

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr B

A report for
NHS England, North Region

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1 Introduction

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

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

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

1.1 Background to the independent investigation

In September 2013, Mr B, a 45-year-old man, killed Mr X. Mr B was found guilty of murder and sentenced to life imprisonment. At the time of the incident Mr B was in receipt of mental health services provided by Northumberland, Tyne and Wear NHS Foundation Trust. He had been under its care since 1994.

1.2 Overview of the trust

Northumberland, Tyne and Wear NHS Foundation Trust (the trust) is a large mental health and disability trust that provides services to people living in Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington.

2 Terms of reference

The terms of reference for the independent investigation, set by NHS England, North, in consultation Northumberland, Tyne and Wear NHS Foundation Trust are as set out below.

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

3 Approach to the independent investigation

NHS England, North Regional Team, commissioned a type C independent investigation. This type of review does not seek to reinvestigate a case from the beginning. The independent investigation team build upon any investigative work that has already taken place by the trust.

The investigation team consisted of Kathryn Hyde-Bales, senior consultant, and Dr Peter Jefferys, consultant psychiatrist. Dr Jefferys provided expert advice and undertook a review of Mr B's clinical records. Chris Brougham, peer reviewed the report. From now on the investigation team will be referred to as 'we'. Our biographies are in Appendix A.

Mr B gave us permission to review his medical records for the purposes of this investigation. We met with Mr B to discuss his care and treatment. He told us that he had post-traumatic stress disorder (PTSD) and asked us to consider whether this had been treated. We sent him a copy of our report to comment on prior to publication.

We met with Mr B's mother at the start of our investigation to explain about the investigation and to see whether she had any views about Mr B's treatment and care. We contacted her again at the end of the investigation to share with her what we found in our investigation.

NHS England wrote to the victim's family at the start of our investigation to explain about the investigation but the letter never reached them. NHS England sent further correspondence. We eventually met with the victim's family after the investigation had started to explain about the purpose of the investigation. We contacted them again at the end to share our findings and provide them with a copy of the investigation report.

We reviewed documentary evidence. This included:

- national guidance;
- trust policies and procedures;
- Mr B's clinical records; and
- the trust internal investigation report.

We held a telephone interview with the lead investigator of the trust serious incident investigation. We also spoke to the trust group nurse director for planned care and the senior clinical nurse for planned care about the trust's action plan.

This independent investigation report includes a chronology outlining the care and treatment of Mr B. Analysis appears in sections 7 to 15 of our report where particular issues and themes are highlighted.

Our report describes Mr B's care and treatment in detail from early 2011 to September 2013 and examines the key issues arising from it. (Appendix B outlines the chronology of Mr B's earlier contact with the trust from 1994 to December 2010.)

4 Executive summary and recommendations

4.1 Overview of care and treatment

Mr B first had contact with the trust's adult mental health services shortly after his release from prison in November 1994. This culminated in his first admission to inpatient services the same month.

Mr B was admitted to inpatient services four more times, twice in 2009 and once in 2010 and in 2011. Mr B engaged with mental health services extensively and was under the care of the community team until the index offence in September 2013. Throughout his care in the community Mr B was predominantly managed by the same care coordinator and consultant psychiatrist.

In the months leading to Mr B's final inpatient admission in August 2011 Mr B was monitored by his care coordinator and consultant psychiatrist. He was also noted to be deteriorating by his carer (his mother) during this period. The care coordinator made arrangements for Mr B to see the dual diagnosis worker to help him with his drug problem. He declined to engage with this service. Mr B was placed on the CRT 'alert' list.

On 12 August the consultant psychiatrist and care coordinator decided that Mr B should be admitted to hospital under Section 3 of the Mental Health Act. Mr B went absent so the police were informed. He voluntarily presented at hospital two days later and was admitted under Section 3. Whilst on the ward Mr B went absent again and later returned inferring that he had assaulted a man he knew. The inpatient consultant psychiatrist put a risk management plan in place for Mr B in light of this new information.

Mr B was granted periods of leave in September 2011 and was discharged the next month. It was agreed that he would continue to be monitored by his community care coordinator and consultant psychiatrist.

Mr B contacted the care coordinator in November 2011 to tell her that he had been arrested for assault and had been bailed to appear in court the next month.

Mr B was stable in the early months of 2012. It was noted by clinical staff that he was due in court in May 2012 to answer charges of carrying a blade in public. Mr B's carer contacted his care coordinator in May 2012 to advise that she thought her son was over using pain relief medication and that his behaviour had changed. Mr B's care coordinator subsequently saw Mr B on 2 July (she had been on leave) and identified that Mr B was in the early stages of relapse. She decided that he should be reviewed with the consultant psychiatrist and that her visits should be increased to once a week.

No further concerns were identified and Mr B's risk was identified as low in August. He remained stable until November when he started to use cannabis and his behaviour was noted to have deteriorated. However his carer became unwell and Mr B's behaviour improved.

In May 2013 Mr B's care coordinator noted that he was caring for his youngest child with the support of his carer. Mr B remained stable and it was agreed that his consultant psychiatrist would withdraw from his care.

Mr B's care coordinator contacted social services in July to advise that she had noted some changes in his behaviour. The two discussed Mr B and his social worker deemed Mr B a supportive father and that there were no safeguarding concerns.

Mr B told his care coordinator at their next appointment the same month that he had recently been in a car accident and had been bailed by the police until September. The care coordinator noted that Mr B had been using tramadol and diazepam and started to show signs of irritability and frustration. The care coordinator updated the consultant psychiatrist and left a message with the social worker.

Mr B started to show signs of relapse and was seen by the care coordinator and consultant psychiatrist on 25 July. He displayed early warning signs that indicated his mental health was deteriorating, though did not have pressured speech nor was his mood elated. The consultant psychiatrist assessed Mr B's behaviour as being reasonably well and considered that his risk was contained. They identified that there was a potential risk of violence/aggression to others should Mr B's condition deteriorate though at the time it remained 'minimal'. It was agreed that the care coordinator would continue to monitor Mr B and he would be reviewed again by the consultant psychiatrist. Mr B was placed on enhanced CPA (Care Programme Approach) status.

Mr B's care coordinator was contacted by his child's social worker on 5 August. She advised that Mr B had been arrested on 26 July following an incident at his home which the police attended. Weapons had been removed from the family home.

Mr B's care coordinator spoke to him and his carer on separate occasions in early August. Mr B told her on 12 August that he had been in court the previous day in relation to custody of his youngest child. He reported that he was stable and had not been taking cannabis.

Mr B was last seen by his care coordinator on 11 September. They discussed his needle phobia. Mr B did not report any concerns in relation to his mood, concentration, appetite or energy levels. He did not present evidence of thought disorder, irritability, pressured speech or perception abnormality. Mr B's risk was recorded as 'low' though there remained a risk of violence/harm to others. Mr B said that he was not taking any medication though he had a supply at home if he needed it.

Mr B missed his appointment with his consultant psychiatrist on 12 September. The consultant tried to contact Mr B but received no response.

Mr B's care coordinator was informed on 17 September that he had allegedly been involved in the murder of Mr X.

4.2 Overview of care and treatment and conclusions

Mr B engaged extensively with mental health services from 1994 until the index offence in September 2013. As a result of this we focused on Mr B's care in the months preceding his final inpatient admission in 2011 until the index offence in September 2013.

Mr B was predominantly managed by his care coordinator with regular input from the community consultant psychiatrist. Mr B could be difficult to manage. Difficulties included:

- abuse of drugs and alcohol;
- failure to engage;
- threatening and/or intimidating behaviour; and
- non-compliance with treatment.

4.3 Diagnosis

We have considered Mr B's diagnosis, and at his request, whether he had post traumatic stress disorder (PTSD) and if this was treated.

Mr B's clinical records describe a man with a long-standing relapsing psychotic illness with prominent manic symptoms when unwell. When unwell, Mr B repeatedly showed the features such as pressure of speech, threatening and/or intimidating behaviour and grandiose and paranoid delusions.

Based on Mr B's clinical history his most likely diagnosis was bipolar affective disorder, a key manifestation of which being repeat manic psychotic presentations. The long duration of Mr B's relapsing psychotic illness with mood change and characteristic manic symptoms makes it most unlikely that Mr B's psychosis was simply drug induced.

Mr B gave a history of some traumatic experience as a child/young adult, including the allegation that he was physically abused by people who said he owed them money in his early twenties (this was not reported to the police). If true, this is likely to have the most relevance to a possible diagnosis of PTSD. However there are no clinical records of Mr B recounting this incident to mental health professionals in any detail. Mr B's mother reported that she was present at a CPA/Hospital appointment where Mr B mentioned 'flashbacks' in relation to the incident to a psychiatrist but Mr B's mother said that the psychiatrist never followed this up.

Although disclosure of details of the key traumatic incident may be delayed in PTSD, the illness almost always presents with obvious symptoms of very severe anxiety associated with flash-backs connected with the original incident and sleep disturbance. Usually when a patient presents with these features, mental health clinicians will try to elicit a fuller account of the initial trauma but there is no written evidence showing that this happened in this case.

There are no entries in Mr B's records during his five inpatient admissions or at any other time that mention flash-back symptoms.

4.3.1 Findings

Based on Mr B's clinical history and his presentation, the most likely diagnosis is bipolar affective disorder. There are no shortcomings in the trust clinicians' approach to Mr B's diagnosis. We have no criticism of the omission of PTSD in their recorded formulation of Mr B's differential diagnosis.

There are no records showing that Mr B's mother shared information with clinical staff about an incident resulting in Mr B being physically abused.

4.3.2 Recommendation

The trust should ensure that a record is made of any information shared by family members/ carers with clinical staff so that the information can be taken into account in planning treatment and care.

4.4 Risk assessment and risk management

Mr B's clinical records from 2010 onwards include completed forms relating to care coordination and risk management plans, usually recorded by his care coordinator. Mr B's risk management plan was consistently updated. Its content clearly linked with the risk assessments already recorded. Clinicians consistently took account of Mr B's views, his compliance and the views of his carer.

The risk assessment processes and recording of risk undertaken throughout Mr B's care by the trust met Department of Health and trust policies applicable at the time. In particular, Mr B's risk was regularly reassessed during his period of community management.

Mr B's risk of violence and issues of drug misuse were consistently recorded by psychiatrists and other clinicians in his clinical records on each admission and outpatient attendance. On every relevant occasion Mr B's risk of violence was recorded. Typically his risk was recorded as low (1) – which was appropriate – however this was increased to significant risk (2) from July 2013 onwards.

Mr B's clinical management plans devised during his inpatient admissions and when supported in the community, consistently took account of the risks documented in his risk assessment.

With respect to his forensic history, there is good evidence that Mr B's most serious past conviction – for GBH (grievous bodily harm) – was known to all the clinicians responsible for his management and they took this knowledge into account.

We have no significant criticism of Mr B's risk management plan. The exception to this is whether his care plan would have benefitted from specialist forensic input.

4.4.1 Finding

Mr B was appropriately risk assessed and managed throughout his care.

4.5 Pathway of care

We considered whether Mr B's pathway of care and care planning was appropriate given his diagnosis and presentation.

Mr B's care pathway had to take into account a number of variables including a diagnosis of bipolar affective disorder with dramatic mood swings; Mr B's extensive and persistent use of illicit drugs that had an adverse impact on his mental state; Mr B's repeat offending; Mr B's denial that he had any serious mental illness; and Mr B's non compliance with medication in the community.

It was appropriate to manage Mr B's bipolar affective disorder when severely psychotic with an inpatient admission or MHA detention (as occurred in August 2011). As an inpatient Mr B received antipsychotic medication consistent with NICE treatment guidelines. Mr B was managed in the community with additional community mental health input for the majority of his 19-year period of care, except when he was in prison. In the community, the monitoring of Mr B's mental state and effective communication with his carer was undertaken to a high standard as evidenced by his clinical records.

Mr B's care coordinator and consultant psychiatrist knew him well. Mr B trusted them which meant reliable risk assessments were made of his evolving risk and his clinical management was appropriately adjusted when necessary. There is no evidence to suggest that their treatment of Mr B was inappropriate, misjudged or wrong.

Repeated attempts were made by those involved in Mr B's community care to persuade him to take antipsychotic medication. This was consistent with NICE guidance. The clinical team discussed whether to compel him to take medication. This would have required compulsory powers under the MHA. There is evidence that this option was discussed prior to Mr B's hospital discharge; however the decision was made not to pursue this.

The majority of experienced consultant psychiatrists would probably have reached the same conclusion not to pursue a supervision order. This would largely have been because of Mr B's clinical circumstances, guidance in the MHA code of practice and research evidence of the effectiveness of community treatment orders in preventing relapse and readmission.

4.5.1 Findings

Mr B's care plan was completed in line with trust policy and guidance.

The care pathways followed by clinicians caring for Mr B were appropriate throughout his care.

4.6 Forensic services and MAPPA

The clinicians caring for Mr B were aware he had a forensic history and offences included convictions for criminal assault and GBH. There is evidence in the notes that Mr B and his family shared information relating to his offences with clinical staff.

If Mr B's minor offence history is considered alone, there would be no indication for the need to seek a forensic psychiatric opinion. However the team could have sought a forensic opinion prior to Mr B's conviction in 1996 for GBH or after his release in October 1999. If such advice had been sought then expert guidance on the issue of a MAPPA referral would have been forthcoming. There is no written evidence to indicate that Mr B's consultant was told about any assault offences committed after his release in 1999 by criminal justice services. It is surprising that the probation service supervising Mr B in 2008 and 2009 did not discuss seeking a forensic opinion with the trust. In March 2010 the clinical notes reference the option of referring Mr B to the complex case panel/forensics and psychotherapy however there isn't a record of a decision or further consideration of a referral.

There is no evidence of a MAPPA referral being considered after Mr B was released from prison in 1994. Mr B's treating team gave priority to managing his complex bipolar disorder and his consultant did not think that this condition was the primary contributing factor behind the assaults. This was not unreasonable and we have no criticism of this.

4.6.1 Finding

The failure of the team to refer Mr B to forensic services may have been a missed opportunity to explore alternative approaches in his care and management.

The trust has now introduced advice clinics where clinicians can seek advice and guidance from specialist forensic staff as required. Therefore we have not made a recommendation.

4.7 Drug and substance misuse

It is clearly documented throughout Mr B's clinical notes that he abused illicit drugs. His drug use typically coincided with periods in which his mental health deteriorated. Mr B was offered a referral to drug and substance misuse services on more than one occasion, however he either declined or did not attend appointments.

Mr B's consistent denial that he had a drug misuse problem meant that there was little chance of a referral ever being successful.

There is evidence that at least from 2011 onwards the trust had a dual diagnosis service. Though Mr B declined to engage with the service his treatment team could have sought advice from the team in relation to treatment strategies which may have been helpful for his management.

4.7.1 Finding

Mr B's treatment team may have benefited from advice from the dual diagnosis service about treatment strategies for him. However Mr B declined to be assessed by the dual diagnosis service.

