**Independent review into treatment and care**

**provided by 2Gether NHS Mental Health Foundation Trust**

**Confidential**

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***experience, knowledge and expertise in managing risk***

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**EXECUTIVE SUMMARY**

**INVESTIGATION INTO CARE AND TREATMENT PROVIDED BY 2GETHER MENTAL HEALTH NHS FOUNDATION TRUST**

1. **Introduction**
	1. This is the report of an investigation commissioned by NHS England into care and treatment provided by 2Gether NHS Mental Health Foundation Trust[[1]](#footnote-1) for `X’ who was on leave from the psychiatric ward when, on 9th January 2018, he killed his mother. We would like to extend our sincere condolences to the victim’s family for their tragic loss, and our sympathy to them for the deep distress caused when X, with whom they were close, became so severely ill that, whilst in a deluded state, he may have believed that killing his mother was a way to save her.
	2. We would like to thank the 21 staff who agreed to participate in the investigation process. The team is also grateful to the Trust for providing open access to policy documents, case notes and other material relevant to the care that was provided for X in the period leading up to January 2017 which also helped us to understand how services are provided now.
2. **Methodology**
	1. Details about how the investigation was commissioned, its Terms of Reference, the team, and the methodology we used can be found in the main report attached. Our team reviewed the `internal’ investigation report prepared by the Trust immediately after the tragic death of X’s mother which concluded that the incident could not have been predicted. However, the Trust investigation report made four recommendations to strengthen services to improve multi-disciplinary team working, risk assessment, training in risk management, and communication.
	2. We are grateful to the staff of the Trust for helping us to understand the progress that has been made to implement these recommendations, and to understand how services were operating then, and now. We were able to speak with staff directly about this, including members of the team who cared for X, either when he was an inpatient or whilst he was being supported in the community. We are grateful to all the staff for their help, and to the Trust for giving us full access to the clinical records, Trust policy documents and staff training records.
3. **Background**
	1. A full chronology of the care and treatment provided for X may be found in the main report. Briefly, prior to the development of what transpired to be a serious mental illness, X had a longstanding history of severe epilepsy which worsened in 1996 after a road traffic accident. He later went to prison for 6 months for an associated dangerous driving offence. By 1999 (age 22) X was being admitted periodically to general hospital care following injuries caused during seizure-related falls. A further head injury sustained in December 1999 – the result of a fight with a bouncer in a nightclub - appears to have exacerbated his condition. In 2000, X was cautioned when he was detained for stealing from the shop where he was working. He also had contact with Police in regard to a neighbour dispute, criminal damage, attempted fraud and `wasting Police time.’
	2. X first presented with depression to his GP in 2005 when he was 28 and he was referred to mental health services in 2007 after trying to take an elderly woman’s handbag at a bus stop, behavior which appeared to have been triggered at least in part by mental changes associated with a seizure. Later, X said he had no recollection of the incident and, as a result of his apparent lack of Criminal Intent, he was not charged. A similar incident occurred later the same year when X (aged 30) was detained for stealing and for threatening behavior. Immediately afterwards, he had a seizure, and whilst he was in the casualty department, he injured his mother as well as a male Nurse, who sustained a suspected broken jaw.
	3. After 2007, X had several admissions to psychiatric hospital, sometimes under Section of the Mental Health Act and, in the early days of his care, X’s diagnosis was given as `post-ictal’ psychosis: an acute and transient mental disturbance with symptoms which can be similar to those seen in schizophrenia. As X’s seizures seemed to increase in frequency after his discharge from hospital, staff also speculated that he might not have been taking all of his prescribed medication. Following an admission in 2009 under Section 2 of the MHA, X nonetheless managed independently until July 2016 when he was discharged from Trust services.
	4. At this point, X began to experience physical symptoms (chest pain, shortness of breath, pain etc.) which were attributed, following extensive physical investigations, to anxiety rather than physical ill health. Furthermore, X’s thought content began to have a distinctly paranoid quality. He disclosed elaborate thoughts about an uncle whom he thought had stolen a machine with which he could control X, other members of his family, and their pets. X thought his own anxiety-related breathing difficulties were caused by this machine and, despite medication, discussion, and staff attempts to persuade him otherwise, X’s thoughts proved very resistant to change; on several occasions X took his concerns to the Police. Between July 2017 and December 2017, X was admitted seven times. From 2017 forwards, and in the context of a much more settled period in relation to control of his epileptic seizures, the psychiatric team caring for X agreed that his diagnosis should be given as paranoid schizophrenia.
	5. During this period, records show that X maintained a good relationship with his family, and particularly with his mother and grandmother whom he visited most weekends. Community team and ward staff maintained regular contact with X’s mother who was herself not well, having struggled with multiple sclerosis for many years. X also had a cat that he loved and, although he had not worked for many years due to his epilepsy, he lived alone in his very well-maintained flat.
	6. Owing to concerns about X’s resistance to continue taking his medication, the nature of his symptoms and his relatively low level of insight, on the 14th December 2017, the Consultant Psychiatrist arranged for X to be subject to a Community Treatment Order (CTO). This is part of the Mental Health Act and it allows a patient to leave hospital and be treated in the community if their level of risk is judged to be acceptable. However, a CTO also requires that certain conditions (such as compliance with medication) are met and a patient subject to a CTO can be recalled to hospital if these conditions are breached.
	7. On 17th December 2017, when Police were called to a disturbance in the city centre caused by X behaving bizarrely, the Trust Crisis team reviewed X’s mental state. Although they judged X to be safe, and not to need an admission at this point, they referred him for a review by the psychiatrist who saw him on 20th December 2017. X’s depot medication (an anti-psychotic given by injection) was increased and the Crisis team arranged to see him daily. X’s mother’s circumstances were also reviewed by the local MASH (Multi-Agency Safeguarding Hub) and a new referral relating to her safety was forwarded to Adult Social Care for review. On 21st December 2017, X himself requested a readmission and, consistent with the terms of his CTO, this was arranged immediately. X remained on the ward until 26th December 2017 when brief home leave was agreed, and this went well.
4. **The incident**
	1. On the 4th January 2018, X took a period of approved unescorted leave in town which also seemed to go well but, over the next two days, X, who very much wanted to be discharged, was frustrated by what he judged to be an error in regard to his hospitalisation; he had thought his admission informal. However, he remained on the ward, taking periodic home leave to look after his cat and to visit his mother which he did, for example, on 8th January 2018.
	2. On the 9th January 2018, it was agreed that X could, again, take day of leave from the ward. Prior to his departure in the morning, a qualified member of the nursing staff team who knew X well completed a formal Risk Assessment and she asked a range of questions relating to X’s mental health, his thoughts and intentions. X seemed pleasant and well-oriented and there seemed no reason not to allow him to go. However, after an episode later that day when Police were called by someone reporting a man behaving strangely, X stepped in front of a motorist and suffered a significant head injury. When Police tried to contact X’s mother, she was found to have been killed. It subsequently transpired that X had been responsible. It therefore seems that X was less well than he appeared when he left the ward, and it is possible that he failed to disclose all his delusional thoughts for fear of being detained.
	3. The following day, the member of the Crisis team who acted as `appropriate adult’ during the initial Police interview witnessed X expressing thoughts focused in a wholly psychotic manner on saving his mother and his cat, rather than upon harming them. For example, after being cautioned, X said: “I love my mum so much and I would never do anything to harm her ever” and “She was the most peaceful and beautiful person on this planet, she would never harm a fly and would do anything for anyone”. X also seemed to be moving in an out of consciousness in association with what appeared to be seizure activity.
5. **Findings and conclusion**
	1. Our team can affirm that the findings of the internal investigation commissioned by the Trust appear broadly sound, and that they accord with the evidence contained in the case notes and the testimony of witnesses. We agree with the authors of the report that the tragic death of X’s mother, with whom he was close, could not have been predicted. However, we did have concerns about the quality of practice in relation to the assessment and management of risk and these are elaborated in the main report.
	2. We believe that X was given appropriate treatment over the course of his time in contact with the Trust, and that his care was managed overall in a safe way, consistent with policy and the legal framework of the Mental Health and Mental Capacity Acts. Whilst there were appropriate restrictions placed upon X whilst he was subject to a CTO, it also appears that risk assessments were undertaken and did not indicate that a longer-term admission to hospital was warranted. Although X had a range of delusional and paranoid beliefs associated with his mental illness, there was no warning that he would harm anyone, least of all his mother with whom he was close.
	3. Over the course of our review, our team identified several areas needing improvement which, whilst not causally related to the outcome in this case, nonetheless represent a concern for the quality and safety of services overall. These areas overlap with those identified by the team completing the internal review commissioned by the Trust. We have therefore made seven recommendations: the first three relate to risk assessment and management; one relates to the provision of inpatient facilities; one relates to multidisciplinary team working, and one to communication. The significance of these areas for the maintenance of safety is such that we will visit again briefly again in six months’ time to review progress.
6. **Recommendations**

**Risk assessment - audit**

* 1. Our team noted the steps that have already been taken to strengthen training about risk, but we recommend that the provision of training about risk and be audited by the Trust in six months’ time to ensure that improvements in both the quality of the content as well as the quality of record-keeping has improved.

**Risk assessment - care planning**

* 1. We recommend that the Trust ensure that the current Care Plan and Risk Assessment forms for each patient are updated appropriately, related clearly to one another and marked very clearly as current. Attention is needed to ensure that risk assessments and care plans are `joined up’ and that essential information is readily available, particularly to staff who do not know a patient well.

**Risk assessment and risk management guidance**

* 1. We recommend that the Trust should ensure that a summary or chronology of health episodes and risk events is provided in the electronic visible to enable practitioners to seek and obtain further information from other health providers to inform their work working.

**Inpatient facilities**

* 1. We recommend that commissioners of the NHS mental health service give urgent and positive consideration to the improvement of inpatient facilities on the ward where X was a patient; this would ideally include number and location of beds; services for people with Personality Disorder, as well as the appointment of support staff. In this way, we believe that care can be delivered more safely, more appropriately, and in a manner that will impact positively upon care quality, recruitment and retention.

