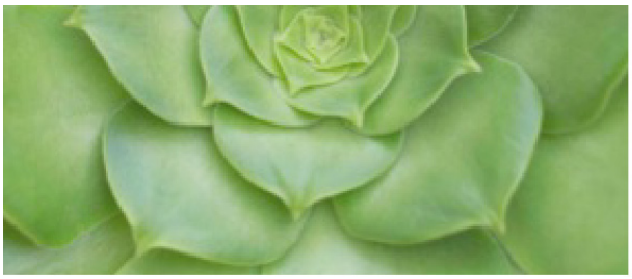

Psychological Approaches

AN INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF Mr X 2017 – (6089)

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CONDOLENCES

The panel would like to offer their condolences to the family and friends of the victim of this tragic event on the 2nd March 2017.

The panel also acknowledges the impact that this incident has had on those staff who worked closely with the victim and the perpetrator.

INTRODUCTION

Details of the incident

1. At 17.54 on 2 March 2017, a neighbour called the emergency services at the request of Mr X, who said he “thought” he had stabbed someone.

2. Police attended and found the body of the victim who was the housemate of Mr X in the property. The victim had sustained incisions to the cheek and neck.

3. Paramedics and a doctor attended at 18.31 and pronounced life extinct at 18.58. Mr X told the officers that he had killed the victim because he had stolen from him. He offered no resistance to arrest and asked if mental health services could be informed, saying he was on anti-psychotic medication.

4. Mr X was arrested and taken to St Mary's Wharf Police Station in Derby.

5. By the next day, Mr X had been assessed by the Forensic Medical Examiner as having the mental capacity to be fit for interview. He was interviewed overnight and admitted to the killing.

6. Mr X progressed through the criminal justice system. He was assessed by two forensic psychiatrists who prepared reports for the Court. In September 2017, he was convicted of manslaughter on the grounds of diminished responsibility and received a Section 45 Mental Health Act (Hybrid Order) with secure hospital treatment and prison sentence (life imprisonment). He must serve a minimum term of 6 years (less time spent on remand) before he will be eligible for parole.

7. He was transferred to Wathwood Hospital, a medium secure unit in Nottinghamshire, where he will remain until such a time that he is deemed well enough to move back into the prison population. Despite two requests Mr X declined to meet with the independent review team for the purposes of this investigation.

The Review Process

8. The team employed a multiple methods approach with a focus on triangulation to validate information regarding current practices. Methods included individual and team interviews and document reviews. We conducted a review of the evidence base regarding perpetrators of a domestic homicide offence who have a diagnosis of severe and enduring mental illness (usually schizophrenia) and who are under the care of community health teams at the time of the offence. A peer review of findings and recommendations took place within Psychological Approaches.

Background

9. The perpetrator was 41 at the time of the offence.

10. Mr X had experienced considerable childhood adversity, extending to the loss of his grandmother, who was his main carer, when he was six. His father did not play any significant part in his life.

11. During the following years, he developed epileptic fits which were found to be due to a brain tumour. This was removed surgically and his fits subsequently resolved.

12. However, he had behavioural difficulties at home and at school throughout his childhood. He was seen by Child and Adolescent Mental Health Services (CAMHS) services. He seemed to initially respond to a change in school but behavioural problems returned, including violence towards his mother.

13. He was sent away to live in a hostel and attended a specialist school for children with emotional and behavioural difficulties at about 12. The school reported that he was easily distracted and had poor social skills.

14. Mr X was re-integrated into mainstream schooling age 14, but his behaviour was unpredictable. In his late teens, he used a range of mood-altering substances.

15. Mr X was admitted to hospital at the age of 20 with a diagnosis of drug-induced psychosis.

16. Over the following 20 years, Mr X spent about 13 years in hospital and was diagnosed as having either schizoaffective disorder or schizophrenia (these are both severe and enduring mental disorders, characterised by hallucinations (false perceptions), and delusions (false beliefs). There is a more prominent mood component – either mood elevation or depression – in schizoaffective disorder).

17. His understanding of his illness was partial. He would sometimes find it difficult to take his anti-psychotic medication.

18. He had a history of missing follow-up appointments regarding both his mental and his physical health.

19. When he was ill, he expressed delusions about fantastic schemes such as curing diseases or time travel. These may have appeared to represent an elevation in mood, but equally, these false beliefs might reflect the grandiosity which can be due to schizophrenia.

20. In view of Mr X's childhood brain surgery, the two psychological assessments of personality and cognitive function conducted in a medium secure setting (when Mr X would have been in a settled mental state) are particularly important.

21. Firstly, in Kneesworth House Hospital (April 1998), a full neuropsychological assessment showed no evidence of cognitive deficit. Secondly, in Wathwood (September 2007), a psychological assessment was reported as follows: "*The personality inventory revealed that Mr X tends to view himself and his difficulties in an overly positive way. No particular personality traits were found. IQ was in the average range and it was felt that this had been adversely affected by poor schooling and mental illness. Importantly, given Mr X's past medical history, there were no neuropsychological deficits or problems such as disinhibition or impulsivity*."

22. The impression on reviewing the records for Mr X is that he could present differently to different people; that he was changeable and unpredictable.

23. His severe psychotic illness caused him to readily be overwhelmed by hallucinatory experiences and these could cause profound anxiety.

24. His condition was complicated by substance misuse. Although he was treated with risperidone by injection (depot), this would not prevent psychotic symptoms when he relapsed into substance misuse and, indeed, the risperidone depot seemed to need augmenting with oral risperidone during one of his many transfers to psychiatric intensive care (PICU) during the Summer of 2016. This is the combination of oral and depot injection which he was prescribed when he left hospital in November 2016. A combination of depot and oral medication is not as robust as depot alone for a patient who has a history of non-adherence to prescribed medication.

25. In terms of non-pharmacological approaches, Mr X was helped by being in an environment which could contain and reassure him.

26. It is noteworthy that his longest stable period in the community followed his admission to medium secure services in 2007. He was discharged via low security in January 2009 to Vinegar House, a 24-hour supported specialist placement on risperidone depot 37.5mg every two weeks within the framework of a Community Treatment Order (CTO).

27. The in-patient team conveyed the following information in the discharge summary in 2009: "*His psychiatric history is characterised by repeated relapses secondary to non-compliance with medication and follow-up arrangements and substance misuse... There is a risk of aggression and violence during a relapse of his mental illness*".

28. After 18 months, Mr X took up tenancy in a two-bedroomed house, with support, but this transition to more independent living was untenable for him and his condition deteriorated with a relapse into cannabis use.

29. The conclusion about Mr X's care needs from this review of his history is that Mr X had great difficulty in managing himself and his illness in settings that were relatively unstructured.

Derbyshire Healthcare NHS Foundation Trust

30. Derbyshire Healthcare NHS Foundation Trust was formed in 2010 and became a Foundation Trust in February 2011. It serves a population of circa 1 million and employs approximately 2,500 staff.

31. In June 2016, the year preceding the homicide, the CQC carried out a detailed inspection of the Trust and found several areas of concern. They issued Requires Improvement notices in seven areas of regulated activity and three enforcement notices. The Trust was given an overall rating of Requires Improvement. They rated each of the five standard domains as follows:

- Are services safe? - Requires improvement
- Are services effective? - Requires improvement
- Are services caring? - Good
- Are services responsive - Requires improvement
- Are services well-led - Inadequate

32. The CQC carried out a further inspection of the Trust in November 2019. This report, published on the 6th March 2020, demonstrated significant improvement and gave the Trust an overall rating of Good. The five domains were rated as follows: -

- Are services safe? - Requires improvement
- Are services effective? - Good
- Are services caring? - Good
- Are services responsive - Good
- Are services well-led - Good

33. In relation to this independent investigation, it is relevant that the recent report indicated that for community-based mental health services for adults of working age, there were still areas of concern. The CQC gave this service area an overall rating of Requires Improvement. The two domains still noted as Requiring Improvement were 'safe' and 'well-led'. Services were noted to have demonstrated improvement in their Responsiveness, which moved this rating from Requires Improvement to Good. The domains of Caring and 'effectiveness' were rated as in the previous report as Good.

34. Again, in reference to this independent inquiry, the CQC highlighted the following areas of concern which required improvement:

- The service had 32 mandatory training courses which did not meet the compliance target of 75%
- Not all teams had adequate leadership to provide staff with support, managerial supervision, clinical guidance and support with incidents
- Managers did not always complete actions in response to incidents in a timely manner.

35. Positively, amongst other points, the reported noted:

- Most teams in the service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of most teams, and of most individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans.

Derventio Housing Trust

36. Derventio Housing Trust first commenced trading on the 1st January 2010, when housing and support services TUPEd across from the DHA.

37. The independent review team met with Derventio's Assistant Director of strategy and the assistant director of operations who informed the team that they began as a project under local housing advice organisation DHA, providing a night shelter (Derbyshire Housing Aid).

38. Today they lease houses from property owners and set them up as units with an intensive housing management officer (IHMO) who do weekly and monthly health and safety checks at the properties. It is supported housing.

39. They will also work with tenants to ensure that rent and individuals contributions to bills is paid, as well as a range of tasks to make sure that people can keep their accommodation, and to assist them to move forward in their life.

40. They help 1100 people per year, of whom 200 get additional support.

41. There are other projects such as a confidence and skills-building project (Growing Lives), employability projects (funded by ESF and National Lottery Community Fund), and Healthy Futures, commissioned by CCGs and homelessness authorities.

42. Mr X and the victim were both supported by the Healthy Futures team. This was a small dedicated team specifically commissioned with the aim to provide a cost effective and rapid response to support hospital discharge to more complex service users. The outputs reported from this project resulted in substantial savings to the public purse.

43. This team was initially funded by the Department of Health's Homeless Hospital Discharge Fund in October 2013 and subsequently by the CCG until June 2018. The overall aim of the project is to act as a bridge between hospital and home for people who have multiple and complex needs cross cutting homelessness, mental health and drug and alcohol issues.

44. It was noted that users of mental health services were consistently the largest group of referrals.

45. In terms of operational practice the team had an open referral system for local hospitals and were tasked with assessing and supporting patients from hospital discharge to the community and to offer intensive support to avoid readmission and to promote independence by helping the patient use health services appropriately.

46. The service met CCG and public health priorities as a Homeless Hospital Discharge (HHD) scheme and its practice, management and reporting systems were considered robust and evidence-based and provided the basis for its Guardian Public Services Award in 2016 in the Health & Social Care category.

47. Governance was reported to be of a high standard and processes proficient. For instance, the risk assessment template was 12 pages and the assessment form nine pages, addressing relevant clinical areas of interest. Formal supervision was monthly with additional ad hoc meetings as required providing an opportunity for reflective practice.

48. The initial anticipated duration of this service was 12 weeks through in practice this may have been extended to six months.

49. At the time of the homicide, the team were fully staffed comprising one full-time manager and three full-time staff including the key worker who was allocated to Mr X for his stay at Allen Street.

50. The three workers identified had a combined 38 years' experience in various forms of housing and homeless support and were 'qualified by experience'. While previous training and experience were critical selection factors, the impression from one interview, was that in-house training was not particularly extensive. Their manager commented that a higher level of training in mental health would have been particularly beneficial given the client group.

51. Each worker had a typical caseload of 15 although this could vary. Due to the bespoke nature of the model the time of support to each resident varied depending on perceived need. The average was about two hours per resident per week but this could be increased up to 10 hours if required.

52. The team operated a solid and self-sustaining service and took responsibility for their own out of hours on-call system which was available 24/7. The project also had its own dedicated units of housing which the staff managed themselves.

53. Overall, the team were regarded as a reputable provider offering practical support and problem solving solutions thus ensuring good outcomes to support care pathways.

54. While a formal information sharing agreement between the Trust and Derventio was not in place, the Derventio consent form allowed for access to clinical information which was clearly forthcoming in the case of Mr X.

55. Following the homicide, Derventio undertook a timely incident review meeting on 8 March 2017 attended by its Chief Executive Officer, the Healthy Futures Team Leader, Head of Human Resources and other members of the Senior Management Team to review staff safety and risk mitigation.

PURPOSE OF REPORT

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

57. The full terms of reference for the independent investigation into the care and treatment of Mr X provided by Derbyshire Healthcare NHS Foundation Trust and Derventio Housing Trust can be seen at Appendix I.

INDEPENDENT PANEL METHDOLOGY

58. A review of the medical files for Mr X including previous reports, notes and related correspondence.

59. A review of the internal report on the incident chaired by DN2. Two authors of this report (DN2 and DR1) were interviewed.

60. Key staff from the Trust and the Housing Association were interviewed. Information was also drawn from personal reports or associated clinical records.