4.7.2 Recommendation

Community teams should seek specialist advice as required in relation to treatment strategies when managing patients with a history of drug and/or alcohol abuse who do not engage with the service.

4.8 Engagement with other agencies

A number of agencies were involved in Mr B's care and management including the trust, his GP, probation services and social services.

4.8.1 Finding

The level of engagement between agencies involved in Mr B's care was adequate however the trust would have benefitted from some agencies (e.g. criminal justice services) sharing information on a more proactive basis.

4.8.2 Recommendation

The clinicians should ensure they comply with the information sharing requirements of the trust *Care coordination policy*.

4.9 Predictability and preventability

In reaching a conclusion about predictability and preventability we set out below the standards against which we have assessed Mr B's care.

We consider that the homicide would have been predictable if there was evidence from Mr B's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

We consider that the homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

We have considered the circumstances, information and means available to the community team about Mr B at the time of the incident in September 2013 and

conclude that the team could not have predicted the incident nor was it in a position to have prevented it.

4.9.1 Findings

We found that the incident in September 2013 could not have been predicted.

We found that the death of Mr X could not have been prevented.

4.10 The trust's investigation and report

The trust internal investigation was conducted in line with trust policy. The report was comprehensive and addressed the terms of reference. It contained a detailed chronology, relevant benchmarks, analysis of key events, findings and recommendations. It identified areas of concern and omissions. The conclusions of the trust investigation were sound and can be endorsed.

4.10.1 Finding

The trust internal investigation fulfilled the terms of reference, was comprehensive and in line with trust policy.

4.11 Involving and supporting the victim's family

The National Patient Safety Agency (NPSA) being open policy states that NHS trusts should involve and support those who have been harmed by an incident. In November 2014, the statutory duty of candour was introduced. This guidance makes it clear that those who have been affected by a serious incident should be told about it whether or not a complaint has been made and provided with reasonable support.

4.11.1 Finding

The trust did not meet the requirements of the NPSA being open policy.

4.11.2 Recommendation

The trust should have a clear process in place to locate and engage the families of any victim's so they have the opportunity to be supported and involved in the trust internal investigation. As a minimum the trust should ensure that the victim's family:

- are provided with and consulted on the terms of reference of the trust internal investigation;
- know how they will be able to contribute to the process of investigation; and
- are informed the findings of the trust investigation.

4.12 Progress on implementing the trust's action plan

The trust's internal investigation identified five key areas that needed improvement and outlined eight actions to implement change.

These areas for improvement are:

1. assessment and management of risk;
2. safeguarding children;
3. Section 117 aftercare;
4. carers' assessments; and
5. incident reporting.

We reviewed the evidence submitted by the trust as evidence of completion and/or progress with the action plan.

We spoke with the group nurse director for planned care and the senior clinical nurse for planned care about the action plan. In particular we focussed our discussion on the steps the trust has taken to embed and monitor any changes.

The trust has provided evidence of progress against the action plan, however work is ongoing and further embedding of the process is needed.

4.13 Recommendations

Community teams should seek specialist advice as required in relation to treatment strategies when managing patients with a history of drug and/or alcohol abuse who do not engage with the service.

The clinicians should ensure they comply with the information sharing requirements of the trust *Care coordination policy*.

5 Chronology of care and treatment

5.1 Personal history

Mr B was one of three children raised in what clinical records described as a happy childhood. His parents separated when he was 16 years old. Mr B trained as a mechanic after leaving school and later trained as a roofer, working for his father's company.

Mr B has three children by different partners.

Mr B alleged that in 1990 or 1991 he was subject to abuse by people who believed he owed them money.

Mr B had an extensive mental health history dating from 1994. He had five inpatient admissions between November 1994 and July 2011, the longest of which was nearly four months in 2010.

Mr B also had a forensic history that included custodial sentences for criminal assault in 1994 and GBH in 1996. In 2008 Mr B was charged with carrying an offensive weapon and faced theft charges in 2009. Further incidents occurred after this, the most recent of which was in August 2013 when the police were called to Mr B's house. The police removed weapons from Mr B's house.

The volume of information in relation to Mr B's care is extensive therefore in the interest of brevity we have focused on the months preceding his last inpatient admission in July 2011, until the index offence in September 2013. When Mr B was not an inpatient he was cared for in the community under CPA. Mr B's primary diagnosis most often reached by clinicians throughout his care was bipolar affective disorder.

A full chronology of Mr B's care between 1994 and December 2010 can be seen in appendix B.

5.2 2011

Mr B was seen by care coordinator¹ 1 in early 2011. Mr B told her that one of his children had needed to stay with him and his mother Ms C who also acted as his carer over the Christmas period. Mr B contacted care coordinator 1 on 18 January to tell her that his child had been involved in an accident and sustained a skull fracture and spinal injuries. Mr B was prescribed diazepam² by GP 1 to help him sleep.

Ms C – Mr B's carer who had a background working as a mental health nurse - contacted care coordinator 1 in advance of Mr B's CPA review scheduled to take

¹ A care coordinator is responsible for managing the overall care of a service user. They have responsibility for the service user's care and treatment, and will liaise/coordinate with any other agencies involved.

² Diazepam is a benzodiazepine used to treat anxiety disorders.

place on 14 March to advise that she thought Mr B had increased his alcohol intake. She did not think he was taking drugs but was concerned he was becoming dependant on diazepam.

Consultant psychiatrist 1 reviewed Mr B on 14 March. He found no evidence of hypomania or psychosis. He believed Mr B remained well and there was no evidence of relapse. Consultant psychiatrist 1 noted Ms C's concerns in relation to the diazepam though on balance felt ongoing short/medium-term use was beneficial to Mr B.

Mr B continued to appear well at appointments (with care coordinator 1 and separately with consultant psychiatrist 1) in March and June. Consultant psychiatrist 1 put a plan in place to reduce Mr B's diazepam use over the following three months. On 20 June Ms C contacted care coordinator 1 to say she felt that Mr B's presentation suggested to her that he had started to use illicit substances. Mr B subsequently admitted to care coordinator 1 that he was using cannabis and over using painkillers including other people's tramadol³. He appeared agitated. Care coordinator 1 updated consultant psychiatrist 1.

Mr B was assessed by care coordinator 1 on 15 July⁴; Mr B admitted to care coordinator 1 that he continued to overuse his prescribed medication and was using cannabis. Ms C (who was present) added that there was ongoing conflict at home. Neither Mr B nor Ms C felt the need to involve the crisis resolution team (CRT) though agreed that Mr B should be placed on 'alert' (which would result in rapid action if further concerns were raised). The care coordinator updated Consultant psychiatrist 1 about the situation.

Ms C contacted care coordinator 1 on 18 July to advise that Mr B had deteriorated further and had become verbally abusive. Care coordinator 1 suggested the additional involvement of the dual diagnosis worker to help with Mr B's drug problem.

Care coordinator 1 visited Mr B at home on the same day. Mr B appeared irritable and pre-occupied with his physical health. He displayed some thought disorder and expressed a number of unusual ideas. Mr B did not want to start taking antipsychotic medication. Care coordinator 1 visited again the next day and found Mr B to be more amenable though still irritable. Mr B said that he was "coming down off codeine". Care coordinator 1 made appointments for her and consultant psychiatrist 1 to undertake a joint visit, and for her to introduce Mr B to the dual diagnosis worker 1.

Consultant psychiatrist 1 and care coordinator 1 carried out a joint visit on 26 July. They found evidence that Mr B had continued to deteriorate. They thought that this was likely to be the result of further illicit substance misuse. Mr B was delusional and expressing grandiose ideas. He would not accept a prescription of olanzapine⁵ but agreed to a trial of aripiprazole⁶.

³ Tramadol is an opioid pain killer.

⁴ Care coordinator 1 was unable to see Mr B weekly due to a period of unplanned sickness/absence.

⁵ Olanzapine is an antipsychotic used to treat schizophrenia.

⁶ Aripiprazole is an antipsychotic typically used to treat schizophrenia and mania.

During the joint visit undertaken by care coordinator 1 and consultant psychiatrist 1 on 28 July, Mr B said that he did not have a drug problem and said he did not intend to take the aripiprazole. Mr B remained on the CRT 'alert'. Care coordinator 1 agreed with consultant psychiatrist 1 that she would discuss use of the MHA with Ms C. Ms C subsequently said that she wanted Mr B to have time to consider complying with his medication before the MHA was used.

Ms C contacted care coordinator 1 on 10 August to advise that Mr B had been verbally aggressive and intimidating towards her. She reported that Mr B continued to over use various prescribed and non-prescribed medication. Care coordinator 1 telephoned Mr B. He agreed to start his aripiprazole as originally planned.

Care coordinator 1 saw Mr B on 12 August. He had deteriorated significantly and – following a discussion with consultant psychiatrist 1 – it was agreed that he should be admitted under Section 3⁷ of the MHA. After his assessment with consultant psychiatrist 1, Mr B went missing and the police were informed. Mr B subsequently presented himself at ward A at hospital 1 on 14 August. He appeared calm and relaxed. A bed was not available so he was transferred to the ward B at hospital 2 under Section 3 of the MHA.

At the beginning of his admission, Mr B appeared guarded and intimidating at times, held grandiose delusions and lacked any insight. Mr B subsequently settled well though he refused to take any antipsychotic medication.

During a ward review on 24 August staff noted that Mr B had become more irritable and demanding – he had also been observed laughing and talking to himself. A drug-screen test was carried out that proved positive for cannabis. Clinical staff carried out a mental state examination. This identified that Mr B was experiencing delusional and grandiose thoughts, a preoccupation with physical concerns and a lack of insight. Mr B agreed to start taking aripiprazole. Staff recorded in the notes that Mr B should be managed in the psychiatric intensive care unit (PICU) if he failed to comply with his medication and started to show evidence of psychotic symptoms that required intra-muscular (IM) medication.

Mr B became settled on the ward until 2 September when he left without permission so was reported absent without leave (AWOL) to the police. Mr B remained AWOL until he returned to the ward of his own volition on 7 September. Mr B told consultant psychiatrist 2 (ward B) that he had left the ward with another patient to "sort out a crack dealer". Mr B went on to intimate that he had assaulted the individual saying they had 'taken him out' but "he's not dead, let's put it that way". Consultant psychiatrist 2 contacted the police about the possible assault and put a plan in place for Mr B.

Consultant psychiatrist 2 contacted consultant psychiatrist 1 to talk about the plan because there was a lack of evidence of a MHA assessment on RiO, a clinical information system used to store electronic patient records securely. Consultant psychiatrist 1 explained that he had tried two different approaches with Mr B in the past – either managing him with a community focus or being more prescriptive and

⁷ Section 3 of the MHA is used formally to admit and detain patients in hospital for treatment.

treating him as an inpatient. Consultant psychiatrist 1 said he had considered a community treatment order (CTO⁸) in the past. Consultant psychiatrist 2 was of the opinion a CTO wasn't feasible at the time because Mr B would not agree to a condition of taking his medication regularly, but if this changed a CTO could be useful. Consultant psychiatrist 2 told consultant psychiatrist 1 that Mr B had remained stable since admission (and during a period AWOL) and did not warrant the use of the PICU or IM medication.

Care coordinator 1 contacted the ward in September to voice her concerns about Mr B being granted leave with a view towards potential discharge and asked that the team speak with Ms C before putting anything in place. Care coordinator 1 put forward a safeguarding alert in the context of her concerns for Ms C. When contacted by the ward, Ms C expressed concerns about the care and plan for leave stating that she did not feel the issues that were prevalent before admission had been addressed. Ms C was advised that Mr B had not displayed any psychotic symptoms on the ward. Ms C believed this was because he had not been challenged. Ms C did not feel she could manage Mr B if he returned home. She was told that Mr B had echoed a similar sentiment and alternative accommodation would be arranged.

On 12 September, Mr B was granted leave from the ward and went to see Ms C. Care coordinator 1 spoke to Ms C that day who said she had talked at length with Mr B who indicated he may be found alternative accommodation. However when care coordinator 1 visited on 14 September Mr B was at home. Care coordinator 1 recorded in the notes that she felt Mr B was mentally unwell.

Mr B visited his GP surgery on 15 September to request pain medication. The GP noted that Mr B was loud and intimidating to reception staff. Mr B was offered an appointment the next day which he attended. The GP noted that the consultation was 'tricky' and that Mr B demonstrated pressure of speech and irritability. Both the ward and care coordinator 1 were updated.

Mr B returned from leave on 19 September. Consultant psychiatrist 2 met with Ms C who reiterated her concerns about her son's mental health and drug use. Consultant psychiatrist 2's impression was that Mr B was unwell with probable grandiose ideas and a degree of thought disorder. However consultant psychiatrist 2 noted that there was a lack of immediate risk and no incidents had occurred when Mr B was on leave, therefore his discharge could be justified. Consultant psychiatrist 2 deferred a decision about discharge as Mr B had appealed against his section and hospital managers' hearing was scheduled for 20 September.

The hospital managers' hearing agreed to discharge Mr B from Section 3 of the MHA on 4 October. Care coordinator 1 was asked to find him suitable accommodation. Mr B was transferred to ward A at hospital 1. The next day Mr B's drug screen was positive for benzodiazepines, methamphetamines, opiates, cannabis and methadone. Mr B denied illicit drug use and refused to take any antipsychotic

⁸ A community treatment order is the process by which patients sectioned under the MHA are given supervised treatment in the community. Failure to adhere to the conditions of treatment may result in the patient being recalled to hospital.

medication. Mr B was noted to be expressing grandiose thoughts and remained preoccupied with his physical health between 22 and 27 September.

Consultant psychiatrist 3 (ward A) interviewed Mr B on 27 September. He was assessed as having a delusional system of a grandiose type. Consultant psychiatrist 3 believed Mr B was likely to be a risk to himself and others. Consultant psychiatrist 3 indicated Mr B should be detained under Section 3 of the MHA. Consultant psychiatrist 3 contacted the MHA office who which advised that Mr B would need to be re-sectioned and that Mr B could not be detained under the previous section given that the managers' hearing had concluded that he was not suffering from a mental disorder. Mr B should have been discharged from his section and not held until 4 October. Consultant psychiatrist 3 was told to proceed with an application for a new Section 3.

Mr B was re-assessed for a 'new' Section 3 on 29 September. Ward staff were advised to consider that he remained on his 'old' section until the 'new' one was completed. Mr B was angry about this given his understanding that his appeal hearing had been successful. He continued to refuse to take antipsychotic medication. Mr B remained volatile between 30 September and 5 October but settled on the ward and utilised unescorted ground leave without incident. There continued to be uncertainty around Mr B's detained status. The head of informatics and the trust solicitor advised consultant psychiatrist 3 that a new section would need to be restarted as the old one was not valid. Consultant psychiatrist 3 was concerned and facilitated a discussion with care coordinator 1, consultant psychiatrist 1 and lead consultant for urgent care 1. A decision was made that the nature of the risks at the time were believed not to be acute nor imminent and if Mr B did not want to stay in hospital informally then a plan to contain the risks and manage his case from the community team would be established. If this was unsuccessful and his risks increased a further admission under the MHA would take place. Mr B was informed of the decision and agreed to remain on the ward informally (with leave) for a week whilst arrangements were put in place.