**Multi-disciplinary team working**

* 1. We recommend that clinical leaders with responsibility for inpatient staff teams take further steps to foster an inclusive, multi-disciplinary approach to clinical care and decision-making. This should include attention to ensuring that team meetings include staff at all levels and that supervision takes place, as agreed.

**Communication**

* 1. We recommend that attention be given to the question of how to ensure that communication between A & E and mental health services is improved.

**INDEPENDENT INVESTIGATION INTO CARE AND TREATMENT PROVIDED FOR X BY 2GETHER MENTAL HEALTH NHS FOUNDATION TRUST**

1. **Introduction**

### This is the report of an investigation commissioned by NHS England under contract: OJEU 2016/S 147-266712, Department of Health guidance relating to Article 2 of the European Convention on Human Rights, and guidance published by NHS England[[2]](#footnote-2) for investigating serious incidents in mental health services.

### Our aim was to review thoroughly the care and treatment provided for a patient (`X’) who was on leave from the psychiatric ward (part of 2Gether Mental Health NHS Foundation Trust - `the Trust’[[3]](#footnote-3)) when, on 9th January 2018, X killed his mother.

* 1. We would like to extend our sincere condolences to the victim’s family for their tragic loss, and our sympathy to them for the deep distress caused when X, with whom they were close, became so severely ill that, whilst in a deluded state, he may have believed that killing his mother was a way to save her.
	2. On 29th November 2018, X was deemed unfit to plead and sentenced in his absence. He was given a `Hospital Order’ under Section 37[[4]](#footnote-4) of the Mental Health Act. This is an order which permits medication to be given without consent although consent is always sought. The judge also imposed a Section 41 `restriction order’ meaning that X will be detained until permission to leave is granted by the Secretary of State for Justice. X is currently detained and being treated in a medium secure psychiatric facility.
1. **Methodology**

### Appendix 1 contains a copy of our Terms of Reference (TOR). Appendix 2 contains details about the investigation team (our team) appointed by NHS England, including individuals with a wide range of relevant skills including Psychiatry, Nursing, Clinical Psychology, policy development, investigations, and staff training. Appendix 3 contains the recommendations of the internal investigation prepared by the Trust immediately after the incident.

### Our team focused primarily on the mental health care provided for X from the point when he first contacted mental health services to the time of the incident. We focused upon the quality of care provided and the circumstance of the incident to help X, X’s family and the Trust staff to understand what happened to learn if there were omissions of care and identify any steps necessary to strengthen and improve mental health services.

###  Initial arrangements for liaison were discussed with the Head of Investigations, Midland & East (East) region for NHS England. The lead investigator and report author then liaised directly with the Trust to reach agreement about the methods to be used to examine the facts of the case, identify ways in which care might have been altered or improved, and to understand the basis for the recommendations made in the Trust investigation report.

* 1. Arrangements were made to conduct personal interviews with 21 staff from the Trust (see Appendix 4). Adapted Salmon Principles[[5]](#footnote-5) were used for this non-judicial investigation meaning that all those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference. They were offered the opportunity to be accompanied to the interviews, if they wished. All the meetings were recorded. Written accounts of the interviews were then verified for accuracy by each participant before being `signed off.’ All witnesses were assured that their testimony would be confidential[[6]](#footnote-6) in that no personally identifying information would be included in the report.
	2. Our team undertook a desktop review of policies and clinical case notes written by staff about X during the period he was in contact with the Trust. Our team is very grateful to the Trust for providing a laptop and a RiO card to facilitate this. Appendix 5 contains a list of the Trust policies, case notes, records and correspondence that were reviewed.
	3. No meetings were held with X, who remained too unwell to provide information, but contact was made with staff from the facility currently providing medium secure care and treatment for him. Consultation was also undertaken with the specialized clinicians involved in provision of care, treatment and support for X’s epilepsy. We would like to thank everyone who was involved.
	4. Following conclusion of the Court case, X’s family said they would prefer not to have any contact with the investigation. No meetings with the family have therefore taken place. However, we are aware that X’s family is in contact with him since his Court case and detention.
1. **Background**
	1. A detailed chronology of care provided for X over the course of his contact with the Trust is provided in Appendix 6. A narrative summary of the facts of the case, information about X’s personal and psychiatric history, the incident, its antecedents and consequences, are provided below. Although our TOR specified examination of care provided by the Trust, information about X’s healthcare at earlier stages of his life have also been included here as they inform the narrative formulation of the mental health and other difficulties that X experienced.
	2. X was born in 1977. There was some evidence of violence when X was a child and one episode was investigated following a referral by X’s headmaster to Social Services and X was placed on the `child at risk’ register. X suffered with epilepsy diagnosed in 1980 when he was young, and he was bullied at school. He left school at age 16 obtaining A to C results in Art, English, and Sciences and an E in Maths. The records show that X was free of seizures between the ages of approximately 15 and 19 but in 1996 he had a road traffic accident (possibly the result of a seizure at the wheel) and he sustained a head injury. X later went to prison for 6 months for an associated dangerous driving offence.
	3. From this point forward, it appears that X’s epilepsy worsened and, by 1999 (age 22) he was being admitted periodically to general hospital care following injury, the result of seizure-related falls. A further head injury sustained in December 1999 – the result of a fight with a bouncer in a nightclub - appears to have exacerbated his condition. X also had some contact with the Police. For example, in 2000 he was cautioned when he was detained by the Deputy Manager of the shop where he was working, and stolen items of property were discovered in his bag. He also had contact with Police in regard to a neighbour dispute, criminal damage, attempted fraud and `wasting Police time.’ More information about this is provided below.
	4. X married after he left home at around the age of 19 in 2000 but he and his wife separated after three to four years in 2003 when X was 26. After this, X lived alone in rented accommodation and he did not work again. This was largely the result of the impact of his very disabling seizures. X was assessed in 2002 as having, on average, 6 fits per month; these were complex partial seizures without lateralising signs that proved very difficult to control. He also had nocturnal generalised seizures, myoclonic jerks and photosensitivity.
	5. X first presented to his GP with mental health-related symptoms (depression) in October 2005 at the age of 28. Over the next two years, he was supported by his GP who liaised with X’s neurologist about his epilepsy treatment. Apart from an encounter with Police which was not pursued by them due to a lack of evidence - the result of a fracas between X and his neighbor whom X regarded as too noisy - X’s management followed the same pattern until January 2007 when the primary care record shows the GP as having described X as `paranoid and confused’. In early in February 2007, X then tried to take an elderly woman’s handbag at a bus stop. He was taken to hospital immediately after his arrest as a result of suffering a seizure and was admitted very briefly to the mental health unit. Later, X said he had no recollection of the incident and, as a result of his apparent lack of Criminal Intent, he was not charged.
	6. In October 2007, the same year (aged 30), X was detained for theft and for threatening a store detective; he was arrested for assault. Immediately afterwards, X was taken into casualty because he had a seizure. X’s mother visited and, without warning, he injured her as well as a male Nurse, who sustained a suspected broken jaw.
	7. X was admitted for just over a month (his second admission) in October 2007 on Section 2 of the Mental Health Act (he had refused an informal admission). His diagnosis was given as `post-ictal’ psychosis – an acute and transient mental disturbance with symptoms which can be similar to those seen in schizophrenia. He was prescribed Haloperidol[[7]](#footnote-7) and Lamotrigine[[8]](#footnote-8) 100mg twice daily. However, X’s fits seemed to increase in frequency after his discharge from hospital leading to speculation that he might not have been taking all the medication that he had been prescribed.
	8. X’s third (informal) admission came in August 2008, almost a year later, when he was taken to A&E following an overdose of paracetamol and Co-Codamol. X reported depression due to the lack of control for his epilepsy and sadness due to the end of his marriage five years before. He was admitted informally for a fourth time in January 2009 for similar reasons but, on this occasion, the clinical picture appears to have worsened. For example, whilst on weekend leave, X went into the local Police Station to report his mother for trying to harm him. Receiving advice with which he did not comply to contact the mental health team, X then travelled to a London Police Station to make the same report. This time, he also took an offensive weapon (an air pistol) to protect himself and he was admitted briefly to a `place of safety’ in Paddington.
	9. Returning with help from one of the crisis team staff on 28th February, X then reported to Police on 1st March that he’d found a ring he’d lost the previous week – he said it was on sale in a local jewellery shop. As X was unable to describe it, and the shop could prove its provenance, the Police did not pursue the matter. However, X then presented himself to the Police station to hand in a knife that 'he feared his mother may have used to threaten him’. The reporting Officer did not observe any (other) signs of mental ill health and X was allowed to leave. Subsequently, a Police National Computer warning marker was placed against his record for weapons.
	10. Overall, and particularly in the light of hindsight, it seems that X’s mental ill health was worsening and his paranoia increasing. Furthermore, it was reported that X disliked taking his medication because it made him very drowsy. It is also clear from notes written at this time that X’s fits were failing to be controlled, despite regular reviews of his medication as well as consideration being given to physical (surgical) interventions that might help. Unfortunately, no surgical intervention proved possible.
	11. On 3rd March 2009, a MH Act Assessment was undertaken in Swindon. The notes are silent with respect to the reasons for X being there although it appears that X presented himself at a mental health drop-in centre. The assessment describes him as having paranoid thoughts about his mother trying to kill him in order to benefit from a life insurance policy, and it describes X as having a range of psychotic beliefs including that there was a conspiracy between the Police and the SAS. X was then admitted to hospital in Weston-Super- Mare under S.2 of the MHA for fifteen days (his fifth admission) owing to a lack of beds locally, where he was described as a high risk of harm to others.
	12. On 10th June 2009, according to the notes, a Multi-Agency-Public-Protection-Panel (MAPPPA) meeting was requested by staff at the Trust. However, the Police MAPPA administrator has no record of X being referred and it appears that no further action was taken.
	13. Between this time and the last (twelfth) admission that immediately preceded the incident that resulted in the death of his mother, X was admitted a further six times to the Trust. The frequency of admissions and their type is as follows:

