a diagnosis of personality disorder[1] rather than paranoid schizophrenia. He also demonstrated many psychopathic features.

It is unlikely Mr K would have still been in prison or hospital so many years after the homicide in 1985, even if he had been diagnosed with a personality disorder. He may have been placed in the care of a different part of the service, such as a community forensic team, but it is likely he would have still been living in the community at the time of Jane Edwards killing even if he had been diagnosed with a personality disorder.

Ashworth Hospital complied with all legal and clinical duties expected of them in discharging Mr K from services.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust continued to comply with Home Office monitoring after his discharge until his absolute discharge from sections 37 and 41 of the Mental Health Act on 17 August 2006. South Staffordshire and Shropshire Healthcare NHS Foundation Trust also complied with all the legal and clinical duties expected of them.

The multidisciplinary team regularly reviewed Mr K's care plans and wellness/recovery plans and they formed the basis of his care.

[1] Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

The multidisciplinary team developed Mr K's care plans with him.

We do not consider the killing of Jane Edwards was predictable. We found no words, actions or behaviour from Mr K in the weeks leading up to the killing that should have alerted his care team.

We do not consider the killing of Jane Edwards was preventable. The care team did not know the danger to Jane Edwards because Mr K did not tell them, even though he had had opportunities to do so.

Following the killing of Jane Edwards, the trust carried out an internal investigation in line with trust policy.

4.5. Recommendations

In future, the trust should conduct a full case review as part of the transfer of care when it accepts a patient from a high secure setting. This case review should not simply accept the existing diagnosis but should challenge and review the diagnosis, treatment plans and the need for on-going forensic input.

The trust should finalise the "Recovery: Service Development and Improvement Support Worker Guide for Divisions and Directorates" policy and the planned pilot to evaluate it.

The trust should develop a system for monitoring investigation teams to ensure there are adequate resources to conduct the work identified in the Incident, Near Miss and Serious Incident Policy.

5. Chronology of care and treatment of Mr K while under South Staffordshire and Shropshire Healthcare NHS Foundation Trust until after the killing of Jane Edwards.

The chronology first focuses on the care and treatment Mr K received on Wroxeter Ward at Shelton Hospital in 2001.

Appendix A provides a full chronology of the care and treatment Mr K received from 1986 until this time.

5.1. Wroxeter ward, Shelton Hospital; Shrewsbury.

In late 2000 the Home Office granted Mr K a six month leave of absence from Ashworth Hospital to Wroxeter ward for a trial period. The Home Office sanctioned this in line with the terms of his section 37/41. Mr K was formally admitted to Wroxeter ward on 4 January 2001 under the care of Consultant Psychiatrist 8.

Mr K was also subject to social supervision as a stipulation of his section 37/41. This meant a social worker was responsible for reviewing his care and reporting to the Home Office. At the time of his admission to Wroxeter, this was Social Worker 1, who had first contacted Mr K when he was at Ashworth Hospital.

Mr K's clinical notes show he was diagnosed with paranoid schizophrenia and was on anti-psychotic medication.

The clinical records show Mr K found the transfer difficult.

The clinical team reviewed Mr K's care in May 2001 under the Care Programme Approach (CPA)[1] and noted his difficulties settling on the ward. During this time, Mr K also started to have separate sessions with Consultant Psychologist 2. He also attended a psychological therapy centre for group work at the end of May 2001.

The clinical team reviewed Mr K's care again in June 2001 under the CPA. This review showed Mr K had settled on the ward and that his mental state was stable with "no evidence of any thought disorder or delusional ideation".

Mr K was granted escorted day leave the same month at Consultant Psychiatrist 8's discretion.

Mr K was officially discharged from Ashworth Hospital on 3 August 2001 and transferred to Shelton Hospital under the care of Consultant Psychiatrist 8.

[1] The Care Programme Approach (CPA) is how services are assessed, planned, coordinated and reviewed for someone with mental health problems. A person under CPA will be allocated a named care coordinator (usually a nurse, social worker or occupational therapist) to manage their care plan. The care coordinator should ensure the CPA care plan is formally reviewed at least once a year. They should also ensure the care plan is recorded and that the person and relevant carers (both family and professional carers) are given copies. The CPA was introduced in 1991 and became mandatory in 1996.

Mr K became involved with service-user work during his stay on Wroxeter ward. The trust service user involvement coordinator for Shropshire told us Mr K began as a patient representative on the ward. A patient representative is a patient on the ward willing and able to provide the patient perspective to service providers. The trust service user involvement coordinator told us that Mr K had been interested in becoming a patient representative shortly after his admission. This was the start of his service user involvement work in the trust

Mr K continued to have escorted leave without incident and Consultant Psychiatrist 8 wrote to the Home Office in September 2001 for permission to grant him unescorted leave.

Mr K applied to a Mental Health Review Tribunal for a conditional discharge from his Mental Health Act sections 37/41 in October 2001. Independent Forensic Consultant Psychiatrist 9, Independent Social Worker 2 and Independent Forensic Psychologist 3 assessed him at a tribunal.

The tribunal concluded Mr K should be considered for a conditional discharge in the future, but did not feel he was ready yet.

They had different views about where Mr K should be placed. Consultant Psychologist 3 felt he should go to a staffed residential facility so he could be supported. Social Worker 2 and Consultant Psychiatrist 9 felt Mr K could be discharged to independent accommodation.

Nurse 1 told us that Consultant Psychiatrist 9 concluded Mr K needed a gradual reintroduction to life outside an institutional setting. The psychiatrist met Mr K and told him this. Nurse 1 told us:

> "[Consultant Psychiatrist 9] said "you have 12 months before your next tribunal. It would be good to see that you reach the point that you can be trusted with leave and even overnight…. In the right kind of place." That happened over the next 12 months."

We conclude from this that although the tribunal rejected the application for conditional discharge, all parties, including the independent assessors, agreed Mr K should be prepared for a conditional discharge in 2002.

Mr K's treatment progressed with gradually increasing leave after the tribunal. Consultant Psychiatrist 8 granted overnight leave with family members for Christmas in 2001. This went well. He had no psychotic symptoms, either on the ward or during leave periods at this time.

The housing association identified suitable supported accommodation for Mr K in 2002. This was a one bedroom flat in a housing complex that the housing association managed.

A Mental Health Act tribunal reviewed Mr K again in August 2002. This time they granted a discharge from sections 37/41 of the Mental Health Act subject to the conditions that:

> "He accepts medical supervision from Consultant Psychiatrist 8 or a nominated successor; that he complies with the social supervision plan approved by Social Worker 1 or nominated successor and that he resides at the supported living accommodation and doesn't move without the approval of the social supervisor".

Mr K was discharged to his supported accommodation later that month. He continued to visit Wroxeter ward as a service-user representative, following on from his role as a patient representative.

5.2. Aftercare following discharge from Wroxeter ward.

The clinical team continued to support Mr K after his discharge from Wroxeter ward.

Social Worker 1 completed update reports for Consultant Psychiatrist 8 and the Home Office and started to arrange a handover to Social Worker 3, the social worker with the locality community mental health team.

Social Worker 1 had successfully referred Mr K to the charity Together[1] before his discharge. After discharge he received a weekly two hour support session with Together to help with his social care including shopping, socialisation and daily-living needs.

The clinical team also referred Mr K to a local mental health day centre on discharge. Mr K was offered a programme of group and individual work for two days a week after an interview in September 2002.

He was registered with GP 1. Consultant Psychiatrist 8 told GP 1 on October 2002 of his most recent outpatient review saying:

> "He has adjusted to the strains and stresses of life outside an institution after 18 years without any recurrence of psychotic symptoms so far. He certainly gets anxiety symptoms but is managing these."

Consultant Psychiatrist 8 also recorded the long-term plan to transfer mental health care from the ward to the locality community mental health team.

Consultant Psychiatrist 8 told the Home Office of the planned transfer of mental health care.

[1] Together is a national charity that provides a range of social support for people with mental health problems. In Mr K's case, Together provided a support worker to give two hour support sessions per week. These involved social activities, shopping and dealing with bureaucracy. NHS services pay for the Together service for set periods of time. This is authorised through application to a funding panel. Prior to 1998, Together was called MACA, although this name was not adopted in Shrewsbury for a number of years. For the purposes of clarity, we have started with the name "Together" rather than change later.

Ward Occupational Therapist 1 also visited Mr K at his flat. Following a visit on 20 November 2002 he records that Mr K was coping but said he was lonely and missed the communal life of an institution.

Mr K was maintained on the same low dose medication prescribed on the ward.

> Comment
> We found no mention of psychotic symptoms in the records of the multiple contacts with Mr K during this time. We found a record of him being continually anxious and lonely at times. This anxiety did not reach a level of clinical concern. We found no record of depression or suicidal ideation.

5.3. Transfer to the community mental health team.

Together conducted a review with Mr K in January 2003. Their report to Social Worker 1 said Mr K was attending a local college and the day centre and his social networks were "developing". The report concluded:

> "Whilst [Mr K] expresses a positive outlook he does still have certain anxieties about his situation..."

Social worker 1 reported to the Home Office on Mr K's progress in May 2003:

> "Mr K has managed the expected anxieties well and his future goals are still realistic and achievable."

Social worker 1 added that Mr K was alarmed to such an extent since discharge at the "incidents of random violence that take place in all communities" that he would not go out at night. She added that he often reflected on the fact that he liked the safety and routine at Ashworth Hospital, but "there has been no recurrence of psychotic symptoms or suicidal ideation".

The clinical team made preparations in May 2003 for Mr K's mental health care to be formally transferred from Wroxeter ward to the South Shrewsbury community mental health team. Consultant responsibility therefore transferred from Consultant Psychiatrist 8 to Consultant Psychiatrist 10.

Mr K's mental health care was formally transferred from Wroxeter ward to the community mental health team in a CPA review in June 2003. Mr K received support from Together, Housing Association Support Worker 1 and attendance at the day centre. Consultant Psychiatrist 11, who became Mr K's consultant before the killing of Jane Edwards was also in the community mental health team. The planned change of social workers also happened at this time.

Social Worker 3, who was now Mr K's supervising social worker in the community mental health team, wrote in July 2003 to the Home Office to confirm the transfer of care. Social Worker 3 reported that Consultant Psychiatrist 10 was seeing Mr K for mental health follow up and Mr K "accepted the change of [consultant] psychiatrist positively".

Consultant Psychiatrist 10 saw Mr K in the outpatient department in August 2003. He had no concerns about Mr K's mental health. The plan was to see Mr K on a monthly basis to assess and monitor him.

Mr K attended his outpatient appointment with Consultant Psychiatrist 10 on 13 October 2003 and said he had experienced a recurrence of "auditory symptoms". Mr K said his auditory hallucinations[1] came in the form of voices mumbling in the background but that he could not make out what they were saying. He said he had experienced the voices for 10 days. Mr K attributed them to the anniversary of his first homicide and described a feeling of "enormous guilt".

Consultant Psychiatrist 10's records say:

> "Last major psychosis was eight years ago in Ashworth. He was put back to a high security ward and treated with depot etc. At the time he was agitated and had command hallucinations."

Consultant Psychiatrist 10 repeated this in a letter to GP 1.

> "last full episode of psychosis [was] eight years ago, whilst he was in Ashworth Hospital. However, over the past two years he describes two short lived episodes of minor hallucinatory experiences similar to those he has been experiencing at present. He did not talk about either of these episodes at the time, fearing putting back his progress towards discharge and the episodes resolved spontaneously after a month or so. However, he felt that now he was in the community with less supervision it was important to be open about his symptoms."
>
> Comment
> We found no record of this episode of "major" psychosis while Mr K was in Ashworth Hospital. We found no record of Mr K being moved to a "high security" ward and treated with a depot in the manner described. With regard to the two "minor" episodes, Mr K had been seen by the clinical team on a regular basis since discharge. There was no record of any worker noting symptoms or concerns about symptoms after coming into contact with him.

Consultant Psychiatrist 10 concluded Mr K had suffered "a minor relapse of his psychosis", but had "good insight" and that risk to himself and others was low. She agreed a management plan with Mr K. He was to increase his antipsychotic medication from 5mg to 10mgs of olanzapine daily. Social Worker 3's visits would be increased from every three weeks to weekly and he was to see Consultant Psychiatrist 10 again three weeks later. Consultant Psychiatrist 10 told GP 1 and Social Worker 3 of the visit, assessment and plan.

Social Worker 3 made a home visit on 20 October 2003 and recorded that Mr K:

[1] An auditory hallucination is where a person hears a sound, noise or a person's voice that has no external stimulus (i.e. is not real). The most common form is a person's voice, which is often referred to just as "voices".

> "had a sense of rustling leaves, not actual voices. He also felt that his olanzapine was working - now up to 10mg from 5mg. [Mr K] appeared quite happy and coping well with life and told me that he had told others he felt the blip in mental health was probably due to being out in the community rather than in the supportive environment of a ward."

Mr K did not want weekly visits from Social Worker 3. He had a full programme of activities on most days and Social Worker 3 felt he would tell her if there were further difficulties.

Social Worker 3 recorded these events in her update letter to the Home Office. Social Worker 3 also outlined the plan to move Mr K from supported housing to independent living.

Consultant Psychiatrist 10 saw Mr K on 10 November 2003 for a follow up and reported that the "minor relapse has resolved." His medication was returned to 5mg of olanzapine daily.

5.4. Independent living and absolute discharge from Mental Health Acts 37/41.

In 2004, the housing association found Mr K a suitable independent flat where he lived until he killed Jane Edwards in 2010.

Mr K reported to the clinical team that his auditory hallucinations had returned while moving to the flat on 17 June 2004. In a letter to Consultant Psychiatrist 10, Social Worker 3 wrote:

> "I visited [Mr K] today and he told me that the voices had returned. He said that when he cancelled his appointment with you he was ok at the time and pre-occupied with the house move…
>
> He has, as a consequence, put up his olanzapine to 10mg. He told me his voices were not violent and were commenting mainly on his inability to cope with the move. He did not feel he needed to see you, that his supports were all in place and that the move which is going to plan…will be completed by July 2004"

Consultant Psychiatrist 10 saw Mr K in July 2004 and reported that his hallucinations were "resolving" although he continued to be anxious. She reported no signs of clinical depression.

Mr K's care package remained unchanged during this time. He continued with a range of activities, including service-user work. He had almost daily contact with services. Consultant Psychiatrist 10 reported he was symptom free during August 2004.

