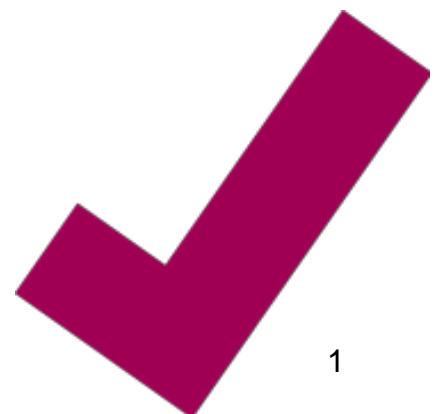




**An independent
investigation into the
care and treatment of
a mental health
service user (S) in
Liverpool**

July 2017



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

The independent investigation team would like to offer their deepest sympathies to the family of S. It is our sincere wish that this report does not contribute further to their pain and distress.

This report was commissioned by NHS England and cannot be used or published without their permission.

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1 Executive summary

- 1.1 On the morning of 19 September 2014 S told his ex-partner that he had killed his parents, and she then called the police. He later made his way by bus to the Scott Clinic.
- 1.2 S was taken into police custody at the entrance lobby of Scott Clinic and was brought to St Helens Police Station where he was interviewed by two Mersey Care NHS Trust consultant forensic psychiatrists. S was admitted from police custody directly to a secure mental health hospital and was detained under Section 3 of the Mental Health Act. He was assessed as extremely psychotic and thought disordered.
- 1.3 NHS England, North commissioned Niche Patient Safety (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (S). Niche is a consultancy company specialising in patient safety investigations and reviews.
- 1.4 The terms of reference for this investigation include a report on quality and governance processes regarding key themes identified from this and previous homicides involving service users of the forensic services at the Scott Clinic, operated by Mersey Care NHS Trust ('the Trust' hereafter). The full terms of reference are at Appendix A.

The independent investigation follows the NHS England Serious Incident Framework¹ (March 2015) and Department of Health guidance (94) 27² on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005.

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

- 1.5 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning. The terms of reference for this investigation included a report on quality and governance processes regarding key themes identified from this and previous homicides involving service users of the Scott Clinic.
- 1.6 The investigation process will also identify areas where improvements to services might be required which could improve quality and help prevent similar incidents occurring. This investigation will also review and comment on changes that have been made in the Trust as a result of learning from previous incidents.

¹ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

² Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services

- 1.7 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.
- 1.8 The investigation team would like to express our sincere condolences to the family of S.

S's mental health history (Overview)

- 1.9 S was diagnosed with paranoid schizophrenia in 1994, after being transferred from prison to the Scott Clinic, which is the inpatient secure forensic mental health service run by Mersey Care NHS Trust in Liverpool. His behaviour was noted to be increasingly bizarre. He spent four months as an inpatient and was treated with antipsychotic medication before returning to prison. There were seven admissions to the Scott Clinic between 1994 and 2003, and S was discharged to the care of the Forensic Integrated Resource Team (FIRT) in 2003. This was the community forensic service which offered aftercare following discharge from the Scott Clinic.
- 1.10 S was admitted to the Scott Clinic in June 1995 under Section 2 of the Mental Health Act 1983³ (MHA), which was converted to Section 3 MHA⁴, and he spent less than a month in hospital. His third admission was in August 1995 after assaults on his parents, remaining under Section 3 MHA for four months.
- 1.11 His fourth admission in February 1996 under Section 3 MHA was after he had become increasingly bizarre, and had stabbed his grandmother's dog to death. On this occasion he was treated with depot medication, and was discharged in August 1996 under a supervised discharge order.
- 1.12 S was settled in the community for the following two years, and had three further informal admissions to Scott Clinic. He requested that he stop his depot medication in March 1999 and was admitted after this. At this time there were doubts about his compliance with oral medication, and he had been using cannabis and alcohol more regularly. He was discharged after three weeks. There was a further informal admission in July 1999, when he asked to be admitted saying he was dangerous, and said he was afraid he would attack his parents. He was discharged in September 1999, and was still subject to the supervised discharge order until August 2000. His last admission was in January 2003, after his mental state appeared to deteriorate. He was discharged after eight days and his Olanzapine⁵ was increased to 30 mg per day.

³ *The Mental Health Act 1983 is an Act of parliament which applies to people in England & Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters.*
<http://www.legislation.gov.uk/ukpga/1983/20>

⁴ *Section 3 MHA 1983 Admission for assessment.* <http://www.legislation.gov.uk/ukpga/1983/20/section/3>

⁵ *Olanzapine is an antipsychotic medication that affects chemicals in the brain. Olanzapine is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression) in adults.*
<http://www.drugs.com/mtm/olanzapine.html>

- 1.13 From 2003 S lived in the community with mental health and housing support provided by Imagine⁶ under the care of the FIRT, which was called the Forensic Outreach Service (FOS) in 2015. His diagnosis of paranoid schizophrenia did not change from this time, and he had a complex delusional belief system in which he believed his parents had harmed him as a child. He experienced auditory hallucinations and had a belief that there was a prophecy which would lead to him killing his parents. This was known to services and his parents, and was regularly discussed with him by professionals in his care team.

Family

- 1.14 S has two brothers, both of whom lived locally and had regular contact with him. S's parents lived nearby, and he saw them regularly.
- 1.15 S has four children, and he had recent contact only with his youngest. His youngest child was born in April 2012, and although the relationship with the mother ended, he had regular unsupervised contact and care up until September 2014.

Sentence

- 1.16 On 16 March 2015 at Liverpool Crown Court S was found guilty of manslaughter on the basis of diminished responsibility. Imposing an indefinite hospital order at a secure mental hospital the judge, Mr Justice King, QC, said: *'It is highly unlikely that Mr S will be released, if at all, for many many years.'*

Internal Investigation

- 1.17 Mersey Care NHS Trust undertook an internal investigation that has been reviewed by the investigation team.
- 1.18 The internal investigation for the Trust was chaired by a Non-Executive Director of the Trust, and had input from senior professionals from the Trust and a neighbouring Trust, NHS England specialised commissioning team, Liverpool City Council, and a service user representative. It was agreed by the Trust and Liverpool City Council that the internal report would also be regarded as a single agency domestic homicide review report.
- 1.19 The internal investigation made 17 individual recommendations, which were then clustered into 8 expected outcomes, with 44 component parts.

Independent investigation

- 1.20 This independent investigation has drawn upon the internal process and has studied clinical information, police information, witness statements, interview transcripts and organisational policies. We also interviewed clinical staff who

⁶ Imagine is a charity that provides range of housing support. <http://www.imaginementalhealth.org.uk/index.php>

had been in contact with S, and senior staff from the Trust and the supported housing support provider.

- 1.21 We met with S to give him an opportunity to contribute to the report, and he gave us his view that he believes he was unstable and should have been 'sectioned' the day before the homicides.
- 1.22 S's brothers met with us and gave us their view that S should have been monitored more closely, and that he should have been 'sectioned' the day before the homicides.
- 1.23 We find that the recommendations made in the internal report did address the contributory factors found through the investigation.
- 1.24 The recommendations from our independent investigation focus on the improvements that we consider should be made across the system.
- 1.25 It is our view that the homicide of S's parents was certainly predictable but was not preventable. However, a more assertive model of care may have alerted services earlier to a change in S's condition which may have led to an earlier response from the FIRT.
- 1.26 We have reviewed the literature on parental homicide (parricide) by patients with schizophrenia and have drawn out some issues for services to consider when managing risk to family members.
- 1.27 We have noted the considerable changes in internal quality governance the Trust has made, particularly since applying to become an NHS Foundation Trust. These processes have been independently assessed. The organisation and its services are now significantly focussed on the governance of quality, with robust processes to assure the organisation that the services it is delivering are of the requisite quality. The Trust is also developing a culture of continuous improvement, and partnerships with other organisations to foster this.

Good Practice

We wish to highlight the following areas of good practice:

- 1.28 The communication between Imagine and the FIRT team was of a very good standard. There was a formal system for sharing information, in weekly updates to the FIRT team, and regular contact by phone and in person.
- 1.29 The communication with social services was also of a good standard, with regular communication and updates sent by the FIRT, and attendance as required at relevant meetings.
- 1.30 Engagement of and communication with S's family after the homicides.

Recommendations

1.31 We have made 12 recommendations.

Recommendation 1:

The formulation of HCR 20 risk assessments in the secure services should be aligned to best practice principles and there should be a quality assurance structure to audit the quality of risk formulations and management plans and ensure they are in line with HCR 20 Version 3 Guide

Recommendation 2:

The planning of victim safety in partnership with individuals concerned, especially where this involves a family member or partner, must form part of the core risk assessment and treatment planning

Recommendation 3:

Ongoing contact with family members or partners must form part of the core risk assessment and care planning by the care coordinator

Recommendation 4:

Where there is a question of responsibility for the welfare of a child, specific focussed risk assessments must be conducted with respect to risk towards the child, in conjunction with other statutory agencies

Recommendation 5:

There should be a robust risk assessment of lone workers in the community, including any pregnant staff, and risk management plans applied

Recommendation 6:

There should be a programme of training for Section 12 doctors and AMHPs on risk assessment in forensic patients, focussing on both the nature and degree of mental disorder

Recommendation 7:

There should be a Trust wide policy on prescribing high dose antipsychotic medication which includes standards for auditing, which should be in line with the Royal College of Psychiatrists guidelines

Recommendation 8:

An audit of the usage of depot medication in the Secure Division should be carried out and anomalies addressed

Recommendation 9:

Liverpool Clinical Commissioning Group and the Trust should ensure that there is a joint approach to physical health checks, and information sharing between GPs & mental health services regarding results of health checks

Recommendation 10:

The Trust should audit compliance with NICE guidelines CG178: Psychosis and schizophrenia in adults: prevention and management, within the Secure Division and implement findings

Recommendation 11:

The Trust should provide quality performance information on services that consistently appear in the top five or other agreed quantity of quality indicators for two or more quality indicators to systematise the triangulation of performance information.

Recommendation 12:

The Trust should ensure that care plans for patients with schizophrenia who are assessed as at risk of harming family members incorporate learning from the evidence on parricide

2 Introduction

- 2.1 S lived in supported housing in Liverpool. In September 2014 he was 47 years old. He had a long history of mental illness, but lived independently with 'floating support'. He was studying music at college, and had an ongoing interest in composing and playing music. He enjoyed visiting auction houses, and attended these with family, often buying furniture and curios. Latterly he spent time looking after his two year old child, and was very involved in their upbringing.
- 2.2 S had called the Scott Clinic on the morning of 18 September 2014, saying he couldn't sleep. A medical review was conducted that day by Dr A, consultant forensic psychiatrist, a Social worker and CPN, and he was regarded as not detainable under the MHA, but a follow up plan was agreed where he was to be seen again later that day, and the following morning.
- 2.3 Early on the morning of 19 September 2014, S went to his parents' house and stabbed them to death. He then went to the home of his ex-partner's mother, and saw his ex-partner and his child. He was described as agitated, and told his ex-partner that he had killed his parents, then left to take a bus to the Scott Clinic. She phoned the police.
- 2.4 Police attended the Scott Clinic and S was arrested on suspicion of the homicide of both his parents, and was taken into police custody.
- 2.5 S was assessed under the MHA 1983⁷ soon after his arrest. He was found to be experiencing a number of psychotic symptoms including auditory hallucinations, ideas of reference, and delusional beliefs that a spaceman had taken over his body.
- 2.6 It was agreed that he be transferred to a high secure hospital, because of the potential risks he may pose to himself and others, and he has remained there.
- 2.7 S pleaded guilty to manslaughter on the grounds of diminished responsibility. On 16 March 2015 at Liverpool Crown Court S was found guilty of manslaughter due to diminished responsibility and detained under Section 37/41⁸ of the MHA 1983.

⁷ The Mental Health Act 1983 is an Act of parliament which applies to people in England & Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters.
<http://www.legislation.gov.uk/ukpga/1983/20>

⁸ Powers of courts to order hospital admission or guardianship. (1)Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law. Power of higher courts to restrict discharge from hospital (1)Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section; and an order under this section shall be known as "a restriction order".

3 Independent investigation

Approach to the investigation

- 3.1 The independent investigation follows the NHS England Serious Incident Framework⁹ (March 2015) and Department of Health guidance (94) 27¹⁰ on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix A.
- 3.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents.
- 3.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning. The terms of reference for this investigation included a report on quality and governance processes regarding key themes identified from this and previous homicides involving service users of the Scott Clinic.
- 3.4 The investigation was chaired by Nick Moor, Director of Niche. The investigation team comprised of Carol Rooney, Senior Investigations Manager and report writer; Dr Huw Stone, Consultant Forensic Psychiatrist. Specialist advice was sought from key professional experts in safeguarding, housing and the Mental Health Act. The investigation team will be referred to in the first person plural in the report.
- 3.5 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.¹¹
- 3.6 The independent investigation team would like to offer their deepest sympathies to the family of the victims. It is our sincere wish that this report does not contribute further to their pain and distress.
- 3.7 We would also like to thank the family for their contribution to our investigation. We acknowledge how hard it must have been for them in this tragic situation.
- 3.8 We have used information from S's clinical records provided by Mersey Care Trust, Imagine Mental Health¹², and the GP practice where S was registered.

⁹ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

¹⁰ Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services

¹¹ National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services

¹² Imagine is a charity that provides range of housing support. <http://www.imaginementalhealth.org.uk/index.php>

- 3.9 We reviewed S's clinical records in his current hospital, and also used information from Merseyside Police, including the police case summary.
- 3.10 A profile of the Trust is at Appendix B and a list of documents accessed and reviewed is at Appendix C.
- 3.11 We conducted a telephone interview with S's GP, the AMHP who assessed S in January 2014, and an Imagine support worker.
- 3.12 We had a telephone conversation about the issues with the Head of Quality/Chief Nurse and the Clinical Quality & Safety Manager of Liverpool Clinical Commissioning group (CCG).
- 3.13 As part of our investigation we held two workshops with:
- clinical staff who had provided care for S before and during 2014, to review his care and treatment during the previous year. Through this process we developed a timeline of events, focussing in detail on the events preceding the 19 September 2014 and
 - senior staff responsible for investigating events of September 2014, and for implementation of the subsequent action plan.
- 3.14 We interviewed the following staff individually:

Mersey Care NHS Trust

- Executive Director of Nursing
- Director of Risk and Safety
- Medical Director and Executive Director of secure services
- Director of Operations
- Deputy Director of Operations
- Director of Patient Safety
- Associate Medical Director for Secure Services
- Head of Quality Improvement and Innovation
- Social Care Strategic Lead
- Forensic Nurse Consultant
- Consultant forensic psychiatrist who was previously the Clinical Director responsible for FIRT
- Consultant forensic psychiatrist who was S's responsible clinician (RC) from 2000 to 2013
- Consultant forensic psychiatrist who was the main internal report author
- Consultant forensic psychiatrist who is now responsible for the Forensic Outreach service (FOS)
- Forensic Outreach Services Manager

Imagine

- Deputy CEO

- 3.15 Where these interviews were recorded they were transcribed (with the exception of telephone interviews). The transcripts were returned to the interviewees for review and signature.
- 3.16 We attended a variety of management and quality assurance meetings at the Trust and Forensic Outreach service. (list of these and documents reviewed is at Appendix C)
- 3.17 We wrote to S at the start of the investigation, explained the purpose of the investigation and asked to meet him. S gave written consent for us to access his medical and other records. We met with S in hospital, and he gave us his view that he believes he was unstable and should have been 'sectioned' the day before the homicides. We offered him the opportunity to meet with us again to discuss the report prior to publication.
- 3.18 The draft report was shared with S and he made no comments to us.
- 3.19 We met with S's two brothers who were supported by their legal advisor. We were given their views that S should have been monitored more closely, and should have been sectioned when he was assessed on the 18 September 2014. They also wanted to know why he had been allowed to keep a dog, when he had previously killed a dog, and why he was allowed to keep swords in his flat.
- 3.20 The draft report was shared with family, who made no comments to us.
- 3.21 The draft report was shared with all identified stakeholders prior to publication. This provided an opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed to review and comment upon the content.

Structure of the report

- 3.22 Section 4 sets out background of the care and treatment provided to S. We have provided a summary of care up to 2013, and covered in detail his care and treatment from December 2013 to September 2014.
- 3.23 Section 5 examines the issues arising from the care and treatment provided to S and includes comment and analysis, with reference to the terms of reference for the investigation.
- 3.24 Section 6 provides a review of the trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.
- 3.25 Section 7 contains a review of the assurance structures in place and actions taken to learn lessons from previous homicides.
- 3.26 Section 8 sets out our overall analysis and recommendations, and comments on predictability and preventability.

4 The care and treatment of S

Childhood and family background

- 4.1 S was born in Cheshire, and his birth and early development have been described as normal. The family moved to Australia and South Africa before settling in Liverpool.
- 4.2 There were said to be no concerns about S until he started school in Huyton, where he experienced bullying and became involved in petty crime. He was seen by an educational psychologist in his teens before being expelled from secondary school because of his behaviour. It was reported that he regularly used cannabis, amphetamines and alcohol.
- 4.3 S's parents lived locally to S, and saw him regularly, with his mother described as his carer. S is the oldest of three sons and both of his brothers lived in Liverpool and had regular contact with S and with their parents.

Relationships and children

- 4.4 S has four children. The eldest two were with a previous partner, and are now adults, and S had no known contact with them.
- 4.5 S was quite involved in his middle child's upbringing and there were times when he had unsupervised care. Her mother took the child to Ireland in 2009 and then told him she wasn't returning.
- 4.6 S had a relationship with another woman H, whom he had known since they were teenagers. It later became clear that this was a very important relationship to him, and beliefs about her were incorporated into his delusional system. With hindsight the significance of the relationship was not fully understood by staff treating S. S had a view that his parents were seeking to keep him apart from H. H became pregnant in 2011, and their child was born in April 2012.
- 4.7 S moved house in November 2013, to a flat also supported by Imagine.
- 4.8 S had agreed to abstain from alcohol and cannabis if he was looking after the child. There were times that S had the child to stay for several days.

Offending and contact with criminal justice systems

- 4.9 S has convictions for wounding and possession of weapons in 1984, 1986 and 1987. He was imprisoned for 18 months in 1986 for malicious wounding, with a further conviction for wounding in 1992.
- 4.10 He was sentenced to four and a half years in March 1994 for the stabbing of a girlfriend's father and brother, and his presentation in prison precipitated his transfer to the Scott Clinic under the MHA. After a period of treatment he was transferred back to prison.

- 4.11 It is reported that he attempted to assault his father with a knife in June 1995. In July 1995 there were two recorded allegations of separate assaults on his parents; he punched his mother twice in the head in a park, and about a week later, head butted his father. There were no criminal charges, although his parents did attend a police station in a distressed state with visible injuries. S was admitted to Scott Clinic on 1 August 1995 under Section 3 MHA.
- 4.12 Police records note that there are ‘other motoring offences & shoplifting.’
- 4.13 The following four offences occurred while under the care of the FIRT.
- 2000 drink driving and battery
 - 2009 drink driving and possession of cannabis
 - 2009 drunk and disorderly
 - 2012 domestic disturbance in which he assaulted his partner (alcohol related)

Mental health history and treatment

- 4.14 S’s first contact with mental health services was in 1994, during a prison sentence for stabbing his then girlfriend’s brother and father. There are no details in the records we saw regarding the circumstances of this offence, and it is also recorded that he stabbed his girlfriend. Whilst at HMP Frankland he described believing that he was at risk from the Irish Republican Army (IRA), that the IRA had been the cause of his elder brother’s cot death, and that his drink had been spiked with amphetamines. The transfer to the Scott Clinic¹³ under Section 47/49 MHA¹⁴ was triggered by an attack on another prisoner. It appears from the records that this attack was prompted by his delusional beliefs about the IRA.