Consultant psychiatrist 1 and care coordinator 1 saw Mr B on 10 October. He reiterated he would not take antipsychotic medication and explained that his carer had agreed he could stay with her. Mr B attended ward A on 11 October where he was formally discharged with the agreement that care coordinator 1 would undertake seven daily follow-up visits that commenced on 13 October. Care coordinator 1 did not identify any mental health issues though Mr B complained of physical pain.

Care coordinator 1 accompanied Mr B to a GP appointment on 25 October. GP 1 prescribed pain medication and referred him to a pain clinic. Consultant psychiatrist 1 saw Mr B on 31 October. He found Mr B to be calm, with normal speech and no thought disorder. Given that Mr B was seeing care coordinator 1 regularly, consultant psychiatrist 1 felt he could review Mr B every three months.

Mr B telephoned care coordinator 1 on 22 November to advise that he had been arrested two weeks earlier. He told care coordinator 1 that he had found out who had nearly killed him three years ago and that he had gone to see him, leading to a fight. Mr B had been bailed to appear at a Magistrates' Court. Mr B told care coordinator 1 he was stable but Ms C disagreed and said that in her opinion Mr B

had not been well since discharge. Care coordinator 1 arranged to see Mr B on 3 December but advised that the CRT could be contacted if there was an urgent need prior to this appointment. There is no evidence in the notes to indicate that this appointment took place. Mr B contacted care coordinator 1 on 14 December in relation to his benefits. Mr B and Ms C said he had not smoked cannabis in five weeks. Mr B added that he intended to plead guilty in court.

5.3 2012

Care coordinator 1 had a period of absence from work in early 2012. During this time Mr B was provided with the details of an alternative care coordinator. Care coordinator 1 contacted Mr B on 28 February to tell him she was back at work.

Care coordinator 1 saw Mr B on 19 April and noted that he was well. Mr B reported that his mental state had been stable for a number of months and that the situation was good. Mr B's clinical records indicate that Mr B was having positive contact with his youngest child and that he was identified as the responsible parent due to their mother having difficulties. Social services were actively involved. Mr B's stability was noted again at a CPA review meeting with care coordinator 1 on 30 April. Clinical staff also noted that Mr B was due in court to answer charges of carrying a blade in public. He told staff that he intended to plead not guilty.

Ms C contacted care coordinator 1 on 30 May to say she thought her son was over using pain relief and that his behaviour had changed at home. Care coordinator 1 agreed to see Mr B when she returned from a period of leave. She saw Mr B with his carer on 2 July. Care coordinator 1 noted that his mood was elevated and he was 'ranting' about his past. Care coordinator 1 identified that his behaviour was indicative of the early stages of relapse. Mr B admitted taking higher doses of his prescribed medication and additionally diazepam that he had bought. They agreed to bring forward his appointment with consultant psychiatrist 1 and, that in the interim, care coordinator 1 would increase her visits to weekly. Mr B and Ms C were given the CRT phone number. However the situation changed; Mr B was noted to be less agitated and more settled on 9 July. Ms C expressed no further concerns.

No further concerns were identified throughout August (a CPA review took place on 2 August) and care coordinator 1 identified Mr B's risk as low. Mr B telephoned care coordinator 1 on 4 September, distressed that he had not received his benefits. Care coordinator 1 noted Mr B had a slight elevation in mood. Mr B told care coordinator 1 there had been an incident a few weeks earlier when he had been stopped by the police after leaving the house of one of his ex-partners. He was issued with a restraining order. Mr B did not give care coordinator 1 any other details.

Mr B was noted to be predominantly stable throughout October. The exception to this was shortly after 17 October (date unspecified) in which Ms C contacted care coordinator 1 to advise that Mr B had deteriorated and she suspected he was over using paracetamol and using cannabis. Care coordinator 1 subsequently saw Mr B and told him she thought he was deteriorating. He disagreed. Mr B agreed to care coordinator 1 increasing her visits but would not consider antipsychotic medication.

Care coordinator 1 saw Mr B on 25 October when he was noted to be stable and there was no evidence of cannabis use.

Mr B's began to use cannabis in early November and his behaviour deteriorated. However his carer, Ms C, became physically unwell which forced him to 'get back on track'. He attended an outpatient appointment with consultant psychiatrist 1 and care coordinator 1 where he was noted to be stable and his risk remained low.

Care coordinator 1 tried to contact Mr B on 19 December but was only able to speak to Ms C who reported a significant improvement in Mr B. Ms C believed he remained drug free and was avoiding excessive alcohol.

5.4 2013

Care coordinator 1 noted Mr B was stable in the early months of 2013. Between 8 February and 2 May he cancelled a planned appointment with consultant psychiatrist 1 and was unable to keep an appointment with care coordinator 1. Care coordinator 1 saw Mr B on 2 May where he was noted to be mentally stable and his risk low. Care coordinator 1 recorded in the notes that Mr B was caring for his child with Ms C's support.

Consultant psychiatrist 1 and care coordinator 1 undertook a CPA review with Mr B on 9 May. Consultant psychiatrist 1 recorded that Mr B had been symptom free for 18 months and had not taken psychotropic medication during this period. Consultant psychiatrist 1 submitted a case summary to Mr B's GP that stated:

“[Mr B] has had recurrent psychotic episodes. The working diagnosis is schizoaffective disorder or bipolar affective disorder. However, illicit drugs have always been a prominent feature and both [Mr B] and his mother believe [Mr B] would remain well if he refrained from illicit drugs (which would be in keeping with a diagnosis of drug induced psychosis)... [Mr B] has a past history of violence unrelated to psychiatric disorder... there is a history of aggression during florid episodes of illness though risks have been minimal/not significant for some time.”

Care coordinator 1 further detailed during the review that Mr B was caring for his child due to their mother experiencing problems. The review team concluded that Mr B's enhanced CPA status should change to non CPA with care coordinator 1 providing lead professional support. Consultant psychiatrist 1 agreed to withdraw from Mr B's care though could be contacted if needed.

Mr B contacted care coordinator 1 on 8 July asked care coordinator 1 to facilitate a prescription of short-term diazepam. Care coordinator 1 contacted social worker 1 who advised that Mr B had been seen regularly and that some changes in behaviour had been observed the previous week. Mr B appeared irritated and lost his temper. Care coordinator 1 detailed in the notes that there were inconsistencies in the information that Mr B had shared with social worker 1 in relation to not taking prescribed medication and his various diagnoses in terms of mental health.

Care coordinator 1 visited Mr B at home the next day (Ms C was on holiday). He noted that Mr B had been in a recent car accident involving the police and Mr B had been bailed until September. Care coordinator 1 also noted that Mr B had been using tramadol and diazepam that he had bought off the street the previous week; and that he had ongoing physical health concerns. Care coordinator 1 identified some evidence of irritability and frustration though Mr B attributed this to a recent court case. Mr B indicated he might consider an oral antipsychotic treatment (recommended by consultant psychiatrist 1) if his thoughts became unmanageable or his mood deteriorated. Care coordinator 1 subsequently updated Mr B's GP and consultant psychiatrist 1. Care coordinator 1 also left messages with social worker 1 to contact her in relation to getting an update about the home visit. Care coordinator 1 arranged for GP 1 to give a short-term prescription of diazepam to Mr B.

Care coordinator 1 spoke to Mr B over the phone on 12 July. No concerns were identified. Care coordinator 1 went on annual leave.

On return from leave care coordinator 1 had four messages from Mr B complaining that GP 1 would not give him more diazepam. Care coordinator 1 believed Mr B was showing signs of an early relapse and arranged an appointment with consultant psychiatrist 1 of 25 July. This appointment was confirmed with Mr B. Care coordinator 1 separately contacted Ms C who believed her son had returned to his old ways and was showing early warning signs of a relapse.

Mr B attended his appointment with care coordinator 1 and consultant psychiatrist 1 on 25 July. Mr B displayed early warning signs that his mental health was deteriorating by talking at length about his physical ailments. However there was no pressure of speech, no elated mood and his speech was normal. Mr B admitted to smoking cannabis though denied taking other illicit drugs or drinking excessively. Consultant psychiatrist 1 assessed Mr B's behaviour as being reasonable and that the risk was contained. Mr B agreed to start taking olanzapine⁹ at night. It was further agreed that care coordinator 1 would continue to monitor the situation, and there would be further review with consultant psychiatrist 1. Consultant psychiatrist 1 and care coordinator 1 considered Mr B's risk and identified there was a potential risk of violence/aggression to others should his condition deteriorate, though at the time it remained 'minimal'. Mr B was placed back on enhanced CPA status.

Social worker 1 contacted care coordinator 1 on 5 August to report that she had learnt Mr B had been arrested by the police on 26 July in relation to an incident. It was understood several youths had attended Mr B's house late at night and that Mr B had chased them away. The police became involved and found weapons at Mr B's house (including a shotgun cartridge though no gun was found). Social worker 1 asked care coordinator 1 to prompt Mr B to contact her.

Care coordinator 1 spoke to Ms C the next day as Mr B was out. Ms C said she was aware of the situation – she had been home when Mr B was arrested. Ms C felt Mr B was improving though was unsure if he was taking his olanzapine. She agreed to let Mr B know care coordinator 1 was trying to contact him.

⁹ It was recorded in the clinical notes on 1 August that Mr B was taking his olanzapine intermittently.

Mr B contacted care coordinator 1 on 12 August. He told her he had been to court that day in relation to his younger child, having applied for full permanent parental responsibility. He was reported overall as being stable and said he had not had any cannabis in over a week and a half. He added he did not need prescribed olanzapine though was taking prescribed diazepam as required.

Mr B refused to attend an appointment for an electrocardiogram (ECG¹⁰) and routine bloods on 3 September. Mr B said that he did not need the tests because he was not taking his olanzapine.

Care coordinator 1 discussed with consultant psychiatrist 1 a request from Mr B to provide a letter of support to his solicitor. This related to a further court appearance where Mr B had been charged with refusing to supply a blood sample following an accident. Mr B said he had a needle phobia and wanted this to be documented. Care coordinator 1 agreed to review Mr B's clinical records to see if there was any information to support his view. She would also see Mr B with a view to exploring this with his GP and dentist.

Care coordinator 1 met Mr B at the Houghton Unit (a community team day unit) on 11 September. They explored Mr B's needle phobia¹¹ and actions to be undertaken in relation to this (e.g. Mr B was going to ask his solicitor to write to his GP). Mr B's mental health was recorded as stable. He reported no concerns with his mood, appetite, concentration or energy levels. There was no evidence of thought disorder, irritability, pressured speech or perception abnormality. Mr B's risk assessment was updated and his risk was recorded as low though there remained a risk of violence/harm to others. Mr B confirmed that he was not taking any medication but did have a supply of olanzapine and diazepam at home. He agreed to take his medication if his symptoms returned. Mr B was using minimal amounts of cannabis.

Mr B missed an appointment with consultant psychiatrist 1 on 12 September. Consultant psychiatrist 1 was unable to contact Mr B.

Care coordinator 1 was contacted by a colleague on 17 September who informed her that Mr B had allegedly been involved in the murder of Mr X. Care coordinator 1 contacted a member of the Criminal Justice Service who confirmed that Mr B was in custody.

Mr B was found guilty of murder at a Crown Court in 2014.

¹⁰ An ECG is used to record the electrical activity of the heart.

¹¹ Mr B's needle phobia had not been recorded in the notes before September 2013.

6 Issues arising

In the following sections of the report we analyse and comment on the issues we have identified as part of our investigation into the care and treatment of Mr B.

The themes are:

- Mr B's diagnosis: the formulation of diagnosis and subsequent management;
- risk assessment and risk management;
- pathway of care;
- forensic services and MAPPA;
- drug and substance misuse;
- engagement with other agencies;
- predictability and preventability;
- the trust's internal investigation and report;
- involving and supporting the victim's family; and
- progress made on implementing the trust's action plan.

7 Mr B's diagnosis

In this section we consider Mr B's diagnosis and whether it was appropriately formulated and evidenced by those responsible for his care. In particular we have considered whether Mr B had PTSD – something he raised with us when we met him at the beginning of this investigation.

Mr B was diagnosed in November 1994 with hypomania probably as a result of illicit drug taking. He was subsequently admitted to hospital for treatment. His clinical records detail an extensive history of relapsing psychotic illness with prominent manic symptoms when unwell (e.g. grandiose and paranoid delusions).

Diagnoses/symptoms include:

- drug-induced psychosis (first inpatient admission, November 1994);
- drug-induced psychotic episode (January 2001);
- episode of hypomania (June 2002);
- bipolar affective disorder with a number of psychotic episodes (February 2004);
- elevated mood and irritability (second inpatient admission, March 2009);
- hostile and confrontational behaviour (third inpatient admission, April 2009);
- manic episode of bipolar disorder or possible schizoaffective disorder with illicit drug use as a significant contributory factor (March 2010);
- fluctuating mental state and obvious psychosis (fourth inpatient admission, August 2010);
- grandiose delusions and fluctuating irritability (fifth inpatient admission, August 2011); and
- schizoaffective disorder or bipolar affective disorder (May 2013).

Mr B's clinical notes repeatedly reference his use of illicit drugs as a trigger and/or significant contributing cause for the relapse of his psychotic symptoms. Illicit drug use was referenced in four of his five inpatient admissions.

The primary diagnosis most often reached by clinicians was bipolar affective disorder (usually presenting with manic symptoms).

7.1 PTSD

There is no specific mention of a possible diagnosis of PTSD in the internal investigation chronology. However there is a record of potentially traumatic incidents in Mr B's earlier life as a child/young adult in the clinical notes:

- bullied at school;
- fractured femur at the age of 18;
- allegedly¹² physically abused early 1990s; and

¹² Mr B told us he never reported the incident to the police however his carer told the internal investigation team that he been involved in an incident where he suffered physical abuse.

- head and neck injuries sustained in an road traffic accident in July 1994.

There are no details in Mr B's notes about the incident. There is no reference in his notes to him having 'flash-backs', sleep disturbance or intense anxiety relating to this incident.

7.2 Analysis

Mr B's clinical records describe a man with a long-standing relapsing psychotic illness with prominent manic symptoms when unwell. When unwell Mr B repeatedly showed the following features:

- pressure of speech with over talkativeness, often associated with irritability;
- threatening and/or intimidating behaviour towards his carer/hospital staff;
- grandiose and paranoid delusions whose content was virtually unchanged with each relapse e.g. he believed that he was a member of the British secret service; and
- Ms C reported episodes when Mr B's mood was "low" or "depressed", which were obvious when assessed by the trust clinicians.