Mr K reported in December 2004 that his auditory hallucinations had returned. He said they had begun "suddenly one morning" and that they were a "clamour in his

head". The voices told him to commit suicide and to "watch his back" because "others are watching him".

Consultant Psychiatrist 10 recorded that Mr K had retained full insight, told his care worker and increased his medication of his own accord. He had no other "associated symptoms of paranoia" or thoughts of harming himself or others. Records show the symptoms resolved within fourteen days and that Mr K's medication was permanently increased.

Mr K spent Christmas 2004 with relatives.

Consultant Psychiatrist 10 and Social Worker 3 completed a CPA review with Mr K on 25 April 2005. They noted Mr K had been symptom free since December 2004 and was positive about the future. They agreed Mr K's medication would be increased to 15mg olanzapine a day if his symptoms returned. Mr K reported he found it difficult to form a relationship with one of his new care workers.

Mr K remained well under this care package.

Social Worker 3 submitted an update report to the Home Office in August 2005. She said Mr K did not present with problems and he was regularly working as a service-user representative on interview panels. Social Worker 3 included a report from a fellow panel member who described Mr K as "totally reliable".

Mr K was also part of an editorial panel assisting with the development of a website. Jane Edwards, was also on the editorial panel.

> Comment
> This is the first record we found of Mr K coming into contact with Jane Edwards.

Consultant Psychiatrist 10 submitted a routine report to the Home Office in August 2005. She wrote that Mr K continued to live independently, was well and active with "domestic tasks, hobbies and worked as a service-user representative" and was compliant with medication. The report noted that Mr K had been in the community for three years and was, in Consultant Psychiatrist 10's opinion, not a risk to himself or others. Consultant Psychiatrist 10 said she would "be happy to support a consideration for absolute discharge from his section."

In September 2005, the Home Office replied to say that they had noted the number of relapses since discharge from Wroxeter ward and would "prefer to see a longer period of stability before reconsidering absolute discharge." The letter outlined that they were willing to review the matter "in a few months' [sic] time if appropriate".

September 2005 was the 20th anniversary of Mr K's first homicide.

Mr K reported in early October that his auditory hallucinations had returned. He told GP 1, before the mental health team. GP 1 wrote to Consultant Psychiatrist 10 saying that Mr K's hallucinations were "accusing him of being worthless and were also encouraging him to harm himself." GP 1 reported Mr K had "full insight" and

independently increased his medication again. Mr K told GP 1 that the hallucinations were already "50 per cent better" since the increase in medication. Mr K was also clear that "at no time were the voices encouraging him to harm anyone else."
GP 1's letter also noted:

> "I spoke to [Mr K] carefully and I am absolutely certain that he has complete insight and he was extremely confident that he could cope with the recent exacerbation…"

Social Worker 3, who had been off sick during this time, saw Mr K shortly after his appointment with GP1. Social Worker 3 records that Mr K "wants an absolute discharge [from Mental Health Act sections 37/41] as he handled this crisis well."

Consultant Psychiatrist 10 saw Mr K in November 2005. He had no symptoms, was well and complying with his community follow up. She reported back to GP 1 saying that the hallucinations in October had "rapidly dissipated" and that Mr K attributed them to the anniversary of his first homicide.

Mr K spent Christmas 2005 with his neighbours.

In February 2006 Mr K appealed for absolute discharge from his sections 37 and 41 of the Mental Health Act. This meant that a mental health tribunal had to consider his appeal. The tribunal requested reports from Social Worker 3, and Consultant Psychiatrist 10.

Consultant Psychiatrist 10 assessed Mr K in the outpatient department in March. Records show he remained well.

Mr K had a CPA meeting with Consultant Psychiatrist 10 and Social Worker 3 in April. His care plan remained unchanged and he continued to be involved with service-user activities.

Mr K attended a mental health tribunal hearing on 17 August 2006. Consultant Psychiatrist 10 and Social Worker 3 submitted reports supporting his appeal. The tribunal granted an absolute discharge from sections 37 and 41 of the Mental Health Act.

On granting the discharge, the panel found:

> "[Mr K] to be a truthful and sincere man and they agree with the clinical team in saying he would not, now, be regarded as someone who would be a risk to others."

The tribunal noted:

- the community care plan would remain the same;
- he was involved with mental services;
- had contact with someone on a weekly basis to provide support; and
- he was a service user working for the local mental services.

The full record of the decision of the tribunal is included in Appendix B.

Comment.
On granting an absolute discharge, Mr K's care team had no legal right to detain him unless they could prove he had suffered a breakdown that made him a risk to himself or others.

The role of the Home Office in overseeing and agreeing to his care also stopped. Social Worker 3's role changed from being his social supervisor under the Mental Health Act to his care coordinator under the Care Programme Approach. As the roles and responsibilities are different, we shall now refer to Social Worker 3 as Care Coordinator 1.

5.5. After absolute discharge until the killing of Jane Edwards.

Mr K told Care Coordinator 1in September 2006 that his neighbour's dogs' barking had disturbed him. He rejected the suggestion of keeping a diary of these disturbances because he thought it would feed his paranoia.

Consultant Psychiatrist 10 saw Mr K in the outpatient department on 2 October 2006. He had no psychotic symptoms, but discussed his agitation with the neighbour's dogs. He said that on one occasion he "felt like killing the dogs" but had made no plans to do it. He said he "knew right from wrong" and that any violence would have repercussions. Mr K agreed to contact Care Coordinator 1 or the out of hours[1] service if he could not cope.

In November 2006, Care Coordinator 1 told Mr K that his care would be transferred from South Shrewsbury community mental health team to North Shrewsbury community mental health team. He would have a new care coordinator in the New Year but would remain under Consultant Psychiatrist 10's care and retain his support from Together. Only his care coordinator would change. Mr K accepted this.

Care Coordinator 1 continued to visit and helped Mr K to plan Christmas with relatives.

In March 2007 Care Coordinator 1 held a handover meeting with Mr K and Care Coordinator 2. He also told Mr K that input from Together would be reviewed in the next year.

Consultant Psychiatrist 10 assessed Mr K at an outpatient appointment on 2 April 2007. Mr K said that he had had an "episode" of voices in February that lasted for six days. He managed this by increasing his medication.

Care Coordinator 2 met with Mr K next day in his home. Mr K told Care Coordinator 2 his life history, routines and coping strategies. They initially agreed to meet every three weeks in the short term. Mr K had been meeting Care Coordinator 1 every six weeks.

[1] "Out of Hours" is a generic term meaning services available to patients outside the office hours of 9am to 5pm.

Comment.
Mr K's episode of auditory hallucinations happened while his care was being transferred. He did not report it to Dr B until two months later. He did not mention it either to Care Coordinator 1 or Care Coordinator 2 as their accounts of meetings with him over this period show.

Care Coordinator 2 met Mr K every three weeks as planned. Care Coordinator 2 also negotiated for the Together service to continue for another six months.

Mr K called Care Coordinator 2 on 8 June 2007 to rearrange a home visit with her. He rang the community mental health team on 12 June 2007 saying his "voice hearing has become more intense" and that he had therefore increased his medication. Care Coordinator 2 was on leave and didn't get the message until 18 June 2007. Care Coordinator 2 then called Mr K and left a message. Mr K rang back and told the team secretaries that he was "feeling much better".

Mr K attended an outpatient appointment with Consultant Psychiatrist 10 on 23 June 2007. Records show that Mr K was well.

Care Coordinator 2 visited Mr K on 26 June 2007 and reported that he was much better. Mr K told Care Coordinator 2 that this relapse had been "different" but that he was "able to retain a good level of self-awareness" that prevented him acting on his "delusions and command hallucinations".

Care Coordinator 2 visited Mr K again on 18 July 2007. He appeared well. Care Coordinator 2 discussed updating his risk assessment but explained it would wait until the outpatient appointment with Consultant Psychiatrist 10. The care worker from Together continued to help Mr K with shopping and provide practical support.

Consultant Psychiatrist 10 made a detailed assessment of the deterioration of Mr K's mental state in June when he attended his outpatient appointment on 30 July 2007. Mr K said he woke with auditory hallucinations urging him to get a knife and stab someone. He said he knew these were hallucinations and made no plans to act on the voices. Records show that Mr K coped with the episode by staying at home and increasing his medication. The hallucinations abated within eight to ten days.

Consultant Psychiatrist 10 recorded:

> "Mr K contacted care coordinator, [Care Coordinator 2] as per plan. Care coordinator on leave. Offered appointment with duty social worker from CMHT, but refused it. Message was not passed on to me. Rest of CMHT unaware of risk issues."

Consultant Psychiatrist 10 told Mr K that his risk assessment and management plan needed to be reviewed and this should involve the care coordinator. Mr K had mixed feelings about this because it could have led to a hospital admission. He said an admission could put him at "risk of behaving violently" but also that the hospital might

be supportive. Consultant Psychiatrist 10 told him that closer monitoring would be needed because of increased “homicidal thoughts.

Consultant Psychiatrist 10 updated the risk and crisis plans and outlined the following plan:

- daily phone contact;
- face-to-face contact with two workers preferably known to Mr K;
- Mr K to visit the hospital to allay his concerns about being admitted; and
- Mr K to consider increasing his diazepam when he is very anxious or has disturbed sleep.

Clinical records show that Mr K remained mentally well. Care Coordinator 2 discussed risk and care management with Mr K during the next home visits on 8 August, 29 August and 21 September 2007. The risk assessment and management plan were updated by Care Coordinator 2. The record said Mr K’s auditory hallucinations did not specify who he should stab (i.e. there was no specific person identified as being at risk.).

The risk assessment documentation shows Mr K had “a long history of schizophrenia” and outlines Mr K’s history and reports of recent symptoms. The section on “summary of “positive” resources and potentials” says:

> “Mr K has generally kept good mental health for many years. He has developed good insight and recognises his vulnerable times and when he is becoming unwell. Mr K works well alongside mental health services/GP/consultant psychiatrist and crisis plan. When unwell has developed his own complementary coping strategies”.

A summary of Mr K’s risk assessment documentation says:

> “With Mr K’s high level of awareness and insight alongside his willingness to take early action and work with his service when unwell he has managed his past relapses in the community well. When Mr K contacts services to inform them that he is unwell there is now an agreed crisis response (outlined in care plan) that needs to be activated. Due to the nature of Mr K’s command hallucinations/delusions – workers should visit in two’s [sic].”

Team Leader 1, who would later become Care Coordinator 3, told us Mr K did not want workers he did not know visiting him. She also told us the care team discussed the incident when had auditory hallucinations telling him to stab someone. They decided workers who did not have regular contact with Mr K should not visit him alone.

However, the care team perceived Mr K to be a risk only to those visiting his home and not to the general public.

Care Coordinator 2 updated Mr K’s care plan at the same time. The care plan recorded that Mr K was to be given an additional contact person in the event of a

crisis. This was Care Coordinator 3, another community mental health team care coordinator who had previously been introduced to Mr K.

Comment
Care Coordinator 3 later became Mr K's care coordinator for two periods of care. These are described below. Care Coordinator 3 was Mr K's care coordinator when he killed Jane Edwards.

The care plan records Mr K's perception of his care as:

> "Mr K fully accepts his diagnosis and that it is a "lifelong condition". He also accepts his prescribed medication. Mr K states that he has a huge insight into his illness and is very responsive to increased medication at time of need. Mr K says that he experiences psychotic episodes approximately three to four times a year – often around dates associated with his past offence, each of duration six –ten days which he feels he manages well with increased medication."

The care plan also provided a summary of Mr K's reported relapse indicators, saying:

- "Mr K feels particularly vulnerable during the month of September and at Christmas which hold particular painful memories for him.
- He may feel increasingly stressed and anxious.
- His sleep pattern deteriorates.
- His personal care may deteriorate.
- He feels paranoid – in a general sense- not directed to anyone/anything in particular.
- He may present as introverted and guarded.
- Mr K has an increasing feeling of fearfulness that he may respond to command hallucinations that instruct him to harm himself and/or others. Mr K's command hallucinations tend to instruct him to harm himself in the initial stages (3-4 days) but they may than proceed to instruct him to harm others (for a further 3-4 days). During these times Mr K may ask to be left alone as part of his coping strategy.
- Mr K has historically felt recovered from a relapse within 6-10 days."

The care plan also provided a detailed account of actions to be taken in case of relapse or disengagement. These included:

- Mr K increasing his medication;
- Mr K can suspend workers visits providing he accepts a daily phone call and an urgent referral to Consultant Psychiatrist 10;
- in the event that Mr K did not return calls, he gave permission for workers to get the keys and enter his flat and assess him with a view to admission to hospital "as a last resort the police may need to assist"; and
- Mr K to visit the hospital ward where he would be admitted if needed.

The clinical team sent copies of the risk assessment and care plan to Consultant Psychiatrist 10, Care Coordinator 3, GP 1 and the liaison person at Together.

Care Coordinator 2 applied for funding from the Together service at this time and it was accepted. Mr K was said to be relieved by the decision to extend the service.

The care plan detailed Mr K's activities when he was well. These included Mr K's service-user work, weekly cinema trips, using the library regularly, socialising and doing short courses at a local college. The service-user work at this time had expanded to involvement with the editorial board for the trust's website, job interview panels and proof reading documents for the trust. The records note that Mr K's episodes of relapse did not affect his participation in these activities, apart from days when he isolated himself. Consultant Psychiatrist 10 told us that Mr K would become anxious during interview panel work and would need extra breaks.

His weekly sessions with Together to help with shopping and other social activities also continued, apart from at times of relapse. In reviews of this contact, the care workers report that Mr K was occasionally anxious in crowded areas such as supermarkets, but generally managed well.

> Comment
> There was a delay in the community mental health team response in June 2007 when Mr K said he had hallucinations telling him to harm someone. However, Consultant Psychiatrist 10 responded appropriately after this with a major review of his care, which resulted in a detailed update of his risk management plan.
>
> Mr K's account of his symptoms changed and his risk increased but was confined to specific and distinct periods. His functioning outside these episodes was unaffected and he maintained a high degree of activity and social interaction although he was occasionally described as anxious.
>
> Mr K remained mentally well after this. On 23 January 2008 Mr K visited the inpatient mental health ward as his risk plan suggested.

Mr K reported another minor relapse on 11 February 2008. Mr K said that this time there were no command hallucinations urging him to harm himself or others. This was managed according to his care plan. Mr K said he was improving a day later and that he was well four days later. Daily contact was maintained throughout.