Abbreviation	Position
	NHS Foundation Trust Employees
DN1	Director of Nursing & Patient Experience
DN2	Deputy Director of Nursing & internal report author
DR1	Consultant Forensic Psychiatrist & internal report author
RC	Responsible Clinician (In-patient care)
CPN	Community Psychiatric Nurse (Care coordinator) Derby
SM1	Interim team manager (incumbent)
SM2	Team manager (returning from secondment)
OT	Occupational Therapist (In-patient care)
MM	Modern Matron (In-patient care)
SW	Locum SW (Care coordinator) Killamarsh team
	Derventio Housing Trust
AD1	Assistant Director of Strategy
AD2	Assistant Director of Operations
HFTL	Healthy Futures (Ex- team Manager)
	Others
Consultant	Independent Consultant Psychiatrist MHRT report (May 2016)

61. Two members of the panel met with the victim's mother and father to discuss their experiences and that of the family and to clarify their expectations of the investigation and the report.

62. A second meeting was held with the victim's father to provide an update following interviews. At his request, feedback was given to the trust requesting that they renew efforts to make contact.

63. The panel formally approached Mr X via his consultant psychiatrist at Wathwood Hospital, to invite him to meet with the panel and participate in the investigation process. His consultant psychiatrist confirmed to the panel that she spoke with Mr X who declined this invitation.

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

65. **The Benefit of Hindsight** – The investigation panel fully accept that they are reviewing the services and care provided to Mr X after the tragic incident of 2 March 2017, giving them the benefit of hindsight. The independent review team's role is to identify missed opportunities, gaps or failings in Mr X's care.

FINDINGS

ToR 01 "Review the Trust's internal investigations and assess the adequacy of the findings, recommendations and action plan."

Note: For the purposes of clarity this section refers to the Trust's "***internal"*** investigation inquiry, led by the Deputy Director of Nursing, and the "***independent"*** inquiry by the team from Psychological Approaches.

66. On the 26 April 2017 the Trust formally established its internal inquiry. The investigation would be conducted by a consultant psychiatrist and the Deputy Director of Nursing. An external psychiatrist was also initially involved but later withdrew. The team were to submit their report to the Trust Serious Untoward Incident group on the 7 December 2017.

67. The purpose and terms of reference of the inquiry was set by the Medical Director and states: "*To thoroughly examine the care and treatment afforded to the service user whilst under the care of Derbyshire Healthcare NHS Foundation Trust, looking specifically at the 12-month period leading up to the incident*".

68. For many investigations this may be a reasonable timeframe. However, due to Mr X's clinical background and presentation, the independent inquiry team concluded that the 12-month time frame did not provide the necessary "deep dive" because Mr X's history suggests profound difficulties in managing his life in the community long before 2016.

69. The internal inquiry was asked to consider the victim's pathway into the accommodation at Allen Street, which led the Trust's lead for Safeguarding Adults to conclude there were no areas of concern. However, the independent inquiry team saw from the records that in the two weeks preceding the incident, Mr X's relationship with his former housemate was becoming difficult as he said the flatmate was taking drugs. This caused Mr X to request to be relocated. Shortly after this, Housemate 1 was relocated on the 24 February 2017.

70. The internal inquiry noted a referral for a forensic opinion was made but by agreement between clinicians was not progressed, following his placement in PICU. The independent inquiry team did consider that with Mr X's known complex and detailed forensic history, this was a missed opportunity.

71. The internal inquiry noted that the option of an in-patient rehabilitation placement was discussed in May and September 2016 during PIPA (Purposeful In-patient Patient Admission) meetings but evidence documenting these discussions could not be found. However, during interviews with inpatient clinicians, the independent inquiry team were told of perceived exclusion criteria for local rehabilitation services which included historical or

current illicit drug use and services not wishing to take patients who did not want to go to the service.

72. The internal report acknowledged that the Trust Board and Commissioners were aware of significant and multiple resourcing challenges in the Derby City neighbourhood team where Mr X was receiving care. This included arbitrary allocation of caseloads irrespective of either clinical need or the experience of the clinician. In this case, Mr X was allocated to a band 5 CPN with limited experience who was not receiving regular quality clinical and managerial support and supervision. Whilst the independent inquiry team were informed of longer term plans to enhance the service, there was limited evidence of short term mitigation plans which robustly addressed this challenge.

73. The review of the CPA documentation by the internal inquiry found it to be incomplete and, in some areas, inaccurate. The internal inquiry noted that Mr X's "*care was not of the standard we would expect*" and further added that there was no evidence of multi-disciplinary discussion, specifically in relation to the early warning signs of relapse.

74. In relation to the oral risperidone, the care plan made no reference to his compliance with oral medication or how the community team might respond should Mr X refuse his risperidone tablets. Given his clinical presentation while an in-patient from March to November 2016, the need for additional oral medication, and Mr X's history of poor compliance with medication, the independent review team also considered this was a significant omission.

75. The report of the internal inquiry noted that whilst a crisis plan was in place, it lacked detail regarding signs of crisis and named contact points, should these be required.

76. The internal inquiry team reviewed Trust policies and spoke with staff to explore the issues surrounding Mr X's transition from the in-patient service to the community and the agreed legal framework of a Community Treatment Order (CTO). They noted that records indicated that discussions took place in pre-discharge meetings. They further noted that the in-patient RC was clearly concerned that the level of risk that Mr X presented was not fully appreciated. This led to him personally writing to the CPN in May 2016 re-emphasising his concerns regarding Mr X's risk factors. When speaking with the independent inquiry team, he acknowledged that this was not his normal custom, but he had done this to convey a detailed account of Mr X's risk factors.

77. The internal inquiry established that the community team did not follow Trust policy in the application of the CTO, nor was the locum consultant psychiatrist proactive when Mr X presented as irritable during his first appointment in January 2017 as shown by the scheduling of the next follow up appointment for

four months' time. The independent review team were of the view that Mr X's presentation at this first appointment warranted a far more robust response, such as a full multi-disciplinary team and partner agency review.

78. The internal inquiry noted that they did not consider that Mr X's clinical presentation in the days before the homicide would have triggered a response such as a recall to hospital, describing that they did not see evidence that Mr X had relapsed but his disturbance may have been related to the stress that he was experiencing, thus consideration could have been given to the suitability of continuing to accommodate him with others until any symptoms had stabilised. The independent inquiry team have come to the different conclusion that both Mr X's call to the out of hours GP (stating that he was hearing voices and seeing things) and the bizarre drawings on his bedroom wall were strong indicators of a relapse of Mr X's psychotic illness, necessitating urgent consideration of hospitalisation to stabilise Mr X's mental health.

79. The internal investigation did review NICE guidelines (NG178) specific to the care of individuals with Psychosis and Schizophrenia. This emphasised amongst several points, the need for engagement rather than risk management and the use of long-acting depot medication.

80. The internal inquiry considered several policies pertinent to Mr X's care and identified a mixed picture in terms of staff's adherence. In part, this may have been due to transitioning from one approach to another, for example with the change from using the FACE risk assessment model to using the Safety Planning Approach. The internal inquiry commented on difference between the quality and adherence to policy between the inpatient service and the community, with evidence of well-documented clinical history and risk management by the in-patient service which did not appear to be replicated or understood once Mr X was in the community.

81. The internal inquiry did note that Mr X had previously experienced interpersonal friction whilst on the ward, therefore the likelihood of this being repeated in the community was predictable. They also considered that a forensic opinion may have assisted the team in clarifying their view about the most appropriate community placement be it Allen Street, or a more structured rehabilitation service.

82. The internal inquiry noted that the community team was a generic community MH team and that Mr X would have probably met the criteria for a community forensic service with a more intensive input. They agreed that this proposal would be taken forward to the CCG.

83. The internal inquiry in their conclusion identified several key factors of concern in Mr X's care. They acknowledged that his history suggested he could present

a “significant risk to others”. That the community team responsible for his care at the time, was experiencing multiple challenges which “might have resulted in a lower level of multi-disciplinary vigilance”. Also, that there was a perception that community team did not share the same opinion as the in-patient service regarding the risk that Mr X may have presented.

84. The internal inquiry and the independent reviewers agree that the explanation of his rights to appeal against the use of the CTO was an example of good practice by the CPN.

85. The Trust action plan is shown as Appendix III.

ToR 01 - Conclusions

86. Summary: The Trust quickly established an internal investigation panel to review this tragic event including an external participant. Unfortunately, forced changes in the membership were made, including the withdrawal of the external member which may have been detrimental to the process.

87. The ToR of the internal inquiry focussed specifically on the 12 months preceding the incident. Whilst Mr X’s broader clinical history was visited, his life from the age of 21 had been very disordered with regular intermittent spells in psychiatric care, often linked to violent and aggressive behaviour. This time framed limited the review. Therefore, the independent investigation considered that the inquiry did not have the necessary rigour of a “deep dive” investigation.

88. The findings of the review noted that at the time of the incident the CMHT was experiencing significant challenges, leading to substandard care. During interviews with the inquiry panel key members of the CMHT were confident that the services today are better supported, although still lacked a breadth of forensic expertise that would support them further. However, it was not clear to the external reviewers how the Trust would objectively measure this progress.

89. Areas of Good Practice:

- The initial inclusion in the internal inquiry of an external Psychiatrist, providing objective review
- It is positive that the review measured the service against external guidance i.e. NICE guidelines (NG178)
- The internal inquiry panel noted areas of good practice such as detailed clinical history whilst in the inpatient services
- The Trust’s approach to supporting staff following serious untoward incidents of this nature, which can have a profound effect on individuals
- The Trust had acknowledged shortfalls in the community services in the Derby Neighbourhood CMHT and reported this to the Board.

90. Areas of Concern:

- The internal inquiry noted that a forensic opinion was requested but not undertaken or followed up. The independent team considered that with Mr X's clinical history, this was a missed opportunity which may have helped to inform the inpatient team's discharge planning. This is particularly relevant because referrals were made to the local rehabilitation service and Derventio housing almost simultaneously due to the perceived belief from the inpatient clinicians that the former would not entertain admission due to Mr X's clinical history.
- The internal inquiry noted the lack of compliance with oral medication and his complaints to the out of hours GP, and drawings on the wall, concluding that this may have been linked to stress as per a "stress-vulnerability model".
- The independent review team acknowledge that Mr X was almost certainly experiencing considerable stress, living in the community with limited support. However, the independent reviewers conclude that the delusions and hallucinations were evidence that Mr X was experiencing psychotic symptoms and that there was an urgent need to manage his deterioration, including a possible recall to hospital.
- The internal inquiry noted that the Trust Board and commissioners were sighted on the challenges faced by the Derby Neighbourhood CMHT. However, the independent reviewers, who admittedly have had limited detail available to them, conclude that the response by the Board appeared inadequate and insufficiently prompt.

ToR 02– "Review the progress that the trust has made in implementing the action plan."

91. The Trust have been unable to support the independent review with information to demonstrate the implementation of the action plan due to the challenges presented by the Covid-19 pandemic which has led to the redeployment of key staff from this team.

92. The Trust's action plan is shown at Appendix III.

ToR 03 – "Review and verify the Trust's chronology of events leading up to the homicide."

93. The investigators prepared a chronology which covers Mr X's life history. It is included in this report at Appendix II.

94. Comparing the two chronologies, the Trust's chronology is an accurate account of the events of the 12 months preceding the homicide. However, it starts 12 months before the homicide, with Mr X out of touch with services. In the opinion of the investigators, it would have been more comprehensive to start the chronology with Mr X's return his locality in June 2015 after being discharged from a three-year in-patient stay in Germany. This is because his history

suggests that he had profound difficulties in managing his life in the community, so it is instructive to understand how services lost contact with him in the Winter of 2015-16.

95. In the opinion of the independent review team, the knowledge held by the service about Mr X should have stimulated a more robust response to his needs during the Autumn of 2015. At that time, he was sent a letter explaining that he could not be allocated a care co-ordinator. The investigators think that this is an important piece of history because it is likely to have contributed to his anxiety that the community was a place where he was not held in someone's mind and where things could go wrong for him.

ToR 03 Conclusions

96. The chronology prepared by the Trust is accurate but commenced 12 months before the homicide, thus it omitted an important area of concern – the lack of provision of a care co-ordinator for Mr X at a time of high risk of relapse because he had declined depot medication. There was a subsequent loss of contact between Mr X and services, during which time he became itinerant.

ToR 04 – "Review the appropriateness of the care, treatment and services provided by the NHS, Housing provider and other relevant agencies from the service user's first contact with services to the time of their offence, focusing on the period preceding the homicide, identifying both areas of good practice and areas of concern."

97. Mr X had developed a severe and enduring mental illness by the age of 21 complicated by violence, on a background of childhood adversity. This combination of difficulties is recognised to be associated with the need for care which provides enhanced containment, both during periods of in-patient care and in the community.