Mr B often denied any drug misuse (e.g. cannabis, amphetamines, opiates and benzodiazepines), despite evidence (e.g. test results and his carer's observations) of abusing illicit substances.

Mr B experienced periods – up to 18 months - when he was apparently free from psychotic symptoms despite not taking his medication.

Based on Mr B's clinical history his most likely diagnosis was bipolar affective disorder, a key manifestation being repeat manic psychotic presentations. Poly-substance misuse was a major contributory factor in triggering relapses. The very long duration of the relapsing psychotic illness with mood change and characteristic manic symptoms makes it most unlikely that Mr B's psychosis was simply drug induced.

The evidence for a possible schizoaffective psychosis is less convincing given Mr B's 19-year mental health history (at the time of this diagnosis). During this period it would be reasonable to see recurrent psychotic episodes with a decreasing recovery, however Mr B did recover after each episode. Mr B's recovery after each episode makes a bipolar diagnosis more likely.

Despite this, schizoaffective psychosis is a diagnosis that might be validly considered by other experienced psychiatrists based on the features of some of his delusional beliefs that are commonly seen in schizophrenia.

Mr B gave a history of some traumatic experiences as a child/young adult, of which his alleged physical abuse is likely to have most relevance to a possible diagnosis of PTSD. However there are no clinical records of Mr B recounting this incident to clinical staff in any detail.

Although disclosure of details of the key traumatic incident may be delayed in PTSD, the illness almost always presents with obvious symptoms of very severe anxiety associated with flash-backs connected with the original incident and sleep disturbance. When presented with these features mental health clinicians will try to elicit a fuller account of the initial trauma. There are no entries in Mr B's records during his five inpatient admissions or at any other time which reference flash-back symptoms.

People with complex mental health conditions often reflect on earlier adverse life experiences, sometimes seeing them as the cause of their subsequent mental ill-health. This is not pathological. Mr B may well have done this, even if his clinical records do not reflect it. However such reflections alone are not sufficient to make a clinical diagnosis of PTSD.

7.3 Findings

Based on Mr B's clinical history his most likely diagnosis is bipolar affective disorder. There are no shortcomings in the trust clinicians' approach to Mr B's diagnosis. We have no criticism of the omission of PTSD in their recorded formulation of Mr B's differential diagnosis.

8 Risk assessment and risk management

8.1 National and local policies

In this section we examine Mr B's forensic history and establish whether it was appropriately taken into account in the risk assessment and risk management process.

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. Risk management should be an integral aspect of CPA. The outcome of risk assessment should feed back into the overall clinical management.

National best practice guidance in managing risk in mental health services (Department of Health, 2007) sets out three risk factor categories. These are:

1. static factors – these are unchangeable, eg a history of child abuse or suicide attempts;
2. dynamic factors – factors that change over time, eg misuse of drugs or alcohol; and
3. acute factors or triggers – these change rapidly and their influence on the level of risk may be short-lived.

The trust has a *Care coordination/care programme approach practice guidance note adult services – planned and urgent care, forensic mental health and specified specialist services*. It was first issued in February 2012 and was scheduled for review in February 2015¹³. The guidance advises that it be read in conjunction with the trust's *Care coordination and care programme approach policy*, the *Management of record policy*, *practice guidance note* and *Record keeping standards*.

Within the main document there is a section on risk assessment and risk management. The policy states that risk assessment is required:

- “As part of initial assessment (documented as a minimum on a FACE risk profile¹⁴)/ongoing assessment/reassessment.
- When admitting and discharging from hospital (documented as a minimum on a FACE risk profile risk) and as part of planning and agreeing leave.
- As part of review considerations. If there is no change to the risk indicators/level of risk recorded on the FACE risk profile then this profile remains current providing there is -clear recording of no change via the review record ie the clinical letter (Appendix 4) or the Care Coordination review form.
- When there are major changes to presentation / personal circumstances or following an incident.
- When alerted by carers.
- When transferring service users to other teams/service providers
- When alerted by other members of the care team about major changes to presentation/personal circumstances/an incident.”

¹³ We received the trust documents in January 2015 before the review deadline.

¹⁴ The FACE risk profile is a tool that allows clinicians to rate current risk on a five-point scale.

It adds:

- “Risk management plans are an integral part of the Care Plan and will be developed when the level of risk is significant, serious, or serious and imminent (FACE risk profile ratings scale 2,3, or 4)
- The management of risk issues that are rated 1 do not require a specific risk management plan and should be covered by the Care Plan and appropriate crisis plan.”

8.2 Risk assessment

Mr B’s risk of violence and issues of drug misuse were consistently recorded by psychiatrists and other clinicians in his clinical records on each admission and outpatient attendance.

From 2008 onwards, Mr B’s risk was systematically recorded on a structured proforma. The tool initially used was the ‘clinical risk management tool’ (adapted from the Sainsbury Centre). In October 2008 the following primary risks were recorded by Mr B’s consultant:

“Potential risk to others – history of section 18 wounding – unrelated to mental health; history of serious psychiatric disorder – Bipolar/dual diagnosis (long history drug misuse). Recent history of hypomanic episodes with aggression + (presumably related) arrests for carrying offensive weapons... limited insight. Compliance issues in the past.”

From 2010 onwards the trust used the adult FACE risk assessment profiles, which were typically completed by care coordinator 1. The tool was completed after CPA reviews and after most community appointments. The most recent assessment took place on 11 September, shortly before the incident.

The following risks were consistently scored as ‘low apparent risk between April 2012 and September 2013:

- risk of deliberate harm;
- risk of suicide;
- risk related to physical condition; and
- potential risk to staff.

Risk of violence/harm to others was usually scored as ‘low apparent risk’ but on 9 July 2013, 1 August 2013 (a brief risk FACE profile) and 11 September 2013 a higher score of 2 (significant risk¹⁵) was given. In the case of the latter, the notes said “risk remains low and manageable at this time”.

¹⁵ “Patient’s history and condition indicates the presence of risk and this [is] considered to be a significant issue at present, i.e. a risk management plan is to be drawn up as part of the patient’s care plan.”

8.3 Care coordination and care/risk management plan

Mr B's clinical records from 2010 onwards include completed forms relating to care coordination and risk management plans, usually recorded by his care coordinator. These forms were refreshed at systematic care plan reviews, which were held regularly from 2010 onwards.

A risk management plan was consistently updated and recorded throughout this period. Its content clearly links with the risk assessment already recorded. Clinicians consistently took account of Mr B's views, his compliance and the views of his carer.

8.4 Forensic history

Key features of Mr B's significant forensic history are noted in his clinical records, in particular a six-year sentence for the offence of GBH in 1996, and an earlier custodial sentence for criminal assault in 1994. In 2008 Mr B was charged with carrying an offensive weapon and faced theft charges the following year. We explore this further in section 10 on forensic services and MAPPA.

8.5 Risk management

Mr B's admission to hospital was promptly arranged on the five occasions when the severity of his psychosis led to concerns about his immediate risk to others and potentially himself.

Mr B's community risk management benefitted from a degree of continuity of the treating consultant and care coordinator/community mental health nurse which is less often seen in mental health services in the past 10 years. The records indicate a depth of understanding on the part of the clinicians in relation to the risks and mitigating factors associated with Mr B's risk management.

8.6 Analysis

The risk assessment processes and recording of risk undertaken throughout Mr B's period of care by the trust met Department of Health and trust policies applicable at the time. In particular, Mr B's risk was reassessed regularly during periods of community management.

On every relevant occasion Mr B's risk of violence was recorded. It was appropriate given the scoring criteria for FACE to award a score of 1 (low apparent risk) as the subjective conclusion on each occasion Mr B's risk was assessed, except for 9 July 2013, 1 August and 11 September 2013 assessments when a 2 (significant risk) was given.

Mr B's clinical management plans devised during his inpatient admissions and when supported in the community consistently took account of the risks documented in his risk assessment. This is evidenced in his clinical progress notes and care plans.

For example, in 2011 Mr B went AWOL when he was an inpatient. When he returned to the ward his management plan was changed to incorporate his allegation that he had “taken out” a drug dealer. The plan included carrying out drug screens, monitoring his behaviour on the ward and continuing Mr B on his medication – though Mr B remained non-compliant¹⁶. The team also told the police of the possible assault.

Mr B’s community risk management plan dated 12 July 2013 (completed by care coordinator 1) highlighted that his mental health deteriorated if he increased his use of illicit substances. Care coordinator 1 recorded other factors that were indicative of Mr B’s deteriorating mental health that included:

- becoming preoccupied with his physical health;
- referencing historical injuries and involvement with the police and criminals; and
- becoming increasingly demanding and intimidating.

The risk plan noted the presence of one of Mr B’s children in his life and flagged that in the event of the risk factors escalating children’s services should be informed.

Mr B’s care plans also documented who to contact in the event of Mr B relapsing or his risk increasing. It included out of hours contact information.

In a joint assessment with consultant psychiatrist 1 and care coordinator 1 on 25 July they recorded in the notes that Mr B was showing early signs of relapse but that the risks were contained. It was agreed with Mr B that he would restart taking olanzapine at night and would be monitored closely by the community team. Consultant psychiatrist 1 was to arrange a follow-up appointment in 6-8 weeks’ time.

With respect to his forensic history, there is good evidence that Mr B’s most serious past conviction – for GBH – was known to all the clinicians responsible for his management and they took this knowledge into account when making and plans for Mr B.

We have no significant criticism of Mr B’s risk management plan. The exception to this is whether his care plan would have benefited from specialist forensic input. See section 10.

8.7 Finding

Mr B was appropriately risk assessed and managed throughout his care.

¹⁶ Consultant psychiatrist 2 considered compulsory medication but deemed this to be unwarranted.

9 Pathway of care

In this section we consider whether Mr B's pathway of care and care planning was appropriate, given his diagnosis and presentation. We have already explored some aspects of this in the previous section on risk assessment and risk management.

The trust made many adjustments and changes to Mr B's pathway of care in the 19 years he was under its care. His care pathway needed to take account of the following variables:

- bipolar affective disorder with dramatic mood swings in mental state ranging from mania to normal;
- Mr B's extensive and persistent use of illicit drugs which had an adverse impact on his mental state;
- Mr B's repeat offending and criminal justice involvement;
- a supportive and reliable carer (his mother) who was potentially at risk when Mr B was deluded;
- Mr B's consistent denial that he had any serious mental illness;
- Mr B's consistent non-compliance with medication in the community; and
- Mr B's child who was subject to safeguarding.

The trust's *Care coordination/care programme approach practice guidance note adult services – planned and urgent care, forensic mental health and specified specialist services* sets out the roles and responsibilities of the lead professional and care coordinator. These include for the lead professional:

“In partnership with the service user and any other significant care provider, including carers, develop a clear understanding of how care and treatment will be carried out, by whom, taking into consideration any existing advanced statement or advance decision to refuse treatment.”

And

“The care plan and risk assessment is subject to on-going review as required, involving the service user and any other significant care provider, including carers.”

The lead professional has a responsibility to involve the service user and any carer (where appropriate). The care coordinator is also responsible for ensuring the involvement of carers:

“Ensure where appropriate, any carer's involvement in the process of decision-making.”

Mr B had a written care plan in place at the time of the index offence. It was last reviewed on 12 July 2013.

9.1 Analysis

It was appropriate to manage Mr B's bipolar affective disorder when severely psychotic with an inpatient admission or MHA detention (e.g. as occurred in August 2011). As an inpatient he received antipsychotic medication consistent with NICE treatment guidelines (e.g. NICE clinical guideline 82). In the community Mr B was managed as an outpatient with additional community mental health nurse input for most of his 19-year period of care, except when he was in prison. The monitoring of his mental state and effective communication with his carer was undertaken to a high standard as evidenced by his clinical records.

Exceptional efforts were made by the trust to provide continuity of Mr B's consultant and care coordinator 1 (during a period of service restructure) to maximise his compliance in the community with considerable success, despite his long-standing denial that he had a mental illness. Both consultant psychiatrist 1 and care coordinator 1 knew him well. Mr B trusted them which meant reliable assessments were made of his evolving risk and his clinical management was appropriately adjusted when necessary. There is no evidence to suggest that their treatment was wrong, misjudged or inappropriate.

Repeated attempts were made by those involved in Mr B's community care to persuade him to take antipsychotic medication. This was consistent with NICE guidance. Mr B never took medication reliably in the community however he did not disengage from the community team. The team observed that there were lengthy periods when Mr B was well whilst not on medication. Maintaining contact with him meant more reliable monitoring of risk, which was of importance.

The clinical team discussed whether to compel Mr B to take medication in the community. This would have required compulsory powers under the MHA. He would have needed to be placed on a supervision order (CTO). There is evidence that this option was discussed prior to a hospital discharge when Mr B was detained under Section 3 of the MHA, which was appropriate. A decision was made however, for valid clinical reasons, not to pursue this option.

In 2013 a majority of experienced consultant psychiatrists would probably have reached the same conclusion, given Mr B's clinical circumstances, guidance in the MHA code of practice and research evidence of the effectiveness of CTOs in preventing relapse and readmission.

Mr B's serious illicit drug use was acknowledged by all clinicians managing him to be a major issue. Serious and repeated efforts were made to encourage him to stop, but without success. Mr B was offered a referral to the specialist drug service more than once, which he refused. Mr B declined to be assessed by the dual diagnosis service in July 2011. The efforts of the clinicians were appropriate and it is unlikely that more could or should have been done.

Mr B's care plan consistently recognised the positive input of his key carer and family but acknowledged the potential vulnerability of the former when Mr B was acutely psychotic. Communication with his carer by clinical staff was maintained to a high standard throughout Mr B's care; most interventions were made with carer knowledge and agreement.

On rare occasions when this did not happen (e.g. in June 2009 when she was not consulted about Mr B's leave plan which included staying with her) steps were taken to remedy this.

9.2 Findings

Mr B's care plan was completed in line with trust policy and guidance.

The care pathways followed by clinicians caring for Mr B were appropriate throughout his care.

10 Forensic services and MAPPA

10.1 Forensic services

The clinicians caring for Mr B were aware he had a forensic history. Mr B was:

- charged in June 1994 with a number of driving offences including driving whilst unfit due to drink or drugs, he subsequently pleaded guilty;
- convicted of criminal assault in July 1994; and
- convicted in 1996 of GBH and received a six-year sentence (he was given early release in October 1999).

Mr B's clinical notes indicate that he and his family shared information relating to his offences with clinical staff. Examples are given below.