First admission to Scott Clinic

- 4.15 During this first admission to the Scott Clinic S was noted to be hallucinating and responding with inappropriate giggling. His parents had contact with the care team and were caring and involved, with no concerns expressed about their son. S was treated with an oral antipsychotic medication, Stelazine.¹⁵ His mental state improved to the extent that community escorted leave was applied for and used successfully. He was transferred back to prison in January 1995. It was felt that his mental state had improved, but he was aggressive towards staff and patients, which was not felt to be related to his

¹³ Mersey Care NHS Trust medium secure service, based at Scott Clinic, Rainhill, provides inpatient assessment, treatment and rehabilitation for men and women suffering from enduring mental health problems. <http://www.merseycare.nhs.uk/our-services/a-z-of-services/medium-secure-unit-scott-clinic/>

¹⁴ Prisoners transferred to hospital – transfer direction Section 47 of the MHA empowers the Secretary of State by warrant to direct the detention in hospital for treatment of a person who is serving a sentence of imprisonment. Under section 49 of the MHA 1983, the Secretary of State may make the transferred prisoner subject to the restrictions on discharge set out in section 41. A restriction direction makes it possible to return the patient to prison at any time before their release date. www.mentalhealthlaw.co.uk/Mental_Health_Act_1983_Overview

¹⁵ Stelazine (Trifluoperazine) is an anti-psychotic medicine in a group of drugs called phenothiazines. Trifluoperazine is used to treat anxiety or psychotic disorders such as schizophrenia. <http://www.drugs.com/mtm/stelazine.html>

mental health, but to 'personality and behavioural style'.¹⁶ His mother contacted his psychiatrist who recorded her unhappiness with his transfer back to prison. It was agreed under Section 117 MHA¹⁷ that community follow up would be provided by the FIRT, based at the Scott Clinic.

- 4.16 S was released from prison on 15 February 1995. He was seen on 28 February by a consultant forensic psychiatrist (Dr B) as an outpatient on his own, and then with his father and the team social worker. S was reported to be paranoid but not psychotic. He was placed on the Supervision Register¹⁸, and was subject to regular reviews.
- 4.17 Community follow up involved both parents, and there were times when his IRA beliefs were mentioned. There was concern about him becoming angry and aggressive when under the influence of alcohol. In May 1995 it was recorded that he had been involved with the police for driving offences while under the influence of alcohol. His mother reported that he had improved but did not always take his medication.

Second admission to Scott Clinic

- 4.18 S was admitted to the Scott Clinic informally on 1 June 1995. This followed his mother contacting the FIRT team social worker after S had been behaving erratically and held a knife to his father's throat. His father had contacted the police on two occasions but it was reported that his mother cancelled the police. He had phoned his mother from his brother's house to say that his father and brother had tortured him as a child. He came to the house and took a knife from the kitchen and '*went to try to stab his father*'.¹⁹ His mother distracted him so that his father could climb out of a window; she gave him a Stelazine tablet and he apparently calmed down. He was seen for assessment that day by a social worker (SW), community mental health nurse (CPN) and a senior registrar. He stated that he had thoughts that his father had tortured him in South Africa as a child, although he said he knew it was a 'delusion'. S said this was first time he had this belief about his father.
- 4.19 S absconded on 5 June 1995 during an attendance at court for a motoring offence. He was found at home the next day, and was detained under Section 4 MHA²⁰, later converted to Section 2 MHA.²¹ S was hostile and expressed

¹⁶ Mersey Care NHS Trust Root Cause Analysis Internal report June 2015 page 14

¹⁷ After-care. (1) This section applies to persons who are detained under section 3 above, or admitted to a hospital in pursuance of a hospital order made under section 37 above, or transferred to a hospital in pursuance of [F1a hospital direction made under section 45A above or] a transfer direction made under section 47 or 48 above, and then cease to be detained and [F2 (whether or not immediately after so ceasing)] leave hospital. <http://www.legislation.gov.uk/ukpga/1983/20/section/117>

¹⁸ Supervision Registers were local registers, maintained by providers of mental health care in England, of patients with severe mental illness identified as being at risk (NHS Executive, 1994). NHS Executive (1994) Introduction of Supervision Registers for Mentally Ill People from 1 April 1994. (HSG (94)5.) Leeds : NHS Executive

¹⁹ Mersey Care NHS Trust Root Cause Analysis Internal report June 2015 page 15

²⁰ Section 4 MHA 1983 Admission for assessment in cases of emergency. <http://www.legislation.gov.uk/ukpga/1983/20/section/4>

²¹ Section 2 MHA 1983 Admission for assessment. <http://www.legislation.gov.uk/ukpga/1983/20/section/2>

delusional beliefs about his father torturing him with electricity and needles. He was regarded as having a relapse of schizophrenia largely due to non-compliance with medication. S was noted by Dr B to be a risk to his father, and that the family would need considerable support. S's beliefs about his father became less evident as he took regular antipsychotic medication.

- 4.20 S was discharged by a Mental Health Review Tribunal²² on 20 June 1995, which was not expected by the care team. A Section 117 meeting was 'hastily' planned for 22 June 1995, which neither S nor his parents attended.

Third admission to the Scott Clinic

- 4.21 Dr B saw S as an outpatient but there were concerns expressed by his parents about his mental state and behaviour. On 28 July 1995 he told Dr B that he knew his father had sexually abused him. S had been speaking to his father about his delusional beliefs and on 30 July said '*I don't know whether to knife you or butt you*', before head butting his father. He talked of his father abusing him so his mother took him for a walk. Whilst out in a park he suddenly punched her twice in the head. When she fell, he kicked her a number of times and said '*now we are even*'. After returning home his mother got him to leave and called the FIRT SW. Police were called and she left with them. Later both parents were at the police station bruised and in a distressed state, but refusing to press charges.
- 4.22 S was assessed by Dr B and admitted to the Scott Clinic on 1 August 1995 under Section 3 MHA.²³ S expressed the belief that his mother had been complicit in the alleged abuse he believed he experienced as a child, and talked of attacks on his parents in a cold emotionless manner. He admitted to not taking medication in the community. S was thought to be floridly psychotic and was prescribed long acting depot medication²⁴. S refused the depot injection and it was felt on balance to be counterproductive to force the issue so oral medication was recommenced. During this admission he appeared to be holding his delusional beliefs less firmly and his parents agreed he could start escorted leave.

On 26 September 1995 Dr B held a meeting with S's parents and the FIRT. Both parents felt he had improved. Dr B informed them that S denied assaulting his mother, and stated his assault on his father was in self-defence. Dr B also expressed concerns to his parents about S's use of weapons. S's parents were told that there was a future risk of S acting on his delusional beliefs and attacking them. It was suggested that the risk may be lessened if he did not live with them, and that they should reduce contact with him.

Fourth admission to the Scott Clinic

²² Patients can apply to the First-tier Tribunal (Mental Health) if they are admitted ('detained') as a patient in a psychiatric hospital ('sectioned') and want to be discharged. The tribunal is independent of government and will listen to both sides of the argument before making a decision. <https://www.gov.uk/mental-health-tribunal>

²³ Section 3 MHA 1983 Admission for treatment. <http://www.legislation.gov.uk/ukpga/1983/20/section/3>

²⁴ Depot medication is a special preparation of the medication, which is given by injection. The medication is slowly released into the body over a number of weeks. <http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/depotmedication.aspx>

- 4.23 S was admitted under Section 3 MHA on 9 February 1996 after being missing from the family home for a week, and his mental state was said to have deteriorated. He was suspected of being threatening to his parents, and had stabbed his grandmother's dog to death. At the time of the MHA assessment he escaped from the house and was apprehended the next day in Leamington Spa. It is not known from records available whether the police were involved.
- 4.24 S subsequently stated that he stabbed the dog because he believed it was talking to him. S was described as deluded on admission, but began to settle although still expressed bizarre beliefs. He was started on depot antipsychotic medication due to his poor compliance in the community.
- 4.25 On 23 March 1996 S's parents admitted to Dr B that they were not always open about their concerns about S and about his poor medication compliance. It was acknowledged that they wanted to support their son but were also fearful of him. The plan was for S to be discharged to a cluster flat at Croxteth Grove rather than to the parents' home. Support was provided through Imagine, a local mental health charity. He was discharged in May 1996 after extended leave, with community care provided by the FIRT, on a Supervised Discharge Order.
- 4.26 S remained in the community under the care of FIRT for around two years, and was described as settled and well.

Fifth admission to the Scott Clinic

- 4.27 S was admitted informally on 23 March 1999, two months after changing from depot to oral medication. He had also been using cannabis, and other residents of the flats had expressed concern about his mental state. He was discharged on 1 April 1999, and it was noted he was not experiencing active psychosis.

Sixth admission to the Scott Clinic

- 4.28 S was admitted again informally on 27 July 1999. He had been spending increasing time with his parents, not attending appointments and was verbalising psychotic beliefs. S asked to be admitted because he said he was dangerous. He was apparently known to have a machete in his room. He later described a fear that he would attack his parents at the time of the eclipse, and this was linked to a complex delusional belief system. He had periods of home leave and was discharged on 21 September 1999, still subject to the Supervised Discharge Order, which expired on 8 August 2000.
- 4.29 Dr C became his consultant forensic psychiatrist in 2000, which remained the case until February 2013.

Seventh (and last) admission to the Scott Clinic

- 4.30 S was admitted informally by Dr C on 20 January 2003. His mental state had deteriorated, and he still described delusional beliefs, although there had not been any violent events. He was discharged on 28 January 2003 on a 'new

oral medication regime²⁵. S was prescribed Olanzapine 30 mg (increased from 20 mg), Dosulepin²⁶ 150 mg, Zopiclone²⁷ 7.5 mg and Procyclidine²⁸ 15 mg. This was his last admission to the Scott Clinic. It is of note that the last three admissions were all informal.

Community care by FIRT from 2003 to 2013

- 4.31 S was settled in a flat in Liverpool, receiving six hours a week support from Imagine. At this time he was being seen weekly by a CPN from the FIRT, and four to six weekly by Dr C. He was seen six weekly by a Nurse Consultant to focus on cognitive approaches to his psychotic symptoms. His Olanzapine dosage changed to 40 mg in 2009, with other medication prescriptions remaining unchanged.
- 4.32 Clozapine was discussed with S at various stages, but he always refused, giving the reason that he did not want blood tests. This was revisited regularly by Dr C, and again in February 2013 before he handed care over to Dr D, locum consultant forensic psychiatrist.
- 4.33 The CPA care plan in January 2009 notes that '*S has a chronic psychotic illness, characterised by an extensive delusional system involving his persecution by other people including his parents and those caring for him. He has acted on these delusional beliefs in the past when they are active but also had personality difficulties in that he is at times lacking interest in other people's feelings, and can be provocative and sometimes hostile. Much of his criminal behaviour has not been psychotically motivated but the assaults on his family in the past have been. His risk are exacerbated when he is intoxicated with alcohol or using illicit drugs*'.
- 4.34 A crisis and contingency plan noted that signs of relapse were: non-attendance at appointments, increase in symptoms and agitation, increased preoccupations with members of his family, increase and chaotic use of drugs and alcohol, increased violence and '*progression through stages of his delusional systems which eventually culminates in violence*'.
- 4.35 In the event of relapse it was noted that there should be an immediate assessment by his care team, and the family should be contacted to discuss risk issues related to them. The 'Effective Care Co-ordination Risk Assessment' document dated 10 April 2008 notes the current risk management strategy to be regular four weekly reviews by the FIRT team

²⁵ Mersey Care NHS Trust Root Cause Analysis Internal report June 2015 Page20

²⁶ Dosulepin is used to treat depression. It is a tricyclic antidepressant, sometimes known as a mood elevator. <http://drugs.webmd.boots.com/drugs/drug-164-talwin-nx-oral.aspx?drugid=164&drugname=talwin-nx-oral>

²⁷ Zopiclone is used for short term treatment of insomnia, including difficulties in falling asleep, nocturnal awakening and early awakening, transient, situational or chronic insomnia, and insomnia secondary to psychiatric disturbances, in situations where the insomnia is debilitating or is causing severe distress for the patient. <https://www.medicines.org.uk/emc/medicine/26364/SPC/Zopiclone+7.5mg+Tablets/>

²⁸ Procyclidine is used to treat side effects of antipsychotic medication such as Parkinsonism; drug-induced extrapyramidal symptoms. <https://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/49-drugs-used-in-parkinsonism-and-related-disorders/492-antimuscarinic-drugs-used-in-parkinsonism/procyclidine-hydrochloride>

including Dr D, weekly reviews by CPN, input and monitoring by nurse consultant, support in activities and daily life by Imagine support worker. Health visiting and social services teams were to be involved as necessary with his contact with his child (until the family moved away in summer 2009).

- 4.36 A detailed list of issues that would trigger a response are given in the risk management strategy, relying on S to make staff or police aware.

These were:

- if his auditory hallucinations keep him awake on two consecutive nights or three nights in one week,
- if a wedding is arranged or he is aware it is happening S has agreed not to attend, would contact the team and would consider self-referral to police for his safety,
- if he becomes intoxicated with alcohol or drugs or argues with his family or named other potential victims and
- if he believes Catholics or Protestants are arguing about him, he has agreed to limit contact with family and consider self-referral to police,
- if there is any lunar peculiarity or astrological occurrence that he believes to be of significance to his family he has agreed to present to the team or the police, not to take possession of a sword.

- 4.37 It was noted that all aspects would be reviewed with S following each risk meeting, and identify risk markers, his actions at times of increased risk and gain reassurance around his willingness to respond as agreed, and the CPN would continue to discuss victim issues with his parents. All of these contingencies however relied on S's self-report initially.

- 4.38 S stated throughout his care that he believed he would marry a woman called N to bring about the end of the world, and at the wedding he would kill his parents and brothers. He said he would kill his mother and one brother with a sword, and kill his other brother and father by kicking them. S had expressed the belief that he was 90% sure this would happen. The team were not sure whether this person existed, so this event was thought unlikely, although S admitted to texting N occasionally but said he didn't get a response. S also held complex delusional beliefs involving ideas of reference, mainly from music, clothing labels, names of drinks and places, and bible references. He also continued to hear a male voice as an auditory hallucination that was at times commanding in nature. This voice had a name and was referred to by S as having told him to kill his parents after the homicides in September 2014.

- 4.39 It was recognised that his parents and brothers were at risk of serious harm, but this was not thought to be imminent, on the basis that the 'N/wedding' scenario was unlikely.

- 4.40 From 2009 Dr C described S as experiencing his delusions in a less intense way and he was less preoccupied with his beliefs. His parents were involved in discussions to develop the HCR 20²⁹ risk assessment.
- 4.41 In a care plan dated 10 November 2011 the balance between his relatively stable functioning in the community and his ongoing delusional systems was discussed. It was noted that S had little insight and his delusional system had been resistant to medication. It was stated that *'on balance it has always been decided that he is not detainable under the Mental Health Act, largely due to his level of compliance and engagement with the service.'*
- 4.42 This summary view of S was repeated in CPA reviews over a number of years. He was regularly noted to be more of a risk to others when under the influence of drugs or alcohol. There were well documented occasions where either concerns were expressed by his mother about his mental state, or he failed to attend appointments. These occurrences were regularly responded to promptly with a heightened level of input and a team and medical review.
- 4.43 A child was born in April 2012 to S's ex-partner H, whom he had known since they were teenagers. It was agreed that S could have unsupervised contact with the child (who was by now about one year old) and that this would be arranged informally by family members. Both of the child's grandmothers were agreeable.
- 4.44 After a caseload review Dr C handed over as responsible clinician to Dr D in February 2013. S did not attend the handover meeting that had been arranged and Dr D initially saw S in April 2013 for the first time. Medication was discussed and Dr D noted that S would not consider any alternative antipsychotic medication to the Olanzapine 40mg that he was taking. The prescriptions for Procyclidine, Dosulepin and Zopiclone were unchanged, and there is no record of a discussion about why S was taking an antidepressant, a high dose of medication for extrapyramidal side effects, and medication for insomnia. Dr D arranged to see S three monthly, where Dr C had been seeing him every four to six weeks. A weekly supply of medication was brought by the CPN when visiting.
- 4.45 In November 2013 S moved to a two bed flat with the intention of having the child to stay. It was agreed that there should be a detailed assessment of the environment before the child could have unsupervised access and stay overnight. A series of recommendations were made to alter the environment, and it was advised that the child's mother H should have some education from the mental health team about S's mental health issues.

²⁹ The HCR-20 was developed to help structured decisions about violence risk. Since the publication of Version 1 in 1995 and Version 2 in 1997, it has become the world's most widely used and best validated violence risk assessment instrument. Hart, S. D., Webster, C. D., & Douglas, K. S. (2001). Risk management using the HCR-20: A general overview focusing on historical factors. In K. S. Douglas, C. D. Webster, S. D. Hart, D. Eaves, & J. R. P. Ogloff (Eds.), *HCR-20: Violence risk management companion guide* (pp. 27–40). Burnaby, BC, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

Version 3 was published in 2013. Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20V3: Assessing risk of violence – User guide*. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University

- 4.46 Overnight contact was agreed by April 2014, and the child stayed at S's flat unsupervised and overnight regularly.

Mental Health Act assessment January 2014

- 4.47 During December 2013 it was noted by the CPN S that S appeared to be under more pressure since moving, and there was a considerable amount of work being done on the flat. S had given up his college course as he said he felt it was too much at present. Imagine staff reported he appeared to be drinking more alcohol and arguments with his parents were reported. An application had been made to increase the six hours floating support that S received from Imagine. CPN S asked for S's permission to contact S's parents to ask for more information, but this contact is not recorded. After Christmas S seemed more settled and had returned to college. Delusional beliefs were openly discussed but there were no concerns about risk.
- 4.48 S had also told Imagine staff that his father had apparently been diagnosed with cancer recently and he had discussed his concern that it might be his last Christmas with him.
- 4.49 Dr D left the Scott Clinic in December 2013, and Dr A took on consultant responsibility from January 2014.
- 4.50 On 16 January 2014 S phoned CPN S to cancel a medical review which was planned for the following Monday. He said he was travelling to Bournemouth because his friend was getting engaged on Monday. The Imagine support worker also expressed concerns to CPN S, stating that S had offered her a cup of tea that had bubbles in it, after which she was very ill. The support worker later had a screening blood test but nothing was found.
- 4.51 S was visited at home by CPN S and SW C, who also knew him well. S talked openly about his delusional beliefs, and said he had cancelled the meeting because he was going to Bournemouth, saying a friend was picking him up and they would drive there and back in the same day, but was evasive about details. He was informed that a medical review would be arranged the following day.
- 4.52 S was seen by Senior Registrar Dr E, with CPN S at 10.45 on 17 January. S said he was being driven by his brother to Bournemouth, but refused to allow staff to verify this with his brother and became evasive and hostile. He said that staff should only worry if he was attending his own wedding. Dr G notes his complex delusion system. Dr E reviewed his notes and discussed his presentation with the FIRT team who knew him well. In light of his presentation at interview and the concern about possibly putting a substance in the support worker's tea, it was felt he may be an increased risk to others. It was agreed he should be assessed for admission to the Scott clinic under Section 3 MHA, and Dr E completed the first Section 12³⁰ medical recommendation.