1. Feb 2007 – informal, brief admission from A&E

2. 18th October 2007 - Section 2 (MHA) for a month

3. 30th August 2008 - informal, brief admission

4. 19th Feb 09 - informal brief admission

5. 3rd March 2009 - Section 2 (MHA)

6. July 2016 – informal, brief admission

7. Jan 2017 - informal, brief admission

8. Feb 2017 - - Section 5/4 (MHA)

9. March 2017 – Section 2 (MHA)

10. July 2017 (S.2 then 3)

11. Nov 17 - S.3 (MHA) followed by a Community Treatment Order (CTO)

12. Dec 17 – X recalled from his CTO

* 1. The list shows that after X’s admission to Weston-Super-Mare in 2009 under Section 2 of the MHA, he managed independently until July 2016, albeit with community support until 2013 when he was discharged from Trust services. Evidence relating to X’s contact with the Police and his GP suggest that he remained to some degree unsettled during this time, even though he did not apparently need secondary specialized mental health care. He was being treated for depression by his GP and it appears that X’s epilepsy was beginning to show signs of being better controlled.
	2. There were several reasons for X being re-referred to services in 2016. According to X’s GP, X had begun to experience physical symptoms (chest pain, shortness of breath, pain etc.) which were attributed, following extensive physical investigations, to anxiety rather than physical ill health. X was also reportedly in debt and X’s seizures were, once again, proving problematic.
	3. It is notable that ward staff and community team staff for the most part found X likeable and easy to relate to, and with one exception, they did not find his behavior challenging. Community staff commented that X’s flat was immaculately clean, and that he had a loving and caring relationship with his mother and grandmother. X also loved his cat, Gizmo, which he had taught to use the lavatory rather than a litter tray.
	4. X’s thought content, as recorded in the notes in 2016, had a distinctly paranoid quality. He disclosed elaborate thoughts centred upon an uncle who, he thought, had stolen a machine with which he could control X, other members of his family, and their pets. X thought his own breathing difficulties were caused by this machine and, despite medication, discussion, and staff attempts to persuade him of the illogicality of this, his thoughts proved very resistant to change. On several occasions X took his concerns to the Police. Between July 2017 and December 2017, he was admitted seven times and of these, only two were technically informal admissions.
	5. On 14th December, the Consultant Psychiatrist arranged for X to be subject to a Community Treatment Order[[9]](#footnote-9) (CTO). The consultant wrote: "X is a 40yr old divorced unemployed gentleman diagnosed with bitemporal epilepsy and paranoid schizophrenia. When unwell he believes that [a family member] is actively trying to murder him using a secret machine built by the SAS to control his thoughts and body. He also believes that his family are in danger from that man and has reported it to the Police. This is his 4th admission this year and he has been non-adherent to medication in the past, despite stating his wish to comply at the point of discharge from hospital. Without treatment he is likely to relapse and make himself vulnerable by alerting the Police, attending A&E and his level of functioning deteriorates further. He needs the CTO to maintain therapeutic contact and to deliver depot medication. His insight is partial at the best’.
1. **The Incident**
	1. On the 18th December, Police had been called to the city centre after a complaint made by staff in a coffee shop. The Police report states X had been discharged earlier that day and had gone to the city centre. Coffee shop staff called Police as X was handing out £20 notes. He had tried to give the staff a large tip and, when they refused it, he started shouting. Following discussion with the Police, X left to go to his mother's house. Police also spoke to X’s mother who agreed to contact X’s mental health workers as it seemed clear that X’s mental health was deteriorating.
	2. Trust Crisis team staff spoke to X on the telephone: he was very loud and stated everything was fantastic. He thought he was being bugged by the SAS and did not need his medication. However, despite his delusional beliefs, staff judged him to be safe. X was then reviewed by the On-Call consultant on 20th December and the notes record that a thorough assessment was undertaken, including of the risks that X might harm himself or others. He was judged not to show obvious signs of psychosis at this time, although staff noted that X might be unwilling to fully share his thoughts with them for fear that he would be detained. A decision was taken to increase X’s depot (an anti-psychotic medication given by injection) from 75mg to 100mg fortnightly and the Crisis team arranged to see him daily.
	3. On 21st December, an assessment completed by a Core Trainee year one doctor indicated that X’s thoughts were becoming more evidently psychotic – their content relating, as before to concerns about the SAS; a machine controlling his and others’ wellbeing; risks that he perceived to be present for his mother; and concerns about relatives wanting to cause them harm. X requested a readmission and, consistent with the terms of his CTO this was arranged immediately. X then remained on the ward until 26th December when brief home leave was arranged, which went well. Despite persistence of the beliefs that medication was designed to address, X was unhappy that his higher dose of medication was making him drowsy.
	4. On the 4th January 2018, X declined his morning dose of Diazepam[[10]](#footnote-10) (in fact, he had to be woken for his morning medication) and he took a period of approved unescorted leave in town (mid-morning until 15:30hrs) which seemed to go well although X declined to elaborate on what he’d been doing whilst he was out. Over the next two days, X, who very much wanted to be discharged, was frustrated by what he judged to be an error in regard to his hospitalization. He had thought his admission informal. Nurses explained that as he was subject to a CTO, approval would be needed before he could be discharged. He therefore remained on the ward, taking periodic home leave to look after his cat and visit his mother which he did, for example, on 8th January 2018.
	5. On the 9th January 2018, it was agreed that X could, again, take day of leave from the ward. Prior to his departure in the morning, a qualified member of the nursing staff team who knew X well completed a formal Risk Assessment and questions relating to X’s mental health, his thoughts and intentions were asked. X seemed pleasant and well-oriented. There seemed no reason not to allow him to take leave.
	6. Police reports indicate that later that day, an elderly woman reported to Police that a man in a taxi had stopped as she was posting mail; he offered her £20 to take a photograph of him, the taxi driver and the post box. She declined but thought the incident suspicious, so she reported it to Police. At just before 6pm, X was seen standing at the side of the road (it was dark). As a motorist approached in a Vauxhall campervan X stepped out into its path, suffering a significant head injury. He was sedated and taken to hospital. Just before 7pm that night, Police tried to contact X’s mother to inform her as next of kin about the accident but there was no reply. When officers returned to make further attempts to contact her, she was seen through a rear window to be lying on the floor, her head covered by a towel; she had been stabbed and killed. Police later went to X’s flat and found the cat Gizmo, also dead due to strangulation. Ward staff later learned about what had happened from X’s uncle, whom the Police had called about the traffic accident.
	7. The following day, X was arrested. After being cautioned he stated, “I love my mum so much and I would never do anything to harm her ever” A few minutes later he stated, “She was the most peaceful and beautiful person on this planet, she would never harm a fly and would do anything for anyone”. Police came to Mortimer ward requesting to search X’s room and several files of writing were removed; these are still in Police possession. Staff to whom the team spoke had been aware that X made notes which he occasionally shared with them, containing `evidence’ relating to the machine he thought able to control him/his breathing. Staff were also aware that X wrote more when he was unwell. However, as the notes were X’s personal property, even though they were aware that X tended to write more when he was unwell, they did not read them.
	8. The member of the Crisis team who acted as `appropriate adult’ during the initial interview of X by Police, who knew X very well, witnessed him expressing thoughts focused in a wholly psychotic manner on saving his mother and his cat, rather than upon harming them. In addition to ideas relating to the SAS and the machine, which X thought was probably responsible for the death of his aunt in 2012, he said that at least the Russians and Americans would now make peace. He also seemed to be moving in an out of consciousness in association with what appeared to be seizure activity. It seems likely that X was less well than he appeared when he left the ward and it is possible that he failed to disclose his thoughts for fear of being detained.
2. **Findings and conclusions**
	1. In this section, our findings are presented in response to the additional health-related Terms of Reference set out at Appendix 1, although to support the development of the narrative, they are not necessarily presented in the same order.

**The Trust’s internal investigation**

* 1. The Trust investigation is a long and very detailed report – 86 pages. Our team looked at the NHS electronic notes and case records to verify the content and, with one minor exception, we believe that the report presents an accurate account of the facts. The anomaly concerns the record as it relates to X’s first admission which is recorded in primary care notes as a very brief admission following a trip to A&E in February 2007 after a seizure. The Trust investigation report, by contrast, records X’s first psychiatric admission as in October of the same year under Section 2 of the MHA. We have not retrieved archived paper records for the period 2013/14 and no information from this time was uploaded into the new notes. However, our team does not believe this omission to be material.
	2. Our team is content to conclude that the Trust investigation process, its conclusions and recommendations appear sound. We believe that the primary conclusion of the Trust investigation is also essentially correct that there was no evidence that X’s actions could have been predicted or prevented.
	3. Prevention means to `stop or hinder something from happening, especially by advance planning or action’ and it implies `anticipatory counteraction’. For X’s mother’s death to have been preventable there would have to have been a level of knowledge; an opportunity to intervene, and the legal means to do so. Very sadly, the evidence suggests that information relating to the first of these was severely restricted. X did not disclose to staff, when asked, that he had any intention to harm his mother. Hindsight, furthermore, does not illuminate the picture. There was no evidence to suggest any failure in the assessment of risk that was undertaken by an experienced member of the staff team immediately prior to X taking agreed leave on January 9th.