- Mr B told consultant psychiatrist 1 in November 2002 that he was facing charges relating to a traffic accident he was involved in when he had been drinking.
- Mr B's family told consultant psychiatrist 1 in August 2008 that he was on bail for carrying an offensive weapon. (The probation service subsequently contacted consultant psychiatrist 1 to advise that Mr B was subject to a community probation order.)
- Mr B told inpatient staff the day he was admitted to hospital in March 2009 that he was due in court the next day to face charges of theft (pertaining to alleged offences in October 2006 and February 2008). The trial was subsequently postponed until June 2009 when Mr B was placed on another community probation order¹⁷.
- Mr B told care coordinator 1 in November 2011 that he had been involved in a fight and was on bail. The outcome was not recorded in the notes.
- Mr B's carer told care coordinator 1 in August 2012 that he was 'down' because of a pending court case. Staff later learnt that Mr B had been issued with a restraining order prohibiting him from approaching his former partner.
- Mr B told care coordinator 1 in July 2013 that he had been charged in relation to a recent car accident. He was subsequently charged for failing to provide a blood specimen and asked for a medical report ahead of the scheduled hearing in September 2013.

Social services contacted the community team in August 2013 to advise that Mr B had been arrested following an incident at home involving his older child and youths. Police had removed some weapons and a shotgun cartridge from Mr B's home.

10.1.1 Analysis

The trust investigation was unable to obtain a complete record of Mr B's convictions. The probation service was unwilling - for reasons unknown - to provide details of Mr B's criminal history. The internal investigation authors subsequently asked the police

¹⁷ There was limited liaison between the probation service and his community mental health nurse in autumn 2009 and in January 2010.

to provide information. The police gave the investigators what it was described as 'relevant' information however the record was incomplete e.g. it did not reference his conviction in 1996 for GBH.

Despite the lack of information sharing between probation services and the trust, the clinicians managing Mr B were aware throughout of the general pattern of his offending.

If Mr B's minor offence history is considered alone, there would be no indication for a general psychiatric service to seek a forensic psychiatric opinion. In these circumstances further forensic advice should have been sought. The team could have sought a forensic opinion prior to Mr B's conviction in 1996 or after his release in October 1999.

If such advice had been sought then expert guidance on the issue of a MAPPA (see below for more information) referral would have been forthcoming. Despite this, typically it is the responsibility of the prison authorities to seek forensic opinion or community forensic management on the release of individuals with complex mental health issues and serious risk of violence to others. In the case of Mr B, this did not happen.

There is no written evidence (e.g. letters) to indicate that Mr B's consultant was told by criminal justice services about any subsequent assault offences committed after his release in 1999. It is surprising that the probation service supervising Mr B in 2008 and 2009 did not discuss seeking a forensic opinion with the trust. In March 2010 the clinical notes reference the option of referring Mr B to the complex case panel/forensics and psychotherapy however there is no record of a decision or further consideration of a referral.

10.2 MAPPA

MAPPA manages the risk posed by the most serious sexual and violent offenders. The police, probation and prison services and other agencies are brought together to share information so that risk assessments and risk management plans can be put in place.

There are three categories¹⁸ of offender under MAPPA criteria:

“Category 1 – Registered sexual offender

Category 2 – Murderer or an offender who has been convicted of an offence under Schedule 15 of the Criminal Justice Act and:

- who has been sentenced to 12 months or more in custody; or
- who has been sentenced to 12 months or more in custody and is transferred to hospital under s.47/s.49 of the Mental Health Act 1983 (“MHA 1983”); or
- who is detained in hospital under s.37 of the MHA 1983 with or without a restriction order under s.41 of that Act.

¹⁸ <http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf>

Category 3 – Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for an offence under Sch.15 of the CJA 2003.”

There is no evidence of a MAPPA referral being considered prior to Mr B’s release from prison in November 1994.

Mr B’s treatment team gave priority to managing his complex bipolar disorder and his consultant did not think that this condition was the primary contributing factor behind the assaults. Based on this we cannot make reasonable criticism of the treating consultant for not seeking a forensic opinion or initiating a MAPPA referral between 2000 and 2013. However in the case of the former, we believe that it may have been a missed opportunity to explore other options of care and treatment.

10.3 Finding

The failure of the team to refer Mr B to forensic services following his release from prison in late 1999 up to the incident in September 2013 may have been a missed opportunity to explore alternative approaches in his care and management.

The trust has now introduced advice clinics where clinicians can seek advice and guidance from specialist forensic staff as required. Therefore we have not made a recommendation.

11 Drug and substance misuse

It is clearly documented throughout Mr B's clinical notes that he abused illicit drugs. His drug use typically coincided with periods in which his mental health deteriorated.

Mr B was offered a referral to drug and substance misuse services on more than one occasion, most recently in July 2011. He either declined or did not attend the appointments – as happened in 2011 when he said that he was no longer interested.

The trust's dual policy, *Management of people with dual diagnosis* (2013), advises:

“Service users with co-occurring mental health and substance misuse needs, requiring secondary specialist mental health services must receive their care and treatment within the Care Programme Approach (CPA). This means that the mental health care co-ordinator or lead professional must retain responsibility for the care of any service user to whom the ‘dual diagnosis’ need applies during their Trust clinical care and Treatment episode. Substance Misuse Service staff members cannot take on CPA care co-ordinator responsibilities.”

11.1 Analysis

Such a clinical scenario is not rare in community mental health services. Effective clinical management of such patients can be challenging. Mr B's consistent denial that he had a drug misuse problem meant that there was little chance of a referral ever being successful.

Some mental health services have specialist ‘dual diagnosis’ teams that have expertise in the management of people with a serious mental illness and a drug misuse problem. These teams may take responsibility for the primary management of such patients but may also provide advice to the existing treating team on treatment strategies. There is evidence that at least from 2011 onwards the trust had a dual diagnosis service. Though Mr B declined to engage with the service his treatment team could have sought advice from the team in relation to treatment strategies which may have been helpful for his management.

11.2 Finding

Mr B's treatment team may have benefitted from advice from the dual diagnosis service about treatment strategies for him.

11.3 Recommendation

Community teams should seek specialist advice as required in relation to treatment strategies when managing patients with a history of drug and/or alcohol abuse who do not engage with the service.

12 Engagement with other agencies

A number of agencies were involved in Mr B's care and management including the trust, his GP, probation services and social services (in relation to his youngest child).

The trust's *Care coordination policy (2010)*, advises:

“...the service user can only benefit from well co-ordinated assessment and planning if there are clear lines of communication between professionals and agencies.”

And

“...it is particularly important that effective links are made with the criminal justice system.”

12.1 Analysis

There was a good level of engagement with Mr B's GP, as evidenced by the correspondence between the GP and trust. There was limited but appropriate engagement with the probation service in 2009 and 2010 when he was subject to a probation order. However the unwillingness of the probation service to share information with the trust investigation makes it difficult to know whether there were any shortcomings in communication between probation and trust services.

During 2012 trust staff learned that social services were involved with Mr B's youngest child, with whom he had contact and later played a significant role in their care. Limited information is available in Mr B's clinical records about the extent of social services' involvement or their particular concerns but telephone liaison took place between Mr B's community mental health nurse/care coordinator and his child's social worker in 2012 and 2013.

In the absence of fuller information from social services it is not possible to know whether all relevant risks had been identified and information shared between the two services. It is possible that the trust should have been more forthcoming at an earlier date with social services about Mr B's risk history but in the absence of reliable records it is difficult to give a firm opinion. We note that the trust internal investigation highlighted that safeguarding children was an area in which improvements could be made and outlined two actions in relation to this (we explore this further in section 14 under the 'trust progress with the action plan'). Regardless of this, local authority social services had the lead role for safeguarding Mr B's child rather than the trust.

12.2 Finding

The level of engagement between agencies involved in Mr B's care was adequate however the trust would have benefitted from some agencies (probation service/criminal justice services) sharing information on a more proactive basis.

12.3 Recommendation

The clinicians should ensure they comply with the information sharing requirements of the trust *Care coordination policy*.

13 Predictability and preventability

In this section we examine whether the incident could have been predicted or prevented.

13.1 Predictability

We assess predictability based on the following principle:

The homicide would have been predictable if there was evidence from Mr B's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

Trust staff were aware that Mr B could be violent. He had criminal convictions for criminal assault and GBH. He could be physically and verbally intimidating both towards trust staff and his carer. In the months preceding the incident the following is of note.

- Mr B showed early warning signs of relapse during an appointment with consultant psychiatrist 1 and care coordinator 1 on 25 July 2013. They noted that there was a potential risk of violence/aggression to others if Mr B's condition deteriorated – scored as 'significant' - though overall Mr B's risk remained 'minimal'. Mr B was put on enhanced CPA status.
- In early August social services told the team that Mr B had been arrested on 26 July 2013. The police had removed weapons from Mr B's home.
- Mr B contacted care coordinator 1 on 12 August 2013 to report that he was stable and had not used cannabis for over a week and a half.
- Mr B was seen by care coordinator 1 on 11 September 2013. His mental health was noted to be stable and Mr B had no concerns in relation to his mood, energy levels, appetite or sleep. He confirmed he was not taking olanzapine and only using cannabis on a minimal basis. Mr B's risk assessment was updated and overall risks were noted as remaining low.
- Mr B failed to attend an appointment with consultant psychiatrist 1 on 12 September 2013. Consultant psychiatrist 1 was unable to contact him but noted the care coordinator's report from the previous day that Mr B was stable.

Mr B was last seen by his care coordinator on 11 September 2013, four days before the index offence. Mr B's risk assessment mirrored those undertaken in July and August 2013. His risk of 'violence/harm to others' remained 'significant' but his overall risk was considered to be low.

There had been other occasions when Mr B's risk of violence/aggression to others was considered 'significant'. On both occasions Mr B was admitted to hospital within a month, on 24 April 2010 and 14 August 2011 respectively (the latter of which was an admission under Section 3 of the MHA). On these occasions Mr B's symptoms were significantly more florid. Crucially Mr B's carer, Ms C reported that

his behaviour had become increasingly volatile in the days leading to his admissions. In August 2011, Mr B was verbally aggressive and intimidating towards Ms C.

In contrast to this, in July 2013 though Mr B showed early warning signs that his mental health was deteriorating – something which his carer had contacted his mental health nurse about - he displayed no hypomania or irritability. Given the raised risk rating on 9 July it was appropriate that consultant psychiatrist 1 and care coordinator 1 reviewed Mr B within a short time (on 25 July). This was good practice. Consultant psychiatrist 1 considered Mr B's risk to be contained, writing in the notes: "[Mr B] is presenting with early warning indicators of relapse though these are mild at the moment, his behaviour is reasonably well contained and the risks are also contained." Consultant psychiatrist 1 recorded that Mr B's mood was not elated, his speech was normal and he did not express any abnormal thoughts. The fuller assessment by the clinicians meant that the judgement of overall risk as 'minimal' was more reliable than earlier scoring by care coordinator 1 alone.

During his appointment on 11 September 2013 with his care coordinator Mr B, was noted to be stable and there was no evidence of thought disorder, pressured speech, irritability nor perception abnormality. The two discussed his needle phobia and agreed Mr B would ask his solicitor to contact his dentist and GP for records of this (in relation to failing to provide a blood specimen to the police).

The failure of Mr B to attend an appointment with consultant psychiatrist 1 on 12 September was not unusual and had happened before. In such circumstances consultant psychiatrist 1 would try to make contact by telephone, as was the case in this instance. Given their relationship this was an appropriate action. It was good practice to review care coordinator 1's assessment undertaken the previous day.

In both July and September, though Mr B showed early warning signs, there was no evidence to indicate that he had been threatening or intimidating to his carer who was typically his first target when his risk of violence escalated. The records indicate a good level of discussion between consultant psychiatrist 1 and Mr B's care coordinator, and confirmation that there was not a relapse of psychosis.

Trust clinicians knew about Mr B's assault convictions and correctly rated risk of violence to others in his risk profile. They were aware that the potential risk of harm to others increased when he developed acute and severe psychotic symptoms, and in these circumstances had previously arranged urgent hospital admission.

In the month preceding the incident Mr B gave no indication to healthcare professionals in terms of his words, behaviour or actions that could have alerted them to the fact he would be imminently violent.

The trust's internal investigation concluded that mental health services could not have predicted the extent to that Mr B's violence would escalate leading to the incident. We agree with this assessment.

13.1.1 Finding

We found that the incident in September 2013 could not have been predicted.

13.2 Preventability

We assess preventability based on the following principle:

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

Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

Mr B's key management and treatment in the two years prior to the incident was closely overseen by consultant psychiatrist 1 and care coordinator 1 who knew him and understood his illness well. Their clinical records show careful consideration and review of all elements of his treatment plan with adjustments as needed. We have previously noted that there was no evidence to suggest that their treatment was wrong or inappropriate.

In the snapshot chronology explored in 'predictability' we outlined that there was no evidence in the preceding month that Mr B's behaviour, actions or words suggested he would be imminently violent. There is no evidence in the records to indicate that Mr B referenced the victim.

Mr B was not severely psychotic and was not threatening harm to anyone when he was assessed on 11 September.

Mr B's failure to attend an appointment on 12 September was not cause to arouse concern given that he was noted to have been stable the previous day and it was not unusual for him to miss appointments. Based on this assessment we conclude that trust clinicians were not in a position to have prevented the events on 15 September 2013.

13.2.1 Finding

We found that the death of Mr X could not have been prevented.

14 The trust's internal investigation and report

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

In this section we examine the national guidance and the trust's incident policy to determine whether the investigation into the care and treatment of Mr B met the requirements set out in these policies.

14.1 National guidance

The NPSA good practice guidance *Independent investigation of serious patient safety incidents in mental health services* (2008) outlines three steps in the independent investigation process, two of which are the responsibility of the trust. These are to undertake an initial service within 72 hours of the incident being reported, and to complete an internal investigation using root cause analysis (RCA).

The NPSA produced *Root cause analysis investigation tools – Three levels of RCA guidance* (2008). It lists three levels of RCA and states that a level 2 (comprehensive investigation) should be:

“Commonly conducted for actual or potential ‘severe harm or death’ outcomes from incidents, claims, complaints or concerns”.

It also states that the investigation should use:

“Appropriate analytical tools (eg tabular timeline, contributory factors framework, change analysis, barrier analysis)”

and that it is:

“Normally conducted by a multidisciplinary team, or involves experts/expert opinion/independent advice or specialist investigator(s). Conducted by staff not involved in the incident, locality or directorate in which it occurred.”

The trust has a number of policies that concern incident investigation and review. These include *Guidelines for conducting an internal review (with an external assessor) of an adverse/untoward clinical event* (2012) and *A guidance note on the investigation of incidents* (2012).

14.2 Detection of the incident

A liaison nurse for the criminal justice team informed the planned community treatment team on 18 September 2014 that Mr B was in police custody for alleged murder.

14.3 The trust internal investigation

The trust commissioned a serious incident investigation into the care on 10 December 2013. The investigation team consisted of:

- an independent investigator (report author);
- a consultant psychiatrist (clinical advisor); and
- a nurse consultant (clinical advisor).

The independent investigator was commissioned by the trust. The consultant psychiatrist and the nurse consultant are employed by the trust however they did not work in the services areas being covered by the investigation and were not involved in the care and treatment of Mr B.

The terms of reference for the investigation included a review of Mr B's care and treatment, the adequacy of risk assessments; recording keeping; communication between all interested parties; and whether Mr B's care was in line with statutory obligations and relevant guidance.