³⁰ Section 12(2) of the Mental Health Act 1983 requires that, in those cases where two medical recommendations for the compulsory admission of a mentally disordered person to hospital, or for reception into guardianship, are required, one of the

- 4.53 A formal MHA assessment request was made by telephone to Careline³¹ at 15.07 on 17 January 2014 and it was arranged that an Approved Mental Health Professional (AMHP)³² and a second Section 12 approved doctor would meet at S's flat to carry out the assessment. Police presence was requested by CPN S because of his known history and access to weapons. It was known that he intended to pick up his child at 17.00, so it was agreed that this assessment was required before then.
- 4.54 The AMHP contacted S's father initially by telephone to discuss Section 3. S's father told the AMHP that he did not agree to his son being sectioned. S's father was the nearest relative³³ as defined by the MHA, and under the terms of Section 3 MHA, had to be consulted. If a nearest relative objects, detention under Section 3 cannot go ahead unless legal action is taken to remove the title of nearest relative (and the rights that accompany the title) from the person who is objecting.
- 4.55 CPN S met the police, the GP Section 12 doctor Dr F and the AMHP outside S's flat. S's parents arrived and made it clear that they objected to the Section 3 being applied. Dr F was known to both parents and S. The AMHP has recorded '*Dr F, after a lengthy interview with Mr S, was of the opinion that Mr S, although he appears to have delusory belief systems, he did not present as psychotic or distressed and therefore, there were not sufficient concerns raised to warrant a compulsory admission to hospital on this occasion*'.³⁴
- 4.56 The AMHP has noted that Dr E had completed a medical recommendation on 17 January 2014, but the AMHP's report does record any contact with Dr E. There is no record of a conversation between Dr F and Dr E. The AMHP recorded that '*the application for admission as recommended by Dr E of the Scott Clinic was not made, due to the fact that Mr S's presentation did not present to either Dr F, or myself, that he was suffering from a mental disorder of a degree that might have warranted compulsory admission to hospital*'.³⁵
- 4.57 It was further noted that S '*appeared to understand why the CPN and Dr E were so concerned, and said he would now not go to Bournemouth and would accept increased support over the next few days*'.

two must be made by a practitioner approved for the purposes of that section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder. Approval is also required for practitioners providing reports or giving evidence under Part III of the Act.
<http://www.rcpsych.ac.uk/pdf/Approval%20under%20Section%2012%20The%20National%20Criteria.pdf>

³¹ Liverpool's social care contact service 'Careline' is the front door for all social care enquiries and referrals from both the public and professionals. <http://liverpool.gov.uk/health-and-social-care/careline/>

³² AMHPs exercise functions under the Mental Health Act 1983. Those functions relate to decisions made about individuals with mental disorders, including the decision to apply for compulsory admission to hospital. [https://www.hcpc-uk.org/assets/documents/1000414DApprovalcriteriaforapprovedmentalhealthprofessional\(AMHP\)programmes.pdf](https://www.hcpc-uk.org/assets/documents/1000414DApprovalcriteriaforapprovedmentalhealthprofessional(AMHP)programmes.pdf)

³³ In this Part of this Act, subject to the provisions of this section and to the following provisions of this Part of this Act, the "nearest relative" means the person first described in subsection (1) above who is for the time being surviving, relatives of the whole blood being preferred to relatives of the same description of the half-blood and the elder or eldest of two or more relatives described in any paragraph of that subsection being preferred to the other or others of those relatives, regardless of sex.

³⁴ AMHP report dated 17.1.14 re T

³⁵ AMHP report dated 17.1.14 re T

- 4.58 Dr E, SW C and CPN J met S and parents the day after the assessment. Dr H records her concern that the presence of S's parents made the assessment of his mental state very difficult, and they were initially very challenging. It appears from the notes that his parents were instrumental in him agreeing not to go to Bournemouth, rather than S deciding. Dr G also recorded the concern that S was not detained, based on his presentation to Dr E, and noted a discussion with the FIRT manager. The result of this was noted as there not being any new information in terms of precipitating a new Mental Health Act assessment. It was agreed that there would be a '*low threshold for intervening and facilitating a further MHA assessment*'.
- 4.59 Contact was made by telephone with S over the weekend by CPNs from FIRT and it was recorded that there were no concerns. He was seen on Monday 21 January 2014 by CPN S and SW C, who delivered medication as usual. Although S was noted to appear guarded, he denied thoughts of attending any weddings, and reported no further overt relapse symptoms that would raise concern that a further MHA assessment was needed.
- 4.60 At the MHA assessment it became known that S's mother was planning to bring the child to see S at his flat, and this was followed up by the CPN. He was advised not to have contact over the weekend, but it was later made known that the child's mother had allowed contact with the child.
- 4.61 Relevant services were informed by CPN S of concerns about S's mental state, and S phoned FIRT on 23 January saying he was unhappy that it had been suggested that he should not have direct contact with the child until a risk assessment was completed. He was encouraged to communicate directly with relevant services, and the CPN also followed up.

February to September 2014

- 4.62 The CPN S was due to leave at the end of January, and SW C took over as care coordinator temporarily. Dr A, a new consultant was due to take over S's care in early February 2014. His previous care coordinator CPN L returned from maternity leave in April 2014 and took over again.
- 4.63 Dr A conducted a medical review on 25 February 2014 accompanied by SW C, and S was noted to be stable but still symptomatic, but accepting of medication and engaging with support.
- 4.64 Concerns were raised by the CPN L on 8 April 2014, as S was openly discussing his delusions, he had decided to look for 'N', and had told his mother to keep 'her husband and sons' away from him. S told CPN L that he was careful not to call his father 'dad' because he did not believe he was his father. There appears to have been an argument with his brother before this. He admitted drinking alcohol and using cannabis the night before.
- 4.65 CPN L asked Dr A to review S, and noted her intention to contact his mother to gain her views. CPN L called in unannounced the following day and found S to be less concerned with delusional thinking, and arranged for him to be seen after the weekend, informing the FIRT manager of the situation.

- 4.66 Dr A saw S at his flat on 15 April 2014, along with CPN L and the Imagine manager. S discussed his delusional system and recent argument with his brother. He told Dr A that he was smoking up to £5 a day of cannabis because it relaxes him and if he does not have any for a few days he starts to become aggressive or angry. He had also told CPN L that he continued to smoke cannabis when his child was in his care (although not in the same room) despite this being one of the conditions of contact. S requested support to stop using cannabis and requested Diazepam³⁶, which was not prescribed. It was agreed that he would accept a referral to the dual diagnosis worker to discuss his care regarding illicit substances.
- 4.67 It was reported at this assessment that S was not preoccupied with finding N, and less convinced of the need to contact her, saying he would do so at some point in the future. The plan agreed was that the dual diagnosis worker would be asked to see S, relevant services would be informed of the cannabis issue, and more frequent visits by FIRT staff would be carried out over the bank holiday (Easter) period. Dr A notes that S appears to be floridly psychotic in the community, despite being prescribed above British National Formulary (BNF)³⁷ limits of Olanzapine, but appears to function to some extent with a lot of structure and support. He notes that he would ideally like to admit S to hospital so that his medication can be reviewed, but was aware of the MHA assessment in January 2014 where he was found not to be detainable by the assessing AMHP. Dr A noted that he would potentially be an excellent candidate for Clozapine. It was agreed that a further medical review would take place with Dr A in four weeks and to return to the question of medication review.
- 4.68 CPN L continued to see S weekly, bringing a week's supply of medication each time. There is one mention of how S was using Procyclidine, he appeared to take some at night and throw others away, and was encourage to use the 5 mg tablets during the day when needed, as he had referred to restless feelings in his legs. Extra floating support by Imagine had been agreed in May 2014, increasing up to 16 hours per week. The medical review was carried out as arranged by Dr A on 15 May 2014, at this time S was unwilling to consider a change to his medication, but agreed to see the dual diagnosis worker.
- 4.69 A CPA review meeting was held on 29 May 2014. There were no current concerns about his care of his child. S disclosed that he was using about £20 of 'skunk' cannabis per week, and drinking about eight cans of lager. It was noted that he had at times expressed a wish to stop smoking cannabis but this had never been consistent. There were concerns '*that as he appeared to be using cannabis to cope with his intrusive psychotic symptoms*' that he would substitute with alcohol if this were to stop. S openly discussed his psychotic symptoms and complex delusional system, but appeared well

³⁶ Diazepam is used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms. www.drugs.com/diazepam.html

³⁷ The 'BNF limit' refers to accepted prescribing maximum dosages <http://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/42-drugs-used-in-psychoses-and-related-disorders/421>

presented and coherent in speech. In Dr A's letter to S's GP it was also noted that he had not had recent health checks and he was asked to see his GP for health checks. A further medical review was agreed for four to six weeks, and CPN L was to update the risk assessment.

- 4.70 The CPA notes of 29 May 2014 record that it was in fact agreed that Dr A would see S in three months, the risk assessment was current, the dual diagnosis worker was to be contacted, and S's mother was to be contacted 'for feedback'. It was noted that the HCR 20 had been updated in April there were no changes to the risk assessment, PNC and Epex markers were updated. At this point in the section of the risk assessment 'offending behaviour and violence' it was indicated only that there was one current concern: use of weapons. 'Paranoid delusions' and 'violent command hallucinations' were no longer seen as present. This change since the last risk assessment is unexplained. We have not been able to locate notes of a further medical review until September 2014.
- 4.71 S acquired a dog in July 2014, and this was discussed in the FIRT team meeting, and concerns were expressed by Imagine staff. It was acknowledged that there were no indications of increased risk regarding the dog, but the situation needed monitoring. At this time S showed CPN L a box he keeps his cannabis in, so that the child could not access it. He again stated he could not give up smoking cannabis.
- 4.72 S was supported to look for a new flat at this time, because the current flat needed remedial work doing on it. This was not anticipated when he was placed in the accommodation with support from Imagine. A move was apparently agreed in August, to take place in the near future.
- 4.73 In August 2014 Imagine staff again raised concerns about the dog, apparently it had snapped at the child, and S had hit the dog. S's mother later took the dog to her house as S was concerned about the dog snapping at the child, and the dog was later rehoused.
- 4.74 At the end of August 2014 CPA care coordination was taken over by CPN J, due to personal circumstances of CPN L. CPN J had known S for many years and was a very familiar face to him.
- 4.75 On 1 September 2014, S told CPN J that he had been to see his GP because he was coughing up lot of phlegm and thinks he may need antibiotics. He said he was due to have a scan that day.
- 4.76 S was in fact due to have a chest x-ray on 1 September, and had told his GP that he had lost some weight and was coughing, and was afraid he had cancer. S did not tell CPN J this. It was later noted by the GP that the x-ray was reported as normal, it is not clear however whether this was conveyed to S. On 9 September 2014 S was noted to have stated he felt physically and mentally well.

Medical assessment September 2014

- 4.77 On 15 September 2014 there was no reply when CPN J visited, but he spoke to S on the telephone and arranged to see him on 16 September 2014. On 16 September S stated he was going to hospital as the child's mother H was in hospital and he was worried she might die. He spoke of his belief that he would have married H but his family were critical of her. S gave an explanation of how powerful he was, and had arranged for H's next baby to be retarded, and spoke of satellite messages and having '*his black hat on*'. CPN J was very concerned, and it was arranged that a medical review would be carried out on 18 September after discussion with Dr A.
- 4.78 S phoned the Scott Clinic at 06.38 on 18 September, stating he was not sleeping as his Zopiclone tablets had been stolen. He also said that someone had been messing with his child and he was worried that her mother might die. Dr A had planned to see S for review that morning anyway, and it was agreed that Dr A would see S at home with SW C. There was a message that S's mother had also phoned the clinic with concerns that S had contacted his parents repeatedly overnight.
- 4.79 S was seen by Dr A, CPN J and SW C. They had brought Section 2 and 3 MHA section papers with a view to requesting a formal MHA assessment and recommending detention. S gave permission for them to contact his mother to discuss any concerns she may have regarding his mental health. S said that he was worried about his child. He was asked for more detail about his worries about the child, and he did not express any particular concerns, but went on to talk about the child in a delusional religious sense. He did say he had not been sleeping because his Zopiclone had been stolen. His medication box was checked, and it contained an excess of Procyclidine and Pirenzepine³⁸, suggesting he had not used these. The absence of Olanzapine was taken to mean he was compliant. He was found to be guarded when talking of his delusional ideas, but appeared no more psychotic than usual. S said he had not used cannabis or alcohol for a while. S's mother was phoned, and after leaving S the review team called in person to S's parents' house after this but got no answer.
- 4.80 Dr A later stated that in his view the nature of the mental disorder that S presented was no different to what was present at the January 2014 MHA assessment and made the point that he could have been detained at that time on the nature of his mental illness alone. Dr A's opinion was that his disorder was of a degree that was no different than it was previously. There was no record of whether S was asked to come in to Scott Clinic informally.
- 4.81 A plan was agreed to follow up after this review: which was to visit S's parents, to be seen again in the afternoon by CPN J, to be reviewed the following morning by Dr A and a FIRT staff member, SW C to contact relevant services, not to have his child that evening, to contact the family, and review his medication supply once per week.

³⁸ Pirenzepine is part of a group of medicines called 'antimuscarinic agents'. It is medicine which is used to help control drooling or dribbling excess saliva. <http://www.merseyscare.nhs.uk/media/2179/pirenzepine-2014.pdf>

- 4.82 Dr A had also agreed with NHS England's North West Specialist Commissioning Team that a bed may be required, it was agreed that if needed S may be admitted to Scott Clinic as an emergency, and that a transfer to an independent provider would be agreed in principle.
- 4.83 Dr A went to S's flat as arranged on the morning of 19 September 2014, with a member of the FIRT team. There was no answer so they phoned S at about 09.45 who said he was on a bus and would be back later on. It was arranged that they would return at 15.30 that day.
- 4.84 It is clear from subsequent information that S had killed his parents by then, and was on his way to see his child to say goodbye, before taking a bus to the Scott Clinic, where he was arrested.
- 4.85 Following police enquiries, it was discovered that S had sent H texts the previous day referring to him killing his parents. Tragically these texts were not accessed until after 19 September 2014. It also became obvious after events of 19 September that S's parents were aware that they were at some sort of risk from him that night, and had gone to the other son's flat initially. They appear to have decided it was safe to return home.

5 Arising issues, comment and analysis

- 5.1 We address each element of the terms of reference in separate sections, supporting our analysis with evidence as appropriate.

Review the care, treatment and services provided by the NHS and other relevant agencies from the service user's first contact with services to the time of the offence. Including specific reference to the review of :

- ***the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern***
- ***the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others***
- ***the effectiveness of the service user's care plan including the involvement of the service user and the family***
- ***compliance with local policies, national guidance and relevant statutory obligations***

- 5.2 We have grouped the issues of concern regarding S's care into the following headings: organisational issues and FIRT, risk assessment, risk to parents and children, use of Mental Health Act, medication, and alcohol and illicit drug use.

Organisational issues and FIRT

- 5.3 The Scott Clinic in Rainhill was one of the first Medium Secure Units to be purpose built in England, opening in 1983. The Forensic Service based at Scott Clinic was brought into the Mersey Care NHS Trust when the Trust was established in 2001.
- 5.4 The Rainhill Hospital campus closed in 1992 and the Scott Clinic service is the only mental health service that is left on this site. It is isolated geographically from the rest of the Trust. There are currently plans to rebuild the Scott Clinic on Mersey Care NHS Trust land adjacent to Ashworth High Secure Hospital.
- 5.5 Those patients discharged by the Scott Clinic and who were thought to require specialist forensic community outreach care (primarily because of risk to others) were followed up by the service. The psychiatrist who had been responsible for each individual patient's in-patient care, a social worker and community nurse were the core team for each of these community patients. The Forensic Integrated Resource Team (FIRT) provided this after care service, with the aim of providing continuity of care.
- 5.6 In September 2014 the FIRT Service had a team of social workers, a budget of just over two CPNs and two part-time CPNs, a senior social worker and four social workers. The social work team primarily worked with inpatients. Each of the five Scott Clinic consultant forensic psychiatrists had patients in

the FIRT service, no one consultant had oversight of FIRT patients. Psychology was not part of the FIRT Service but input was on a consultation case-by-case basis. The FIRT Service developed in about 2006 as a way of bringing together and managing all the forensic service CPNs and social workers into a single team.

- 5.7 In 2011 the operational management structure of the Trust consisted of five 'Clinical Business Units' (CBU), each with their own senior leadership teams under a Service Director. The CBU known as 'SaFE Partnerships' (Secure and Forensic Environments) was managed by a Service Director and Clinical Director, who had both left by December 2010. A new interim Service Director and interim Clinical Director were appointed in January 2011. A further change was introduced to split the CBU into a service for 'beds' and non-beds'. In May 2011 Clinical Director Dr K was appointed across medium secure, low secure and the offender health provision.
- 5.8 It was decided after the arrival of a new Chief Executive that there should be a streamlining of the structures for both clinical and corporate services. What was five clinical business units was streamlined into two clinical areas, a secure division and a local division. At that point what had been the 'SaFE' CBU became part of the Secure Division. From that point until 2015 Dr K remained in the Clinical Director role but with some changes to his remit from early 2013.
- 5.9 The Clinical Director responsibilities moved to the newly appointed Associate Medical Director for the Secure Division in November 2014, with Clinical Director responsibility for high, medium, and low secure and community forensic services.
- 5.10 During the time of these changing structures another patient of the FIRT L, had killed his mother in April 2010, and an internal review was commenced. In November 2011 an independent investigation into L's care was commissioned by NHS North West Strategic Health Authority, and the report was completed in October 2012. A Trust action plan was created in response to recommendations made in the internal investigation, and following the independent investigation, a further action plan was developed. These action plans became the operational responsibility of the FIRT team manager R, who chaired a steering group to implement action plans and report on progress to the Quality Assurance Committee. During this time of change the line management of the FIRT manager changed several times.
- 5.11 The draft FIRT Service 'Operational Policy' document is dated 12 November 2012. This document does not appear to have been signed off formally, and as far as we could tell remained in draft form until the FIRT was restructured and became the FOS in late 2015. The service is described as *'a recovery based, accessible, responsive and adaptable service, prioritising the needs of people with complex needs, to maintain safety of service users, families, carers and the general public.* Under the aims and objectives of the service, the first identified focus is on improving engagement, the third of the eleven aims and objectives listed being to reduce risk. There is no section in the Operational Policy referring to management of risk where specific individuals

at risk are identified. There is no section in the Operational Policy referring to management of and ensuring compliance with medication.

- 5.12 In September 2014, after the homicide by S, a review of FIRT patients was commissioned by the Executive Director of Secure Services, and carried out by the Associate Medical Director of Secure Services. At this time there were 38 patients being cared for by the FIRT, having reduced from over 70 in a year. This review noted a general failure to prioritise risk attributable to untreated or partially treated schizophrenia, and a reluctance to jeopardise a therapeutic alliance with regard to assessment and management of risk.
- 5.13 A key recommendation from this report is the provision of clinical leadership in the form of a dedicated consultant psychiatrist allocated to the team, instead of the previous pathway of care model, where each consultant retained responsibility for their patients based on a geographical catchment area.
- 5.14 We have not made any recommendations about the structure or management of the FIRT. The service has been substantially redesigned and restructured, and we have seen the revised model of care and operational policy, and is now called the Forensic Outreach Service (FOS).
- 5.15 The policy and procedure for the management of service users under the care of the forensic service outreach service was finalised in February 2016 and was accepted by the Clinical Governance committee and Senior Leadership Team in March 2016. This policy gives detailed guidance about how risks will be monitored and managed, the role and function of team meetings, and how medical reviews and care coordinators work will be overseen.
- 5.16 Where the service changes relate to issues directly relevant to S's care and treatment, we have referenced this in the following sections.

Risk assessment

- 5.17 Mersey Care *'Corporate Policy and Procedure for the Care Programme Approach'* dated October 2014 states that *'All Service Users under CPA will have a risk assessment'*. Staff involved must attend the appropriate trust training course/s. Any risks or issues around safety identified will be incorporated into the care plan and reviewed, as appropriate, at least every 12 months.
- 5.18 The Trust's *'Policy and Procedure for the use of Clinical Risk Assessment Tools'* dated May 2015 states that *'clinical risk assessment and management are integral to the Care Programming Approach'* and describes three levels of risk assessment:
- 5.19 *'Level One risk assessments are those assessments that are brief to do and report, involve a review of mainly recent clinical information and are likely to inform risk management in the following few days or weeks. Level Two risk assessments involve a little more work than Level One assessments and risk formulation and risk management planning are detailed and explicit. The*

same tools may be used as in Level One assessments but the practitioner spends more time thinking about the information to hand, preparing a formulation and designing a risk management plan. Alternatively, more specialised tools, such as the Short-Term Assessment of Risk and Treatability³⁹ (START), may be used to make more detailed observations about risk and protective factors and more comprehensive risk management plans’.