**Referral and discharge arrangements and concordance with policies and guidance**

* 1. Overall, the circumstances relating to and the practice in relation to X’s referral and discharge arrangements indicate that care was provided in a manner that accords with good practice. Our team considers that it was appropriate to place X on a Community Treatment Order (CTO) in December 2017 as the least restrictive means to ensure that he could obtain support from community services and be admitted if his level of risk rose. Furthermore, whilst X was in the community, our team considered that the Crisis Team responded to his needs in a highly professional and appropriate manner; they also maintained good contact with X’s mother who knew who to call in an emergency.
	2. Furthermore, there is no suggestion staff on the inpatient ward missed important information about X’s state of mind; the notes make it clear that X was assessed and cared for appropriately although his insight was noted to be limited. However, we learned from witnesses that the period when X was most recently admitted (December 2017) was exceptionally busy. As the only adult ward in the locality, the ward to which X was admitted must take all-comers, including patients with a learning disability and occasionally adolescent patients. A high percentage of bank and agency staff were also being employed at that time, and staff vacancies were running at a relatively high level (around 40 per cent). Staff found it challenging to deal with the demands they were facing.
	3. Ideally, our team believes that this ward might be configured differently, with two smaller units rather than one large one to facilitate the management of patients with challenging behavior, personality disorder, and/or patients who are detained to ensure that essential information relating to risk is not missed. We understand that there are plans for this and we would wholly support them to be realised as soon as possible. We also note that a series of very positive steps are being taken to improve recruitment and retention.
	4. We note that, as compared with the mental health provision delivered elsewhere by the Trust, inpatient services are very poorly supplied with support staff to deliver activities such as physiotherapy and occupational therapy. As a result, staff believe, informal inpatients are reluctant to stay on the ward for as long as might be helpful for them. We do not have evidence that this was material in relation to the care provided for X. However, it is unusual to find such support services missing in inpatient care today and it would improve the quality of ward-based care if this could be strengthened.
	5. In similar vein, our team noted the absence of specific services for people with Personality Disorder. Whilst this was not material in relation to X (he did not have a personality disorder) there is no doubt that the management of patients on the ward who do, presents a challenge to the delivery of inpatient care. We learned from witnesses that the presence of such patients (as in December 2017) affects demand on the service and potentially drives down lengths of stay for patients who might benefit from a longer period of assessment. We note that proposals to develop a PD service will be considered by commissioners in due course and we hope that it will be possible for them to respond positively.

**Communication**

* 1. Whilst staff-patient ratios, and the ratio of qualified to unqualified staff on the ward are (and were at the time) consistent with national averages, staff with whom we spoke were being stretched to work with several very challenging clients; there had been a death on the ward, and (unrelatedly) several of the more experienced staff had left or were planning to leave. Some staff were doubtful that it was the right decision to give X leave from the ward during December. Our team therefore tried to understand how decisions taken at the Multidisciplinary Team are communicated and shared, and whether concerns from staff, including the more junior members of the team, are always heard. We learnt that team meetings might commonly contain very few members of the team and that junior staff seldom attended at all.
	2. We therefore recommend that attention be given by clinical team leaders to foster a more inclusive approach to MDT meetings and that junior (healthcare assistant) staff as well as qualified staff be included where possible so they can contribute, for example, information about patients they have been working with and/or observing directly. This is particularly important in the assessment of risk.
	3. Our team noted that whilst supervision and support for staff is technically available, clinical needs commonly take precedence and supervision sessions are quite often missed. Safeguards such as supervision for the team are very important when complex, but not necessarily very demanding patients like X are on the ward, so we urge the clinical teams to continue to monitor this to ensure that it does occur.
	4. The Trust investigation contains a recommendation about the importance of improving communication with other specialties. Our team asked witnesses about communications with primary care, Police, A&E, and the epilepsy specialists with whom X had contact. We did not find communications in any of these areas to have been inadequate, although it is notable that the specialist epilepsy nurse did not have a number to call when/if X presented in crisis. Although there was never evidence that X behaved in a threatening way towards the epilepsy nurse with whom he got on very well, this would have been a sensible precaution. It is also notable that staff in A&E cannot generally access a patient’s RiO (electronic) notes. Although they can speak quickly to a member of the Psychiatric Liaison Team based at the hospital, A &E staff frequently see psychiatric patients and it would be helpful to review this restriction.
	5. It is striking that X’s own communication was restricted and highly selective. For example, X maintained a very positive relationship with those supporting him to manage his epilepsy, but he failed to discuss any aspect of his mental health with them. Both the specialised epilepsy nurse and the neurologist who knew X were therefore astonished and very disturbed to learn what had happened on 9th January 2018. X also admitted to withholding information from time to time from the mental health staff, especially if he thought it likely that he would be detained.
	6. The Consultant Neurologist thought that communication could have been better between the mental health services and her own, and she advocated that there should be joint clinics as there is in some other parts of the country. Like the specialist epilepsy nurse, she also thought it would be helpful if community psychiatric nurses could attend clinics such as those provided for local patients with learning disability and epilepsy.

**Appropriateness of treatment**

* 1. Treatment plans start with a clear formulation and diagnosis and the case notes and other reports make it clear that there was considerable debate over the years about the most appropriate diagnosis in X’s case. Significantly, his diagnosis was changed in 2017. Instead of `post-ictal psychosis’ or Geschwind syndrome (a psychotic condition associated with temporal lobe epilepsy), X was given a diagnosis of paranoid schizophrenia.
	2. We believe that X’s mental health diagnosis of paranoid schizophrenia was appropriate and that his treatment (injections of an antipsychotic) coupled with tranquilizing medication given when necessary was correct. Although X didn’t like his medication, it is also clear that he generally took it. Furthermore, X’s medication had been raised in the period immediately prior to the incident.
	3. The team currently caring for X concur with this diagnosis although they also believe that post-ictal changes (brief changes in mental state in association with seizures) are also evident, suggesting that both diagnoses are appropriate.
	4. The Consultant Neurologist supporting X with his epilepsy to whom we spoke confirmed X’s epilepsy diagnosis (refractory focal epilepsy). She confirmed that X was not a candidate for surgery as he had electrical discharges relating to his seizures from both sides of the brain. She did not think that X’s psychosis was related to his epilepsy which was, by the time of the incident, well-controlled. She also thought it unlikely that his mental health-related medication would have lowered X’s seizure threshold.
	5. Our team examined the pattern of mental health care provided for X over the course of his contact with the Trust. In our opinion, care was generally provided in accordance with national standards. Indeed, there were some positive features of service delivery and management which elevate the Hereford service above the norm. For example, there are good contacts between the inpatient and community teams and the Crisis Team in particular, appears to operate very effectively.
	6. A question was raised during our conversation with mental health Trust staff about whether X’s antipsychotic medication was sufficient (125mg of Haldol by intra-muscular Injection (IMI) every two weeks with the last injection on 3rd January) to control his psychotic thoughts. The dose X was given is within the therapeutic range as recommended in the BNF[[11]](#footnote-11) and there is no reason to suggest that it was not effective. However, X lacked insight into his psychosis; he sometimes reported that `the thoughts are still somewhere at the back of my mind’, and he could relapse very quickly. Given that medication might also tend to help X to order his thoughts more coherently, ongoing risk assessments containing full information would be very important to complete.

**Risk assessment**

* 1. A thorough assessment of risk should include information from the patient about his/her thoughts; information from his or her family, carers, primary care and other agencies, as appropriate, and information about the past. Such information can be potentially vital to assist in case formulation, the management of risk and the prevention of relapse. Achieving this can be very challenging, especially if a patient has withheld information in the past and/or lacks insight.
	2. The internal report commissioned internally by the Trust contains a recommendation about the implementation of Trust policy on risk assessment; this is because elements of X’s historic record had been deleted by a trainee doctor who failed to operate the electronic system properly; he deleted some historical information by accident. In addition, some risk assessment forms had not been completed in full. Our team verified that the likelihood of this problem re-occurring has now been reduced through training.
	3. We also noted that the assessment of, and communication about risk on the ward has been strengthened by the establishment of what are known locally as `safety huddles.’ These small group meetings help to improve the reliability and validity of communications about safety and risk and they are valued by staff. However, our team has some concerns that risk assessment and relapse prevention should be strengthened further.
	4. It is very challenging for staff to balance their legal and professional responsibilities to the patient, with their responsibility to protect others. For example, staff were aware, and had verified, that X, for the most part, had a very good relationship with his mother; but whilst X’s thoughts were generally focused on protecting his mother from the harm he thought might be caused to her by the SAS machine he believed was controlling the family, there were also several occasions (in 2007, 2008, 2009 and 2017) when he thought she was trying to harm him. Furthermore, he had injured her once before.

* 1. It was also known that X tended to write a lot when he was unwell, but staff did not ask to read his notes (unless he shared them) and staff reminded us of the importance of respecting patient’s privacy. We were concerned that, had X been persuaded to share his written thoughts, it might have contributed meaningfully to the assessment of the risk he posed, particularly as hindsight appears to suggest that he was less well than he appeared when he left the ward on 9th January 2018.
	2. These are difficult areas and we would like to encourage the Trust and those providing pre-registration training to ensure that staff have the opportunity, through training, to develop their skills in the assessment of risk.

**Care planning**

* 1. Like the authors of the Trust investigation report, we noted that X had as many as nine separate care plans, each relating to an aspect of his care (support and safety, risk and aggression, rights, etc.). Whilst this is not inconsistent with policy or the operation of the electronic system used by the Trust, it mitigates against the ease with which staff (perhaps especially bank, agency or locum staff) can quickly find a single narrative summary of a patient’s care and risk that highlights the issues with which it is essential they are familiar. We therefore urge the Trust to ensure that the current Care Plan and Risk Assessment forms for each patient are updated appropriately, related clearly to one another and marked very clearly as current.
1. **Recommendations**

**Risk assessment - audit**

* 1. Our team noted the steps that have already been taken to strengthen training about risk, but we recommend that the provision of training about risk and be audited by the Trust in six months’ time to ensure that improvements in both the quality of the content as well as the quality of record-keeping has improved.

**Risk assessment - care planning**

* 1. We recommend that the Trust ensure that the current Care Plan and Risk Assessment forms for each patient are updated appropriately, related clearly to one another and marked very clearly as current. Attention is needed to ensure that risk assessments and care plans are `joined up’ and that essential information is readily available, particularly to staff who do not know a patient well.