98. This containment should be both structural (for example, locked doors) and relational (for example, a staff team who is reflective about the patients, sharing their experiences of caring for them in protected team meetings). Such containment, particularly structural security, characterises care in forensic settings. Mr X had been appropriately detained in forensic settings under the MHA following his convictions for violence. Of his 20-year history in mental health services, he had spent nearly 12 years in forensic psychiatric services. The table below shows the dates of his admissions to forensic settings, the nature of his subsequent placement in the community and the outcome of that placement.

99. Despite these lengthy admissions, his subsequent periods in the community were characterised by rapid disengagement except for his placement in Vinegar House, from January 2009 until August 2010, when he took up an

independent tenancy with support. His stability in the independent tenancy faltered after a few months and the subsequent year was chequered, with a recall to hospital and the cessation of depot so that he was out of touch with services by February 2012. At this stage, he was discharged from the service.

100. Dates of admissions to forensic settings:

Dates of in-patient care	Discharge destination	Outcome
April 97 – July 04	Hart House (Supported accommodation)	Left within a few days, disengaged from services
Feb 07 – Jan 09	Vinegar House (24-hour supported specialist placement)	Sustained stability for 18 months. Did not maintain this in subsequent independent tenancy
Sep 12 – May 15 (Germany)	Stayed with a friend in Derby, homeless	Out of touch with services, presentations in crisis.

101. This review of the history of Mr X's community care suggests that he benefited from the 24-hour support and the structure of the regime in Vinegar House. He was subject to the framework of a Community Treatment Order (CTO), doing voluntary work and taking risperidone depot regularly. His mental state was stable. There is a record of his out-patient reviews in the notes from the years 2009 and 2010 which document his engagement with services. The records suggest that the regime in Vinegar House was a containing one.

102. However, when Mr X was in less structured placements, he could quickly falter in his engagement with services and his compliance with medication. A good example of this can be seen in the period after his return from Germany, in June 2015. He did not have a structured care plan that met his needs for containment; rather, he was given depot, which he changed to oral within a couple of months. He was not allocated a care co-ordinator when his care co-ordinator left the service in November 2015. There followed a period of homelessness and presentations in crisis in Sheffield and London. On occasion, he could appear mentally ill to one observer, but not to another (for example, during the MHA assessment on 2 December 2015). This period shows how hard it was for Mr X to use support, and how he could not find stability without it. This is important when considering his placement in the Allen Street house.

103. In the opinion of the independent review team, Mr X's experience of care in the community following his return from approximately three years in hospital in Germany was likely to have been fragmented and unhelpful. He was not good at working with services and his mental state could be difficult to assess. Although he initially asked his GP for his depot, he quickly decided to request a

change to oral medication and there seems to have been no recognition or concern on the part of his psychiatric service that his mental state would quickly deteriorate. In fact, he was sent a letter explaining that it was not possible to allocate a care co-ordinator in November 2015. Mr X had subsequent presentations in crisis and relapsed into psychosis and rough sleeping during the first few months of 2016. The independent reviewers conclude that he might have felt apprehensive about a return to the community, where he had - both historically and recently - found it very hard to sustain stability in his life.

104. During the Summer of 2016, Mr X was an in-patient. His condition improved when he had been re-started on the depot injection. This had to be done within a psychiatric intensive care setting (PICU) where he had been placed due to his agitation and hostility. A referral was made to forensic services on 29 June 2016, but there is no record of any response to that referral letter. By September 2016, Mr X's condition had stabilised on a combination of depot and oral risperidone, commenced within the PICU. The doses were increased but the combination of depot and oral was not rationalised in favour of one mode of administration. A referral was considered for a period of rehabilitation, but this was not pursued because Mr X was reluctant and there was a concern by his Responsible Clinician and the clinical team that his substance misuse might lead to him being viewed as not suitable for a rehabilitation setting.

105. Planning for Mr X's discharge commenced with leave to a community placement in May 2016 which failed within days despite this placement having an element of support. There was consideration of a referral to a rehabilitation service, which he declined. Subsequently there were parallel referrals to supported accommodation.

106. At this stage, it was clear that his vulnerabilities included:

- A history of seeking to cease depot medication and of stopping oral medication
- The rapid re-emergence of delusions with a grandiose quality when without medication
- A history of losing contact with services when mentally ill, including sleeping rough
- A risk of relapsing into street drug use
- The experience of observers that his mental state could be difficult to assess.

107. The placement in the community of someone with multiple vulnerabilities relies heavily on all the community team to support each other in being alert to any changes in his condition. In the case of Mr X, any of the above were potential indicators of increased risk.

108. Such a placement should have been to a service which recognised and met Mr X's needs for structure and containment. The Derventio 'Healthy Futures' Project was not designed or resourced to provide the level of containment needed by Mr X to sustain him in the community.

109. Similarly, the community team was lacking a sufficiently containing structure. During our interview with his CPN and two senior colleagues, they describe the period when he was placed at Allen Street, as a time when the community team was under great pressure:

- There was a waiting list of over 100 people for allocation of care coordinators
- Allocation of cases did not always take account of the complexity of the case and the experience of the practitioner
- Supervision was relatively unstructured. The CPN said "this was the ward coming up with this plan, and me just going along with it." "At the time, I could access supervision from a psychologist, but I do not remember discussing Mr X".
- The team had had multiple locum consultant psychiatrists, so there was a lack of continuity and consistency in the availability of a medical opinion to the team. In fact, the only contact Mr X had with a psychiatrist was an outpatient appointment on 25/1/17, where he was described as "dishevelled" and expressed dissatisfaction with the need for monitoring of his physical health. This appointment should have been attended by the care co-ordinator. It offered an opportunity for a collaborative CPA review to help Mr X understand that he had a team around him in the community. The key worker from Derventio Housing was there.

110. The CPN confirmed that liaison between himself and the Derventio key worker was conducted by telephone. He recalled no occasion when himself, Mr X and the key worker met together. Even when Mr X had drawn diagrams and written about his plans to cure diseases on the wall of his room, the two workers did not meet with him together to reassess whether the level of risk had altered, because they usually visited the property singly.

111. There was a lack of social care. The community care plan omitted to show that Mr X was entitled to Section 117 Aftercare and the care plan omitted key areas of social care and support. The care plan was based almost solely on compliance with the depot, and the CTO was solely linked to default from the depot medication rather than other areas of his care plan, such as the risk assessment or the risk to others if he became unwell.

112. The use of the CTO was appropriate[1]. It was a minimum discharge requirement because:

[1] There is not a good evidence base for the use of CTOs. They do not reduce the overall rate of hospital admission but patients are subjected to a curtailment of their personal liberty (Burns, T,

- Mr X met the criteria
- The use of a CTO was indicated by his history of rapid disengagement, needing structured care plan, needing robust monitoring and MDT collaboration to manage the risks associated with his care in the community
- Mr X's mental illness had previously shown that he responded to medication
- Mr X needed a legal framework to underpin his community care and to support medication compliance, and
- the power of recall was necessary and appropriate.

113. This is the background to the relapse of Mr X and the failure of his community team to manage this robustly with his return to hospital in the nine-day window before the homicide.

ToR 04 Conclusions

114. Areas of Concern and Areas of Good Practice

- For the purposes of this investigation, areas of concern and areas of good practice will be described for the period starting in the Summer of 2015, because this was Mr X's last experience of care in the community before his admission in April 2016 and his discharge to the Allen Street flat in November 2016.

115. Areas of Good Practice relating to this period:

- The use of the CTO was appropriate
- Awareness of rights under the Mental Health Act - The notes show that his care co-ordinator had read out his rights to Mr X while visiting him in the community
- Clarity about actions to be taken in the event of default from the depot medication – the CPN's notes contained a clear plan for the use of the CTO in the event of Mr X failing to accept the depot.

116. Areas of Concern relating to this period:

- The Nov 2015 letter to say that it was not possible to allocate a care co-ordinator - it is clear from the Chronology that Mr X's needs were enduring. He had spent much of his adult life detained in forensic settings. The failure to provide a named worker in the community for someone with this level of vulnerability is an area of concern
- The decision to discontinue the forensic referral of 29 June 2016 - in view of Mr X's complex presentation and long forensic history the independent inquiry team viewed this as a missed opportunity to gather another perspective about care and treatment and possibly future placement
- The decision-making surrounding the placement of Mr X in independent accommodation when the community placement six months earlier had failed within a week

OCTET trial, Lancet, 2013). However, many clinicians would use a CTO where it might offer a framework for compliance with medication, as was necessary in the care of Mr X.

- The allocation of a complex case to a relatively inexperienced member of the psychiatric community team
- The lack of a clear structure in the community team for the discussion and escalation of urgent clinical concerns
- The failure to hold a CPA meeting with the RC, the CPN and the key worker from Derventio.

ToR 05 – "Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming them self or others."

117. The risk assessment process for Mr X is assessed against the orthodox risk assessment processes of information gathering, assessment, and risk formulation, risk planning, risk management and review. It is also recognised that a patient's risk profile can be raised due to a change of setting such as discharge which also entails a change of team and key personnel.

118. Best practice in risk assessment advises that the patient is engaged in the risk assessment process to understand and appreciate their risk and to give them insight and a sense of personal responsibility in owning and managing their risk. This would have been an important but challenging task for clinicians.

119. **Information gathering and assessment** - The formal inpatient risk assessment used the FACE Risk Assessment which was completed and signed off on 28 November 2016. This was available electronically to the CMHT. This gives a detailed and accurate history of Mr X's offences and forensic admissions. There is little evidence to assume risk to self and the nature and level of his risk is clear.

120. There is limited information relating to Mr X's risk regarding arson. There are references in reports to incidences of arson at an early age but there are no convictions. However, his RC clearly pursued the risk of arson as shown by his contacting and writing to the police on 21 October 2016.

121. There is limited appreciation of Mr X's potential risk to females. The FACE notes the offence against the female nurse manager in 2009, but there are other instances of concern, for example his arrest after allegedly assaulting his girlfriend in May 2005. He was sexually disinhibited in July 2016, and in September 2016 he is reported to have been flirting with a nurse, texting a 15-year old girl and engaging in oral sex with a female patient. A female patient made a complaint about him. (In October a safeguarding alert was made regarding financial exploitation of Mr X by this female patient.)

122. The CPN described visiting Mr X with a female student, who was left feeling very uncomfortable by Mr X staring at her.

123. In November 2016 his inpatient RC records an updated written risk assessment in the community notes and itemises sexually inappropriate behaviour as one of 5 clear risks to be included in a CPA care plan and risk assessment. This was not undertaken.

124. It is unclear whether this perceived risk to women is habitual or increased with deteriorating mental health. However, the risk assessment documentation including the FACE and consequently the Detention risk assessment lacked acknowledgement that there was evidence of risk in this area. The independent review team considered that current and future staff should have been aware of his potential risk in interpersonal relationships with females whether in a professional or private capacity.

125. **Formulation** - The risk management tools were not effectively employed to facilitate the process of formulation. The FACE document is a factual and a narrative assessment. While the RC's letter to the CPN (May 16) and the narrative risk assessment of 17 November 2016 did consider protective factors and a management plan these do not appear to have been transposed into a formal and central plan that the MDT agreed.

126. Thus while stable accommodation, proactive problem solving and social skills training were identified as risk reduction factors they were never fully incorporated into Mr X's care plan. The risk management plan relied heavily on the CTO which emphasised compliance with medication and use of recall should Mr X default on his depot. This was a key requirement for Derventio.

127. During Mr X's final admission prior to his discharge to Allen Street he had been transferred to enhanced care and a PICU indicating difficulties in him managing his interpersonal relations both with other patients and staff. These relationship difficulties do not seem to have been adequately analysed and transposed into the risk formulation. Despite this, his leave at Allen Street between 25 October 2016 and his discharge on 28 November 2016 was lengthy and there were no discernible problems. However, a formulation of his relationship problems and how they might present themselves in Allen Street was not evident.

128. The tools used to assist formulation and apply risk management were limited. FACE did not have evaluative capacity i.e. a RAG rating or a risk management matrix. The FACE document may have therefore created a false sense of safety and undermined the importance of clinical observation and judgement skills.

129. There is a START risk assessment completed by nurse at the Cygnet in August 2016 which does adopt a basic rating system but this approach was not then followed.

130. During Mr X's admissions to medium and low security a HCR20 risk assessment was undertaken and incorporated into contemporary risk planning. The the risk formulation and scenario planning from this structured professional risk assessment was lacking in Mr X's later risk assessment.

131. Whilst reviewing the risk management plan the independent review team considered it lacked attention to social factors or a review date for reassessment of the risk.