Care Coordinator 2 assessed Mr K at his home. Mr K reported he was "over his relapse". He felt the anniversary reminding him of the index offence and on-going back pain had triggered it. He confirmed the relapse did not include command hallucinations telling him to harm anyone. Mr K said he would keep to the higher dose of medication "for a few days".

In June Mr K had a week's holiday in France with friends.

Mr K contacted the community mental health team on 28 August 2008 to say he was experiencing auditory hallucinations. This relapse was managed with daily phone

contact from Care Coordinator 2 and Mr K increasing his medication. Mr K phoned the community mental health team on 2 September 2008 to say he was better and planning to go out on a trip with Together.

Care Coordinator 2 visited Mr K at home as planned on 5 September 2008. Mr K reported he had had command hallucinations again telling him to harm himself and then to harm others, although these were "non-specific". Care Coordinator 2 saw a kitchen knife in the hall of the flat. Mr K told her the knife had been there "for approximately twelve to eighteen months". He said it was for personal protection against potential intruders. Mr K said he did not trust the police and would only use the knife as a last resort. The clinical records do not show if Care Coordinator 2 gave him advice, or if the risk management plan was reviewed.

Care Coordinator 2 updated Consultant Psychiatrist 10 on 9 September 2008 about this home visit. Care Coordinator 2 also contacted Together to get an update on the continuation of their service, because the extension of their funding would soon finish.

Consultant Psychiatrist 10 cancelled an outpatient appointment for 22 September 2008 because of "unforeseen circumstances."

Care Coordinator 2 made a home visit on 29 September 2008. Mr K said he felt much better, was carrying out activities and had no psychotic symptoms. They discussed a forthcoming panel hearing that would consider further funding for the Together service. They also reviewed his risk assessment and care plan. Care Coordinator 2 did not mention the knife again.

Care Coordinator 2 visited Mr K at home again on 31 October 2008. Mr K signed his risk assessment and care plan. He felt the care plan had been useful during his relapses and helped him manage his hallucinations, although he could "never be 100% sure of this." We found no record if this comment was discussed further.

Mr K attended an outpatient appointment with Consultant Psychiatrist 10 on 3 November 2008. They reviewed his recent relapses. Mr K again said he was anxious that he could not "100% guarantee [he] will retain insight and not act on voices". Consultant Psychiatrist 10 outlined some alternatives to the care plan including increased face-to-face contact, hospitalisation or using a crisis house. Mr K was not happy to consider these options. He told Consultant Psychiatrist 10 that if these were considered he would be "less likely to be open about my symptoms". They planned instead to tighten up the phone contact he had with the community mental health team and plan what Mr K should do at weekends or when Care Coordinator 2 was on leave.

Consultant Psychiatrist 10 and Mr K devised draft questions the community mental health team could ask him to speed up an assessment.

> Comment
> The list of questions Consultant Psychiatrist 10 and Mr K drafted was an example of good communication because they provided structure for the care team and Mr K in the event of a relapse. At the time these were not shared

with the care team as they were recorded on a separate sheet of paper and not attached to care plans or other documents. This was identified and addressed in the trusts' internal investigation (see section 7 of this report).

Consultant Psychiatrist 10 also suggested that the crisis team would provide cover if Mr K relapsed at the weekend. They also discussed increasing his medication, although Mr K felt his relapses had decreased since his last medication increase. We found no record of a discussion between Care Coordinator 2 and Consultant Psychiatrist 10 about the knife in the hall. Consultant Psychiatrist 10 recorded Mr K's risk as low. Consultant Psychiatrist 10 contacted Care Coordinator 2 to update her.

Together agreed on 13 November 2008 to continue to provide funding for Mr K's support.

Care Coordinator 2 made a home visit on 28 November 2008. Care Coordinator 2 recorded that Mr K was mentally and physically well. Mr K had been considering his options should he relapse. In this, he had considered increasing his medication and meeting the crisis team in case he needed them at weekends. He said he would also consider using a crisis house and wanted to visit one.

In December Care Coordinator 2 cancelled a home visit with Mr K.

Mr K contacted the community mental health team on 5 January 2009 and said he was having a relapse. The team managed this with daily phone contact and Mr K increasing his medication. Mr K said he was "improving" on 8 January 2009. He did not contact Care Coordinator 2 on Friday 9 January 2009 so Care Coordinator 2 left a message for him with the out of hours contact numbers for the weekend. Care Coordinator 2 called Mr K on Monday 12 January 2009. He said he was feeling "much better" and was planning to go out. Care Coordinator 2 called again on 13 January 2009 and Mr K said he was planning to go out with the care worker from Together.

Care Coordinator 2 made a home visit on 16 January 2009. Records show that Mr K was well. Mr K told Care Coordinator 2 that he still did not want the crisis team to see him, but would consider a crisis house in the event of a relapse and wanted to visit one. Care Coordinator 2 told him she was going on study leave so his care coordinator would change.

Mr K attended his outpatient appointment with Consultant Psychiatrist 10 on 2 February 2009 and they discussed his recent relapse. Consultant Psychiatrist 10 reported that the relapse followed the usual pattern but did not record what the auditory hallucinations had said. Mr K was unwilling to increase his medication. She discussed options with Mr K and recorded:

> "He remains unwilling to allow face-to-face contact or input from crisis team during periods when he is symptomatic – feeling he copes better if keeps self to self [sic] until symptoms have passed. This continues to raise concerns re risk assessment and management. On the positive side he has completed care plans and agreed and coped with many episodes of being symptomatic over the years without adverse events."

Consultant Psychiatrist 10 discussed the change of care coordinator and the visit to the crisis house with Mr K. She also suggested she should be present at the handover meeting between the coordinators and that this handover would include a review of Mr K's risk assessment.

Care Coordinator 2 carried out a home visit on 6 February 2009. She noted Mr K was well and was reconsidering his refusal to increase his medication. He said he was willing to review his risk assessment. Care Coordinator 2 told Mr K she would like to invite a crisis team worker to meet Mr K so he would know the worker if he needed to be involved with Mr K in future.

Mr K was active and continued to be involved with service-user representation. He was also having weekly sessions with Together.

Care Coordinator 2 contacted Mr K on 15 February 2009 to confirm a meeting with the new care coordinator. This was to be Care Coordinator 3, who had become his second contact from the community mental health team in 2007. Care Coordinator 2, Care Coordinator 3 and Mr K planned to meet for a handover on 24 March 2009.

Consultant Psychiatrist 10 referred Mr K to the trust's Forensic Liaison Team on 2 March 2009 on behalf of the community mental health team. Consultant Psychiatrist 10 asked the Forensic Liaison team for advice about risk management. Consultant Psychiatrist 10 outlined her concern that the risk management plan relied so heavily on Mr K's "self-report and self-control." Consultant Psychiatrist 10 added:

> "[Mr K] reported to his care coordinator in recent months that he keeps a kitchen knife in his hall. He says it is for self-defence should he ever have intruders in the house and only be used [sic] as an absolute last resort."

Consultant Psychiatrist 10 and the team were given an appointment in May 2009 to discuss Mr K's risk management plan with the Forensic Liaison Team.

Care Coordinator 3 made a home visit on 11 March 2009. She reported everything was well and Mr K was planning a trip to a horseracing event. Care Coordinator 3 and Mr K discussed meeting the crisis team.

Care Coordinator 3 visited Mr K on 9 April 2009. Records show that Mr K remained well and continued his activities as usual. Care Coordinator 3 and Mr K discussed Mr K's relapse pattern. Care Coordinator 3 reported no evidence of psychosis.

Mr K failed to attend a planned outpatient appointment with Consultant Psychiatrist 10 on 27 April 2009. She recorded this was "out of character" for Mr K. Consultant Psychiatrist 10 subsequently asked Care Coordinator 3 to make a home visit.

Care Coordinator 3 made the home visit on 29 April 2009. Mr K remained well. Care Coordinator 3 suggested a review of his care plan. Mr K was unwilling to do this because he said he was "not well enough acquainted" with Care Coordinator 3. Mr K also said that little had changed since the last care plan review.

The Forensic Liaison Service met Consultant Psychiatrist 10 on 14 May 2009 to discuss Mr K's referral of 2 March. Consultant Psychiatrist 10 gave a detailed outline of Mr K's care including his periods of stability and his activities but also the relapse patterns, his auditory hallucinations (including those urging him to harm neighbours), the incident with a neighbour's dog, his increased drinking and that he kept a knife in the hall for self-defence. They agreed the following actions:

- to clarify details of the first homicide;
- to ensure all care workers were aware Mr K had kept a knife in the hall;
- review care plan around known risk times (i.e. anniversaries); and
- given Mr K's mistrust of the police, consider making links with the local community support officer.

Staff at the meeting also discussed Mr K's work as a service-user representative and whether this was adding to his stress. Consultant Psychiatrist 10 agreed to discuss this with Mr K and suggested Mr K sought advice from Service-user Coordinator 1. A review meeting was planned for 28 August 2009.

Care Coordinator 3 made a home visit on 19 May 2009. Mr K asked for a change of care coordinator because he had "not gelled" with her and felt this would make him vulnerable during a relapse. They agreed to look at getting an alternative care coordinator. Care Coordinator 3 reminded Mr K of the plan to visit a crisis house. Mr K did not accept that a crisis house would suit him and said she did not understand his needs. Despite this, he agreed to visit the crisis house.

Care Coordinator 3 and Mr K visited the crisis house on 27 May 2009. Mr K was impressed with the service and said he would be interested in accessing it during a period of relapse. Care Coordinator 3 said this would be dependent on his risk assessment at the time. Care Coordinator 3 also told Mr K that the care team were considering his request for a change of care coordinator.

Mr K attended his outpatient appointment with Consultant Psychiatrist 10 on 8 June 2009. He apologised for missing his last appointment, saying he had a hangover. He reported he was well, with no psychotic symptoms since his last period of relapse in January 2009. Consultant Psychiatrist 10 assessed Mr K's alcohol consumption, which had increased over the past year and was concerned it was higher than the recommended level.

Consultant Psychiatrist 10 asked Mr K about his relapse pattern. Mr K said the voices he heard were changing from harming himself to harming others, and that the voices mentioned specific people. He then named two of his neighbours and said the voices told him the neighbours were laughing at him and that he should harm them. He interpreted the voices as telling him to gather weapons. Mr K said he had not gone along with the voices "in any way". Consultant Psychiatrist 10 asked about the knife that Care Coordinator 2 had previously seen in the hall and Mr K told her that this was for protection in case anyone broke into his flat. Consultant Psychiatrist 10 questioned this, pointing out that he could misinterpret a situation and that if he harmed someone it would not be seen as self-defence. Mr K agreed to put the knife back in the kitchen.

Consultant Psychiatrist 10 asked Mr K if he carried a knife and he said he didn't.

Mr K told Consultant Psychiatrist 10 about his visit to the crisis house, saying that he had liked it but preferred to deal with relapses by isolating himself. He also repeated his request to change care coordinator because he "can't talk to them as he did with (his) previous" care coordinator.

The plan was:

- to discuss change of care coordinator with the community mental health team;
- review the care plan;
- increase medication during key times when Mr K was reminded of his first homicide because they may trigger relapse;
- Mr K to move knife in kitchen;
- make a referral to the dual diagnosis service for alcohol assessment; and
- to discuss referral for cognitive behavioural therapy for anxiety at next appointment.

Mr K cancelled a home visit with Care Coordinator 3 for 18 June 2009 saying he was "stable". Care Coordinator 3 told him he had been allocated a new care coordinator and that this was Care Coordinator 4.

The dual diagnosis[1] team leader assessed Mr K on 23 June 2009. Mr K was "talkative and insightful". Mr K said he drank over 80 units of alcohol a week and regularly gambled, losing 200 pounds per week on average. He also said he had an addictive personality and he "won't be told to stop drinking or gambling." He said that a return to a high secure hospital would be "a solution but not a positive one" because he would not be able to drink or gamble. He said he sometimes thought he should stop taking his medication and "let chaos take its course". The dual diagnosis team leader offered Mr K the opportunity to make another appointment with the dual diagnosis service if he felt he needed it.

Together contacted Mr K's Care Coordinator 3 on 24 June 2009. Mr K had told her that he had increased his alcohol consumption and gambling and had high levels of anxiety. He had been to see GP 1. Care Coordinator 3 agreed with Together to contact the crisis house to check for spaces, but no beds were available. They were unable to contact Mr K. We cannot tell from the clinical records if Together or Care Coordinator 3 were aware of his assessment with the dual diagnosis service the previous day.

Mr K called Care Coordinator 3 on 26 June 2009 to tell her he had seen GP 1 about chest pains but had "sorted life out". Mr K said that his meeting with the dual diagnosis team had gone well.

[1] Dual Diagnosis in this context means having both mental health problems and substance misuse problems.

Care Coordinator 3 made a home visit with Care Coordinator 4 on 1 July 2009. Mr K said he had limited his alcohol intake and gambling since meeting with the dual diagnosis service. He was considering the Alpha Course[1] with his local church. Care Coordinator 4 made a home visit on 15 July 2009. Mr K said he was better after what he called a "wobble". Mr K was planning to attend the Alpha Course and two courses (psychology and pilates) at a local college in the autumn.

Mr K attended his outpatient appointment with Consultant Psychiatrist 10 on 20 July 2009. Records show that Mr K remained well and there were no concerns. Mr K said the meeting with the dual diagnosis worker had been useful and that he had reduced his drinking and gambling. Mr K also agreed to an increase in medication starting in September 2009 to try to prevent a relapse of psychotic symptoms.

Mr K told Consultant Psychiatrist 10 that he had moved the knife from the hall back to the kitchen. He also told his care worker of this.

Care Coordinator 4 made a home visit on 8 August 2009. Mr K was noted to be well and there were no concerns. They again discussed the relapse plan and how to manage relapses out of hours. Care Coordinator 4 told Mr K that the next care programme approach meeting was planned for 27 August 2009.

Care Coordinator 4 called Mr K on 24 August 2009 to tell him that the care programme approach meeting had to be cancelled because Consultant Psychiatrist 10 was unavailable.

Care Coordinator 4 made a home visit on 27 August 2009. Mr K was noted to be well and there were no concerns. Care Coordinator 4 advised Mr K that the care programme approach meeting had been rescheduled for 8 October 2009.