**Risk assessment and risk management guidance**

* 1. We recommend that the Trust should ensure that a summary or chronology of health episodes and risk events is provided in the electronic visible to enable practitioners to seek and obtain further information from other health providers to inform their work working.

**Inpatient facilities**

* 1. We recommend that commissioners of the NHS mental health service give urgent and positive consideration to the improvement of inpatient facilities on the ward where X was a patient; this would ideally include number and location of beds; services for people with Personality Disorder, as well as the appointment of support staff. In this way, we believe that care can be delivered more safely, more appropriately, and in a manner that will impact positively upon care quality, recruitment and retention.

**Multi-disciplinary team working**

* 1. We recommend that clinical leaders with responsibility for inpatient staff teams take further steps to foster an inclusive, multi-disciplinary approach to clinical care and decision-making. This should include attention to ensuring that team meetings include staff at all levels and that supervision takes place, as agreed.

**Communication**

* 1. We recommend that attention be given to the question of how to ensure that communication between A & E and mental health services is improved.

**APPENDIX 1**

**TERMS OF REFERENCE**

* The investigation will examine the NHS contribution into the care and treatment of the service user (X) from his first contact with specialist mental health services up until the date of the incident.
* It will critically examine and quality-assure the NHS contributions to the Domestic Homicide Review.
* Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user.
* Review and assess compliance with local policies, national guidance and relevant statutory obligation.
* Examine the effectiveness of the service user’s care plan and risk assessment, including the involvement of the service user and his family.
* Review the appropriateness of the treatment of the service user in the light of any identified health needs/treatment pathway.
* Provide a written report to NHS England that includes measurable and sustainable recommendations to be published either with the multi-agency review or standalone.

**APPENDIX 2**

Investigation team

Anne Richardson, BSc, MPhil, FBPsS, Director of ARC, is a clinical psychologist by training; she formerly specialised in work with adults with severe mental ill health and long-term needs and is an experienced trainer having jointly directed the DClinPsy programme at University College London. As Head of Mental Health Policy at the Department of Health she was instrumental in the development of the National Service Framework for Mental Health and for the development and delivery of the national learning disabilities inquiry `Healthcare for All’ (2008). Anne has worked on many investigations into the quality of NHS care and treatment provided for people who lost their lives unexpectedly, or for those who were themselves responsible for a death whilst in contact with services.

Hugh Griffiths, MB BS, FRCPsych, is a former consultant psychiatrist in the North-East of England where he carried responsibility for in-patient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health he led the development of the Government’s Mental Health Strategy “No Health Without Mental Health” (2011) and was instrumental in its subsequent Implementation Framework. Hugh currently works as Non-Executive Director in a mental health trust in the north of England.

Adrian Childs RMN RGN Dip.N (Lond) MSc Dip. Leadership Mentoring & Executive Coaching,

trained both as a general and mental health nurse. He worked as Director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust and earned a distinction in his MSc at the University of East London in the mid-1990s. Adrian also holds a diploma in leadership, mentoring and executive coaching. He has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. His previous experience includes serving as Deputy Chief Executive and Director of Nursing at Devon Partnership NHS Trust and Newcastle, Northumberland and North Tyneside Mental Health Trust. Adrian most recently worked as Director of Nursing at Leicestershire Partnership Trust. In 2014 he was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester.

**APPENDIX 3**

**Recommendations made in the internal Trust investigation**

1. Multidisciplinary Team (MDT) preparation sheets should be completed by nursing staff prior to MDT meetings. The preparation sheets should capture up to date information including current nursing observations, risks, leave and significant incidents and a general account of the patient’s presentation since the last MDT.

Action: Community Service Manager

Target Date: October 2018

1. Risk policy guidance should be implemented, when risk assessments are completed. Risk assessments should include all the areas recommended by the policy.

Action: Community Service Manager

Target Date: October 2018

1. Managers / supervisors to ensure that their staff have completed the Trust risk training and that clinicians remain up to date with training refreshers.

Action: Community Service Manager

Target Date: October 2018

1. Consideration to be given around how we can improve communication with other specialities where a patient has had another health condition which may have an impact on their mental health.

Action: Director of Service Delivery

Target Date: December 2018

**APPENDIX 4**

**Staff interviewed** (individual names have been removed)

Ward and Deputy Ward Managers (4 people)

Qualified nursing staff (3 people)

Health Care Assistants (4 people)

Nursing staff from the Assertive Outreach and Community Mental Health Teams (4 people)

Specialised Epilepsy Nurse (1)

Consultant Psychiatrist (1)

Clinical Psychologist (1)

Neurologist (1)

Locality Manager (1)

Crisis team qualified nurse (1)

Healthcare clinical team (3) in the Medium Secure Unit where X is currently detained

**APPENDIX 5**

**Policies and documentation reviewed**

1. RiO electronic case notes and specifically:
	1. Epilepsy Care Plan – Due for review on 22nd December 2017
	2. Physical Health Care Plan – Due for review on 22nd December 2017
	3. Informal Admission Care Plan – Due for review on 28th November 2017
	4. Rights as an Informal Patient Care Plan – Due for review on the 30th December 2017
	5. Points of Contact Care Plan – Due for review on the 30th December 2017
	6. Support and Safety Care Plan - Due for review on the 30th December 2017
	7. Violence and Aggression Care Plan - Due for review on the 30th December 2017
	8. Risk Assessments – last reviewed 9th January 2017
	9. Depot Care Plan - Due for review on the 30th December 2017
	10. Nurses Progress Notes
	11. Correspondence, including the Consultant Psychiatrist’s report for the Court and correspondence with Police regarding X’s previous offending history.
2. Guidance for staff on the conduct of Risk Assessments
3. Risk Assessment training schedule
4. Report into a Homicide committed by an In-patient – the report of the Trust investigation.