132. The risk assessment did not address the potential responses of the community team to changes that may arise in the community. It therefore lacked a strategy or plan for individual workers and agencies to monitor, review and manage the risk.

133. Risk management is a dynamic process that needs to include both a long term and a short-term perspective. Such reviews commonly occur as a prelude to or part of a CPA Review and should include the canvassed views of the patient and key stakeholders. The care plan of 5 December 2016 was not comprehensive. Therefore, critical aspects of recovery and therapeutic activities and support were absent to the detriment of his overall risk management.

134. The CPN undertook a review of the FACE risk assessment on 9 January 2017. Mr X was marked low on all categories of risk including violence to others. Section 117 aftercare was left unchecked and the box indicating clinical symptoms indicative of risk was in the negative. The assessment was signed off by the line manager.

135. In addition the CPN completed a Safety Assessment Summary on 10 February 2017. This would appear to have been done without Mr X's direct involvement as it was completed between visits on 30 January 2017 and 13 February 2017.

136. From the records it does not appear that either assessment was shared or discussed with Mr X, Derventio or the GP.

137. Mr X's inpatient RC expressed concern that the community team did not fully appreciate the patient's risk and was keen to ensure this was addressed during the transfer of care and discharge. To convey his concerns, he personally wrote to the care coordinator in May 2016.

138. The FACE risk assessment was forwarded to Derventio as part of their own risk assessment process as completed by their key worker on 6 December 2016. This indicates that Derventio received the same risk management tool as used by the community team.

139. In the view of the independent review team, best practice would have been to undertake a shared a risk assessment between Derventio and the CMHT, prior to the introduction of the victim to the Allen Street House. However, it is noted that this may not have been possible within the operational processes of the Healthy Futures team, which was built on the urgent placement of homeless individuals in crisis.

140. The communication between the CPN and the Derventio key worker caring for Mr X was critical. Both considered Mr X to be stable and not relapsing, and that he had a relatively good relationship with the previous resident with no reported conflicts. However, the records indicate that his relationship with this individual had become increasingly difficult, leading to Mr X asking for him to be moved.

141. During a visit by the CPN on 21 February 2017, Mr X stated that he was well. He was taking his depot medication. He showed the CPN diagrams drawn on his bedroom wall, with grandiose content. They were a key marker of psychosis and associated heighted risk. The CPN arranged to visit later that week.

142. Derventio may not have appreciated this risk as the referral form completed by the ward rates his risk to others/self as low and omits key areas regarding harassment of others, sexual aggression, and engagement with services. Although Derventio staff attended ward rounds and the S117, the RCs letter and stated concerns as expressed in his risk assessment of 17 November 2016 may not have been fully relayed to Derventio.

ToR 05 Conclusions

143. Summary

- The risk assessments recorded a history of Mr X's offences and risk but lacked a formulation of the risk and management plan as to how risk would be measured, communicated and mitigated.

144. Good Practice

- The CPN sent the FACE Risk Assessment to forensic services in London in April 2016.
- The RC's practice approach to ensuring that Mr X's risk was relayed to the CMHT. The RC sought information from the police about the risk of arson.

145. Areas of Concern

- Given his history and long inpatient stay there is an absence of psychology input to the risk assessment process which may have enhanced understanding and planning for interpersonal relations.
- The risk assessment should include psychological and environmental factors and be part of the CPA Care Plan, but the CPA care plan of 5

December 2016 left key sections on daytime activities, social and safeguarding needs blank, undermining the risk mitigation.

- There is also doubt that the plan was communicated to Derventio and the GP.

ToR 06 - "Examine the effectiveness of the service user's care plan including the involvement of the service user and any family/careers involvement."

146. A discharge plan was completed on 28 November 16 and signed by Mr X, detailing the seven day follow up from the CPN with a planned visit on 2nd December to administer his depot. It provides contact details names for the CPN, Derventio, GP and Crisis Team but is otherwise limited in detail.

147. The discharge plan (community care plan) lacked evidence of comprehensive multi-disciplinary planning in that Occupational Therapy and Psychology were omitted. The independent review team considered it missed key structural elements of how Derventio and the community team could ensure regular communication and joint visiting to support Mr X, particularly given his risk and history of disengagement.

148. There is little consideration of Mr X's social needs and how they might be met to improve his well-being and relationship with services. Large sections of the community care plan completed on 5 December 2016 were left blank. This included sections on his recent progress, daytime activities, occupation, employment, education, social, financial, legal and safeguarding needs.

149. The care plan indicates that Mr X is not seen as having entitlement to free services under Section 117 of the Mental Health Act and unmet need is marked as 'unmet'.

150. The care plan appears not to have the involvement of Mr X. Neither was a further review date set. It appears that copies were not shared with Mr X, the GP or Derventio.

151. The CPA is a holistic approach that incudes addressing aspirations and developing strengths. The promotion of well-being and social inclusion to support mental health recovery are notable omissions here. Mr X's history of voluntary work while at Vinegar House in 2015 and his use of the gym at the Hartington unit were not proactively developed.

152. The primary focus of the care plan is on medication and compliance with the CTO, emphasising what steps will be taken should Mr X default on his depot. The CTO and the care plan appear overlapping, leading to an over-simplification and reliance on compliance with the depot as being the only requirement to sustain his recovery and engagement in the community.

153. Mr X was given details of the Crisis and Home Treatment Team (CRHT) but was not provided with a crisis or contingency plan as part of his care plan. Had this been provided it may have helped him to manage an internal or interpersonal crisis.

154. Given Mr X's risk and support needs, it would have been prudent for the out-patient appointment with his community RC on 25 January 2017 to have been a multidisciplinary review. The key worker from Derventio attended.

155. There is an absence of social care principles to the care plan and care pathway. This contrasts to the previous discharge in 2009. The Care Act 2014 encompasses provision for housing related support (i.e. help to maintain a tenancy/pay bills) and that anyone with an appearance of a need for care and support is entitled to an assessment. There are protocols for the discharge of people requiring care and support contained in Annex G of the Care Act, 2014.

156. The independent inquiry team understand that Mr X's tenancy at Allen Street was funded by housing benefit and the CCG via Derventio funding. Therefore, it may have been meeting Care Act assessment criteria. However, Section 117 after-care responsibilities should have been offered and met as part of discharge and community care plan.

157. It is of note that the SW completed a Social Circumstances Report on Mr X on 6 October 2016 and key areas of S117 aftercare, vocational activities should have been addressed in interview with Mr X and transposed into the care planning process. Unfortunately, the report is not on file. However, the community notes on 20 October 2016 reference a funding application for an enhanced community care package for the S117 panel but it does not indicate what this specifically relates to.

ToR 06 Conclusions

158. The role of care co-ordination can be extremely challenging requiring a wide knowledge base and range of skills, particularly when caring for individuals with complex and high-risk presentations and histories of limited engagement. Such cases would usually be allocated to more experienced community staff with regular access to senior clinical supervision.

159. The care plan in place at the time of the homicide had notable deficiencies. Mr X had a lengthy admission and an extensive psychiatric and forensic history. The care plan lacked consideration of this history with its associated risk and perceived protective factors. It failed to address Trust policy principles of recovery, social inclusion and well-being, principles which are closely allied to promoting risk mitigation. Crisis management planning was absent and the care plan lacked curiosity and the engagement and involvement of Mr X. It was also not shared with Derventio.

160. We note that the risk assessment of January 2017 was signed by the CPN's line manager. However, it is unclear to what the expectations of the Trust have regarding the supervisory responsibility to ensure adequate care plans are in place for complex patients such as Mr X with forensic histories and S117 status. Given the concerns raised by the inpatient RC and the care coordinator's lack of experience, robust support and supervision were required.

ToR 07 - "Involve the relatives of both the service user and victim in the investigation as fully as appropriate, and in accordance with their wishes."

161. At the beginning of the investigation process, contact was made with the father of the victim, to explore whether the family wished to meet with the panel and share any views or make any contributions to the proposed terms of reference.

162. The panel subsequently met with the victim's father and mother on the 3rd February. The terms of reference for the investigation was shared, with no representation for further additions.

163. The family expressed a lack of trust and confidence in the internal investigation and expressed a clear view that they considered their son had been in an unsafe situation.

164. The Mother stated she had understood that the perpetrator would be maintained in a secure environment and would not ever be released.

165. The panel were shown a copy of the internal investigation which had been sent to the family, which was heavily redacted to maintain individuals' confidentiality.

166. The independent review team committed to maintain communication and provided contact details of the Chair of the panel.

167. The panel had a further meeting with the victim's father on the 16th March. The victim's mother had been invited to this meeting but did not attend. During this meeting, he informed the investigating team of the positive experience he had with a charitable organisation SAMM (Support after Murder & Manslaughter). He had been signposted to SAMM via the Cruse Bereavement Care.

168. The independent review team understood from reports that Mr X's mother (a single parent), had not been actively involved with her son for several years, and had not wished to participate in the investigation process. Mr X also reinforced this position during an interview with the forensic psychiatrist who had prepared a court report. The panel had no contact with either of Mr X's parents.

ToR 07 Conclusions

169. In discussions with the family, which was also acknowledged by the Trust, the independent review team noted a gap in follow up support once the Police family liaison/victim support officer's role diminished after court.

ToR 08 – "Review the service user compliance with his Community Treatment Order (CTO), medication and his care in the community."

170. The Chronology and Background sections of this report illustrate that Mr X had spent more years in institutions during his adult life than in the community, and that he had profound difficulty sustaining an adaptive structure to his life when in the community.

171. In the opinion of the independent reviewers, his difficulties in this regard are more profound than mere 'compliance' with a care plan. It is not clear that Mr X had the capability to 'comply' unless he was in receipt of a comprehensive, structured and containing care package comprising substantial psychiatric and social support to complement his accommodation.

172. This review has described the use of the CTO as an area of good practice (section 4.4). The CTO replicated in part the structure which led to Mr X's successful placement in Vinegar House in 2009, but that placement was much more than just the legal framework requiring compliance with medication.

173. The independent review team considered that in 2016 the CTO, as a framework to support the multidisciplinary team, should have been part of a structured, well monitored collaborative MDT care plan working to manage and mitigate risk.

174. On discharge to the tenancy with floating support on 28 November 2016 the CTO required that Mr X be concordant with his prescribed medication and engage with his community team.

175. With regard to his medication, Mr X was discharged from hospital on a combination of risperidone depot medication (50mg fortnightly) plus risperidone tablets (4mg per day), adding up to 125% of the British National Formulary (BNF) maximum dose. From the record, mention of the oral medication is omitted from some of the clinical notes (see 'Care Plan' dated 5 December 2016, page 176 in the community care notes pdf) and Mr X stopped this without the knowledge of his care co-ordinator in January 2017. In fact, there is no mention of any specific inquiry about compliance with the oral medication in the community care notes.

176. Regarding the oral medication, Mr X therefore did not comply with the requirements of the CTO.

177. Regarding the depot risperidone, Mr X was given his depot at fortnightly intervals regularly until his arrest, except for 27 January, when he was not at home. He had this injection three days later. He was compliant with the requirement to accept depot medication.

178. Regarding his care in the community, Mr X was available to meet with his care co-ordinator for his depot injections and he attended his out-patient appointment with a consultant psychiatrist on 25 January 2017. Thus, Mr X did meet the requirements to engage with his care team. However, these requirements were minimal and his care plan was sparse and opportunities for the care team to detect his deteriorating mental state were missed.

ToR 08 Conclusions

179. Summary

- The independent reviewers concluded that Mr X did engage with his care workers in the community. Mr X did not comply with the terms of his CTO as he did not take his oral medication, although he accepted the depot.

180. Areas of Good Practice

- On 27 January, Mr X was not at home for his depot injection, explaining that he could not get back from Chesterfield. The care co-ordinator did draw up a safety plan following this.

181. Areas of Concern

- The letter from the psychiatrist describes him as “dishevelled” and “irritable”, but this did not prompt any closer scrutiny and Mr X was scheduled for review in four months’ time.
- On 19 February, Mr X made an emergency call to the out of hours’ general practitioner service, describing hallucinations. On 20 February Mr X showed his care co-ordinator deluded material written the wall of his bedroom. These events did not prompt a more detailed assessment or a change in the care plan.
- There was no record of any specific inquiry from the CPN whether Mr X was taking his prescribed oral risperidone.

ToR 09 - “Review the arrangements surrounding the service user’s placement in the supported housing, the plans in place for the service user’s support in the community and the appropriateness of the accommodation.”

182. Mr X presented with complex housing and placement needs and expressed a reluctance to be dependent on services. His inpatient admission entailed two changes of care which disrupted working relationships. Therefore, his transition

and discharge back to the community setting necessitated an integrated and collaborative approach between the in-patient team, receiving CMHT and housing providers to ensure a safe and containing outcome.