- 5.20 *‘Level Three Assessments: The most detailed level of clinical risk assessment require comprehensive tool-based evaluations of historical and clinical risk factors. Level Three assessments are the most demanding in terms of time (they require upwards of a day to complete due to the need to research clinical notes, interview the service user and others, and write a detailed report running to several pages in length) and skill base (i.e., training in the use of specific clinical risk assessment tools plus supervised practice). An example of Level Three risk assessment is as follows: HCR-20⁴⁰ violence risk assessment guide. Findings at this level of risk assessment will be informative for periods of time from several months up to a year although reviews can take place more regularly depending on the service user’s clinical presentation and their place on the care pathway. In general, however, such assessments are regarded as longer-range forecasts of risk as compared to Level One and Two assessments’.*
- 5.21 As would be expected in someone with S’s history, a ‘level 3’ HCR 20 risk assessment was in place. This risk assessment was reviewed regularly as would be expected, with the most recent assessment completed in HCR 20 version 3 on 24 April 2014.
- 5.22 We have conducted a detailed review of S’s HCR 20 risk assessments, and the full analysis is at Appendix D.
- 5.23 It is quite clear that the previous revisions of the Version 2 HCR 20 from 2010 to 2013 were virtually identical to each other. While certain parts of the HCR 20, notably the Historical risk factors, will remain unchanged between revisions, it is unusual for the Clinical and Risk Management factors, which are both dynamic factors, to be unchanged. In the later revisions, there were additions to some of the items but these did not affect the scores for those items. For the HCR 20 to be effective as a risk management tool in patients who are considered to be at longer term high risk of violence, based on their historical factors, it should become a ‘live’ document. In practice when the HCR 20 is reviewed, we would expect some change in the content of the Clinical risk factors, based on changes in the patient’s clinical presentation in the previous 6 months. In the same way, the Risk Management factors which inform the risk management plan over the coming 6 to 12 months, would also

³⁹ *The Short-Term Assessment of Risk and Treatability (START) is a structured professional clinical guide for the dynamic assessment of seven risk domains (violence, suicide, self-harm, victimization, substance use, unauthorised leave, and self-neglect). Webster, C. D., Martin, M., Brink, J., Nicholls, T., & Middleton, C. (2004). START: the Short Term Assessment of Risk and Treatability. Hamilton: St Joseph’s Healthcare.*

⁴⁰ *HCR-20: assessing risk for violence by: Christopher D. Webster, Simon Fraser University. Mental Health, Law, and Policy Institute, Forensic Psychiatric Services Commission of British Columbia.*

change, especially in patients with chronic resistant schizophrenia complicated by drugs and alcohol use.

- 5.24 We consider that this lack of change in his dynamic factors was as a result of the mind-set within the team that believed he was unchanged from year to year, unless certain delusions were acted upon. It ignored other aspects of his behaviour such as drug and alcohol abuse, history of acquiring weapons, attitudes to his family, ex-partner and child. If the changes in his dynamic risk factors had been recognised, it is possible that a longitudinal view of these factors would have been undertaken. The fact that there had been a steady increase in the 'Clinical and Risk Management' factors might then have been understood, which would have alerted the team to reconsider S's risk management plan.
- 5.25 In the scenarios, the section on 'Monitoring' is very detailed and notes the regular input with his CPN weekly and 4 to 6 weekly risk reviews with the multidisciplinary team. This is then followed by a statement that S's '*involvement with risk assessment is ongoing*'. It is said that this has led to a formulation of a plan to respond to changes in the response to his beliefs. There is then a list of symptoms including if his auditory hallucinations keep him awake, a wedding is arranged or he becomes intoxicated with drugs and/or alcohol and argues with his family, 'astrological occurrences' of significance, not to take possession of a sword and finally if Max his dog starts to talk to him, but it notes he has got rid of the dog.
- 5.26 This management plan was based on a reliance that S would volunteer changes in his delusional beliefs, including that he would refer himself to the police. There did not appear to be any evidence that he had ever done this in the past, therefore we do not consider that this was a credible plan.
- 5.27 It was also focused on particular delusions (albeit that these were long-standing) based on a few themes, e.g. the wedding to N, the use of a particular sword etc. This therefore led to an attempt to base a logical and predictable process (i.e. risk assessment) on something that was delusional and by definition, therefore could not be logical or predictable.
- 5.28 The 'Severity of future harm' item notes the '*potentially very serious physical harm*' to his family members. The management of this risk refers to '*progression along his risk formulation*'. This is another reference to using the delusions that he has described as part of his risk management plan.
- 5.29 The risk formulation which was unchanged throughout all 8 revisions of the HCR 20 between 2010 and 2013 provides a good summary of his previous illness and its relationship to his risk to others, particularly his parents.

It suggests that the following are Protective factors:

- His level of engagement with the community forensic service

- His insight into the potentially negative effect of illicit drugs and alcohol and its relationship to increasing his risk, which they state has improved.
- It notes that living in the cluster flats at Croxteth Grove '*where other residents are likely to inform the team quickly should he begin to behave bizarrely or in an unsocial manner*'.

- 5.30 This statement about his insight appears to be at variance with the previous information in the HCR 20. Also, as was becoming increasingly recognised over this three-year period, he was continuing to use illicit drugs and alcohol. It also bases a risk management plan on relying on the other residents to effectively manage his risk by informing the staff of Imagine and the community forensic team about changes in his behaviour. When he subsequently moved house in late 2013, this was not acknowledged as a potential increase in risk.
- 5.31 The formulation goes on to list the well-recognised psychotic symptoms which are all based on his delusions. It again states that he is '*actively involved in his own risk assessment*'. It also notes that previous '*structured work*' has not affected his insight, but '*affected his control in terms of actions around his beliefs*'. It is not entirely clear what is meant by this statement. There are recorded instances in his CPA reviews where it is noted that he does not agree with his risk assessment.
- 5.32 While Version 3 of the HCR 20 may appear very similar to Version 2, there are some significant differences. This includes changes to the name and content of some of the 20 basic risk factors and the addition of sub-items for complex risks factors. In addition, for the first time, it was suggested that a risk formulation should be completed. Finally, before the risk factors are scored, there is an important new section of information, 'Summary of Future Plans'. This should provide a brief summary, under a number of structured headings of the forthcoming plan for the patient over the stated rating period. The headings include, Residence, Relationships, Education/employment, Physical health care, Mental health care, Substance misuse, Supervision, and Avoiding past problems.
- 5.33 The HCR 20 risk assessment dated 24 April 2014 is the one which was current at the time that S killed his parents. As noted earlier, the addition of the 'Summary of Future Plans' to Version 3 of the HCR 20 helped to clarify what the treatment plan was for the patient being assessed. However, the summary in this HCR 20 risk assessment was lacking in detail.
- 5.34 In the section entitled 'Relationships', it includes reference to his delusional beliefs relating to 'N'. This section is intended to refer to actual relationships. Also, in the section 'Substance Misuse' it notes that he is a long term cannabis user who '*uses cannabis to curb some of his symptoms*'. It is stated that he wants to stop using cannabis but it is not clear whether this is feasible. It then goes on to state '*at times risks may increase without the effects of cannabis*'. This appears to be further promoting the, in our opinion, completely mistaken belief that S's use of cannabis was a positive action and reduced his

risk to others, although the potential for risk to increase without the use of cannabis is also acknowledged. In patients with chronic resistant schizophrenia such as S, most practitioners would accept that continued use of cannabis is likely to worsen their illness which in S's case would increase his risk to others.

- 5.35 Under 'Supervision' it is stated that he is informal and '*engages with the team via his own free will*'. There is no reference as to what additional interventions will be required because there is no statutory basis for his supervision. Finally, under 'Avoiding past problems', it is stated that S '*avoids conflict with his parents by not consuming alcohol in their company*'. By April 2014 there is sufficient evidence from the clinical records that this statement is not true.
- 5.36 The formulation is now presented under the headings of 'Predisposing Factors, Precipitating Factors, Protective Factors and Perpetuating Factors'. However, there is a serious error in the way that this has been written. The notes from the case discussion of S on 11 January 2013 include an almost identical formulation. It is clear from that document that the factors under 'Protective and Perpetuating' have been transposed so that they appear under the wrong heading in the HCR 20. This is a significant error in our opinion and could lead to somebody misinterpreting behaviours as protective, when they may be increasing the risk. It is surprising that this document was in existence for 5 months prior to S killing his parents, however nobody noticed this error.
- 5.37 The risk formulation should answer the question, why is this person violent? It should also cluster the relevant HCR 20 risk factors to develop the risk management plan. This is clear from the bullet points at the beginning of this section. Although the information in the formulation addresses one of the 6 bullets, it does not begin to address any of the other 5 questions, all of which are relevant to managing the risk of violence
- 5.38 The change to Version 3 of the HCR 20 was an opportunity to completely review the structured clinical risk assessment for S. While this appeared to happen with the Clinical risk factors, where the scoring increased significantly, it did not seem to occur for the 'Risk Management' factors which remained underscored. This then did not prompt a review of his risk management plan. Also, it is not clear if the review, discussion and agreement of the Version 3 HCR 20 was undertaken by the whole team, which is considered good practice.
- 5.39 In summary, we have found fundamental errors in S's structured risk assessment. We believe these have contributed to an approach to S's risk management which placed an over reliance on self-reporting, a lack of evidence of engagement in his own risk management plans, and an over reliance on psychotic symptoms as indicators of degree of risk.
- 5.40 The FIRT did not have dedicated psychology input up to and including September 2014 and we were told that the HCR 20 assessments were prepared by the care coordinator, and discussed as a team. The lack of

consistent clinical leadership has been referred to in the 'organisational issues' section of this report.

- 5.41 We have been made aware that the restructured community team (Forensic Outreach Service - FOS) has both dedicated consultant leadership and a psychology resource allocated. The February 2016 'policy and procedure for the management of service users under the care of the forensic outreach service' describes the responsibilities of the team psychologist as *'responsible for leading on case consultations and reviewing HCR20 and other risk assessments, as well as providing advice on referrals for additional psychological input'*

Recommendation 1:

The formulation of HCR 20 risk assessments in the secure services should be aligned to best practice principles and there should be a quality assurance structure to audit the quality of risk formulations and management plans and ensure they are in line with HCR 20 Version 3 Guide.

Risk to parents and children

- 5.42 In the narrative of S's care, it is documented that S believed there was a prophecy which would lead him to kill his parents and brothers. The assessment of the likelihood of this scenario became focussed on the intensity of S's delusional thinking, described to us by FIRT staff as *'where he was in the progress of his delusional thinking'*, i.e. how imminent he believed the N/wedding scenario to be. In our opinion this assessment minimised the real hostility that S expressed towards his father in particular, but also to his mother whom he believed was complicit in his alleged abuse as a child.
- 5.43 There are few notes of open discussion between FIRT and S's parents about the risks to them, and how safety and contingency plans would be managed. There was clearly ambivalence for his parents about the conflict between loyalty to S and concerns about risk, but there is no evidence in the clinical record that open and frank discussions were attempted with them.
- 5.44 Within the HCR 20 the 'Victim Safety Planning' noted that there should be liaison with his family who were said to be aware of the issues of concern and increased risk such as becoming intoxicated with him. It was not clear from the clinical records how often there was regular liaison with his family, or whether this was only reactive to particular incidents. In 2014 there were several occasions when risk appeared to be increased, particularly in January and April 2014 and September 2014. There are notes made of the intention to speak to S's mother and gain her perspective, but the outcome of these contacts is not consistently recorded.
- 5.45 The 'Victim Safety Planning' includes communication with his parents and to offer further education around his illness. However, there is no evidence that this was offered and what the response of his parents was to it.

- 5.46 Under 'Avoiding past problems', it is stated that S '*avoids conflict with his parents by not consuming alcohol in their company*'. By April 2014 there is sufficient evidence from the clinical records that this statement is not true, and we believe this assessment should have been revised.
- 5.47 We are concerned to note that the care of the two year old child was seen as a protective factor for S. While we accept that the relevant services were fully involved in the assessment process, it is clear that the child was in the care of a man who had florid psychotic symptoms, and continued to use alcohol and cannabis.
- 5.48 The presence of the dog in July 2014 did trigger a discussion about possible risk, in relation to previous history of killing a dog. We believe this should have triggered a review and revised risk assessment, not least of the choices he was making. The dog arrived at a time when he was having the child to stay for longer periods, and at best could be described as an unwise decision.
- 5.49 The presence of weapons in S's flat was discussed with him by Dr C initially, and by FIRT staff periodically. A particular sword that S believed was part of the prophecy was taken from him, and although he asked for it back periodically, this was consistently refused. It was known however that he had several ornamental swords, described as in frames and cases. Police did not express any concern about these at the January 2014 MHA assessment, having checked his flat for weapons. None of these swords were in fact used in the homicides.
- 5.50 There was an environmental risk assessment done at S's flat in early 2014 that made recommendations about the safety of the environment. This also resulted in swords being removed and/or placed out of reach. It was noted that in May 2013 the CPN L recorded that she did not believe the flat was suitable for a child, with reference to use of cannabis and the presence of weapons. However it was further suggested that it would severely damage S's relationship and increase risks if the decision not to allow the child to visit were to come from the FIRT team.
- 5.51 We believe that the presence or absence of swords should have been subject to more assertive challenge by the FIRT, particularly as staff were seeing him by themselves in his flat. The lack of intervention in this situation appears to have been influenced by the overarching acceptance of certain aspects of S's lifestyle choices in a so called recovery model of care.
- 5.52 One further concern is that we noted that one of the CPNs visited S at his flat whilst pregnant, and recorded that S did not smoke in front of her, which was interpreted as his awareness of the need to manage risks regarding smoking in front of his child.

Recommendation 2:

The planning of victim safety in partnership with individuals concerned, especially where this involves a family member or partner, must form part of the core risk assessment and treatment planning.

Recommendation 3:

Ongoing contact with family members or partners must form part of the core risk assessment and care planning by the care coordinator.

Recommendation 4:

Where there is a question of responsibility for the welfare of a child, specific focussed risk assessments must be conducted with respect to risk towards the child, in conjunction with other statutory agencies.

Recommendation 5:

There should be a robust risk assessment of lone workers in the community, including any pregnant staff, and risk management plans applied.

Use of Mental Health Act

- 5.53 Within the HCR 20 risk assessment between 2010 and 2013 S's long-standing mental illness is noted of the '*many discussions over the years*' which have taken place, it is stated that '*on balance it has always been decided that he is not detainable under the Mental Health Act, largely due to his level of compliance and engagement with the service*'. In our opinion this is a very significant statement to include in a risk assessment which is then consistently repeated throughout subsequent HCR 20 risk assessments. Any mental health professional involved in a Mental Health Act assessment would infer from this that the view of the community forensic team is that he is not detainable. However, the MHA Code of Practice (2008)⁴¹ notes that it is inconsistent with the Mental Health Act to state in advance that someone is or is not detainable under the Act. This can only be determined at a point in time when a Mental Health Act assessment is undertaken.
- 5.54 The January 2014 MHA assessment was a significant event in S's care, and the outcome of this assessment we believe influenced later decision making about possible detention. The Scott Clinic psychiatrist Dr G had completed the Section 12 application papers with a view to detention under Section 3. The AMHP had already ascertained that the nearest relative (father) was objecting, before he arrived at the scene. The AMHP has recorded that '*his presentation did not suggest to either Dr F Section 12 doctor, or to myself, that he was suffering from a mental disorder of a degree that might have warranted compulsory admission to hospital*'.
- 5.55 This assessment was a missed opportunity in that the emphasis became focussed on the degree rather than the nature of S's mental illness in relation to compulsory admission. This was referenced both in April 2014 and in September 2014, with professionals later noting that S could have been detained if the nature alone of his illness was the focus.

⁴¹ MHA Code of Practice 2008 Department of Health.(revised in 2015)

- 5.56 The internal report suggests that the nearest relative could or should have been displaced, or that Section 2 could have been used. Under Section 2 the law does not give the nearest relative the power to object. However in this situation, the AMHP had only one medical recommendation, with Dr F stating he did not agree that detention was warranted on the degree of S's illness. Therefore we have to conclude that Dr F would equally not have recommended a Section 2. There is no record of a discussion between the two doctors about their perspectives on detention, which would have been good practice.
- 5.57 We suggest that the degree of concern generated by S's presentation should have prompted an escalation of concerns to senior management based on the strength of conviction that S should have been detained. A contingency plan should have been agreed, which could have included a request for another Section 12 doctor assessment, with further discussion about nature and degree.
- 5.58 Within the 'policy and procedure for the management of service users under the care of the forensic outreach service' dated February 2016, there is a protocol for the escalation of concerns, this could be used where the opinions of clinicians are at such wide variance, and could minimise the risk of this type of situation recurring. We have therefore not made a recommendation about this aspect.

Recommendation 6:

There should be a programme of training for Section 12 doctors and AMHPs on risk assessment in forensic patients, focussing on both the nature and degree of mental disorder

Medication

- 5.59 S had been prescribed Olanzapine in high doses since 2009. He was also prescribed an antidepressant, Dosulepin, and a regular dose of Procyclidine. We could find no reference to any assessment which concluded that S had features of a depressive illness, so we question why he was prescribed Dosulepin.
- 5.60 We found one reference only (in 2013) to S describing restlessness in his legs that is linked in the record to use of Procyclidine being helpful in minimising side effects of medication. In our view 'restless legs' is not sufficient to justify a prescription of Procyclidine. This is usually prescribed for extra-pyramidal side effects, principally limb stiffness, tremor, dystonia⁴², and akathisia⁴³. If

⁴² Dystonia is a state of abnormal muscle tone resulting in muscular spasm and abnormal posture, typically due to neurological disease or a side effect of drug therapy. <http://www.dystonia.org.uk/index.php/about-dystonia/symptoms/tremor>

⁴³ Akathisia is movement disorder characterized by a feeling of inner restlessness and a compelling need to be in constant motion, as well as by actions such as rocking while standing or sitting, lifting the feet as if marching on the spot, and crossing and uncrossing the legs while sitting. <http://www.medicinenet.com/script/main/art.asp?articlekey=33264>

Procyclidine is prescribed, it should be reviewed to see if it has alleviated the problem.

- 5.61 We would also expect that such medication would be prescribed on an 'as required basis'. The medication was supplied weekly in person by CPNs, so we were particularly surprised at the lack of enquiry documented about S's adherence to his medication regime. Both Procyclidine and Dosulepin have been known to be drugs of abuse, but this does not appear to have been considered.
- 5.62 The internal report notes that it would have been fairly usual to expect that someone on 40mg Olanzapine would gain weight, which S did not. We consider that there was an over reliance on his self-reported compliance with medication, and a lack of checking and scrutiny, and this was linked to the FIRT's recovery focussed approach which resulted in a lack of challenge to S's stated refusal to consider any other medication. Assay levels on arrival at Ashworth in September 2014 suggest he was not taking Olanzapine regularly, and S has admitted this.
- 5.63 The long term prescription of Zopiclone is equally open to question. Zopiclone is not intended for long term usage. S's concern about lack of sleep and the degree of his distress after losing a night's sleep should have indicated that his mental state was very fragile.
- 5.64 We consider that his medication should have been subject to more critical review, but acknowledge the detail provided regarding efforts made to challenge S's attitude to medication at the change of responsible clinician in February 2013. Between April, June and September each clinical interview records S being challenged about continuing Olanzapine at 40mg, and he is described as 'adamant' that he would not consider a change.
- 5.65 In the 'policy and procedure for the management of service users under the care of the forensic outreach service' dated February 2016 there is a structure in place within the FOS that now arranges periodical checks for medication assay levels to check for compliance with medication, so we have not made a recommendation regarding this. Based on experience however we believe it is good practice to consider the use of depot medication in the community. We have reviewed the POMH-UK⁴⁴ audits carried out in August 2015, and this demonstrates that the Scott Clinic had a much lower rate of prescription of depot medication than the low secure service. Given that most of the patients in the FIRT were discharged from the Scott Clinic directly, this is also likely to reflect a low rate of prescription in that team.
- 5.66 With respect to monitoring of the usage of high dose antipsychotics, there was no process within the Scott Clinic or FIRT to audit prescribing or peer review prescribing practice. We have seen notes of medical audit meetings in 2015

⁴⁴ The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice. POMH-UK, with its member organisations, identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes <http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/prescribingpomh/prescribingobservatorypomh.aspx>

where high dose prescribing was discussed, and a pharmacy audit of high dose prescribing carried out in Ashworth in August 2015.