**APPENDIX 6**

**Chronology of care provided for X by 2Gether Mental Health NHS Foundation Trust**

|  |  |
| --- | --- |
| **DATE** | **HISTORY OF CONTACT**  |
| Aug 03 | X, aged 26, was referred to the City adult locality team for domiciliary services for OT re-ablement advice, referral to welfare rights and general support. The referral outlined that X had epilepsy and that he was claiming Disability Living Allowance. X had signed on for job seekers allowance and housing benefit. He had complained that he felt unsafe using domestic equipment (cooking, ironing) and was anxious. The notes record that X planned to move to new accommodation as he was at this time separating from his wife. |
| Oct 03 | An epilepsy medication review was recorded in the notes. X’s drugs were changed to Oxcarbazine. His seizure frequency was recorded as more than 1 per week. |
| Jun 04 | X had a grand mal fit and injured his mouth/tongue quite badly, needing to attend A+E. The next few months were characterized by several more fits and accidents and it appeared that the fits were not being controlled well. X reported problems with paperwork; he was attending a course and his benefits were stopped. The hospital suggested he should try to do a bit less and it was suggested he might claim a higher rate of DLA |
| 29 Sep 04 | A referral was completed to welfare rights. |
| 20 Dec 04 | X referred himself for an assessment for mental health community support. The Social Worker’s report indicates that X’s seizures were not well managed and that he was having up to 3 per day, with `absences’ sometimes lasting for up to 24 hours. X was described as being unable to cook or bathe without another person present due to the possibility of an accident.  |
| Oct 05 | X (age 28) reported to his GP that he was feeling depressed. He had initially attended for a flu vaccination. The primary care record indicates that X said he sometimes felt it was not worth living, but that he had never harmed himself. He reported a significant amount of family disharmony. A referral was made to mental health services.  |
| 19 Oct 05 | X’s GP wrote to his Neurologist about X’s anti-epilepsy drugs which were causing `a profound loss of "mental agility" leading to X being keen to stop taking his medication. His medication was therefore reviewed. |
| 19 Feb 06 | X (age 29) reported to Police that he was having problems with noisy neighbours. Police were called following an altercation in the hall after the neighbour went downstairs to take out his rubbish and clashed with X. A scuffle ensued and X ended up on the floor. The Police did not find sufficient evidence to pursue the case. X and his neighbor agreed to drop the matter.  |
| 1 Feb 07 | X phoned his GP worried about side effects from a new tablet. He was described as paranoid and confused, with regular seizures still occurring. He was advised to come in for an assessment. |
| 2 Feb 07 | (Age 29) X was arrested on 1st Feb after an outburst, apparently following a seizure, when he’d tried to take a woman’s handbag at a bus stop. He was admitted to psychiatric hospital immediately afterwards. However, he had no recollection of what happened, and it appeared that his behavior may have been linked to a seizure. As a result of his lack of criminal Intent, X was not charged.  |
| 17 Oct 07 | (Age 30) X was arrested for assault and theft. After this, he was taken into casualty because he had a fit. X’s mother visited and, without warning, X grabbed her and smashed her head against the rail causing facial injuries. In addition, whilst at the hospital being seen by a male staff Nurse, X kicked him in the face causing a suspected broken jaw. Again, these events appear to have been attributed to a post-ictal mental state (a term referring to temporary mental changes associated with seizure activity). |
| 18.10.07-21.11.07. | X was admitted to a psychiatric bed on Section 2 of the Mental Health Act (MHA). His diagnosis was given as post-ictal psychosis. X had refused informal admission and medication. He gave a history of child abuse (violence) and bullying at school. His first seizure, he reported, was at age 13. His epilepsy then stabilized but was exacerbated following a road traffic accident at age 20. He was prescribed Haloperidol and Lamotrigine 100mg b.d. (down from 300mg b.d.). However, his fits seemed to increase in frequency after his discharge leading to speculation that he might not have been taking all the medication he had been prescribed. |
| 8 Feb 08 | A letter to the GP from the CPN suggested it would be appropriate to reduce X’s Haloperidol to 2.5mg over 2 weeks. X also had an epilepsy review and a plan was made for him to come off Haloperidol completely and reduce his Lorazepam as he was feeling better. |
| 27 Mar 08 | Police wrote to the Neurologist asking for information in relation to the above incidents to ask whether or not X’s behavior could be attributed to his epilepsy, to which there was a reply in the affirmative. Police took no further action. |
| 27 Jun 08 | X was involved in a fight with his father and he smashed his car windscreen when the latter said he couldn’t bring X back from a hospital appointment. X was cautioned for causing Criminal Damage to property and for assault by beating. The NHS psychiatric notes say X was remorseful afterwards. These notes also indicate that such outbursts could be early warning signs of relapse as X appeared to be becoming increasingly paranoid and concerned that he was being poisoned by his mother. However, notes also record that X had a loving and protective relationship with his mother, who was not physically well herself. X visited her often. |
| 30 Aug 08 | X was taken to A&E following an overdose (a mix of paracetamol and Co-Codamol). He had been feeling depressed due to his epilepsy and the fact that he and his wife (a marriage of approximately 4 years duration) had separated. X had also lost his job following his contact with the Police. He was admitted informally to the psychiatric hospital for two days. |
| 05 Sep 08 | The neurology centre discussed their findings following an epilepsy review with the psychiatric unit. They said that a surgical intervention for X was unlikely to help him because the focus for his seizures was too diffuse. They thought it possible that another procedure (vagal nerve stimulation) might help and they wanted X to be seen in a specialized clinic in Liverpool. The letter states that X's epilepsy was severe and resistant to many previous drug therapies, resulting in unpredictable seizures that occurred most days. It points out that X lived alone, a fact that poses other risks to health as he was unable to use a cooker due to risk of burns and /or injury. He had also been advised not to have baths alone because of risk of drowning. It reported X as commonly having seizures in his sleep and that he was prone to post-ictal confusion. |
| 11 Dec 08 | X’s mother brought X into the surgery in an agitated state, not having slept for some days; he’d also had an alcohol binge.  |
| 09 Jan 09 | The Neurologist reiterates history in a letter to the Trust; it comments that X is better in company and that he’s now got a cat. |
| 09 Feb 09 | X was admitted informally between 9th Feb and 1st March after being detained briefly on S.5/2 of the MHA. He was noted to be at high risk of suicide. |
| 27 Feb 09  | X was given weekend leave from psychiatric inpatient care as he seemed well. However, he then presented himself to the Police station saying his mother was trying to harm him. As the Police accurately identified that X was unwell, they did not respond in the way that X thought they should; they advised contact with the mental health team. X then travelled to a London Police Station to report the problem again, this time with an offensive weapon (an air pistol) to protect himself. A member of the mental health crisis team helped X to get home, as once released from St Mary’s where the Police had taken him, he had no way to get home and was not certain where he was. It appeared that his behavior related to his seizures. |
| 1 Mar 09 | X reported to Police that he’d found a ring he’d lost the previous week on sale in a gold shop. The shop said they’d had the ring for two months and as X couldn’t describe any of its features the Police did not pursue the matter.  |
| 1 Mar 09 | X went to the counter at the local police station and handed a brown handled kitchen knife to officers. He stated that 'he feared his mother may have used it to threaten him, and he’d therefore taken it from her home address to hand over to the police’. The reporting Officer did not observe any other signs of mental health problems and X was allowed to leave, having given a lawful excuse for possession of the knife. After making further enquiries it became clear that X had taken the knife from his mother's home address but there had been no confrontation or threats. X then apparently decided that the police and the SAS were in league with his mother. A Police National Computer warning marker was placed against his record for weapons. |
| 03 Mar 09 | A MH Act Assessment was undertaken in Swindon. It describes X’s paranoid thoughts regarding his mother whom X thought was trying to kill him for the insurance. He also described in a psychotic manner what he thought was a conspiracy between Hereford Police and the SAS. He was admitted to an out-of-area Psychiatric Intensive Care Unit on S.2 of the MHA between 03.03.09 and 18.03.09 He was described as at a high risk of harm to others. Once again, with treatment, X’s symptoms improved. |
| 14 Apr 09 | (Age 32) X was referred to a Consultant Neurologist at the Royal Hampshire Hospital in Sheffield for another opinion about possible epilepsy surgery which was subsequently deemed too dangerous. The letter also says: "predominantly focused around concerns that his mother is trying to poison him".  |
| 10 Jun 09 | A MAPPA meeting was requested by the psychiatric team according to the NHS record. However, the Police MAPPA administrators do not have a record of X being referred and it appears that no further action was taken.  |
| 8 Jan 10 | X went reluctantly to A&E after a fit |
| 12 Feb 10 | X reported to Police that he’d lost £2000 via a bogus internet transaction (phishing). He also reported that he bought himself an Orange I-phone and an Omega watch which was snatched from him by a white male wearing grey tracksuit bottoms and a grey hoody. However, the items were subsequently found on EBay with X identified as the seller. X was arrested for attempted fraud & wasting police time. He was given a community order and a curfew with a tag. X was not in contact with the Trust at this time, being managed by his GP |
| 10 Jul 10 | Admitted to A&E. Tag noted.  |
| 18 Jan 11 | Psychiatric notes report X as saying there were significant family issues/tensions as allegedly, X’s grandmother was being abused by her daughter (X’s aunt) and was therefore living with X’s mother. A Safeguarding Referral for the grandmother was completed as she was also allegedly being defrauded of money as well. At this time, X was still being supported by a CPN and he was being prescribed prn olanzapine 5mg, which it was suggested should be increased by 2.5mg daily if he found the stress of coping with family issues too much.  |
| 23 Feb 12 | X’s aunt was found dead, apparently having fallen down the stairs. |
| 7 Jul 12 | Family dispute following Aunts death resulted in a Court case and his grandmother was awarded £40,000 for the house. X’s Great Aunt also died. GP note records: `Patient feeling exhausted by family issues and having seizures weekly’. |
| 16 Oct 12 | A lengthy report in the GP notes describes X as having a depressive disorder since his wife left him almost ten years ago for his best friend – who were now married with a child; his mother has severe MS, his aunt died, and there are also problems with his Gran, The only day he looks forward to is Sunday PM which he spends with his mum and gran, a pub lunch then tv at his flat. X was described as calm, and as denying suicidal ideation but the previous admission after an O/D is noted. X talked freely about his problems, including his epilepsy which is upsetting and poorly controlled. The GP suggested counselling. |
| 17 Apr 13 | CPA review with GP.  |
| April 13 | Routine reports of seizures and of presentations with various injuries to A&E as the result of falling. Mother still very unwell with MS. |
| June 2013 | In June 2013, X was discharged from the Recovery Team back to the care of his GP.  |
| 28 Aug 14  | X’s mother phoned the GP, concerned about X’s delusions about being poisoned by her, she wanted to know what was said yesterday... GP explained `I can't discuss his notes with her due to confidentiality and the best thing to do would be for her to get him to make an appt and for her to come too if he wants this.” |
| 09 Dec 14 | The GP decided to refer X back to the psychiatric team. In fact, X was referred to the health psychologist.  |
| 3 Feb 15 | X was reviewed by the psychiatrist from the Recovery Team who described him as well with no paranoia. Still having 4/5 fits per week. |
| Nov 15 | Another trip to A&E after a seizure |
| July 16 | X was admitted to psychiatric hospital informally, complaining of large debts which he was unable to pay, frequent seizures (currently daily), and side effects of multiple medications that cause tiredness, poor concentration and poor memory. X was finding it difficult to manage his own affairs as a result. His mood was low though variable from day to day. He was not currently on any mental health medication.  |
| 16 Dec 16 | GP notes relate discussion with X about the nature of his chest pain – an alleged breathing problem. X seemed prepared to agree that anxiety may have been at the root of this as extensive examination and investigations proved negative. |
| 21 Jan 17 | The GP had a telephone conversation with X regarding what appear to be paranoid thoughts about alien piranha fish with teeth attacking him. These thoughts started yesterday but have now eased off. He had halved his medication (Clonazepam). The GP gave a small dose diazepam to help X over w/e and referred him to `Let’s Talk,’ the counselling service. |
| 21.1.17 | X went to A&E accompanied by a friend feeling as if his heart was slowing down and that he would soon be dead. Said his mother is "spiritual and is sending bad spirits to him" and it would be his mother’s fault if he died. He said he’d phoned the psychiatric hospital and `Let's Talk’ but no-one would help him. He was discharged from A&E and admitted informally to the after assessment by the CAHTT team. However, he left within 24hrs against advice (because he needed to feed his cat). |
| 22.1.17 | X seemed much better the following day and said `couldn’t believe’ he’d had such thoughts about his mother. X said he thought his symptoms related more to his epilepsy than his mental health. |
| 11 Feb 17 – 1st March. S.2 admission for assessment following a 5/4 and a 5/2 | There is a similar pattern: A&E + admission offered but as the bed was in Gloucestershire, X refused (too far from Hereford; his mother couldn’t drive, and the cat needed feeding) A MHA assessment was requested. X was then admitted to psychiatric hospital in Gloucester. During the assessment X rested his hands on his stomach and told them that a spirit was in there. He said the spirits were becoming overpowering and he believed he may not be able to resist their commands in the future. Following discussion about the benefits of coming into hospital for a period of assessment X eventually accepted informal admission.  |
| 13 Feb 17 | A discussion was held with X’s mother about the circumstances of his admission. She reportedly had noticed X seeming a little odd recently and had been concerned about his animosity towards her. She thought his presentation could be due to his medication and his epilepsy. X was worried that his mother was worried about him. Medical Review: X disclosed that at times he was `possessed by spirits and an entity instructs him’ to behave aggressively and to put himself and others in danger. He often does not recall the actual incidents and was apologetic. Staff conclude that X’s psychotic presentation seems to be episodic. |
| 14 Feb 17  | X discloses he is worried about the effect on his mother if he should die |
| 18 Feb 17 | X moved back to Mortimer ward on the psychiatric unit in Hereford where there was now a bed, making it easier for him to get home to feed his cat. |
| 1 Mar 17 | X attended the MDT where he reported that he was enjoying home leave and not experiencing any psychotic episodes. Assessed as Low risk and was discharged. |
| 1 Mar 17 | Mother, very distressed, phoned CAHTT to say she had had a very upsetting phone call from X who sounded psychotic. X was saying that a family member (an ex brother-in-law) had been at his house and was trying to kill him with cyanide. X said his ex brother in law could also communicate with the dead and was formerly a member of the SAS. A home visit to mother’s house was undertaken. She had just returned home from visiting X in his flat. She described him as being preoccupied with the belief that he is being poisoned with cyanide and that if she stayed with him, she would also die. However, X’s mother did not feel that X would harm himself. |
| 13th Feb 2017 | The consultant documented that “on examination, the patient was exhibiting classic symptoms of the controversial Geschwind syndrome (a psychotic condition associated with temporal lobe epilepsy): hyper religiosity, collapse, and pedantic speech with extraordinary circumstantiality (or Viscosity) tend to continue conversations for a long time.’ |
| 22 Feb 17 | X’s diagnosis was recorded in the notes as F239 Acute and transient psychotic disorder, unspecified, secondary to complex bilateral temporal seizure. A comment was added that X had `a history on noncompliance with medical treatment and regimen’. |
| 1 Mar 17 | The Crisis Team nurse requested a MHA assessment and then visited X’s flat later that evening with the AMHP. He was much calmer by then. The nurse observed X take his medication. He was pleasant and relaxed throughout. However, he was guarded with regards to paranoid thoughts. A MHAA was not thought to be necessary and arrangements were made for X to be visited at home by the crisis team. |
| 2 Mar 17 | The Crisis team nurse discussed X’s case with the On-Call Consultant Psychiatrist and Medical Director. It was concluded that X’s symptoms were `not consistent with a typical psychotic process, organic or not. I note that all risks of concern are historical and there have been no significant incidents in the last 9-10 yrs’. |
