An independent investigation into the care and treatment of a mental health service user (Mr N) in Derbyshire

November 2019

V3.3

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

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1 Executive summary

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

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

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

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning. It was agreed by NHS England that this should be commissioned as a level 3 independent investigation, as a 'near miss'. It was felt that the risks presented by Mr N on release from HMP Nottingham were of sufficient concern to regard this as a 'near miss' event, and that learning should be drawn out that could be shared across systems.

1.5 The independent investigation was carried out by Dr Carol Rooney, Head of Investigations for Niche, with expert advice provided by Dr John McKenna, retired Consultant Forensic Psychiatrist.

Events of 10-15 February 2016 - the 'near miss'

1.6 Mr N had been on remand in custody at HMP Nottingham since 3 December 2015, with a trial date set for 28 January 2016. He faced charges of criminal damage on Trust premises (on 10, 16 and 18 November 2015), and a public order offence (on 1 December 2015). As far as we are aware, none of these charges related directly to threats made against Trust staff.

1.7 There were concerns about his mental state in prison, and he had been referred to the prison inreach mental health team provided by Nottinghamshire Healthcare NHS Foundation Trust (NHCFT). He was seen for assessment on 24 December 2015, and it was advised to continue the prescription of antipsychotic medication.

1.8 In January it was noted that he was paranoid, and had anxieties around Court and the criminal justice system building a conspiracy against him. When seen for a

[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*
[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidents. https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

psychiatric assessment on 4 February 2016 he became hostile and physically aggressive.

1.9 Mr N was released from HMP Nottingham at 8.00 pm on Friday 12 February 2016. He had been seen by two Section 12 Mental Health Act (MHA) approved doctors and medical recommendations were completed, recommending that he be admitted to hospital under Section 2 of the MHA. He was seen by an Approved Mental Health Professional who was minded to complete an application for detention under Section 2 MHA, but a suitable bed could not be found. He was therefore released from prison, given a sum of money and placed in a taxi to take him to Derby.

1.10 In the evening of Saturday 13 February, Mr N approached a police officer in Derby by flagging down his car, and said he was hearing a voice telling him to kill or harm people, and that his father-in-law had placed a microchip in his head. The officer noted that he appeared 'otherwise calm and rational', and contacted the Derbyshire Healthcare NHS Foundation Trust (DHCFT) street triage team. A discussion about the use of Section 136 MHA (1983) was noted, and it was decided that he did not require this. The police accompanied him to Royal Derby Hospital Emergency Department (ED), arriving at 6.01 pm.

1.11 A bed was not found until the evening of 15 February 2016.

Analysis and conclusions

1.12 We have reached a number of conclusions related to care and treatment of Mr N, and the systems within which care was provided, which contributed to the 'near miss' situation.

1.13 We note that in February 2016 Mr N was assessed by a number of different services, who all agreed that he was inappropriately placed in Radbourne Extra Care Ward (ECW). However none of these services, which arguably had higher staffing ratios and more robust physical and procedural security, offered to take him to a suitable, or even a less unsuitable, place until the matter escalated to the ultimate security level , i.e. the High Secure service.

1.14 Mr N was identified as presenting particular challenges when an inpatient in ECW in 2015, and had been removed from the ward by police. We consider it would have been reasonable to agree contingency plans in case of a re-presentation to mental health services.

1.15 NHCFT had no control over the impending release of Mr N from prison in February 2016, and the intention had been to treat his psychosis in prison, and keep this under review. When it became obvious that he was to be released imminently, an AMHP assessment and recommendations for Section 2 were obtained.

1.16 NHCFT clinicians and the assessing Section 12 doctor believed a Low Secure service was appropriate. Efforts were made to find him a low secure bed at Kedleston urgently, and this was considered an unsuitable environment. The level of security would normally be agreed by the clinician who carries out the gate keeping assessment, when one is requested through NHSE Specialised

Commissioning. Within the service specification the level of urgency is decided by the assessor, not the referrer, and there is no process in place to challenge this.

1.17 In this case the Low Secure referral was refused, and usual local acute bed management processes were actioned simply as a default position rather than as a positively agreed, clinically appropriate action.

1.18 There was no escalation of this issue by NHCFT clinicians to involve NHSE specialised commissioning and Kedleston clinicians in finding a solution.

1.19 Efforts then moved to obtaining a bed through DHCFT bed management structures which were not successful.

1.20 There was no escalation to DHCFT Executive team to alert senior staff that a Derby patient who had been deemed to require detention in hospital may be released into the community.

1.21 There is an unusual situation in Derbyshire regarding the provision of PICU beds. There is no suitable premises in Derbyshire, and NHS Hardwick CCG retains the budget for Psychiatric Intensive Care (PICU) beds and has obtained a block contract with an independent provider. NHS Hardwick CCG no longer exists, and mental health commissioning in 2019 is provided by NHS Derby & Derbyshire CCG. Recommendations for future action by the CCG are identified as the responsibility of NHS Derby & Derbyshire CCG.

1.22 We have considered whether the lack of directly managed DHCFT PICU beds has had a direct impact on the care of Mr N in this situation. It appears likely that efforts would have been made to access locally managed PICU beds if they had existed, either by prioritising or adjusting beds and/or resources. In this kind of situation experience suggests that with local control over admission and discharge the system can respond more flexibly.

1.23 The system in Derby did not respond flexibly at this time, but nor did it behave as a comprehensive and integrated system. In this situation the issue was not just about failing to ‘bend the rules’ and admit someone somewhere quickly, it was also about the whole system failing to take ownership and ensure it does not have gaps for people to fall into by default.

1.24 The process of accessing a secure gatekeeping assessment through NHS England Specialised Commissioning did not include a process for responding to an urgent referral, with no opportunity to have multi professional urgent case management discussions to problem-solve and source a shared solution.

1.25 While DHCFT did take responsibility for ownership of his immediate clinical treatment needs, the option chosen, to admit him to ECW, was not in our view the best decision for Mr N or the ECW staff, and at least his care should have been monitored formally with senior support.

1.26 In our opinion the lack of senior oversight and support for the clinical team at ECW is an omission and allowed the prescription of seclusion and continuation of a plan of care that was excessively restrictive, and did not allow Mr N the

opportunity to benefit from appropriately managed healthcare. This also did not allow the team to benefit from support and advice in what was undoubtedly a difficult and distressing clinical scenario.

1.27 We have had sight of senior level communications between DHCFT and NHCFT since this time, with principles agreed going forward for the future management of people with mental health care needs who are to be potentially released from prison. The need for access to PICU beds, better communication from HMP Nottingham about offenders needs and potential release where possible have all been identified as issues.

1.28 DHCFT have now established a PICU liaison nurse, who provides communication links between the Trust and Derby patients in need of transfer or ongoing care, which has been noted to have improved communication.

1.29 DHCFT currently has no established community forensic service, which could provide inreach to prison and maintain contact with patients who are also under criminal justice restrictions. We have seen the proposals for a local community forensic service and would regard this as a positive development.

1.30 We have made 10 recommendations for NHS services to address in order to further improve learning from this event.

Recommendations

1.31 We suggest that these recommendations be commenced immediately and completed within six months.

Recommendation 1

DHCFT must ensure that a risk management plan is developed and implemented when risks are identified, incorporating the review and use of recent and past records, using clinical risk assessment tools.

Recommendation 2

DHCFT should ensure that all safeguarding referrals are actioned appropriately and outcomes recorded.

Recommendation 3

The NHS England secure service specification should ensure that:

- a standard operating procedure is in place for all referrals, with clear timelines and accountability for decision making, which addresses how to negotiate the pathway between CCG and NHSE commissioned services;

- provision of a single point of access, with a written response to referrals with a jointly agreed contingency plan if there is no suitable bed available;
- a pathway for urgent referrals is in place, with agreed escalation on urgency or level of security, and
- there is a dispute resolution protocol with named partners
- a process for responding to an urgent referral, with the opportunity to have multi professional urgent case management discussions to problem- solve and source a shared solution.

Recommendation 4

DHCFT should ensure that the management of requests for inpatient admission in DHCFT should incorporate escalation actions to take place in cases where there is the likelihood of a patient requiring detention under the MHA, and is in need of a Derbyshire placement urgently.

Recommendation 5

All relevant providers must ensure that when external referrals for a mental health bed are made by prison healthcare psychiatrists, the process designed to achieve this should be locally agreed between the commissioners and providers, and relevant clinicians should be apprised of the situation in good time.

Recommendation 6

NHS Derby & Derbyshire CCG must provide assurance that there are arrangements in place to access PICU beds in urgent situation, including an escalation protocol with timescales and stepping up process agreed.

Recommendation 7

DHCFT should ensure that the Trust emergency management/business continuity plans include serious interruption of services and that there is a structure to ensure such occurrences are managed with appropriate leadership and senior oversight.

Recommendation 8

DHCFT should ensure that seclusion practice is monitored to provide assurance that policy requirements for reviews are met and adhered to.

Recommendation 9

DHCFT should align the definition of long term segregation in their policy with that of the MHA code of practice, develop a system to identify any cases of long term segregation, and any instances of long term segregation should be reported and monitored formally through quality structures.

Recommendation 10

DHCFT should ensure that the exclusion criterion regarding admission under Section 2 MHA be removed from the Kedleston Unit operational policy.

Good practice

1.32 Royal Derby Hospital Emergency Department has developed a risk assessment tool (VISA) that provides a quick assessment of need in relation to mental health that is easily applied in an emergency department. In this case staff were able to use the VISA tool to provide meaningful feedback about Mr N to senior managers and clinicians to aid decision making. We commend this as an example of good practice.

1.33 The assessment made at ED was that Mr N should remain there until the mental health bed was sourced. This was despite him not having a medical reason to stay in ED, and breaching their expected timescales.

1.34 The input to Mr N on ED was in our view 'above and beyond' what would be expected in an emergency department, including allowing his mother to spend time with him.

1.35 The DHCFT mental health liaison team provided good support and psychiatric advice during his stay in ED, which is an example of good practice.

1.36 We would like to acknowledge the forbearance of the ECW staff who had to manage a very difficult and distressing situation for far longer than should be expected.

1.37 In our view the speed of assessment, decision-making and transfer to Rampton was at that stage an appropriate and timely response to the situation in which the ECW clinicians and Mr N found themselves in, and we commend this as an example of systems working swiftly and effectively.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework[3] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services[4]. The terms of reference for this investigation are given in full in Appendix A.

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

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

2.4 The investigation was carried out by Dr Carol Rooney, Head of Investigations for Niche, with expert advice provided by Dr John McKenna, Retired Consultant Forensic Psychiatrist.

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

2.6 The report was peer reviewed by Nick Moor, Partner, Niche.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance[5].

2.8 Access to relevant records was obtained through NHS England.

2.9 As part of our investigation we interviewed:

<u>Derbyshire Healthcare NHS Foundation Trust (DHCFT) staff:</u>

- Executive Medical Director
- Executive Director of Nursing
- General Manager, Acute Services
- Consultant Psychiatrist for Mr N
- Senior Nurse, Enhanced Care Ward (ECW) Radbourne Unit

[3] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*
[4] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*
[5] *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

- Consultant Forensic Psychiatrist, Kedleston Unit
- Lead pharmacist

Nottinghamshire Healthcare NHS Foundation Trust (NHCFT) staff:

- Senior Nurse, mental health inreach (HMP Nottingham)
- Healthcare Manager (HMP Nottingham)
- Consultant Forensic Psychiatrist, Offender Health
- Consultant Forensic Psychiatrist/Clinical Director, Offender Health
- Staff Grade Doctor, Wathwood Hospital
- Social Worker, Wathwood Hospital
- Consultant Forensic Psychiatrist, Rampton Hospital
- Social Worker, Rampton Hospital
- Consultant Forensic Psychiatrist (Section 12 MHA approved)

Other organisations:

- Assistant Director, NHS Hardwick Clinical Commissioning Group (CCG)
- Approved Mental Health Professional (AMHP), Nottingham City Council
- Emergency Medicine Consultant, Royal Derby Hospital, Derby Teaching Hospitals NHS Foundation Trust

2.10 We had a written submission to our request for information from Derbyshire Constabulary.

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

2.12 The draft report was shared with NHS England, Derbyshire Healthcare NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, Derby Teaching Hospitals NHS Foundation Trust, NHS Hardwick Clinical Commissioning Group and Derbyshire Constabulary. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with Mr N

2.13 We offered Mr N the opportunity to meet with us to contribute to the investigation, contacting him through his clinical team. We met Mr N in May 2018 and he gave us his thoughts on his recent experiences in mental care. He expressed concern that there was a great deal of personal information in the report about himself and

his family. He was assured that the published document would be an anonymised summary of lessons learned.

2.14 We sent his clinical team a final draft of the report, so that he could read it and comment in a supported environment.

Contact with Mr N's family

2.15 We met with Mr N's mother and her partner to gather their perspective on Mr N's recent care. They were concerned about why he was released from prison with no after care, why he was in seclusion in the Radbourne Unit for such a long period, and that they were not allowed to visit him during that period in the Radbourne. His mother said she felt he needed to stay in the secure hospital for longer, as it seemed to her that it was a good environment for him.

2.16 His mother was unable to comment further due to personal circumstances, but was sent a final draft of the report.

Structure of the report

2.17 Section 3 provides background information about Mr N's personal life.

2.18 Section 4 sets out the details of the care and treatment provided to Mr N.

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

2.20 Section 6 sets out our overall analysis and recommendations.

The 'near miss'

2.21 Mr N was released from HMP Nottingham at 8.00 pm on Friday 12 February 2016. He had been seen by two Section 12[6] Mental Health Act (MHA) approved doctors and medical recommendations were completed, recommending that he be admitted to hospital under Section 2 of the MHA[7]. He was seen by an Approved Mental Health Professional (AMHP) who was minded to complete an application for detention under Section 2 MHA, but a suitable bed could not be found. He was therefore released from prison, given a sum of money and placed in a taxi to take him to Derby.

2.22 In the evening of Saturday 13 February, Mr N approached a police officer in Derby by flagging down his car, and said he was hearing a voice telling him to kill or harm people, and that his father-in-law had placed a microchip in his head. The officer noted that he appeared 'otherwise calm and rational', and contacted the DHCFT Mental Health Advice Hub who are located in Police HQ control room. A discussion about the use of Section 136 MHA (1983)[8] was noted, and it was

[6] *Medical recommendations given for the purposes of application of detention under the Mental Health Act.* https://www.legislation.gov.uk/ukpga/1983/20/section/12
[7] *Section 2, Admission for assessment for up to 28 days, Mental Health Act 1983.* https://www.legislation.gov.uk/ukpga/1983/20/section/2
[8] *Section 136 MHA(1983) concerns the removal of mentally disordered persons form a public place without a warrant.* https://www.legislation.gov.uk/ukpga/1983/20/section/136

decided that he did not require this. The police accompanied him to Royal Derby Hospital Emergency Department (ED), arriving at 6.01 pm.

2.23 The police did not stay with him at the ED, and DHCFT psychiatric liaison mental health team[9] staff were aware of his presence at ED from 6.18 pm. It was believed that an appropriate bed was being sought, and arrangements were made for a Derby City Approved Mental Health Professional (AMHP) to see him to complete the recommendations for Section 2 MHA (1983). He presented as cooperative and responding to boundaries, but at times agitated, and voicing paranoid ideas.

2.24 He was prescribed quetiapine[10] 400 mg, diazepam[11] 10 mg and methadone[12] 5 mls daily, and was co-operative with taking medication.

2.25 Mr N remained in the ED until 8.45 pm on Monday 15 February, when he was admitted to the Enhanced Care Ward (ECW) at the Radbourne Unit, provided by DHCFT. He was detained under Section 2 MHA. He was placed in seclusion on admission, and was managed continuously in seclusion for 23 days until he was transferred to Rampton Hospital on 10 March 2016.

2.26 It was agreed by NHS England that this investigation should be commissioned as a level 3 'near miss' independent investigation.

2.27 The NHSE Serious Incident Framework (2015) discusses the approach to a near miss:

> *'It may be appropriate for a 'near miss' to be a classed as a serious incident because the outcome of an incident does not always reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. Deciding whether or not a 'near miss' should be classified as a serious incident should therefore be based on an assessment of risk that considers: The likelihood of the incident occurring again if current systems/process remain unchanged; and The potential for harm to staff, patients, and the organisation should the incident occur again. This does not mean that every 'near miss' should be reported as a serious incident but, where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk'*.

2.28 It was felt that the risks presented by Mr N on release from HMP Nottingham were of sufficient concern to regard this as a 'near miss' event, and that learning should be drawn out that could be shared across systems.

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[9] The DHCFT Psychiatric Liaison Team provides advice, support and a signposting service to patients over the age of 17, where potential mental health and/or drug and alcohol issues are identified. Following referral from a health professional in Accident and Emergency (A&E) or an inpatient ward within the general hospital, the team will offer a high-quality intervention, assessment and discharge process that covers all aspects of mental health - including drug and alcohol use and self-harming.
[10] Quetiapine is an antipsychotic medication prescribed for the symptoms of schizophrenia; and mood disorders associated with bipolar disorder. https://patient.info/medicine/quetiapine-seroquel
[11] Diazepam is a sedative prescribed for anxiety. https://patient.info/medicine/diazepam-a-benzodiazepine-diazemuls-stesolid
[12] Methadone is a strong, synthetic narcotic that acts on the central nervous system (brain) in a manner similar to other narcotics. It is used in the management of narcotic addiction. https://www.medicinenet.com/methadone_liquid-oral/article.html

3 Background of Mr N

Childhood and family background

3.1 Mr N was 31 years of age at the time of this report.

3.2 Mr N's birth and developmental milestones are reported as normal. In 1989 (aged 3), his parents separated, after which he lived (mostly) with his father.

3.3 In 1993 (Mr N was aged 6) his father took him to see a community paediatrician, reporting severe behavioural difficulties. He was defiant and stealing in school. GP records noted a diagnosis of 'behavioural and emotional disorder with onset in childhood'. Mr N has since reported that he was bullied at primary school (and that he bullied others at secondary school).

3.4 Mr N has since reported that he was abusing solvents at this time. In May 1999, he was referred by his GP to Child and Adolescent Mental Health services (CAMHS), because of 'experiencing distress and extreme rage'. In June 1999, a letter from the family support team noted that his mother's partner had been found guilty of common assault[13] of Mr N, and undertakings were given that he would have no contact with Mr N. Mr N was not seeing his mother consistently, however.

3.5 In August 1999 Mr N's GP referred him to CAMHS, noting nightmares, irritability and anger (and that his father was struggling to cope).

3.6 In January 2000, after Mr N (aged 13) had refused to see CAMHS, his case was closed. Records refer to tantrums, non-compliance, aggression, school discipline problem, physical abuse, adverse social circumstances and general family relationship problems. By February 2000, Mr N was accommodated in a family centre at his own request.

3.7 In May 2000, Mr N was admitted to the Emergency Department (ED) after 'glue sniffing all day with a friend'.

3.8 In July 2000, when seen by CAMHS after excessive ingestion of solvents, he said he was upset about separation from his family, and that solvents helped with painful feelings.

3.9 Mr N said he had tried to hang himself two years previously, and saw his family as not caring for him. In July 2000, his GP records noted 'glue sniffing dependence'.

3.10 In August, it was noted that family work was not possible because Mr N had no contact with his father and only extremely sporadic contact with mother. Later that month, he was described as not attending Youth Offending Team (YOT) and was refusing to leave his mother's address. In December, he was back at his accommodation, and was using cannabis. In January 2001, the CAMHS referral was again closed, after Mr N (aged 14) had failed to attend any appointments. He has more recently disclosed that aged 14, a 13 year old girl had a son by him.

[13] *Common assault (section 39, Criminal Justice Act 1988)*
A person is guilty of common assault if they either inflict violence on another person – however slight this might be – or make that person think they are about to be attacked. https://www.sentencingcouncil.org.uk/blog/post/assault-offences-explained/

3.11 In May 2002, Mr N was referred by a community paediatrician to CAMHS. He had recently had to attend a Coroners Court after seeing a man throw himself under a train, and presented with anger, flashbacks, nightmares, verbal and physical aggression, and fear of losing control. The referral letter reports that he had experienced 'serious physical violence, emotional abuse, rejection, abandonment and disruptive family moves … experience of living with serious family violence'. Mr N was described as frequently using solvents and other drugs (cannabis, MDMA)[14] [15].

3.12 In February 2003 it was noted by his GP that efforts to live with his father had not succeeded. In March 2003, Mr N's GP notes state 'verbally abusive behaviour – resulted in removal from GP list'. There had been several temporary school exclusions (a later report states he 'terrorised' the school), before he left school aged 16 without any qualifications (he later took GCSEs in prison). By the time Mr N failed to attend a CAMHS appointment in July 2003, he had not been seen since July 2002.

3.13 Mr N left school aged 16 without any qualifications (he later took GCSEs in prison). He has since stated that he began using heroin on a daily basis from around this time.

3.14 Mr N lived with partners for some time, and was effectively homeless and living in either Approved Premises[16] or homeless accommodation from late 2013. He has been unemployed throughout his life.

Relationships

3.15 In October 2008 Mr N's then partner, Ms F, gave birth and several reports described this as his child, but in fact he was not the father.

3.16 In 2011 it was reported that he was still living with this partner, who was then pregnant with his child. The child was born in June 2012 and the relationship later broke down.

3.17 In November 2015, a safeguarding alert was raised in relation to his new partner, who was four months pregnant and known to social services. A paternity test was requested by courts in relation to the baby's future. In July 2016 it was confirmed that Mr N was not the baby's father and he was supported to adjust to this news.

Contact with police and criminal justice system

3.18 Mr N did not agree to disclose the details of his probation records to us, and we have gathered some information from health service and local authority records. As of 2014, Mr N was said to have 22 previous convictions involving 46 offences (and 2 cautions) between 2000 (aged 14) and 2014, including 'violent offences against partners, family members, police officer and members of the public'. His

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[14] Cannabis is the most widely used illegal drug in use in Britain. It is naturally occurring - it is made from the cannabis plant. The main active chemical in it is tetrahydrocannabinol (or THC for short). http://m.talktofrank.com/drug/cannabis?detail=drug

[15] MDMA is a synthetic drug that alters mood and perception (awareness of surrounding objects and conditions). It is chemically similar to both stimulants and hallucinogens, producing feelings of increased energy, pleasure, emotional warmth, and distorted sensory and time perception. https://www.drugabuse.gov/publications/drugfacts/mdma-ecstasymolly

[16] Approved Premises are premises approved under Section 13 of the Offender Management Act 2007, similar to a bail hostel

convictions included assault, robberies, burglaries, and drugs offences, and 'much of his early offending centred on the care home property and staff'.

3.19 In January 2003, it was reported that Mr N (aged 16) had committed offences of assault and criminal damage. He left school aged 16 without any qualifications, although he later took GCSEs in prison.

3.20 In April 2003, Mr N was made subject to a four-month Drug Treatment Order (DTO), following conviction for criminal damage, and spent two months in custody. He left custody in late June 2003.

3.21 In November 2003, Mr N punched a young boy in the face and stole his bike and was later convicted of robbery.

3.22 In January 2005 (aged 18), Mr N was released from custody on licence.[17]

3.23 Mr N was arrested in February 2005, records state that after using cocaine, alcohol and cannabis, he and two others were involved in an incident in which a 13 year old victim was assaulted and his bike and other personal property stolen. Later in February 2005 he was sentenced to three years in prison, and released from HMP Nottingham in July 2006. This was his third custodial term, having previously been incarcerated as part of the DTO, and then for over a year for robbery.