- 5.67 The medical audit meeting appeared to us to be principally be a peer review of patients on high dose medication and reviews of patients in seclusion. Based on experience we would not describe these as audits of high dose medication because there is no related policy, and no audit or best practice standards are described.
- 5.68 Audit results were not formally presented, a list of patients who are on high doses of medication and polypharmacy was presented. There appeared to be little discussion (with one or two exceptions) of alternatives to be considered and no outcome from the discussions is recorded in the minutes. There was no evidence of a similar meeting for medium or low secure services.
- 5.69 The POMH⁴⁵ audit was undertaken by the pharmacist dated August 2015. It appears that they undertake the first part of this audit each year as part of their contribution to the POMH at the Royal College of Psychiatrists. An audit of a sample of 16 patients on high dose antipsychotic medication looked at their physical health monitoring. This appears to be in response to issues identified by the CQC inspection in June 2015 about physical healthcare monitoring after rapid tranquillisation. It concluded that none of the 16 patients who were audited had received the appropriate level of physical health monitoring for their high dose medication. This audit applied to Ashworth only.
- 5.70 Of interest in the results which looked at the whole secure division is the one on prescribing of depot medication. In the Scott Clinic the prescription of depot medication appears to have nearly halved between March 2012 and August 2015. In the low secure unit over the same time period it has increased to a point where nearly half of the patients received depot medication. A question in our review of S's care has been the prescribing practice in relation to depot medication. If the Scott Clinic is not discharging patients on depot medication, then it would certainly be difficult to initiate this in the community.
- 5.71 However, there has been an increase in the prescription of Clozapine in the Scott Clinic and this may explain why some patients are not treated with a depot. Clozapine use is the recommended treatment of choice in long term schizophrenia, with the expectation that adults with schizophrenia that has not responded adequately to treatment with at least 2 antipsychotics drugs are offered Clozapine⁴⁶. Also high dose antipsychotic prescribing appears to be relatively low in the Scott Clinic and decreasing over the past 3 years.

⁴⁵ The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice. <http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/prescribingpomh/prescribingobservatorypomh.aspx>

⁴⁶ NICE Quality statement 4: Treatment with clozapine. <https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-4-treatment-with-clozapine>

- 5.72 We note that at least annual physical health checks should be carried out when prescribing antipsychotic medication. There was a system in place to request results from S's GP, but records were not completed.
- 5.73 S's GP accepted that the health checks are the responsibility of the prescriber, and the GP electronic system flags the requirement to offer physical health checks when prescribing antipsychotic medication. As part of the GP Quality and Outcomes Framework⁴⁷ (QOF) there is an expectation of reporting on a range of annual physical health checks for patients prescribed antipsychotic medication. The GP reported great difficulty in engaging cooperation from patients. We recommend that there is a joint approach to increase concordance with health checks, and a system for these results to be shared with the mental health services.

Recommendation 7:

There should be a Trust wide policy on prescribing high dose antipsychotic medication which includes standards for auditing, which should be in line with the Royal College of Psychiatrists guidelines⁴⁸

Recommendation 8:

An audit of the usage of depot medication in the Secure Division should be carried out and anomalies addressed

Recommendation 9:

Liverpool Clinical Commissioning Group and the Trust should ensure that there is a joint approach to physical health checks, and information sharing between GPs & mental health services regarding results of health checks

Alcohol and illicit drug use

- 5.74 It is clearly documented in the clinical records that S continued to use cannabis and other illicit drugs, and that both Imagine and FIRT staff were well aware of this. When it became known that he had broken the terms of the agreement not to smoke cannabis while having care of his child, the relevant services were informed by FIRT staff. Apparently S was smoking out the window, and said he believed he had agreed not to smoke in the flat, rather than not to smoke while having care of the child. This should have triggered a reassessment.
- 5.75 There are many examples of FIRT staff accepting S's reassurances about the use of drugs and alcohol, and he later admitting to them he was still using. In September 2014 he denied recent use of either, but was found to be positive

⁴⁷ Quality Outcomes Framework
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213226/Summary-of-QOF-indicators.pdf

⁴⁸ CR190. CONSENSUS STATEMENT ON HIGH-DOSE ANTIPSYCHOTIC MEDICATION.
<http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr190.aspx>

for cannabis and amphetamine after the homicides. At interview he told us that *'speed keeps the weight off'*, suggesting that he used amphetamines.

- 5.76 In the HCR 20 formulation there is a statement which relates to his drug use that states that cannabis *'produces some reduction in his level of arousal'*. It also notes that he has taken cocaine and *'occasionally ecstasy'*. It is stated that he is regularly counselled about his drug use but that he *'does not wish to engage in any specific work'*. It also notes his problems with his use of alcohol. It would appear that this is at variance with the information provided for other risk factors which imply that his abstinence from drugs is evidence of his improved insight into the relationship of his drug used to his risk to others.
- 5.77 He was offered opportunities to meet with the Dual Diagnosis service, and at times stated that he would like to reduce his dependence on cannabis. He did however request that the doctor prescribe something instead, which would keep him calm. He stated that without cannabis he would get angry and aggressive.
- 5.78 In the HCR 20 dated 24 April 2014 section 'Substance Misuse' it notes that he is a long term cannabis user who *'uses cannabis to curb some of his symptoms'*. It is stated that he wants to stop using cannabis but it is not clear whether this is feasible. It then goes on to state *'at times risks may increase without the effects of cannabis'*. In our opinion this appears to be further promoting the completely mistaken belief that S's use of cannabis was a positive action and reduced his risk to others. In patients with chronic resistant schizophrenia such as S, most practitioners would accept that continued use of cannabis is likely to worsen their illness, which in S's case, would increase his risk to others.
- 5.79 We are aware that there is now an expectation that regular Urine Drug Screening will be carried out on all forensic community patients, and there will no longer be a reliance on self-reporting. Care coordinators are now expected to conduct regular drug screening and alcohol breath tests. In the first instance this will be at least monthly and prior to medical reviews.

Based on overall investigative findings, constructively review any gaps in inter-agency working and identify potential opportunities for improvement

- 5.80 We have commented at 5.68 regarding a lack of communication between the Trust and GPs regarding physical health checks.
- 5.81 The communication between Imagine and the FIRT team was of a very good standard. There was a formal system for sharing information, in weekly updates to the FIRT team, and regular contact by phone and in person.
- 5.82 The communication with services relevant to the child was also of a good standard, with regular communication and updates sent by the FIRT, and attendance as required at meetings.

6 Internal investigation

6.1 The terms of reference for this element of the investigation require that we:

Review Mersey Care NHS Trusts internal investigation of the incident to include timeliness and methodology to identify if:

- ***the internal investigation satisfied the terms of reference***
- ***all key issues and lessons were identified***
- ***recommendations are appropriate and outcome focussed***
- ***affected families were appropriately engaged with***

6.2 The Trust were made aware of the homicide following contact from Merseyside police at 11.15 on 19 September 2014. They had received a phone call from S stating he had killed his parents and was on his way to 'Rainhill Clinic'. S arrived at Scott Clinic shortly after this, police were contacted immediately and he was arrested in reception. A consultant forensic psychiatrist assessed S in custody and the notes of this assessment are in his clinical record.

6.3 The Trust conducted an investigation into the care and treatment of S, completing this in May 2015, with involvement of family. The lead investigators and report authors were the Head of Nursing and Patient Experience, and a consultant forensic psychiatrist from Ashworth. They were supported by a panel which included a Non-executive director, the Director of Social Care and Safeguarding, and Complaints Lead. External panel members were: Low Secure Case Manager, NHS England North West Specialised Commissioning Team, Executive Director of Nursing, Cheshire and Wirral Partnership NHS Foundation Trust, Team Leader, supporting victims and vulnerable people, Liverpool City Council and a service user representative.

6.4 The report is described a Level 3 Root Cause Analysis⁴⁹ (RCA) independent investigation, because the panel membership contained both internal and external Trust membership. It is however entitled 'Internal review into the mental health and social care of patient' (hereafter referred to as internal review or IR). The NHS England Serious Incident Framework (March 2013)⁵⁰ states that '*The need for independent investigations is identified and arranged by the commissioner or NHS Commissioning Board, for example a major system failure with multiple stakeholders. Homicides following recent contact with mental health services require an independent investigation. These will be commissioned by the relevant NHS Commissioning Board area team*'. This clearly applies to independent investigations only according to the NHS England Serious Incident Framework. However, according to the Trust's

⁴⁹ Root Cause Analysis investigations in the NHS identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for patients.
<http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/>

⁵⁰ <https://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf>

Policy and Procedure for the reporting, management and review of Adverse Incidents dated January 2014 there are four levels of investigation.

6.5 A Level 3 – Chief Officers Investigation is described as:

NPSA's comprehensive review but will be conducted when: -

- *The incident is of a high public interest.*
- *Service users of the Trust have been involved in an alleged homicide incident.*
- *The incident fits the definition of one of the NPSA's Never Events.*
- *The incident involved the death of a service user whilst they were an inpatient.*
- *Article two of the European Convention on Human Rights is likely to be engaged.*
- *The Chief Executive will agree the terms of reference for the incidents including the panel convened to facilitate the review, which will: -*
 - *Be chaired by an Executive Level member of staff.*
 - *Have an independent / external representative.*
 - *Have a service user/ carer representative.*
 - *Members will be representative of the professionals involved in the care delivery.*
 - *Be supported by an Administrator.*
 - *The panel should not exceed more than five individuals.*
 - *The report will be formally validated by the Trust Board.*

6.6 A Level 4 – Independent Investigation is described as:

The Strategic Health Authority on behalf of the Department of Health has a statutory responsibility to consider whether they should commission an independent review into certain serious and untoward incidents. HSG(94)27: Guidance on the discharge of mentally disordered people and their continuing care in the community and investigation of adverse events in mental health services provides guidance to the cases that should be considered and the scope of such a review. The NPSA clarify that: -

Reviews must be commissioned and conducted by those independent to the provider service and organisation involved.

Commonly considered for incidents of high public interest or attracting media attention.

6.7 According to Mersey Care's own policy, this investigation meets the Trust's internal criteria for a Level 3 investigation, however we suggest that the policy is reviewed to align with the NHS England Serious Incident Framework⁵¹ (March 2015) which states '*Within the NHS there are three recognised levels of systems-based investigation (currently referred to as RCA investigation)*'. These are Level 1- Concise internal investigation, Level 2 – Comprehensive internal investigation, Level 3 Independent investigation. We suggest that the Trust's Policy and Procedure for the reporting, management and review of

⁵¹ NHS England Serious Incident Framework March 2015

<https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

Adverse Incidents dated January 2014 should be updated to align with the NHS England Serious Incident Framework March 2015

6.8 The terms of reference for the internal investigation were as follows:

- 1. Establish a chronology of the care and associated events leading up to the incident involving S on 19 September 2014*
- 2. Examine the quality and efficacy of the care and treatment provided to T by Mersey Care NHS Trust staff and, in particular, the processes used to:-*
 - Assess and manage the service user's health and social care needs;*
 - Assess risk and develop risk management plans in association with S and his family;*
 - Engage and work with S's family;*
 - Share information and the quality of work undertaken as a multidisciplinary team;*
 - Work with external agencies which provided support, housing and care for S*
- 3. Consider if any deficits in care identified have been highlighted in previous reviews within the Secure Division*
- 4. Raise immediate concerns with the Chief Operating Officer for Secure Services to ensure that any necessary remedial action can be taken without undue delay*
- 5. Consider any specific issues that the family of S/friends may wish to raise, with due regard to confidentiality*
- 6. Identify any health care related root cause or influencing factors that contributed to the incident occurring*
- 7. Identify where improvements in practice/systems could be made to prevent a similar incident occurring in the future*
- 8. To consider the appropriateness and effectiveness of the managerial and specialist support provided to staff*

6.9 The report is constructed as an RCA, with detailed contributory factors listed and analysed. We were informed that it had been agreed by Liverpool City Council that the Trust's internal investigation should serve the purpose of a Domestic Homicide Review (DHR) 'single agency review' and this was confirmed by telephone and email contact with the 'Supporting Victims and Vulnerable People' unit at Liverpool City Council. It was noted in the IR panel meeting minutes that the report would need to be shared with Liverpool City Council. The terms of reference for the IR do not specifically state this, and there is no reference to this in the report.

6.10 The purpose of a DHR⁵² is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and interagency working’.

6.11 We have been informed that the Mersey Care internal report has been accepted as a single agency DHR report by Liverpool City Council. The Mersey Care report was presented to the Liverpool Community Partnership Citysafe⁵³ Board on 15 December 2015. The Board agreed the report with the recommendation that actions should be monitored by the Board of the agency that completed the review (in this case the Mersey Care Trust Board). It was noted that completed actions should be fed into the Community Safety Partnership via the Trust representative on the Citysafe Board.

6.12 We have seen notes of the IR panel meetings, and the transcripts of interviews with witnesses. The process was clearly well managed with milestones and formal notes made of decisions and plans. The report was finalised in May 2015, seven months after the homicides, and this timescale was agreed with commissioners.

6.13 The IR notes four care delivery problems:

CDP 1: The risk assessment was not adequate

CDP2: T’s mental illness was not robustly treated, and his compliance with medication was not addressed as it should have been

CDP3: The full powers of the Mental Health Act were not used to detain S in hospital

CDP4: The difficulty for both of the deceased to act as caring parents and also to recognise and manage the risks to them from their son were not addressed in a consistent manner. Nor was there consideration of how these

⁵² Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised – applicable to all notifications made from and including 1 August 2013 Home Office.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

⁵³ Citysafe is Liverpool's Community Safety Partnership, organised by Liverpool City Council.
<http://liverpool.gov.uk/council/strategies-plans-and-policies/crime-and-community-safety/citysafe-community-safety/>

ambivalent feelings towards their son could be properly managed through father's role as Nearest Relative, under the Mental Health Act.

- 6.14 We agree with these above, but would add two 'Service Delivery Problems'⁵⁴
- 6.15 SDP 1: Isolation of Scott Clinic and FIRT during the Trust's management changes
- 6.16 SDP 2: the medical management and clinical provision of the Scott Clinic.

Contributory factors

- 6.17 We have listed the IR Contributory factor list below in italics, and indicate our findings alongside. The contributory facts are noted as CF (causal factors) or as IF (influencing factors) and this is well articulated as follows:

IF = an influencing factor, that is something that influenced the occurrence, or outcome, of an adverse event. Generally speaking, the adverse event may still have occurred, and removal of such a factor may not prevent incident occurrence but will generally improve safety of the care system under review.

CF = A Causal Factor is something that led directly to the adverse event. Removal of a causal factor will prevent or reduce the chance of a similar type of incident happening in similar circumstances in the future.

Organisational and Strategic Factors

FIRT primary focus on patient's engagement and recovery rather than risk (IF)

Clinical Leadership of FIRT and the consultant psychiatrist's role (IF)

We agree with these findings.

Task Factors

Inadequate risk assessment and use of CPA and risk documentation (CF)

Accepting that he could look after his child on his own (IF)

Accepting he could look after a dog (IF)

Drug and alcohol use (CF)

We agree with these findings.

Out of Hours Service (IF)

Equipment and resource factors

Working condition factors (IF)

⁵⁴ Acts or omissions identified during the analysis of the incident, but not associated with direct care provision.
<http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60180>

We agree with these findings.

Individual factors

Clinical competency

Admission under the Mental Health Act (CF)

We agree with the finding that assessment of risk was inadequate, and became focussed on the N/wedding scenario. We agree there should have been a review of treatment approaches, particularly in regard to medication and the question of detention.

We believe that the evidence does not support the criticism about the lack of consideration to displacing the nearest relative. This criticism is described thus: '*It is of concern that consideration was not given to displacing the nearest relative in relation to the January 2014 Mental Health Act assessment*'. We have reviewed the AMHP notes and the interview with the AMHP and discussed it with the AMHP ourselves. It is clear that there was only one medical recommendation at this assessment, and that neither the AMHP nor the Section 12 doctor agreed admission. We agree with the finding that the January 2014 MHA assessment directly influenced thinking about subsequent assessments, but have suggested that this is addressed in two ways, an escalation process if a consultant remains very concerned that detention is required after a MHA assessment and training and awareness raising with local AMHPs and Section 12 doctors on risk assessment in forensic patients. (See recommendations 5 and 6)

Communication factors

RC to RC patient handover

We agree with the comments about RC to RC handover. The statement '*It is also reasonable to ask why one of the more risky community patients was given to the newest appointed consultant to take on RC responsibilities*' we believe this relates to a wider issue regarding the configuration of consultants across Scott Clinic and the community services. (see comments at Section 5)

Communication of risk to family (CF)

We agree with this finding.

Education and training factors

Understanding of Mental Health Act (CF)

We agree with this finding, but also regard this as a wider issue for the AMHP and Section 12 Doctor services. (see recommendation 5)

NICE Guidelines

NICE Guideline⁵⁵ Psychosis and schizophrenia in fact states: ‘Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user’.

Team and Social Factors

A learning service and critical supervision

We agree with the comments about a lack of critical review, however we consider this was partly as a consequence of the Scott Clinic and FIRT being allowed to become isolated from the Trust management structures. Therefore this needs be viewed as a systems rather than purely individual failure.

Safeguarding and Risk

We agree that there was a lack of consideration given to risk of harm to the child, to S’s parents and brothers and to a risk of domestic violence generally.

Patient factors

We agree with these findings

Root causes

The IR states that ‘The root case in the case of S’s killing of his parents is that he was in the community with access to his parents, whilst actively suffering from a psychotic illness, rather than being detained in hospital’.

We agree that this is a root cause, but also believe that a further root cause is the particular clinical organisation and management arrangements of the Scott Clinic and FIRT, which generated the conditions in which S remained in the community in the manner described.

Engagement with S’s family

- 6.18 According to the Trust’s Policy and Procedure for the reporting, management and review of Adverse Incidents dated January 2014, a senior manager should be agreed responsible for informing family formally, agreeing a process for involving them in an internal review. There should be an agreement about ongoing support and about how the report should be shared.
- 6.19 Contact was made with the family by the lead investigation author and the Director of Patient Safety, who was not directly involved in the investigation.

⁵⁵NICE guideline CG 178 Psychosis and schizophrenia. <http://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions/psychosis-and-schizophrenia>

- 6.20 Several meetings took place with a range of family members, and the Director of Patient Safety maintained links with family members since the incident and offered support and information about the investigation process when required.
- 6.21 The family were invited to meet formally with the Investigating Team to be interviewed but declined, asking to meet when the report was available.
- 6.22 The Chief Executive of the Trust wrote to both of S's brothers in November 2015 acknowledging that the internal report made a number of criticisms, and apologising to the family for letting them down in such terrible circumstances.
- 6.23 We consider the Trust's approach to the family after the tragic homicides has been an example of very good practice.

Internal recommendations

- 6.24 The internal report made 17 recommendations:
1. Develop a strategy and improve leadership and morale across the Scott Clinic and FIRT Service
 2. A review of the FIRT Service
 3. Review of Scott Clinic Consultant Psychiatric Body Clinical Practice
 4. Agree a clear management structure of the FIRT and Scott Clinic In-patient Service
 5. CPA and Contingency planning
 6. Nearest relatives who are potential victims
 7. Service level recommendations
 8. On-going critical review of FIRT patients – externally facilitated
 9. Compliance testing, use of alcohol and drugs
 10. Psychological treatment interventions and NICE guidelines
 11. RC to RC handover
 12. Working with families and specific individuals at risk
 13. Mental Health Act training
 14. Completing the CPA and risk documentation
 15. Clinical competency

16. Shared learning for AMHPs and community forensic and wider Trust community teams

17. Shared learning on SUIs and action plans

- 6.25 We broadly agree with these 17 recommendations, and have made several comments on the detail. We have not repeated these, although we also make other recommendations.
- 6.26 A key part of the internal terms of reference were to '*Consider if any deficits in care identified have been highlighted in previous reviews within the Secure Division*'. This refers to investigations into previous homicides of patients under the care of the Scott clinic, and references to the findings of a previous independent investigation into a homicide in 2010 are made where appropriate.
- 6.27 Our overall view is that the report did answer its own on terms of reference, taking the information above into consideration.