Care Coordinator 4 called Mr K the next day. He said he was low, but was not experiencing psychotic symptoms and that he was much better than he had been in previous years around the time of the anniversary of the index offence. Care Coordinator 4 offered a home visit, but Mr K declined saying he was busy with service-user work. Care Coordinator 4 therefore brought the next home visit forward.

Mr K attended his outpatient appointment with Consultant Psychiatrist 10 on 14 September 2009. Records show that Mr K did not have psychotic symptoms. Mr K had increased his medication at the beginning of September 2009 as agreed. Consultant Psychiatrist 10 felt that the medicine might have sedative effects. Mr K said he still felt low, but not suicidal or depressed. He had been drinking more since feeling low. They discussed his service-user work and Mr K said he could say "no" to requests from the trust and did not feel the work was stressful. Consultant Psychiatrist 10 advised him to reduce his alcohol consumption and to maintain the increased dose of medication until the end of September 2009.

[1] The Alpha Course is a series of eleven interactive sessions that introduces and discusses the basics of the Christian faith. The discussions take place in established churches. Each session starts with a meal, followed by a video and/or discussion in small groups. We are unclear how many sessions Mr. K attended.

Care Coordinator 4 made a home visit on 30 September 2009. Mr K said he was well and had started some courses. Care Coordinator 4 told Mr K that there has been another “mix up” in his care programme approach meeting date and that it would instead be held in October 2009.

Care Coordinator 4 attended the funding panel for the continuation of Mr K’s Together service on 7 October 2009. They agreed to fund him for another year.

Care Coordinator 4 and Consultant Psychiatrist 10 attended the follow up meeting with the forensic liaison service on 8 October 2009. Consultant Psychiatrist 10 told the service that Mr K had removed the knife from the hall and had told her he “does not carry a knife or other weapon on his person.” The staff at the meeting reviewed Mr K’s drinking, involvement with courses, care plan and his risk assessment. They then closed the case. The follow up letter to Consultant Psychiatrist 10 confirming this says:

> “You shared with us the contents of your management plan and relapse signature. The Team felt that this plan had evolved over the time you have worked with [Mr K] and seemed to address all the issues in a pragmatic and collaborative way.”

Mr K, Consultant Psychiatrist 10, Care Coordinator 4 and Together attended Mr K’s care programme approach meeting on 15 October 2009. Although invited, the crisis team did not attend. They discussed and updated Mr K’s care plan.

Care Coordinator 4 made a home visit on 21 October 2009. Mr K said that his gambling had increased and was “out of control”. He had sought help from a gambling addiction service who had offered counselling. Mr K had taken up running in an attempt to get fit. There was no mention in the records of psychosis or other symptoms.

Care Coordinator 4 made a home visit on 11 November 2009. Mr K reported he was very well. He had started both individual and group counselling for his gambling, which he said was helping him control his spending.

Mr K attended his outpatient appointment with Consultant Psychiatrist 10 on 16 November 2009. Consultant Psychiatrist 10 again said he was “doing very well”. He told him he had stopped gambling, reduced his drinking and was attending courses. He also told Consultant Psychiatrist 10 that he had made friends with a woman on one of the courses and was “intending to ask her out.” Consultant Psychiatrist 10 discussed medication with Mr K and they decided to maintain him on the increased dosage.

Care Coordinator 4 went on long-term sick leave. Care Coordinator 3 took his care coordination on again. This was the previous care coordinator whom Mr K asked to be changed.

Care Coordinator 3 made a home visit on 22 January 2010. Mr K reported he had not relapsed over the Christmas period. He said he was regularly attending the

church where he had attended the Alpha Course sessions. He was keeping his exercise regime up and felt that these activities were helping him remain well.

Care Coordinator 3 made a home visit on 17 February 2010. Mr K was well. He told Care Coordinator 3 that he had told the elders at the church of his history, which had caused him some anxiety, but said he was managing this well.

Mr K attended his outpatient appointment with Consultant Psychiatrist 10 on 22 February 2010. Mr K had again increased his medication over the Christmas period and felt this may have contributed to the fact that he hadn't relapsed. Mr K said his gambling and drinking were under control and that he felt positive about his involvement with the church. Consultant Psychiatrist 10 and Mr K discussed Care Coordinator 3 being his care coordinator. Mr K said he was happy with this, but saw it as temporary because Care Coordinator 3 was the care team leader and only covering until a new care coordinator could be allocated. Consultant Psychiatrist 10 told Mr K that the service was to be changed. This would mean she would hand over his medical care to another consultant in the future.

Care Coordinator 3 made a home visit on 9 March 2010. Mr K had again increased his medication because this was a "trigger" month that reminded him of the index offence. Mr K had also been concerned about his disclosure of his history to church elders but they had reassured him it would remain confidential. Care Coordinator 3 discussed the change in consultant and she and Mr K agreed to her remaining as care coordinator for the next year to give him some consistency.

Care Coordinator 3 made a home visit on 7 April 2010. Mr K had reduced his medication because he had not suffered a relapse in March. Mr K remained active in his social and service-user activities. Care Coordinator 3 told Mr K that Consultant Psychiatrist 11 would be taking over as consultant in the future and Care Coordinator 3 discussed organising a joint meeting with Consultant Psychiatrist 10 and Consultant Psychiatrist 11 to handover care, which Mr K agreed to.

Mr K attended his outpatient appointment with Consultant Psychiatrist 10 on 26 April 2010. The records show that Mr K was well and had no psychotic symptoms. He said his mood had been low for a few days but that this did not need intervention and had passed without incident. Mr K said he was abstaining from gambling and drinking and was "pleased with the changes he had made in his life." Mr K planned to apply for a job in the service-user team. They discussed how to manage the criminal records bureau check. Consultant Psychiatrist 10 mentioned the need for a handover meeting with Consultant Psychiatrist 11. Mr K told Consultant Psychiatrist 10 he was planning a holiday.

Care Coordinator 3 made a home visit On 23 May 2010. Mr K had booked his holiday, but said travelling on public transport made him anxious. Care Coordinator 3 discussed distraction and relaxation techniques used to cope with anxiety.

Care Coordinator 3 made a home visit on 17 June 2010. Mr K was well and active. No symptoms or other issues were noted. Care Coordinator 3 told Mr K that the handover of the consultants meeting would take place with him on 22 July 2010.

Care Coordinator 3 sent Mr K a letter on 6 July 2010 confirming the handover meeting.

Care Coordinator 3 made a home visit on 14 July 2010. Mr K had hurt his ankle. He told Care Coordinator 3 he had had two episodes of psychotic symptoms since she had been his care coordinator, but that he had felt unable to tell her at the time. Mr K said these episodes had happened before he felt he could trust her. Mr K said both episodes lasted for four days and that he had managed them by not going out and increasing his medication. Care Coordinator 3 and Mr K discussed his relapse plan at length. Mr K said he needed reassurance that hospital admission would not be the first option the care team considered unless the risk of harm to others was high. Care Coordinator 3 agreed to take Mr K's comments to the handover meeting with Consultant Psychiatrist 10 and Consultant Psychiatrist 11 a week later.

> Comment
> We found no record of why Mr K did not talk to other care contacts, such as the care support worker from Together or GP 1 about these episodes.

Care Coordinator 3 accompanied Mr K to the handover meeting with Consultant Psychiatrist 10 and Consultant Psychiatrist 11 on 22 July 2010. Mr K repeated his account of the two recent episodes of relapse saying they were accompanied with "extremely violent imagery". He said he had "locked himself in" and would not open the door to people because he could not be certain he would not act on the commands telling him to hurt them.

Mr K said he did not want the crisis team involved with his care because he "couldn't guarantee their safety". Nor did he want to be admitted when he relapsed because he felt it "may put others at risk."

Mr K's care plan was reviewed by the clinical team and amended to include 5mg of diazepam if he experienced hallucinations. Consultant Psychiatrist 11 also discussed a referral for cognitive behavioural therapy to help with unwanted thoughts.

> Comment
> The care team were in a difficult position because Mr K provided a retrospective account of his concerning symptoms. He displayed no symptoms at the time of his account. He would not have met the criteria for detention under the Mental Health Act at the meeting because he seemed well, with insight into his symptoms and was compliant with all treatment.

Care Coordinator 3 made a home visit on 6 August 2010. Mr K's ankle was better and he had resumed running. Mr K had withdrawn his application for the service user job because his criminal records bureau return would have mentioned his index offence. Care Coordinator 3 gave Mr K his amended risk assessment and care plan and Mr K signed them.

Mr K attended his first outpatient appointment with Consultant Psychiatrist 11 on 27 August 2010. He told Consultant Psychiatrist 11 he had withdrawn his application for the service user job. He was also waiting for a benefits review and was concerned he could be considered fit for work. Mr K felt he might be asked to take on work or

courses, which would increase his anxiety and that he might become unwell and "won't be able to control his actions". Consultant Psychiatrist 11 found Mr K otherwise well and planning appropriate strategies to deal with increased anxiety.

Care Coordinator 3 made a home visit on 28 August 2010. Mr K said he was well, but anxious about his approaching holiday. Mr K was particularly anxious about travelling on public transport. Care Coordinator 3 and Mr K discussed coping strategies including taking diazepam. Care Coordinator 3 sent copies of Mr K's care plan and risk assessment to the mental health services in the area he was taking a holiday in, so they would know how to manage Mr K if he relapsed.

> Comment
> Care Coordinator 3 faxing Mr K's care plan and risk assessment to the appropriate care team to provide information if he relapsed on holiday is an example of good practice.

Care Coordinator 3 made a home visit on 8 September 2010. Mr K had returned from holiday and had experienced no psychotic symptoms.

Mr K cancelled a home visit with Care Coordinator 3 scheduled for 16 September 2010 because it clashed with Mr K assisting with interviews for the trust. Mr K and Care Coordinator 3 agreed a new date.

Care Coordinator 3 made the rearranged home visit on 1 October 2010. Mr K said his mood had been low for a few weeks, that he had spent a day in bed and had fleeting thoughts of suicide. He had increased his anti-psychotic medication because he recognised that this was a potential relapse time. Care Coordinator 3 discussed a referral for cognitive behavioural therapy with him to explore his thoughts and low mood. Mr K agreed and Care Coordinator 3 said she would discuss it with the psychology team.

Care Coordinator 3 made a home visit on 22 October 2010. Mr K was well and planning a long weekend away with a friend from church. The Together care worker contract was up for review and Mr K and Care Coordinator 3 discussed the issue.

Care Coordinator 3 made a home visit on 9 November 2010. The records show that Mr K was well, with "no evidence of psychosis". Mr K and Care Coordinator 3 completed the funding application for continuation of the Together service.

Mr K attended his outpatient appointment with Consultant Psychiatrist 11 on 17 November 2010. Consultant Psychiatrist 11 said Mr K was coping well and getting on with day to day living. Mr K said he was looking forward to his break with a friend. Consultant Psychiatrist 11 had made a referral for cognitive behavioural therapy and told Mr K they were waiting for an appointment. When interviewed, Consultant Psychiatrist 11 said

> "We had talked about CBT because he was saying this was a particular way of thinking about things and that would wind him up."

> "There were no psychotic symptoms evident that were causing him trouble, so the rest of it was anxiety and getting on with improving [his] quality of life and [his] coping mechanisms."

Care Coordinator 3 visited Mr K in his flat on 1 December 2010. This was a routine home visit and the last contact trust services had with him before Mr K killed Jane Edwards. Mr K reported he had had a good weekend break and that he had also visited family. Mr K said he had been eating and sleeping well and had not experienced relapses in his mental state. Care Coordinator 3 told Mr K that he would have a new care coordinator in the New Year, which Mr K was "in agreement with."

When we reminded Care Coordinator 3 of this visit, she said:

> "It was a routine visit wasn't it? Mr K thought it had been a good week. He had been down to Weymouth."

Mr K killed Jane Edwards at her flat on 14 December 2010.

5.6. Assessments of Mr K after the killing of Jane Edwards.

Several professionals assessed Mr K after the killing. The documents show Mr K had given a different picture of his mental state to that recorded in his notes.

Approved Mental Health Professional 1,[1] Consultant Psychiatrist 11 and Independent Doctor 1 assessed Mr K on 15 December 2010. They assessed if he was fit for police to interview him about the killing of Jane Edwards and conducted a formal Mental Health Act assessment.

Consultant Psychiatrist 7, in her role as a Consultant Forensic Psychiatrist from the regional medium secure unit, and Senior Occupational Therapist 1 from the Prison In reach Service interviewed Mr K on 20 December 2010. Consultant Psychiatrist 7 recorded that an exchange of clinical information between Consultant Psychiatrist 10, Consultant Psychiatrist 11 and herself had prompted the interview and led to her making recommendations about the placement of Mr K in secure services as opposed to prison.

Consultant Psychiatrist 9, assessed Mr K while he was on remand in prison on 20 February 2011, in order to prepare a report for the courts.

Consultant Psychiatrist 9 also assessed him for the courts again on 25 May 2011. The police gave a copy of this report to Jane Edwards' family. Jane's family asked us to include the report in the documents we reviewed.

Mr K gave his account of events leading to the killing of Jane Edwards in these assessments:

[1] Under the Mental Health Act 2007, the role of approved social worker was abolished and replaced by that of Approved Mental Health Professional in England and Wales. Professionals are non-medical mental health workers trained to enact elements of the mental health act and provide a balance to the medical review of patients during assessment under the act.

- Mr K began to question whether to continue taking medication after attending sessions of the Alpha course at a local church (Autumn 2009);
- after discussing this with the church elders he decided to stop taking medication and rely instead on prayer and a belief in God;
- he stopped taking his medication in November 2010 and heard God's voice;
- God's voice told him to kill Jane. The voice said she was a witch;
- he did not tell his care team or other contacts this;
- at first Mr K resisted the voice, but then acquiesced and began to plan the killing;
- he began to take his medication again the evening he killed Jane and instantly felt a positive effect; and
- he regained insight immediately after taking his medication and realised that the voice of God had not been real.

However, we found some discrepancies in Mr K's accounts.

In his first assessment on 15 December 2010, the day after the killing, Mr K said the people in his church told him to stop taking his medication:

> "He was envious that he could not hear God despite endless prayer. He reported that he discussed this at the church and was told it was either prayer or pills and he should commit to one or the other not both."

In the assessment on 25 May 2011 he changed this:

> "He was quite clear that no one at [the] Church actually told him to stop his medication but that it was suggested to him that if he believed that God could cure him, then he should place his faith one hundred per cent in God."