3.24 In January 2008, Mr N (aged 21) committed an offence of theft of a pedal cycle, hence also breaching a Suspended Sentence Order.[18]

3.25 By early May 2008, he had breached a Community Order with a Drug Rehabilitation Requirement[19] (DRR) within a week of its imposition, and he failed all subsequent probation appointments. Testing showed he continued to use methadone, heroin and cocaine.

3.26 Because of the DRR breach, Mr N was remanded in custody between 25 June and 23 July 2008.

3.27 Mr N was then subject to two periods on remand in custody in 2008 (17 August to 9 September, 28 September to 14 October).

3.28 According to a newspaper report, on 19 December 2009 Mr N was sentenced to three and a half years imprisonment, following convictions for offences of burglary and robbery. In a planned incident, he grabbed a taxi driver around the neck,

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[17] *A prisoner serving a determinate sentence is normally released automatically halfway through their sentence. If their sentence is 12 months or more, they'll be released on probation licence, which means they have to meet conditions set by probation. https://www.gov.uk/leaving-prison.*

[18] *Suspended sentence orders are when a court imposes a custodial sentence of between 14 days and two years (or six months in the magistrates' court), the court may choose to suspend the sentence for up to two years. This means that the offender does not go to prison immediately, but is given the chance to stay out of trouble and to comply with up to 12 requirements set by the court. https://www.sentencingcouncil.org.uk/about-sentencing/types-of-sentence/suspended-sentences/*

[19] *Under Section 209 of the Criminal Justice Act 2003, a Drug Rehabilitation Requirement (DRR), comprising structured treatment and regular drug testing, is available to courts as a sentencing option for offences committed on or after 4 April 2005. A DRR can be made as part of a community order (CO) or a suspended sentence order (SSO). Supporting Community Order Treatment Requirements (February 2014).*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/426676/Supporting_CO_Treatment_Reqs.pdf

while an associate punched him in face, and cash and car keys were taken; this was his third robbery conviction.

3.29 He was released from custody on 17 May 2011 on licence until February 2013. By 22 August 2012, Mr N had moved out of Derby, apparently reporting that he had previously robbed local drug runners (with his father and uncle paying off dealers), and that he was feeling pressured to sell drugs in order to settle a debt for robbing them.

3.30 It appears that on 7 September 2011, he was again remanded in custody, but it is not clear why. On 19 November 2012, Mr N was recalled to custody for a further seven months. On 21 November 2012, according to local newspaper reports, Mr N was jailed for eight months after pleading guilty to an offence of possession of cannabis with intent to supply.

3.31 Mr N was again released from custody on 19 March 2013. On 28 January 2014 he was arrested on suspicion of possession of a firearm with intent to cause fear of violence and of possession of a Class B drug, and was bailed. Concerns were expressed about his use of cannabis and M-CAT,[20] and his association with known offenders.

3.32 On 8 April 2014, Mr N was arrested on suspicion of causing a breach of the peace. After a relative received a text from him suggesting he would commit suicide, police officers found him to be aggressive and *'clearly under the influence'*. He reported he had taken crack cocaine. When Mr N was reviewed by the Criminal Justice Mental Health Team (CJMHT) on the morning of 9 April, he was reported as 'rude', dismissive and unwilling to complete an assessment. He denied any mental health concerns, stated he was under the care of secondary mental health services, and merely wished to return home to take his medication. Mr N denied any thoughts of self-harm, suicide or harming others. It appears that he returned to live at his mother's address.

3.33 On 17 April 2014, Mr N was arrested on suspicion of assault and criminal damage (it was alleged that he had grabbed his partner and damaged a child's pushchair). He told the police he was suicidal, but then denied this. He was seen again by the CJMHT and he claimed that the allegations were false, and that he had been set up by his girlfriend. He feared recall to custody as he had been found with illicit drugs while subject to a DRR. It was concluded that there were no signs of mental illness.

3.34 In May 2014 at Derby Magistrates Court, he pleaded guilty to an offence of possession of an offensive weapon in a public place (a large metal multi-tool at a garage), and was fined.

3.35 On 20 June 2014, after breaking into a property from which he had been evicted, Mr N was arrested. It seems that he was then seen in ED after a *'mixed overdose*', before being returned to police custody.

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[20] *Mephedrone (sometimes called M-CAT or 'meow meow') is a powerful stimulant and is part of a group of drugs that are closely related to amphetamines, like speed and ecstasy.* http://www.talktofrank.com/drug/mephedrone

3.36 On 27 June 2014 his previous partner Ms F reported that Mr N had been throwing stones at her window and that he had threatened to kill her.

3.37 It seems that on 16 July 2014, Mr N was arrested on suspicion of assault by beating and a public order offence (the alleged incidents occurring on 15 and 16 July, and both directed at his previous girlfriend).

3.38 On 17 July 2014, when reviewed by the CJMHT, Mr N again denied events as reported, and felt he had been 'set up' by his ex-partner. He said he had been diagnosed with a personality disorder, and that he had not been taking his medication since discharge from the Radbourne Unit on 9 December 2013.

3.39 On 25 July 2014, after appearing at Derby Magistrates Court, Mr N was remanded in custody, being in breach of an order, where he was to remain for nearly seven weeks. On 10 September, following conviction for offences of assault by beating and threatening behaviour, Mr N received a concurrent sentence.

3.40 It appears that he was released from custody on 10 September, and that on 11 September he was evicted from Milestone House (a homeless hostel in Derby) following an 'altercation'.

3.41 Mr N was in custody during the period 5 to 6 October 2014. On 9 October, he was in police custody following breach of a restraining order (not to approach his ex-partner).

3.42 On 20 November 2014 he was admitted to hospital with a stab injury, and was later discharged from hospital to police custody, reportedly on suspicion of breaching a restraining order and assault occasioning actual bodily harm. It appears that he remained in custody until 6 March 2015. On release from HMP Ranby on 6 March, Mr N was prescribed methadone (30 mls daily) and quetiapine,[21] and apparently stayed with his mother. It appears that on 7 March, Mr N was arrested at his mother's house after a fight with his brother (later records suggest mother has reported that on this date he was hit on the head by a vase, and lost consciousness).

3.43 On 10 March 2015, Mr N committed an offence of making off without payment from a taxi (in which he and an associate had transported scrap metal). He then snatched a mobile telephone out of the driver's hand as he telephoned police.

3.44 On the evening of 22 March 2015, the Crisis Team received an urgent referral after Mr N presented at a walk-in centre and said he felt unwell, and the notes record: *'acutely psychotic, pressured speech, thought disordered, GP felt admission was indicated'*. He apparently asked to be 'sectioned'. It seems that he was then taken by the police to ED because of concerns about his physical health. Overnight medical admission was suggested pending a mental health review in the morning, but once medically fit he was instead taken into custody.

3.45 On the morning of 23 March 2015, the CJMHT received a police referral, but assessment was not then possible due to apparent intoxication. The CJMHT and

[21] *Quetiapine is an antipsychotic medication used to treat psychosis and bipolar disorder.* https://www.nhs.uk/conditions/bipolar-disorder/treatment/#antipsychotic-medicines

his care coordinator reviewed him in the afternoon and he was found to be still extremely volatile and verbally aggressive, he '… *punched the door numerous times and spat at the door, threatening to cut the heads off anyone he came into contact with'*. Mr N said he had not taken [quetiapine] for over a week, and was not engaging with his care team. It was agreed to refer him for a MHA assessment.

3.46 On 24 March 2015, Mr N appeared in Court in relation to charges of theft and making off without payment (in relation to the taxi incident), and was bailed. He was staying at Milestone House, and was being prescribed methadone and quetiapine 300 mg daily.

3.47 On 8 April 2015, Mr N was in police custody on suspicion of theft. In the early hours of 10 April, he was seen in ED with a possible hand injury, having *'very obviously'* used mephedrone. He had arrived via a police van, but the police had not come into the department. He wanted an assessment by the CJMHT as he was querying his diagnosis. He was advised it was not appropriate for the CJMHT to see him, as he had a community mental health nurse and drug worker in place, and has appointments with a community psychiatrist which he had not attended.

3.48 On 15 April 2015, after non-attendance at Court, a warrant without bail was issued. Mr N was known to be homeless. By 28 April 2015 he was back in prison. He made inquiries about being admitted to a drug rehabilitation service, but did not then complete the necessary paperwork.

3.49 On 22 June 2015, Mr N was released on licence, with a condition that he reside at an Approved Premises[22] in Derby. He was prescribed buprenorphine[23].

3.50 On the day of his release, Mr N told his drugs worker that he had already been taking drugs (£200 of cocaine and an unknown substance intravenously), and he then failed to reside where directed. It seems that 'breach proceedings' were then initiated.

3.51 On the following day, 23 June 2015 Mr N was arrested on suspicion of wounding (involving a machete that he was carrying), but the victim – described as a street drinker – declined to co-operate, and Mr N was not charged. He appeared to be heavily intoxicated when later seen by substance misuse services.

3.52 When eventually arrested on 27 June 2015, Mr N appeared paranoid, suggesting that people were controlling his mum and if it didn't stop someone would get seriously hurt. Officers asked the CJMHT nurse to assess but this was refused, with the rationale that he was being recalled to HMP Nottingham and he would get the help there.

3.53 On 28 June 2015, Mr N was remanded in custody at HMP Nottingham. He reported that he had been using heroin intravenously three times weekly, and mephedrone for the previous five years. On 18 August, he was due in Court

[22] *Approved premises are primarily a public protection measure for offenders released from prison on licence. https://www.justice.gov.uk/downloads/offenders/probation-instructions/pi-32-2014-approved-premises.doc*

[23] *Buprenorphine and the combination of buprenorphine and naloxone are used to treat opioid dependence (addiction to opioid drugs). https://medlineplus.gov/druginfo/meds/a605002.html*

(whilst in prison) on charges of police assault and failure to comply with a post-custodial supervision order.

3.54 On 21 August 2015, he was released from prison. On 27 August 2015, he was evicted from the Approved Premises where he was meant to reside, after three days' absence.

3.55 On 30 August 2015, Mr N was recalled to custody for breach of licence and other matters (public order offence, police assault, possession of amphetamine). In custody, he confirmed that he had been heavily using mephedrone by injection (methadone was again prescribed). On 18 September, he was sentenced to 35 days imprisonment. It was noted that he was not allowed contact with daughter, and that his ex-partner still had a restraining order in place.

3.56 On 1 October 2015, Mr N was released from custody (prescribed quetiapine 300 mg and methadone 25 mls daily), on licence. He stayed with his mother, and reinstated illicit drug use. By 26 October 2015, he was listed at Court for failing to comply with the requirements of post-custodial supervision. It seems he was then remanded in custody, and released on 4 November 2015.

3.57 On 10 November, Mr N was taken to Radbourne Unit Section 136 suite in handcuffs, having presented himself at a police station wanting to report a serious crime. He said that he had been sexually abused, that he owned Boots (chemist), was in talks with the music industry, and was owed millions of pounds. He referred to a conspiracy against him, instigated by his family and involving threats to his life. He presented as hostile, abusive, threatening, spitting, and shouting.

3.58 He was assessed under the Mental Health Act and detained on Section 2 MHA, and admitted to the ECW, Radbourne Unit. After the police left, and whilst a bed was being sought, he tried to strangle himself with laces, and then threw furniture against walls and windows, and threatened staff. This episode later led to a charge of criminal damage.

3.59 On 15 November, Mr N stated that if he were not discharged the following day, he would start punching other patients. On Monday 16 November, he absconded from ECW (by scaling a wall and a fence), and then went to the substance misuse service, where he appeared to be under the influence of illicit drugs. It appears that Mr N then left the substance misuse service, took illicit drugs, went to ED, discharged himself, and then returned to ECW.

3.60 While at ECW he threatened to smash the ward up, ripped a TV from a wall (leading to a later charge of criminal damage), and threatened to snap the necks of staff. He was secluded, and the police were asked to attend. Mr N kicked and punched the door and window, stated he had schizophrenia, made sexually inappropriate comments to and about staff, said he would kill everyone when he got out, and threatened to rip faces off. Police assistance was required to enter seclusion.

3.61 The ECW consultant psychiatrist (Dr R) reviewed him on 17 November, and it was decided that rescinding the Section 2 and discharging him from hospital was appropriate, proportionate and necessary. Mr N was noted to have damaged a TV

and tiles, threatened to assault key worker and to snap necks of nurses. The seclusion room was entered with police assistance. Given the destruction of property and aggression, with evidence of mental illness, he was discharged to police custody. Whilst being escorted from the ward, he threatened to assault Police Officers, threatened to follow and kill the Ward Manager, and spat in nursing staff's faces. Reports of threats to assault were made to police by hospital staff, however we have not been able to ascertain what the outcome of these complaints has been.

3.62 On 19 November, Mr N appeared in Court in relation to three counts of criminal damage (two of hospital property, and one of police property), and was bailed.

3.63 On 1 December 2015 Mr N was involved in an incident that lasted between 10.45 and 12.15 hours. After he presented at the probation office asking for assistance with accommodation, a staff member contacted the police because there was a warrant out for his arrest. When Mr N was seen in the 'secure room' (because of recent aggression and intoxication), he talked about conspiracies involving money, and spoke incoherently and intermittently *'in rhyme and rap …. Not making much sense*'. He made threats, saying people in the bank had taken all his money and he would kill them and chop off their heads. He then threatened to take off his clothes and defecate in the office bin, and said that the government needed to do something for him or he would come after the police and probation.

3.64 The police were called and checks showed he was wanted for breach of court order. There was a further call from probation stating that Mr N was becoming violent and threatening people. Officers attended and Mr N picked up a pair of scissors making threats to stab people and take hostages.

3.65 When a police officer arrived and told him there was a warrant out for his arrest, Mr N said he would not go with her, took a pair of scissors from his pocket, and made threats to cut himself, to stab her if she entered the room, and to stab "innocent people" in reception. A police dog was in attendance and authority was given to use a Taser if required. Neither was deployed because Mr N handed over the scissors and he was arrested for Public Order offences and the outstanding warrant. This incident led to later charges of criminal damage (damaging a police van by spitting in it) and threatening behaviour.

3.66 On the morning of 2 December 2015, Mr N was seen by the CJMHT after the police referred him. He was described as 'lucid and coherent … aggressive, making threats to harm and kill if his needs were not met. He appeared to be experiencing both auditory and visual hallucinations and said he needed to be in hospital. He was noted to make reference to conspiracy theories and that the banks needed blowing up. He was nevertheless described as 'not presenting with features of a psychotic nature'. A Mental Health Act assessment was however requested by the CJMHT

3.67 He was seen for assessment by an AMHP and a consultant psychiatrist who had assessed him previously. It was concluded that any reported psychotic symptoms were related to either substance misuse or to malingering ('*manipulation*'), and that hospital admission was not required or justified.

3.68 On 3 December 2015, after appearing at Derby Magistrates Court Mr N was remanded in custody at HMP Nottingham, with a trial date set for 28 January 2016. He faced charges of failure to comply with supervision, three counts of criminal damage (on 10, 16 and 18 November 2015), and further counts of criminal damage and a public order offence (on 1 December 2015).

3.69 He remained in HMP Nottingham, and on 10 February 2016 the healthcare team were informed that all charges against Mr N had been dropped.

3.70 Because the MHA assessment did not result in a transfer to a mental health inpatient bed, (discussed below in detail from paragraph 4.71) Mr N was released from HMP Nottingham at 20.00 on Friday 12 February 2016. He gave several addresses to healthcare staff and it was not possible to ascertain which one was the appropriate address. He was given a grant of £45 and placed in a taxi to take him to Derby.

4 Care and treatment of Mr N

Summary of care

4.1 Mr N was first referred by his GP to DHCFT CAMHS services in 1999, with a diagnosis of '*behavioural and emotional disorder with onset in childhood*'.

4.2 He was referred again to CAMHS in 2001 and 2002, but attended few appointments. He was discharged from CAMHS for the third time in July 2003 after a period in custody, having not been seen since July 2002.

4.3 His first contact with adult mental health services was in relation to substance misuse in March 2013. He was referred to DHCFT community mental health services by his GP in March 2013 after being released from custody. His GP had noted a diagnosis of emotionally unstable personality disorder in January 2013, but the origin of this diagnosis is not stated. The referral to mental health services noted that he had self-harmed in prison, had been taking olanzapine in prison for possible paranoia, that he felt medication was helping him and was happy to be referred to mental health services. He did not attend any mental health service appointments, and was discharged back to his GP in July 2013.

4.4 His first admission to the Radbourne Unit was from 26 November 2013 until 9 December 2013, as an informal patient.

4.5 He was referred to community mental health services again in December 2013 after discharge from his first admission to ECW, but did not maintain contact. He was eventually discharged from community mental health services in August 2014 after failing to attend appointments.

4.6 In November 2014 Mr N was referred to Derby Recovery Team by his GP, but he was in custody by the time an appointment was offered later in November. He was allocated a community nurse who is referred to in the records as a care coordinator, although he was not on the Care Programme Approach (CPA). Substance Misuse Services (SMS) maintained contact with prison healthcare services, and a further appointment with the Derby Recovery Team was offered in February 2015 after his release. He did not attend the appointment, although his mother did call the Recovery Team to express concern about his mental health.

4.7 His care coordinator attempted to keep in contact and had many failed appointments and home visits, and in April 2015, after failing to attend another outpatient appointment, he was discharged from DHCFT community mental health services back to the care of his GP.

4.8 There were five emergency mental health assessments at Royal Derby Hospital (RDH) ED between November 2013 and February 2016.

4.9 Mr N had also been assessed by the CJMHT after police contact five times between April 2014 and December 2015.

4.10 He had been formally assessed for detention under the MHA four times, within one year.

- On 23 March 2015 he was formally assessed at the request of the police, after attending a walk-in centre intoxicated and apparently psychotic. He was not considered detainable, or in need of community mental health input.

- On 10 November 2015 he was brought by police to the Radbourne Unit under Section 136 MHA. He was subsequently detained under Section 2 MHA and admitted to the Radbourne Unit (his second inpatient admission). He was discharged from the Section 2 into police custody on 17 November 2015 after physical aggression to staff and to property, and threats to kill ECW staff. The diagnosis was of multiple drug use and dissocial personality disorder.

- On 2 December 2015, he was formally assessed after a violent incident at the probation offices, and not detained, and it was suggested he had no evidence of mental illness, had psychopathic traits and should be dealt with via the criminal justice services.

- On 11 February 2016 he was assessed in HMP Nottingham and admission under Section 2 MHA was recommended, but no bed was found. He was eventually admitted to ECW under Section 2 MHA on 15 February 2016.

4.11 There have been two occasions when mental health services declined to offer him an assessment; MHLT on 8 April, and CJMHT on 27 June. Both of these requests were made by police after arrest.

4.12 He has been admitted to the Radbourne Unit ECW three times:

- Informally from 26 November 2013 until 9 December 2013;

- On Section 2 MHA from 10 to 17 November 2015;

- On Section 2 MHA from 15 February (converted to Section 3 on 26 February 2016) to 10 March 2016.

4.13 Subsequent admissions are as follows:

- Rampton Hospital 10 March 2016 to 22 August 2016;

- Wathwood Hospital 22 August 2016 to 21 August 2017;

- Sherwood Lodge 21 August 2017

4.14 We outline a chronology of his care, starting with substance misuse services contact. His contact with services following his imprisonment in HMP Nottingham in November 2015 is examined in detail, and critically analysed in Section 5 below.

Substance misuse and mental health care to December 2015

4.15 The first reported instances of Mr N abusing substances are in May 2000 (aged 14), when he was admitted to hospital after 'glue sniffing all day with a friend'.

4.16 In July 2000, when seen by CAMHS after excessive ingestion of solvents, he said he was upset about separation from his family, and that solvents helped with painful feelings.

4.17 In May 2002, Mr N was referred by a community paediatrician to CAMHS (for the third time). It was noted that he frequently used solvents and other drugs such as cannabis and MDMA. In August 2002, his GP refers to 'ecstasy misuse' and 'cannabis dependence'. He said he used drugs to escape and for distraction from the family situation. In April 2004 (aged 17), his GP records state 'cocaine dependence, continuous'.

4.18 Mr N (aged 19) was released from HMP Nottingham around July 2006. In September, GP records note that he had been discharged from care and removed from the 'looked after register'. In December, GP records noted 'heroin dependence', and he was seen by the Derby Substance Misuse Service [SMS], which was at that time provided by Phoenix Futures.[24] He reported smoking heroin daily and using freebase and 'crack' cocaine[25] regularly, and was prescribed methadone[26] (40 mls daily).

4.19 In October 2007, Mr N (aged 20) reported that he had been using illicit drugs and his partner's methadone, and he tested positive for benzodiazepines, cocaine, methadone and opiates. By December 2007, his methadone prescription had increased to 60 mls daily.

4.20 In January 2008 he reported that he was 'topping up' prescribed methadone with purchased methadone and heroin (in February, he also tested positive for cocaine). In April 2008, Mr N reported daily use of heroin and cocaine. By early May, he had breached a Community Order with a Drug Rehabilitation Requirement within a week of its imposition, and he failed all subsequent probation appointments. Testing showed he continued to use methadone, heroin and cocaine.

4.21 In June and July 2008 he was in prison, and tested positive for methadone (he was being prescribed 60 mls daily), opiates and cocaine.

4.22 In February 2009, he reported using cocaine and heroin, and urine samples were also positive for benzodiazepines[27] in March and July 2009.

4.23 It appears that when Mr N was released from custody on 17 May 2011 (on licence until February 2013) he was still being prescribed methadone (10 mls). In the

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[24] *Phoenix Futures provides community support for people with drug and alcohol problems in Derby.* https://www.phoenix-futures.org.uk/derby-drug-and-alcohol-service

[25] *Freebase' cocaine (powder cocaine that's been prepared for smoking) and 'crack' cocaine (a 'rock' like form of cocaine) can be smoked. This means that they reach the brain very quickly, while snorted powder cocaine gets to the brain more slowly.* http://www.talktofrank.com/drug/cocaine

[26] *Methadone is a drug that is similar to heroin, although it lasts a lot longer in the body. It can be prescribed as part of a treatment regime for heroin addiction.* https://patient.info/health/recreational-drugs/methadone-replacement-for-heroin

[27] *Benzodiazepines are a group of medicines that are sometimes used to treat anxiety, sleeping problems and other disorders.* https://patient.info/health/insomnia-poor-sleep/benzodiazepines-and-z-drugs

community, he reported daily heroin (intravenous) and crack cocaine use, and by June 2011 he was also being prescribed methadone 40 mls daily. In August, Mr N stated that he was buying mirtazapine[28] (sedative antidepressant, which was then prescribed), amitriptyline[29] (antidepressant) and zopiclone[30] (hypnotic), as well as using crack cocaine, methadone, heroin, and alcohol.

4.24 He was living with his then pregnant girlfriend, and said that he wished to abstain as a result, and attended probation and drug service appointments. Mr N has since reported having been abstinent from illicit drugs for a two year period while living with Ms F (although this assertion does not seem entirely compatible with other contemporaneous records). By October 2011, Mr N was being prescribed methadone 50 mls daily, and it was recorded that engagement had declined and his relationship with Ms F was 'problematic at times'. By mid-November, he had not been seen at the SMS clinic for several weeks.

4.25 In the community in June 2012, Mr N was being prescribed 30 mls methadone and mirtazapine, and reported that he was using heroin and crack cocaine.