7 The Assurance section

- 7.1 There have been other incidents of parental homicide (parricide) by Mersey Care service users prior to (and since) the homicide of S's parents.
- 7.2 In July 2015 a joint NHS commissioner and provider workshop was held to consider this specific case and previous incidents of homicide involving service users of the Scott Clinic (secure services). The workshop provided an opportunity to collectively review the relevant investigation reports and identify any common service delivery problems, care delivery problems, contributory factors or root causes. The review process resulted in the identification of a number of common themes. Each theme was considered by the group in terms of its significance and impact and through collective agreement a number of key themes were identified for further analysis. These are described below in the 'supplemental terms of reference section'. An update on the Trust position in relation to these elements was provided to us by the Director of Patient Safety, and this is included in the relevant sections.
- 7.3 The focus of this section is on the implementation of the internal action plan following the homicide of S's parents, and on the assurance structures in place in the Trust. The intention is to consider whether lessons have been learned, and to comment on the effectiveness of the current clinical quality governance and assurance structures.
- 7.4 To inform our understanding of the current structures and how they have supported change we attended a FOS team meeting, a Trust quality surveillance meeting, a secure division surveillance meeting and the CEO's 'stand up Thursday' meeting where agreed actions from surveillance meetings are feedback.
- 7.5 We have read surveillance meeting notes, seen the secure division and Trust wide governance structure diagrams and had access to the Trust's quality monitoring information data set. We have seen reports commissioned by the Trust to audit the implementation of the action plan from the previous parental homicide in 2010.
- 7.6 The following section reviews in more depth the two key areas of:
- Implementation of the internal investigation action plan
 - The overarching governance framework which provides assurance of the implementation and alerts the Trust when there are risks to the quality of clinical services.

Internal investigation action plan

- 7.7 The relevant section of the terms of reference are:

the Trust can evidence implementation of the internal action plan and improved outcomes

- 7.8 The internal investigation made 17 individual recommendations, which were then clustered into 8 expected outcomes, with 44 component parts.

The action plan has generated the following outcome areas:

- Effective clinical leadership to deliver safe and effective care
- Competent and capable staff to provide the community forensic service
- Clear clinical guidelines for effective risk management including compliance testing and contingency management
- Clear procedures to address risk to named individuals/family members
- Effective CPA process
- Staff working to best practice guidelines/evidence based practice
- Learning culture encouraging critical enquiry amongst team and wider service
- Robust governance process to ensure service delivery

- 7.9 The action plan updates are stored in the Datix system directly. The overall Head of Nursing and Patient Experience holds responsibility for the action plan, with operational responsibility delegated to the FOS service manager. Updates are discussed monthly at the Secure Division Governance Board, and we saw the February 2016 update. It is due for presentation at the March 2016 Quality Assurance Committee.

- 7.10 The operational philosophy and approach of the then FIRT team was found by the S internal report to be a fundamental issue in relation to patient care in the forensic community service. It was noted that the service was not sufficiently focussed on risk assessment and management of individual service users.

- 7.11 Based on our observations we consider that the service has made radical changes in the approach of the team, and has moved to a model where decisions are based on evidence based risk management information, rather than on self-report and emphasis on therapeutic relationships.

- 7.12 We comment on each element of the action plan in turn.

Effective clinical leadership to deliver safe and effective care

- 7.13 The FIRT service has been fundamentally redesigned and restructured, with a new manager who commenced in post in September 2015. This manager is a member of the Secure Division surveillance committee and provides regular

updates to both Secure Division and Trust surveillance meeting, and has been attending 'stand up Thursday' to give direct feedback on progress to the executive team on the progress of the action plan.

- 7.14 A revised operational policy and model of care has been agreed and signed off in February 2016. The model now offers a 12 month period of intensive support post discharge, with clear milestones and outcomes identified. There is a stated intention to transfer the service user to mainstream mental health services after 12 months, mental state and risk assessment permitting. Prior to this, service users were previously maintained on the FIRT caseload for many years.
- 7.15 The emphasis is now on managing and reducing risk through effective evidence based formal assessments and using the case consultation model. Family involvement and victim safety plans are seen as critical in this, and all patients will have crisis plans in place.
- 7.16 A review of staffing has taken place, and as part of this change a single Responsible Clinician for the FOS has been agreed and is in post. In practice this is likely to be filled by two part time RCs, who can provide operational cover. However the previous model of RC's maintaining the responsibility from Scott Clinic into the community has been changed as recommended. The RC attends the weekly team meeting, and has oversight across all patients on the FOS caseload.
- 7.17 The role of social work in the team has changed, so that no social workers have dual inpatient and community caseloads. There is a dedicated psychology resource to the team.
- 7.18 An internal review of community patients was conducted by the Associate Medical Director of the Secure Division, and an external review of the FIRT was conducted by the Royal College of Psychiatrists 'invited review' service⁵⁶ in autumn 2015.
- 7.19 Links have been established with other providers of forensic community services to benchmark and share practice.

Clear clinical guidelines for effective risk management including compliance testing and contingency management

- 7.20 There is a clear protocol for the monitoring of compliance with medication, including blood tests to check assay levels.
- 7.21 It is expected that routine drug screening and alcohol breath testing with clear timeframes will form part regular risk assessments, and be part of the care coordinators report for CPA and medical reviews.

⁵⁶The Invited Review Service (IRS) of the Royal College of Psychiatrists was previously known as the External Clinical Advisory Service, (ECAS). It has been developed to support NHS and independent sector provider organisations by conducting robust, transparent and objective reviews in response to concerns about the professional performance of individual psychiatrists and the functioning of local services. <http://www.rcpsych.ac.uk/workinpsychiatry/invitedreviewservice.aspx>

- 7.22 We recognise the considerable improvements that have taken place in clarifying practitioner and team roles in managing alcohol abuse and drug screening with service users. However, we suggest that the FOS, like many services around the country now need to consider how to assess and address the risk posed by new psychoactive substances (NPS) or legal highs, since most are not detectable by existing routine testing.
- 7.23 At the FOS meeting attended by one of the investigation team, a review template was used to structure the discussion for each patient, focussed on evidence for compliance, victim safety issues, family involvement and risk management. The template for this is in the appendix of the operational policy. A key element of this meeting, and which underpins the new model of care and operational policy is the reinforcement of a shared team caseload and emphasis on the management of risk. At the meeting we observed clinical challenge and consideration of risk for the service users discussed was encouraged across the team.
- 7.24 The processes for ensuring that messages are passed on has been strengthened and the handover standard in place across the Trust is now in use.
- 7.25 Initially all service users are to be seen at least weekly. The operational policy clarifies the expectation that service users will be seen in their own home, at least monthly, even if the service user requests to be seen outside of their home. There is an expectation that every room in the service user's home is seen when undertaking home visits.
- 7.26 We have noted and read the Trust policy **SD32: Policy and procedure for staff action following concerns regarding weapons in the community** which clarifies the escalation and reporting requirements of staff finding weapons in the possession of service users in the community.

Clear procedures to address risk to named individuals/family members

- 7.27 There is a strong focus in the new policy on the expectation that the care coordinator will have regular contact with family members, next of kin and significant others. These contacts are expected to ascertain family views around presentation and potential changes to risk.
- 7.28 A victim safety plan is expected to be discussed at the FOS team meeting, and a crisis plan develop that is reviewed monthly with family members.
- 7.29 The recommendations of the commissioned report on carer involvement are in the process of being implemented.
- 7.30 A bid for innovation monies has been submitted to: develop a screening tool to identify potential victims, especially family; develop policy and strategy for Trust support to victims; design an intervention/education programme for families and carers; and a training programme for staff. We understand this is still in progress.

Effective CPA process

- 7.31 The CPA process review is incomplete, and is part of a review of process across the secure division. This remains on the S action plan as an outstanding item.
- 7.32 A two year review of this process has been carried out in the Trust. One of the problems identified was the way clinical records were completed. An outcome of this was the purchase of a new clinical records system and amendments to all forms being used. It is envisaged this will streamline the process and make it easier for staff to undertake assessments and share information.
- 7.33 The elements that relate directly to the FOS are a revision of the policy set for FOS, evidencing a clear process for contingency planning which takes account of risk, victims and potential victims of violence.
- 7.34 The policy revision was accepted in February 2016, and is currently at the implementation stage.

Staff working to best practice guidelines/evidence based practice

- 7.35 The revised policy is in place, and work is in progress to map against the CCQI Standards for Community Mental Health services.⁵⁷
- 7.36 The use of Community Treatment Orders is now being monitored, and the action plan update notes that numbers are increasing.
- 7.37 The action against the item regarding integration of the recommendations of the NICE guidelines for the management of psychosis and schizophrenia in adults⁵⁸ is an audit of medication review. We suggest a wider review of this is required.

Recommendation 10:

The Trust should audit compliance with NICE guidelines CG178: Psychosis and schizophrenia in adults: prevention and management, within the Secure Division

Learning culture encouraging critical enquiry amongst team and wider service

⁵⁷ CCQI National Clinical Audits, Service Quality and Accreditation Projects
<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqipprojects.aspx>

⁵⁸ Psychosis and schizophrenia in adults: prevention and management NICE guidelines [CG178] Feb 2014
<https://www.nice.org.uk/guidance/cg178>

- 7.38 Supervision and appraisal structures have been updated in the FOS team, and Aston coaching⁵⁹ has been introduced.
- 7.39 A learning event has been held to convey findings of the internal report, and further learning events are planned.
- 7.40 A review of training in mental health act procedures, and also in clinical risk assessment has been undertaken. Bespoke mental health act training sessions have been carried out. Specific aspects of displacing nearest relatives and decision making regarding Section 2 and Section 3 are yet to be completed.
- 7.41 The Trust has included 'Failure to learn from the S incident' as an item on the Trust risk register, to ensure it has executive team attention.

Robust governance process to ensure service delivery

- 7.42 The revision of the Trust's divisions into two business units has enabled a focus on robust line management and governance (this is discussed more fully in the later section on Trust quality governance and assurance).

Supplementary terms of reference

- 7.43 From the July 2015 joint commissioner and provider workshop held to consider this specific case and previous incidents of homicide involving service users of the Scott Clinic (secure services), supplemental terms of reference to this independent investigation were agreed.
- 7.44 The relevant section of the terms of reference for this review are:

Examine the identified key themes from this and previous homicides involving service users of the Scott Clinic. Provide a written report with recommendations on the quality and governance processes (including organisational culture and leadership) in the following identified services/areas within the Scott Clinic and where appropriate, across Mersey Care NHS Trust:

- ***Dual Diagnosis Service – interface with the Scott Clinic***
- ***Carer involvement – including availability of information resources, engagement with and sharing of information, the protection of carers and the potential barriers of consent and confidentiality***
- ***Medication Issues - including compliance testing and use of the Mental Health Act***
- ***Risk assessment - focussing on the known and evolving risks, planning for reduction and mitigation of risk, sharing of information in relation to risk***

⁵⁹ Aston provides tools for organisational development. <http://www.astonod.com/team-tools/>

- **Pathways of care for service users with a diagnosis of paranoid schizophrenia, including:**
 - **treatment of condition**
 - **access to psychological interventions**
 - **care co-ordination**
 - **engagement both with and between patients and carers**
 - **communication between the Trust and primary care services**

Where partially implemented recommendations from previous homicides are identified determine if there are organisational barriers to full delivery

7.45 Our findings in these areas are summarised under individual headings, and we will provide an overview of Trust quality and governance processes, reflected against forensic service issues from 7.64 below.

Dual Diagnosis Service – interface with the Scott Clinic

7.46 This is an area that is recognised by the Trust as requiring ongoing oversight with the aim of ensuring that all staff have a good knowledge of the effects of illicit substance and alcohol misuse on the mental state of service users and how to intervene appropriately.

7.47 We have noted the recent policy “**SD37: Management of Service Users who have coexisting problems related to Illicit Substance / Alcohol use**”. This policy explains in detail how the Trust staff should engage with service users with co-morbid mental health and substance misuse problems.

7.48 The Trust has implemented the initial recommendations from the homicide reviews, in relation to enhancing training and providing information on resources to staff so they could sign post service users and their carers. Following the incidents The Trust organised specific dual diagnosis network training events on: legal highs, alcohol misuse, cocaine and heroin usage, support for carers, physical health problems and alcohol misuse and voluntary provision.

7.49 With respect to the issues highlighted in the care of S, the FOS team approach to alcohol and substance abuse has been radically changed, with an emphasis on evidence based decision making, and routine screening and monitoring rather than on self-report.

7.50 The Trust has stated it will continue working on this area with the aim of improving awareness of staff and the care provided.

Carer involvement – including availability of information resources, engagement with and sharing of information, the protection of carers and the potential barriers of consent and confidentiality

7.51 The Trust has an ongoing project in this area led by the Service User and Carer Lead for the Trust. The Triangle of Care is used to monitor compliance

and direct the work of staff in both community and in-patient settings. The Trust currently has plans to increase the size of its PALs team to enable further support to be given directly to service users / carers and to guide staff in involving carers in their patient's care planning processes.

- 7.52 Training is available to all staff on how and why to involve carers. The Trust scores positively on the use of the Triangle of Care when considered against benchmarking data.
- 7.53 The issues regarding carer involvement and family victim safety planning in the FOS have been addressed with clear policy guidance in the latest operational policy.

Medication Issues - including compliance testing and use of the Mental Health Act

- 7.54 The Trust has an ongoing programme of work to oversee and monitor the use of the Mental Health Act. A Law Governance Group chaired by an Associate Hospital Manager oversees practice by monitoring KPIs, CQC reports, training uptake and internal audits.
- 7.55 When the incidents initially occurred the Trust responded and reviewed guidance currently available to staff. Pharmacists are allocated to clinical areas and provide advice and guidance on adherence and procedures
- 7.56 The Care Quality Commissions (CQC) comprehensive review in June 2015 was complementary about the governance of the Mental Health Act. Specialist support and guidance is available regarding complex cases which is well used and positively regarded. This can be accessed via the telephone, email or specialists will attend team meetings to discuss at a more in depth level.
- 7.57 The issues regarding compliance testing with reference to the issues in S's care have been addressed by a fundamentally different approach in the FOS policy – see 5.59 to 5.73 and recommendations 7 and 8.
- 7.58 ***Risk assessment - focussing on the known and evolving risks, planning for reduction and mitigation of risk, sharing of information in relation to risk***
- 7.59 This remains an issue for the Trust. There are several pieces of work ongoing to improve the way staff identify risks and identifying remedial actions which are inclusive of social aspects of life.
- 7.60 The Trust recently achieved positive results in the National Patient Survey which highlighted positive scores in the planning and reviewing of care. Scores were not as high in relation to plans considering social and environmental support. This deficit is being actioned by the Local Services Clinical Division.

- 7.61 Within the Strategic Framework the Trust outlines its intent to improve the quality of clinical care. The Trusts stated ambition is to deliver 'Perfect Care' and become the world's leading organisation in mental health, addiction and learning disabilities. This is highlighted by the Trusts commitment to 'perfect care' and a zero tolerance approach to the suicide of patients in its care. The suicide prevention programme of work is the Trust's major activity to enhance assessment of risk and enable staff to formulate effective interventions to manage suicidality and risk.
- 7.62 It has just appointed an Associate Medical Director and Suicide Prevention Nurse Specialist to undertake this work which includes a total revision of its training programme and support arrangements.
- 7.63 With reference to S's care the issues have been discussed at 5.17 to 5.41 and at recommendation 1.

Trust quality governance and assurance

- 7.64 The Trust has had a five year Quality Strategy in place since 2011, with an agreed Quality Model based on the Institute for Healthcare Improvement model. However, from 2013 the Trust has undergone a significant step change in its quality governance and assurance processes, and how it manages risk. A significant driver for this has been the application process to become a Foundation Trust (FT), initiated following implementation of the Health and Social Care 2012 in April 2013 which allowed providers of high secure services to apply to become FTs.
- 7.65 Since 2010, the application process to become an FT requires applicants to have developed robust quality governance and assurance processes. These are assessed using the "Monitor Quality Governance Framework", now the "Well Led Framework".
- 7.66 The characteristics of a well-led organisation, as defined by the Care Quality Commission (CQC), Monitor and the NHS Trust Development Authority (TDA) are now identical. This aligned view of a well-led organisation is reflected in CQC's assessments and ratings, as set out in its provider handbooks, while Monitor and TDA now use the updated well-led framework as the point of reference for NHS trusts and foundation trusts.
- 7.67 Only trusts that have robust quality governance processes and are deemed to be 'well led' are allowed to become FTs. Applicants to FT status must be supported by the NHS Trust Development Authority (TDA) and for Trusts providing high secure services, such as Mersey Care, NHS England. Applicants must achieve an assessed quality governance score of less than 4 before being allowed to proceed.
- 7.68 Mersey Care NHS Trust achieved an external rating for their quality governance of 2.5 in November 2012, and a recent self-assessment rating of 1.5 in September 2015. In April 2015 the Trust engaged the Good

Governance Institute (GGI) to undertake an independent assessment of its quality governance processes.

- 7.69 After this assessment of quality governance, an applicant trust must pass a CQC inspection (receiving either a 'good' or 'outstanding' rating) under the Chief Inspector of Hospitals' (CIOH) regime before being referred to Monitor for assessment. If this final assessment is passed, it will lead to the Trust being authorised to become and FT.
- 7.70 Mersey Care NHS Trust received a 'Good' overall rating following the CQC CIOH inspection in May 2015. The Trust were assessed as 'Good' across 4 of the 5 headline domains with the Trust assessed as 'Requires Improvement' against the Safety domain. The main issues behind this assessment on this domain were isolated issues on particular wards, rather than systemic issues across services or the organisation more generally.⁶⁰
- 7.71 Mersey Care NHS Trust has defined its processes for managing quality and risk within its Strategic Framework 2013-14, and then in the subsequent Strategic Framework 2014 - 2016.
- 7.72 The Trust Quality Assurance Committee receives a monthly quality dashboard, 'Care at a Glance'. This permits the Board to analyse and interrogate the Trusts performance on a range of quality metrics with a high degree of granularity across a range of metrics, and the key quality performance indicators for the Trust.
- 7.73 As part of the continued development to improve quality there has been the realignment of roles for the responsibility of safety (now the Executive Director of Nursing) and quality improvement (now the Executive Medical Director).
- 7.74 The Trust ratified a risk management strategy, **SA02: Risk Management Strategy**, in November 2015.
- 7.75 In January 2014 the medical director submitted a paper to the Trust Board which proposed the establishment of a Centre for Perfect Care and Well-being, to make best use of the resources currently deployed for quality governance, quality improvement, innovation, and research and development.
- 7.76 Since then the Centre for Perfect Care has been at the forefront of leading quality improvement within the Trust. Through the Centre for Perfect Care and Well Being, the Trust has made a commitment to eliminate suicide for all those in its care, seeking to emulate the Henry Ford Health Care system in Detroit, USA, which has reduced the rate of suicide of people in its care by 75%. This is one of the 6 priorities for quality improvement in 2015-16.
- 7.77 Over the past year the Centre has focussed on establishing new partnerships with Lockton (independent insurance brokers), Mills & Reeve Solicitors and The Risk Authority (from Stanford University Hospitals). This has included a complete review of risk management and participation in a unique

⁶⁰ <http://www.cqc.org.uk/provider/RW4/inspection-summary#safe>

collaborative for evidence based clinical risk management (along with seven other UK healthcare providers and six US healthcare providers). Further clinical discussions between Stanford and Mersey Care are taking place to develop joint work in a unique international programme called Partnerships for Patient Protection.