Mr K did not talk about his decision to stop his medication with Care Coordinator 3, Consultant Psychiatrist 11, Together or GP 1. He had several opportunities to do so because his care team saw him throughout this period.

In the May interview with Consultant Psychiatrist 9, Mr K said he knew that his care team would have advised against stopping his medication.

Mr K said in the same interview that this would have been different if he was still under Consultant Psychiatrist 10's care:

> "I am sure if she'd still been my psychiatrist I would have talked to her about wanting to stop my medication and we could have done this together."

Mr K also blames his actions on his care team in other parts of the interviews. In the interview on 15 December 2010 Consultant Psychiatrist 7 recorded that Mr K:

> "felt he had a better rapport with [Consultant Psychiatrist 10] and since the change he had felt unhappy with the new people and so less inclined to let us [sic] know what was going on."

In the interview on 25 May 2011 Consultant Psychiatrist 9, recorded that:

> "[He] went on to say that the one thing missing from his life was a professional that he trusted and could talk to about stopping his medication."

The interviews also reveal that Mr K had not always been open and honest with professionals and was selective about what he had disclosed previously. For example, in the interview with Consultant Psychiatrist 7 on 20 December 2010, Mr K admitted to carrying the knife used to kill Jane Edwards for several years without the knowledge of his care team. Consultant Psychiatrist 7 records:

> "He then admitted that on discharge from Wroxeter ward [in 2003] he had bought a folding hunting knife and carried it with him always because he felt vulnerable. On close questioning he admitted that he carries it during all his activities with our trust including appointment advisory committees and so on."

In the interview on 25 May 2011, Consultant Psychiatrist 9 records Mr K saying:

> "The voices would then pick on someone…for example, a neighbour. The voices would say that he should smash the person over the head with a lump hammer or stab them in the chest with a carving knife…he said the voices always told him to stab or kill someone that he knew and that each time he would tell his Social Worker what was happening and be told to take {extra medication."

Mr K's claim that he told care workers of his violent thoughts in this much detail is not reflected in the notes, or our interviews with care staff.

At his outpatient appointment with Consultant Psychiatrist 10 on 8 June 2009, where Mr K disclosed more specific thoughts of harming two of his neighbours, Consultant Psychiatrist 10 directly asked Mr K if he carried a knife and he said he didn't. Mr K was clear in the meeting that he retained insight and would not act on thoughts to harm his neighbours.

Mr K reported in the handover meeting between Consultant Psychiatrist 10 and Consultant Psychiatrist 11 in 2010 that he locked himself inside when he had violent imagery. He also said he managed these situations without informing care staff.

In other care meetings, Mr K emphasised that he had insight into his condition, that thoughts of harming others were vague and not targeted at anyone and that he would never act on these thoughts.

> Comment
> Mr K gives a broadly consistent account of the killing of Jane Edwards, but his accounts also project some of the responsibility for his actions onto others.
>
> Mr K had demonstrated he was assertive about his care package and capable of commenting on the lack of confidence he had in several professionals before he killed Jane Edwards. He had met Care Coordinator 3 and Consultant Psychiatrist 11 several times before the incident and, after an

initial rejection of Care Coordinator 3 sometime earlier, seemed to engage with her.

Consultant Psychiatrist 11 expressed surprise at Mr K's comments after killing Jane Edwards because Mr K had attended his outpatient appointments and discussed his needs at length. Consultant Psychiatrist 11 said:

> "He was always perfectly polite in the meetings and seemed very comfortable and was happy to talk about what was going on. I was quite surprised that he felt that we didn't get on because that didn't ring true with replaying those patient sessions; he was perfectly relaxed and happy to chat away."

His GP had not changed and he did not mention his concerns as he had done in October 2005 when his care coordinator was on leave. Neither is there any record that he mentioned his concerns to any Together workers.

Mr K also disclosed after killing Jane Edwards that he had carried a knife at all times since discharge and that his thoughts were more personally directed and violent than he had led people to believe.

This casts a doubt on Mr K's ability to give an honest account of his thoughts, feelings and behaviour.

6. Issues arising

In the following sections we analyse and comment on issues relating to Mr K's care and treatment.

We considered the following issues:

- diagnosis and treatment;
- transfer and discharge planning from high secure care;
- CPA, risk assessment and management;
- the management and governance arrangements for service-user representatives and other voluntary workers;
- predictability and preventability;
- the trust's internal investigation; and
- progress on implementing the action plan.

6.1. Diagnosis and treatment

Several related factors made diagnosing Mr K difficult.

- Mr K is an intelligent man who is controlling and manipulative;
- he often appeared open when interviewed, but accounts of his history, behaviour and thought processes could not be fully trusted;
- a range of professionals assessed him. These assessments depended on previous assessments for determining diagnosis; and
- our medical advisors say it is difficult to challenge an established diagnosis particularly if other professionals have accepted it for many years and it has been determined after a course of treatment in a high secure forensic facility as in Mr K's case.

The most comprehensive discussion of Mr K's diagnosis came in a major case review Consultant Psychiatrist 6 conducted in November 2011 after the killing of Jane Edwards, when Mr K was in Ashworth Hospital.

Consultant Psychiatrist 6 concluded that Mr K did not satisfy the criteria for a diagnosis of paranoid psychotic illness but did satisfy the criteria for personality disorder. Our investigation team agreed with Consultant Psychiatrist 6 because:

Mr K's attitude to his diagnosis changed over time in Ashworth and the regional medium secure units. Mr K first preferred to be seen as having a personality disorder. His attitude to medication was particularly striking because at first he did not see a need for it. He later accepted it, because it may have helped his transfer.

Mr K's account of his auditory hallucinations also changed over time. The frequent relapses the community mental health team accepted as the norm did not occur during his time at Ashworth Hospital or Wroxeter ward.

Mr K's account of his psychotic symptoms was not typical. Symptoms rarely come in such an organised manner or respond to medication so quickly. An example of this is

the change he reported after he killed Jane Edwards and then took one dose of medication.

Dr Locke, the Forensic Psychiatrist helping our team told us that his psychotic symptoms might have been pseudo auditory hallucinations[1], sometimes seen in patients with personality disorders. They are typically relatively brief and often associated with stress or unpleasant events. Mr K reported such symptoms in later years when he was either stressed or exposed to unpleasant events, such as the anniversary of his index offence. He often reported them after a change in his care team, such as the consultant psychiatrist handover meeting in 2010.

Consultant Psychiatrist 6 concluded that although the nature of Mr K's psychotic experience was unclear, he did satisfy the criteria for a personality disorder.

We find that the care team often doubted the diagnosis of psychosis. Care Coordinator 3 and Consultant Psychiatrist 11 told us they doubted the diagnosis, but that it was long established and Mr K seemed to accept it. When asked if she felt Mr K had psychosis, Care Coordinator 3 said:

> "I personally didn't, because I had never seen him being psychotic. I had never observed it, and even in the conversations that we had with him, to my memory, when we had spoken to him when he was unwell, he would report having had psychotic symptoms but never sounded distracted. So there was some query whether there was a psychosis. But we know that the diagnosis when he was in Forensic Services had been of psychosis."

Finding

Mr K's presentation satisfied a diagnosis of personality disorder. He also demonstrated many psychopathic features[2].

6.2. Would Mr K's treatment have been different if he was diagnosed with a personality disorder?

Mr K's passage through the psychiatric system would not have been significantly different if he had been diagnosed with a personality disorder rather than paranoid psychosis or paranoid schizophrenia. It is likely he would still have progressed to absolute discharge and been living in the community.

[1] A pseudo hallucination is an abnormal sensory experience vivid enough to be considered a hallucination, but recognized by the person as not externally triggered. The continual assertion that Mr K had insight when he was said to experience "voices" would indicate the possibility they were pseudo hallucinations.

[2] There is much debate in forensic psychiatry about what constitutes psychopathic features. In Mr K's case, his double homicide, seeming failure to accept full responsibility for his actions and his need to control others may indicate some degree of psychopathology.

Dr Locke has told us it is more likely a forensic psychiatric team would have followed him up after conditional discharge and he would also have spent longer as a conditionally discharged patient before he was given absolute discharge if he had been diagnosed with personality disorder.

Clinical staff often described Mr K as a "model patient" and an absence of concern would have allowed him to progress through the levels of security to a conditional discharge. If he continued to cause no concern and was compliant with the treatment plan in the community, it is likely he would have also progressed to absolute discharge despite a diagnosis of personality disorder.

> Comment
> It seems evident now that Mr K did not suffer from paranoid schizophrenia or paranoid psychosis. His diagnosis should have been a personality disorder. It is possible he suffers from pseudo hallucinations when stressed.
>
> Although his care team had doubts about his diagnosis, the fact that he had been diagnosed and medicated in high secure care for many years influenced them.

Finding

Although the accuracy of Mr K's diagnosis can be questioned, the likely alternative diagnosis would have led to the same outcome in terms of discharge. In other words, he may have been in a different part of the service, such as under the care of a community forensic team, but it is likely he would still have been living in the community in 2010, even with a diagnosis of personality disorder.

6.3. Transfer and discharge planning from high secure care.

Mr K was admitted to Broadmoor Hospital under sections 37 and 41 of the Mental Health Act in April 1986. He was moved to Ashworth Hospital in July 1987 because of overcrowding. Mr K was under the care of Ashworth Hospital for a total of 16 years.

He was given leave of absence from Ashworth Hospital to attend regional medium secure units twice before his move to Shropshire. Both visits happened after Mental Health Act tribunals and were on a trial basis. Both were unsuccessful and he returned to Ashworth.

He was moved to Wroxeter ward on a trial basis after an independent assessment from a mental health tribunal.

Wroxeter ward staff attended his care programme reviews before his transfer to Ashworth Hospital. Ashworth Hospital also provided follow up, as they had with his previous leaves of absence.

Mr K was formally discharged from Ashworth Hospital in 2001, but remained under sections 37 and 41 of the Mental Health Act until 2006. This meant the Home Office still monitored his care. He was only given absolute discharge from sections 37 and 41 after a tribunal hearing in 2006. The Home Office therefore monitored him for five

years after discharge from Ashworth Hospital. He could still have been recalled to Ashworth Hospital or another high secure hospital if the home office or clinical staff had any concerns.

Mr K became an informal patient living in the community, no longer under Home Office monitoring in 2006. The decision of the final tribunal in 2006 is included in Appendix B and shows the tribunal was satisfied Mr K had fully engaged with his care team.

Mr K described symptoms after his absolute discharge but was also apparently compliant with his treatment and engaged with his care team. Mr K did not present in a way that demonstrated he was suffering from "a mental disorder of a nature or degree that warranted detention in hospital for assessment" or that he should be detained in the interests of his own health or safety.

Finding

Ashworth Hospital complied with all legal and clinical duties expected from them on discharging Mr K, even if they were incorrect about his diagnosis.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust complied with Home Office monitoring after his discharge until his absolute discharge from sections 37 and 41 of the Mental Health Act. South Staffordshire and Shropshire Healthcare NHS Foundation Trust also complied with all the legal and clinical duties expected of them.

6.4. CPA, risk assessment and management

The South Staffordshire and Shropshire Healthcare Care Programme Approach Policy (CPA) says:

> "The term 'Care Programme Approach' (CPA) has been used since 1990 to describe the framework that supports and coordinates effective mental health care for people with severe mental health problems in Secondary Mental Health Services."

This policy was formulated on the basis of national guidance and the Department of Health's refocusing CPA guidance[1]. The latest version was implemented in January 2011 after guidance from the Department of Health in 2008.

The CPA applies to hospital inpatients and clients in the community. This means Mr. K's care in the trust was managed under the CPA from January 2000 until December 2010.

[1] Department of Health Policy and Practice guidance *Refocusing the Care Programme Approach* (March 2008).

CPA requirements ensure:

- service user's health and social care needs are assessed, including an assessment of jeopardy to their safety or the safety of others;
- a multi-disciplinary care plan is made that details how these needs will be met, including crisis and contingency plans;
- a Care Coordinator is allocated to the service user to oversee care plan implementation and to link service users to other appropriate services; and
- regular reviews are made to ensure the care plan remains appropriate.

National CPA guidance says that carers or family should be consulted if they are involved with a client's care.

We found clearly documented evidence that Mr K's treatment was continuously managed under the CPA.

Our investigation shows there were regular multi-disciplinary meetings and records of review while Mr K was on Wroxeter ward.

Mr K was formally discharged from the ward to the community under the CPA in June 2003. Consultant Psychiatrist 8 reviewed his care continually in the community after that. We found clear records of CPA meetings. Mr K attended all these meetings and signed copies of resulting care plans[1] .

The dates of care plans after his discharge from Wroxeter ward were:

- 22 February 2004
- 13 October 2004
- 25 May 2005
- 23 June 2005
- 27 April 2006
- 26 June 2007
- 23 October 2007
- 31 October 2008
- 31 October 2009
- And finally 23 July 2010 (signed by Mr K on 5 September 2010)

The proposed date for the next care plan review was 30 January 2011.

The standard of the care plans is good. They are clear, written in the client's language and incorporate social needs as well as health needs. All care plans are signed by Mr K. Care Coordinator 3 told us that when she worked with Mr K he would read them carefully before signing.

[1] Care plans were renamed wellness/recovery plans after a policy review in 2008.

These care plans had been carefully considered by his care teams and are referred to in other documentation such as outpatient notes from care coordinator meetings with Mr K.

With regard to carer involvement, Mr K's cousin was nominated his next of kin when he was first discharged from Ashworth Hospital. Mr K had no main carers or family locally after she emigrated in 2002, although he visited his aunt and uncle on occasions.

As the chronology of Mr K's care shows, his care teams reviewed risk assessment and risk management plans at CPA meetings. The quality of risk assessment is satisfactory in that they are clearly written and chart the changes in risk presentation and risk management over time.

> Comment
> The community mental health team showed good practice in their management of Mr K under the CPA.
>
> However, the care team advised its workers that Mr K should be visited in pairs if workers did not know him. We found no evidence that the care team considered him a risk to the public at that time. Instead, the advice to attend in pairs was designed to support his care.

Finding

The multidisciplinary team regularly reviewed Mr K's care plans and wellness/recovery plans and they formed the basis of his care.

The multidisciplinary team developed Mr K's care plans with him.