4.26 On 6 July 2012, he attended ED after using heroin, cocaine and alcohol. On 26 July 2012, at an SMS appointment, Mr N reported that he was then using methadone, pregabalin[31] benzodiazepines, gabapentin[32], quetiapine[33] and dosulepin.[34]

4.27 Mr N was released from custody in March 2013. In May and June 2013, he provided 'clean' samples at SMS appointments. On 14 June, his GP noted: *'coping well, diagnosis of personality disorder, and is stable now'*. On 3 July, a further outpatient appointment with a community consultant was cancelled by the service. On 24 July, after a re-booked appointment was cancelled by his partner with an hour's notice, Mr N was discharged back to his GP. He had been prescribed olanzapine[35] and methadone in prison, and these were continued by his GP.

4.28 Further 'clean' samples were provided by Mr N on 24 July, 2 September, 17 September and 11 November 2013. He was reported to be living with his partner, Ms F, and two children, and on 28 October a family worker reported that she was pleased with his progress. On 14 October, his GP noted: 'history of anxiety and anger outbursts with paranoid thoughts, denies any substance misuse now'. He was still being prescribed olanzapine (12.5 mg) as well as methadone (23 mls, thrice weekly pick-up).

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[28] *Mirtazapine is one of a group of medicines called antidepressants, and is used to treat depressive illness. https://www.medicines.org.uk/emc/product/4514/pil*
[29] *Amitriptyline is a medicine used to treat pain and symptoms of depression. https://beta.nhs.uk/medicines/amitriptyline-for-pain/*
[30] *Zopiclone is a type of sleeping pill that can be taken to treat bad bouts of insomnia. https://beta.nhs.uk/medicines/zopiclone/*
[31] *Pregabalin is used to treat epilepsy and anxiety. https://beta.nhs.uk/medicines/pregabalin/*
[32] *Gabapentin is used to treat epilepsy and/or nerve pain. https://beta.nhs.uk/medicines/gabapentin/*
[33] *Quetiapine is an antipsychotic medicine used to treat symptoms of schizophrenia and mood disorders. https://patient.info/medicine/quetiapine-seroquel*
[34] *Dosulepin was prescribed for depressive illness, particularly where sedation is required (not recommended—increased risk of fatality in overdose). https://bnf.nice.org.uk/drug/dosulepin-hydrochloride.html#indicationsAndDoses*
[35] *Olanzapine is an antipsychotic medicine used to treat the symptoms of schizophrenia and mania; preventing high mood swings in bipolar disorder. https://patient.info/medicine/olanzapine-arkolamyl-zalasta-zyprexa*

4.29 At around 6.00 am on 20 November 2013, Mr N was detained under Section 136 MHA after the police found him with his trousers around his ankles, stating someone had injected him, and 'responding to an alien'. He reported that after taking vodka and 'legal highs' (i.e. novel psychoactive substances/NPS)[36] he had started to hallucinate. The letter from the consultant psychiatrist who assessed him to his GP noted: *'had ripped his shirt apart … seen interacting with aliens and was talking about unusual creatures and Martians … was able to see and hear things which he had never experienced in his life [after using NPS] … guarded and evasive'.* Mr N's presentation was considered to reflect a drug-related acute confusional state rather than mental illness.

4.30 On 26 November 2013, Mr N's GP recorded: *'trying to kill himself … thinking aliens are coming to get him … [partner] called 999'*. He attended RDH ED at 17.58, where his partner reported that at 2.00 am she had found him: *'naked, lying in the street with a knife placed across his stomach … hoping to be run over …so that he would end his life … he did not want to hurt his partner'*.

4.31 When Mr N was assessed by Mental Health Liaison Team nurses, at 8.15 pm, he denied heroin use for the previous year and reported that he '*continued to see aliens and claimed they were still talking to him, requesting admission as he did not feel safe'.* Mr N reported that he had been experiencing psychotic symptoms since taking a legal high a week previously, and that when seen on 20 November he had lied to a psychiatrist as he had wanted to return home. In fact, he said, he had been seeing and hearing an alien talking to him all the time: *'Since returning home he continues to hallucinate, seeing aliens who want to talk to him and [tell him] … to harm his partner by strangling her and then they will stop talking to him … [Ms F] confirms all of the above … denies taking any recent illicit substances and she confirmed that she believes he has not taken anything'*.

4.32 Mr N said that at home he had been hiding in wardrobes and under the sink, as 'if he hides from them they can't see him'. Ms F said his bizarre behaviour had included talking in an unknown language and sitting for long periods under the sink with his hands over is ears. Mr N reported increasing suicidal thoughts, as he felt he needed to die in order to stop himself from hurting his partner. It was also reported that he had been verbally abusive in ED, asking why he was not being seen by a f****ng doctor, and saying he wanted to be sectioned.

4.33 Later that evening, Mr N was admitted on an informal basis to ward 33, Radbourne Unit, his first admission under the care of Dr R consultant psychiatrist. In the early hours of 27 November 2013, a 'safeguarding children' form was completed by CLMHT. When Mr N was clerked in by a junior trainee (CT3), he said he had been diagnosed with paranoid personality disorder while in prison, and with emotionally unstable borderline personality disorder (EUPD) by SMS staff. The trainee double underlined his entry: 'very vague description', and added: *'I'm extremely unconvinced by the hallucinations which come and go … have a comic book quality to them …'* Mr N refused physical investigations, but a urine

[36] *Legal highs is a commonly used, but inaccurate term, describing a range of synthetic drugs that have come onto the drug scene since 2008/09. From May 26 2016 'legal highs' became controlled under the Psychoactive Substances Act 2016. The more accurate term for this group of drugs is 'new (or novel) psychoactive substances' or NPS. New psychoactive substances (NPS) are drugs which were designed to replicate the effects of illegal substances like cannabis, cocaine and ecstasy whilst remaining legal – hence their previous name 'legal highs'.* http://www.drugwise.org.uk/legal-highs/ , http://www.drugwise.org.uk/new-psychoactive-substances/

drug screen taken at 01.15 hours tested positive for cocaine, methadone and opiates, and negative for cannabis. The junior doctor completed a 'PbR form' (payment by results clustering tool) as *'Care Cluster 11: Ongoing recurrent psychosis*[37]*.*

4.34 Mr N confirmed a history of multiple drug use (cannabis, MDMA, heroin, cocaine), previous intravenous use, and more recently abuse of 'MCAT' (mephedrone). During this admission, his SMS key worker, reported that Mr N had been 'drug free for ages and has been reducing methadone'.

4.35 Mr N continued to attend SMS. On 10 January, his GP noted that he presented as: 'anxious and agitated, says he has been taking weed (sic)'. On 13 January, he cancelled an OPA with CMHT psychiatrist. On 24 January, he initially refused to provide urine drug samples, and said he was using cannabis and that '[Ms F] had thrown him out'.

4.36 On 28 January 2014, Mr N was arrested on suspicion of possession of a firearm with intent to cause fear of violence and of possession of a Class B drug, and was bailed. Concerns were expressed about his use of cannabis and M-CAT, and his association with known offenders.

4.37 On 7 April 2014, Mr N refused to provide a mouth swab (needed to detect MCAT) to the SMS, but did provide a urine sample. He then used the needle exchange, saying it was for friend and denying using illicit drugs.

4.38 At around 22.00 hours on 15 April 2014, Mr N attended RDH ED, explaining that he had not taken quetiapine for four days, but had drunk alcohol. Earlier that day, when his mood had lowered and he felt suicidal, he said he had used a large amount of intravenous mephedrone as a form of self-harm.

4.39 On 7 May 2014, Mr N attended SMS intoxicated, and reported he was using mephedrone intravenously. On 14 May, he was banned from the dispensing chemist after several warnings.

4.40 On 20 May 2014, Mr N attended SMS, refused testing, and reported he was using intravenous heroin and mephedrone, and that he was homeless. As of 31 May, he was known to be 'off his script' of methadone (30 mls daily). On 4 June, there was a failed home visit by the care coordinator, and on 12 June he failed to attend SMS. On 20 June, after breaking into a property from which he had been evicted, Mr N was arrested. It seems that he was then seen in ED after a 'mixed overdose', before being returned to police custody.

4.41 On 24 June, Mr N's failure to attend a third SMS appointment led to his keyworker discharging him from SMS (on 7 July).

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[37] *Payment By Results (PbR) is the system used to collate diagnoses for planning and providing care. In this context a cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT). The clusters allow for a degree of variation in the combination and severity of rated needs. CARE CLUSTER 11: Ongoing Recurrent Psychosis (Low Symptoms) This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all.*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf

4.42 On 10 September, following conviction for offences of assault by beating and threatening behaviour, Mr N received a concurrent sentence.

4.43 It appears that Mr N was released from custody on 10 September, and that on 11 September he was evicted from Milestone House[38] following 'an altercation'. On 12 September, he attended SMS (where he was prescribed methadone 30 mls). It was noted that he was now homeless, he denied any drug use but refused to provide a urine sample.

4.44 In the afternoon of 20 September Mr N attended ED, having been found in a house stairwell. He told an ambulance crew he had taken £400 of mephedrone intravenously, with the intent of ending his life. He was seen by the mental health liaison team (MHLT), and reported ongoing substance misuse. He was discharged to his mother's address at his own request.

4.45 On 25 September 2014, the SMS noted that Mr N had '*gone on a miss*' (i.e. failed to collect prescribed methadone), and that he was using street methadone, injecting heroin and using cocaine daily, and using mephedrone intermittently (urine testing was also positive for cannabis). He was re-prescribed methadone 40 mls daily.

4.46 On 2 October 2014, Mr N was banned from Centenary House[39] accommodation (due to aggression). On 3 October, he attended SMS, where he said that: 'he felt out of control and could be responsible for harming himself or others, and he was frequently using large amounts of M-CAT'.

4.47 On 9 October 2014, Mr N was in police custody following breach of a restraining order (not to approach his ex-partner). On 10 October, a saliva test was positive for mephedrone, opiates and cocaine. When he attended SMS, he stated that he had used intravenous heroin that day and that he was also injecting mephedrone on a daily basis.

4.48 On 16 October 2014, Mr N was noted to be staying with his mother, and on 24 October he tested positive for heroin, opiates, cocaine and mephedrone. When he was admitted to hospital after being stabbed (see paragraph 3.22) in November 2014 the MHLT, noted that Mr N denied recent use of illicit substances and continued to receive methadone (40 mls daily, daily supervised consumption) from Derby SMS.

4.49 An outpatient appointment was arranged with the DHCFT Recovery Team for 9 March, when he was due for release from prison. He had been diagnosed as infected with hepatitis C virus (HCV).

4.50 On release from prison on 6 March 2014, Mr N was being prescribed methadone (30 mls daily) and quetiapine, and apparently stayed with his mother. When he attended SMS that day, it was noted that he wanted to sort his life out, and to go on buprenorphine. It was reported that Mr N stated that he is also on

[38] *Milestone House is a homeless hostel in Derby.* https://www.homeless.org.uk/homeless-england/service/derby-homes-milestone-house

[39] *Centenary House is a hostel for homeless people in Derby.* https://www.riverside.org.uk/in-your-neighbourhood/derby/care-and-support/centenary-house-derby/

dihydrocodeine,[40] quetiapine (he stated for his EUPD) and zopiclone. He said he wanted to get better so that he can see his child. Mr N reported that he had used intravenous mephedrone on a daily basis for two years. He was prescribed buprenorphine (8 mg; in place of methadone).

4.51 In the early evening of 23 March, Mr N was seen for a MHA assessment after being detained by police. He was reviewed at the Police Station by two Section 12 MHA doctors and an AMHP, and it was noted that he was a lot more settled and willing to co-operate. In addition to M-CAT [daily intravenously], he used cannabis. He was thought not to be detainable, and not requiring admission or CHRT input.

4.52 On 15 April 2014, after non-attendance at Court, a warrant without bail was issued. Mr N was known to be homeless. On 23 April, he was prescribed buprenorphine, and a urine screen the following day was positive for this, heroin, cocaine, benzodiazepines and cannabis.

4.53 On the day of his release from prison in June 2015, Mr N told his SMS worker that he had already taken drugs (£200 of cocaine and an unknown substance intravenously), and he then failed to reside where directed. It seems that 'breach proceedings' were then initiated.

4.54 On the following day (23 June 2015) Mr N was arrested on suspicion of wounding (involving a machete that he was carrying), but the victim – described as a street drinker – declined to co-operate, and Mr N was not charged. He appeared to be heavily intoxicated when later seen by SMS.

4.55 On 28 June 2015, Mr N was remanded in custody at HMP Nottingham. He reported that he had been using heroin intravenously three times weekly, and mephedrone for the previous five years.

4.56 On 21 August 2015, Mr N was released from prison. On 27 August, he was evicted from the Approved Premises where he was meant to reside, after three days' absence. He attended SMS (for methadone) and stated he was using novel psychoactive substances (NPS), and he was reported to have dismissed any suggestion that they could exacerbate any underlying mental health problems.

4.57 During his second admission to ECW, on Monday 16 November 2015, he absconded by scaling a wall and a fence, and then went to the SMS service, accompanied by Ms T. He presented there as argumentative, thought disordered and sedated. It appears that Mr N then left the SMS service, took NPS, went to ED, discharged himself, and then returned to ECW. He threatened to smash the ward up, ripped a TV from a wall (leading to a later charge of criminal damage), and threatened to snap the necks of staff. He was secluded, and the police were asked to attend.

4.58 Mr N kicked and punched the seclusion door and window, stated he had schizophrenia, made sexually inappropriate comments to and about staff, said he

[40] *Dihydrocodeine is an opioid medicine used to treat mild to severe pain caused by conditions such as; shingles, sciatica, post-surgery pain and joint and bone pain.* https://www.ukmeds.co.uk/treatments/pain-relief/dihydrocodeine-30mg-tablets/

would kill everyone when he got out, and threatened to rip faces off. Police assistance was required to enter seclusion.

4.59 On 17 November, Mr N was described as threatening towards his drug key worker (who had persuaded him to return to the ward) and racially abusive, with no clear cut signs of psychosis. Dr R consultant psychiatrist, reviewed him that morning, noting that he justified his actions, made threats to assault and kill staff, and wanted quetiapine. Dr R recorded that there was no evidence of distress, hallucinations nor delusions, thought process appeared intact, no evidence of thought disorder, speech and behaviour in line with coming off illicit substances. It was planned to discharge him that afternoon.

4.60 Dr R noted that Mr N expressed no remorse, had no obvious signs of ongoing psychosis. He prescribed quetiapine 400 mg and diazepam 15 mg daily. At 14.30 hours, he recorded that there was a *'consensus'* about the diagnosis and about further hospital stay being unnecessary, and that while in hospital he had used drugs, which increased the risk to patients and staff. It was decided to rescind the Section 2 MHA, and that discharge from hospital was appropriate, proportionate and necessary, given the level of risk, aggression and destruction to property. He was discharged into police custody on 17 November 2015.

4.61 Whilst being escorted from the ward, he threatened to assault Police Officers, threatened to follow and kill the Ward Manager, and spat in nursing staff's faces. Dr R noted: *'If [he] presents to frontline mental health services again, inpatient admission should not occur without clear identification of a realistic purpose, and the increased risk that he poses whilst an inpatient should be a key part of the formulation*'.

4.62 On 19 November, Mr N appeared in Court in relation to three counts of criminal damage (two of hospital property, and one of police property), and was bailed. On 20 November 2015, the urine sample taken in hospital was seen to be positive for benzodiazepines, methadone and opiates.

4.63 On 23 November 2015 Mr N attended the SMS service requesting buprenorphine. He spoke rapidly and made threats to cut people, specifying various staff members who he said had a duty of care towards him and who had let him down.

4.64 He then removed his shirt, handed to staff scissors he had tucked into his trousers, made reference to using a shotgun, and made related gestures. The police were called, and after initially then refusing to leave until he had different medication or accommodation arranged, Mr N was told not to return.

4.65 On 24 November 2015, Mr N was formally banned from the SMS service for three months, meaning that his prescription would be stopped. A safeguarding alert was raised in relation to his partner, Ms T, who was four months pregnant and known to social services.

4.66 Also on 24 November, Mr N attended Milestone House with Ms T, appearing drowsy and reporting NPS use. He then became abusive to, and threw a cigarette at, a staff member and kicked a vending machine, and so was barred for 28 days. It appears that Mr N was also by then in breach of bail and probation conditions.

4.67 On 27 November (in prison) a urine sample was seen to be positive for morphine, methadone, mephedrone, lorazepam, and thebaine[41] (poppy seed).

4.68 On 1 December 2015 Mr N was involved in an incident at the probation office. This incident led to later charges of criminal damage (damaging a police van by spitting in it) and threatening behaviour.

4.69 He was referred to the CJMHT on 2 December 2015 by police whilst in custody (their fifth assessment). An MHA assessment was arranged and he was not detained. It was noted he may be 'feigning' mental illness, and made threats to kill the professionals present if they did not agree to his admission to a psychiatric unit. He expressed the belief that he was a millionaire, but this was noted *'not believed to be a delusional belief*', and was described as 'nonsense'. The opinion recorded was '*I do not believe that this man has any mental health problems whatsoever and should not be dealt with by the psychiatric services, but rather via the Criminal Justice System from now on. Diagnosis: no mental illness. ASPD[42] with psychopathic traits'*.

4.70 On 8 December 2015, he reported that he had been using NPS as well as methadone. On 10 December 2015, SMS services advised the prison team that because Mr N was banned from there until February, they should seek a rapid reduction in his prescription of methadone, because they could not oversee the prescription.

HMP Nottingham December 2015 to February 2016

4.71 On 3 December 2015, after appearing at Derby Magistrates Court Mr N was remanded in custody at HMP Nottingham, with a trial date set for 28 January 2016. He faced charges of failure to comply with supervision, three counts of criminal damage (on 10, 16 and 18 November 2015), and further counts of criminal damage and a public order offence (on 1 December 2015).

4.72 Mr N was seen by healthcare staff as is the norm at reception screening and it was noted that he had a history of contact with mental health services and had been prescribed methadone and quetiapine in the community. DHCFT CMHT staff contacted the healthcare centre and advised that he had been '*diagnosed with no mental health disorder*'. It was also noted that he had been prescribed quetiapine in prison previously, and when released from HMP Nottingham on 4 November 2015 he had been given two weeks supply.

4.73 He was admitted to the prison assessment and stabilisation unit, he was placed on an ACCT (self-harm risk plan)[43] and was referred for further mental health assessment and to the substance misuse team. He presented as '*erratic and threatening … stating he is going to slash a number of prisoners due to his mental health'.* Mr N was prescribed methadone 25 mls and quetiapine 300 mg daily. He claimed to have been drinking heavily and asked for assistance with

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[41] *Thebaine is a drug drug that is derived from opium, which contains from 0.3-1.5% thebaine depending on its origin. https://pubchem.ncbi.nlm.nih.gov/compound/thebaine#section=Top*

[42] *Antisocial personality disorder is a particularly challenging type of personality disorder characterised by impulsive, irresponsible and often criminal behaviour. https://www.nhs.uk/conditions/antisocial-personality-disorder/*

[43] *Assessment, Care in Custody and Teamwork, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). PSI 64/2011. https://www.justice.gov.uk/downloads/offenders/.../psi-64-2011-safer-custody.doc*

detoxification, but this was thought not to be necessary as he was not showing any signs of alcohol withdrawal. He was prescribed zopiclone to aid sleep, and his GP was contacted to confirm details of his medication prescription. The GP confirmed a prescription of quetiapine 300 mg per day. Mr N was placed on the substance misuse withdrawal monitoring protocol, and he was asymptomatic.

4.74 At a 'core professional meeting' attended by probation, housing, SMS and the Recovery Team care coordinator, the latter was asked to visit Mr N in prison. It was recorded that he was 'due for release 25 January 2016'. GP records confirmed only very occasional, and irregular, prescription of quetiapine in community.

4.75 On 6 December 2015 Mr N was moved from the prison assessment and stabilisation unit to normal location.

4.76 The ACCT was reviewed on 7 December 2015, which involved healthcare centre staff as expected. Mr N said at the review that he was upset about his medication but this was sorted out now, and had no thoughts of self-harm, and the ACCT was then closed. He was referred to the mental health team, and was due to be seen on 8 December 2015 by the substance misuse element of the mental health team.

4.77 Substance misuse healthcare staff discussed treatment options with him on 8 December 2015. It was noted that he was Hepatitis C (HCV)[44] positive, had been seeing SMS services in Derby and was prescribed methadone 25 mls. He stated he was taking 'black mamba'[45] as well as methadone in the community.

4.78 Mr N said he was hoping to be released when he had the video link court appearance planned for 11 December. He was angry that no-one had helped him in the community with housing and his mental health issues, and that he was diagnosed with a personality disorder. He stated that he requires medication to help with his mental health.

4.79 He was accepted on to the substance misuse programme and he requested to have treatment for Hepatitis C. One to one counselling and and group treatment was agreed, focussing in on harm reduction, looking at changes and ways to maintain changes alternatives to drugs. It was recognised that continuity of treatment was important, and contact was made with the Derby SMS service with a view to maintaining treatment when he was released.

4.80 Because of the ban on Mr N attending the SMS service for three months, he would not be able to access methadone subscriptions from there if he was released. It was therefore requested that the team at HMP Nottingham instigate a methadone withdrawal regime before release, as if he was released in the current circumstances, he would be provided with a 7 day rapid reduction prescription only from a designated chemist. Mr N was discussed in the weekly secondary

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[44] *Hepatitis C is a virus that can infect the liver. If left untreated, it can sometimes cause serious and potentially life-threatening damage to the liver over many years. https://www.nhs.uk/conditions/hepatitis-c/*

[45] *'Black Mamba' is a street name for a type of synthetic cannabinoid, which are chemicals that have been developed to act like the main psychoactive chemical in cannabis, tetrahydrocannabinol (THC) which acts on cannabis receptors in the brain. http://www.talktofrank.com/drug/synthetic-cannabinoids*

mental health multidisciplinary meeting, and accepted by the substance misuse team, and was awaiting an assessment by a psychiatrist.

4.81 On 15 December Mr N told substance misuse staff that he wanted to withdraw from methadone because it did not taste right and he thought that 'they' were trying to poison him. He was offered reassurance and encouraged to take the methadone until a safe reduction plan could be developed. It was noted that he had an assessment by the inreach psychiatrist Dr A on 24 December.

4.82 Mr N asked to be seen by health professionals on 15 and 16 December, asking to go to hospital because he was worried that his heart had stopped. He was listed for a triage assessment by healthcare, which is a preliminary or screening assessment to see if a more detailed assessment (e.g. by a secondary care worker or psychiatrist) is needed.

4.83 A video link court appearance was planned for 23 December, and healthcare staff faxed his methadone prescription to the Derby SMS service, so that this could be picked up if he was released. Derby SMS service staff phoned again to inform the healthcare team that Mr N was banned from the SMS service and would not be able to access a prescription form them. The SMS service again suggested that he be detoxified in prison. It was reported by healthcare staff that at that time Mr N was mentally unstable and had been locked in due to making a weapon, and detoxifying him was potentially challenging, but was to be discussed with the team.

4.84 On 18 December a substance misuse team meeting discussion concluded that a methadone reduction regime would have to be instigated in prison, in case he was released by the court on 23 December 2015. This was because he would have no recourse to methadone prescription in the community due to his ban from the SMS service. If he was not released on 23 December this plan would be reviewed.

4.85 Mr N was seen to discuss this, and he appeared distracted and said there were people listening. He was transferred to a 'stabilisation' cell and was informed that his methadone would be reduced by 5 mls every 5 days. He was noted to appear to understand this eventually, but talked of feeling he was going to die, that he might have HIV, and people were trying to poison him. He was encouraged to speak to the psychiatrist on 24 December.