The internal investigation panel reviewed Mr B's clinical notes (some paper-based notes predating 2009 where not available), trust policies and procedures and met with his carer. The panel was unable to meet Mr B due to ongoing court proceedings at the time though shared the final report with him. The panel was not directed by the trust to engage with the victim's family.

The panel led an After Action Review (AAR) that took place in February 2014. This review was attended by four members of staff; Mr B's CPN, his consultant psychiatrist and two clinical leads. Mr B's GP gave his/her apologies. The report author told us that the AAR involved a group discussion which provided the interview evidence used in the investigation report – there were no individual interviews.

The investigation report contained a detailed chronology and explored a number of areas including clinical issues, inter-agency working and safeguarding. The final report was completed in May 2014.

We asked the lead author if he encountered any difficulties during the course of the investigation and if there were areas he would have liked to explore further. He told us that probation services were reluctant to share records with the internal investigation because of the ongoing criminal case against Mr B. He added that it would have been helpful to have had probation's view of Mr B.

The investigation panel was not given a complete set of records by the police and the information provided was received at a late stage of the investigation. The police did not give an explanation for the gaps.

We asked if the panel explored Mr B's belief that he had PTSD due to the alleged abuse that took place in the early 1990s. The lead investigator told us that though they were unable to speak to Mr B until after the investigation was completed, Ms C had told them about the incident. However the police records did not mention the incident. In addition, he said that PTSD did not feature significantly in Mr B's diagnosis.

The lead author told us that he believed the trust's failure to engage MAPPA and/or seek further forensic input may have been a missed opportunity. The trust has an expert panel for forensic cases and the investigation team believed that Mr B would have benefitted from a panel review.

In addition he highlighted the following as areas of concern:

- safeguarding of Mr B's child; inter-agency working and collaboration; and
- staff understanding of Section 117.

In parallel with the above, he highlighted aspects of good practice in Mr B's care including the trust's decision that vulnerable individuals should keep the same care coordinator. Mr B's care coordinator worked hard to work with Mr B who at times could be difficult to engage. He added that the care coordinator and lead psychiatrist developed a relationship with Mr B that facilitated communication.

14.3.1 Analysis

The trust internal investigation was conducted in line with trust policy though not within the guided timeframe. The After Action Review and SI investigation were completed after the recommended 10 and 30 working days after the incident, respectively. The investigation was delayed until the police gave the trust permission to proceed.

The report was comprehensive and addressed the terms of reference. The report authors set out a detailed chronology, relevant benchmarks, analysis of key events, findings and recommendations. It identified areas of concern and omissions. The conclusions of the trust investigation were sound and can be endorsed.

14.3.2 Finding

The trust internal investigation fulfilled the terms of reference, was comprehensive and in line with trust policy.

14.4 Supporting and involving the victim's relatives

The NPSA good practice guidance *The investigation of serious patient safety incidents in mental health services* (2008) states that an opportunity should be provided for the victim and their family to meet senior, appropriately experienced staff from the trust. At this meeting their involvement in the investigation process can be discussed. The guidance also states that families should be consulted on the terms of reference for both internal and independent investigations, be provided with the terms of reference, know how they will be able to contribute to the process of investigation, for example by giving evidence. Subsequently, the findings of the internal investigation and the actions to be taken should be discussed with them.

The NPSA *Being open guidance: communicating patient safety incidents with patients, their families and carers* (2009) states that being open about what

happened and discussing incidents promptly, fully and compassionately can help families to cope better with the after effects.

More recently, the statutory duty of candour has been introduced. The intention of this regulation is to ensure that trusts are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The focus of this guidance is in relation to hospital patients, however the principle of being open and transparent should be applied to all those affected by a serious incident.

14.4.1 Analysis

We reviewed all the records and found no evidence that the trust made any effort to locate the victim's family so that they could involve and support them during the trust investigation and share the findings of the report.

The duty of candour guidance was not in place at the time this incident occurred in September 2013. Statutory guidance was implemented in November 2014.

The trust stated they are reviewing their 'Being Open' guidance that sits within the trust's incident policy, to include responsibilities around duty of candour to all affected by serious incidents. All independent investigations will include within their terms of reference contact with the perpetrator, the family of the perpetrator and the victim's family as appropriate. This will provide an opportunity to answer any questions that they may have around the incident and if appropriate the care and treatment provided by the trust prior to the incident.

14.4.2 Finding

The trust did not meet the requirements of the NPSA being open policy or the duty of candour statutory guidance.

14.4.3 Recommendation

The trust should have a clear process in place to locate and engage the families of any victims so they have the opportunity to be supported and involved in the trust internal investigation. As a minimum the trust should ensure that the victim's family:

- are provided with and consulted on the terms of reference of the trust internal investigation;
- know how they will be able to contribute to the process of investigation; and
- are informed the findings of the trust investigation.

15 Progress on implementing the trust's action plan

In this section we look at the trust's progress in implementing the action plan developed in response to the trust's internal investigation report.

The report identified five areas for improvement:

- assessment and management of risk;
- safeguarding children;
- Section 117 aftercare;
- carers' assessments; and
- incident reporting.

The action plan sets out eight recommendations. We set these out below under the relevant headings.

The trust's serious incident group reviewed the action plan in May and November 2014, and again in June 2015.

We reviewed the documents submitted by the trust as evidence of completion and/or progress with the action plan. We also spoke to the group nurse director for planned care and the senior clinical nurse for planned care about the action plan. We focused our discussion on the steps the trust has taken to embed and monitor any changes in practice.

15.1 Assessment and management of risk

The trust internal report noted that the task of assessing and managing Mr B's risk was complex and had proved challenging for the team. Although the report did not go as far as saying opportunities had been missed, it did say that opportunities were not "maximised". It made two recommendations.

15.1.1 "The team manager should, within the next three months, utilise this report within peer supervision and/or a learning event to enable reflection and discussion on any lessons to be learnt"

We have seen the minutes of the Working Age Adult directorate Red Team meeting on 3 June 2014. This meeting was attended by 23 members of staff, including 12 CPNs. The incident was discussed during this meeting – for which the incident report was sent in advance. It is noted that the group discussed the use of Section 117 aftercare, MAPPA, the involvement of children's social services, referral to forensic services, and the appropriateness of home visits.

This action was achieved ahead of the scheduled deadline of August 2014.

15.1.2 “Message for staff to be circulated via CAS and Chief Executive’s Bulletin with regard to what is available to support teams”

The trust staff bulletin dated 14 October 2014 included a section entitled ‘safety issues’. The section highlighted that the trust had reviewed a number of serious incidents in which earlier involvement of forensic services might have improved the outcome. The briefing goes on to recommend that forensic services be contacted either for advice or for a referral when there is a history of violent or sexual offending, and a potential risk to others. The briefing concludes with details (including contact information) about how to access advice and support from the forensic community team at the forensic liaison clinic.

This action was completed after the deadline of July 2014.

In July 2015 the trust adopted a new approach to providing clinical supervision and support to staff working with patients with complex needs (such as those with dual diagnosis and those requiring forensic risk assessment and management). It is referred to as ‘scaffolding’. We were told that it remains a relatively new concept for staff and the trust will routinely seek data in relation to this. In the interim, there are methods by which the trust can monitor the use of scaffolding. For example clinical records can be reviewed to see how many staff have sought advice.

The trust introduced a *Clinical risk strategy guidance note* in February 2015 and a *Clinical risk assessment and management policy* in March 2015.

15.2 Safeguarding children

The trust internal report stated that the approach taken by the trust to safeguard Mr B’s child did not put their needs first, nor was the approach comprehensive or integrated. It made two recommendations.

15.2.1 “The importance of children’s needs being a primary issue for all mental health staff providing services to adults should be reinforced through the Chief Executive’s bulletin”

The trust staff bulletin dated 5 November 2014 contained a ‘safety message’ that highlighted the importance of children’s needs being a priority for mental health staff when assessing adults with a parental or caring responsibility. The briefing goes on to advise that:

“All assessments must inquire about the children in the adult’s family or a child for whom the adult is the parent and/or has parental responsibility, or with whom the service user has substantial contact, even if there appears to be no immediate concern of significant harm.”

This action was completed after the deadline of July 2014.

15.2.2 “Assurance is required from the safeguarding team that a comprehensive integrated approach is being embedded throughout the organisation and how it is being taken forward by partner agencies”

The trust action plan advises that the Head of Safeguarding sent an email in August 2014 to the safeguarding and public protection (SAPP) team advising it to adopt a ‘think family’ integrated approach to its safeguarding and public protection. (A ‘think family’ practitioner had been appointed in June 2014.) The action plan states that the SAPP team ensures staff are aware of their responsibilities in terms of providing reports and/or attending children protection conferences.

In addition the action plan says the SAPP team has embedded the reporting system for all incidents.

We asked the trust to provide evidence that the SAPP team had adopted a ‘think family’ approach and embedded the IR3 reporting system. We were told that a group business meeting chaired by the director of nursing and operations reviews all safeguarding incidents and alerts.

We asked the trust how it monitors whether the SAPP team ensures staff are aware of their responsibilities. We were told that this is monitored by the Local Safeguarding Children Board (LSCB). A trust representative (e.g. the group medical director) attends the LSCB meetings and reports back to the trust. We were told that when there have been problems (e.g. a report not received) the LSCB has raises them with the trust representative.

We were told that the local authorities monitor the LSCB.

The action plan also advises that the head of safeguarding sent an email in November 2014 to confirm that a *Keeping children safe* document had been discussed at the last SAPP team meeting. The trust provided a copy of this email and the minutes of the meeting. The trust also provided details on the early help assessment pilot taking place in Northumberland.

The trust provided details of its *Getting to know you* guide used across the trust. It sets out the procedures that staff should employ in relation to engaging with the families and carers of patients.

This action was achieved after the July 2014 deadline.

15.3 Section 117 aftercare

The report noted that the clinical team had limited awareness of the implications of Section 117 aftercare and was unable to demonstrate compliance. It made one recommendation.

15.3.1 “The trust should review within three months, in partnership with local authority and clinical commissioning groups, the effectiveness of the current policy and governance arrangements in relation to Section 117 aftercare”

The trust action plan states that it has been working to develop a clear Section 117 process and guidance for staff in October 2013. It has drafted guidance that at the time of writing was with the local authority for review. The trust has assumed the CCG’s Section 117 responsibilities except in instances of out of area treatment. Once the guidance has been agreed with the local authority the trust will share it with staff.

The trust care coordination lead has drafted an item for the myth busters section of the weekly bulletin when the guidance is shared. This will include a link to further details for managers that can be used for a staff briefing about Section 117.

The action plan said that on 22 December 2014 that the care coordination lead and trust MHA lead were arranging a meeting with the lead for CCG Section 117 work from NHS North England Commissioning Support Unit.

We were told that discussions around Section 117 guidance remain ongoing and the guidance is yet to be agreed. At the time of writing there were ongoing discussions amongst the CCGs as to the level of responsibility of each CCG and whether they can delegate responsibilities to the trust.

We were told that steps need to be taken to ensure that the guidance is in line with the Care Act (2014) which was introduced on 1 April 2015.

We were told that finalising the guidance is a high priority for the trust and that all the agencies involved are working together to achieve this.

15.4 Carer’s assessment

Mr B’s carer did not receive a formal carer’s assessment. The internal investigation made one recommendation.

15.4.1 The team manager should with immediate effect ensure a clear understanding of the access arrangements for carers’ assessments and monitors their uptake

The trust has advised that an email was sent to all staff reminding them that even if a patient does not consider a family member their carer, staff can still offer them support. In instances where the patient does not give consent to share information, family members/carers are still entitled to meet with staff to discuss their concerns and needs and receive general advice around the patient’s diagnosis.

This action was achieved in June 2014 ahead of the July deadline.

We were told that supporting carers has been a significant focus for the trust in the past three years. The trust has developed a *Carers’ charter* that outlines staff responsibilities in relation to supporting carers. It provides training about the charter.

The trust monitors this as part of the Commissioning for Quality and Innovation payments framework (CQUIN).

The trust has also developed guidance in relation to patient confidentiality when supporting carers. 'Carer champions' have been appointed across trust services and meet regularly.

15.5 Incident reporting

The report noted that there was an incident when Mr B absconded and this was not reported on an incident report form. The internal investigation made one recommendation.

15.5.1 "Head of Safety and Patient Experience to circulate a CAS alert out to remind staff about the importance of incident reporting"

The trust decided that a CAS alert was not the best approach to addressing what it deemed to be a one-off oversight. The ward from which Mr B absconded has since closed and the staff transferred. During this transfer all staff were given an induction that included incident reporting and the importance of learning from incidents.

15.6 Comment

The trust has provided evidence of completion and/or progress against the action plan. In areas where work is outstanding, completion of these tasks will fulfil the obligations of the action plan.

We note in some instances progress has been slow, particularly in relation to finalising the Section 117 guidance (largely due to multi-agency working) which started in October 2013 and was scheduled to be finalised in March 2015 though at the time of writing is yet to be signed off. Further to this, though the actions serve to address the issues identified in the internal report, this is little in the way of monitoring or assurance beyond this. For example, in relation to the assessment and management of risk, a learning event was held in June 2014, however there is no evidence to indicate that trust managers have taken steps to test if this learning has been implemented into everyday practice.

Similarly, in relation to safeguarding children the trust has not set out any methods by which it will test ongoing assurance that an integrated approach towards safeguarding has been embedded across the trust. This could be assessed via supervision, team meetings and training however the trust does not outline any ongoing monitoring.

15.7 Finding

The trust has provided evidence of some progress against the action plan however work is ongoing and further embedding of process is needed.

15.8 Recommendation

The trust should provide assurance that the systematic changes being made deliver the required service improvements.

Biographies

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. As head of training Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people. Chris heads up Verita's office in Leeds.

Kathryn Hyde-Bales

Kathryn is a senior consultant at Verita with a background in investigations and regulation. She previously worked at the Care Quality Commission (CQC) where she managed the provision of analytical support to standalone projects and regional teams covering the NHS, independent and social care sectors. At Verita she has worked on numerous mental health homicides, reviews of safety at homes providing care for the elderly and on clearing a backlog of complaints at a Midlands trust. Kathryn was a member of the team that provided oversight of the three main NHS investigations into allegations about sexual abuse by Jimmy Savile.

Dr Peter Jefferys

Peter is an experienced consultant psychiatrist specialising in old age and a former trust medical director. He is a non-executive director for Norfolk and Suffolk NHS Foundation Trust. He has investigated unexpected mental health deaths for health authorities, the Mental Health Act Commission and the CQC, and conducted extensive suicide audits. A former advisor to the parliamentary and health services ombudsman, he chairs the Medical Practitioners Tribunal Service and the General Medical Council Fitness to Practice Panels and serves on mental health review tribunals.