- 7.78 These steps are all significant. The organisational learning and revised processes which will stem from these will also have a significant impact on the management of risk including those patients at risk of harming others.
- 7.79 There is a Board Quality Governance Memorandum (QGM), which outlines the process and steps that the Trust Board will take to assure itself of the quality of its services. This was approved at the Trust Board meeting of 16 December 2015. It is a requirement to submit this as part of the application to Monitor, to become authorised as an FT.
- 7.80 The Board Quality Governance memorandum outlines the steps the Trust has taken to improve quality governance over recent years. This includes the Trust surveillance process, *The Framework for the Governance of Quality*. This places routine quality monitoring by clinical services at the heart of the Trusts approach to the governance of quality. The Trust has a three tiered surveillance system, with each clinical division reviewing a set of data on a weekly basis to identify areas that require enhanced support and direction. Corporate oversight is gained by each division sharing their identified teams and themes at a weekly corporate surveillance process where areas of concern will be identified as an '*emerging concern, requires improvement or inadequate*'.
- 7.81 Teams and themes highlighted as being '*inadequate*' will be raised at the weekly executive surveillance meeting where plans for improvement are discussed. On-going oversight through the surveillance process is maintained until the area highlighted as a risk is felt to have achieved the required improvement this is usually checked by achieving a good grade during the trusts internal Quality Review Visit.
- 7.82 Regular reporting back and support with problem solving ensures that the teams retain ownership of their local issues, and engage in creative solutions, but can also access the support of the executive team. The scrutiny involved is not meant to be seen as punitive but intended to help the service management by providing support, advice and additional resource to address the underlying issues. Our observation was that the process was helpful and supportive, and the managers present confirmed that this was their experience. Surveillance meetings are held weekly and are seen as developmental as much as reporting.
- 7.83 Each of the two divisions (Local and Secure) have monthly divisional governance meetings. These meetings report on and triangulate quality information across a wide range of domains, such as numbers of incidents, restraints, complaints, sickness and absence, staff receiving supervision and other workforce issues, by each service.

- 7.84 We have observed the Secure Division governance meeting. We noted that individual service quality performance was reported on, and for each indicator a list of the 'top three' services with the worst performance was provided
- 7.85 Although it was immediately apparent if a service appeared in several categories facilitating triangulation of data, this was still more by 'gut feel' rather than from a system. It was possible for a service to be performing sub optimally across every area, and not appear on the top three list. We suggest that in order to provide a more systematised approach to triangulation, information is provided that captures those services that are in the 'top five' or other agreed quantity on two or more quality indicators.

Recommendation 11:

The Trust should provide quality performance information on services that consistently appear in the top five or other agreed quantity of quality indicators for two or more quality indicators to systematise the triangulation of performance information.

- 7.86 Where there are emerging concerns about a service it is placed under 'surveillance'. The 'surveillance' structure ensures that it is noted that the executive team has raised a concern with the service, and has an expectation that action will be taken and reported back. This allows time for teams and services to gather local information and problem-solve issues, and report back to the surveillance meetings at defined intervals. Regular reporting back and support with problem solving ensures that the teams retain ownership of their local issues, and engage in creative solutions, but can also access the support of the executive team. The scrutiny involved is not meant to be seen as punitive but intended to help the service management by providing support, advice and additional resource to address the underlying issues. Surveillance meetings are held weekly and are seen as developmental as much as reporting.
- 7.87 There is a local version of the surveillance structure, chaired by a senior operational manager, where local quality issues are noted and highlighted. The Secure Division has its own surveillance meetings to review actions required, and the FOS has been under surveillance at these meetings. The process of working through the FOS issues systematically through these meetings has been described to us in detail, and we attended one of the meetings. Our observation is that this process has been successful in driving and supporting the changes required.
- 7.88 Services placed under surveillance can also be asked to attend the weekly 'Stand up Thursday' meeting where the concerns are more serious.
- 7.89 'Stand up' Thursday (short for both 'stand up for quality', and because those attending physically stand up) is a short focussed meeting attended by a multi-disciplinary team including the Executive Director of Nursing and other

senior clinicians and managers. At this meeting the service manager reports on their action plan to address the quality concerns, and outlines steps taken to address quality issues. Those present both support and further challenge/question the steps taken.

- 7.90 When those attending 'Stand up' are all satisfied that the issues have been addressed, the service is taken off 'surveillance'.
- 7.91 We have witnessed both surveillance and 'stand up' meetings, at which the action plan arising from the internal investigation into S's care was reported. For the time being, it has been agreed that the FOS remains under surveillance because the recent changes to operating policy and responsibilities have not had chance to be embedded.
- 7.92 This independent investigation has concluded that the Trust has made a great deal of progress in the governance and assurance of service quality across the Trust.
- 7.93 We are aware that there have been other previous homicides committed by services users of Mersey Care NHS Trust, with subsequent independent investigations. The Trust also responded appropriately on those occasions with focussed action plans, revised managing care and quality governance and reviews of implementation of the action plans. A recent investigation into a 2006 incident, undertaken in 2011 and published in 2014 also comments on the Trusts improved quality governance processes.⁶¹
- 7.94 However, the governance and assurance processes we have observed and seen documented are much changed and significantly improved from 2011. Most recently the Trust has had several external reviews of their quality governance processes, including from the Good Governance Institute and the NHS TDA as part of the FT application process.

⁶¹ *Independent Investigation into the Care and Treatment Provided to Mr. W by the Mersey Care NHS Trust.*
<https://www.england.nhs.uk/wp-content/uploads/2014/02/sha-report-mr-w.pdf>

8 Overall analysis and recommendations

- 8.1 The internal investigation by Mersey Care identified many areas of learning, which we support and have expanded upon. We have made 12 recommendations for wider systems learning.
- 8.2 Since this incident the Trust has taken significant steps to improve the management of risk within the Forensic Outreach Services, and also significantly revised and improved its processes for the governance and assurance of quality.
- 8.3 Key to this has been the development of a culture of continuous quality improvement. We expect that the Trust will want to take on board our recommendations to help it further improve its services.
- 8.4 NHS England have commissioned Niche Patient Safety to undertake an audit against the recommendations that will involve input from both the providers and commissioners within 12 months of the completion of the report.

Predictability and preventability

Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement.

- 8.5 Predictability is '*the quality of being regarded as likely to happen, as behaviour or an event*'.⁶² An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.⁶³
- 8.6 We conclude that there was sufficient evidence of risk of serious harm to S's parents, and this was known to practitioners working with S. In our view it was predictable that S was highly likely to kill his parents.
- 8.7 Prevention⁶⁴ means to '*stop or hinder something from happening, especially by advance planning or action*' and implies '*anticipatory counteraction*'; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.
- 8.8 We believe that we have outlined the systemic issues that influenced practice in the forensic community team during 2014. While we consider that systems

⁶² <http://dictionary.reference.com/browse/predictability>

⁶³ Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000)176: 116-120

⁶⁴ <http://www.thefreedictionary.com/prevent>

issues influenced practice, there is nevertheless some learning for individual practitioners.

- 8.9 Our view is that the homicide of S's parents was not preventable. But a more clinically assertive evidence based model of care might have alerted services to a change in S's condition earlier.
- 8.10 We note that the service concerned has now adopted a much more clinically assertive process to help manage the risks of similar patients in the community.

Parricide and schizophrenia

- 8.11 As part of the investigation, we were asked by the Trust to comment on the any background that may help understand the incidences of parricide in the Liverpool area. We conducted a short review of the current literature on parricide and schizophrenia. Parricide is defined as the killing of a parent by a child of any age. This could include biological parents, step parent or adoptive parents. Matricide is defined as the killing of a mother by their son/daughter and patricide the killing of a father by their son/daughter.

Rate of parricide in UK

- 8.12 The criminal statistics for England and Wales do not provide separate statistics for parricide. However, as most authors on this subject have noted, it is a relatively rare form of homicide. The rate that is quoted in most studies varies between 2 to 4% of all homicides. Double parricide, which is the killing of both parents by one child is even rarer and no figures are quoted for this. However in one large study from Canada (Bourget et al 2007)⁶⁵, which looked at the numbers of all parricide offences committed over a 15 year period, out of 74 parricide offenders, 9 had killed both their parents.

Characteristics of parricide offenders

- 8.13 A review of parricide undertaken as part of the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness identified 2 types of parricide offences, from their review of the literature. These are those offences committed by adolescents and those committed by adults. In the latter group, they found that the perpetrators were either mentally ill, particularly with psychosis or there was antisocial behaviour or a violent personality. They also noted that schizophrenia was the most common diagnosis.

Parricide and mental disorder

- 8.14 The rates of mental disorder in parricide offenders varies according to the population studied. For example, in the Canadian study quoted above, only

⁶⁵ Bourget, D., Gagne, P. and Labelle, M-E. (2007) Parricide: a comparative study of matricide versus patricide. *J Am Acad Psychiatry Law.* 35, 306 – 312.

8% of matricide perpetrators and 6% of patricide perpetrators were found not to have a mental disorder. In that sample, two-thirds of the male parricide offenders were motivated by delusional thinking. This reflects other studies, for example in a study from the USA, they identified 4 factors which were significant in the parricide offences. These were:

Acute psychosis - 47%

Impulsivity - 28%

Alcohol and substance misuse - 24%

Escape from enmeshment - 15%

- 8.15 In another large study from a high secure hospital in England (Baxter et al, 2001)⁶⁶, they studied consecutive admissions over a 25 year period and identified 98 admissions over that period who had committed parricide offences, of whom 6 were double parricides. They compared this group with a group of patients who had killed strangers. They found that the group committing parricide offences had a higher proportion of patients with schizophrenia compared to the other group where the commonest diagnosis was of personality disorder. They also found that the parricide group were less likely to have a criminal history, there was a higher incidence of previous attacks on the victim. One important factor that they noted was that they concluded that the parents may have placed themselves at risk by being more tolerant of violence and seeing it as an inevitable consequence of their son or daughter's schizophrenic illness.
- 8.16 In the study from Canada which identified 9 cases of double parricide, they found that all 9 offenders were male and two-thirds had a diagnosis of schizophrenia and were actively psychotic at the time of the offence. They also noted in the whole group of parricide offenders the significance of persecutory delusions, especially when accompanied by heightened emotional distress and that the offence may have been predicted when there was a deterioration in the person's mental state.
- 8.17 In another study undertaken as part of the National Confidential Inquiry (Rodway et al 2009)⁶⁷ which was not specifically focused on parricide, they studied the methods of homicide compared by diagnostic group. They found that just over half of all perpetrators with schizophrenia had killed a family member or current/former spouse. They found that the majority had active symptoms at the time of their offence, mostly delusions and/or hallucinations. And of these, over two-thirds reported experiencing delusions specifically related to their victim. They found that of all homicide offenders with severe mental illness, half also had a comorbid alcohol and/or drug dependence/misuse problem. They also found that these patients were more likely to use a sharp instrument in the homicide and therefore highlighted the

⁶⁶ Baxter, H., Duggan, C., Larkin, E., Cordess, C., and Page, K. (2001) mentally disordered parricide and stranger killers admitted to high security care. *The Journal of Forensic Psychiatry*. 12, 287 – 299.

⁶⁷ Rodway, C., Flynn, S., Swinson, N., Roscoe, A., Hunt, I. M., Windfur, K., Kapur, N., Appleby, L., and Shaw, J. (2009) Methods of homicide in England and Wales: a comparison by diagnostic group. *The Journal of Forensic Psychiatry & Psychology*. 20, 286 – 305

importance of enquiring into the carrying of weapons by patients with schizophrenia.

8.18 However, in our view all of this work highlights 3 important factors:

- The importance of active symptoms of mental illness at the time of the offences. This is particularly true when these are delusions relating to family members. In turn, this then emphasises the importance of optimum clinical management of patients, particularly ensuring assertive treatment, including compliance with antipsychotic medication.
- Comorbidity of mental illness with alcohol and/or drug use. This has long been recognised as a very significant factor in increasing the risk of violence towards others in patients with schizophrenia.
- Effective liaison with the family, not only to obtain information related to risk but also to offer illness education for the family and highlighting the importance of compliance with medication for their family member. This was also highlighted by the National Confidential Inquiry who recommended that services should explore the relationship between family members and in particular, enquire about previous violence and delusional beliefs relating to family members.

8.19 Finally, a number of these studies (Byoung-Hoon Ahn et al, 2012)⁶⁸ raise the issue of increasing risk of harm to parents who actively seek to promote treatment compliance in their children or who may be actively involved in their in voluntary admission to hospital. This is particularly relevant to their role as the Nearest Relative under the Mental Health Act, where their consent is required for admission under Section 3.

8.20 While we cannot therefore comment on the prevalence of parricide in Liverpool, we believe there is some learning from the evidence that can be applied in the Trust.

Recommendation 12:

The Trust should ensure that care plans for patients with schizophrenia who are assessed as at risk of harming family members incorporate learning from the evidence on parricide

⁶⁸ Byoung-Hoon Ahn, Jeong-Hyun Kim, Sohee Oh, Sang Sub Choi, Sung Ho Ahn and Sun Bum Kim. (2012) Clinical features of parricide in patients with schizophrenia. *Australian & New Zealand Journal of Psychiatry*, 46, 621 – 629.

Recommendations

Recommendation 1:

The formulation of HCR 20 risk assessments in the secure services should be aligned to best practice principles and there should be a quality assurance structure to audit the quality of risk formulations and management plans and ensure they are in line with HCR 20 Version 3 Guide

Recommendation 2:

The planning of victim safety in partnership with individuals concerned, especially where this involves a family member or partner, must form part of the core risk assessment and treatment planning

Recommendation 3:

Ongoing contact with family members or partners must form part of the core risk assessment and care planning by the care coordinator

Recommendation 4:

Where there is a question of responsibility for the welfare of a child, specific focussed risk assessments must be conducted with respect to risk towards the child, in conjunction with other statutory agencies

Recommendation 5:

There should be a robust risk assessment of lone workers in the community, including any pregnant staff, and risk management plans applied

Recommendation 6:

There should be a programme of training for Section 12 doctors and AMHPs on risk assessment in forensic patients, focussing on both the nature and degree of mental disorder

Recommendation 7:

There should be a Trust wide policy on prescribing high dose antipsychotic medication which includes standards for auditing, which should be in line with the Royal College of Psychiatrists guidelines

Recommendation 8:

An audit of the usage of depot medication in the Secure Division should be carried out and anomalies addressed

Recommendation 9:

Liverpool Clinical Commissioning Group and the Trust should ensure that there is a joint approach to physical health checks, and information sharing between GPs & mental health services regarding results of health checks

Recommendation 10:

The Trust should audit compliance with NICE guidelines CG178: Psychosis and schizophrenia in adults: prevention and management, within the Secure Division and implement findings

Recommendation 11:

The Trust should provide quality performance information on services that consistently appear in the top five or other agreed quantity of quality indicators for two or more quality indicators to systematise the triangulation of performance information.

Recommendation 12:

The Trust should ensure that care plans for patients with schizophrenia who are assessed as at risk of harming family members incorporate learning from the evidence on parricide

Appendix A – Terms of reference

The Terms of Reference for independent investigation 2014/30776 are set by NHS England, North, in consultation with Liverpool CCG. These terms of reference will be developed further in consultation with the successful offeror of the independent investigation and family members.

Core Terms of Reference

1. Review Mersey Care NHS Trusts internal investigation of the incident to include timeliness and methodology to identify if:
 - the internal investigation satisfied the terms of reference
 - all key issues and lessons were identified
 - recommendations are appropriate and outcome focussed
 - the Trust can evidence implementation of the internal action plan and improved outcomes
 - affected families were appropriately engaged with
2. Review the care, treatment and services provided by the NHS and other relevant agencies from the service user's first contact with services to the time of the offence. Including specific reference to the review of :
 - the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern
 - the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others
 - the effectiveness of the service user's care plan including the involvement of the service user and the family
 - compliance with local policies, national guidance and relevant statutory obligations
 - the adequacy of risk assessments and risk management, including the risk of the service users harming themselves or others
3. Based on overall investigative findings, constructively review any gaps in inter-agency working and identify potential opportunities for improvement
4. Involve the affected families as fully as considered appropriate, in liaison with Victim Support, police and other support organisations
5. Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement
6. Provide a written report to NHS England North that includes outcome focussed measurable recommendations
7. Assist NHS England, North in undertaking a brief post investigation evaluation

Supplemental to core Terms of Reference

In July 2015 a joint commissioner and provider workshop was held to consider this specific case and previous incidents of homicide involving service users of the Scott Clinic (secure services). The workshop provided an opportunity to collectively review the relevant investigation reports and identify any common service delivery problems, care delivery problems, contributory factors or root causes. The review process resulted in the identification of a number of common themes. Each theme was considered by the group in terms of its significance and impact and through collective agreement a number of key themes were identified for further analysis

8. To review the Governance arrangements for the three divisions within Mersey Care: the local division, acute services and secure division which brings together high, medium and low secure and community services ensuring consistent approaches are applied across the Trust.
9. Examine the identified key themes from this and previous homicides involving service users of the Scott Clinic. Provide a written report with recommendations on the quality and governance processes (including organisational culture and leadership) in the following identified services/areas within the Scott Clinic and where appropriate, across Mersey Care NHS Trust:
 - Dual Diagnosis Service – interface with the Scott Clinic
 - Carer involvement – including availability of information resources, engagement with and sharing of information, the protection of carers and the potential barriers of consent and confidentiality
 - Medication Issues - including compliance testing and use of the Mental Health Act
 - Risk assessment - focussing on the known and evolving risks, planning for reduction and mitigation of risk, sharing of information in relation to risk
 - Pathways of care for service users with a diagnosis of paranoid schizophrenia, including:
 - treatment of condition
 - access to psychological interventions
 - care co-ordination
 - engagement both with and between patients and carers
 - communication between the Trust and primary care services
10. Where partially implemented recommendations from previous homicides are identified determine if there are organisational barriers to full delivery
11. Support Mersey Care NHS Trust to develop a comprehensive outcome focussed action plan based on both the investigation and reviews findings and recommendations including identifying potential organisational barriers to delivery
12. Support Liverpool CCG to develop a structured plan to review implementation of the action plan including the identification and evidence of measurable change

13. Conduct an assessment (within an agreed timeframe) on the implementation of the agreed action plan in conjunction with Liverpool CCG and Mersey Care NHS Trust and provide written feedback of the assessment to NHS England, North highlighting areas of good practice and measurable improvement or areas of concern.

Appendix B – Profile of the Trust and service

Mersey Care NHS Trust provides specialist mental health services in North West England and beyond. The Trust vision is to become the leading organisation in the provision of mental health care, addiction services and learning disability care.

The Trust provides specialist inpatient and community mental health, learning disabilities, addiction management and acquired brain injury services for the people of Liverpool, Sefton and Kirkby, Merseyside. We also provide secure mental health services for the North West of England, the West Midlands and Wales. We are one of only three trusts in the country that provide these services.

Clinical services are provided across more than 30 sites across Merseyside. These teams are supported by a corporate team based at Trust offices in Kings Business Park, Prescot, Merseyside.

4000 staff serve a population of almost 11 million people. In 2014/15 care was provided to more than 36,000 people across Liverpool, Sefton, Kirkby, and St Helens.

Mersey Care is dispersed across over 32 sites and had 641 inpatient beds and 482,184 outpatient attendances and contacts as at 31 March 2015.

During 2014/15, Mersey Care provided care, treatment and support to 38,729 service users (37,813 in local services and 916 in secure services).