183. Mr X's discharge to Vinegar House in 2009-10 demonstrated that he benefitted from a high support placement and a defined step-down care pathway to lower support.

184. Therefore, the discharge from Vinegar House in 2010 provided a good template for discharge from the Hartington unit and may have been an alternative to further in-patient rehabilitation. Positively, it demonstrated clear discussion between services and the provider as to Mr X's risk and management needs. There was an emphasis from Vinegar House management on getting to know him prior to admission and how to manage his risk. Top up funding was requested and agreed for extra dedicated staff to enable this support.

185. In addition to the above, the CPA care plan was supported by the legal structure of a CTO. Mr X was robustly supported with his voluntary work. Reviews were well attended and documented and Mr X was an active participant in the process, as shown by his signed care plan which contained social care components and was developed by experienced community staff, including a forensic social worker.

186. Due to his positive progress, when Mr X eventually requested to be move to independent accommodation, it was agreed. This included his preference not to share accommodation and he was stepped-down to a house by himself. Unfortunately, despite the input of a dedicated floating support worker and a community social worker, he relapsed into drug use and left his tenancy unannounced. This behaviour emphasised the likelihood that despite his preference and probable assurances, any future placement in independent accommodation without a high degree of floating support as part of an assertive outreach model entailing good communication and collaboration between services and a housing provider was unlikely to succeed.

187. During his last admission to the Hartington unit, Mr X was referred to three housing providers. Derventio, Rethink and Anchor Housing. Despite being in Chesterfield, at Mr X's request, he was given trial leave to Brockhill Court (Anchor Housing). This trial leave ended with his rapid return to hospital.

188. Rethink made an assessment but did not offer a service. Derventio's initial assessment was undertaken by one of the Healthy Futures team on 13 October 2016, following which Mr X was allocated a key worker and offered a placement at Allen Street on the 19 October 16 with a possible move in date of 24 October 2016.

189. At the ward round on 25 October 16, attended by the Healthy Futures team, Mr X was granted leave to reside at Allen Street. Notes indicate that he was "feeling stable had an increased tolerance of others and had shown an ability to control self and anger". In addition, the Healthy Futures team agreed to bring Mr X to the next ward round.

190. Mr X returned from leave on 1 November 2016. The ward team decided that the level of care offered by Derventio would be appropriate and proceeded with further leave and discharge arrangements. A Section 117 discharge planning meeting was held on 21 November 2016 attended by, among others, the CPN and his Derventio key worker.

191. Notes indicate that the SW from the Killamarsh team visited Mr X at Allen Street on 8 November 2016. The Derventio key worker told the SW that 'everything is going well'. The SW notes that his house share (flat mate) is present and the accommodation is newly decorated. However, whilst Mr X liked the accommodation and the area, he planned to save up for a deposit for a flat in Chesterfield and asked the SW to sign his passport application. The SW referred him to his GP and remarked that he had a Derby GP and so should not have been accepted by the SW's team in Chesterfield.

192. At the discharge planning meeting Mr X recommenced leave, being discharged to Allen Street on 28 November 2016. It is unclear if he was given a copy of his discharge care plan or whether this was left to community services. Arrangements were made for the CPN to visit on 5 December 2016 to administer the depot and undertake the seven day follow up.

193. The Derventio key worker undertook his risk assessment with Mr X on 6 December 2016.

194. Therefore, in the weeks preceding Mr X's discharge there was confusion as to who was going to be the responsible care co-ordinator. The CPN (from the Derby CMHT) was first allocated in February 2016. In May 2016, the SW from the Killamarsh team was allocated when Mr X was given leave at Brockhill Court (Chesterfield) on 16 May 2016. This leave only lasted 4 days.

195. In the electronic inpatient record (Paris) Mr X was allocated to two teams. To clarify the position, the ward telephoned the Derby CMHT on 26 October 2016 to enquire if Mr X was still open to the CPN and to arrange discharge and a follow-up meeting, leaving a message for the CPN to contact them.

196. Nursing notes identify the SW as the care coordinator following him telephoning the ward. However, the following day an email was sent to the CPN in Derby requesting he contact the ward about discharge. The discharge form of 28 November 2016 identified both the SW from Chesterfield and the CPN from

Derby as the care coordinator. (The notes indicate that when the ward contacted the CMHT on 8 November 2016, they were made aware of the CPN's leave until 21 November 2016). Unfortunately, this confusion as to who was the care coordinator would not have helped Mr X.

197. There was a disconnect between Mr X's housing provider and the receiving care coordinator in regard to the shared care. The CPN indicated during interview that when he attended ward rounds and learnt of the plan, he thought: "Derventio were going to support because otherwise he'd be homeless, that's what they specialise in".

198. 17 Allen Street was a newly refurbished 2 bedroomed terraced house with shared toileting and kitchen facilities. It is likely that most people living with someone newly introduced to them might experience anxiety around sharing.

199. In the view of the independent inquiry team, Mr X was not well suited to share with another individual. Mr X could be sensitive to the actions of others and misinterpret their motives. Mr X had previously stated his aversion to sharing accommodation. He had also left an address in Derby in 2015 claiming bullying in the house that he was living in.

200. Given this history, it would have been beneficial for introductions between Mr X and any incoming new resident. It was known that Mr X had expressed concern with his previous house-share prior to him moving out. However, there did not appear to be any discussion or contingency planning as to what should happen if the house mates did not get on, or how conflicts could be resolved. Mr X's risk in this area had been highlighted in a Tribunal report in May 2016, in which the consultant psychiatrist stated:

"I find it likely that within a short space of time, someone to whom Mr X is presenting his ideas would take exception to them, pour scorn upon them or otherwise ridicule them. In such circumstances, I would be incredibly concerned about the risk of significant violence, with associated risk to these others but also to Mr X himself".

This should have been incorporated into a risk assessment.

201. The Derventio Healthy Futures model was based on rapid access to units of accommodation as and when required. Therefore, tenants were informed of the possibility of house-shares moving in at short notice. Generally, some notice was given but on occasion, where an individual was discharged the same day as the referral, this was not always possible.

202. The Derventio model and staffing complement emphasised practical and problem-solving support from experienced housing professionals. This did not provide the framework for a more psychological and containing environment for

Mr X. The model of care suggested that there was no set pattern to visits but was on an 'as needed' basis.

203. The Derventio key worker and the CPN were aware of tension between Mr X and his original cohabitee prior to his departure. Records also indicate that relations between Mr X and the eventual victim following his move into Allen Street quickly became strained. After the homicide, staff surmised that Mr X might have told the victim that he knew people who were involved in the homicide of the victim's sister some years earlier.

204. The health care records indicate that the deficits in Mr X's ability to develop and maintain inter-personal relationships were known. On occasion he required reassurance from experienced staff in a supervised setting to calm him. Whether his previous experience of the victim (or their wider family) was distorted due to a deteriorating mental state or lack of conflict resolution skills is not known. This appears to be a significant gap in his community support.

205. The relationship between Mr X and his victim seems largely undocumented and uncommunicated between agencies. During the panel's interview with the CPN he was unaware that Mr X had reported that the victim had stolen his phone and food, which was noted in later court reports. Whilst Mr X may not have divulged this information directly to his CPN, the was a lack of evidence of professional curiosity in what potentially was a risk relationship.

206. The floating support model for an individual with a risk profile such as Mr X would require a high degree of communication and joined up working between the housing provider and community services. The independent inquiry team were shown no evidence of emails exchanged but did hear of some phone calls being made and messages left by the key worker to the CPN but these are not recorded in the community notes.

207. Derventio reported that they consistently found it hard to reach care coordinators who were under pressure. However, community staff also commented that there was a lack of cohesion and relationship with the housing providers.

ToR 09 Conclusions

208. Summary

- Community services and inpatient services did not have a consensus on the objectives for Mr X nor how these would be achieved. There seemed to be an ongoing and unhelpful polarisation of aftercare options between further inpatient rehabilitation and some form of accommodation to address the issue of his homelessness. This resulted in a fragmented approach to his placement and management in the community. There was a lack of cohesion between inpatient services, community services and Derventio.

- Though there was a trial period, Mr X went from an inpatient environment to fortnightly visits from a CPN primarily to deliver a depot injection and one or two hours a week from the floating support worker. The structural and relational support mechanisms were vastly reduced and ultimately inadequate.
- In retrospect, the Derventio model of providing for rapid discharge from hospital was not adapted enough to cater for Mr X's complex and often perplexing presentation. It is our view that Mr X's history and presentation suggested that he needed a placement with 24-hour support and not accommodation with floating support.

209. Areas of Good Practice

- An appropriate period of leave for Mr X to acclimatise himself to his first house mate and the arrangements at Allen Street.
- Section 117 meetings were convened in advance of discharge. They were relatively well attended and the envisaged community RC was notified.

210. Areas of Concern

- The systemic failure of communication between Derventio and the CMHT.
- The omission of a social work opinion - in the light of Mr X's previous discharges – on the proposed placement and the notion of future step down to independent accommodation.

ToR 10 – "Review and assess compliance with local policies, national guidance and relevant statutory obligations."

211. The independent review team considered the management of Mr X in the light of national guidance and legislation current at the time. References to these documents are included at Appendix IV.

CONCLUSION & RECOMMENDATIONS

212. The independent reviewers were unanimous in concluding that the homicide was not a predictable outcome. Based on Mr X's history, the risks of a deterioration in his mental state included a relapse to substance misuse and a disengagement with services.

213. However, the independent review team did conclude that not detailing Mr X's ongoing concordance with oral Risperidone from the conditions of his CTO was an omission. In addition, when Mr X took his CPN to his bedroom and showed him the bizarre drawings he had made on his wall, this raised a clear concern which should have precipitated a discussion about possible recall with the community consultant psychiatrist. This omission strongly suggests to the independent reviewers that the necessary culture of reflection and proactive

supervision to support curiosity and intervention by practitioners was not in place in the community team at that time.

RECOMMENDATION 1

To implement effective multi-agency management of patients that may present long-term risks.

214. The legal framework of a Community Treatment Order exists to support patients who are discharged from hospital and living in the community. In this case the principal responsibilities lay with the following organisations:

- Derbyshire Healthcare NHS Foundation Trust (the Trust)
- NHS Derby and Derbyshire Clinical Commissioning Group
- Derventio Housing Trust.

215. The panel recommend an inter-agency collaboration facilitated by NHS Derby & Derbyshire CCG, with representation by a senior clinician and senior manager from the Trust and a senior case worker and senior manager from Derventio Housing Trust and other organisations with a stake in housing service users such as Mr X.

216. The expected outputs should include a quality improvement programme to:

- Produce, implement and monitor an agreed protocol for interagency working
- Analyse systemic factors impeding joint working and address these, including the use of software for remote working, which has become common practice
- Focus on risk management and information sharing, with particular relevance to times of transition between levels of care
- Agree a process for ongoing monitoring and reporting to ensure progress is maintained.

RECOMMENDATION 2

To review and standardise the role of the Care Co-ordinator.

217. A quality improvement programme around this role should be developed to promote good practice. The following should be included:

- An analysis of systemic factors impacting on the care co-ordinator role and addressing these
- The identification of a named individual to provide practice leadership and head the production of a development programme for the care-coordinator role. This could include the audit of care plans and the use of templates
- The inclusion of service user and carer input into the development programme
- Ensuring that knowledge and skills matches service user complexity and acuity, including working proactively with psychosis and dual diagnosis and an emphasis on empowerment and self-care

- Multi-disciplinary input to develop and implement clinical formulations for all service users.

RECOMMENDATION 3

To consider the need for development of a dedicated community forensic team and high support hostel for the population of Derbyshire.

218. This would be informed by a needs analysis of the current Derbyshire patient population in secure mental health services commissioned by NHS England and a projection of those held in the criminal justice system considered to have a profound mental health need.

    - Using a needs-led approach, develop a business case informed by current data to identify the population
    - Consider options available to best serve this population to reduce risk, assist through put and provide best value for money
    - Liaise with project lead for IMPACT (the provider led care collaborative for the East Midlands) to ensure plans are compatible.

219. In liaison with third sector providers, consider options for the development of a high support hostel for patients who require on-going 24-hour support post discharge due to their clinical histories and risk profiles.