| 2 Mar 17 | A home visit by the crisis team nurse revealed that X had not disclosed that he was hearing 3 voices, helpful and unhelpful. One had told him to jump off cliffs. He admitted to having hallucinations and believed people on the TV were are talking about him and controlling him. He was also experiencing suicidal thoughts. Staff removed a bag of old medication for safe keeping. However, X continued to believe there was cyanide in the flat and this was affecting the cat. Staff and patient were not sure if he experienced a seizure and was post-ictal. |
| 3 Mar 17 | A telephone call from X to the crisis team was made, during which X said that spirits/demons had entered him. He had apparently not wanted to disclose this when on the ward as he had wanted to go home but the situation was getting difficult for him now. |
| 5 Mar 17 | X recorded as now much better. |
| 7 Mar 17 | X presented in A & E again, complaining of (probably) anxiety-related chest pain and breathing problems. The Police were involved as X was disruptive and had damaged equipment. They took him to the S.136 (place of safety) suite. His symptoms, when assessed, were thought to relate to epilepsy rather than to an ongoing mental health condition. |
| 8 Mar 17 | X had an appointment with his Neurologist. X reported that since changes to his epilepsy medication he has had more psychotic episodes. However, the Neurologist did not think this was the case, and she did not think the episodes were due to a psychotic illness either. The Neurologist suggested that he might have a Personality Disorder and a reduced dose of Clozanepam was reinstated. Notes on the patient record state that there is still confusion about the cause of the patient’s symptoms and risks and unmet needs still exist which are unexplained if not due to psychosis. Mental health staff do not think patient has a PD |
| 9 Mar 17 | The crisis team met to consider X’s case and they noted some personality changes that might be due either to active epilepsy or the effect of withdrawal of Clonazepam. |
| 14 Mar 17 | A note in the GP record describes X as coming in very agitated and angry that his problems don’t appear to be being sorted out. In particular, his chest tightness and breathing difficulty /choking which has happened several times. The GP record describes that X has been advised to restart Clonazepam but X was very reluctant. X was reported as feeling that no-one is listening to him & he became very agitated. The GP had to ask a colleague to help and X was persuaded to go. He eventually left the waiting room after an hour. A note was added to the record to say that he should not be seen alone.  |
| April 17 | Support from CAHTT continued. Referral to recovery team not thought appropriate. X seems calmer.  |
| 12 May 17  | GP note reports X to be hearing voices instructing him to perform a list of tasks to prevent harm to his Nan. `He seemed calm - and I don't believe is a risk to himself or others -- but I think needs reviewing by the MHT -- I will write.’ `Don't think need to initiate any treatment in the meantime -- but suggest he contact us again as necessary. |
| 9 Jun 17 | Police were called to Hereford A&E where X was causing a disturbance, being disruptive and shouting. Upon arrival, X was lying on the floor on his front, face down, stating that "Any minute now, this will be my last breath….I’m dying from the toes up. My legs are dying". Medical staff had seen X multiple times and deemed him physically fit. He was detained under S136 of the MHA. |
| 26 Jun 17 – 6th July S.2 | X was referred back to mental health team by GP who reported X as having abnormal feelings of being controlled by others and hearing voices threatening him and directing him, with persecutory and derogatory perceptions and death threats. X said he was being controlled by wireless technology, which was also controlling his Nan and his Mother and threatening family life. He was detained at Stonebow on S2. Psychiatrist requested JN to be reviewed urgently by the neurologist for decisions on future management plans and to assist the mental health team in referring him to a specialist neuropsychiatric centre. Advice was also requested re anti-epileptic medication. At the end of this month, his risk rating was recorded as HIGH. |
| 28 Jun 17 | X informed staff that he had stopped taking his meds prior to this admission as he didn’t feel it was helping. He was annoyed at being admitted and was planning to appeal. |
| 6 Jul 17 | X was taken off his Section but remained as an informal patient. It was noted that X had not had a confirmed seizure for over 6 months. |
| 10 Jul 17 | X was discharged from psychiatric hospital but then went straight to the Police station to report he was being controlled by electrical devices. He was detained again on a S.136. He said he could not disclose this to medical professionals as only the police could investigate it. He believed that if he told ward staff he would not get leave or be discharged. X reported that his mind (and the cat) were being controlled by people through extreme technology or microwaves in the form of electrical neural harassment which could inflict pain and control other’s minds, instigated by his Uncle (who used to be in the SAS) and his Uncle's daughter. He expressed concerns about his mother's and grandmother's safety due to the people controlling him. Police took him back to Stonebow. However, both the AMHP and the assessing doctor agreed he did not need an admission. It was agreed that X would receive support from the crisis team (CAHTT) starting the following day. During the assessment X denied that voices were telling him to harm himself or others. He said that the voices did not concern him as they were not continuous. He was willing to engage with the CAHTT. The report states X appeared to have "good insight" into his illness – although this is contradicted in other notes which describe X as very reluctant to believe he had a mental illness. The Risk assessment stated he was at medium risk of deterioration without support. He was described as at low risk of self-harm or suicide and aggression. In the section of the form entitled `risk to others’ it said: `No known risk to others’. X was described as presenting as calm and cooperative during the assessment. |
| 10 Jul 17 | Notes report that in the early hours JN had placed a letter through his neighbour’s letter box accusing the occupant of playing mind games with him. |
| 18 Jul 17 | X’s diagnosis recorded as F062 Organic delusional (schizophrenia-like) disorder. |
| 21 Jul 17 | X’s MHA detention was changed to S.3. The assessment outlines a discussion with X’s mother who said there was some substance in some of what J said about family members. For example, X’s father had had a relationship with her sister. The sister (X’s aunt) died 6 years ago in what the Coroner called suspicious circumstances. Also, X’s uncle (BC, former armed services) was genuinely angry with X’s mother, blaming her for `failing to keep her husband under control’ after an affair with his wife, and he had behaved in a threatening manner. X believed his uncle to be employing 20 people at £20 per hour to provide round the clock surveillance of him. Then, Police became involved when someone shot at X’s mother and she also moved home after someone stalked her. X’s Great Uncle was also allegedly frightened of X’s uncle.  |
| 7 Aug 17 | Some improvement was noted. X described his mood as improved due to contact with his family and a family meal. He planned to spend time with Mother on her birthday. |
| 12 Aug 17 | Home Visit – Crisis team reported X to be experiencing less interference from his neighbours. However, X was reported as continuing to be at Medium risk due to historic incident of attack on staff. It was reported that his illness fluctuated rapidly and is affected by seizures which are difficult to predict. The diagnosis was recorded in the notes as paranoid schizophrenia.  |
| 7 Nov 17 | X attended A&E by ambulance believing his organs were being shut down by remote control and feeling unable to walk or stand due to `a remote attack ‘. His Mum and Gran were in attendance. It was noted by the Crisis Team that X appeared `a little brusque and was irritable towards his mother, but there was no hostility’ |
| 8 Nov 17 | In A&E again for the same reason. CAHTT team visited X at home. X was described as clearly still deluded but not expressing hostile thoughts. `He is close to mother and speaks on the phone every day and sees her several times per week’. |
| 12 Nov 17 | Long phone call between staff and X’s mother about X; she was worried about his panic attacks and finds it difficult to know what to do; she said X firmly believes his life is in danger and that he is becoming more unwell though lack of sleep, which she thought a key indicator of relapse. The crisis team discussed X’s current diagnosis of schizophrenia and what she could do to help X relax. She reported that X’s uncle was in the SAS and was a lock picker so he may have accessed X’s flat at some time (as reported by X). X was also recorded as being unwilling to take more medication because of the side-effects  |
| 16 Nov 17 | Police record shows X complaining about the allegedly noisy neighbour again, which the neighbour denied. |
| 20 Nov 17 | Police record shows X phoning them to say his mind was being controlled. X was admitted to psychiatric hospital later that day for a month. X said that there was a machine/military control device controlling his body and his mind that could cause a heart attack, suffocation and render people unconscious. This was especially dangerous to weaker people like his mother and nan. The technology, he thought, had been stolen from the Government by his uncle. The machine was also affecting his cat. X wanted to leave the ward and report everything to Police. The Consultant’s summary describes X as agitated and pacing, writing many notes about the threats he perceived to himself and his family from his uncle and the machine. However, medication appeared to be effective after a few days and he was allowed unescorted leave. X’s diagnosis as this point was given clearly as paranoid schizophrenia. Correspondence indicates that X only engaged sporadically with the Crisis team and had halved his epilepsy medication against advice (although he had not had a seizure for some time), believing that he didn’t need it. Notes suggest X lacked insight into his psychosis. Even with treatment, X says that `the paranoid thoughts are still somewhere at the back of my mind’. |
| 22 Nov 17 | The Psychiatric Unit requested the attendance of a Police Officer to assist in talking with X about his delusion that the SAS were coming after his family.  |
| 29 Nov 17 | Unescorted leave was agreed |
| 6 Dec 17 | MDT record states X was less preoccupied, less agitated, and that his mental state was improved. The team notes X to be using periods of unescorted leave to good effect. Meds are settled and no seizures reported for a long time. |
| 12 Dec 17 | X disclosed to staff that he was feeling better able to control his thoughts about mind control and worries about his family. He acknowledged he had been ill in the past and was looking forward to spending more time with his family especially his Nan as he believes other members of the family are manipulating her. |
| 13.12.17 | A discharge summary sent by the Consultant describes X’s medication as Diazepam 5mg bd, Lacosamide 250mg bd, Lamotrigine 300mg bd, Clonazepam 0.5mg od, Zopiclone 7.5 mg od, and phenobarbitone 30 mg od. |
| 13 Dec 17 | At the Discharge Planning Meeting, a clear plan was agreed although X did not attend as he was late back from home leave. It was noted that X had shown some significant improvements. Although delusional thoughts were still present, they were not as overpowering and X reportedly felt he could cope. On his return, X agreed with the plan and he appeared bright and sociable. |
| 14 Dec 17 | A copy of the Section 17A Community Treatment Order (CTO) form was signed by the Consultant (the Responsible Clinician) on 07/12/2017, by the AMHP on 14/12/2017 and countersigned by the consultant who commented: "X is a 40 year old divorced unemployed gentleman diagnosed with bitemporal epilepsy and paranoid schizophrenia. When unwell he believes that his aunt's former husband who is a former SAS soldier is actively trying to murder him using a secret machine built by the SAS to control his thoughts and body. He also believes that his family are in danger from that man. He reported it to the Police. this one is his 4th admission this year and he has been non-adherent to medication in the past despite stating his wish to comply at the point of discharge from hospital. Without treatment he is likely to relapse and make himself vulnerable by alerting the Police, attending A+E and his level of functioning deteriorates further. He needs the CTO to maintain therapeutic contact and to deliver depot medication. His insight is partial at the best’. The consultant imposed the following conditions: 1) X will take medication as prescribed 2) X will attend appointments with the community psychiatric services. |
| 18 Dec 17 | Police were called to Hereford City Centre after a complaint made by Costa Coffee. Report states X had been discharged from the psychiatric hospital earlier that day and had gone to Costa Coffee in High town Hereford. Staff had called Police as he was telling everyone he was coming into millions and was handing out £20 notes. He had tried to give the staff a large tip, and when they refused to take it, he started shouting. Police attended and following discussion with them X left to go to his mother's house. Police spoke with X, X’s mother, who agreed to contact X’s mental health workers as she felt his mental health was deteriorating again. This was reviewed by Hereford MASH (Multi-Agency Safeguarding Hub) and a referral was forwarded to Adult Social Care and Mash nurses. Stonebow staff spoke to X on the phone – he was very loud and stated everything was fantastic. However, he thought he was still being bugged by SAS and did not need his depot medication as agreed. |
| 21 Dec 17 | X was reported as `not feeling right’ following 48-hour follow up by the crisis team. He was still reporting feeling controlled by a computer system invading his body and causing his brain to shut off when watching TV. He believes something may have happened to him.  |
| 22 Dec 17 | X was escorted back to the ward and subsequently he was taken on escorted leave to visit his mother and grandmother. X disclosed to staff that he was being controlled by computers that have been taken illegally from SAS. X was concerned that his mother would be in danger on Christmas Day. He did not believe these thoughts were part of a mental illness. |
| 26 Dec 17 | J had 4 hours of home leave alone, which went well.  |
| 3 Jan 18 | MDT meeting reports that J is still unwell.  |
| 4 Jan 18 | Mother’s cat died yesterday – X feeling sad |
| 5 Jan 18 | A medical review was completed as X was requesting discharge. He appeared well and was not expressing any psychotic thoughts but not all staff were convinced he was well enough to return home. |
| 7 Jan 18 | Home leave went well |
| 8 Jan 18 | ditto |
| 9 Jan 18 | X requested home leave until 9pm which as agreed following a full risk assessment during which he disclosed no abnormality of thought. Later, an elderly woman (72 yrs) reported a male to Police. He had been in a Taxi and he stopped as she was posting mail, offering her £20 to take a photograph of him, the taxi driver and the post box. She declined but thought the incident suspicious, so she reported it to Police. At 17:50 hrs X was seen standing at the side of the road in Hereford (it was dark). As a motorist approached in a Vauxhall campervan he stepped out into its path, suffering a significant head injury. He was sedated and taken to the QE hospital in Birmingham. At about 7pm that night, Police tried to contact X’s mother to inform her as next of kin but there was no reply. At 22:20 hrs officers returned to X's mother’s home to make further attempts to contact her. An officer checked at a rear window and saw her lying on the kitchen floor with her head covered by a yellow towel. The side gate to the property was open but all doors were locked. She had been stabbed and 2 knives were found. Police later went to X’s flat and found his cat, also dead due to strangulation. The ward learned of this from X’s uncle, whom the Police had called about the RTA. |
| 10 Jan 18 | At 17:19 hrs on Tuesday 10th January 2018 at the QE Hospital X was arrested. After being cautioned he stated, “I love my mum so much and I would never do anything to harm her ever” A few minutes later he stated, “She was the most peaceful and beautiful person on this planet, she would never harm a fly and would do anything for anyone”. Police came to Mortimer ward requesting to search X’s room and several files of writing were removed |
| 13 Jan 18 | X was charged and remanded. A member of the crisis team who knew X very well acted as Appropriate Adult. X seemed calm and was not distressed but he was floridly psychotic in his beliefs about his uncle, the SAS and their mind control machine. X thanked member of staff for their support during the day. |
| 02 Jul 18 | X appeared in Court (not by video link) but it was reported that he said little.  |
| 06 Aug 18 | X was transferred to a medium secure unit on S. 48/49 with a recommendation that this be converted to a S. 37/41. The note suggests that X was again refusing medication. |
| 29 Nov 18 | X was given a hospital restriction order (Section 37/41). X was found to be responsible for the death of his mother after being deemed unfit to plead due to his mental ill health. The Court heard that X had recorded a message on his iPhone to say that he didn’t want to, but he was ending his own life, his cat’s life and the life of his mum to end their nightmare. `The last thing I would ever want to do is harm anyone’ but he wanted ` to take us all to a more comfortable happy place’. He was remanded to prison. |
| 6 Aug 18 | X was transferred to medium secure care on Section 48/49 of the MHA. |
| 26 Nov 18 | The Crown Court heard the case against X in his absence as he was deemed unfit to plead and he was found guilty of manslaughter with diminished responsibility due to mental ill health. Care continues to be provided for X in a medium secure facility under S. 37/41 of the MHA. His medication currently includes Risperidone 2mg bd and he remains on Level 4 observations owing to the risk of suicide. X also continues to have 8-10 seizures per month. The clinical team consider that X shows co-morbidity (post-ictal psychosis as well as schizophrenia) and that his clinical presentation remains much the same as previously. |