7. The management and governance arrangements for service-user representatives and other voluntary workers

Mr K was involved in a lot of service-user involvement work from 2001 to 2010. We have summarised this activity below. Mr K:

- assisted several trust groups;
- assisted in a wide variety of staff training;
- sat on the editorial board for various trust websites;
- attended the Department of Psychological Therapies' monthly development meetings; and
- was trained to sit on staff interview panels. He was on panels for a variety of staff jobs and appointment panels from 2002 to 2010.

Jane Edwards also assisted the Trust. Service-User Involvement Coordinator 1 told us she volunteered with the editorial board for Trust websites and attended meetings at the Department of Psychological Therapies. Service-User Involvement Coordinator 1 and Care Coordinator 3 told us that Jane Edwards also helped with staff interviews.

It is possible Jane Edwards and Mr K met at these activities, but the Trust Service-User Involvement Coordinator for Shropshire told us they became friends while working on the editorial board for trust websites.

Consultant Psychiatrist 11 told us that Mr K had mentioned his friendship with Jane in their out-patient meetings in late 2010. Her recollection was that they were meeting regularly at that time.

> "We were talking about activities and social things and what was he interested in. I think he was weekly round at her house. I don't know what she was like, but presumably they talked about something other than the superficial stuff we got to talk about."

Consultant psychiatrist 11 told us that these meetings were social meetings rather than on any form of trust business.

> "I remember him saying that he would go round to her house for dinner and they would share a bottle of wine or something."

After the homicide, Mr K said that he and Jane were just friends and there is no evidence that the relationship was romantic or sexual.

Mr K was a service-user representative because he was receiving care under the CPA. Jane, who did not receive services, was a volunteer for the Trust.

We recognise the benefit of service users and volunteers working for the Trust. Modern mental health services rightly encourage this type of involvement to improve

services and help service users in their recovery from mental health problems. However, this involvement needs to be carefully managed and subject to good governance.

Governance systems were still in the early stages of development at the trust when Mr K started service-user representative work. Service-User Involvement Coordinator 1 monitored individual service-user involvement but there was no central management under a formalised governance process.

We have sought assurance from the trust that such management and governance now exists at the Trust.

Company Secretary 1 told us several changes had taken place since 2010. The Trust has developed several "peer support worker" roles[1]. It is also developing "Service Development and Improvement Support Workers" who will carry out the same type of activities as Mr K and Jane Edwards under a new governance structure.

The Trust brought service and carer involvement under one corporate team in 2014, the "Involvement and Experience Team."

We saw a draft copy of the recently developed "Recovery: Service Development and Improvement Support Worker Guide for Divisions and Directorates" policy. It outlines the recruitment, management and supervision of the Service Development and Improvement Support Workers.

The policy says workers can be employed for either particular roles or to undertake time limited projects.

> "Each role and project should, through the project plan, ensure that clear objectives and outcomes were established at the outset including clarity over expectations in terms of what is realistic and achievable including the timeframe. In doing this, it will be important to focus equally on the outcomes for the Trust as on the recovery outcomes and benefits for the service users and carers participating in this work."

Trust staff told us in interviews and focus groups that care coordinators will be important for identifying potential workers, risk assessing them and providing support to maintain their mental health during the work.

> "what we would expect is that we would register those people as involvement representatives, and we would liaise with their care coordinators to make sure that they were (a) supported and (b) well enough, and (c) risk assessed to be able to contribute in … The Involvement Experience [team] would say this person is being put forward or we would like to ask this person to do x, and they would liaise with the Care Coordinator to make sure that those three things were assured for them to do it."

[1] Peer support workers are people who have experienced mental health problems either themselves or as a carer. The trust employs them to use their experience to support service users alongside trust care staff.

Care coordinators would also be involved in reviewing the service user's specific involvement.

Company Secretary 1 told us the Involvement and Experience Team intends to monitor service user activity by creating a database of roles and projects authorised by the trust.

The policy is yet to be finalised and the process piloted in a service directorate.

> Recommendation
> The Trust should fully support the finalisation of the "Recovery: Service Development and Improvement Support Worker Guide for Divisions and Directorates" policy and the pilot that will evaluate it.

8. Predictability and preventability

In this section we examine whether the killing of Jane Edwards could have been predicted or prevented.

8.1. Predictability

We assess predictability based on the following principle:

> The homicide would have been **predictable** if there was evidence from Mr K's words or behaviour that could have alerted professionals he might become violent imminently, even if this evidence had been unnoticed or misunderstood.

Mr K said in July 2010 that he could not be certain he would not act on the hallucinatory auditory commands. He said in August he might become unwell and wouldn't be able to control his actions. We found no evidence in his words, actions or behaviour that could have alerted professionals that Mr K might become imminently violent, despite these vague threats.

To the best of our knowledge, Mr K and Jane Edwards had known each other from at least 2004 when they sat on a trust panel together. At some time during this, they became friends. There is no evidence that their relationship was romantic or sexual. By the time of the homicide they were meeting regularly, including some occasions when Mr K visited Jane's flat.

We found no evidence that Mr K told his care team or others that Jane Edwards was at risk from him or that he was planning to kill her. Also, none of the care team knew he was due to visit her on 14 December 2010 and would not have had reason or power to prevent the visit even if they had.

Mr K told the police after he killed Jane that he had informed his care team he was going to kill someone. However, we found no documentary or oral evidence to support this.

Finding

We do not consider that the killing of Jane Edwards was predictable. We found no words, actions or behaviour from Mr K in the weeks leading up to the killing that should have alerted his care team.

8.2. Preventability

We assess preventability based on the following principle:

> The homicide would have been **preventable** if professionals had had the knowledge, legal means and the opportunity to stop the violent incident from happening, but did not do so.

Establishing that there were actions that could have been taken would not provide evidence of preventability, because there are always things that could have been done to prevent tragedy.

Mr K was an informal patient in the community at the time of the killing, so would not have been obliged to follow the advice of Consultant Psychiatrist 11 or Care Coordinator 3.

His care workers would have needed evidence of imminent self-harm or harm to others before they could have legally intervened and admitted him to hospital under the Mental Health Act. Mr K did not present in a way that demonstrated he was suffering from "a mental disorder of a nature or degree that warranted detention in hospital for assessment" or that he should be detained in the interests of his own health or safety, or to protect others, before killing Jane Edwards.

Mr K was assessed immediately after killing Jane and found not detainable under the Mental Health Act 1983 because he was not seen to be suffering from a mental illness.

Finding

We consider that the killing of Jane Edwards was unpreventable. The care team did not know the danger to Jane Edwards because Mr K did not tell them even though he had had opportunities to do so.

8.3. The Trust's internal investigation and progress on implementing its action plan

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

In this section we examine the national guidance and the Trust's incident policy to determine whether the investigation into the care and treatment of Mr K met requirements.

The National Patient Safety Agency (NPSA) good practice guidance, *Independent investigation of serious patient safety incidents in mental health services*, February 2008*,* stipulates that an internal NHS mental health trust investigation should take place after a homicide to establish a chronology, identify underlying causes and further action needed.

Good practice also highlights that staff should be interviewed by the internal investigation team or write statements, depending on how important they are to the case. There should be an enduring record of the interview, which staff should sign.

Trust policy also advises that an internal investigation should take place after a serious incident to determine what can be improved.

The Trust policy at the time was the “Incident, Near Miss and Serious Incident Policy” implemented on 1 July 2011.

According to trust policy, the investigation was graded level two. This required that:

- two or three professionals, led by a registered investigator, perform a comprehensive root cause analysis review;
- an initial report was given to the commissioner within 48 hours of the incident; and
- the report was completed within 45 days of the incident unless the Associate Director of Quality and Risk agreed an extension.

In Mr K’s case, the Trust undertook an internal investigation, appointed a post-incident review investigator to lead it, and developed its terms of reference. These terms are outlined below:

- To establish the facts i.e. **what** happened, **when, how** and **why**
- To establish impact on care or treatment
- To identify areas for improvement.
- To establish how recurrence may be reduced or eliminated
- To formulate *recommendations and an action plan*
- To provide a *report* as a record of the investigation process
- To provide a means of *sharing learning* from the incident

Lead Investigator 1 told us that the investigation started with a team of three, but that they did not work together throughout the whole process.

One worker completed a review of the notes. As far as we know, this was their only contribution and they had no part in considering or drafting the final report.

The two other workers liaised with Jane Edwards’ family. Mr K’s family was estranged from him at the time of the investigation.

Lead Investigator 1 interviewed key staff and drafted the report and recommendations.

> Comment
> For an incident as serious as the killing of Jane Edwards, the Trust needs to ensure the investigation has three people working on it for the entire duration of the investigation.
>
> Recommendation
> The trust should develop a system to monitor investigation teams and ensure resources are adequate to meet standards identified in the Incident, Near Miss and Serious Incident Policy.

Lead Investigator 1 also told us that the Trust had to manage another level-two incident investigation at the time.

Lead Investigator 1 was trained in root cause analysis and was experienced in conducting serious incident investigations.

The investigation conducted interviews with three staff members: the care coordinator 3 and two consultants, Consultant Psychiatrist 10 and Consultant Psychiatrist 11.

The investigation team liaised with Jane Edwards' family, writing to them and meeting them throughout the investigation. As with our investigation, they found the police had given Jane Edwards' family information about the case and they had several questions as a result. The investigation attempted to answer them.

Finding

- The investigation resulted in a report outlining the chronology of Mr K's care.
- It identified no failures or errors in care or service delivery.
- The Trust investigation identified no significant contributory factors.

In agreement with our report, the Trust investigation did not consider the killing of Jane Edwards predictable or preventable.

It did identify two actions for improving communication and risk management. These were:

1. "The alert card at the front of the clinical notes is to be completed for all service users. Staff to be reminded to complete."

The action plan records that the trust circulated an "urgent safety alert" in November 2011. The alert card system referred to in the recommendation has been made redundant since the introduced of electronic records. The electronic records contain an automatic alert in the event of risk being identified.

2. "Meetings to be held with key members of the team to discuss the need to include any planned interventions that were considered to be part of risk management should be explicitly documented in the risk management or relapse plan rather than in separate documents."

Recommendation 2 is difficult to understand. When we interviewed Lead Investigator 1 she explained that this action refers to the questions Consultant Psychiatrist 10 and Mr K drew up at his outpatient appointment on 3 November 2011 (see page 26 of this report). They were the template for phone calls between the community mental health team and Mr K. The clinical team considered the questions an important part of monitoring Mr K's risk, but there was concern that many staff members would not be aware of them if they were separate from other risk management or relapse plan documents.

The Trust investigation lead did not question Mr K's diagnosis, but we have had the benefit of a great deal of extra information which was made available to us following Mr K's assessment at Ashworth Hospital.

Finding

The Trust carried out an internal investigation in line with Trust policy. Given the information the review team had a time, its findings are adequate, but the recommendations of the review were not clear.

Appendix A – Chronology of care from 1986-2001

Early life to admission to Ashworth Hospital

Early life.

Mr K was born in 1959. He was the eldest of four children.

Medical records relating to his first homicide in 1985 refer to his childhood.

Mr K caused concern to his school and local social services as a child, which led to him being placed in a children's home on one occasion.

After school until first homicide

Mr K moved between jobs after leaving school. He joined the army twice, first when he was 17, completing a three-year commitment and rising to the rank of Lance Corporal. After this he joined the police and completed training before becoming a beat constable. He found this difficult and left the police force. He re-joined the army in 1982 for his second term.

During his first period in the army he came to the attention of army psychiatrists when he stripped naked during a routine exercise. During his second period in the army Mr K developed an interest in the Nazis. This led to disputes with his colleagues. Mr K then made an unsuccessful suicide attempt by cutting his wrists. We are unclear if this was linked to the dispute with colleagues. The injury was severe, needed surgery and led to long-term complications. The army deemed him "unfit for duty" in 1983 and discharged him.

After a short period of staying with friends, he moved back in with his parents. He secured a council flat shortly after this.

Mr K looked for employment. He was interviewed for a position once but turned down when his army discharge was taken into account.

Mr K became despondent and depressed after this. He increased his drinking and a gambling habit that had started in his teens. He became increasingly resentful towards his family.

In April 1985 Mr K took a serious overdose of medication. He alerted a neighbour and was taken to hospital. He was then admitted to psychiatric hospital. Mr K discharged himself three days later.

Mr K committed a homicide and was remanded in prison in September 1985.

Remand and first mental health diagnosis

Mr K became suspicious of the prison guards while on remand in prison. He felt they were conspiring against him and punishing him. He said he heard prison officers

talking about him and thought other prisoners were laughing at him and mocking him.

However, Mr K also described making friends in prison for the first time in two years and that the possible auditory hallucinations (i.e. the guards talking about him) stopped when Mr K felt the staff were treating him better.

Two experienced forensic psychiatrists gave Mr K two psychiatric assessments for the courts while he was held on remand. Both assessments concluded Mr K was suffering from a "paranoid psychosis" at the time of the killing.

Mr K appeared at Crown Court in April 1986 where he was convicted of manslaughter by reason of diminished responsibility. He received a hospital order with restrictions without limit of time.

Care and treatment at Ashworth Hospital

Ashworth Hospital First admission: 22nd July 1987 to 26th July 1995

Mr K was admitted to Owen ward at Ashworth. This ward was for people with mental illness. On the ward, staff initially described Mr K as pleasant and cooperative on the ward. Over time, ward staff doubted the original diagnosis of paranoid psychosis:

> "…the majority opinion was that he is not suffering from mental illness… his index offence was premeditated. This patient displays manipulative behaviour, is very controlling emotionally and regards his index offence as only a blot on his copy book."
> (Entry in Ashworth records in November 1987 as quoted in later report. Original recorder not identified.)

Mr K was transferred within Ashworth from Owen ward to Forster ward in October 1988. Forster ward at that time was for patients with a psychopathic disorder rather than mental illness.

Mr K was under the care of Consultant Psychiatrist 1 on Forster ward. In a case conference in February 1989 Consultant Psychiatrist 1 recorded:

> "…at our recent case conference the Patient Care Team felt that he had probably been psychotic at the time of his index offence and this psychosis has resolved. However, we are left with a man who had a personality vulnerable to the development of paranoid psychosis and in a stressful situation, such as trying to survive in the community; there may be a further relapse of his paranoid psychosis."

Mr K began psychological treatment exploring family dynamics, distortions in thinking and understanding his thoughts and emotions before and after his offence. Mr K was said to be "highly motivated to participate constructively."

Mr K was permitted leave in the grounds at the responsible medical officer's discretion by April 1989. This was extended in August 1989 to occasional rehabilitation trips out of the hospital.