4.86 It was thought possible that he may be released on 23 December, therefore a prescription for methadone 20 mls until 30 December was prepared and stored safely, to be used if he was released. A pharmacy in Derby was contacted, who agreed to dispense the methadone. Mr N was seen by substance misuse staff to explain this, and discuss harm reduction and risk of overdose if not used safely, which it was noted he appeared to understand.

4.87 Mr N's GP surgery in Derby however contacted the substance misuse team and stated they would not write prescriptions for methadone under any circumstances, as this should be managed through the SMS service. The SMS service reiterated that he was banned and could not attend. It was decided to advise Mr N that he

should attend his GP surgery if released, and discuss whether alternatives could be prescribed.

4.88 On 24 December Mr N was seen in his cell by healthcare staff after an emergency call. He complained that his heart had stopped and asked to be taken to hospital. There were no physical abnormalities observed when his observations were taken, and he was observed to be laughing and joking. Later that morning he attended to have methadone administered without the corresponding ID card. When informed it could not be administered Mr N became aggressive and threatened to kill the nurse. He was removed from the medication hatch by officers, and did not receive either methadone or quetiapine. It was noted that this was to be discussed at the next healthcare team meeting.

4.89 Mr N was also seen by the consultant psychiatrist Dr A on 24 December, who had seen him several times before. Mr N was noted to say he took some 'black mamba' and he had palpitations and thought he was going to die, and his heart stopped, but has not taken any for a few weeks. He said his head was hurting and he needs to be checked out. The summary by Dr A recorded that he is due be seen for a psychiatric report, mentally he appears as before, but with some agitation and ideas of reference, and the quetiapine was continued at the current dose. He was due to see physical health care, and was awaiting an appointment.

4.90 On 25 December he was seen by healthcare staff after an emergency call, because he was complaining of chest pain, but physical observations were within normal limits.

4.91 On 31 December he was seen by the GP, complaining that his heart had stopped. Observations were normal, and he was reassured there were no obvious problems with his heart. An electrocardiogram (ECG)[46] was ordered to explore this further.

4.92 On 4 January 2016 Mr N was seen by the dentist and diagnosed with multiple dental caries for which he was given filings and dental advice. He did not attend the nurse triage appointments on 5 or 6 January 2016.

4.93 On 14 January 2016 he was seen on the stabilisation unit by the substance misuse team worker, to discuss planned withdrawal from methadone if he was released. Mr N was described as talking in a constant stream about conspiracies in prison and the government to deny him his rights, and accusing the staff member of being part of the conspiracy to ruin his life, the interview was terminated because Mr N was unable to engage in the discussion, and it was decided to discuss his presentation in the team meeting.

4.94 A case discussion was held with senior clinical managers, particularly around the risk presented if he was released without community support with methadone prescription and treatment. The plan agreed was to clarify the ban from Derby SMS services and confirm if this was still in place, speak to the probation Offender

[46] *An electrocardiogram (ECG) is a simple test that can be used to check the heart's rhythm and electrical activity.* https://www.nhs.uk/conditions/electrocardiogram/

Manager regarding homelessness and substance misuse, if he was released from prison next week,

4.95 Later discussions confirmed that his housing options were very limited given his previous behaviours, and his case had been allocated to an Offender Manager with the National Probation Service, because he was seen as 'high risk'. It was confirmed that he could self-refer to Derby SMS from March 1 2016, but he would not be seen before then.

4.96 A mental health nurse appointment assessment was planned for 19 January, he did not attend but was followed up on the wing. His Recovery Team care coordinator was informed of his possible release.

4.97 Mr N was not released from court on 20 January. Follow up appointments in prison by the substance misuse team were not successful, he once refused to attend, and on one occasion the prison was on 'lockdown'[47].

4.98 On 22 January, Mr N was assessed on behalf of his defence lawyers by Dr I, consultant forensic psychiatrist, who noted that he might be suffering from psychotic symptoms. He presented as very paranoid about Dr I, claimed that he had more than £50 million stolen from him. He said both Dr I and the solicitor knew who had done this. He was noted to show markedly pressured speech, and flight of ideas; talking about Hitler and paedophiles. He was also very irritable, with extensive paranoid and potentially grandiose ideation, and again said his food and methadone were poisoned.

4.99 On 26 January, Mr N declined to attend a substance misuse clinic session. On 27 January, it appears, he failed to attend an appointment with a mental health nurse (Nurse O), but was then seen later that day, after Dr I reported that he had presented as unwell and apparently psychotic.

4.100 Nurse O advised Dr A and Dr I of his presentation, opened an ACCT, and noted *'consider hospitalisation if thought appropriate*'.

4.101 At a team meeting on 4 February it was noted that Mr N had a diagnosis of EUPD but was currently exhibiting pressured speech, paranoia, had anxieties around Court and that the criminal justice system was building a conspiracy against him. He believed that Dr I was being paid by the Courts. He then asked to see Dr I again. At interview with Dr I, Mr N became hostile, physically aggressive, and paranoid; believing his grandfather put a chip in him. He smashed the healthcare computer and destroyed a video link, when removed from the interview room he jumped on the wing netting, and was placed in segregation.

4.102 That afternoon, he was reviewed by Dr A, who noted that he was presenting differently to his past behaviour, very loud, irritable and paranoid, and appeared psychotic, which may have been due to drug use. His olanzapine was increased from 300 mg to 600 mg.

[47] *In its most common usage in corrections units, the term lockdown can be defined as a course of action to control the movement of prisoners, typically confining them to cells to contain risk.*

4.103 On the morning of 5 February Nurse O noted: ‘pressured speech, paranoia, delusional thoughts … conspiracy theory that the criminal justice system have against him and are fraudulently holding him against his will, so they can get their hands on his money … he suggested that he needs to be in hospital before his Court date, when informed this was not possible … became agitated … went on to explain how he would also ‘hurt as many people as he can’ and get away with this as this would show how mentally unstable he is … and would mean he got to hospital sooner … attempted to pull TV from wall … to be managed behind locked door … until moved to segregation later today …’

4.104 Over the next few days he was noted to be paranoid, questioning the authenticity of medication. Dr I was commissioned by the defence legal team to write an independent report to Court. His report on 8 February states that Mr N presented as acutely disturbed with paranoia, psychosis and features of hypomania at both his interviews, which were two weeks apart. Dr I suggested that Section 48 MHA would allow him urgent in-patient treatment, and that he would be unfit to plead, however Dr I did not have the authority to actually instigate a Section 48 admission.

4.105 On 10 February, Mr N was assessed again by Dr A, who found him to have pressure of speech, paranoid ideas and was hypomanic. The delusions expressed were that he had a chip in his head which was placed there by his grandfather, that large sums of money had been taken out of his bank account, thoughts are being taken out of his head via the chip. These delusions became a continuing feature of his later presentation. Dr A notes he is to be reviewed again in two weeks, and increased his olanzapine to 800 mg. The possibility of using the MHA to allow hospital admission is not mentioned.

4.106 On 11 February the healthcare team were informed that all charges against Mr N were dropped. The Offender Management Unit was contacted for clarification, and the healthcare team were informed that the Court outcome had not been confirmed, and that he should remain in prison until this was clear. Probation staff clarified that Mr N was recalled to prison by probation for a separate matter, and was due in Court on 16 February 2016 for this to be heard, however this could be heard on 12 February and rescinded, to enable early transfer to hospital. It was decided that a MHA assessment was appropriate, with a view to transfer to hospital, because of his current presentation. Dr A completed a recommendation for Section 2 MHA on 10 February.

4.107 A request was made to Nottingham City AMHP service for an MHA assessment, and Mr N was seen by an external forensic consultant psychiatrist and the Nottingham City AMHP SW C. Two medical recommendations were in place, but at this stage the AMHP could not complete the application for admission because no mental health bed was identified.

4.108 A lengthy communication process ensued (discussed below in section 5) but a bed was not found. Nurse O took the two Section 2 MHA medical recommendations to the designated safe at a local Nottinghamshire Healthcare NHS Foundation Trust hospital.

4.109 Mr N was placed in a taxi to Derby with a £45 grant, and left HMP Nottingham at 20.00 on 12 February 2016.

4.110 It is not known where he spent the night of 12 February, but Mr N has said that he spent it on the streets in Derby.

Royal Derby Hospital 13-15 February 2016

4.111 In the evening of 13 February 2016, Mr N approached a police officer in Derby City by flagging down his car. He said he was hearing a voice telling him to kill or harm people, and that his father-in-law had placed a microchip in his head. The officer noted that he was 'otherwise calm and rational', and accompanied him to Royal Derby Hospital (RDH) ED, arriving at 6.01 pm. The ED log notes that the police called DHCFT Street Triage team when they had arrived, for advice. The police did not feel he needed to be put on Section 136 MHA despite what he was saying, as he was presenting as calm in manner.

4.112 The police did not remain in ED with Mr N, and the DHCFT mental health liaison team (MHLT) were made aware of his presence in ED by 6.18 pm. The information noted was the the MHLT were aware there were two completed medical recommendations for Section 2, and that a PICU bed was being sought. The Street Triage team made a case note, recording that he was 'booked in' for a MHLT assessment, and that they would be requesting a MHA assessment by the Derbyshire Duty AMHP team.

4.113 Mr N was 'triaged' at ED by MHLT at 7.22 pm, and said he was having sick thoughts, referring to harming people, and presented as agitated. He was described as very anxious but calm and polite, and said he had nowhere to stay so had wandered around the streets, and was expecting to be admitted to a mental health hospital.

4.114 The MHLT contacted the Derby duty AMHP team to advise that there were two medical recommendations in place and clinician at HMP Nottingham had advised that a low secure bed was required, it was reported that the duty AMHP asked for an opinion about whether an MHA assessment was still necessary, as there were pressures on the system that night. The MHLT recorded that this would not be appropriate for them to do.

4.115 It was confirmed with the Radbourne Unit on call manager that there were currently no beds available in the service, and the advice from the on-call DHCFT consultant was that the two medical recommendations would need to be reviewed to see what led to the need for assessments the day before.

4.116 Blood tests were taken at ED, and by 9.30 pm he was described as

> *'Rambling +++ speaking very fast about lots of disconnected things … has a chip in him somewhere that predicts his future that his friend put in him when he was 7 or 10 that he doesn't know where it is … his grandad [deceased] paid for it … so that [he] could control him … others now control him and play him like a tamagotchi … has died three times from the chip … has millions of pounds of frozen money and he needs to leave the country … so he can have the money and stop being controlled … last time he felt*

like this he nearly killed his friend and pulled a knife on him and cut his hand … when he walks through town past people he can see into their minds and see what they are thinking … he knows he is dying but does not know what of'.

4.117 The Radbourne Unit night coordinator completed a referral form for a PICU in West Bromwich, this referral referred to a diagnosis of personality disorder, despite the medical recommendations both clearly stating he appeared to be suffering from psychosis.

4.118 Later that night hospital security staff were asked to attend as Mr N was described as talking rapidly, using profanities, and saying he needed his head sorting out. He threatened observing staff with a machete: '*his life is predicted because of the [chip] and that 'they' are watching him right now'*.

4.119 At 1.15 am on Sunday 14 February he was seen by MHLT staff and a Derby City AMHP, and an application for Section 2 MHA was completed, specifying the Radbourne Unit, although it was noted that the Radbourne Unit were 'looking for a bed nationally'. Mr N was seen by the on call DHCFT Senior Registrar at 3.00 am, who supported admission to a low secure or PICU bed, and noted that the on-call consultant agreed. The Section 2 application was completed by the AMHP, identifying a bed in the Radbourne Unit, on 14 February and marked as being due to expire on 16 February.

4.120 Mr N admitted to have taken heroin and cocaine during the day, and was at times agitated, although responded well to diazepam 5 mg.

4.121 On 14 February an ED doctor called HMP Nottingham healthcare to ascertain his previous prescription of methadone, as Mr N stated he had lost his prescription. The methadone dose of 25 ml and planned detox regime was confirmed.

4.122 Later that morning the Radbourne on-call manager confirmed to ED staff that efforts were still being made to find a bed nationally. The issue was escalated by ED management to DHCFT senior management. At 6.30 pm because of staffing issues, and he would need to stay at ED with 1:1 mental health staff. It was agreed that he would be assessed in the morning by the Executive Medical Director (Dr Y) for DHCFT the following morning.

4.123 A Health Care Support Worker was supplied to provide 1:1 care that night.

4.124 He was seen at 8.00 pm on 14 February by the MHLT consultant, and he presented as overtalkative, and said he had a chip in his brain implanted by his grandad, that he was being watched and had lots of money in banks, and that he had continual urges to attack and kill people. He also said he had used cocaine and heroin two days ago earlier. He agreed to remain in ED until seen by [Dr Y] in the morning: "*does respond to boundaries … pressure of speech … probable delusions … some elation … agreeing to be in a psychiatric hospital*". He was advised that the police would be called if he was threatening to leave the hospital, and he said he would not be aggressive, that he did not want to go to prison, and that he wanted help with his mental health. Shortly after this Mr N was moved to an observation ward which is part of the ED, which was quieter and where he could have more privacy.

4.125 On Monday 15 February, Mr N was seen by Dr Y and a liaison team consultant psychiatrist, as no suitable psychiatric bed had been identified, and noted that the history was:

> *'consistent with chronic paranoid schizophrenia … history of extreme violence to others, stabbing and slashing with knives, scissors, and machete … he considers he is capable of extreme violence'.*

4.126 Dr Y noted pressure of speech and various delusions, there was a chip in his head implanted by his grandfather, which gave him special powers to see back in time. He could also read the minds of passers-by – who thought he was a 'smack-head' and towards whom he felt violent. He believed that others had made millions exploiting his special powers, and resented the fact that they were living the 'high life' abroad. Mr N said he was anxious to be admitted to a psychiatric unit 'to sort my head out'. He denied current suicidal thoughts, and said he felt safe in hospital and then he knew he needed psychiatric help. There was no current aggression, and he was fully cooperative and asking for appropriate treatment, but it was recognised that there had been violence and threats in past, including violence in the Radbourne Unit.

4.127 Dr Y noted that the service was trying to arrange admission as soon as possible, and that it '*may be possible to nurse him on Radbourne as he is currently settled, non-threatening*'. He recorded that he would discuss the case with the Executive Director of Nursing for DHCFT. Mr N was then prescribed quetiapine 400 mg, diazepam 10 mg and methadone 5 mls daily. By this point, it may be noted that four consultant psychiatrists had confidently made a diagnosis of psychotic disorder, two in HMP Nottingham and two in the ED.

4.128 At 9.30 am, Mr N was described as calm and as *'grateful'* when told that admission to the Radbourne Unit was anticipated.

4.129 At 10.20 am an ED doctor noted: 'currently settled, no threatening behaviour presently … fully co-operative and asking for appropriate treatment … some pressure of speech … wants psychiatric treatment'.

4.130 At 12.45 pm, the on-call manager at Radbourne stated that there were no plans to admit Mr N, and that they were in contact with other hospitals.

4.131 At 3 pm, the issue of Mr N remaining in ED was again escalated, with ED senior management recording that they have spoken to the Executive Director of Nursing for DHCFT reporting that that there was to be a 'three way move' in order to accommodate Mr N on the Radbourne Unit.

4.132 At 4.50 pm hours, Dr R recorded that following discussion, the decision to admit Mr N to the Radbourne Enhanced Care Ward (ECW) had been taken:

> *'despite the significant concerns that have been expressed over the last 48 hours … it would appear likely that any acute presentation is linked to intoxication with drugs….Admit directly to seclusion … to manage to risk of aggression to staff and vulnerable other patients … proportionate response to the threat … a number of PICUs have refused to offer a bed … based upon his risk to others … drug-free assessment as far as possible …'*

4.133 Mr N left RDH ED at 8.45 pm, accompanied by an ECW Healthcare Support Worker, a hospital security officer and his mother.

Radbourne Unit ECW February to March 2016

4.134 Mr N was admitted to ECW at 9.00 pm on 15 February 2016. The nursing admission entry notes that the plan is that he should spend one night in seclusion and to be assessed the following day. A PICU referral and gatekeeping assessment were noted to have been requested.

4.135 Dr R's plan was written on 15 February before his admission to ECW. It was noted that a decision had been made to admit him to ECW, despite the serious concerns expressed about this decision. Given the team's previous knowledge of Mr N it was thought likely that his presentation would be influenced by intoxication with drugs. The admission to seclusion was explained as to manage the risk of aggression to staff and vulnerable other inpatients. Given that his previous violence and damage to property was significant, this was noted to be '*a reasonable and proportionate response to the threat'.*

4.136 The immediate plan was:

1. to admit directly to seclusion
2. drug free assessment as far as possible but if needed, first line: lorazepam 1-2 mg as required orally or by injection, second line: olanzapine 5-10 mg as required orally
3. for urgent low secure gate-keeping assessment tomorrow
4. any queries to be referred to the on-call consultant

4.137 Mr N was apparently settled on arrival at 9.00 pm, but became agitated *'once in seclusion'*, and was described as '*instantly verbally aggressive and hostile*', threatening staff and using abusive language. He threw water at the door and spat at staff.

4.138 He was noted to be asleep in seclusion from 10.00 pm until 2.00 am, when he awoke and banged on the door, shouting to be let out. He settled after discussion with the observing nurse and slept from 3.00 am until 9.00 am on 16 February. The nursing review at 11.00 pm noted that he had made a bed for himself and gone to sleep.

4.139 The 1.00 am medical review by the duty doctor noted that the plan was that staff would not enter seclusion whilst he was hostile and making threats to harm staff. Physical observations had been taken by ED staff and were noted to be within normal limits. Seclusion was not entered for the medical review because he was asleep, and *'the risk of assault remains high'*.

4.140 The nursing review at 3.00 am described his initial presentation as 'fluctuating', at times talking calmly to staff, and at others banging on the door shouting and making threats. It was recorded that Mr N had been agitated and verbally aggressive to staff, '*however the level of his aggression has decreased notably*'.

The plan suggested was that if his level of agitation continues to lower, staff should organise a control & restraint (C&R)[48] team to enter seclusion and give him some food and drink. This was done at 4.30 am.

4.141 Later on 16 February Dr R noted that on reflection adding 5 mls Methadone 'may possibly decrease risk and any imagined withdrawal symptoms, despite how unlikely I find this'.

4.142 Dr R noted that Mr N had been irritable, agitated, repeatedly kicking door, abusive, using *'deeply offensive sexualised language'*, dismissive, and demanding to be allowed to smoke. He stated that £46 billion had been removed from account, money that came to him because of (unnamed) celebrity cousins, which he realised after seeing something in the newspaper. He said that a 'robotic chip' put in his head by grandfather allowed him to read other people's thoughts. His grandfather also gave him businesses (JD Sports, Footlocker, Audi). He detailed a number of violent altercations, including almost killing his friend. There was evidence of pressured speech, and paranoid and grandiose delusions, with Dr R noting that: '*I remain of the view that [he] cannot be safely assessed in this environment'*. Mr N requested quetiapine, diazepam and methadone, and was prescribed quetiapine 800 mg, diazepam 30 mg, and methadone 5 mls daily.

4.143 Dr R noted faecal smearing, shouting, agitated, persistent spitting, and screaming threats to throw faeces in staff's faces. Staff had requested police assistance, this was recorded as: '*A number of discussions were held between nursing management and the local constabulary with our team requesting assistance from the police in order to be able to open the [seclusion room] door … All requests were denied'*.

4.144 The following day, 17 February, 10.45: Dr R requested an urgent forensic gate-keeping assessment via Kedleston Unit, describing him as having emotionally unstable, dissocial and paranoid personality disorders and that he was presenting with features suggestive of psychosis, and that assessment cannot be safely carried out within an acute hospital setting.

4.145 At a risk strategy meeting attended by Dr R, Dr B, locum consultant forensic psychiatrist, Kedleston Unit, it was agreed that medium secure care was indicated. Dr B reportedly then made a referral to Wathwood Hospital (MSU), Rotherham.

4.146 Dr B noted extant diagnoses of EUPD, dissocial PD and multiple substance misuse. Mr N's drug use was noted to appear to be 'indiscriminate, including heroin, cocaine, solvent, mephedrone (MCAT), prescribed medication (quetiapine, methadone) and more recently legal highs (black mamba)'. When she reviewed Mr N in seclusion, wearing PPE and with more than six staff present, he was coherent and apologetic. He said that brainwaves had made him smear faeces; that he was tired of the chip in his head, and that people were after him because the chip was valuable as it could predict the future.

[48] *DHCFT Positive and Safe Management of Violence and Acute Psychological Distress Policy and Procedure, May 2016*

4.147 Mr N said he had a lot of money in the bank, which his brother had taken, and that the charges against him had been dropped because they had been made up. He said he had thoughts of killing people, but did not want to, that he had previously assaulted people with bladed implements (machete, cleaver, knife), that he always carried a weapon, that he needed to protect himself, and that he would not hesitate to use it if necessary.

4.148 Dr B noted pressure of speech, thought disorder, persecutory, grandiose and bizarre delusions, and passivity phenomena. She also recorded that there had been a '*notable change in presentation'* since 2013, involving increased indiscriminate drug use, psychotic symptoms, chaotic behaviour, challenging behaviour and crisis presentations, and that it was '*perhaps somewhat too simplistic to attribute his risk behaviours and current presentation wholly to [drug use] … without further assessment*."

4.149 Dr B concluded that Mr N required Medium Secure placement due to violence risk, weapon carriage and use, unmanageable behaviour, absconding risk, threats, and 'psychosis with personality disorder'. The commissioners (Specialised Commissioning, NHSE Midlands and East) and Wathwood were urgently advised of this.

4.150 On 18 February Mr N appeared angry that medications are not prescribed at the exact time that he would want them, and made threats that if he is now allowed out of seclusion, he would tie ligatures around his neck, smear faeces on the window and assault staff who entered. He was described as persistently verbally aggressive.

4.151 Police assistance was requested again to permit Mr N to be moved to another seclusion room which was declined, with the police reportedly saying they would never assist or restrain detained patients, and that there should be sufficient numbers of trained staff to allow restraint of patients.

4.152 Mr N was verbally abusive, placing a ligature round his neck, spitting at the window, and obscuring the window with a blanket.

4.153 On Friday 19 February Mr N placed his bed against door and refused to move it. Staff entered the seclusion room in full personal protective equipment (PPE). Mr N demanded to smoke, and said that his head was now sorted, he no longer required detention, and he wished to stay with his friend. He expressed concern that staff might have been going through his belongings in order to steal his identity. Soon after this review, he tied a torn strip of blanket around his neck, and staff entered the room again.

4.154 At a multi-disciplinary meeting, it was decided that Mr N would remain in seclusion until secure transfer. It was not known at this time that transfer would not occur for a further 20 days. In effect, it seems, the plan of care already explicitly included continuing management in seclusion: *"All on call consultants over the weekend are aware … not to let him out of seclusion due to high risk of hostility and aggression"*.

4.155 Dr R recorded that there was a risk strategy meeting that afternoon:

'following discussions between … Acting Chief Executive and the Police Chief Constable it was clarified that police would not attend or intervene in anything that they felt was linked to the delivery of … healthcare … it was clear to me that [Mr N] understood the threats he was making to staff. He was aware of his hepatitis C status and was clearly stating that if his demands were not met he would carry out an act that he knew would cause harm … [and] if all his demands were met, no-one would come to any harm …'

4.156 Disturbed behaviour continued, he was agitated and hostile, and spat at a female nurse who entered the room, having previously threatened to break her jaw.

