

An independent investigation into the care and treatment of P, a mental health service user in St Helens

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

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1 Executive summary

- 1.1 Niche Patient Safety was commissioned by NHS England in September 2015 to undertake an independent investigation into the care and treatment of mental health service user P. P pleaded guilty to the homicide of M, a 17 year old young man who was part of his extended family. Two others were involved. P had just been released from a three month prison term for three counts of battery when he jointly committed the murder. In July 2015 he was sentenced to 19 years imprisonment.
- 1.2 We begin this report by expressing our sincere condolences to M's family.
- 1.3 The independent investigation follows the revised Serious Incident Framework (SIF) published by NHS England in April 2015¹, in particular Appendix A *Regional Investigation Teams: Investigation of homicide by those in receipt of mental health care*. Our terms of reference are at Appendix A of this document.
- 1.4 The aims of independent investigations are set out in pages 47-48 of the SIF. The SIF aims to ensure that mental health care-related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process will also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.5 5 Boroughs Mental Health Partnership Trust (which we refer to as Trust 1) had provided community mental health services to P between June 2013 and October 2014 when he was imprisoned for three assaults on his partner. Following his release, the Trust would have resumed care coordination if P had not been arrested on suspicion of murder. In addition, Bridgewater Community Healthcare NHS Foundation Trust (Trust 2) had been involved in assessing P. Mersey Care NHS Trust (Trust 3) provided mental health care to P while he was in HMP Liverpool between October and December 2014. Lancashire Care NHS Foundation Trust took over the running of all health services in HMP Liverpool from 1 June 2015. While Lancashire Care did not provide care to P during the span of this investigation, we direct our recommendations concerning prison health care to it.
- 1.6 Shortly after the homicide, Trust 1 carried out an internal serious incident (SI) investigation into P's care. It concluded that while P's tendency to violence was predictable, the homicide was not preventable through NHS care. That is the same conclusion which we have reached through our independent investigation. Some recommendations were made by Trust 1 to improve its services, most of which we endorse.
- 1.7 In our investigation we have reviewed Trust 1's SI report and action plan as well as all the available NHS and GP records relating to P. We have also

¹ <https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incident-framework-upd2.pdf>

reviewed the probation providers' records concerning P and records of his dealings with Addaction, a voluntary sector service for people wishing to reduce or stop their alcohol and/or drug consumption. We spoke to staff from Trust 1, Trust 2 and Trust 3 and met with P. We were pleased to meet with M's mother and one of his sisters who decided that they would not contribute further to this investigation. We also spoke to P's mother who also decided that she would not participate in the investigation.

1.8 Through this process we considered whether there were any identifiable factors which could have caused or contributed to this tragic incident. We found no specific causal factors. However we identified some areas for improved working which we address through the recommendations in paragraph 1.10.

1.9 We also identified good practice which included:

- The strenuous efforts of PO1, P's first probation officer, to link him with services which would reduce the high risk she had identified of him becoming involved in violent drug and alcohol-related crime
- The allocation by Trust 1 of SNP2, a skilled and experienced care co-ordinator to P, within a team geared up to address his presentation of first episode psychosis. SNP2 was able to provide consistent care of a high standard to P for the duration of his 18 month engagement with Trust 1
- Well documented thorough assessments, risk assessments and reviews by all three trusts who worked with P
- Appropriate prescribing and provision of therapeutic support by the staff of Trust 1 and Trust 3
- Tenacious implementation of a pre-birth assessment referral by SNP2 despite the failure of the partner agency, a probation provider, to make the referral as agreed
- Clear communications with partner agencies and full implementation of a Child Protection Plan for P's baby daughter by Trust 1
- Effective risk management by Trust 1 in the known risk areas
- Good communications between Trust 1 and Trust 3 during P's imprisonment and effective communication of clear plans for a seamless resumption of mental health care in the community following his release.

1.10 We offer the following recommendations:

Recommendation 1:

Lancashire Care NHS Foundation Trust should ensure that prisoners with known mental health problems are fully reviewed no later than in the first weekly mental health service allocation meeting following their primary care assessment in the prison.

Recommendation 2:

Lancashire Care NHS Foundation Trust and Mersey Care NHS Trust should review the effectiveness of their systems for receiving information about prisoners from external agencies and entering it into the health care record. The aim should be to ensure that information from other agencies, while subject to the required protection, is made available quickly to the staff that need it.

Recommendation 3:

5 Boroughs Partnership NHS Foundation Trust should review the effectiveness of its policies and procedures for working in partnership with other agencies, including probation, where a service user has a known risk of domestic violence.