GLOSSARY OF TERMS

Abbreviation	
ABH	Actual Bodily Harm
BNF	British National Formulary
CC, Care co-ordinator	A care coordinator job is often the single most important role involved in the care of any individual patient. Supervising interdisciplinary care by bringing together the different specialists whose help the patient may need, the coordinator is also responsible for monitoring and evaluating the care delivered
Conditionally discharged	The requirement to meet conditions in the community set by a tribunal. Failure to do so may lead to recall to hospital
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPA	Care Programme Approach The CPA process and CPA care plans are the basis of supporting recovery and ensuring that the process is structured and recorded. 'Modernising the CPA' and subsequent policy and practice advice states that care plans should include action and outcomes in all aspects of an individual's life. Psychological and physical needs, social functioning, occupational activity as well as housing and welfare benefits should all be assessed and planned for. Care plans for those on the Enhanced Level of CPA should include crisis and contingency plans. Inpatient CPA systems should record and collate the information and share it with the community care coordinator so there is an agreed plan that is shared between all parties to ensure safe passage into the community. A review date should be recorded.
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission – The independent regulator for health & social care in England
CTO	The Community Treatment Order is a legal framework to support the MDT in delivering the care plan
FACE risk assessment	A questionnaire which collects information about a service user's past behaviours which put themselves or others at risk
Formulation	A formulation considers the patient's history in the context of their current situation and addresses the interplay between internal and external factors. In risk management, the formulation describes potential risks and derives a risk management plan, including any mitigating or protective factors
HCR20 Risk Assessment	A structured risk assessment which gives a score for risk depending on past behaviours, current psychiatric vulnerabilities and future care plans
Low secure care	This usually refers to a psychiatric inpatient ward which is locked
MDT	Multi-Disciplinary Team

Abbreviation	
Mental Health Review Tribunal	An independent quasi-judicial body established to safeguard the rights of persons subject to the Mental Health Act
Medium secure care	This describes a psychiatric inpatient service with architectural modifications to increase security, such as a perimeter fence, airlocks and secure windows
RAG rating	'Red/Amber/Green' coding for the assessment of possible adverse outcomes or potential risk
RC	Responsible Clinician
Risperidone	Antipsychotic medication which be taken as tablets and also administered as a long-acting depot injection
Section 37/41 Aftercare	Hospital Order with Restrictions - MHA1983. This order sentences a convicted mentally disordered offender to hospital
SS	Social supervisor
Supervision	The discussion of the clinical and relational issues raised in working with a client, either individually or within a group of colleagues. It provides an opportunity for considering the issues with someone who brings a different perspective.

APPENDICES

Appendix I

Terms of Reference for the Independent Investigation into the care and treatment of JE 2017/6089

Purpose of Investigation

To identify whether there were any gaps or omissions in the care and treatment of JE which could have helped avoid the homicide from happening. The investigation process should also identify areas of good practice, opportunities for learning and areas where improvements to services may be required Specifically,

1) Review the trust's internal investigations and assess the adequacy of the findings, recommendations and action plan.

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

3) Review and verify the trusts chronology of events leading up to the homicide.

4) Review the appropriateness of the care, treatment and services provided by the NHS, Housing provider and other relevant agencies from the service user's first contact with services to the time of their offence, focusing on the period preceding the homicide, identifying both areas of good practice and areas of concern

5) Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming them self or others

6) Examine the effectiveness of the service user's care plan including the involvement of the service user and any family/careers involvement

7) Involve the relatives of both the service user and victim in the investigation as fully as appropriate, and in accordance with their wishes

8) Review the service user compliance with his Community Treatment Order, medication and his care in the community

9) Review the arrangements surrounding the service user's placement in the supported housing, the plans in place for the service user's support in the community and the appropriateness of the accommodation.

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

11) Provide a written report to NHS England that includes agreed, measurable and sustainable recommendations

12) Produces a learning document, suitable for sharing with other providers, on the learning from the investigation

13) Undertake an assurance follow up review 6/12 months after the report has been published to assure the report's recommendations have been fully implemented

Appendix II

Chronology

15 Aug 75	Mr X born in Leicester.
1976	Mr X's father left his mother when he was 6 months old. Mr X living with his mother and maternal grandparents
Age 6, 1981	Grandmother dies. Mr X and his mother confirm that his grandmother was the primary carer for Mr X. The family were devastated by her sudden death. Mr X set a fire in his bedroom.
1982	The family had support from Social Services
Ages 8 - 10	Mr X had medical care for glue ear and he also developed seizures. He is also described as aggressive to his mother during his childhood.
Jan 85	Diagnosis of a brain tumour (astrocytoma)
Mar 85	Neurosurgery to remove the astrocytoma.
Mar 85	problems at school – suspended from primary school due to aggression to classmates
Apr 85	request for help in school due to his difficulties. School was small and open plan, with a liberal approach
Sept 85	CAMHS working with Mother and Mr X because of behavioural difficulties, not thought to be due to brain surgery, more due to his mother's management of him.
Feb 86	changing schools has helped a lot – moved to a more 'traditional' primary school.
Mar 86	settling in his new school.
Jun 86	CAMHS closed his case due to his good progress and settled state
Age 12 to 14, 1989	Violent towards his mother. Attended specialist school for children with emotional and behavioural difficulties, necessitated living in hostel. School reported that he was easily distracted and had poor social skills. Re-integrated into mainstream schooling age 14. Mother described Mr X as charming one moment, and violent the next.
Age 15	Expelled from school for smoking cannabis
Age 16	investigated for skin lesions, no cause found
Age 16	sniffing glue. Violent towards mother.
1992	Mother took out an injunction to stop Mr X visiting her. Mr X lived in different hostels
1993	Grandfather dies; Mr X moves to Torquay. Ran up large debts; collected by uncle.
1993 or 94	Relationship with next door neighbour, then moved to Lowestoft
Sep 95 (20yr)	Admitted to Northgate Hospital, Lowestoft, diagnosis drug induced psychosis Noted to be using methadone, butane gas and petrol. After discharge, did not comply with community care plan.

1995	Returned to Leicester, demanded money, violent towards mother, who took out a further injunction against him
Dec 96	Admitted to Princess Alexandra Hospital, Harlow, diagnosis schizophrenia and drug induced psychosis. Slapped elderly patient when irritated. After discharge, did not comply with community care plan
Jan 97	ABH on female nurse manager at Harlow Hospital, punched and kicked her several times. Bailed.
Feb 97	Breached bail, sent to HMP Chelmsford; subsequently sent to bail hostel in Leicester then absconded
7 Mar 97	Charged with assault: allegedly hit the shop manager in a music shop in Cambridge
16 Apr 97	Arrested and remanded to HMP Chelmsford
29 Apr 97	Admitted to Shannon House ICU (Princess Alexandra Hospital, Harlow) under Section 35 following the assault on the nurse in Jan
27 Jun 97	Sentenced and transferred to Runwell MSU
Apr 98	Transferred to Kneesworth House Hospital, initially under Section 38, then Section 37. Placed in the Personality Disorder Unit. Full neuropsychological assessment showed no evidence of cognitive deficit. Managed initially without medication but developed psychotic symptoms with associated irritability and diminished impulse control which could lead to violent behaviour. Diagnosis paranoid schizophrenia. Continued to use substances as an in-patient.
Jun 98	Convicted of ABH in Kneesworth, for which Mr X received a 2-year conditional discharge (not clear who was the victim).
Early 2002	Home authority changed from Leicester to Essex
Jun 03	Transferred back to Runwell (still under Section 37). Continued to use cannabis and alcohol.
Jun 04	Discharged from Runwell to Hart House (supported accommodation) by MHRT
Jul 04	Had left Hart House after a few days to live with girlfriend
Nov 04	letter requesting handover from forensic to general adult services
Jan 05	Correspondence from forensic services at Runwell - extends back into 04. Mr X was anxious about mother's visit for Xmas.
May 05	start of correspondence from psychiatric outpatients in Southend.
22 May 05	Arrested & bailed for assaulting girlfriend before presenting at A&E.
26 May 05	Assessed in A&E and admitted, known schizophrenia, using substances. One night admission to Basildon Hospital. Deterioration in mental state attributed to abuse of cannabis and butane gas.
Nov 05	CPA Missed outpatient appointments noted. "smelled strongly of alcohol".
During 2005	Poor compliance with outpatient appointments
About 2005	Diagnosed HCV +ve, possibly associated with previous IV drug use
2006	Lost to follow-up

2006	Returned to Leicester to look for his mother. Broke into Leicester College
31 Oct 06	Detained in HMP Leicester
2006	Assessment by court team. Noted the two previous convictions for ABH: 1998 (Hospital Order)& 1999 (2 year conditional discharge). Pleaded guilty to possession bladed article, violent behaviour and theft of food and drink. Received a Section 37 disposal
6 Feb 07	Admitted Wathwood MSU from HMP Leicester under Hospital Order (Section 37) – had killed pigeons with a plastic knife and set fires in his cell. Mr X had spent four months in segregation unit because of disturbed behaviour. Grandiose delusions. Drug screen on admission negative.
Mar 07	one of many letters from blood transfusion services trying to catch up with him – almost certainly because hepatitis C virus had been detected.
Spring 07	Wathwood - Unwell, described as volatile and changeable, irritable, thought disordered, responding to auditory hallucinations, over-familiar and grandiose. Punched another patient (after provocation) and had to be managed in seclusion on a few occasions.
April 07	Started to improve.
June 07	Wathwood "diagnosis changed to schizoaffective disorder in view of the prominent mood symptoms in addition to his psychosis". Some evidence of non-compliance with oral risperidone. Medication changed to depot injection
Sep 07	Wathwood – assessment of personality and cognitive function completed: "The personality inventory revealed that (Mr X) has a tendency to view himself and his difficulties in an overly positive way. No particular personality traits were found. IQ was in the average range and it was felt that this had been adversely affected by poor schooling and mental illness. Importantly, given (Mr X)'s past medical history, there were no neuropsychological deficits or problems such as disinhibition or impulsivity."
Autumn 07	Better able to manage frustration on the ward. Using leave to the local community.
Jan 08	Wathwood RSU comprehensive MHRT report, from which the above quotations were taken: "After detailed psychology assessment it is no longer felt that he has any significant cognitive or personality difficulties as a result of his frontal lobe damage". Diagnosis – schizoaffective disorder: "When unwell, his illness has been characterised by grandiose and persecutory delusions about being attacked by police or having the ability to invent novel ways to cure the world's ills or design fantastical machines. He appears to have responded well to his current antipsychotic medication….If Mr X were to become non-compliant with medication and his mental state deteriorated, there would be a significant risk of violence." The plan was to manage Mr X's discharge to the community carefully because he had found it difficult to engage with community services in the past.

Aug 08	Transferred to low secure ward (Kedleston Unit, Kingsway Hospital, Derby) from Wathwood, on risperidone depot 50mg fortnightly.
Jan 09	Discharged from Kedleston Unit to Vinegar House, a 24 hour supported specialist placement on risperidone depot 37.5mg every two weeks. Subject to Community Treatment Order (CTO). "His psychiatric history is characterised by repeated relapses secondary to non-compliance with medication and follow-up arrangements and substance misuse... There is a risk of aggression and violence in the midst of a relapse of his mental illness".
Feb 09	Forensic follow up. Residing at Vinegar House and doing well on risperidone 37.5mg fortnightly
Apr 09	Forensic follow-up – well, engaging with rehabilitation and started voluntary work Mr X was advised to see his GP about his hepatitis status
Jul 09	Forensic follow up – stable mental state and good progress with his rehabilitation
Sep 09	MHRT determined that Mr X should not be discharged from CTO
Sep 09	Forensic follow up – progressing well, but continuing to complain of lethargy so risperidone depot reduced to 25mg every two weeks
Dec 09	Forensic follow up- CPA meeting – Mr X stable and progressing well. Plan to move him into independent accommodation next year.
Jan & Feb 10	Stable progress, voluntary work
Mar 10	Forensic follow up "responded well to increased structure & routine'. On risperidone depot 25mg every two weeks.
Jun 10	Forensic follow-up – well and stable.
July 10	CPA review: well at forensic follow up. Living in supported accommodation. Not taken any illicit drugs. Discharged from CTO
23 Aug 10	Took up tenancy in a two-bedroomed house, with support from Creative Support, who were also the landlord (eight hours per week).
Dec 10	Joint visit – social worker and worker from Creative Support. Mr X settled in well, managing to budget. Seeing mother regularly. Attending depot clinic and self-injecting treatment for hepatitis C.
Dec 10	Well at forensic follow up on risperidone depot 25mg every two weeks.
Jan 11	In debt – supported to address this
Mar 11	Concerns about Mr X's money issues – has been spending money on alcohol
Apr 11	Appears dishevelled, worker thought he might be using substances because of transactions from his bank account
May 11	Stopped voluntary work, reduction in his availability to meet with workers
Jun 11	Weight loss, mood less stable, sometimes angry (current depot risperidone 25mg) Abusive to support worker
4 Jul 11	Disclosed to care team that he has been using cannabis for last three months