4.157 On 22 February Dr R noted that the seclusion room walls were covered with food. While Mr N stated that his mind was then better and that he did not have 'celebrity cousins', he was certain that there was a chip implanted in his brain, that £46 billion had been removed from his account, and that HMP Nottingham was involved in a conspiracy about this. That evening he seemed calmer and said he felt better, although was still saying he had a chip in his head. The 'clustering tool' was completed by Dr R between 15 and 22 February, concluding 'Superclass: Psychosis' and 'Care Cluster: Psychotic crisis'.

4.158 A speciality doctor to the locum consultant forensic psychiatrist at Wathwood assessed Mr N on 23 February, and stated he would be discussed at their referral meeting on 25 February. Mr N was then being prescribed methadone 5 mls, diazepam 30 mg and quetiapine 800 mg daily, as well as olanzapine (up to 20 mg daily), midazolam (up to 15 mg daily) and lorazepam (up to 3 mg daily) on an as required basis. It was noted that Mr N had made several seemingly calculated attempts, as well as threats, to spit in the faces of staff. He had issued threats to assault, stalk and kill nursing staff. Nearly all of the interview was conducted through a locked door. Mr N reported that he had been non-compliant with medication prescribed when last in custody. He complained persistently about his situation and care, and became increasingly hostile. It appears that during the interview, he reported that he had stabbed a drug dealer when in the community.

4.159 This doctor noted that there may be some underlying psychotic illness. His later recommendation was that 'in view of the current level of hostility, threatening and subversive behaviours, it was decided to seek an opinion from Rampton Hospital'.

4.160 Dr R noted that after taking a shower on the morning of 24 February, Mr N had repeatedly accused staff of *'taking the p***'*, refused to go back into seclusion, stated *"it's on"*, punched a wall and door, tore a soap dispenser from a wall and threw it at a nurse, and told staff he would assault them, threatening specific individuals, if they approached him. After staff left and locked the bathroom, they heard property being damaged, as Mr N tore off metal from the sink and other piping, which he then used to smash a window. After four police officers armed with batons and spray entered the bathroom, Mr N dropped items he had been wielding. It was then discovered that he had secreted a metal lock barrel in underwear, and he said he would have hit someone on the head with it. Mr N was returned to seclusion, and given intramuscular midazolam. Mr N then shouted about police corruption, smeared faeces on the window, and shouted that he hoped staff were raped.

4.161 The DHCFT MHA team reported that because they had only received the Section 2 papers on 23 February (because the originals had been kept on the ward), scrutiny had not occurred within 14 days, and two amendments were required. This was achieved and the papers were duly amended within the required time frame.

4.162 On Thursday 25 February Wathwood advised Dr R that in their view Mr N met the criteria for a High Secure hospital, and that they would be referring him to Rampton.

4.163 The referral letter to Rampton from Wathwood mentions established diagnoses of emotionally unstable and paranoid personality disorders, and substance misuse, but does not mention psychotic disorder other than 'quasi psychotic features of unknown aetiology'. This letter does not mention any resource constraints at Wathwood, which were later referred as the reason for not admitting him to Medium Security.

4.164 On review, Dr R noted that Mr N believed that two female staff had been laughing at him, and that he had a robotic chip in his head. He referring to *'phase 2 ultrasonic'* that could be used for *'gangstalking'*, and said that he was experiencing two light flashes in his right eye, which he took to be confirmatory and as meaning *'he should not discuss his beliefs with us'.*

4.165 Dr R completed the first medical recommendation for Section 3 MHA, recording: 'diagnosis of dissocial personality disorder … also presents with symptoms of acute psychosis, including persecutory and grandiose delusions'.

4.166 The Wathwood doctor, Dr A emailed the gatekeeping assessment and a covering letter to Rampton MHA office and to the NHSE's specialised commissioner, marked 'urgent referral'. Dr R noted that Mr N expressed fixed ideas about money and that he should own buildings, and made links to police corruption. An appeal against detention was lodged on his behalf.

4.167 At a risk strategy meeting attended by Dr R, it was noted that Mr N was declining nicotine replacement therapy and demanding to smoke, and that he had stated an intention to infect staff with HCV by spitting. The notes state that the option of requesting a transfer to police custody was considered: *"Is there a point at which we state we cannot provide an appropriate service and discharge him?"* It was also noted that because of a breach of seclusion protocols, on-call consultants must attend in person for all reviews.

4.168 There was said to be significant tension between ward staff and police, with the police being very reluctant to attend. No seclusion suite was available. By then, ECW was closed to admissions, and the unit Section 136 suite had been temporarily decommissioned to provide a seclusion room.

4.169 The second medical recommendation was completed by his previous community consultant psychiatrist, who noted 'diagnosis of dissocial [pd] and intermittently presents with psychotic symptoms … currently reporting grandiose delusions, somatoform delusions, auditory hallucinations, paranoia and agitation …' The

AMHP assessment was undertaken and the application for Section 3 MHA was then completed.

4.170 Dr R noted that Mr N had given staff an ultimatum, saying he was '*giving you until Wednesday*' to be out of seclusion, or he would smear faeces, attack staff and assault female staff. He believed that the police were present and listening in, saying "*I feel like just banging someone out*".

4.171 Dr R also noted that Mr N spoke rapidly, with all content related to delusions. He said that his visual field was projected onto computer screens, and hence visible to others – like an avatar in a computer game. He was preoccupied with 'predictors', and asked to speak to MI5 as some aspects of the chip related to national security. He made threats to named staff: '*When I get out of here, I'll be waiting at the gate'*. Assessments by an independent sector Medium Secure unit and Rampton were awaited. Dr R completed a report for the First Tier Tribunal in relation to the Section 3 MHA and noted: *'established diagnosis of dissocial personality disorder … current presentation also includes apparent features of acute psychosis … has not had access to illicit substances for 14 days and so this would seem to indicate that there may be an Axis 1 psychotic illness in addition… the nature of this aspect of his presentation is at this point unclear'.*

4.172 He also noted that for the last two weeks each PICU that has been approached has declined to him because of the level of risk that he poses, he was however now accepting oral medication.

4.173 On Tuesday 1 March Dr R noted a discussion with Mr N's Offender Manager to discuss the possibility of him being recalled to prison, as he was issuing threats to take staff hostage and to snap their necks when the door is opened. He was described as having been extremely agitated, hostile, aggressive, and threatening to take hostage, including threatening to kill any males who entered the room. He had again smeared faeces, and stated that the colour of his faeces provided evidence that staff were poisoning him.

4.174 On 2 March Mr N stated that people were leaving him to rot for money. He did consent to a physical examination. He was also assessed by Cygnet, Bury (Medium Secure unit), and it was noted that he expressed multiple grandiose and persecutory delusions, with pressure of speech, and the conclusion was that he was *'clearly psychotic*'.

4.175 The First Tier Tribunal panel directed the exclusion of Mr N (at Dr R's request) because of the risk of violence, including HCV transmission, to anyone present. The panel noted that they were satisfied '*on the medical evidence … that the patient has a mental disorder, namely dissocial personality disorder and a psychotic illnes*s. *The primary working diagnosis is a schizoaffective disorder'.*

4.176 On Friday 4 March Mr N was seen for assessment by Dr L, consultant forensic psychiatrist, Rampton, who concluded that Mr N was probably developing psychosis, and recommended High Secure hospital admission although he could not give a timescale for this. He also suggested reconsidering the use of

zuclopenthixol acetate.[49] Dr L noted that Mr N had talked about how many months in custody he would get if he assaulted individual staff of various grades.

4.177 On Monday 7 March Mr N was described as having been alternately calm and threatening. Dr R recorded on 8 March that Mr N had been threatening him over the weekend, claiming he was withdrawing from quetiapine, and stating he wanted 100 mg diazepam. Later that evening he presented as overtalkative with pressured speech, saying he had cameras in his eyes and was seeing visions, and that he wanted to go back on quetiapine

4.178 On Tuesday 8 March it was confirmed that he would be transferred to Rampton on 10 March 2016.

4.179 Mr N was transferred to Rampton on 10 March 2016 with police assistance (handcuffed in a police van). He was being prescribed haloperidol 15 mg, diazepam 30 mg, methadone 5 mls daily, plus 'as required' zopiclone, lorazepam, haloperidol and procyclidine. Dr R noted:

> *'florid psychotic symptoms in absence of continued drug use … there may be an Axis 1 psychotic disorder in addition to the dissocial personality disorder'.*

4.180 An additional diagnosis was recorded: F23.1 Acute polymorphic disorder with symptoms of schizophrenia.[50]

4.181 After admission to Aldwick ward at Rampton, Mr N presented as hostile, abusive, derogatory and aggressive. He was restrained and secluded shortly after his arrival. He repeatedly threatened to stab staff in the neck and to locate their home addresses, and called them *"paedos*" (sic).

[49] *zuclopenthixol acetate is an injectable antipsychotic medication, used for short-term management of acute psychosis, mania, or short-term management of exacerbation of chronic psychosis.*
https://bnf.nice.org.uk/drug/zuclopenthixol-acetate.html

[50] *An acute psychotic disorder in which hallucinations, delusions or perceptual disturbances are obvious but markedly variable, changing from day to day or even from hour to hour. Emotional turmoil with intense transient feelings of happiness or ecstasy, or anxiety and irritability, is also frequently present. However, some symptoms typical of schizophrenia are also in evidence for the majority of the time. If the schizophrenic symptoms persist the diagnosis should be changed to schizophrenia.*
https://icd.who.int/browse10/2016/en#F23.2

5 Arising issues, comment and analysis

5.1 We have structured our analysis under the headings of the specific terms of reference, with the overall aim of reviewing the appropriateness of the treatment of Mr N in the light of any identified health and social care needs, identifying both areas of good practice and areas for concern.

5.2 The terms of reference also require us to review and assess compliance with local policies, national guidance and relevant statutory obligations, and communication and information sharing between NHS services and partner organisations. We will address these where they are relevant to each section. Recommendations are included as they arise in the narrative.

Risk assessment and risk management

5.3 DHCFT uses 'FACE'[51] as the structure for clinical risk assessment. Within the clinical records there are completed FACE assessments on 20 November 2013, 26 November 2013, 13 November 2015 and 25 February 2016.

5.4 The first FACE risk assessment was carried out on 20 November 2013 as part of a MHA assessment at a police station, following Mr N's detention under Section 136 MHA. He had been found in a street at 6 am with his trousers around his ankles, and appeared to be in distress, saying that someone had injected him. He presented as anxious and agitated but did not meet the criteria for detention under the MHA or admission to hospital.

5.5 It was noted that there was no history of significant risk behaviour, and in the section on risk to others or risk to self, there was no history of risk to either. Risk of abuse/neglect /exploitation by others was rated as 2- considered a significant risk at present. It was noted that the current history included recent severe stress, physical problems, family history of suicide, concern expressed by others, socialisation, rootlessness and abuse/victimisation by others. No contingency plan was developed however.

5.6 A further FACE risk assessment was completed by the MHLT on 26 November 2013, when he was assessed in the ED. He stated he lied to the psychiatrist when he was recently assessed under Section 136 MHA, because he wanted to go home. At this assessment he said he was scared of harming his partner, as he was hearing the voices of aliens telling him they would leave him alone if he strangled his partner. He had been hiding in cupboards at home so the aliens would leave him alone. The night before he had gone out at 2.00 am naked and lay in the road hoping a car would run him over. His partner confirmed these details and believed he had not taken any illicit substances.

5.7 The presence of two small children in the household was noted, and it was noted that a safeguarding referral was made. This was made on the electronic reporting system and logged, noting that Mr N was aware of, and had consented to, the

[51] *Functional Analysis of Care Environments (FACE)*

referral. The referral noted that there was no evidence of risk of harm to the children, but was made because of Mr N's erratic presentation at ED.

5.8 In the risk section, the family history of suicide was again noted, recent severe stress and physical problems, were marked as 'no', personal history indicative of risk was ticked 'yes', as was 'recurrence of circumstances associated with risk behaviour' and 'concern expressed by others'. The 'persons potentially at risk were noted to be partner, self and staff members. Risk to children is ticked 'no'. The summary noted that he was experiencing auditory and visual hallucinations, and was then expressing suicidal ideas because he does not want to act on the voices, which were telling him to strangle his partner.

5.9 This FACE risk assessment also noted that he was a user of amphetamines, intravenous heroin user, and he was already in treatment for substance misuse. He said he had not used heroin for 12 months, but was on a methadone prescription.

5.10 Informal admission to the Radbourne Unit was agreed.

5.11 The risks identified:

- Risk to others.
- Self-harm.
- Vulnerability.
- Risk related to children.

5.12 In January 2014 a mental health clustering tool was completed, and noted that there were no problems with physical aggression or risk to himself, but there were 'mild problems' with problem drinking or drug taking and occupational activities, 'minor problems requiring no action' with hallucinations/delusions, relationships, and other mental and behavioural problems. The historical ratings noted: no repeat self-harm, no safeguarding or vulnerable adult issues (which was not true), no issues with engagement or vulnerability.

5.13 The cluster assigned was 'Care Cluster 11: Ongoing Recurrent Psychosis (Low Symptoms)'.

5.14 In April 2014 Mr N was seen again by the CJHMT at the police station, after being arrested for Breach of the Peace, details of which include he had sent a text to a member of his family stating that he is going to commit suicide, and when police were alerted and officers arrived, Mr N was '*clearly under the influence of drugs and admits to taking crack cocaine, displayed aggressive behaviour and was arrested'*. Mr N was described as alert and orientated to time and place and able to recall the reasons for being in police custody. It was noted that there was a previous safeguarding referral made, regarding two children living with him and his partner. The outcome of this referral was not recorded. Mr N was rude and dismissive and the assessment could not be completed, but it was noted he was under the care of secondary mental health services.

5.15 Mr N presented to ED later in April 2014, explained at the time that he had not taken his psychotropic medication for 4 days, but had drunk alcohol that day. That day his mood had lowered and he felt suicidal, so used a large amount of intravenous mephedrone, as a form of self-harm. He also reported that he had tried to walk into traffic but that his cousin had prevented him from doing so.

5.16 Mr N was assessed by the MHLT, and appeared angered and irritated by the assessment, and ultimately walked out. The opinion recorded by the MHLT was that his presentation on this occasion was very much in keeping with previous assessments, including dissocial personality disorder and substance misuse. He clearly presented an ongoing risk of harm to himself and suicide attempts, but it was noted that he has tended to make suicidal gestures in ways that allow intervention, and that as such, the risk of significant harm or fatality might not be fully intentional. His care coordinator and SMS worker were informed of his presentation. The FACE risk assessment was again incomplete following his lack of co-operation.

5.17 A further assessment was undertaken by the CJMHT in July 2014, when he made a self-referral to the CJMHT, whist at a police station. He had been arrested for assault and criminal damage. It is alleged that he grabbed his partner and damaged the child's pushchair. The identified mental health symptoms were recorded as 'personality disorder' and it was noted that there was no risk of self-harm. Mr N had told police he had felt suicidal, and reported feeling suicidal to the CJMHT, however this appeared to be related to the prospect of going back to prison. Mr N did not have any plans or intent to commit suicide. He reported that prior to being in custody he did not have any thought of suicide or self-harm. He reported that he had in the past tried to self-harm but would not elaborate any further. It was noted that his suicidal ideation appears to be in response to his current situation, of being in custody. He is currently under a DRR and a suspended sentence, in view of the offence and drugs found in his possession he feels he will be returned to prison.

5.18 The opinion recorded was that Mr N did not present with symptoms indicative of mental illness requiring further input, he was advised upon release to visit his GP regarding his medication.

5.19 Mr N was seen again by MHLT in ED, in September 2014, after being taken by ambulance. He had told the ambulance crew that he had tried to kill himself by injecting himself with £400 worth of M-CAT. He was noted to have been released from prison the previous week and was of no fixed abode. It was felt he may be using threats of suicide to gain admission to hospital. The FACE assessment was not fully completed.

5.20 The plan agreed was for Mr N to engage with his care team on Monday as they had requested, for him to attend the SMS service for substance misuse, attend his GP, and a local homeless hostel was contacted to hold a bed for him. He chose to leave and go to his mothers' house eventually.

5.21 A further FACE risk assessment was carried out while he was an inpatient in the ECW 13 November 2015, and at this time there had been a marked change in the risk assessment. His risk of violence was rated as 2 'significant risk', risk of self-

harm, suicide, severe self-neglect, and risk related to his physical condition were rated as 1 ‘low apparent risk current but with known history’. Risk to children/vulnerable other was rated as 2 ‘significant risk’.

5.22 The other risks identified were high risk of relapse, risk to staff, with a requirement to discuss a risk management plan with the MDT.

5.23 The risk summary noted that he had been

> *‘diagnosed with drug induced psychosis, emotional unstable and antisocial personality disorder. [Mr N] had a long history of poly substance misuse. Increased substance misuse is a relapse signature of his. Some history of self-harm and suicidal ideation. [Mr N] states that he has self-harmed in the past but has not elaborated on this. Self-harmed when he was recently in prison, which he did by using razor blades to cut his upper arm. Experienced suicidal ideation which increases when he is in police custody. He denied any current thoughts of self-harm or suicide. Has made threats to kill himself in the past. Previously has lay in the road with knife threatening to kill himself to stop himself hurting his family and ex-partner. Made an attempt to ligature with his clothing when he was in seclusion on ECW. Has previously had command hallucinations which told him to kill his ex-partner by strangulation. Currently states that demons tell him to kill people. Experiences grandiose delusions. On admission to ECW stated that he is a millionaire and someone has stolen his money from him. Currently he believed that people are against him and a lot of people are involved with having all of his money taken off him. Believed that people want to hurt him. Previously and currently had ideas of harming others which includes his ex-partner and mother. On admission to ECW has said that he will kill staff and ‘blow them up’. States that he can get a fire arm and he will use it. Impulsive and risk taking behaviour associated with drug use’.*

5.24 The current indicators of risk were threats, intimidation, child protection issues, drug/alcohol abuse, reckless or unsafe behaviours, and physical condition. The history noted previous threats to harm, carrying weapons, plans to self-harm and prepare for suicide, evidence of targeting children/females, absconding and fire setting. The current ‘persons potentially at risk’ were partner, general public, staff members, his child and his mother.

5.25 The evidence for this was that there were child protection procedures in place, but the details needed to be confirmed. He had thoughts of harming his ex-partner in the past, and had assaulted her and damaged a pushchair (in 2014). He was noted to have a difficult relationship with his mother, who is supportive, but he has stolen from her and been violent to her in the past, resulting in an injunction against him.

5.26 His risk of physical health problems and self-neglect were noted, and his diagnosis of HCV and risk of further harm through IV drug use.

5.27 A child safeguarding referral was noted to have been made due to his current girlfriend stating she was pregnant. Much later it was found to not be his baby, but

it was believed to be his at the time. There is no outcome of follow up recorded about this safeguarding referral.

5.28 This risk assessment reflects the history as noted in previous assessments, with an increase in violence towards his ex-partner, threats convictions for criminal damage and assaults on police, threats of harm to nursing staff and damage to property. He had smashed furniture in the Section 136 suite prior to admission, and was initially nursed in seclusion on ECW. There is no evidence in the notes of fire-setting however.

5.29 Risk management plans for the November 2015 risk assessment could not be located, however there are detailed MDT team notes of discussions about how to manage his risks. Mr N went absent without leave from the ECW on 16 November, and was physically aggressive and threatening to staff on return. The ECW consultant and Responsible Clinician, Dr R noted:

> *'no evidence of distress, hallucinations nor delusions, thought process appeared intact, no evidence of thought disorder, speech and behaviour in line with coming off illicit substances … plan to discharge this afternoon'.*

5.30 The Section 2 was rescinded and Mr N was discharged into police custody on 17 November 2015, while spitting and threatening to attack staff. He was arrested on suspicion of causing criminal damage.

5.31 Dr R then wrote an alert, which is flagged in his electronic notes:

> *'during [assessment] his established diagnoses of dissocial personality disorder and opioid dependence were felt to be appropriate …The established risks to himself and others were not managed by virtue of his inpatient admission, and indeed the risks to others were instead focused on NHS staff and vulnerable unwell patients …Whilst being escorted from the ward, he threatened to assault Police Officers, threatened to follow and kill the Ward Manager, and spat in nursing staff's faces. If [he] presents to frontline mental health services again, inpatient admission should not occur without clear identification of a realistic purpose, and the increased risk that he poses whilst an inpatient should be a key part of the formulation'*.

5.32 He later also wrote to the GP:

> *'I was, and remain of the opinion that further admission or treatment in hospital are not necessary … [he] has made it clear that he does not want to be in hospital … in order for him to remain in hospital there would be an inherent unacceptable increase in the levels of risk to everyone around him…if [he] were to present to front door mental health services again, it would be very important to consider the need for potential re-admission in the light of events that have taken place during this one'.*

5.33 The last FACE assessment dated 25 February 2016 noted risk of violence to others as 4 'serious and imminent risk' with risk to children/vulnerable others rated as 3 'serious risk'. Risk of suicide, self-harm, accidental self-harm, and severe self-neglect were rated as 1 'low apparent risk'.

5.34 A high risk of relapse, potential risk to staff members were identified, with the expectation that a risk management plan would be developed, and there would be MDT discussion. We have not been provided with a contingency plan.

5.35 He was noted to have ideas of harming others, believing that people were against him and and a lot of people are involved in stealing his millions. Ideas of harming his ex-partner and mother were noted, and on admission said he will kill staff and blow them up, saying he can get a firearm and would use it.

5.36 It was recorded that his current girlfriend had just had a baby and there was uncertainty about whether Mr N was the father.

5.37 The plan was noted to be that Mr N would be moved to a more secure environment so that assessment and treatment can be facilitated.

5.38 The seclusion care plan which was written on 19 February 2016 can be regarded as the risk management plan. The care plan noted that his risks were deemed to be too high to manage on an open ward, due to highly likely outbursts of aggression and violence, placing staff and other patients at risk.

5.39 The plan was to contain and support Mr N through this period, in a seclusion setting. The risks identified were:

- physical aggression
- tying ligatures in seclusion
- obscuring staff observation view with faecal smearing
- spitting at staff (HCV positive)/threats to infect staff

5.40 The interventions were focussed on maintaining observations and safety, with the requirement for C&R trained staff to be fully clothed in personal protective equipment (PPE) before entering the room. It was stated that staff would need to determine when it is necessary to enter seclusion if a ligature was observed, acknowledging the time delay in preparing the team, which could increase risk to Mr N and staff. This was required to be kept under constant review.

5.41 Police assistance was to be requested if the level of violence and aggression was felt to be unmanageable, and based on '*a capacitous decision to cause harm to himself, staff or the public'.*

5.42 This care plan was reviewed on 3 March 2016, noting that he had now been assessed as requiring a high secure hospital bed. The plan included:

- to administer and monitor the effects of antipsychotic medication;
- MDT to review seclusion on a regular basis;
- assess risk from linen and other ligature possibilities in the room and balance removal of clothing against dignity;

- staff were to assess whether it was safe to enter on each review, and all staff entering were required to wear full PPE; and

- should his level of aggression present as too high for safe entry and access is required to perform essential and urgent tasks, the police should be called for assistance. If there were issues with police attendance senior management and on-call managers' should be contacted.

5.43 The ED at RDH have developed an assessment tool (VISA) for use in ED where there may be concerns about mental health issues or risk of self-harm in ED patients. VISA stands for: Violent/Irrational/Suicidal intent remains/Alone. This can be followed if needed by an 'extended mental health observations' chart, which is normally used to document 15 minute intervals, but can be adjusted as required.

5.44 The intention of the tool is to provide a quick snapshot of any presenting risks, with guidance about actions to follow. Mr N had a VISA assessment in ED on 13 February at 7.15 pm. This assessment led to the decision to place him on continuous observation with documented notes made every 15 minutes on the 'extended mental health observations' chart. This was carried out by staff from the ED, with some input from DHCFT staff.