Recommendation 4:

Clear procedures should be built into 5 Boroughs Partnership NHS Foundation Trust's Incident Management Policy to ensure that staff whose practice is subject to criticism have an opportunity to comment before the investigation is finalised. The policy should also provide clear procedures for confirming the accuracy of witness evidence before it is incorporated into an investigation report.

Recommendation 5:

5 Boroughs Partnership NHS Foundation Trust's implementation of its Incident Management Policy should ensure that the outcome of an SI investigation is shared where possible and appropriate with all parties to the investigation.

1.11 In this report we set out our findings and the facts which we have obtained which have led us to make our recommendations.

2 The offence

- 2.1 P was released from HMP Liverpool on New Year's Eve 2014. He had served three months of a six-month sentence for three counts of battery against Ms Y, his partner of two years and the mother of his baby daughter. While in prison P had established a friendship with a cellmate, X. On his release P was met by X and others outside the prison. This group included F, the partner of one of P's sisters. P attended a belated family Christmas dinner. The group then purchased large quantities of alcohol for a celebration party to be held that evening in his flat in St Helens. The flat had been used by X, F and others while P had been in prison.
- 2.2 At P's flat the group continued to drink alcohol as well as taking cocaine and cannabis. The court would hear that by the evening episodes of violent and threatening behaviour had broken out in the flat and nearby. Knives were brandished by X and P. In the early hours of New Year's Day, M, an extended family member aged 17, joined the party.
- 2.3 In his sentencing remarks, the Judge stated that from about 9.20am on New Year's day, P and his two accomplices "*viciously attacked*" M. They punched, kicked and stamped on him. He was then stabbed fatally by DW and while he was dying the three men tried to disguise the scene by setting him on fire. Later that day P and X handed themselves over to the police and confessed to killing M. Because F was arrested later and pleaded not guilty a trial was listed.
- 2.4 On 29 July 2015, during the five-day trial at Liverpool Crown Court, P and X pleaded guilty to murder. F was found guilty of murder. Before sentencing, P's lawyer told the court that the murder had been prompted by a cocktail of drink and drugs and had not been premeditated. Starting fires, he pleaded, had been an act of panic rather than of further degradation. He told the judge that P was on medication for mental health issues.
- 2.5 The Judge said he could not be sure that P had intended his victim to die but he expressed disbelief at the plea that P felt remorse. He did not accept that there was convincing evidence of any relevant psychiatric history before the court.
- 2.6 All three men were sentenced to life imprisonment. Due to P's guilty plea, the minimum term of 22 years was reduced to 19.

3 Independent investigation

Approach to the investigation

- 3.1 The basis of this independent investigation is set out in section 1. The investigation was carried out by Jon Wigmore for Niche, with expert advice provided by Dr Ian Cumming and Carol Dudley. The investigation team will be referred to as “we” in this report. This report was peer reviewed by Carol Rooney, Senior Investigation Manager, Niche.
- 3.2 The investigation comprised recorded interviews with:
- SNP1, the senior nurse practitioner who undertook P’s first mental health assessment for Trust 1 in December 2012
 - SNP3, the senior nurse practitioner in Trust 1’s Early Intervention Team (EIT) who was involved in P’s care between May and December 2014
 - ST6/1, the senior registrar (now consultant) who assessed P in August and September 2013 in Trust 1
 - P
 - SNP5, the senior nurse practitioner from Trust 3 who was P’s care co-ordinator during his imprisonment in 2014
 - Ms Y (supported by her mother), P’s ex-partner and the mother of his child.
- 3.3 SNP2, the senior nurse practitioner who was P’s care co-ordinator between July 2013 and December 2014, was unavailable to the investigation due to maternity leave.
- 3.4 In addition, we scrutinised records and policies from the three NHS Trusts involved in P’s care and the probation providers who administered P’s community order between June 2012 and June 2014². We also examined records from P’s GP and Addaction³ (a third sector substance misuse agency which P would be referred to in 2012 and 2014).
- 3.5 After meeting with us on 18 November 2015, P did not engage further with the investigation process or decide to meet with us and NHS England. We also

² Between the imposition of P’s two year community order on 25 June 2012, and 31 May 2014, the Merseyside Probation Trust provided the probation services P received. From 1 June 2014, in line with national changes under the Government’s Transforming Rehabilitation agenda, the National Probation Service was created to protect the public from the most dangerous offenders. At the same time the provision of probation services to offenders like P assessed as low or medium risk was transferred to local Community Rehabilitation Companies (CRCs). This meant that the last three weeks of P’s two year community order were delivered by Merseyside CRC. In this report when we refer to “probation providers” we mean whichever provider of probation services was working with P at the time. However our comments largely concern Merseyside Probation Trust which delivered all but the final three weeks of P’s order. Our Recommendation 3 (paragraph 5.19) refers to both the Merseyside CRC and the National Probation Service.