26 Jul 11	Mr X appeared agitated and bizarre. Had reduced contact with care team. Mr X has animals in his flat in a poor condition (six cats, eight fish, one toad).
27 Jul 11	Recalled to hospital and CTO revoked to Scarsdale Ward under Section 3 because of decline in mental state and self-neglect, admitted to smoking cannabis during the preceding three months.
Aug 11	Neurology assessment and MRI brain scan – no evidence of recurrent tumour
5 Oct 11	Discharged from Kedlestone low secure unit (Kingsway Hospital, Derby) to his flat on depot risperidone, 37.5mg, to attend depot clinic. Creative Support to offer face to face support three times per week. Mr X to make repayments to the cost of redecorating and re-carpeting the flat. Mr X issued with a warning letter from Creative Support. Job in charity shop identified for J Mr X.
Nov 11	Reviewed in general adult psychiatric outpatient clinic. Using cannabis. Requesting reduction in depot risperidone, but agreed to remain at current dose of 37.5mg.
Dec 11	Hepatitis C virus negative following 6/12 anti-viral therapy
7 Dec 11	Phone call from key worker from Creative Support – Mr X unwell, "paranoid and aggressive", sent home from his voluntary job.
12 Dec 11	record of attending depot clinic, one week late. "Seemed mentally well".
29 Dec 11	Last record of attending depot clinic for this period: "Mentally seemed reasonably well".
2011	Last had contact with mother (by Mr X's report)
3 Jan 12	Mr X abusive to support worker
9 Jan 12	Mr X had left his flat without any notice and was located by the police in a homeless hostel in Leicester
22 Feb 12	"It is suspected he is now residing in Mansfield". Discharged from Clinic.
Apr 12	Cancelled outpatient appointment with general adult services: "We will send him another appointment in six months' time. In case of problems I assume his care co-ordinator…will let us know".
Sep 12	Admitted to forensic psychiatric unit in Lippstadt, Germany. Mr X is described as grandiose with an elevated mood. Later in this admission Mr X stayed on a voluntary basis.
May 15	Discharged from psychiatric unit in Germany.
Jun 15	Requested depot from GP, having returned from Germany. Assessed by CPN and Approved Mental Health Professional on 22 June. Staying with a friend in Derby, flat squalid, but mental state stable. Suggestion of drug use. Referred to depot clinic.
Jul 15	In touch with CMHT. FACE risk assessment completed by care co-ordinator.
4 Aug 15	J Mr X called CMHT asking for admission as he was homeless. The team appeared unable to have face to face contact with Mr X until Oct 15:
8 Aug 15	Visit to house to remind Mr X of missed depot injection
Sep 15	Telephone call to Mr X as he had not attended depot clinic – Mr X out

Oct 15	Despite several attempts, CMHT unable to contact Mr X, who had missed his depot medication.
26 Oct 15	Mental state appeared stable, given a prescription for oral risperidone. Mr X said he planned to stop medication completely in the future.
28 Oct 15	Home visit. Working in a charity shop twice per week; appeared stable. Accepting oral meds but wants to stop medication in the future (may be same encounter as 26 Oct)
11 Nov 15	Home visit - seen in the road – Mr X did not let workers in his house. Said he had collected medication from his GP. Mr X was offered fortnightly contact, said he preferred four-weekly.
23 Nov 15	Letter to psychiatrist from depot clinic – discharged from depot clinic as no longer on depot.
27 Nov 15	Letter to Mr X – care co-ordinator leaving the service and his case will be re-allocated as soon as possible. Advised of phone number to call in case of problems. *(Community care file, page 11)*
2 Dec 15	Section 136 assessment at Radbourne Unit MHA assessment – deteriorated; smoking mamba in city centre, agitated and aggressive towards police. Requested admission but mental state unremarkable. Overnight bed found for him in a hostel.
26 Feb 16	CMHT contacted by a homeless charity in Sheffield. Mr X sleeping rough, having left the flat and walked to Sheffield because he was being bullied. Not clear if taking medications. CPN had rung the GP and there was no record of repeat prescribing. Mr X staying in a B&B in Sheffield for rough sleepers.
8 Mar 16	CPN phone call to Sheffield housing worker for update – no reply to two calls. Message left.
5 Apr 16	CPN again attempted to contact the B&B in Sheffield. No answer on mobile phone.
26 Apr 16	CPN contacted by rough sleeping organisation in Islington. Gave them the Face Risk assessment.
27 Apr 16	Admitted to Morton Ward, Hartington Unit in Chesterfield following presentation to A&E at the Whittington Hospital in London; Mr X had been sleeping rough in Islington and reported feeling angry, anxious, paranoid and depressed. Mr X reported going to London to meet Alan Sugar about a business idea, and to collect his Nobel prize. He said he had run away from Derby because he owed money for cannabis. Said he had a tenancy in a Sheffield bedsit. Not on medication.
29 Apr 16	CPN attended ward round - plan for in-patient assessment, and for the CPN to refer to social care to find accommodation.
13 May 16	CPN attended 117 Meeting. Discussion re accommodation. Mr X said he wanted his own flat, not supported or shared. Plan for one week's trial leave to Brockhill Court (homeless accommodation, with part-time residential support) in Chesterfield.
16 May 16	Trial leave to Brockhill Court commences.
17 May 16	Letter from Responsible Clinician on the Hartington Unit to the CPN, describing Mr X's history, risks and current care needs

17 & 18 May 16	Uncertainties around medication compliance, eg tablets missing and missing doses
20 May 16	Mr X visited by staff from the ward. He appeared guarded and 'on edge', spoke about a "secret project", but did not share details. Staff at Brockhill very concerned about him. Not taking oral antipsychotic medication – leaving it around Brockhill Court. Refused to return to the ward.
20 May 16	MHA assessment under Section 135. Appeared pleasant and calm and agreed to return to the ward without the use of the MHA.
24 May 16	Discussed in ward meeting. Possibly to be referred for a period of rehabilitation. Consideration given to detention under Section 3.
27 May 15	Left the ward without leave
31 May 16	Mr X self-presented at Barnet Hospital, saying he requires help with his mental health and he is currently missing from the Hartington Unit Returned to hospital from London
2 Jun 16	AMHP assessment for detention under Sec 3 on Morton Ward. It is documented that Mr X's longest periods of mental health have been while he has been on a long-acting (depot) injection of anti-psychotic medication, and that his deteriorations in mental health are characterised by grandiose delusions (ie, false beliefs), such as being able to cure disease or travel through time. His insight into his psychotic illness (ie, loss of contact with reality) was poor. The ward team were seeking his transfer to a Psychiatric Intensive Care Unit, and were discussing a forensic referral, because Mr X had been hostile and abusive to staff.
6 Jun 16	Referral for Rehabilitation Service: "(Mr X) was living at homeless accommodation prior to admission but was struggling to live independent (Mr X) requires further support to build life & independent living skills"
14 Jun 16	Transferred to Enhanced Care Ward. Refusing olanzapine, an oral antipsychotic medication (was no longer on depot injection and refused to start it again). Presenting as agitated and hostile, interfering with other patients and threatening to nursing staff. Had threatened to stab another patient in the neck with a pen. Mr X discussed his invention of "clear fuel" and wanted to speak to a lawyer about getting a patent for his design. Denied that he had a mental illness. Heard responding to auditory hallucinations.
22 Jun 16	Decision taken to move Mr X to Psychiatric Intensive Care Unit (PICU) for re-starting depot and stabilisation of mental state.
22 Jun 16	MHRT report prepared in support of continuing detention under Section 3. It describes Mr X's delusions and his lack of awareness of his illness.
29 Jun 16	Forensic referral seeking forensic admission from Enhanced Care Ward.
2 Jul 16	Transferred to Psychiatric Intensive Care Unit (Austen Ward, Cygnet, Bradford)
15 Jul 16	Transferred back to Radbourne Unit from Cygnet Hospital under Section 3. Being prescribed risperidone depot injection 37.5mg fortnightly plus risperidone oral dispersible 2mg twice daily.

	Behaviour became increasingly hard to manage – confrontational especially in regard to 'no smoking' policy, sexually disinhibited so transferred to male ward. Refused risperidone either by injection or orally.
19 Jul 16	Transferred by police to Branwell Ward, Cygnet, Bradford
1 Aug 16	Behaviour more settled, accepting medication, but recent verbal altercation with smoking cessation worker.
7 Sep 16	Transferred under Section 3 to Morton Ward, Hartington Unit on risperidone depot 37.5mg fortnightly and risperidone 2mg at night from Cygnet Hospital. Mr X denied any mental illness, and wanted to stop his depot, with a view to coming off oral medication in the future.
8 Sept 15	Referral to rethink for housing support with Mr X's approval.
16 Sept 16	Prescribed risperidone depot 50mg fortnightly plus risperidone 4mg at night.
29 Sept 16	Discussed on ward, plan for referral to in-patient rehabilitation (Cherry Tree/Audrey House).
30 Sept 16	Referral sent to Derventio Housing.
2 Oct 16	Nursing report for MHRT – had followed care plans, but instances of inappropriate sexual acts with fellow patients.
5 Oct 16	117 Meeting on ward, attended by ASW from N Chesterfield Community Team
6 Oct 16	Social Circumstances Report for MHRT completed.
10 Oct 16	Mr X assessed by Rethink and offered support with finding accommodation and also with follow-up.
17 Oct 16	Risk Assessment shared with Derventio with consent of J Mr X.
19 Oct 16	Offer of accommodation from Derventio – available from 24 Oct, Derventio support worker allocated. J Mr X consented to Occupational Therapy initial assessment.
20 Oct 16	Paperwork emailed in support of application for funding for enhanced community package from Section 117 panel.
21 Oct 16	Request to Derbyshire Police from Hartington Unit for disclosures relating to three incidents of possible fire setting by Mr X over the last thirty years
2 Nov 16	Mr X on a week's leave to Healthy Futures (Derventio) in Derby
17 Nov 16	Risk Assessment to be incorporated into CPA document written by in-patient consultant. It describes Mr X's past convictions, his risk of disengaging from services, substance misuse, impulsiveness, early violence and early possible fire setting, emphasising that his risk of violence "is in the context of illness and the perception that he is in danger or under attack in some way".
21 Nov 16	Discharge meeting.
28 Nov 16	Discharged from Morton Ward on zopiclone 7.5mg at night (a sleeping pill) and risperidone (antipsychotic) tablets 4mg at night plus risperidone depot 50mg every two weeks. Subject to Community Treatment Order (CTO), conditions: take medication as prescribed; see community nurse and members of the CMHT as agreed and see consultant or deputy at appointments.
1 Dec 16	Seven-day follow-up by ward staff with CPN/care co-ordinator.

5 Dec 16	Care Plan document completed by CPN. Specifies Risperidone Consta (ie, depot injection) 50mg two-weekly, but omits to mention the oral risperidone.
19 Dec 16	Home visit to administer risperidone depot. Mr X seemed well and said he was getting on with his house mate.
3 Jan 17	Home visit to administer risperidone depot. Mr X seemed well, but said he did not like having the injection.
9 Jan 17	Face Risk assessment completed.
16 Jan 17	Home visit to administer risperidone depot. Mr X is described as 'bright, pleasant and engaged in conversation', although anxious at times. He spoke of wanting to return to work, and his past work experience.
Jan 17	Mr X stopped the oral risperidone because he wanted to learn to drive. He remained on the depot risperidone.
25 Jan 17	Mr X seen in psychiatry out-patients, attended with support worker from Derventio Housing. Mr X is described as 'somewhat dishevelled'. Mr X seemed irritable, especially because he needed to have blood tests. 'For review in 4 months.'
30 Jan 17	Home visit to administer risperidone depot – Mr X out, being collected from Chesterfield by support worker. Mr X said he had fallen out with his girlfriend and was staying at a friend's house. His mental state seemed settled.
10 Feb 17	Safety Assessment Summary agreed with Mr X, giving the level of current concern about these events as 'Medium', and the severity of past events as 'High'.
13 Feb 17	Safety Assessment – Part 2 (structured) completed by CPN.
13 Feb 17	Home visit to administer risperidone depot. Mr X is described as pleasant and engaged in conversation. Denied any symptoms, or any use of mood-altering substances.
19 Feb 17	Telephone call to Crisis Team from out-of-hours GP, who had received calls from Mr X "saying that he is hearing voices and seeing things. They have called him several times on his mobile and he has not replied." The GP had been at his home address but Mr X was not answering calls or opening the door.
20 Feb 17	CPN attempts to phone Mr X – no answer, so left message for him and for support worker.
21 Feb 17 (Tuesday)	Home visit to Mr X, who is described as 'pleasant and engaged in conversation'. He said that he had been tired when he felt like he was hearing and seeing things. Mr X denied any mental symptoms, but did take the CPN to his room "where he had writing and diagrams on wall; showing how he was going to build a time machine, make a solar energy car and cross pollinate plants to make new drugs to cure diseases. (Mr X) said that his house mate had been using drugs and he felt that "he could not live in the property anymore because of the drug use... would like to move". The plan was for the support worker to see Mr X on the Thursday, and for the CPN to see him on the Friday.
24 Feb 17	Home visit to administer risperidone depot. Mr X is described as bright, pleasant and engaged in conversation, although slightly

	anxious as a new house mate was moving in that afternoon. He denied any mental symptoms.
2 Mar 17	Index offence. Assessed by FME, found to be capacitous and fit for interview.
3 Mar 17	Interviewed by police and admitted to the offence.
3 Mar 17	Assessed by Criminal Justice MH Team. Mr X disclosed that he had stopped the oral risperidone for 'over a week' because he had received a letter from the DVLA saying that he could not drive because of the medication he was on. Mr X appeared calm and his conversation was lucid and coherent, with no evidence of psychotic thoughts. Mr X referred to the offence as a 'cry for help' and said he had been deteriorating in the community for around 4 weeks. He did endorse auditory hallucinations.
Mar 17	Remanded in custody, HMP Nottingham, charged with murder.
3 Apr 17	The medium secure service forensic psychiatrist prepared his first report. In prison, Mr X was on oral risperidone, 4mg daily. He appeared distressed by internal experiences and had no memory for the offence.
5 Jun 17	The forensic psychiatrist prepared a second psychiatric report.
6 Jul 17	The Crown's forensic psychiatrist prepared a report. Diagnosis: organic personality disorder secondary to frontal lobe damage and schizoaffective disorder. A defence of diminished responsibility was available to Mr X. Recommended a Hospital Order with Restrictions (Section 37/41).
24 Jul 17	The medium secure service consultant prepared his third forensic psychiatric report. Mr X on risperidone 4mg orally per day. Diagnosis: atypical schizoaffective condition leading to severe psychosis. Recommended disposal under Section 37/41 to medium secure psychiatric services.