5.45 The observation chart requires staff to tick a box showing either calm, distressed, agitated, aggressive or absconded. Mr N was described on this chart as initially agitated and distressed on 13 February. Between 14 and 15 February he was noted to be becoming agitated on the morning of 14 February, when he was asking for diazepam and said he wasn't given the right medication. All other assessments described him as calm.

Comment 1: <u>Risk assessment and management</u>

We have not seen evidence of risk management care plans following from the FACE assessments 2013 or 2015. The structure of the FACE assessment that we have seen in the electronic records does not appear to include a section on risk management and care planning.

The 'Assessment and Management of Safety Needs Policy' (May 2015) has the expectation that *an intervention (safety) plan is used by practitioners to detail interventions that the service user/receiver should expect to happen in order to promote safety and reduce risks*.

We have not found a safety plan prior to February 2016 for Mr N. His risks have been clearly documented, but the assessments have not met the expectations of the Policy, which is that '*assessments will be narrative rather than relying on tick boxes and will include an understanding of the relevant context, triggers maintaining and protective factors'.*
We found that the FACE risk assessments contained a long list of risks, in the form of tick boxes, with some narrative description, but with no attempt to explore triggers, contexts or maintaining and protective factors.

It is evident that Mr N's risk profile changed markedly between his admissions to ECW in 2013 and 2015, and we have not found evidence of any exploration of this.

The care plans developed after the admission in February 2016 are focussed on the immediate management of risk, rather than on exploring the context. Although during the period 2013 to 2014 Mr N expressed a number of odd ideas (e.g. beliefs about aliens) and associated paranoid behaviours, these were regarded as related to drug use and acute intoxication. However, on several occasions from October 2014 onwards (November 2014, March 2015, June 2015, October 2015), there were more consistent reports of quite diverse and qualitatively different unusual beliefs (e.g. being a millionaire, family stealing from him and plotting to kill him, text messages being stolen, being poisoned, fraud related to a will). These ideas were expressed by Mr N, and independently reported by his parents. A wide variety of such ideas were expressed by Mr N when admitted in November 2015 (including multiple paranoid beliefs - involving, for example, disinheritance, jealousy, poisoning, subliminal messages, and ideas of reference), and by the time of his discharge into police custody he was being prescribed an antipsychotic and a benzodiazepine. These ideas again surfaced during the incident in the probation office on 1 December 2015, during the CJMHT assessment the following day, and then in custody from no later than January 2016. While it has to be recognised that Mr N's contacts with services during this period (late 2014 to early 2016) were chaotic and challenging, it does not appear that a 'longitudinal' view of his presentation, and associated risks, was developed during this time. In retrospect at least, it seems very likely that he was experiencing quite persistent persecutory delusional beliefs during this period, and that while drug use almost certainly exacerbated his difficulties it was not likely that they fully accounted for them.

The decision to place Mr N in seclusion appears to have been based on previous knowledge and experience of his violence as an inpatient, and did not in our view take the current contextual information into consideration. Mr N had approached a police officer asking for assistance with his mental health, and requesting that he be taken to hospital. He remained in the ED at RDH for three days, without any signs of physical aggression, and he was described at assessment by two consultant psychiatrists as settled, non-threatening and cooperative.

While the RDH VISA tool has not been developed using any formal evidence base, it does provide a quick assessment of need in relation to mental health that is easily applied in an emergency department. In this case staff were able to use the VISA tool to provide meaningful feedback about Mr N to senior managers and clinicians to aid decision making. We commend this as an example of good practice.

Recommendation 1

DHCFT must ensure that a risk management plan is developed and implemented when risks are identified, incorporating the review and use of recent and past records, using clinical risk assessment tools.

Safeguarding

5.46 With regard to safeguarding, a possible risk to Mr N's partner and child is noted after his presentation to mental health services under Section 136 MHA in November 2013, when it is noted that he was worried that he would harm his partner, as he was hearing voices telling him to strangle her.

5.47 Within the initial FACE risk assessment on 27 November 2013, it was documented that there had been verbal contact with the safeguarding team, that the children did not appear to be at risk at present as they were residing with their mother, but that a referral for a social care assessment had been made because of Mr N's presentation at ED.

5.48 There is no evidence of what actions were taken in Mr N's electronic notes. We asked DHCFT to clarify what, if any, actions were recorded and it has been confirmed that there is no other information related to this contact with the safeguarding team.

5.49 In November 2015, risk of harm to his mother, ex-partner and children were noted, although it was documented that he had no contact with his ex-partner's two children. The FACE risk assessment notes that his current girlfriend is pregnant and that *'a safeguarding children's referral has been made but this needs to be confirmed'.* DHCFT have been unable to determine if this referral was confirmed or followed up. The same information has been pulled though to a subsequent FACE risk screen on 25 February 2016 regarding the referral but it has not been updated.

5.50 The SMS notes recorded that on 24 November 2015 an email had been sent to the Safeguarding Midwife Lead at RDH, informing her that Mr N had been banned from the SMS service for three months and that he has a partner (Ms H) who is four months pregnant. It had been discussed at the MDT meeting in the SMS service, and it was agreed that these concerns should be conveyed as a safeguarding referral.

5.51 On 18 January 2016 the SMS records noted that he may be released from prison soon, and noted that there was a domestic violence and child protection 'flag' at probation, that his now ex-girlfriend Ms T, was pregnant and there was social services involvement.

5.52 It is recorded in the SMS notes that '*he turned up at the RDH on the Friday night* (12 February 2016) *to try to see the baby'.* The baby was born at 26 weeks gestation, and it is noted that child protection proceedings cannot apparently start until 28 weeks. The baby was in a Nottingham Hospital in a special care unit. There does not appear to have been any safeguarding information involved in this transfer, or information shared about potential risks.

5.53 A safeguarding adult referral was made to Derbyshire Police by a Rampton social worker, after a disclosure by Mr N that a step-father had abused him as a child. This was initially investigated by Derbyshire Police, but this was not continued because Mr N decided not to pursue the allegation. It was agreed it would be left on file in case he wished to pursue it in the future.

Comment 2: Safeguarding Adults and Safeguarding children's procedures in the context of this risk

There have been risks and concerns identified by DHCFT staff regarding Mr N and his behaviour towards two ex-partners, and associated children. Risk assessments in his clinical records note that safeguarding referrals should be made, and this needed to be followed up.

DHCFT have been unable to provide details of what safeguarding notifications or actions have taken place, if any.

Recommendation 2

DHCFT should ensure that all safeguarding referrals are actioned appropriately and outcomes recorded.

Clinical presentation whilst in HMP Nottingham

5.54 A detailed account of Mr N's presentation in HMP Nottingham is outlined above from paragraph 4.71. In this section we focus on the actions taken after the decision was made that Mr N may require a transfer to a mental health bed from prison.

5.55 The Healthcare service in HMP Nottingham is run by Nottinghamshire Healthcare Foundation NHS Trust (NHCFT) and includes primary care, secondary mental health care and substance misuse services. Dr A had known Mr N over many years, and was familiar with his presentation when under the influence of NPS or other substances. He had previously been treated by both substance misuse services and secondary mental health services while in the prison.

5.56 From late January 2016, Mr N was noted to present as markedly paranoid, with definite features of psychosis. He was hostile and aggressive towards Dr I in early February, and was reviewed by Dr A, who noted that he was presenting differently to his past behaviour, very loud, irritable and paranoid, and appeared psychotic, which may have been due to drug use. His quetiapine was increased from 300 mg to 600 mg, with the expectation at that time that he could be treated in prison.

5.57 Dr A noted that Mr N is to be reviewed again in two weeks, and he increased his quetiapine to 800 mg. The possibility of using the MHA is not mentioned, however Dr A clarified at interview that he considered that Dr I's report to court could serve as a recommendation for a Section 48 MHA transfer, but at that point he did not think he needed to be transferred, which is why he noted that he was to be

reviewed in two weeks. In other words, it was thought he could be adequately treated in prison at the time.

5.58 The decision to request a formal MHA assessment was made on 10 February, not because of a change in his clinical presentation, but because the mental health team were informed that the charges would be dropped and Mr N was going to be released imminently. NHCFT have an agreement with Nottingham City Council that if there is a need for a MHA assessment in prison, a local Nottingham AMHP will be provided, regardless of where the prisoner resides.

5.59 It was arranged that a probation recall would allow him to remain in custody for a further two days. This was due to expire on 12 February, after which it would no longer be possible to keep him in custody legally. The clinical team view at that point was that Mr N would require a low secure bed. Mr N was asked if he would be willing to be admitted informally to a mental health hospital and he did not agree.

5.60 The AMHP has recorded that the referral to the Nottingham AMHP service was made at 11.00 hours, and that by 11.30 hours she had made contact with DHCFT and telephoned the Derby Recovery Team manager to request information. She also advised that charges had been dropped and that release was imminent.

5.61 Dr A completed one medical recommendation for Section 2 MHA on 10 February, and another Section 12 MHA approved doctor (Dr S) completed a recommendation for Section 2 on 11 February. Mr N was seen by both doctors and the AMHP in segregation because of his recent violence.

5.62 Dr S's recommendation notes: 'demonstrates mental illness … pressure of speech … paranoid delusions … his thoughts can be read via a chip … inserted into his brain by the government at the request of his grandfather … volatile … can hear people talking about him … does not believe he is ill'.

5.63 The AMHP report notes that he is 'clearly suffering from a mental disorder … pressure of speech … paranoid about the warders' radios and worried that they were transmitting what he was saying … things popping into his brain and hearing people saying disgusting things about him, such as him being a paedophile, a rapist … hears them all the time … feeling violated all his life … chip implanted in his brain … controls him … denied there was anything wrong with his mental health … subliminal messages'.

5.64 The AMHP report noted that his mother supported the plan to detain him in hospital under the MHA.

5.65 On the evening of 11 February the AMHP telephoned the Derby 'bleep holder'/bed manager to request a bed, asking for a PICU bed as a minimum, but ideally a secure unit. Dr A has since reported that the view of the two medical practitioners was that Mr N required at least a Low Secure placement. Dr S confirmed that a Low Secure bed would be appropriate, and that he did not at that stage feel that Mr N needed Medium Security. The DHCFT on call 'bleep holder' advised that Mr N would need to be referred to the Kedleston Unit, Kingsway Hospital, Derby (a DHCFT male low secure unit).

5.66 The AMHP told us that they made contact directly with the Kedleston Unit and was told that the Unit did not take people from prison in these circumstances, they do not usually admit people on Section 2 MHA, they would have to make a thorough assessment, and would need at least 48 hours' notice. We have not been able to fully evidence this aspect as the ward manager is now deceased, the AMHP has however recorded this in Mr N's clinical record. The unit's consultant psychiatrist has also confirmed to us that the Unit does not take urgent admissions, and that it did not admit patients detained under Sec 2 MHA, entirely in line with the ward manager's recorded comments.

5.67 The decision to admit a patient (if accepted clinically through an access assessment) to a low secure unit such as Kedleston Unit lies with NHS England specialised commissioners.[52] At this point it appears the NHSE specialised commissioners were not contacted to request that an access assessment was conducted, because the referral had been refused.

5.68 According to the 'Service specification: Low Secure mental health services (Adult)' there are two distinct groups of patients within low secure services[53]:

- Those requiring forensic low secure admission and will generally have been transferred directly from prison or court or have been charged with an offence whilst in the community or another hospital inpatient setting.

- Those requiring forensic low secure rehabilitation and who will generally have been transferred from medium secure inpatient services, will have been convicted of a serious offence and be subject to a hospital order (often with restrictions) or have been transferred from prison.

5.69 A process for urgent referrals is described, and the service specification states that 'the urgency of the referral is determined by the receiving clinical team but must be informed by discussion with the referrer'.

5.70 In this case the message from the Kedleston Unit was that this was not an appropriate referral, partly because of its urgency, and also because the unit does not admit patients on Section 2 MHA.[54]

5.71 On the evening of 11 February, the Derby Recovery Team Manager noted that Mr N's release could not be delayed beyond 8.00 pm the following day, and decided to contact Derbyshire police. They were informed by the contact centre (and this was checked by them with the sergeant on duty) that this is not a call they would log and they would not take the information. The police have no record of this.

5.72 After the refusal by the Kedleston Unit, and the advice from Kedleston that the only option for a secure bed would be a PICU, the AMHP called the DHCFT bed

[52] *Service specification: low secure mental health services (Adult). https://www.england.nhs.uk/publication/service-specification-low-secure-mental-health-services-adult/*
[53] *Service specification: low secure mental health services (Adult).*
[54] *OPERATIONAL POLICY AND PHILOSOPHY OF CARE THE KEDLESTON LOW SECURE UNIT exclusion criteria, page 5. (2014) DHCFT.*

manager to advise them of the situation, and they agreed to search for a bed. It was decided also to call independent providers of PICUs from the the prison. Nurse O and the AMHP began working through a list of providers between them. The DHCFT bed manager found several available PICU beds in independent hospitals, but all were refused after information was faxed over, on the grounds of risk.

5.73 The AMHP then called the DHCFT bed manager, the Derby City Recovery Manager, the crisis team and street triage team. The plan was for the Derby crisis and recovery teams to attempt to follow up Mr N, using the four addresses he had provided.

5.74 When the AMHP called his mother, she said that his partner had just given birth (at 26 weeks gestation). It is noted in his SMS notes that probation had been informed that the baby had been born at 26 weeks and was currently in special care at a Nottingham Hospital. It was noted that Mr N had turned up at RDH on the Friday night assuming the baby was there, but the origin of this information is unclear. The Nottingham AMHP did not have access to this information at the time.

5.75 It was recorded by Nurse O at 6.00 pm on 12 February that Mr N was to be released from custody because a bed had not been found, and that the AMHP had communicated with the DHCFT out of hours services and the police regarding risks and current presentation. The DHCFT bed manager was fully aware of the situation.

5.76 Nurse O arranged for the Section 2 MHA medical recommendations to be kept securely at a local NHCFT hospital for when they were needed.

5.77 Mr N was placed in a taxi to Derby with a £45 grant, and left HMP Nottingham at 8.00 pm on 12 February 2016.

5.78 It is not known where he spent the night of 12 February, but Mr N has said that he spent it on the streets in Derby.

Comment 3: <u>assessment prior to release and events leading up to his actual release and the appropriateness of actions</u>

At HMP Nottingham the usual process for requesting a secure bed would be to follow the NHSE Specialised Commissioning guidance, and then make contact directly with a clinician to discuss a gatekeeping assessment.

In this case the AMHP spoke to the DHCFT bed manager on 11 February who advised that if a low secure bed was needed, it would have to be made as a referral directly to the Kedleston Unit. It is clear from later discussions that usual expected practice would be that such a request be escalated through the on call structures, for senior management review (see recommendation 4).

The following day the Kedleston Unit manager informed the AMHP that the Kedleston Unit does not take emergency referrals and/or patients on Section 2 MHA.

We highlight the statement in the NHSE service specification that '*the urgency of the referral is determined by the receiving clinical team and should be informed by discussions between themselves and the referrer'*.
We consider that this statement does not provide sufficient clarity in terms of implementation and accountability.
The statement that *'discussion should take place'* we believe is not enough if the receiving team can decide to downgrade a referral from urgent to standard, without a full discussion with NHSE specialised commissioners.

The NHSE Low Secure service specification does not preclude patients detained on Section 2 MHA, and in this case the Kedleston Unit effectively closed the Low Secure referral without discussion, and there is no evidence of any attempt to conduct an urgent assessment at the time. An urgent assessment was however later conducted, even though Mr N remained on Section 2 MHA. While the later opinion that he required medium security was a clinical one, we explored the question of why Kedleston as a low secure unit was judged to not have been able to provide a safer environment than the ECW. We have been subsequently advised that there were operational pressures in the Kedleston unit that, in the views of senior DHCFT management, precluded admitting Mr N at that time. A CQC inspection in February 2016[55] stated that the low secure service 'required improvement', and of particular relevance is the requirement that '*the trust must ensure that facilities used for the*
purpose of seclusion are of sufficient size to safely accommodate a resistive patient and a minimum of three staff when implementing seclusion'. This suggests that the seclusion facilities at Kedleston were of a greater concern than at ECW. The Trust has addressed this in their CQC action plan.

However, in our view the NHSE Low Secure service specification should ensure there is a standard operating procedure in place for all referrals, with clear timelines and accountability for decision making, particularly with regard to the management of urgent referrals.

Recommendation 3
The NHS England secure service specification should ensure that:

- a standard operating procedure is in place for all referrals, with clear timelines and accountability for decision making, which addresses how to negotiate the pathway between CCG and NHSE commissioned services;

- provision of a single point of access, with a written response to referrals with a jointly agreed contingency plan if there is no suitable bed available;

[55] *Derbyshire Healthcare NHS Foundation Trust CQC inspection report June 2016 https://www.cqc.org.uk/sites/default/files/new_reports/AAAF6108.pdf*

- a pathway for urgent referrals is in place, with agreed escalation on urgency or level of security, and
- there is a dispute resolution protocol with named partners; and
- a process for responding to an urgent referral, with the opportunity to have multi professional urgent case management discussions to problem- solve and source a shared solution.

Timeliness and decision making and actions at key stages from the point [Mr N] entered Nottingham Prison until the point of admission to High Secure Services.

5.79 We have reviewed decision making and actions at the following points:

- Referral for a mental health bed from HMP Nottingham to DCHFT
- Bed management decisions at DHCFT
- DHCFT decision to admit him to ECW
- Referrals to Secure mental health beds from ECW

Referral for a mental health bed from HMP Nottingham to DHCFT

5.80 As discussed above in section 5, the initial review of Mr N by Dr A was that he could be treated for his mental health issues in prison. He was well known by the team, his medication had been increased on 10 February and he was to be reviewed again within two weeks. The decision to request an MHA assessment was made after the information was received from probation that he was to appear in Court by video link on 10 February and was likely to be released.

5.81 Charges were dropped and it was arranged that he would be kept in custody under a probation service 'recall notice' for the next two days (until 8.00 pm on 12 February) to allow time for an MHA assessment to be arranged, and a bed found.

5.82 Nurse O asked Mr N if he would be prepared to be admitted to hospital informally, but he did not agree. The referral was made to DHCFT bed manager on 11 February, when the two medical recommendations had been completed for Section 2 MHA. The AMHP intended to make the application for Section 2 MHA, but as discussed, a bed was not found.

5.83 A Low Secure bed was identified as needed, based on the clinical opinions of both Dr A and Dr S. The urgent referral for a Low Secure bed was turned down by the Kedleston Unit. No contact was made by HMP Nottingham clinicians to discuss this any further with the Kedleston Unit. There was no contact made with NHSE Specialised Commissioners to request a gatekeeping assessment, or arrange a discussion regarding the urgent nature of the referral.

5.84 This then reverted back to the DHCFT bed manager to find a secure bed, and a PICU bed was then suggested by the DHCFT bed manager.

5.85 The DHCFT bed manager was at the time the on call 'bleep holder' for acute services. The AMHP (SW C) had many conversations with DHCFT bed managers after the call to Kedleston, and was given information about available beds in independent providers.

5.86 Over two days SW C spoke to four different bed managers about locating a bed. On Friday 12 February SW C asked that this be escalated because Mr N's release was due that evening. SW C spoke to the senior manager on call who made contact, and when a bed could not be located, supported SW C by making contact with Derby police, DHCFT street triage and crisis and recovery teams.

5.87 The DHCFT bed manager gave SW C information about PICU beds which were available and SW C then had to follow up directly with referral information and risk assessment forms as requested by the various services. SW C made many phone calls and faxed information on various referrals forms as requested by the individual services. SW C described then waiting for services to respond, having said they would make a decision 'within the hour'. This process took most of Friday 12 February, and SW C had attended work to see this through on a non-working day.

5.88 No bed was found by 8 pm, when Mr N was due for release. Nurse O took the two Section 2 MHA medical recommendations to the designated safe at a local Nottinghamshire Healthcare NHS Foundation Trust hospital.

5.89 Mr N was placed in a taxi to Derby with a £45 grant, and left HMP Nottingham at 20.00 on 12 February 2016. It is not known where he spent the night, but he has since said he spent it on the streets in Derby.

Bed management decisions at DHCFT

5.90 The operational responsibility for bed management in DHCFT services was at the time devolved to the senior nurse on call, i.e. the acute services 'bleep holder'. This role was passed across to the next senior nurse at shift changes. The bed manager attempted to locate beds from the list of contacts, and let SW C know where they were so they could follow up. After his release from prison efforts to locate a PICU bed continued, still delegated to the 'bleep holder'.

5.91 The acute inpatient operational policy[56] includes a section on bed management that describes a process for decision making about admission to the Radbourne Unit, but does not provide any detail about the process of locating a PICU bed. At the time there were no commissioned PICU beds in DHCFT, and provision had to be sourced through 'spot purchasing' an individual bed wherever one could be found.

5.92 There were discussions about whether a further MHA assessment was required when Mr N was at ED, and some confusion about whether further medical recommendations were needed. Mr N was seen by the duty team AMHP on the

[56] *DHCFT Acute Inpatient Operational Policy for Radbourne Unit 2014, for review December 2017.*

night of 13 February, who completed a Section 2 MHA application in the early morning of 14 February, specifying admission to the Radbourne Unit.

5.93 We have not made any recommendations about the process of providing PICU beds because there have been considerable changes in how PICU beds are sourced, and how the individual patients are monitored. DHCFT has developed a senior role whose responsibility it is to maintain an overview of patients in PICU services, and support the communication with their DHCFT clinical team to plan ongoing care. We have however made a recommendation about the process of bed management at DHCFT, and about access to PICU beds.

5.94 NHS Hardwick CCG has conducted an options appraisal for the provision of PICU beds for DHCFT patients. There is no provision in DHCFT that could be commissioned to provide PICU beds under current environmental and service standards. A service level agreement has been reached with a nearby NHS Trust and an independent provider to 'block book' male and female PICU beds, based on past and projected expected usage.

5.95 These 'block booked' beds have been available since January 2018 and their usage is monitored by NHS Hardwick CCG, who share this information with other Derbyshire CCGs and DHCFT. NHS Hardwick CCG no longer exists, and mental health commissioning in 2019 is provided by NHS Derby & Derbyshire CCG. Recommendations for future action by the CCG are identified as the responsibility of NHS Derby & Derbyshire CCG.

DHCFT decision to admit him to ECW

5.96 Discussions about how to manage the situation took place over the weekend, with the on call manager discussing the issues with the Executive Director on call. The Executive Director of Nursing requested that the Executive Medical Director (Dr Y) assess Mr N in ED early on the morning of Monday 15 February.

5.97 Following the assessment of Mr N by the inpatient clinical director and the Executive Medical Director, further senior level discussion at DHCFT followed. Both the DHCFT consultant psychiatrists were of the view that he was psychotic at this stage. There were discussions about admitting him directly to the Kedleston Unit but this was discounted because of the mix of patients there, and it was felt that admitting Mr N would be unsafe. Dr Y had noted that he was settled and non-threatening, and that it may be possible to admit him to ECW. A decision was made at Executive Director level that Mr N would be admitted to the ECW at the Radbourne Unit.

5.98 The ECW consultant Dr R and the senior nurse were told on the morning of Monday 15 February that he was to be admitted to the ECW that day, and he was eventually admitted at 20.45.

5.99 It was left to the clinicians to decide how best to manage him after admission, and it was decided to admit him directly into seclusion.

5.100 Staffing support was arranged and the then Head of Nursing supported the ECW team to develop and implement plans of care.