1. Gloucestershire Health and Care NHS Foundation Trust was formed in October 2019, following the merger of 2Gether NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust. [↑](#footnote-ref-1)
2. NHS England Patient Safety Domain (2015) `Revised Serious Incident Framework: Supporting learning to prevent recurrence.’ www.england.nhs.uk/patientsafety/ [↑](#footnote-ref-2)
3. Gloucestershire Health and Care NHS Foundation Trust was formed in October 2019, following the merger of 2Gether NHS Foundation Trust and Gloucestershire Health and Care NHS Foundation Trust. [↑](#footnote-ref-3)
4. Section 37 of the Mental Health Act is used by the Crown Court to ensure that someone is detained in hospital for treatment. Section 41, used if the patient represents a risk to the public, restricts the patient from leaving. A patient can appeal to Hospital Managers and the Mental Health Review Tribunal (MHRT). The Secretary of State for Justice (the Ministry of Justice) decides after hearing recommendations when a patient may leave or be discharged from these Sections. [↑](#footnote-ref-4)
5. The Salmon Principles are six requirements set out under the Tribunals and Inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations. This investigation was not judicial, and solicitors were not involved in the investigation process. [↑](#footnote-ref-5)
6. A Court may subpoena witness statements in certain circumstances. [↑](#footnote-ref-6)
7. Haloperidol is an antipsychotic drug. [↑](#footnote-ref-7)
8. Lamotrigine is used alone or with other medications to prevent and control seizures. [↑](#footnote-ref-8)
9. A CTO is part 17A of the Mental Health Act. It allows a patient to leave hospital and be treated in the community. However, adherence to certain conditions (such as compliance with medication or other treatment) is necessary and a patient can be recalled to hospital if these conditions are breached. [↑](#footnote-ref-9)
10. Diazepam is one of the family of benzodiazepine drugs and it has a calming effect. [↑](#footnote-ref-10)
11. The British National Formulary the UK pharmaceutical reference book containing information on prescribing, doses and facts about medication used within the NHS. [↑](#footnote-ref-11)