Mr K's clinical team were considering a transfer to a regional medium secure unit[1] in 1990.

Mr K attended the mental health review tribunal in June 1990, which assessed his suitability for transfer to the medium secure unit in Manchester. The tribunal rejected the application for transfer saying:

> "we are not satisfied the Mr K's insight into the index offence and the episode in the army, were more than limited… his firm refusal to consider a transfer to the Prestwich [regional medium secure unit] … struck us as unduly rigid."

Mr K was again transferred within Ashworth from Forster ward to Lawrence ward in September 1990. Lawrence ward was also for patients with a psychopathic disorder. On Lawrence ward Mr K received further psychological therapy. This included a family therapy session that was described in his notes as "quite successful", although not all Mr K's family attended.

Mr K was transferred back to Forster ward in early 1992 at his own request because there were tensions between him and other residents of Lawrence ward[2].

We found a detailed account in the notes of Mr K's reactions to these tensions:

> "…he has found himself slipping into the old pattern of thinking of retribution and doing something extreme to hurt everyone who has hurt him. In this case he wanted to take it out on patients and on objects to show people how badly he was feeling but at the same time he didn't want to do these things and has held onto the feelings. He is scared he will act if he is not removed from this ward…"

The cause and response to these tensions became a part of his therapy on Forster ward. Mr K also started to attend a communication skills group.

Mr K changed his name by deed poll in January 1993. His parents met with a social worker afterwards and said that Mr K had changed his name "to hurt them". The social worker reported that his parents' comments shocked Mr K.

[1] Regional Medium Secure Units are units that offer a level of "medium" security for patients. They operate as a step down from high secure units (such as Broadmoor of Ashworth Hospitals), but with higher levels of security than "low" secure or open units. There can sometimes be confusion because Regional Secure Units can also be described as Medium Secure Units because the "regional" is a geographical prefix, while "medium" describes the level of security. The most accurate title would in fact be "Regional Medium Secure Units" which we shall use throughout this report.

[2] Lawrence ward eventually became the subject of the Fallon Inquiry for which Mr. K was interviewed

Mr K asked for prophylactic medication to be prescribed in May 1993. Consultant Psychiatrist 1 turned down the request because Mr K had not displayed psychotic symptoms during his admission to Ashworth or during recent tensions with his family.

Mr K visited a regional secure unit in Bristol in June 1993 in preparation for a possible move. Mr K asked for a mental health review tribunal in October to consider a request for conditional discharge from his section 37. The tribunal did not support his request, but did recommend a move to a regional medium secure unit.

Mr K had begun a relationship by February 1994 with a former voluntary visitor to Ashworth. The case review following the killing of Jane Edwards records that the relationship lasted for some years and that Mr K had visited her alone when on rehabilitation visits. This was strictly against hospital policy.

During this time Mr K also made a claim for a War Disablement Pension on the grounds that service in the army caused his mental illness. This was accepted with payment suspended until he was released from hospital.

Mr K was transferred to Macaulay ward in Ashworth Hospital on 1 April 1994.
Mr K changed his name by deed poll again on 3 May. He did not return to his original name but chose a new one. He said he changed it again in response to his parents' objections.

Whilst on Macauley ward, Mr K said he would accept that he would be transferred to a regional medium secure unit when he came out of high secure services. He continued his relationship with the former voluntary visitor. In November a mental health review tribunal agreed to transfer Mr K to the regional medium secure unit in Bristol.

Mr K had a two-night trial stay in the medium secure unit in April 1995. He was formally transferred from Ashworth in July 1995. This meant he was on a leave of absence from Ashworth and Ashworth would have followed him up until he was fully discharged. Home Office approval was needed for this leave of absence.

Bristol regional medium secure unit: July 1995 to October 1995

Mr K made several complaints to ward staff about his care within a month of admission. These included not being allowed enough leave from the unit, the working of his care team, the provision of financial aid for his female friend's visits and his difficulties with other patients.

Mr K's dissatisfaction with his care continued throughout his time on the unit. Mr K was involved in a fight in September 1995 with a disabled resident who was shouting at him.

A case conference was held on 21 September 1995 at Mr K's request and he complained again about his care.

Mr K wrote letters to his Bristol care team and staff at Ashworth after the case conference. He also phoned a Consultant Psychologist 1 at Ashworth. He outlined

his concerns about his care, admitted to drinking alcohol and said he wanted to go back to Ashworth.

24 September 1995 was the 10th anniversary of the index offence. Mr K discussed this with his care team in Bristol.

Mr K was prescribed stelazine[1] on 2 October 1995 after advice from Consultant Psychiatrist 1 in Ashworth. This was described as a prophylactic measure because there is no record of active psychotic symptoms.

Ashworth Hospital agreed on 4 October 1995 to transfer Mr K back to their care. On his discharge from Bristol, Consultant Psychiatrist 2 recorded:

> "From the very beginning he [Mr K]… pushed the boundaries and demanded that the whole rehabilitation programme run at high speed…His complaints involved everything… Then came a time when he communicated to staff that he wished to go back to Ashworth. To emphasis this point he made it explicit that, if his wishes were not met very soon, he knew how to orchestrate such a move."

Mr K was transferred on 7 October 1995 back to Ruskin ward, a high dependency ward at Ashworth Hospital.

Return to Ashworth 7th October 1995 to 16th of July 1998

Mr K stayed on Ruskin for approximately six weeks after readmission. The stelazine was discontinued by medical staff because Mr K said he no longer needed it. Mr K was not allowed leave from the ward due to being assessed after readmission. Mr K complained about these restrictions and not being able to return to Ashworth with the same level of leave as when he left. His female friend continued to visit.

Mr K was transferred to Owen ward on 10 November 1995. He restarted psychology input and was granted leave.

Mr K was implicated in a fraud scam on the ward in January of 1996 when he was found with a chequebook, driving licence, birth certificate and an expired passport.

Mr K's female friend attended a case conference on Owen ward on 13 February 1996. In the case conference Mr K asked if he could stop psychology sessions and that he would like to return to the regional medium secure unit in Bristol. He felt the move had failed because he "had not been committed to the transfer".

Mr K's psychology sessions were stopped at his request in April 1996.

[1] Stelazine is a trade name for trifluoperazine. It is used in the long-term management of psychotic conditions such as schizophrenia. It can also be used in the short-term to manage severe anxiety and severely agitated or dangerous behaviour.

Mr K asked in May 1996 to be referred to Amber ward, a mixed sex ward, after an incident where he punched a fellow patient. The request was accepted and a referral made.

Mr K had a mental health review tribunal in October 1996 and said he was anxious about moving to Amber. In November Mr K changed his mind about moving to Amber saying he would be in a "stronger position" if he remained on Owen ward.

Consultant Psychiatrist 3 took over consultant responsibilities from Consultant Psychiatrist 1 in March 1997. Mr K also confirmed in March 1997 that his relationship with his female friend had ended. Mr K was prescribed antidepressant medication for low mood but the clinical notes are unclear if these events were connected. A case conference record on 18 March 1997 indicates that his return to the regional medium secure unit in Bristol was no longer possible.

Wales July 1998 to February 1999

Mr K was transferred to a regional medium secure unit in Wales in July 1998 on a six-month leave of absence. On transfer, Mr K was allocated and followed up by a resettlement nurse from Ashworth Hospital.

Mr K was later admitted to the acute admission ward at the regional medium secure unit. Staff reported that he was "initially bored" on the ward and was "irked" by delays in completing admission assessments. After a long interview with a social worker in September, Mr K is said to have been angry and aroused. After first refusing medication, he was eventually prescribed a "prophylactic" anti-psychotic. This was flupenthixol[1], which is administered as a depot injection. Mr K developed marked side effects to this medication.

Mr K sought a conditional discharge from sections 37 and 41 from the mental health review tribunal again in October 1998, but this was denied. In its ruling the tribunal said "more work needs to be done in hospital before discharge should be considered".

Mr K was also prescribed fluoxetine[2] in December, due to low mood. This was only prescribed for a short time and a subsequent report on his return to Ashworth Hospital noted that he was off all prescribed medication at the start of 1999.

Subsequent discharge summaries record that Mr K "showed no signs of hallucinations, delusions or disturbed thinking patterns" during his stay.

By the end of 1998 there was a plan to transfer Mr K from the acute ward in the unit to the rehabilitation ward. Formal transfer of care from Ashworth to the regional medium secure unit needed Home Office approval. The Home Office imposed a

[1] Flupenthixol is an antipsychotic. It is prescribed to diminish disturbed thoughts, feelings and behavior in psychotic illness such as schizophrenia. It has a calming effect and controls aggression, delusions and hallucinations. It also has several distressing side effects.

[2] Fluoxetine (more commonly known as Prozac) is a selective serotonin reuptake inhibitor (SSRI) antidepressant. It affects chemicals in the brain that may become unbalanced and cause depression, panic, anxiety, or obsessive-compulsive symptoms.

further four months leave of absence from Ashworth before transfer could be considered. This delayed the move within the unit and meant that Mr K remained on the acute ward.

Mr K rang his resettlement nurse at Ashworth in January 1999 requesting a return to Ashworth. The nurse recorded;

> "Mr K feels present ward does not meet his needs and is frustrated with delay in transfer. Mr K also says that he is ambivalent about future freedom as he doesn't "deserve a second chance…"

When Mr K was transferred back to Ashworth, Consultant Psychiatrist 4, in Wales reported that:

> "[Mr K] had done all that could be expected of him in regard to cooperating with treatment and psycho-dynamic work…"

Second return to Ashworth Hospital February 1999 to January 2001

Mr K was readmitted to Lawrence ward at Ashworth Hospital on 3 February 1999. He also returned to the Wordsworth service[1].

Mr K discussed his attitude to medication at the Wordsworth service. He felt he had not needed it for 13 years and did not understand why this had changed. He also felt that taking it may be "beneficial to [him] in the future, if a tribunal recommended medication as part of a discharge plan."

Mr K was transferred back to Owen ward in July 1999.

In a letter to Mr K's lawyers, Consultant Psychiatrist 5 of Ashworth Hospital said Mr K had reasonable concerns about the care he received in the unit in Wales and that medication was "clearly not indicated." However Consultant Psychiatrist 5 also wrote that medication to reduce "tension" would be helpful.

Consultant Psychiatrist 6 from Ashworth Hospital wrote to the Home Office in April 2000 saying he still wanted to transfer Mr K to a regional medium secure unit. Consultant Psychiatrist 6 has already contacted the Bristol unit again and they said they would be willing to consider a re-referral.

Consultant Psychiatrist 7 assessed Mr K in May 2000 for a forthcoming mental health review tribunal. Consultant Psychiatrist 7 accepted the diagnosis, which had been changed to "paranoid schizophrenia", and recommended Mr K should be prescribed an antipsychotic drug to give Mr K "protection from relapse". Consultant Psychiatrist 7 advised that Mr K should regularly take an anti-psychotic before referral to a regional medium secure unit could be considered.

[1] The Wordsworth Service was a day service separate to the wards that provided a range of therapies.

Consultant Psychiatrist 7 told us:

> "he was on no anti-psychotic medication, and I said, in a nutshell, that I wouldn't bring him to medium security unless he did have because I felt that there was significant evidence that he had failed before in medium security in relation to stress..."

The mental health review tribunal on 16 June 2000 accepted that Mr K did not require the maximum security of Ashworth Hospital and could be managed "in conditions of lesser security".

The tribunal suggested two units for transfer. One was a regional medium secure unit in Stafford and the other was Wroxeter ward, a low secure rehabilitation ward in Shelton Hospital, Shrewsbury.

Mr K's referral to Wroxeter ward was accepted and arrangements were made for his transfer. Mr K was granted two days leave of absence from Ashworth to stay on Wroxeter ward in October 2000.

The stay was successful and the Home Office subsequently granted Mr K a six-month leave of absence from Ashworth Hospital to Wroxeter ward. Mr K was transferred to Wroxeter ward in January 2001.

(to continue the chronology, go to page 12 of this report.)

Appendix B – Decision of tribunal (2006)

Mental Health Review Tribunal granting absolute discharge from Section 37/41

Decision of the Mental Health Review Tribunal.

17th of August 2006

Mr K seeks an absolute discharge.
His [first homicide was] in 1985,
At the time of that offence he was suffering from paranoid schizophrenia.
At the Crown Court he was placed under sections 37 and 41 of the Mental Health Act 1983.
He spent some years at Ashworth Hospital after which he was transferred to Shelton Hospital for further treatment and rehabilitation.
He was fully compliant with his treatment plan and by June 2003 he was residing in the community.
Whilst he was subject to a conditional discharge he experienced some minor relapses and minor auditory voices (sic).
On each occasion he recognised that his illness was returning and he behaved appropriately by increasing his medication and contacting mental health Services.
There was never any necessity for hospital admission. He knew who to contact out of hours.
The community care plan will remain the same should there be an absolute discharge.
He is well involved with mental services and has contact with someone on a weekly basis.
He is currently engaged in service user work for the local mental services.
He has moved to a Housing Association flat and has adapted well to community life.
He has an amicable relationship with his neighbours.
He expresses deep remorse for what he did
He does not have contact with his family.
He has made no attempt to contact them.
The panel found [Mr K] to be a truthful and sincere man and they agree with the clinical team in saying he would not, now, be regarded as someone who would be a risk to others.
Having looked at the whole of the evidence the panel concur with the team that an absolute discharge is merited, and we do order an absolute discharge.

Appendix C – Response to Jane Edwards' family

Specific Questions from Jane Edwards' family

1. How did Mr K and Jane Edwards meet?

Mr K and Jane were part of an editorial panel helping to develop a website for trust service users. This panel began work in 2005. As far as we know, Mr K and Jane first met during this work.

From the evidence we have seen and heard, Mr K and Jane were meeting each other on a regular basis in the months before her death. As far as we are aware, they were meeting as friends and not about their activities with the trust.

2. What was the process through which Mr K was discharged from Special Hospital Care (i.e. Broadmoor and Ashworth Hospital)?

In the report we referred to Broadmoor and Ashworth Hospital as high secure Hospitals rather than "Special Hospitals" under the Special Hospitals Service Authority.[1]

This is to clarify the security level of each hospital involved in Mr K's care, rather than which NHS department is responsible for them.

Mr K was admitted to Broadmoor Hospital under sections 37 and 41 of the Mental Health Act in April 1986. He was moved to Ashworth Hospital in July 1987 because of overcrowding. Both hospitals have wards for people diagnosed with psychosis.