³ <http://www.sthelensgateway.info/organisations/addaction>

spoke to his mother who decided not to accept our offers of involvement in the investigation process.

- 3.6 We liaised throughout the investigation with officers of St Helens Council. With their support, we were able to meet M's family and offer them involvement in this investigation on 24 November 2015. They did not ask for any specific questions about P's care to be addressed in the investigation. After further communications they chose not to meet us and NHS England to discuss the investigation findings. We would like to thank M's family sincerely for meeting with us in the aftermath of the very traumatic circumstances of M's murder.
- 3.7 We were also assisted by a Clinical Manager from Bridgewater Community Healthcare NHS Foundation Trust (Trust 2) in building our understanding of how Trust 2's Open Mind service (which closed in 2015) had been involved in two mental health assessments of P in 2013.

Structure of the report

- 3.8 Section 4 sets out the details of the care and treatment provided to P. Within section 4 we have also taken the opportunity to comment on aspects of care relevant to our terms of reference.
- 3.9 Section 5 summarises the issues arising from the care and treatment provided to P and includes comment and analysis.
- 3.10 Section 6 provides a review of the trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.
- 3.11 Section 7 summarises our overall analysis and sets out our recommendations.
- 3.12 Appendix A contains our terms of reference.
- 3.13 Appendix B consists of the fishbone diagram summarising our analysis.
- 3.14 Appendix C summarises the symptoms of serious mental illness which P presented between 2012 and 2014.
- 3.15 Appendix D provides an overview of the three NHS trusts involved in P's assessment and treatment between 2012 and 2014.

4 Panel commentary on the care and treatment of P

Childhood and family background

- 4.1 P's father has seven children of whom P knew a sister and a step brother. Until the age of 11, he was brought up by his mother with his sister and a maternal half-sister (who were a year and four years older than him, respectively).
- 4.2 A paediatric assessment described P's behaviour from the age of 18 months as including temper tantrums and smashing objects. P described a difficult childhood. His father lived with the family only briefly, in that time subjecting P and his mother to violence. At the age of 5 an assessment sent to his GP described P as *"difficult to understand with limited vocabulary ... Behaviour very bad, getting worse – destructive, punches people."*
- 4.3 P was bullied at junior school for being overweight and having limited speech. He often got into trouble for fighting and being disruptive in class. He made good progress aged 5-7 years old with speech and language therapy and was statemented for special educational needs.
- 4.4 At the age of 11, P and his mother and sisters moved out of the family home into a refuge for six months due to allegations concerning his stepfather. P did not go to school during this time.
- 4.5 On returning to St Helens, P began high school where his violent behaviour continued. He would later report that it was here that he *"turned bad"* and became a bully. He reported drinking alcohol and smoking cannabis increasingly from the age of 13 leading to difficulties at home and at school. P was expelled from high school aged 14 years for fighting. He told us he regularly drank with his father as a teenager. At that age he was treated in hospital for a broken nose which he said had been inflicted by his father. By the age of 15 P had started using ecstasy and cocaine. He attended a special school until he was 16 years old, obtaining two GCSEs.
- 4.6 At about the age of 16, P moved in with his disabled grandmother. He described himself as her main carer. P depicted her as a matriarchal figure in the family. P described feeling devastated after she died unexpectedly in 2010 aged 58. He took his first overdose the following day, aged 17. P would repeatedly refer to his distress about his grandmother's death when he was assessed by services over the following four years.
- 4.7 P struggled increasingly with lowered mood. He could not come to terms with his grandmother's death. He told us he became an alcoholic. He would describe himself as a *"thug"*, a drinker and a *"messer"*, who always resorted to alcohol as a coping mechanism for stress. During this period, he was living between his sisters' and his mother's homes and his drinking was causing increasing friction.
- 4.8 After a brief spell doing art and design at college, P undertook various jobs on a short-term basis.

Contact with criminal justice system

- 4.9 P's first contact with the criminal justice system was aged 13, when he was cautioned for assaulting a fellow pupil. His convictions prior to the murder are summarised below.