Mr B chronology 1994-2010

1994

At the age of 25 Mr B was charged with Section 18 Wounding with Intent. He had used a broken bottle to cut a man's throat. The injury was not life threatening. He was remanded in prison in July 1994 where he became mentally unwell. He was seen by a psychiatrist who assessed him as having amphetamine-induced psychosis which was treated with chlorpromazine. Mr B was released on bail in November of the same year.

In November 1994 Mr B was seen at home by consultant psychiatrist 4. He presented with hypomania thought to be the result of taking illicit drugs. Consultant psychiatrist 4 made arrangements for Mr B to be informally admitted to hospital 3. Upon admission Mr B admitted to a history of taking illicit drugs and abusing alcohol on a regular basis from the age of 14. He was observed to be expressing delusional thoughts and pressured speech during his admission. Mr B was transferred to a locked ward and placed on Section 2 of the Mental Health Act (MHA) but was later granted periods of overnight leave. Mr B was discharged on 20 December with a diagnosis of drug-induced psychosis.

1995

Mr B was seen by consultant psychiatrist 4 on 16 January. Mr B attributed his previous violent behaviour to being high on ecstasy and alcohol. He said that between the age of 20 and 22 he had been dealing and using illicit drugs. He said that he was physically abused by individuals who believed he had stolen money from them. Mr B did not report this to the police.

Consultant psychiatrist 4 saw Mr B again for review on 23 January. He subsequently referred Mr B in April to a community addictions team. The service operates an opt-in model. Mr B failed to reply to the offer of an appointment and was consequently discharged on 11 May without being seen.

Consultant psychiatrist 4 told GP 2 on 24 May that Mr B was well from a psychotic perspective though there had been issues: Mr B's girlfriend had contacted the police alleging that he had slapped her. Consultant psychiatrist 4 recommended that Mr B be given anti-depressant medication to address his low mood. He also referred Mr B to social work support to explore his day-time activity and relationship with his girlfriend.

Social worker 1 contacted consultant psychiatrist 4 in June 1995 to advise that Mr B had indicated he wished to pursue his own employment options. Social worker 1 did not think it appropriate to become involved in any relationship therapy and stopped working with Mr B in August having deemed that he had made enough progress not to warrant her involvement. Consultant psychiatrist 4 noted on 3 July that Mr B was not regularly taking his anti-depressant medication so he stopped his prescription. Mr

B did not present psychotic-related problems though his anxiety and depressive symptoms remained.

At consultant psychiatrist 4's request, Mr B was seen by CPN 1 at home on 5 September. An initial assessment was conducted and depot medication administered. CPN 1 saw Mr B again on 21 September with Ms C, his mother, a psychiatric nurse. They were happy with his progress – Mr B had a job and was looking to restart working as a roofer.

In October Mr B had a court appearance scheduled in relation to drink driving charges for which he had previously pleaded guilty. As part of this process consultant psychiatrist 4 provided a report to Mr B's solicitors in which he noted that Mr B was emotionally stable, was in full-time employment and overall had made fairly good progress. Mr B failed to attend court and a warrant was issued for his arrest.

1996

Mr B was arrested by the police in early January. He was remanded to prison until his next court appearance.

There is a gap in the chronology until 2001. It is known that Mr B was in prison in 1996 having been sentenced to six years for GBH. A CPA review took place at this time. It is also known that Mr B was released 14 months early from prison in October 1999.

2001

In the early months of 2011, Mr B's mental health fluctuated. In early January there were concerns about his behaviour and mood which had appeared both 'high' and 'low' over the Christmas period. He admitted to, his GP, on 10 January that he was regularly taking cannabis in addition to the fluoxetine he had been prescribed in prison. Mr B was reluctant to see a psychiatrist or CPN because he was concerned he would be detained under the MHA again.

Ms C contacted Mr B's GP on 15 January to advise that Mr B's condition had deteriorated. Mr B had threatened to kill her and believed that he had been talking to God. This information was shared with consultant psychiatrist 1 who agreed to see Mr B urgently at an outpatient clinic on 18 January.

Mr B presented at the clinic with an episode of acute psychosis that may have been drug induced (Mr B denied drug use beyond cannabis however his mother suspected otherwise). Consultant psychiatrist 1 could not rule out an underlying severe mental illness such as bipolar affective disorder or schizophrenia. Mr B declined to be informally admitted to hospital and was ambivalent towards taking antipsychotic medication. Ms C did not want her son to be detained under the MHA. It was agreed with consultant psychiatrist 1 that Ms C would trial managing Mr B at home with the potential to escalate his care if necessary.

Mr B continued to display bizarre behaviour throughout January and February though was noted by consultant psychiatrist 1 to be calmer and less agitated. Towards the end of February and during March a significant improvement was noted though Mr B was not taking his antipsychotic medication. Mr B had reduced his level of isolation and his sleep and energy levels had improved. His consumption of alcohol and cannabis was variable during this period. Consultant psychiatrist 1 recorded in the notes that Mr B's symptoms had improved since reducing his illicit drug use and that the episode experienced may have been drug induced.

Mr B was accompanied by his father, Mr A, to an outpatient appointment on 9 March. During this appointment Mr A said that his son had taken a number of ecstasy tablets (over Christmas) a short time before the onset of any symptoms.

Mr B failed to attend appointments with consultant psychiatrist 1 in April and June. Mr B's mother, Ms C reported that Mr B was not displaying psychotic symptoms but appeared mildly depressed and had been drinking heavily. Mr B was not taking any medication prescribed by consultant psychiatrist 1. Consultant psychiatrist 1 reviewed the position with Mr B's mother who reported that he was well, showing no affective or psychotic symptoms. She was unsure whether he was taking illicit drugs but had no evidence to suggest that he was. Mr B had returned to work and had not taken any antipsychotic medication for three months. Consultant psychiatrist 1 agreed with Ms C that he would review Mr B in three months (an appointment was made for 17 September), but Ms C should make contact earlier if Mr B started to deteriorate.

Mr B attended the 17 September appointment. Consultant psychiatrist 1 observed him to be well and stable. Mr B acknowledged his heavy drug use prior to the onset of the symptoms he experienced at the beginning of the year. This reinforced consultant psychiatrist 1 diagnosis of drug-induced psychosis.

2002

Ms C spoke to consultant psychiatrist 1 in early January. She outlined that Mr B had relapsed over the Christmas period. His thoughts were mixed and his conversation had developed religious overtones. Ms C was unsure whether Mr B had been taking illicit drugs. She had been giving Mr B diazepam that he had left from a previous prescription.

Consultant psychiatrist 1 saw Mr B with Ms C on 4 March. Mr B reported that he was well and confirmed that he was smoking cannabis. Mr B did not show any psychotic symptoms during the appointment. Consultant psychiatrist 1 wrote in the notes that he believed Mr B had experienced a minor relapse but it was unclear whether Mr B was taking illicit drugs at the time. Consultant psychiatrist 1 prescribed a one-week course of diazepam for Mr B to take as required for his insomnia or agitation. It was planned that Mr B would be reviewed in four months.

Mr B was seen for an urgent appointment on 24 June before the planned review took place. Ms C reported that Mr B had deteriorated over the previous week; he had

started talking about Jesus, believed he had special powers and was physically overactive. His cannabis use had increased and Ms C suspected he was taking other illicit drugs. Mr B admitted to consultant psychiatrist 1 that he was smoking cannabis but denied other drug use. Mr B appeared irritable during the appointment. Consultant psychiatrist 1 believed Mr B was experiencing an episode of hypomania. He agreed that Mr B could be managed at home (he was living with Ms C) unless the circumstances deteriorated. Mr B agreed to start taking olanzapine at night and diazepam as required.

Consultant psychiatrist 1 referred Mr B to CPN 1 on 26 June. Consultant psychiatrist 1 indicated to CPN 1 that CPN input would be helpful for Mr B in relation to managing his episode of illness and providing support to Ms C. An appointment was arranged for 9 August.

Consultant psychiatrist 1 reviewed Mr B routinely between July and November. During the appointments in July and August Mr B continued to voice grandiose and bizarre ideas. Ms C told consultant psychiatrist 1 in July that she was giving Mr B olanzapine without his knowledge. In August she told consultant psychiatrist 1 that Mr B had attended a funeral in August during which he drank alcohol and became verbally aggressive. Consultant psychiatrist 1 stopped the olanzapine because Mr B said he was not taking it. He agreed to start taking risperidone. Consultant psychiatrist 1 noted that if Mr B deteriorated further/failed to improve, it might be necessary to consider the compulsory powers of the MHA.

Mr B told consultant psychiatrist 1 at his September appointment that he was feeling "ok" and had started exercising. He said he was still smoking cannabis but denied any other drug use. Ms C told consultant psychiatrist 1 that Mr B was not taking the risperidone. She admitted that she continued to covertly administer olanzapine to Mr B without his knowledge. Consultant psychiatrist 1 told Ms C that Mr B should only receive medication that he was aware of and her actions were not acceptable.

Consultant psychiatrist 1 noted at the October appointment that Mr B had made some progress though still voiced abnormal thoughts and had refused to see CPN 1. Mr B showed further improvement in November. Ms C confirmed to consultant psychiatrist 1 that Mr B had significantly improved and had stopped smoking cannabis. However it was noted that Mr B had been in a road traffic accident a number of weeks previously having drunk five pints of beer then driven and crashed his car. Mr B was to face charges for this offence.

2003

Consultant psychiatrist 1 saw Mr B on 17 January. He noted that Mr B had significantly reduced his cannabis and alcohol intake since his car accident. Mr B appeared reasonably well and stable though occasionally referenced being able to cure asthma.

Mr B failed to attend his outpatient appointment with consultant psychiatrist 1 on 28 April. Consultant psychiatrist 1 contacted Ms C who said Mr B had been well over the previous three months and had not shown any abnormal or psychotic symptoms.

He had been taking his medication during the previous five weeks. Ms C was concerned because Mr B had resumed his relationship with a previous girlfriend who she viewed to be a bad influence over her son. Mr B's court case pertaining to the road traffic accident was postponed until July.

Mr B was seen by consultant psychiatrist 1 in October (having failed to attend an appointment in August). He reported that he was well and had not experienced any abnormal thoughts. He displayed insight in relation to his previous psychotic symptoms, attributing these to his ecstasy and cocaine misuse, and excessive use of cannabis. Mr B was not taking psychotropic medication other than diazepam as required.

2004

Consultant psychiatrist 1 saw Mr B for review on 16 February. Mr B had deteriorated, expressing beliefs that he could heal people with his "divine gift". Consultant psychiatrist 1 noted that Mr B appeared calm and displayed no pressure of speech and was not aggressive, intimidating or inhibited. Consultant psychiatrist 1 contacted Ms C the next day to discuss Mr B. She outlined that his mental state fluctuated on a daily basis but she was not concerned that he would become violent or aggressive. They agreed to keep the situation under review. Mr B had admitted that he was smoking cannabis however denied using any other drugs. He was not taking antipsychotic medication and was reluctant to do so.

Consultant psychiatrist 1 referred Mr B for CPN input. In his referral he outlined that he believed Mr B to have a bipolar affective disorder with a number of psychotic episodes that had occurred in the context of illicit drug use. Consultant psychiatrist 1 noted that he had initially diagnosed drug-induced psychosis, but now considered that Mr B's symptoms could not all be related to drug use. Consultant psychiatrist 1 believed Mr B needed ongoing CPN support. He highlighted previous risk factors in his referral, relating to aggressive and intimidating behaviour that had predominantly been verbal. He noted Mr B's conviction for GBH though added that it was unrelated to Mr B's psychiatric symptoms.

Consultant psychiatrist 1 saw Mr B urgently on 10 May at the request of Ms C. Mr B had returned from a week in London displaying features of hypomania with grandiose thoughts. He had wired his mobile phone to a lamp, and had become verbally abusive and threatening towards Ms C. Mr B agreed with consultant psychiatrist 1 that he would start taking olanzapine at night. Mr B refused CPN input.

When seen again on 19 July, Mr B was noted to have significantly improved. He no longer held abnormal beliefs and demonstrated insight into his illness. Mr B's olanzapine was reduced (he had been experiencing excessive weight gain which is a side effect).

2005

Consultant psychiatrist 1 noted Mr B to be well and free of psychiatric symptoms in early 2005. He was not taking psychotropic medication, indicated that he had

stopped smoking cannabis and had reduced his alcohol intake to four cans of lager a week. Mr B was noted to be actively engaged in the family business.

Having failed to attend a review appointment in June, Mr B was next seen by consultant psychiatrist 1 on 12 October. Mr B said that he had not smoked cannabis or used illicit drugs in the previous months. His alcohol consumption continued to be controlled and he had not encountered any further problems with the police. Consultant psychiatrist 1 summarised that Mr B's mental health was good and there continued to be no evidence of psychotic or affective symptoms. Mr B was not taking any psychiatric medication. Consultant psychiatrist 1 believed if Mr B could abstain from illicit substances it was possible he would remain well. However, there remained the possibility of an underlying predisposition to mental illness, such as bipolar affective disorder. Consultant psychiatrist 1 decided to continue to provide occasional outpatient follow-up.

2006-2007

Mr B failed to attend outpatient appointments in April and September. Consultant psychiatrist 1 wrote to GP 1 to outline that Ms C had contacted him with concerns that Mr B had 'gone to ground'. Consultant psychiatrist 1 added that services would continue to try to engage Mr B and asked GP 1 to provide any information that became available.

Consultant psychiatrist 1 saw Mr B on 13 November. Mr B reported that he was well though admitted that he was smoking cannabis. He denied using any other drugs. Mr B did not display any psychotic symptoms. Ms C subsequently contacted consultant psychiatrist 1 to advise that her son had accumulated a significant amount of debt. She described the situation as difficult and stressful. Consultant psychiatrist 1 gained consent from Mr B to provide Ms C with a letter to support her in addressing the debt issues.

It was noted in December that Mr B had gone to Dubai with his father. Ms C wrote to consultant psychiatrist 1 in March 2007 to advise that Mr B remained in Dubai. He was well and she did not have any concerns about him. She wrote that she would arrange a follow-up appointment for Mr B when he returned.

2008

Consultant psychiatrist 1 saw Mr B on 4 August. Mr B described himself as 'excellent' and outlined that he had returned to the UK in December 2007 and had been living with his mother. Mr B appeared calm and denied taking illicit drugs. He showed no evidence of hallucinations though expressed some grandiose ideas. Consultant psychiatrist 1 believed that these were early indications of a relapse of psychosis/hypomania. Mr B was unwilling to take any medication.

Mr B's family contacted the crisis team on 9 August to report that Mr B had attempted to assault Ms C. The family requested an out-of-area admission bed (Ms C worked at the local mental health hospital). Mr B could not be admitted without assessment therefore it was agreed that he would be seen by the crisis team at the

A&E at hospital 4. At the appointment Mr B was noted to be intimidating and uncooperative; the assessment was not completed. Mr B was given a two-day supply of lorazepam and zopiclone to reduce agitation and promote sleep. It was agreed that Ms C would arrange an early appointment with consultant psychiatrist 1, but if this was not possible she would contact the crisis team.