Appendix C – Documents reviewed

FIRT team operational policy in place covering the period 2010 to end of 2014

Transfer protocols to/from FIRT team

Description of staffing complement and management structure for FIRT team

Current FOS team treatment model, multidisciplinary structure, model of supervision

Organisation chart including board oversight & operational management of Forensic Service inpatient/community teams from 2010 to 2015

Trust clinical risk assessment & management policy May 2015

Trust CPA policy

Trust safeguarding policy

Trust's evidence file of any changes since the implementation of the action plans above

Royal College of Psychiatrists invited review report 2015

Tony Ryan Associates report re carers

Quality/ Governance structure chart, showing subcommittee structure

Mental Health Act policy, including the admission of informal service users to secure environments

Quality Review Visit notes relevant to FIRT

Quality assurance Self-Assessment results for FIRT for 2013/2014/2015

Associate Medical Director's caseload review report

Schedule of interviews & transcripts of interviews for S internal investigation

Minutes of S internal investigation panel meetings

Trust protocols for Oxford Model Events

Evidence of high dose medication monitoring for Trust/Secure Division/FIRT

Outputs of 'Stand up' and surveillance meetings where FIRT (and S) was discussed – last three meetings

Quality Assurance Committees notes relevant to FIRT

Secure Governance Board minutes discussing homicide action plans, monitoring and closure of actions

Secure Divisional Surveillance Group notes 8 Feb 2016

Letter from Chair of Liverpool City safe Board 27 May 2016

Appendix D – Comments on HCR 20

We have reviewed the following documents in detail; HCR 20 Version 2 documents, dated: 23/09/2010, 24/11/2010, 24/03/2011, 10/11/2011, 02/02/2012, 17/05/2012, 15/11/2012, 06/06/2013. (There appears to be a further revision on 28/11/13, but this was not done as a new version, but the comments were added to some of the items in the previous one), HCR 20 Version 3 dated 24 April 2014, clinical notes covering the same period of time as the above risk assessments 01/09/2010 to 24/09/2014. Notes from a case discussion of S held on 11 November 2013.

The HCR 20 documents between September 2010 and June 2013 were Version 2 of the HCR 20, which had been in use since 1997. During 2013 the revised version of the HCR 20, Version 3 was published. Therefore the next review of S's HCR 20 was done as Version 3, dated 24 April 2014. This was the version which was current at the time when S killed his parents in September 2014.

While Version 3 of the HCR 20 may appear very similar to Version 2, there are some significant differences. This includes changes to the name and content of some of the 20 basic risk factors and the addition of sub-items for complex risks factors. In addition, for the first time, it was suggested that a risk formulation should be completed. Finally, before the risk factors are scored, there is an important new section of information, "Summary of Future Plans". This should provide a brief summary, under a number of structured headings of the forthcoming plan for the patient over the stated rating period. The headings include, Residence, Relationships, Education/employment, Physical health care, Mental health care, Substance misuse, Supervision, and Avoiding past problems.

Comments on HCR 20 Version 2 documents 23/09/2010 to 06/06/2013:

At the end of this section we have included a table which indicates the scoring for each risk factor across the 8 documents covering this period of time.

Historical risk factors

The historical risk factors of the 8 HCR 20's during this period of time remained consistent. 8 out of the 10 H risk factors were scored as being present and the 2 remaining risk factors were scored as partially present. These 2 latter factors were H7 Psychopathy and H9 Personality Disorder. This is not surprising given that his principal diagnosis was Schizophrenia.

Clinical risk factors

As can be seen by the table, the scoring of the Clinical risk factors remained identical throughout the 8 revisions of the HCR 20. These are described in detail below because of their importance as dynamic risk factors.

C1 Insight is rated as partially present. The description notes that S had *'very good compliance with medication'*. Also that his *'abstinence from cocaine is as a result of his good insight'*. It is not clear that there was evidence to support the belief that he was fully compliant with medication throughout this time. Also, later on in the three-year period covered by these HCR 20's it was recognised that his drug use was greater than had been previously recognised.

Although this item was updated with additional information on 28 November 2013 with the statement *'continues to lack insight'* there was no change to the scoring.

C2 Negative Attitudes: this is consistently rated as partially present. An update in June 2013 which noted that an increase in violent attitudes was evident from his speech, though he had not acted on them, did not result in an increase in the scoring. Likewise the review on 28 November 2013 noted *'threat last Friday (22/11/13) regarding killing the XXX family'* also did not result in the change in the scoring.

C3 Active symptoms of a Major Illness: This noted that S had required a high dose of olanzapine and that he had consistently refused depot medication and also refused clozapine. It is stated that his symptoms *'do not appear to affect his day-to-day functioning to a significant degree'*.

C4 Impulsivity: Consistently rated as absent.

C5 Unresponsive to Treatment: Consistently rated as partially present. It was noted that his illness had partially responded to treatment but was likely to be *'resistant in terms of medication'*. It was also noted that he refused treatment with clozapine and it was believed that he was *'very compliant with oral medication'*. It was noted that he was responsive to visits from the community forensic team.

There is no reference to other treatments, including psychological therapies or treatment of substance misuse problems, which should be included here and would be likely to increase the score to Yes.

Risk Management factors

These dynamic factors are important because they inform the risk management plan.

R1 Plans Lack Feasibility: This is rated as absent because it is noted that he wished to remain in his then current accommodation, which up until late 2013 was the cluster flats. It was consistently stated that *'his plans are generally day-to-day and remain feasible within his current lifestyle'*.

The plans referred to in this risk factor should include more than just where the person resides. It should include the plans to supervise and monitor him as well as whether the patient undertakes a program of meaningful activity each week and whether this is all feasible.

R2 Exposure to Destabilisers. This was rated as partially present and made reference to alcohol and drugs. It is noted that *'primarily these are mediated by the type, timing and venue of social contact'*. It is not exactly clear what this means. Other destabilisers are linked to his well-recognised delusional beliefs. It was also noted that his family, in particular his brothers and parents could have a destabilising influence on him.

Given S's continuing use of drugs and alcohol and the fact that his family are recognised as destabilisers as well, we believe this should have been rated as Yes, definitely present.

R3 Lack of Personal Support: This is consistently rated as 'Not present'. This is based on the statement that he has the support of the Forensic Psychiatry service and Imagine. This is despite the fact that the scoring booklet for HCR 20 Version 2 makes it clear that this item refers to personal support and should exclude professional support. It also states that he has support from his mother noting that it is at times unhelpful when they consume alcohol together.

In our opinion this should be scored at least partially present but could be seen as becoming definitely present, because it is recognised that his main support is from his parents, who are also identified as his potential victims. It is also noted that he drank alcohol with his father. It is also noted in R5 below that *'interactions with his family can induce pressure and expectation that is stressful'*. This would strongly suggest that they are not able to provide effective personal support to him.

R4 Non-compliance with Remediation Attempts: This is consistently rated as absent until the last Version 2 which increase the rating to partially present. It is stated that he is *'generally compliant' with 'occasional lapses in the past with illicit drug used'*.

However, he had consistently refused treatment with depot medication or clozapine, both of which would have significantly reduced his risk to others. In the Formulation which accompanied all 8 revisions of the HCR 20 it is stated that he had refused to engage in substance misuse work. In the case discussion dated 27 December 2012, it is stated that he was unwilling to have psychological input. Therefore, in our opinion this should have consistently been scored as Yes present.

R5 Stress: This is consistently scored as Yes present throughout all revisions of the document. As noted above his interactions with his family were recognised to increase his stress as was the effect of drug and alcohol use.

Scenarios

All 8 revisions of the HCR 20 have 8 separate scenarios listed. In the clinical practice of our forensic consultant psychiatrist, who has used the HCR 20 over the past 10 years and from reading HCR 20 risk assessments from other secure services, he has never seen 8 separate scenarios before. When each are looked at in detail, it is obvious that the first 5 could be combined into one

single scenario, not least because all of the subsequent items are identical across the scenarios. The scenario relating to the risk to his ex-partner and child could remain as a separate scenario. The HCR 20 however makes it clear that risk of violence to animals is not included in the structured risk assessment. The information in this scenario should be included as a risk factor for violence to others, especially towards his family and included in the other scenarios relating to that risk. The final scenario relating to risk to sex workers does not appear to be based on any actual evidence of violence or threats of violence towards these women. Therefore it is a hypothetical risk and is also not referred to in any of the H, C or R risk factors.

The Severity of future harm item notes the '*potentially very serious physical harm*' to his family members. The management of this risk refers to '*progression along his risk formulation*'. This is another reference to using the delusions that he has described as part of his risk management plan.

The section on Monitoring is very detailed and notes the regular input with his CPN, attending the Outpatients department least weekly and 4 to 6 weekly risk reviews with the multidisciplinary team. This is then followed by a statement that T's '*involvement with risk assessment is ongoing*'. It is said that this has led to a formulation of a plan to respond to changes in the response to his beliefs. There is then a list of symptoms including if his auditory hallucinations keep him awake, a wedding is arranged or he becomes intoxicated with drugs and/or alcohol and argues with his family, '*astrological occurrences*' of significance, not take possession of a sword and finally if Max his dog starts to talk to him, but it notes he has got rid of the dog.

This management plan was based on a reliance that S would volunteer changes in his delusional beliefs, including that he would refer himself to the police. There did not appear to be any evidence that he had ever done this in the past, therefore, we question whether this was a credible plan. It was also focused on particular delusions (albeit that these were long-standing) based on a few themes, e.g. the wedding to N, the use of a particular sword etc. This therefore led to an attempt to base a logical and predictable process (i.e. risk assessment) on something that was delusional and by definition, therefore could not be logical or predictable.

The 'Victim Safety Planning' noted that there should be liaison with his family who are said to be aware of the issues of concern and increased risk such as becoming intoxicated with him. It was not clear from the clinical records how often there was regular liaison with his family, or whether this was only reactive to particular incidents.

Risk Formulation

The risk formulation which was unchanged throughout all 8 revisions of the HCR 20 between 2010 and 2013 provides a good summary of his previous illness and its relationship to his risk to others, particularly his parents.

It suggests that the following are Protective factors:

His level of engagement with the community forensic service

His insight into the potentially negative effect of illicit drugs and alcohol and its relationship to increasing his risk, which they state has improved.

It notes that living in the cluster flats *'where other residents are likely to inform the team quickly should he begin to behave bizarrely or in an unsocial manner'*.

This statement about his insight appears to be at variance with the previous information in the HCR 20. Also, as was becoming increasingly recognised over this three-year period, he was continuing to use illicit drugs and alcohol. It also bases a risk management plan on relying on the other residents to effectively manage his risk by informing the staff of Imagine all the community forensic team about changes in his behaviour. When he subsequently moved from the cluster flats in late 2013, this was not acknowledged as a potential increase in risk.

The formulation goes on to list the well-recognised psychotic symptoms which are all based on his delusions. It again states that he is *'actively involved in his own risk assessment'*. It also notes that previous *'structured work'* has not affected his insight, but *'affected his control in terms of actions around his beliefs'*. It is not entirely clear what is meant by this statement.

At the end of the paragraph which notes his long-standing mental illness and the *'many discussions over the years'* which have taken place, it is stated that *'on balance it has always been decided that he is not detainable under the Mental Health Act, largely due to his level of compliance and engagement with the service'*. In our opinion this is a very significant statement to include in a risk assessment which is then consistently repeated throughout subsequent HCR 20 risk assessments. Any mental health professional involved in a Mental Health Act assessment would infer from this that the view of the community forensic team is that he is not detainable. However, the Code of Practice⁶⁹ notes that it is inconsistent with the Mental Health Act to state in advance that someone is or is not detainable under the Act. This can only be determined at a point in time when a Mental Health Act assessment is undertaken.

Of particular concern is the statement later on in the formulation which relates to his drug use and states that cannabis *'produces some reduction in his level of arousal'*. It also notes that he has taken cocaine and *'occasionally ecstasy'*. It is stated that he is regularly counselled about his drug use but that he *'does not wish to engage in any specific work'*. It also notes his problems with his use of alcohol. It would appear that this is at variance with the information provided for risk factors C1 and R2 which imply that his abstinence from drugs is evidence of his improved insight into the relationship of his drug used to his risk to others.

⁶⁹ MHA Code of Practice published in July 2014, updated in January 2015
<https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice>

HCR 20 Version 3 dated 24/04/2014

This HCR 20 structured risk assessment is the one which was current at the time that S killed his parents. As noted earlier, the addition of the Summary of Future Plans to Version 3 of the HCR 20 helped to clarify what the treatment plan was for the patient being assessed. However, the summary in this HCR 20 risk assessment was lacking in detail.

In the section entitled 'Relationships', it includes reference to his delusional beliefs relating to 'N'. This section is intended to refer to actual relationships. Also, in the section Substance Misuse it notes that he is a long term cannabis user who *'uses cannabis to curb some of his symptoms'*. It is stated that he wants to stop using cannabis but it is not clear whether this is feasible. It then goes on to state *'at times risks may increase without the effects of cannabis'*. This appears to be further promoting the, in our opinion, completely mistaken belief that S's use of cannabis was a positive action and reduced his risk to others. In patients with chronic resistant schizophrenia such as S, most people would accept that continued use of cannabis is likely to worsen their illness, which in S's case, would increase his risk to others.

Under 'Supervision' it is stated that he is informal and *'engages with the team via his own free will'*. There is no reference as to what additional interventions will be required because there is no statutory basis for his supervision. Finally, under Avoiding past problems, it is stated that S *'avoids conflict with his parents by not consuming alcohol in their company'*. By April 2014 there is sufficient evidence from the clinical records that this statement is not true.

Historical risk factors

Most of these risk factors relate directly to the previous ones in Version 2 of the HCR 20 and are unchanged in this assessment.

H5 Substance Use. This states that S *'currently uses cannabis on almost a daily basis'*. It also noted his previous cocaine use and his use of amphetamines in the past.

H7 Personality Disorder this is rated as Omit. It is not clear why this is scored in this way as the User Guide states that if a formal diagnosis has not been made that it should be scored No however the presence of antisocial traits are noted and again, the User Guide states that this can lead to a score of Partially present.

H9 the description included under this risk factor would appear to justify, in my opinion, a score of Yes present.

H10 the scoring of this item has been omitted, probably as an error, given the description it would probably score Yes present.

Clinical risk factors

It is interesting that the scoring of these 5 Clinical risk factors is significantly higher than the scoring of the clinical risk factors from the previous Version 2

HCR 20 risk assessments. In our opinion these are now more appropriately scored. However the rating period has not been stated. It is generally accepted that this is usually between the previous 6 to 12 months.

C1 Insight: This is now scored as definitely present. It is interesting that under insight into violence risk, it notes that S does not see himself as a risk. This would again appear to be at variance with the previous statements that he is involved in his violence risk assessment.

C2 Violent ideation or Intent: This is now scored as yes present on the basis of his delusional beliefs. However the User Guide is clear that in this situation any violent ideation or intent based on psychotic symptoms should be scored under C3.

C3 Symptoms of Major Mental Disorder: This is rated as Yes present.

C4 Instability: This is now rated under 3 subheadings, Affective, Behavioural and Cognitive. Although it is noted that S can be 'very chaotic', it is felt that his contact with his child has a calming and positive influence on him. It does not really address the 3 areas of instability. In our opinion, his chronic thought disorder and the concerns which led to the MHA assessment in January 2014, would have been evidence of cognitive instability over the previous 6 months.

C5 Treatment or Supervision Response: This is rated as Yes present. Although he is stated to be fully compliant, it is noted that his mental illness has not been effectively treated by his current treatment.

Risk Management Factors

Despite the more realistic scoring of the Clinical risk factors, it appears that the Risk Management factors have not been assessed in the same way. The information to support the scoring is very brief in all 5 risk factors. These factors should be forward looking (once again that the rating period which could be from 3 months to 12 months, is not included) overall, these factors appear to be underscored which is important because they inform the risk management plan.

R1 Professional Services and Plans. This is rated as not present on the basis of his "long history of engagement with the FIRT service". The plans rated under this factor should ensure "positive, stable adjustment to institutional or community life that minimises any violence risk posed". In my opinion there is insufficient detail to justify the rating of no problems with this area.

R2 Living Situation. This is also rated as not present because of his recent move of accommodation.

R3 Personal Support. This is rated as not present on the basis that his mother is "very supportive" and his ex-partner, h has accepted mental health education from social workers. Again, this raises the question whether this is sufficient personal support, given that both are potential victims, to justify a rating of no problems in this area.

R4 Treatment or Supervision Response. This is now rated as 'Yes present' because although S is described as compliant with his treatment it is recognised his 'illness is largely unresponsive'

R5 Stress or Coping: This is now reduced to not present because it is stated he has demonstrated his ability to cope with stress related to his move of accommodation and the restrictions in contact with his child. However, the previous stressors which were recognised including his family and substance misuse are now not included. In our opinion this item should still be rated as Yes present.

Risk Formulation

This is presented under the headings of Predisposing Factors, Precipitating Factors, Protective Factors and Perpetuating Factors. However, there is a serious error in the way that this has been written. The notes from the case discussion of S on 11 January 2013 include an almost identical formulation. It is clear from that document that the factors under Protective and Perpetuating have been transposed so that they appear under the wrong heading in the HCR 20. This is a significant error in our opinion and could lead to somebody misinterpreting behaviours as protective, when they may be increasing the risk. It is surprising that this document was in existence for 5 months prior to S killing his parents, however nobody noticed this error.

The risk formulation should answer the question, why is this person violent? It should also cluster the relevant HCR 20 risk factors to develop the risk management plan. This is clear from the bullet points at the beginning of this section. Although the information in the formulation addresses one of the 6 bullets, it does not begin to address any of the other 5 questions, all of which are relevant to managing the risk of violence.

Scenarios

In this HCR 20, there are now 3 scenarios, which would be considered more realistic. The headings under Step 5 are consistent with the scenarios in the previous Version 2 HCR 20s.

In Step 6: Develop Case Management Plans, the following is noted under the section Monitoring.

There will be weekly CPN visits to monitor delusions, the reviews with the consultant psychiatrist are now stated to be 12 weekly, as opposed to 4 to 6 weekly previously.

It is still stated that S will engage with the risk assessment, including agreeing to refer himself to the police. However as noted under risk factors C1, it is stated that he does not have any insight into his own violence risk. Therefore we question the credibility of this Management plan

Once again, risk factors related to known delusions are used to construct the risk management plan.

The focus of the risk management plans appears to rely on S recognising the increased risk and taking action to decrease the risk. However there is no the evidence that he had ever been able to do this.

Under the Treatment section of the risk management plan, it is stated that he will be offered informal admission and if he refuses consider Mental Health Act assessment. His continuing refusal take clozapine is also noted. However there is no reference to his refusal to engage in psychological therapy or in treatment of his substance misuse problems.

The plans listed under Supervision are the same as in previous HCR 20's.

The Victim Safety Plan includes communication with his parents and offer further education around his illness. However, there is no evidence that this was offered and what the response was to it.

Scoring of HCR 20 assessments, Version 2 – 23/9/10 to 6/6/13 and Version 3 – 24/4/14

	23/9/10	24/11/10	24/3/11	10/11/11	2/2/12	17/5/12	15/11/12	6/6/13	24/4/14 V3
H	2	2	2	2	2	2	2	2	2
1	2	2	2	2	2	2	2	2	2
2	2	2	2	2	2	2	2	2	2
3	2	2	2	2	2	2	2	2	2
4	2	2	2	2	2	2	2	2	2
5	2	2	2	2	2	2	2	2	2
6	2	2	2	2	2	2	2	2	2
7	1	1	1	1	1	1	1	1	Omit
8	2	2	2	2	2	2	2	2	2
9	1	1	1	1	1	1	1	1	1
10	2	2	2	2	2	2	2	2	Absent
C									
1	1	1	1	1	1	1	1	1	2
2	1	1	1	1	1	1	1	1	2
3	2	2	2	2	2	2	2	2	2
4	0	0	0	0	0	0	0	0	0
5	1	1	1	1	1	1	1	1	2
R									
1	0	0	0	0	0	0	0	0	0
2	1	1	1	1	1	1	1	1	0
3	0	0	0	0	0	0	0	0	0
4	0	0	0	0	0	0	0	1	2
5	2	2	2	2	2	2	2	2	0

Note - 0 = not present
1 = partially present
2 = definitely present