Referrals to secure mental health beds from ECW

5.101 At ECW Dr R requested an urgent forensic gate keeping assessment two days after admission, on 17 February. A risk strategy meeting was attended by Dr R, Dr B, locum consultant Forensic Psychiatrist, Kedleston Unit, and Mr N was seen by Dr B.

5.102 Dr B's assessment report dated 21 February noted that Mr N was inappropriately placed on the ECW and the PICUs that had been approached would not accept the referral due to his risk of violence. Dr B's view was that the risk of violence, aggression and absconsion he presented were beyond the capability of a Low Secure unit, and recommended an assessment with a view to transferring him to a Medium Secure service. Dr B noted that she had alerted the NHS England Specialised Commissioners and forwarded a copy of her report.

5.103 Mr N was seen for a gatekeeping assessment on 24 February by a specialist doctor from the Medium Secure unit at Wathwood, which is provided by NHCFT. His presentation in seclusion was noted, and the assessing doctor interviewed him briefly in seclusion with accompanying staff, whilst wearing full biohazard clothing, including 'masks and face shields'. Mr N had been smearing faeces in seclusion and became hostile, which meant the assessment had to continue by interviewing him through the door. However, he again began to escalate, smearing food on the observation window and being verbally hostile. Mr N was described as very fixed in his belief that he had lost a large sum of money, that he had chips in his head and arms, and that there was a conspiracy against him.

5.104 The opinion was that Mr N presented with complex needs, and was currently presenting with predominantly dissocial and emotionally unstable personality disorder traits, with evidence of an underlying psychotic illness. Significant risks were noted as present:

- spitting at staff (he is Hep C positive)
- previous absconsion from ECW
- history of carrying weapons
- continued threats of harm towards staff
- destruction of property
- active non-engagement

5.105 Mr N's care was discussed at the Wathwood bed management meeting on 25 February, and it was concluded that:

> *'He presented with features indicative of personality disorder, however he also appears to have developed psychosis, the aetiology and diagnosis of which remains unclear. The associated risks of further violence, sexually disinhibited behaviour, self-harm and suicide were significant and were further aggravated by his mental illness. There is no prospect of [Mr N] accepting appropriate treatment in the current environment. His behaviour and risks likewise cannot*

be managed in a medium secure hospital setting. In view of the current level of hostility, threatening and subversive behaviours, it was decided to seek an opinion from Rampton Hospital'.

5.106 No recommendations were made to assist with his ongoing care at ECW. A gatekeeping assessment letter was sent from Wathwood to Dr L at Rampton, and a covering letter to Rampton MHA office and to NHS England Specialised Commissioners, marked 'urgent referral'.

5.107 Dr L assessed him for possible admission to Rampton Hospital on the evening of Friday 4 March, and informed ECW staff that there was a provisional decision to admit him, that would need confirming on the following Monday. He was transferred to Rampton on 10 March 2016.

Comment 4: <u>timeliness, decision making and actions</u>

HMP Nottingham/NHCFT

The actions taken by HMP Nottinghamshire healthcare staff in response to the news that Mr N would be released imminently were timely and appropriate in arranging an MHA assessment and communicating with Kedleston Unit and DHCFT bed managers.

We do however consider that it would have been appropriate for senior clinical (HMP Nottingham/NHCFT) staff to maintain oversight of the progress of the request for a Low Secure bed, and to have involved NHS England specialised commissioners in a request for an urgent admission, although we acknowledge that there is no clear pathway for urgent referrals.

DHCFT

In our view the contact made to Kedleston should have triggered an internal Trust discussion about the need for a bed, which would have alerted senior managers, and helped to take ownership of the issues. If it was identified that an assessment for a secure bed was needed, NHS England specialised commissioners should have been alerted.

The response by DHCFT to the urgent request for a bed should have been escalated to senior management as soon as it was received on 11 February 2016, and a senior level action plan agreed.

Mr N was well known to DHCFT mental health services, and there were risk flags in his clinical records from his most recent admission in late 2015. It was known that there had been two medical recommendations for Section 2 MHA and a secure bed had been requested, but not found After a recent admission, the ECW consultant had concluded that Mr N could not be safely managed on this ward, yet he had been returned there.

NHS Hardwick CCG

The current arrangement for the provision of PICU beds for Derbyshire patients is that a number of block booked beds have been purchased from a local

independent provider. The use of these is being monitored by the CCG, and while this may improve access to PICU beds, in our view this is not a substitute for locally managed PICU beds that are accessible by clinical staff, without the need for the input of commissioners.

Recommendation 4

DHCFT must ensure that the management of requests for inpatient admission in DHCFT should incorporate escalation actions to take place in cases where there is the likelihood of a patient requiring detention under the MHA, and is in need of a Derbyshire placement urgently.

Recommendation 5

All relevant providers must ensure that when external referrals for a mental health bed are made by prison healthcare psychiatrists, the process designed to achieve this should be locally agreed between the commissioners and providers, and relevant clinicians should be apprised of the situation in good time.

Recommendation 6

NHS Derby & Derbyshire CCG must provide assurance that there are arrangements in place to access PICU beds in urgent situations, including an escalation protocol with timescales and stepping up process agreed.

Admission to the ED at Royal Derby Hospital

5.108 This section includes the use of Section 136, and assessment, interventions and decision making prior to transfer to ECW.

Police actions in taking him to ED

5.109 Mr N flagged down a police car in Derby on the evening of Saturday 13 February, and told an officer he was hearing a voice telling him to kill or harm others. Police called DHCFT street triage team apparently to discuss whether to apply Section 136 MHA. The officer noted that he was *'otherwise calm and rational'*, and accompanied him to Royal Derby Hospital ED, arriving at 18.01 hours. The police officer did not remain with him. There is no further detailed record available about this from the police, and it can be inferred that because Mr N attended the ED voluntarily, there was no immediate concern required to detain under Section 136, which appears reasonable.

Actions taken at RDH

5.110 The MHLT were informed of Mr N's presence shortly after his arrival at ED, and attended to assess and support ED staff. Mr N was assessed at triage as would be expected in an ED, and the VISA assessment was completed. His previously prescribed medication details were obtained from HMP Nottingham healthcare staff, and he was prescribed antipsychotic medication and methadone.

5.111 ED staff provided one to one observations, and a decision was made to move him to a quieter ward area of ED partly because DHCFT were unable to provide a staff member to assess him, and ED were unable to release staff from ED to stay with him consistently.

5.112 Concerns about his continued presence in ED while apparently awaiting a mental health bed were escalated to RDH senior management on Sunday 14 February, and it was noted that the on-call Executive team member for RDH had escalated the issues to the DHCFT on call executive.

5.113 The MHLT liaison team kept in touch with ED, and it was noted by the ED lead consultant for mental health that there is a very good working relationship between the two teams, with MHLT providing a 24-hour service. His length of stay would be considered a breach of ED waiting times, but he was not discharged from the ED because it was believed that Mr N was awaiting a mental health bed.

5.114 The communication between the Executive team on-call for both Trusts resulted in the decision that an assessment would be made by Dr Y, Executive Medical Director for DHCFT, and the consultant psychiatrist who was the clinical director for inpatients.

5.115 This was done on the morning of 15 February, and he was admitted to ECW in the evening of 15 February.

5.116 NHS Hardwick CCG has shared an analysis of MHA assessments and Section 136 use in Derby over the past three years. The use of Section 136 decreased dramatically in 2014/2015, with a decrease sustained over time until 2017. In 2018 there has been a 37% increase in the number of people assessed under Section 136, and an increase in Section 2 MHA admissions.

5.117 These figures show that there is good oversight of the use of Section 136, which is fed back to the Crisis Concordat meetings.

Comment 5: <u>admission and care at ED, and use of Section 136</u>

Royal Derby Hospital ED
The assessment made at ED was that Mr N should remain there until the mental health bed was sourced. This was despite him not having a medical reason to stay in ED, and breaching their expected timescales.

The input to Mr N on ED was in our view 'above and beyond' what would be expected in an emergency department, including allowing his mother to spend time with him.

The DHCFT mental health liaison team provided good support and psychiatric advice during his stay in ED, which is an example of good practice.

Section 136

There does not appear to be a concern regarding the use of Section 136 in Derby amongst providers, and the ED consultant lead for mental health cited positive working relationships with mental health services and with the police.

The terms of reference required an examination of the question of whether Section 136 could or should have been used in the case of Mr N's conveyance to ED on 13 February 2016. We conclude that Mr N asked for help and was expecting to go to hospital, so was conveyed informally by the police appropriately without the use of Section 136.
This was not seen as a problem by the ED, and does not appear to be a common or concerning occurrence.

Treatment and care in ECW, seclusion, escalation and requests for help

5.118 Including requests for help, both from within and outside of NHS services, and the involvement of Mr N and his family.

5.119 As discussed above (from section 4.136) Mr N was placed in seclusion in February 2016 based on the knowledge of his previous risks as an inpatient (serious threats to harm and kill, absconding, damage to property, spitting at staff) and in the community (violence towards his ex-partner, using a weapon with threats in probation, using a weapon with threats to harm himself and others at SMS).

5.120 Placing him in seclusion effectively meant that there was little opportunity to establish a rapport and talk through care planning and what he may expect at the ECW.

5.121 There was an alert placed on his clinical file by Dr R in November 2015, that advised that:

> '*if [Mr N] presents to frontline mental health services again, inpatient admission should not occur without clear identification of a realistic purpose, and the increased risk that he poses whilst an inpatient should be a key part of the formulation*'.

5.122 There was no contingency plan developed, and the alert had not been tested in any way because Mr N had not presented as requiring admission until the February 2016 admission following the recommendations made for Section 2 MHA on 10 and 11 February.

5.123 Dr R recorded in the clinical record that Mr N's presentation was 'likely' to be linked to drug use, and so a drug-free assessment 'as far as possible' was planned.

5.124 The care plans written on 15 February clearly stated that Mr N was to be secluded based on his previous presentation. Mr N initially stated that he was having thoughts of harming people, and he thought seclusion would be a safe place for him.

5.125 We have seen the room that was in use for seclusion at the time. This was a room the size of an average modern mental health hospital bedroom, with a strengthened door and window, and a mattress on the floor. There was no access to fresh air though the window, and no toilet facilities. There was no secure external fresh air facility, and no intercom. Mr N had to eat and sleep and use portable bedpans as toilet in the seclusion room. He frequently smeared food and faeces on the door, walls and observation windows, and tipped drinks and body fluids on the floor. The CQC brief guide to seclusion rooms[57] notes expectations of the physical requirements of seclusion rooms, and references the expectations of MHA Code of Practice (2015).[58]

5.126 The MHA Code of Practice (2015) describes the following factors which should be taken into account in the design of rooms or areas where seclusion is to be carried out:

- the room should allow for communication with the patient when the patient is in the room and the door is locked, eg via an intercom
- rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- there should be no apparent safety hazards
- rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside) rooms should have externally controlled lighting, including a main light and subdued lighting for night time
- rooms should have robust door(s) which open outwards
- rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature. Rooms should not have blind spots and alternate viewing panels should be available where required
- a clock should always be visible to the patient from within the room, and
- rooms should have access to toilet and washing facilities.

[57] *CQC Brief guide: seclusion rooms* https://www.cqc.org.uk/sites/default/files/CQC%20mental%20health%20brief%20guide%202%20-%20seclusion%20rooms.pdf
[58] *Mental Health Act 1983:Code of Practice (2015).* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

5.127 It was recognised by DHCFT that the room used for seclusion at the time on ECW was not adequate for Mr N to use for any sustained period of time.

5.128 This room has now been decommissioned as a seclusion room, and we have seen the new re-provided seclusion rooms which have been built to standard expectations.

5.129 In terms of the practice of seclusion, the MHA Code of Practice (2015)[59]

> *'if a patient has either been secluded for eight hours consecutively or for 12 hours intermittently during a 48-hour period, an independent MDT review should be promptly undertaken. Appropriate membership of the meeting should be determined by provider policies, but as a minimum they should include a doctor who is an approved clinician, or an approved clinician who is not a doctor a nurse and other professionals who were not involved in the incident which led to the seclusion and an IMHA[60] (in cases where the patient has one). It is good practice for the independent MDT to consult those involved in the original decision. If it is agreed that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan*'.

5.130 DCHFT Seclusion and Psychiatric Emergency Policy and Procedure[61] required that if the patient is secluded for more than:

> '8 hours consecutively or for 12 hours intermittently during a 48-hour period; (if the 8 hours consecutively occurs at night and the patient is asleep and remains asleep then the review can and must occur at 09.00- see section 9)
>
> An independent multi-disciplinary team review must be promptly undertaken where a patient has either been secluded for eight hours consecutively OR for 12 hours intermittently during a 48-hour period.
>
> - Membership of the meeting as a minimum they should include a senior doctor or approved clinician, nurses and other professionals who were not involved in the incident which led to the seclusion and an IMHA. It is good practice for the independent multi-disciplinary team to consult those involved in the original decision. Consideration should be given to the involvement of the Divisional Nurse, Associate Medical Director and Service Line manager.
>
> - If it is agreed that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan,

[59] *MHA Code of Practice (2015) Chapter 26, page 306.* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF*

[60] *The Independent Mental Health Advocacy (IMHA) service came into effect in England in April 2009 as part of a new statutory provision in the revision to the 1983 Mental Health Act passed in 2007. The revised legislation provides a safeguard and right to advocacy for 'qualifying patients' detained under the Act.*

[61] *Seclusion – Psychiatric Emergency Policy and Procedure V5, September 2014, for review September 2017.*

- A ‘Seclusion - Exception Report’ form must be completed, as soon as possible/next working day and submitted to the Mental Health Act Manager,

- A formal appointment with a Clinical Psychologist to review the care and treatment of this individual, with case history, reflection and interview with the patient to assess the impact of this restrictive practice and to assess and plan to minimise psychological harm from a prolonged period of restrictive practice and isolation’.

5.131 The plans in place for Mr N were not reviewed as expected by an independent clinical team, which we believe is a breach of the policy.

5.132 The 2014 policy makes no reference to long term segregation, which was described in the MHA Code of Practice (2015) as:

> *‘long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis’.*

5.133 The expectation is that the local safeguarding team should be made aware of this plan and there should be a system of formal reviews involving the full MDT. Provider’s policies should provide for periodic reviews by a senior professional who is not involved with the case. The outcome of all reviews and the reasons for continued segregation should be recorded and the responsible commissioning authority should be informed of the outcome.

5.134 The plans in place for Mr N clearly met the criteria for long term segregation. On 19 February a decision was noted following an MDT review that he would remain in seclusion until transferred to a secure environment. In effect, it seems, the plan of care already explicitly included continuing management in seclusion: ‘*All on call consultants over the weekend are aware … not to let him out of seclusion due to high risk of hostility and aggression’.* He would remain in seclusion for a further 20 days, until 10 March.

5.135 The plan of care written on 19 February 2016 included reference to informing on call consultants, senior managers and police if the situation escalated. Police had been contacted and the response was that they could not attend or intervene in anything that they felt was linked to the delivery of healthcare, the care plan included contacting the police ‘*if there was a capacitous decision to cause harm to staff/public’.*

5.136 Mr N began to spit at staff, throw fluids, smear faeces and food and tie ligatures around his neck. As he was Hepatitis C positive there were additional concerns about infection control, and staff entering seclusion needed to dress in full protective clothing and equipment before entering. This inevitably caused a delay in entering if he was harming himself, and the tying of ligatures was seen as instrumental in requiring staff to enter the room.

5.137 A series of continual violent threats were made, he threatened to kill and rape staff, take hostages, to *'snap their necks',* spread infected body fluids, made personal threats such as *'I hope your car crashes and your children die'*. Mr N was also racially abusive. A number of these threats were directed personally at individual members of staff.

5.138 A care plan to monitor his physical health and wellbeing was in place, covering food and fluids, physical observations where possible, and access to washing facilities. He was to be moved between rooms whenever possible to provide opportunities for deep cleaning. There is good evidence that the observations were carried out as expected by policy, food and fluid intake was recorded, and physical observations were taken when it was safe to do so. There is reference to keeping his mother and solicitor informed. There is a record of him speaking to an IMHA in March, through the seclusion door. At that time, he asked for help in making a complaint and he was offered the opportunity for photographs to be taken of the room, but he declined. It is not clear from the records whether a formal complaint was made.

5.139 At a seclusion review on 20 February Mr N was told that his mother had phoned, and he agreed for information to be shared with her. He was also informed about later calls from her. There is no record of his mother visiting.

Requests for help (from police)

5.140 For further detail see 5.170

Comment 6: <u>treatment in ECW, requests for help and family involvement</u>

DHCFT

After the decision to admit him to ECW was made on 15 February, a subsequent decision to admit him directly to seclusion was made. The rationale for this was based on his previous aggression, violence and threats while an inpatient at the ECW. While we understand this perspective, we consider that this decision did not take sufficient consideration of the recent assessments by <u>five</u> psychiatrists that he was presenting with psychotic symptoms, nor his current settled and cooperative presentation; and we question whether the use of seclusion at the time was reasonable, proportionate and necessary.

A drug free regime was a reasonable aspiration in our view, given his history of substance misuse and the potential for his psychotic symptoms to be the result of intoxication. Appropriate medication was prescribed shortly after his arrival however.

If a collateral history had been taken, particularly involving his mother, we believe it would have demonstrated that he had been consistently unwell for some time, and had been regarded as psychotic by the previous three psychiatrists who had seen him in HMP Nottingham, and the two psychiatrists who saw him on 15 February.

There are no formal records that show the seclusion care plan was reviewed by an independent clinical team, and we consider that this is a breach of the policy.

In our view the clinical team should have been supported to access a formal second opinion about immediate management pending any transfer. The case of Mr N was a high profile case in the Trust with diagnostic uncertainty, significant risk concerns and a highly unusual and restrictive management plan of seclusion without an identified end point.

Given that the care of Mr N effectively 'paralysed' the ECW and Section 136 suite for nearly four weeks, we would have expected to see a plan of action that had high level oversight, invoking the Trust's emergency response/business continuity plan. This oversight should then have been formally reviewed and minuted, to provide senior support and guidance.

The practice of prescribing seclusion as a preventative practice is not in accordance with the MHA Code of Practice, and any use of long term segregation should have had the expected safeguards of oversight and external review. The DHCFT seclusion and long term segregation policy (page 6, March 2016) defines long term segregation as:

'The act of separating a person from a part or a section of others. By definition not from the whole body of others and not to be alone. In the case of this policy it means enhanced levels of therapeutic support, observation and engagement'. According to this definition it was felt that Mr N could not be treated with a long term segregation plan because this was viewed as requiring him to be with staff under their supervision in an environment *'not separate from the whole body of others',* and it was unsafe to do so.

We refer to the MHA Code of Practice (2015)[62] in which long-term segregation refers to:
'a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment'.

The MHA Code of Practice definition is also referred to in Appendix 3 of the DHCFT policy. This definition does not limit the intervention to avoid the person being alone. We suggest that DHCFT review the wording of the long term segregation policy to ensure this is aligned to the MHA Code of Practice, and develop a system to identify any cases of long term segregation, with appropriate monitoring.

[62] *MHA Code of Practice (2015) Chapter 26, 26.150 -26.160.26.*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHACode_of_Practice.PDF

In our opinion the ECW team made strenuous efforts to care for Mr N safely, considering his dignity as much as was possible. When he was settled enough he was supported to access fresh air, use a shower and bathroom for toileting, and was given reassurance and as much information as was available. It was accepted that the ECW was an inappropriate environment for him. We would like to acknowledge the forbearance of the ECW staff who had to manage a very difficult and distressing situation for far longer than should be expected, as good practice.

In this respect we consider that senior management in DHCFT should have instigated a formal structure for managing strategy, communications and problem solving, and maintained formal records of decisions and actions. It is evident from copies of emails that we have seen that there was communication from DHCFT at a senior level with CCG and NHSE commissioners, and clinical and managerial staff, to effect a move to another environment. We consider this process would have been strengthened by using business continuity management structures, with formal recording of requests and decisions made.

His mother raised the concern that she was not allowed to see him, and there is no reference to this in his care plan.

Requests for help from police

It has not been possible to gather a senior police perspective about conversations at the time between police and DHCFT, due to personnel changes. However, DHCFT have reported that there have been discussions at senior level between the Trust and Police, and there is now a greater clarity about expectations on both sides, and a working agreement to discuss any requests for assistance at a senior level.

Previous police responses in mental health hospitals have been occasionally open to criticism, and there has been a lack of guidance on the degree of involvement appropriate where the presenting issues are clinical. The College of Policing has issued a Memorandum of Understanding[63] regarding Police use of restraint in mental health & learning disability settings which can be used to underpin local agreements.

Recommendation 7

DHCFT should ensure that the Trust emergency management /business continuity plans include serious interruption of services and that there is a structure to ensure such occurrences are managed with appropriate leadership and senior oversight.

Recommendation 8

[63] *The Police Use of Restraint in Mental Health & Learning Disability Settings. College of Policing (2016)*

DHCFT should ensure that seclusion practice is monitored to provide assurance that policy requirements for reviews are met and adhered to.

Recommendation 9

DHCFT should align the definition of long term segregation in their policy with that of the MHA code of practice, develop a system to identify any cases of long term segregation, and any instances of long term segregation should be reported and monitored formally through quality structures.

Referral to Medium and High Secure services

5.141 This section includes a review of provider and commissioner responses and the timeline to transfer to High Secure services.

5.142 Each NHS England geographical region has their own local pathway and local process for access to secure services, based on the national service specification. The pathway for Derbyshire patients is that Low Secure referrals go to the Kedleston Unit. For mental illness the Medium Secure access assessments go to Wathwood Hospital, and for personality disorder they go to Arnold Lodge, both of which are provided by NHCFT.

5.143 There are 'threshold caps' in place, for instance to access High Secure beds a patient would need to have an 'access' or gatekeeping assessment from Medium Secure to say that they can't be managed at that level. Referrals to Rampton High Secure hospital are therefore only accepted when a Medium Secure access assessment has been made and the referral turned down.

5.144 The acceptance criteria for Low Secure environments include:

- Presence of a mental disorder which is of a nature and/or degree warranting detention in hospital for medical treatment under the Mental Health Act.
- Patients predominantly present a significant risk of harm to others and to manage this risk requires specialist risk management procedures and specialist treatment interventions.
- Prisoners suitable for transfer to low secure inpatient care will generally be charged with, or have been convicted of, a specified violent or sexual offence as defined in Schedule 15 of the Criminal Justice Act 2003 or another serious offence, such as arson.
- Patients may be accepted without criminal charges pending, where there is clear evidence of a significant risk to others in the context of mental disorder. There will generally be a pattern of assaults and escalating threats.

- Potential to benefit from the treatment/assessment provided or to prevent deterioration.
- The patient is not safely managed in a non-secure environment.
- Patient may present a risk of escape.
- Patients with a mental disorder directed to conditions of low security by the Ministry of Justice.

The exclusion criteria are:

- Patients who present a grave and immediate risk or serious risk to the general public and must be managed in high or medium security.
- Patients who present with disturbed or challenging behaviours during episodes of mental disorder that are likely to be relatively brief. These patients are more appropriately cared for in local generic mental health provision including adult Psychiatric Intensive Care Units (PICU).
- Where the predominant risk is of self-harm and there is no significant risk of harm to others. An exception to this might be for individuals serving long prison sentences for non-violent or non-sexual offences who, because of the risk of escape or as a result of MoJ direction, cannot be transferred to a non- secure environment.