Mr B was seen with Ms C by GP 2 on 11 August. They had requested an urgent psychiatric assessment. Mr B's engagement with the crisis team was noted along with the fact the police had been called to the family home following a verbal outburst by Mr B. GP 2 recorded in the notes that Ms C did not feel at risk. GP 2 made an urgent referral to consultant psychiatrist 1. GP 2 was aware that Consultant Psychiatrist 1 was on annual leave until 18 August. Mr B and Ms C opted to wait to see consultant psychiatrist 1 though agreed to contact on call cover if the situation escalated. Mr B agreed to stop drinking alcohol and was prescribed a week's course of lorazepam.

Consultant psychiatrist 1 saw Mr B on 18 August. He was accompanied by Ms C and his brother, Mr D. Mr B denied any problems with his mental health however Ms C and Mr D did not agree with this. They described incidents that had happened when Mr B was intoxicated which would not have occurred if he were well. He had caused damage to the family home, verbally threatened a neighbour, held a knife to his own throat and his speech had become bizarre. Mr B had been arrested and was on bail for carrying an offensive weapon. Ms C and Mr D said that Mr B had been binge drinking for about four months. Ms C had started to administer a previous prescription of olanzapine to Mr B; consultant psychiatrist 1 expressed his concern to Ms C about her giving Mr B medication without his or GP 2's agreement.

It was agreed that Mr B would take aripiprazole at night and would be closely monitored by the crisis team – which would observe him taking his medication. However Mr B's family contacted consultant psychiatrist 1 shortly after to advise that Mr B was refusing to take his medication. The crisis team indicated an unwillingness to accept Mr B due to his potential risk (and that he was outside of its catchment area). As a result consultant psychiatrist 1 decided Mr B warranted detention under Section 3 of the MHA for further assessment. Consultant psychiatrist 1 completed the medical assessment however Mr B left the family home and the police were informed he had gone missing. Consultant psychiatrist 1 asked social worker 1 to monitor the situation daily in relation to locating Mr B.

Social worker 1 wrote to consultant psychiatrist 1 on 2 September to advise that Ms C had confirmed Mr B had not visited his mother because he was fearful of being detained under the MHA. Ms C had been able to see him and reported that he appeared 'level' and she did not observe any signs of mental illness. Having been advised that the original MHA assessment was now invalid, Ms C said she thought Mr B would be willing to see consultant psychiatrist 1. An appointment was made for 22 September however Mr B failed to attend having double booked an appointment with his GP. Ms C phoned the service to arrange another appointment. She reported that Mr B was "really good" and she didn't have any concerns.

A new appointment was arranged for 1 October however Mr B cancelled saying that he had a court appearance. Ms C spoke to consultant psychiatrist 1. She said

there was no evidence of psychiatric illness and Mr B was level headed. He had not been drinking and there was no evidence of drug taking. There hadn't been any further incidents. Consultant psychiatrist 1 reiterated that Mr B should have CPN involvement.

At this time consultant psychiatrist 1 wrote to the assistant medical director, hospital 1 to explain the family's position in relation to their wish that Mr B be treated outside of the local catchment area. The assistant medical director replied that it would be difficult to facilitate community services from another locality, and it would be more appropriate for Mr B to be treated within the local catchment. It was agreed however that if Mr B required admission he should not be placed at the hospital where members of his family worked.

Mr B failed to attend an outpatient appointment on 26 October. Consultant psychiatrist 1 spoke to Ms C and Mr B over the phone. Ms C said she had no concerns and Mr B reported that he was well. He was calm, coherent and rational. Consultant Psychiatrist 1 contacted Mr B's probation officer indicating that it would be helpful to maintain regular contact with Mr B who had been placed on a community probation order.

2009

Mr B was seen by consultant psychiatrist 1 on 7 January. Mr B reported he was "ok". Mr B had not been taking his prescribed medication. He agreed to CPN involvement. Consultant psychiatrist 1 contacted the rehabilitation recovery team to request the allocation of a CPN. He provided a Sainsbury risk assessment (dated 1 October 2008) and a narrative overview of key longer-term risks relating to other periods of illness. Consultant psychiatrist 1 outlined that these risks increased in relation to aggressive or reckless behaviour when Mr B was non-compliant with medication or disengaging from services. Consultant psychiatrist 1 added that he believed Mr B to be stable at the time and of low risk.

Mr B was seen by the rehabilitation recovery team on 11 February. The team did not identify any rehabilitation needs – Mr B indicated that he could manage on his own and did not require support. The team did not accept Mr B onto its caseload. Consultant psychiatrist 1 planned to refer Mr B to the planned care team for CPN input.

Ms C contacted consultant psychiatrist 1 on 26 February to report that Mr B had deteriorated. Consultant psychiatrist 1 and social worker 1 undertook a home visit. Mr B admitted that he occasionally smoked cannabis, and had been drinking heavily to help him sleep but denied any problems. The clinicians' impression was that there had been an early relapse of a bipolar disorder and that Mr B required close monitoring given that his behaviour could escalate quickly. Admission was considered however a trial of home treatment was agreed with Ms C, on the basis that this would involve the local team. A short-term prescription for diazepam was given to Mr B and a follow-up appointment was scheduled for 9 March.

The crisis resolution team (CRT) undertook home visits on 27 and 28 February and 1 March. The diazepam Mr B had been prescribed was noted to have had a positive and calming effect. The CRT contacted consultant psychiatrist 1 on 2 March to advise it felt Mr B could be discharged from the service. The team suggested it undertake a seven-day follow-up visit after Mr B was discharged.

Ms C contacted the CRT on 8 March to say she was concerned about Mr B's behaviour. Consultant psychiatrist 1 became involved and arranged for Mr B to be informally admitted to hospital 4 that day. Mr B said he had not been taking his medication. He reported an elevated mood, increased irritability, and that he was not coping at home and had not slept in the previous 48 hours. It was thought that his deterioration in mood was partly due to his pending court case. Mr B had been scheduled to attend court on 9 March in relation to two offences of jewellery theft. Consultant psychiatrist 1 had previously identified that Mr B was not fit to stand trial and the case had been adjourned.

Mr B was settled during his period of inpatient care and was granted overnight leave. Mr B did not return to the ward on 14 April following a period of leave, and it was agreed he could be discharged. It was agreed at the post discharge CPA meeting on 21 April that consultant psychiatrist 1 would follow up with Mr B.

CPN 2 contacted Mr B to offer an appointment for assessment. Mr B did not respond therefore CPN 2 discharged him from his caseload without being seen on 28 April. Mr B was referred again for CPN input in May. CPN 3 met Mr B on 28 May who agreed to engage with the service.

Consultant psychiatrist 1 saw Mr B on 1 June. His mood was noted to be fairly stable though he was stressed about his impending court case.

Ms C contacted GP 2 on 4 June to report that Mr B had reverted to his previous behaviour since seeing consultant psychiatrist 1. He was hostile and confrontational – Ms C suspected he was taking drugs. Mr B failed to attend a planned appointment with GP 2 that day. GP 2 asked Ms C to get Mr B to contact him.

Consultant psychiatrist 1 saw Mr B on 8 June. His behaviour had become increasingly erratic and he was informally admitted to ward C. Mr B's urine test was positive for a morphine-based substance.

Mr B attended court on 15 June (a decision supported by consultant psychiatrist 1) and returned to ward C the same day. He was found not guilty in relation to a burglary charge but was to attend court on 10 July in relation to another offence. Throughout June Mr B showed no evidence of psychosis or elevated mood. He was granted regular leave. Mr B attended court on 10 July. He was found guilty and received a 12 month probation order.

Mr B deteriorated during a period of authorised leave and presented as aggressive. Ms C contacted the ward to voice her concerns in relation to the management of Mr B's leave and the failure to consult her when a leave plan was being developed.

Consultant psychiatrist 1 reviewed Mr B on 30 July. He decided that Mr B should return to the acute ward when a bed became available, but be granted ground leave at the discretion of nursing staff. Consultant psychiatrist 1 was considering a referral to MAPPA (Multi Agency Public Protection Arrangements). Ms C believed that Mr B should be detained for 28 days without leave. However it was agreed at an MDT (multi-disciplinary team) meeting on 3 August that Mr B could be discharged home after his mother had indicated she was happy for him to be discharged. Mr B was discharged and a seven-day follow-up appointment arranged for him to be seen on the ward. The CRT was informed of the discharge.

Mr B failed to attend the seven-day follow-up appointment. Consultant psychiatrist 1 saw him on 17 August. Mr B reported he was well and planning to get back to work. He reported he was taking his olanzapine. In advance of this appointment Ms C had confirmed with consultant psychiatrist 1 that Mr B was well though she was unsure if he was taking his medication.

Mr B contacted care coordinator on 18 August to explain that he could not attend their appointment that day. Another appointment was arranged which Mr B again failed to attend. Care coordinator made a number of attempts to contact Mr B and subsequently contacted consultant psychiatrist 1 and the probation service to discuss his non engagement.

Care coordinator attended Mr B's appointment with consultant psychiatrist 1 on 19 October. Mr B appeared well though indicated he had stopped taking his medication. Mr B confirmed he was amenable to an ongoing dialogue with mental health services and the probation service. Care coordinator made two appointments to see Mr B, neither of which he attended.

2010

Consultant psychiatrist 1 and care coordinator saw Mr B together on 11 January. Consultant psychiatrist 1 recorded no concerns. Mr B appeared mentally well. Mr B continued to fail to engage with care coordinator, saying he would call her if he needed support. Ms C told care coordinator on 19 January that she had concerns about Mr B whose behaviour suggested he had started taking drugs again. Ms C thought he was abusing his prescribed medication. Care coordinator spoke to Mr B over the phone and it was agreed she would visit him on 21 January. Care coordinator contacted the CRT to place Mr B on 'alert', and updated consultant psychiatrist 1 of the situation.

Care coordinator saw Mr B at home on 21 January. He told her he was implanted with poison from dog bites. Ms C outlined to care coordinator that Mr B had been physically and verbally intimidating. Mr B displayed slight pressure of speech and continued to take his antipsychotic medication. Care coordinator referred to the CRT, asking it to contact Ms C that evening and see him the next day.

The CRT was unable to contact Ms C – the phone was either engaged or not answered. Care coordinator spoke to Ms C the next day who asked that there be no contact from two members of the CRT who she had previously had bad experiences

with. Ms C said that she would manage the situation at home but would contact the CRT if the risk changed. The situation was monitored by care coordinator and probation officer and remained unchanged throughout January and early February. Probation officer was aware Mr B had been actively using cannabis and his mental health was showing early signs of relapse.

Ms C contacted care coordinator on 15 February to ask for help. Care coordinator arranged to visit the next day and brought forward Mr B's planned appointment with consultant psychiatrist 1. During the planned visit care coordinator found Mr B presented with symptoms of further relapse. Care coordinator accompanied Mr B to his appointment with consultant psychiatrist 1 the next day. Mr B was prescribed olanzapine and diazepam.

Care coordinator noted during a home visit on 2 March that Mr B's behaviour had deteriorated further. It was agreed that CRT involvement should be activated to support home treatment in addition to arranging a short supply of diazepam. The CRT visited the next day. The home situation was described as fraught however Ms C indicated that she would prefer to manage Mr B at home. The CRT arranged a further a medical review for 4 March and asked Ms C to contact the team if she needed help. Ms C requested a carer's assessment.

Consultant psychiatrist 3, CRT undertook an assessment on 4 March. His impression was that Mr B was presenting with a manic episode of what appeared to him as bipolar affective disorder or possibly schizoaffective disorder with illicit drug use being a significant factor. Mr B's risk was seen to be low but he required ongoing assessment. A plan was agreed between care coordinator and the CRT. The CRT visited Mr B regularly during which time the team considered a hospital admission.

Consultant psychiatrist 1 reviewed Mr B on 12 March. It was noted that Mr B remained unwell – his behaviour was less irritable though it was known he was continuing to use cannabis. Consultant psychiatrist 1 felt Mr B could be managed at home. His medication was increased. The CRT and care coordinator continued to engage with Mr B throughout March. Mr B was seen by consultant psychiatrist 1 and care coordinator on 23 March. He continued to express grandiose ideas but was not irritable. He declined a hospital admission. Further medication was prescribed and Mr B agreed to continued contact with care coordinator.

Mr B's engagement with care coordinator and consultant psychiatrist 1 was variable in April and he was informally admitted to hospital 4's acute inpatient ward on 24 April. Mr B was an inpatient from 24 April until 19 August. During his admission Mr B's behaviour and presentation fluctuated. Incidents included Mr B presenting as intoxicated, irritable, exhibiting bizarre behaviour and going AWOL.

Mr B's behaviour was described as floridly psychotic on 11 May. Staff noted his behaviour as intimidating and he absconded from the ward the next day. He was subsequently detained by the police under Section 136 of the MHA¹⁹. Mr B was

¹⁹ The police later contacted the ward to advise they suspected Mr B had broken into a vehicle when he was AWOL on 10 May.

subsequently detained under Section 2 of the MHA. During his admission Mr B spent periods in the psychiatric intensive care unit (PICU).

Mr B was granted periods of escorted ground leave from 18 May. The MDT met on 1 June. Plans were made by the team that included encouraging Mr B to contact the relevant drug advisory service in the area. Random drug screening was introduced in parallel with two-hour-a-day unescorted ground leave.

Mr B tested positive for cannabis, benzodiazepines and morphine on 5 June. On 8 June it was decided by inpatient staff that Mr B's section should be converted from Section 2 to a Section 3. Consultant psychiatrist 1 completed the first medical recommendation. However the second opinion doctor asked to assess Mr B concluded he could not support a Section 3 therefore when the Section 2 expired at midnight Mr B became an informal patient. Mr B was reassessed two days later and he was detained under Section 3 of the MHA. Mr B made a formal appeal against his detention the next day.

Between 12 and 30 June Mr B was generally described as settled though concerns remained that he was accessing illicit drugs when on leave. Mr B continued to be generally settled in July and appropriately utilised periods of leave during this period. The MDT decided on 19 August to revoke the Section 3 and he was discharged. It was agreed care coordinator would maintain weekly contact and that consultant psychiatrist 1 would resume his responsibility as the consultant lead in the community.

Mr B attended his seven-day follow-up appointment on 22 August. Mr B appeared well when seen by his care coordinator in August, September and October though he told her he had been arrested and interviewed regarding the alleged incident on 10 May. Ms C was present during some of these visits. During the September visit Mr B said he had experienced some problems obtaining his medication because of this he had reduced his intake of olanzapine. Care coordinator resolved the issue in relation to his prescription however Mr B continued to reduce his intake on olanzapine without following care coordinator's advice that he consult consultant psychiatrist 1 first. Mr B continued to see care coordinator and consultant psychiatrist 1 until the end of 2010. No concerns were raised during this period with the exception of Mr B refusing to take olanzapine. Additionally he told care coordinator he had accrued some debt in relation to his mobile phone.