Derbyshire Healthcare NHS Foundation Trust - Mr X - Action Plan

Ref	Recommendation	Action	Responsible Officer	Completion Date	Evidence Required
1	Undertake a Trust wide learning review with regards to this case	Open forums to be advertised across the Trust for staff to attend	Medical Director	30th April 2018	Attendance list and structure of the presented information
2	Process to be agreed between in-patient and community areas to ensure that discharges only proceed when there is a clearly agreed and documented multi-disciplinary discharge plan, care plan and safety plan.	Task and finish group to be established to clarify and agree best practice	Deputy Medical Director	30th April 2018	Record of plan with agreement from all present, incorporated into a revised Core Care Standard and Care Programme Approach Policy and Procedure.
3	Review of communication processes between inpatient areas and community teams, in particular processes for resolving perceived disagreement or perceived lack of engagement of colleagues.	Task and finish group to be established to clarify and agree best practice	Deputy Medical Director	30th April 2018	Record of plan with agreement from all present, incorporated into a revised Core Care Standard and Care Programme Approach Policy and Procedure.
4	Review expected standards of practice for those on CTO. Complete a Trust-wide audit	Review current policy in line with learning from this incident and amend as necessary	Medical Director	31st March 2018	Documented evidence of review within the Community Treatment Order Policy.

	of these revised standards and then monitor via a six monthly audit cycle.	Baseline audit to be commissioned, with action plan as appropriate and subsequent audit cycle	Medical Director		Baseline and subsequent audits
5	Trust-wide audit of the detail and quality of Safety Plans	Baseline audit to be commissioned, with action plan as appropriate and subsequent audit cycle	Medical Director	31st March 2018	Baseline and subsequent audits
6	Clarification of communication processes between Trust teams and non-statutory providers	Review and clarify current guidance for teams, review current practice and action as necessary	Assistant Director for Clinical and Professional Practice	31st March 2018	Report to summarise current guidance from the Information Governance agreement with external (or third) parties (contractual arrangements) policy and procedure, and to identify recommendations action plans
7	Review standards, training and then audit relapse prevention plans within community mental health teams	Commission a review of the Core Care Standard and Care Programme Approach Policy and Procedure, it's focus on relapse prevention, and training available local to staff	Executive Director of Nursing and Patient Experience	28th February 2018	Reporting summarising the current
8	Review the potential benefits of using the HCR20 risk assessment tool in community	Clinical evaluation of the potential clinical and risk benefits or challenges from using the HCR20	Consultant Clinical Psychologist	30th April 2018	Report to summarise this evaluation with recommendations for future practice

	patients with extensive risk or forensic profiles	within generic community mental health settings			
9	The investigators will ask to see SU, to explore what he might have wanted to be different in the support he received	Request to be sent to ask SU in his current hospital		28th February 2018	Documented record of this meeting in SU's notes, including any views raised by SU
10	Explore with commissioners the commissioning of a community forensic team and the potential risks and benefits of this model of practice	For this to be placed on the agenda for a meeting between the Trust and the Clinical Commissioning Group	Executive Director of Nursing and Patient Experience	31st March 2018	Minutes of meetings where this has been formally discussed
11	Review the number of funded Care Programme Co-ordinators in community teams, benchmarked against comparable Trusts per 100,000 population	Freedom of information request to be sent to comparable Trusts nationally, asking for the number of Care Programme Approach Co-ordinators for their over 18 services, excluding Early Intervention in Psychosis, and also the size of the population they cover.	Investigation Team	30th April 2018	Report to benchmark and compare current resource nationally against resource within Derbyshire Healthcare NHS Foundation Trust.
12	Review the application of the blood borne virus policy, and required action from this investigation	Review of current policy and its application in this case, including action as appropriate for all involved	Interim Assistant Director of Physical Health and Public Health	31st March 2018	Report summarising the learning from this investigation with regards to blood borne virus.
13	Review the level of clearly	Casenote audit and team	Area Service Manager	31st March 2018	Report to summarise the

	documented multi-disciplinary input to care planning and care delivery for people subject to a Community Treatment Order within Derby City Neighbourhood Team C.	discussion about all people subject to a Community Treatment Order in that team	and, Service Manager		multi-disciplinary input to both care planning and to care delivery for this population
14	Review current processes around how referrals are allocated and decisions made as to who is managed on a waiting list	Review how decisions are currently made, and discussion of all those on the waiting list to ensure that it is appropriate for them to be managed there.	Area Service Manager and, Service Manager	31st March 2018	Report to summarise and assure the current situation in the team
15	Feed back to the clinical team and all practitioners involved	Face to face meeting with colleagues, so they can be briefed on the report and the identified recommendations, with a focus on learning, best practice, and identifying ways forward	Trust - Investigation team	31st March 2018	Attendance list from the meeting and documented record of the discussion
16	Reflective session to be held with the consultant psychiatrists involved in SU's care, with a focus on CTO planning and forensic referrals	Face to face meetings	Medical Director	30th April 2018	Summary of the outcome of the discussion
17	Apologise to the family for their loss, explore the family's wishes to comment on	Face to face meeting to be offered with victim's parents	Medical Director	31st March 2018	Documented evidence of communication with victim's family

	the draft investigation findings, give them the opportunity to ask any questions, explore support and their right to involvement in the Independent Inquiry, and explore any support required wider than the Trust can offer.				

Appendix IV

National guidance and relevant statutory obligations

1) Refocusing the CPA Policy and Positive Practice Guidance, Department of Health 2008 https://proceduresonline.com/trixcms/media/1116/refocusing-the-care-programme-approach.pdf

2) Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services-DoH (2009).

3) Protocols for the discharge of people requiring care and support contained in Annex G of the Care Act, 2014: https://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/next-steps-after-assessments/enacted

4) Royal College of Psychiatrists Standards for Community-Based Mental Health Services, 2015

5) NICE guideline [NG53] Published 30 August 2016. Transition between inpatient mental health settings and community or care home settings https://www.nice.org.uk/guidance/ng53

6) NICE guideline [NG58] Published 30 November 2016. Coexisting severe mental illness and substance misuse: community health and social care services https://www.nice.org.uk/guidance/ng58

Reviewing the Evidence Base

Psychological Approaches aim to support their investigation approach by reviewing the published evidence base for relevant information.

In this instance, we wanted to explore the evidence for homicides perpetrated by individuals with a diagnosed mental illness whose victims were

a) Residing with them, and
b) Also had a diagnosed mental illness or known psychological difficulty

There are, of course, a large number of papers that have examined the rate and nature of violence perpetrated by individuals with a diagnosed mental illness and/or individuals who have been in contact with mental health services prior to the offence. There are a smaller number of papers that have examined the rate and nature of violence experienced – as victims – by individuals with a diagnosed mental illness. However, there was very little reference to the key search items detailed above, and the rather sparse findings should be interpreted with caution.

Overall, individuals with mental health difficulties have been shown to have a three to six times increased risk of being a victim of homicide; this is particularly the case for individuals with a primary diagnosis of alcohol and/or drug misuse (Rodway et al., 2014). Perpetrators with a diagnosis of mental illness have been found to be similar to their victims (with a mental health difficulty) when compared on a range of characteristics, although perpetrators have been found to be more likely to have a psychotic disorder, and less likely to have a diagnosis of substance misuse; the converse is found in victims.

In terms of a consideration of violence (not restricted to homicide alone), a large study based on the original MacArthur Violence Risk Assessment Study, found that the likelihood of patient victimisation was greatly increased by three factors: homelessness, the presence of symptoms/severity of symptoms of mental illness, and alcohol abuse (Teasdale, 2009).

In Rodway's study – reviewing a consecutive series of cases of homicide in England and Wales between January 2003 and December 2005 – they found that of the 90 patient victims (6% of the whole sample), 29 (32%) were killed by another patient. In this study, most patient perpetrators had a primary diagnosis of a psychotic illness (50%) with a history of substance misuse (93%); most victims had a history of substance misuse (66%) but their current primary diagnosis was more varied, including substance misuse, and affective disorders, as well as psychosis. Of relevance to this investigation, 38% of the perpetrator-victims were known to each other as acquaintances (with 35% being intimate partners). Finally, the most likely method of homicide was use of a sharp instrument (blade) in 41% of cases, followed most closely by hitting or kicking (20%).

In terms of the location of the homicide, the Office for National Statistics (ONS, 2019) published a review of homicide data; for the ten years from 2009 to 2019, around 2% of all reported homicides where the victim was male, took place in a residential

setting such as shared supported accommodation (ONS, 2019); this compares to an average of around 10% of female victims. Only one paper comments on co-habitation other than within an intimate relationship or family household. The Social Care Institute for Excellence were commissioned by the Mayor of London (2020) to review homicide and serious incident reviews – including Safeguarding Adult Reviews, Independent Investigation Reports, Domestic Homicide Reviews and Serious Case Reviews – from 2016 to 2019. The findings are not representative of wider incidents across London, as specifics of the case influence whether or not one of the above reviews take place. Nevertheless, SCIE reported that *'in several cases, the victim and perpetrator knew each other because they lived together in supported residential accommodation….**it is important to think about the risks involved where a number of vulnerable adults are brought together, often in environments which the reviews found had poor safeguarding arrangements or security measures such as locks on doors'*** (page 9). In 13 cases (20% of their sample), there was peer on peer violence; of the nine such incidents reviewed, a knife was the weapon used in the homicide, and the perpetrator-victim relationship was one of acquaintance on seven occasions

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Psychological Approaches CIC and Review Team Members

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

Review Team Members

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

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

Dr Deborah Brooke

Deborah is a Consultant Psychiatrist with 40 years in the NHS. She currently works with sick doctors.

Deborah qualified at Guy's, and trained in general practice in Nottingham, becoming interested in the problems of alcoholics. She trained in psychiatry in London, undertaking research at the Institute of Psychiatry before joining Oxleas NHSFT in 1996 as a consultant forensic psychiatrist. She retired from this post in 2016, but continues as the Appraisal Lead for Oxleas.

She has extensive experience in ensuring quality in postgraduate medical education and appraisal and has had a regulatory role for over ten years with the General Medical Council's fitness to practice procedures – first as medical examiner and supervisor, then as panellist for the Medical Practitioners' Tribunal Service; panel chair since 2012.

Deborah has published research in both addictions and forensic psychiatry.

Mr Paul Ralph

Paul is a highly experienced independent social worker in community and forensic mental health. Paul has acted as an Approved Mental Health Professional (AMHP) and has a background in commissioning and service design. Besides providing independent Tribunal reports, Paul has recently advised an NHS Trust and been active in relocating forensic patients along their care pathway from secure settings into supported community placements thus entailing a high degree of safeguarding advice, liaison with Multi-Agency Public Protection Arrangements (MAPPA) partners and working between CMHT's, family and carers and supported housing providers.

Paul works on an ad hoc basis for Psychological Approaches.