Mr K spent most of his time in Ashworth hospital on wards for people with personality disorders. He was under the care of Ashworth Hospital for 16 years in total.

He was given leave of absence from Ashworth Hospital twice before his move to Shropshire. This was on a trial basis to attend regional medium secure units. Both trials were unsuccessful because Mr K found the change difficult. The move to Wroxeter, the low secure rehabilitation ward, was more successful.

Mr K was formally discharged from Ashworth Hospital in 2001, but remained under sections 37 and 41 of the Mental Health Act until 2006. This meant the Home Office still monitored his care. He was only given absolute discharge from these sections after a tribunal in 2006. Mr K then became an informal patient living in the community and the Home Office no longer monitored him. The Home Office monitored him for five years after discharge from Ashworth Hospital. He could have been recalled to hospital if the home office or the clinical team had any concerns The decision of the final tribunal in 2006 is included in Appendix B and shows the tribunal was satisfied Mr K was fully engaged with his care team.

[1] The Special Hospitals Service Authority was a special health authority of the National Health Service in England from 1989 to 1996. It was responsible for managing the three high security "special" psychiatric hospitals in England: Ashworth Hospital, Broadmoor and Rampton.

Mr K did not describe psychotic symptoms at Ashworth Hospital. Although we propose that Mr K was wrongly diagnosed on discharge from Ashworth Hospital, we do not believe this would have changed his progress through the psychiatric system.

In discharging Mr K, Ashworth Hospital complied with all the legal and clinical duties expected of them, even if they were incorrect about the diagnosis.

3. Did Mr K make a direct threat of harm to Jane Edwards and, if so, why was she not informed?

We found no documentary or oral evidence that Mr K made a direct threat to Jane Edwards or that he told his care team he was going to harm her.

Mr K described “command hallucinations” which are voices telling a person to carry out specific acts. Mr K generally said these voices told him to harm people in general, rather than specific individuals.

Mr K once said these voices told him to harm specific neighbours, but he assured his care team that he knew the voices were not real and that he would not act on the commands.

Mr K did not tell his care team that these voices changed before killing Jane Edwards, despite having opportunities to do so.

4. How was Mr K’s risk monitored when he was in the community?

We found clear documentary evidence that Mr K’s care plan and risk assessment were monitored regularly. The risk assessment was amended in light of Mr K revealing more detail about his thoughts and voices.

Mr K was in control of the care he accepted from his care team and said he would isolate himself when was relapsing.

His care team never saw symptoms of mental illness. They responded to his accounts of symptoms. Mr K’s symptoms and reaction to medication are not typical of someone with psychosis because they seemed to happen in set patterns and were sensitive to medication.

Mr K did not come to the attention of the police while living in the community. We found no reports of concerns in his social activities, family visits or holidays. Mr K was reported to be anxious and low in mood at times, but not violent or threatening. Mr K spent a lot of time in service-user activities and, although we found accounts that he was sometimes anxious in these activities, we found no reports of identified risks.

On occasion the care team decided Mr K should only be visited in pairs if he did not know the workers. We found no record of Mr K threatening workers.

One worker visiting Mr K in 2009 noticed a knife in the hall. Mr K said it was for his own protection in case someone broke into his flat. His care team took the advice of the local forensic mental health team and advised Mr K to return the knife to the kitchen, which he did.

Mr K's consultants asked him directly if he carried a weapon when he left his flat. He said he did not. After killing Jane Edwards, Mr K said he had owned a knife since his discharge and carried it with him at all times. From the evidence we found, Mr K's care team were unaware of this.

5. What happened on specific dates?

We have covered all the interventions of the care team in detail above, and have extracted the text covering specific dates to answer this question. Page references allow them to be found easily in the earlier sections of the report.

a. 30 July 2007

The deterioration of Mr K's mental state in June was reviewed on 30 July 2007 when Mr K attended his outpatient appointment with Consultant Psychiatrist 10. Consultant Psychiatrist 10 carried out a detailed assessment. Mr K said that he woke up with auditory hallucinations urging him to get a knife and stab someone. He said he knew these were hallucinations and made no plans to act on the voices. Records show that Mr K coped with the episode by staying at home and increasing his medication. The hallucinations abated within eight to ten days. **(Page 21 of this report)**

b. 28 August 2008

On 28 August Mr K contacted the community mental health team to say that he was experiencing auditory hallucinations. This relapse was managed with daily phone contacts and Mr K increasing his medication. On 2 September Mr K phoned the community mental health team to say he was better and planning to go out with care worker. **(Page 24 of this report)**

c. 5 September 2008 and 3 November 2008

On 5 September 2008 Care Coordinator 2 visited Mr K at home as planned. Mr K reported that he had again had command hallucinations telling him to harm himself and then to harm others, although these were "non-specific". Care Coordinator 2 saw a kitchen knife placed in the hall of the flat. She discussed this with Mr K who said that the knife had been there "for approximately twelve to eighteen months". He said it was for personal protection against any potential intruders. Mr K said he didn't trust the police and would only use the knife as a last resort. The clinical records do not record whether any advice was given, or whether the risk management plan was reviewed.

On 9 September, Care Coordinator 2 updated Consultant Psychiatrist 10 about the home visit. Care Coordinator 2 also contacted "Together" to get an update on the continuation of the service as the extended time was soon to be up.

A planned outpatient appointment for 22 September was cancelled by Consultant Psychiatrist 10 due to “unforeseen circumstances.”

On 29 September 2008 Care Coordinator 2 carried out a home visit. Mr K reported feeling much better, was carrying out activities and had no psychotic symptoms. They discussed a forthcoming panel hearing for funding for the “Together” service. They also reviewed his risk assessment and care plan. There is no further mention of the knife, i.e. if it was discussed or if it had been moved.

Care Coordinator 2 again visits on 31 October. Mr K signed his risk assessment and care plan. Mr K felt the care plan had been useful during his relapses and helped him manage his hallucinations, although he “can never be 100% sure of this.” There is no record if this was discussed further.

On 3 November 2008 Mr K attended an outpatient appointment with Consultant Psychiatrist 10. They reviewed the recent relapses. Mr K again said he was anxious that he “can’t 100% guarantee [he] will retain insight and not act on voices”. Consultant Psychiatrist 10 outlined some alternatives to the care plan including increased face to face contact or possible hospitalisation or use of a crisis house. Mr K was not happy to consider these options. Mr K told Consultant Psychiatrist 10 that if these were considered he would be “less likely to be open about my symptoms”. Instead, they planned how to tighten up the phone contacts with the community mental health team and what Mr K should do at weekends or when his care coordinator was on leave.

Consultant Psychiatrist 10 and Mr K devised draft questions to be asked when Mr K contacted the community mental health team to speed up an assessment. (**Pages 25 and 26 of this report)**

d. March 2009

We have included dates in March and April 2009

On 11 March Care Coordinator 3 carried out a home visit. She reported that everything was well and Mr K was planning a trip to a horse racing event. Care Coordinator 3 and Mr K discussed a planned meeting with the crisis team.

Care Coordinator 3 visited Mr K on 9 April. Records show that Mr K remained well and that he continued his activities as usual. Care Coordinator 3 and Mr K discussed Mr K’s relapse pattern. Care Coordinator 3 reported no evidence of psychosis.

On 27 April Mr K failed to attend a planned outpatient appointment with Consultant Psychiatrist 10. She then contacted the care coordinator to ask for a home visit.

On 29 April Care Coordinator 3 carried out a home visit as planned. **(Page 27 of this report)**

e. 8 July 2009

There is no specific entry for 8 of July 2009, although there are other contacts in that month.

On 1 July 2009 Care Coordinator 3 carried out a home visit with the new care coordinator Care Coordinator 4. Mr K says he has limited his alcohol and gambling since meeting with Dual Diagnosis. He is now considering the Alpha Course with his local church.

On 15 July Care Coordinator 4 carries out a home visit. Mr K says he is better after what he calls a "wobble". Mr K is now planning to attend the Alpha course and two courses at the local college (psychology and Pilates) over the autumn.

On 20 July 2009 Mr K attended his outpatient appointment with Consultant Psychiatrist 10. Mr K remained well and there were no concerns. Mr K said a meeting with [the] Dual Diagnosis worker had been useful and that he had reduced his drinking and gambling. Mr K also agreed to an increase in medication at the start of September to try and prevent a future relapse of psychotic symptoms**. (Page 30 and 31 of this report)**

f. 22 July 2010

On 14 July Care Coordinator 3 carried out a home visit. Mr K had hurt his ankle. Mr K told Care Coordinator 3 that he has had two episodes of psychotic symptoms since she has been his care coordinator, but that he felt unable to inform her at the time. Mr K said these episodes were before he felt he could trust her. Mr K said both episodes lasted for four days and that he managed them by not going out and increasing his medication. Care Coordinator 3 and Mr K discussed his relapse plan at length. Mr K said he needed reassurance that hospital admission would not be the first option considered unless the risk of harm was high. Care Coordinator 3 agreed to take Mr K's case to the handover meeting with Consultant Psychiatrist 10 and Consultant Psychiatrist 11 in a week's time.

On 22 July 2010 Care Coordinator 3 accompanied Mr K to the handover meeting with Consultant Psychiatrist 10 and Consultant Psychiatrist 11. Mr K repeats his account of the two recent episodes of relapse saying that they were accompanied with "extremely violent imagery". He said that he locked himself in and would not open the door to people as he could not be certain he would not act on the commands.

Mr K said he did not want the crisis team involved with his care as he "couldn't guarantee their safety". Nor did he want to be admitted at these times as he feels it "may put others at risk."

Mr K's care plan was reviewed and amended to include possible use of diazepam when he experienced symptoms. Consultant Psychiatrist 11 also discussed a referral for cognitive behavioural therapy to help with unwanted thoughts. (**Page 34 of this report)**

We comment that there were others to whom Mr K could have confided in and sought advice from. He did not do this.

We also comment that the team were in a difficult position in that Mr K is giving a retrospective account of some very concerning symptoms but also saying he will not accept certain types of treatment such as hospital admission or visits from other services.

At the time of his account he was not displaying any of the symptoms he said he had.

If they had applied, it is unlikely that he would have met the criteria for detention under the mental health act as he seemed now to be well, with insight into his symptoms and compliant with all treatment.

g. 6 October 2010

There is no specific entry for 6 October 2010, although there are other contacts in that month

On 1 October Care Coordinator 3 carried out the rearranged home visit. Mr K said that his mood had been low for a few weeks, that he spent a whole day in bed and has had fleeting thoughts of suicide. He had increased his anti-psychotic medication as this was a potential relapse time and what was outlined in his care plan. Care Coordinator 3 discussed a referral for cognitive behavioural therapy to explore thoughts and low mood. Mr K agreed and Care Coordinator 3 said she would discuss this with the clinical psychologist.

On 22 October Care Coordinator 3 carried out a home visit. Mr K was well and planning a long weekend with a friend from church. **(Page 34 of this report)**

h. 12 December 2010

We have seen no record of contact with services on 12 December. His last contact was 1 December when Care Coordinator 3 visited him. This meeting was described to us as routine in that Care Coordinator 3 did not notice any concerns and Mr K did not raise any. It may have been that Mr K had contact with support services, but there is no record that his care team were informed of any such contact.

6. Why was Mr K on oral medication that he was allowed to self-administer?

Mr K's medication history is not typical. He was originally prescribed medication at Ashworth Hospital for short periods to protect him against stress and psychotic symptoms. Anti-psychotic medication is normally given in response to symptoms. However, the care teams felt Mr K was at risk of symptoms, hence the referral to medication as a prophylactic or preventative measure.

Mr K seemed to change his attitude to medication during treatment at Ashworth and afterwards.

Although his medication started at a low dose[1] when he was in the community and progressed to a normal dose, Mr K continued to report symptoms.

Mr K's account of regaining insight after taking just one dose of medication after the killing of Jane Edwards is not credible. After a long period of time without medication, a single dose of oral medication would not be enough to reach a therapeutic level. .

With respect to Mr K self-administering medication, once Mr K was discharged from sections 37 and 41 he was an informal patient. This meant he did not have to take the medication his psychiatrist prescribed if he did not want to.

[1] 5mgs of olanzapine a day is a low dose for someone with psychosis

Appendix D – Team biographies

Chris Brougham, Senior Consultant
Chris Brougham is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people. She is an advisor on mental health for the CQC.

Geoff Brennan, Senior Consultant
Geoff Brennan is a registered nurse for the mentally handicapped and a registered mental health nurse. Geoff works part time as a senior consultant with Verita. He has worked in a variety of clinical and academic posts, mainly in London and the south east of England. Geoff has practised and taught psychosocial interventions for psychosis since the early 1990s. Geoff was involved in benchmarking London mental health inpatient services for the London Development Centre. Geoff is also employed as a nurse tutor in psychosis with the Institute of Psychiatry. In this post his role has three functions:

- assisting the "Safewards" RCT research study (commissioned under a programme grant by the National Institute for Health Research);
- supervision and education of ground floor nurses working in South London and Maudsley NHS Trust;
- designing and developing e-learning package nurses working with people with psychosis.

Dr Mostafa Mohanna, Consultant Psychiatrist
Dr Mohanna is a consultant psychiatrist. He gained his basic training in psychiatry in Leicester after graduating with an MB Bch. He subsequently became a member of the Royal College of Psychiatrists and lecturer with the Leicester Medical School. He took up his first consultant post in Lincoln in 1990. He combined this role with various management positions. In 2001 he became the medical director for the newly formed Lincolnshire Partnership Trust, a post he held until 2013. As medical director, Mostafa was joint lead, with the director of nursing, on clinical governance and quality, and the lead on research and clinical effectiveness. Mostafa is a Fellow of the Royal College of Psychiatrists (FRCPsych).

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

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

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

Derek Mechen, Partner

Derek has been involved in healthcare for over 30 years, holding senior operational management positions in both the NHS and independent sector. He has also worked for the National Audit Office where he led value-for-money studies and spent a year on exchange at a teaching hospital in Chicago. He has overall responsibility for the quality of all investigations, and along with Chris Brougham heads up Verita's Leeds office. He is experienced in working on cases involving high security patients having previously work with Robert Francis on the independent investigation into the care and treatment of Peter Bryan at Broadmoor Hospital and with Jane Mishcon on the investigation into the care and treatment provided to Peter Bryan in the community.