5.145 A Low Secure referral was in fact made in the first instance before Mr N left HMP Nottingham, to the Kedleston Unit. As discussed above this was refused, and there was no further communication by HMP Nottingham clinicians to try to locate a Low Secure bed, or request an urgent gatekeeping assessment. The access assessment (East Midlands) guidance 2015[64] does not prohibit admission to Low Secure beds to patients who are subject to Section 2 MHA.

5.146 At ECW Dr R requested an urgent forensic gate keeping assessment two days after admission, on 17 February. A risk strategy meeting was attended by Dr R and Dr B, locum consultant forensic psychiatrist, Kedleston Unit, and Mr N was seen by Dr B.

5.147 NHSE Specialised commissioners were made aware that Dr B believed he was not suitable for admission to Low Secure on 19 February, and the report was provided. NHSE Specialised commissioners then shared this report with the Medium Secure service at Wathwood. On 23 February the Wathwood specialist doctor saw him for assessment.

5.148 We were told at interview with NHSE Specialised commissioners that Wathwood did not have an available bed in their intensive care area, otherwise he could have been admitted to a Medium Secure service, however the assessment reports at

[64] *Adult Secure Mental Health and Learning Disability Inpatient Services Referral and Access Assessment Guidance December 2015 (East Midlands).*

the time clearly state that Wathwood felt he could not be managed in Medium Security.

5.149 On 25 February the gatekeeping assessment for referral to High Secure was received by NHSE Specialised commissioners and forwarded to Rampton.

5.150 Dr L from Rampton saw Mr N at ECW on the evening of 4 March as an urgent assessment, and accepted him in principle. The normal process for High Secure admission decisions would be for the assessment to be discussed at the regular admissions panel. Dr L arranged for a discussion with key colleagues at Rampton with reference to his assessment, and an executive decision was made to agree admission out with the panel process.

5.151 The normal processes are that an assessment would be made within 21 days of receipt of all relevant information. If considered suitable for admission, a referral to the admissions panel should be made within 14 days of assessment. A formal written report should be sent within seven days of the admission panel meeting, and written confirmation of the decision of the admission panel would be provided, to include timescale for admission or rationale for decision not to admit and alternative recommendations.

5.152 A formal written report and confirmation of the decision to admit would be sent to the NHSE Specialised commissioner, and a bed offered within 24 weeks of the assessment.

5.153 A bed was available on Aldwick Ward, which is the intensive care ward for men with mental illness at Rampton, and where Dr L was the RC.

5.154 High Secure Services are provided for: 'Individuals with mental disorder or neuro-development disorder who are liable to be detained under the Mental Health Act (1983) and whose risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings, require care and treatment within a secure mental health service'… 'All individuals admitted to High Secure Services will be detained under the Mental Health Act (1983 amended in 2007) and fulfil the criteria as defined by the NHS Act 2006, for people who "require treatment under conditions of high security on account of their dangerous, violent or criminal propensities".[65]

5.155 The response to the request for an urgent referral to Rampton was immediate, and a decision in principle was conveyed directly to ECW clinicians. It is clear from our discussions and interviews that the acceptance of Mr N as appropriate for admission to Rampton was grounded in the context in which he was currently, i.e. he was in an unsuitable environment in which he could not be treated safely and appropriately. This was also true however at the previous two assessments for Low and Medium Security.

5.156 Mr N was informed of the acceptance in principle by Rampton directly after Dr L's assessment on 4 March, which is good practice. He was given further information

[65] *2014/15 NHS STANDARD CONTRACT FOR HIGH SECURE MENTAL HEALTH SERVICES (ADULTS).*

over the ensuing days and offered reassurance and support regarding the question of transfer to Rampton.

5.157 Mr N was transferred to Rampton with police assistance on 10 March 2016.

Comment 7: Referral to Medium and High Secure

In our view the speed of assessment, decision-making and transfer to Rampton was at that stage an appropriate and timely response to the situation in which the ECW clinicians and Mr N found themselves in, and we commend this as an example of systems working swiftly and effectively.

We have found that the circumstances and context in which he was being contained in ECW was a major contributing factor in his acceptance by Rampton. His threats made about infecting staff with HCV were also taken into consideration.

Mr N was assessed by Low and Medium Secure services prior to this, with both agreeing that ECW was unsuitable, but without offering support with treatment planning, or admission to a higher level of security.

His transfer out of ECW to an NHS England specialised commissioned service is regarded by practitioners as very swift, in a system that has a limited number of beds and resources. While this may well be true, we consider that the system did not initially respond appropriately to the urgency of the situation in ECW, and the outcome of successive assessments was simply to agree he was misplaced, but without an offer of support or solutions.

In our view the system should have enabled Mr N to have been admitted to a Low Secure service in the first instance from HMP Nottingham, and as such provided ownership of the issues.

See Recommendation 3

Recommendation 10
DHCFT should ensure that the exclusion criterion regarding admission under Section 2 MHA be removed from the Kedleston Unit operational policy.

Care and treatment within the High Secure Service

5.158 This section includes reference to the appropriateness of his admission and discharge. The decision-making about referral and acceptance to Rampton Hospital is discussed above from paragraph 5.147.

5.159 However, one of the issues in this case was the fortuitous availability of a Rampton bed, which meant that it was possible to transfer Mr N very quickly, in six days from the assessment. High Secure beds are not usually so readily available, and if one had not been available, Mr N would have stayed where he was on ECW for a further period of time, in the absence of an identified alternative

at that point. The only alternative plan in place at DHCFT should he either not be accepted, or if he had to wait for admission, was to continue to refer him to PICUs or private Medium Secure services.

5.160 Patients admitted to Rampton are rarely admitted directly to seclusion, as there is a reliance on higher and more robust measures of environmental, procedural and relational security. A risk management meeting was held by the MDT on Aldwick Ward the day before his admission, and a plan of initial care was written. It was planned that Mr N would be admitted to seclusion in safety clothing, due to his recent presentation in seclusion in ECW. His past and current risk history was discussed, and contact was made with his mother to take a detailed history and gather her perspective.

5.161 After admission Mr N presented as hostile, abusive, derogatory and aggressive. He was restrained and secluded. He repeatedly threatened to stab staff in the neck and to locate their home addresses, and called them "*paedos*" (sic).

5.162 Mr N continued to be irritable, loud, rude, constantly complaining, abusive, and demanding more benzodiazepines. He insisted his camera was linked to the internet, and asserted that paedophiles were watching him. Mr N made sexually offensive remarks, and threats to sexually assault female staff, and accusing staff of "*perving*" (sic) on him. By 17 March he had become more settled and seclusion was discontinued. He continued to push boundaries and be hostile, making threats to assault staff and start a *"dirty"* protest, and he was secluded again from 26 to 29 March.

5.163 His mother visited on 10 April and maintained contact with ward staff regularly. Social workers contacted the various services who were in contact with Mr N's child, and the baby born to Ms T in February 2016. The Rampton social worker attended social services meetings in relation to the new baby, and supported Mr N through the process of determining that he was not in fact the baby's father.

5.164 Medication was gradually adjusted, decreasing the prescription of diazepam, and methadone was discontinued by 24 March.

5.165 Mr N complained of multiple physical problems since stopping methadone, and physical healthcare investigations were carried out, and treatment for HCV was commenced.

5.166 At a Care Programme Approach meeting on 6 June, a referral to Medium Security (Wathwood) was made. Although Mr N remained argumentative and boundary-pushing at times, he was not threatening and was compliant with medication, and it was thought he could be managed in Medium Security.

5.167 According to the NHS England service specification, exit criteria for individuals from High Security are when:

- They no longer need a category B or above perimeter
- They no longer present a grave danger to the public

- They no longer present a severe risk of escape or absconding from a lower degree of security

- They no longer require the enhanced levels of physical, relational and procedural security provided in a high secure environment.

5.168 The Rampton notes record that there was a gate-keeping assessment on 13 July which turned him down, which we presume was for Medium Security, but we have not been able to locate the report. It is recorded that there were inaccuracies in this report which would be taken up with the author.

5.169 On 23 June however, a request was made by Wathwood to Kedleston that he bypasses Medium Security because he had been reported to be 'largely behaviourally settled and asymptomatic'. This was not agreed and he was admitted to Wathwood on 22 August 2016 on a short trial leave basis.

Comment 8: <u>Care and treatment in High Secure</u>

Mr N was admitted to Rampton six days after Dr L's assessment in March 2016. This was an example of a system working swiftly to resolve an inappropriate placement that was placing undue pressure on the inpatient mental health services in Derby; and that was not providing appropriate care for Mr N.

We consider this an example of excellent practice in both clinical leadership and problem-solving.

We have been asked to consider whether his admission to High Security was appropriate. Under normal circumstances Mr N would not have met the clinical threshold for admission, particularly as a period in medium security had not been attempted. However in this case it appears the context in ECW in which he was being treated was a major contributing factor in his admission. Given that Mr N's care pathway by this point had reached an impasse, with no plan to desegregate Mr N and no clear decisions to alter his antipsychotic regime, the action of the Rampton team could be described as that service, in effect, taking responsibility for ownership of his immediate clinical treatment needs.

His care and treatment at Rampton focussed on the initial management of risk, stabilising his mental state and continuing with antipsychotic medication. This was successful in that his move to Medium Security was managed in less than six months.

Information sharing from the police to the NHS

5.170 Derbyshire Constabulary informed us that they did not attend the Radbourne Unit on 16 or 18 February, because their assessment was that the request was to assist in clinical care, as the call stated that staff were struggling to control Mr N. ECW staff stated on 16 February they needed to move him to another room as he had smeared faeces on his walls and wanted police to attend in case he committed any offences. On 18 February the assistance was requested in relation

to Mr N ligating himself with bed sheets. This was declined due to having no powers in the circumstances after consultation between the control room and Radbourne staff.

5.171 On the 19 February 2016 the police received an ‘information only’ call from Radbourne advising of their intention to transfer Mr N to a secure hospital and would be requesting police assistance to transport once a place is approved.

5.172 Another call was made to police to request assistance on 21 February, Mr N was still at Radbourne Unit and had caused criminal damage to property. Police reported that they attended but healthcare professionals retained primacy and managed to sedate and gain control of Mr N. Details were taken for the damage offence.

5.173 On 8 March a request was made for police to transport Mr N to Rampton, which was a request for Police assistance to transport Mr N on the 10 March. This was subsequently agreed and Mr N was transported by Police to Rampton.

5.174 It has not been possible to gather a senior police perspective about conversations at the time between police and DHCFT, due to personnel changes. However, DHCFT have reported that there have been discussions at senior level between the Trust and Police, and there is now a greater clarity about expectations on both sides, and a working agreement to discuss any requests for assistance at a senior level.

5.175 We have also been unable to ascertain what the outcome of ward staff complaints to the police regarding threats to kill made to staff in ECW in November 2015. We have been informed that it is the responsibility of the police to ensure victims are kept informed of the outcome of complaints, although if the case goes to court the responsibility is transferred to the courts. This did not occur in this case and we suggest that DHCFT explore this directly with local police, both to follow through on these complaints and to agree future communication channels.

6 Overall analysis

6.1 We have reached a number of conclusions related to care and treatment of Mr N, and the systems within which care was provided, which contributed to the near miss situation.

6.2 We note that in February 2016 Mr N was assessed by a number of different services, who all agreed that he was inappropriately placed in ECW but none of these services, which arguably had higher staff ratios and more robust physical and procedural security, offered to take him to a suitable, or even a less unsuitable, place until the matter escalated to the ultimate security level, i.e. the High Secure service.

6.3 Mr N was identified as presenting particular challenges when an inpatient in ECW in 2015, and was removed from the ward by police. We consider it would have been reasonable to agree contingency plans in case of a re- presentation to mental health services.

6.4 NHCFT had no control over the impending release of Mr N from prison in February 2016, and the intention had been to treat his psychosis in prison, and keep this under review. When it became obvious that he was to be released imminently, an AMHP assessment and recommendations for Section 2 were obtained.

6.5 NHCFT clinicians and the assessing Section 12 doctor believed a Low Secure service was appropriate. Efforts were made to find him a low secure bed at Kedleston urgently, and this was refused. The level of security would normally be agreed by the clinician who carries out the gate keeping assessment, when one is requested through NHSE Specialised Commissioning. Within the service specification the level of urgency is decided by the assessor, not the referrer, and there is no process in place to challenge this.

6.6 In this case the Low Secure referral was simply refused, and usual bed management processes were actioned simply as a default position rather than as a positively agreed, clinically appropriate action.

6.7 There was no escalation of this issue by NHCFT clinicians to involve NHSE specialised commissioning and Kedleston clinicians in finding a solution.

6.8 Efforts then moved to obtaining a bed through DHCFT bed management structures which were not successful.

6.9 There was no escalation to DHCFT Executive team to alert senior staff that a Derby patient who had been deemed to require detention in hospital may be released into the community.

6.10 There is an unusual situation in Derbyshire regarding the provision of PICU beds. There is no suitable premises in Derbyshire, and NHS Hardwick CCG retains the budget for PICU beds and has obtained a block booking with an independent provider. The CCG has provided evidence to show that subsequently procured

beds with an independent provider are in place and they have launched a further procurement of a larger number of beds based on analysis of 18 months use.

6.11 We have considered whether the lack of directly managed DHCFT PICU beds has had a direct impact on the care of Mr N in this situation. It appears likely that efforts would have been made to access locally managed PICU beds if they had existed, either by prioritising or adjusting beds and/or resources. In this kind of situation experience suggests that with local control over admission and discharge, and the ability to flex security levels, the system can respond more flexibly. In our view it would certainly be preferable for continuity of patient care for DHCFT to have access to directly managed PICU beds.

6.12 The system in Derby did not respond flexibly at this time, but nor did it behave as a comprehensive and integrated system. In this situation the issue was not just about failing to bend the rules and admit someone somewhere quickly it was also about the whole system failing to take ownership and ensure it does not have gaps for people to fall into by default.

6.13 The process of accessing a secure gatekeeping assessment through NHS England Specialised Commissioning did not include a process for responding to an urgent referral, with no opportunity to have multi professional urgent case management discussions to problem-solve and source a shared solution. The option chosen, to admit him to ECW, was not in our view the best decision for Mr N or the ECW staff, and we consider that his care should have been monitored formally with senior support.

6.14 In our opinion the lack of senior oversight and support for the clinical team at ECW is an omission and allowed the prescription of seclusion and continuation of a plan of care that was excessively restrictive, and did not allow Mr N the opportunity to benefit from appropriately managed health care. This also did not allow the team to benefit from support and advice in what was undoubtedly a difficult and distressing clinical scenario.

6.15 We have had sight of senior level communications between DHCFT and NHCFT since this time, with principles agreed going forward for the future management of potential prison releases who are in need of mental health care. The need for access to PICU beds, better communication from HMP Nottingham about offenders needs and potential release where possible have all been identified as issues.

6.16 DHCFT have now established a PICU liaison nurse, who provides communication links between the Trust and Derby patients in need of transfer or ongoing care, which has been noted to have improved communication.

6.17 DHCFT currently has no established community forensic service, which could provide inreach to prison and maintain contact with patients who are also under criminal justice restrictions. We have seen the proposals for a local community forensic service and would regard this as a positive development.

6.18 We have made 10 recommendations for NHS services to address in order to further improve learning from this event.

Recommendations

6.19 We suggest that these recommendations be commenced immediately and completed within six months.

Recommendation 1

DHCFT must ensure that a risk management plan is developed and implemented when risks are identified, incorporating the review and use of recent and past records, using clinical risk assessment tools.

Recommendation 2

DHCFT should ensure that all safeguarding referrals are actioned appropriately and outcomes recorded.

Recommendation 3

The NHS England secure service specification should ensure that:

- a standard operating procedure is in place for all referrals, with clear timelines and accountability for decision making, which addresses how to negotiate the pathway between CCG and NHSE commissioned services ;
- provision of a single point of access, with a written response to referrals with a jointly agreed contingency plan if there is no suitable bed available;
- a pathway for urgent referrals is in place, with agreed escalation on urgency or level of security;
- there is a dispute resolution protocol with named partners; and
- there is a process for responding to an urgent referral, with the opportunity to have multi professional urgent case management discussions to problem- solve and source a shared solution.

Recommendation 4

DHCFT must ensure that the management of requests for inpatient admission in DHCFT should incorporate escalation actions to take place in cases where there is the likelihood of a patient requiring detention under the MHA, and is in need of a Derbyshire placement urgently.

Recommendation 5

All relevant providers must ensure that when external referrals for a mental health bed are made by prison healthcare psychiatrists, the process designed to achieve this should be locally agreed between the commissioners and providers, and relevant clinicians should be apprised of the situation in good time.

Recommendation 6

NHS Derby & Derbyshire CCG must provide assurance that there are arrangements in place to access PICU beds in urgent situations, including an escalation protocol with timescales and stepping up process agreed.

Recommendation 7

DHCFT should ensure that the Trust emergency management /business continuity plans include serious interruption of services and that there is a structure to ensure such occurrences are managed with appropriate leadership and senior oversight.

Recommendation 8

DHCFT should ensure that seclusion practice is monitored to provide assurance that policy requirements for reviews are met and adhered to.

Recommendation 9

DHCFT should align the definition of long term segregation in their policy with that of the MHA code of practice, develop a system to identify any cases of long term segregation, and any instances of long term segregation should be reported and monitored formally through quality structures.

Recommendation 10
DHCFT should ensure that the exclusion criterion regarding admission under Section 2 MHA be removed from the Kedleston Unit operational policy.

Appendix A – Terms of reference

This is an unusual case as a homicide was not committed; threats to kill were made but not carried out. Multiple organisations were involved in [Mr N's] care, both across organisations and geographical boundaries. Individual organisations have reviewed their internal processes; the Independent Investigation will need to not only review individual organisations contributions but also across organisation boundaries and services.

The serious incident framework recommends learning to prevent reoccurrence of patient safety or public safety incidents. This review is undertaken to embed a culture of reflection, learning and systems changes to provide a safer service.

- Review the care, treatment and services provided by the NHS and other relevant agencies from the service user's first contact with services to the time of his discharge from High Secure Services
- Compile a comprehensive chronology of events from [Mr N's] imprisonment in HMP Nottingham, November 2016, until his admission into High Secure Services
- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas for concern
- Review the adequacy of risk assessment and risk management, including the risk of the service user harming themselves, including the Safeguarding Adults and Safeguarding children's procedures in the context of this risk.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and their family
- Examine [Mr N's] clinical presentation whilst in HMP Nottingham, the assessment prior to release and events leading up to his actual release and the appropriateness of actions
- Examine the communication between NHS services and partner organisations and the adequacy of information sharing
- Examine the impact and learning on systems and process of information sharing from the police to the NHS
- Consider the appropriateness of [Mr N's] admission to the Emergency Department at Royal Derby Hospital, and the local Section 136 protocol
- Consider the assessment, interventions and decision making at the Royal Derby Hospital prior to the transfer to the Enhanced Care Ward at Derbyshire Healthcare NHS Foundation Trust and whether or not this was a suitable resource to meet his needs and manage the risks

- Examine [Mr N's] treatment and care during his stay within the Enhanced Care Ward, including the use of seclusion, escalation and request for help, both from within and outside of NHS services

- Examine the referral processes to medium and high secure services and the providers response

- Examine the timeline and length of time it took to progress the transfer to High Secure Services and the response of commissioners of services

- Examine the care and treatment of [Mr N] within the High Secure Service and the appropriateness of his admission and discharge from these services

- Consider the timeliness and decision making and action taken at key stages from the point [Mr N] entered Nottingham Prison until the point of admission to High Secure Services

- Review and assess compliance with local policies, national guidance and relevant statutory obligations

- Highlighting areas of good and excellent practice along with any areas where lessons can be learned

- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations

- Assist NHS England in undertaking a brief post investigation evaluation

- 6 months after the report has been published undertake an assurance follow up review, to assess the implementation of the report's recommendations and produce a short follow up report that will be made public

Appendix B – Documents reviewed

Derbyshire Healthcare NHS Foundation Trust
Policy and Procedure for 'Duty of Candour and Being Open' May 2015
Crisis Assessment and Home Treatment Operational Policy and Procedure November 2016
Infection Prevention & Control December 2013
Joint Policy for Derbyshire on the Operation of Section 136 of the Mental Health Act 1983 June 2015
Criminal Justice Liaison & Diversion Team Operational Policy April 2010
Liaison Team North Operational Policy March 2015
Observation of Patients Policy and Procedures September 2014
Observation of Patients Policy and Procedures June 2016
On call information sheet undated
Operational Policy and Philosophy of Care, Kedleston Low Secure Unit July 2014
Policy & Procedure Kedleston Low Secure Unit draft 2017
Derbyshire Constabulary and Derbyshire Healthcare NHS Foundation Trust Street Triage Team Operational Policy October 2013
PMOVA training pack
Positive and Safe Management of Violence and Acute Psychological Distress Policy and Procedure May 2016
Derbyshire Safeguarding Adults at Risk Partnership Safeguarding Adults Policy and Procedures June 2011
Assessment and Management of Safety Needs Policy May 2015
Seclusion – Psychiatric Emergency Policy and Procedure September 2014
Seclusion and Long Term Segregation – Psychiatric Emergency Policy and Procedure March 2016
Trust Management Structure December 2017
Untoward Incident Reporting and Investigation Policy and Procedure October 2017
A new model of a Community Forensic team – Our vision for the Derbyshire Integrated Community Enterprise (DICE) March 2018

NHS Hardwick CCG
Psychiatric Intensive Care Unit (PICU) Options and Appraisal Paper April 2016
Derbyshire CCG Block Booking of PICU Beds: 2018-19 Agreement
Provision of 6 female PICU beds October 2017
Copy of PICU patients April 2018

Derby Teaching Hospitals NHS Foundation Trust
Trust Policy Being Open & Duty of Candour April 2016
Trust Policy & Procedures for Incident Reporting, analysing investigating & learning including serious incidents May 2017
Trust Policy & Procedures for Maintaining a Safe Environment (incorporating the management of threatening behaviours in the workplace) November 2016
Trust Policy for Safeguarding Adults November 2015
Suicide Risk - Full Clinical Guideline May 2016
Trust Capacity Escalation Plan December 2016
ED police undated
ED legal guidance undated

NHSE Specialised Commissioning

NHS Standard Contract Variation Agreement HMP Nottingham 2018
NHSE Adult Secure Mental Health and Learning Disability Inpatient Services Referral and Access Assessment Guidance December 2015
NHSE Adult Low Secure Services including Access Assessment Service and Forensic Outreach and Liaison Services 2014
NHSE service specification Medium and Low Secure Mental Health Services (Adults) 2013/14
NHSE Information and Specification Pack for the Tender of Integrated Health Care Services at HMP Nottingham

Others

Derbyshire and Derby Safeguarding Adults Policy and Procedures May 2015
Derby City Council and Derbyshire County Council Report on Mental Health Act Activity 2014 - 2018
HMPPS Nottingham Urgent Notification: Initial Response Action Plan March 2018

Appendix C – Professionals involved

Pseudonym	Role and organisation
Dr R	Consultant psychiatrist, DHCFT
Dr Y	Executive Medical Director, DHCFT
Dr A	Consultant Forensic psychiatrist HMP Nottingham inreach
Dr I	Consultant Forensic psychiatrist HMP Nottingham inreach
Dr S	Consultant Forensic psychiatrist (Section 12 MHA)
Dr B	Locum Consultant Forensic psychiatrist, Kedleston Unit
Dr W	Locum Consultant Forensic psychiatrist, Wathwood Hospital
Dr L	Consultant Forensic psychiatrist, Rampton Hospital
Nurse O	Mental health nurse, HMP Nottingham inreach
SW C	AMHP, Nottingham City Council