Date of offence	Age	Offence	Sentence date & outcome
25/1/2007	14	Assault occasioning actual bodily harm (ABH)	5/4/2007: 9 months referral order, compensation £50, costs £50
30/3/2009	17	Interfering with vehicle	17/9/2009: action Plan Order 3 months, compensation £50
20/06/2010	17	Handling stolen goods	16/09/2010: conditional discharge - 12 months
9/08/2011	18	Damage to property	28/9/2011: Costs £50, Compensation £50
28/8/2011	18	Assault occasioning ABH	25/6/2012: Community Order –2 years, supervision requirement – 2 years, programme requirement, residence requirement, 3 months curfew, 3 months tagging
5/9/2011	18	Failing to surrender to custody at appointed time	28/9/2011: No separate penalty
14/10/2011	18	Failing to surrender to custody at appointed time	17/10/11: Fine £50, Victim surcharge £15
23/10/2011	18	Aggravated vehicle taking	9/2/2012: Community order, endorsed, costs £85, disqualified, 3 month curfew (reduced to 15 days)
26/11/2011	19	Failed to comply with community order	4/1/2012: Order revoked.
23/2/2012	19	Assault occasioning ABH (committed on bail)	25/6/2012: Young Offenders Institution 122 days (spent on remand)
26/8/2014	21	Battery	3/10/2014: 2 months imprisonment, restraining order (consecutive)
27/9/2014	21	Battery (two counts)	3/10/2014: 4 months imprisonment (consecutive)

- 4.10 P's violent offences are of particular relevance to this investigation. On 28 August 2011, P assaulted his father resulting in a fractured eye socket and broken ribs. The assault was committed with his half-brother. His father was hospitalised and P was put on police bail. In February 2012, P was arrested for a drug-related assault. He was then remanded in custody where he would remain for four months until his court date. On 25 June 2012, at Liverpool

Crown Court, P pleaded guilty to the two assaults. He was sentenced to 122 days in a young offenders' institution (which he had served on remand) with a two-year probation order which included attendance on the Thinking Skills Programme (TSP), a course aimed at reducing criminal behaviour including domestic violence⁴.

- 4.11 Just over three months after the order expired, on 3 October 2014, P was sentenced to a total of six months imprisonment for three counts of battery against Ms Y, his partner. At this stage he had been in the care of Trust 1 for 15 months. These were his first convictions while receiving community mental health services. Within 24 hours of his release, with two accomplices, P murdered M, a 17 year old extended family member, for which he is serving a 19 year life sentence.

Panel commentary on P's mental health-related treatment

- 4.12 P first reported symptoms of mental health problems to his GP aged 19, in January 2012. These included a long history of lowered mood and insomnia. P also disclosed his excess consumption of alcohol. Bloods were taken but the laboratory results were largely normal. Shortly afterwards P was subject to a four month prison sentence.
- 4.13 Following his release on 25 June 2012, P, began a two year probation order which included compulsory attendance on the TSP. P told us that the TSP had been added to the conditions of his order because his attack on his father had been classed as domestic violence. He had been through a detoxification programme in prison. No reference to a mental health problem was made anywhere in the probation documentation.
- 4.14 On his release P resumed drinking and his first probation officer, PO1, tried to engage him with alcohol and substance misuse counselling. Supported accommodation and gaining employment were also goals. PO1 rated P as medium risk to the public and known adults in the community. He was graded tier 3 which equated to a high likelihood of reoffending and a medium risk of causing serious harm⁵. He had weekly appointments with PO1.
- 4.15 On 10 September 2012, P was referred to Addaction for the first time by PO1. Over the following two years he would be re-referred to the service by probation, Trust 1 and social services. P, who said he could not cope with group sessions, would never engage with the service.
- 4.16 On 17 October 2012, PO1 referred P to 5 Boroughs Partnership Trust's (Trust 1) St Helens and Knowsley Assessment Team (KAT). In her referral she

⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217289/correctional-services-accreditation-panel-report-09-10-annex-e.pdf

⁵ <http://webarchive.nationalarchives.gov.uk/20100105030830/http://www.probation.homeoffice.gov.uk/files/pdf/OM%20National%20Standards%202007.pdf>

referred to P's poly drug use, alcohol dependence (and recent relapse) and unresolved grief about his grandmother's death.

Initial assessment by Trust 1: 5 December 2012

- 4.17 On 18 October 2012, Trust 1 received the referral and a KAT duty practitioner rang P to screen the referral against the team's urgent, emergency or routine criteria. P was advised in the call that his difficulties with his mood were probably related to his drinking. P insisted that he wanted a mental health assessment. PO1 was rung but was on annual leave. No attempt was made to discuss the referral with her at a later date. A routine appointment was made for 9 November 2012, which was 16 working days later (and over a week beyond the KAT target time of 10 working days). Two practitioners were recommended for the assessment given P's history of assault. The appointment was then postponed until 13 November 2012 by the KAT and then until 5 December 2012 as P was unable to attend on the second date.
- 4.18 On the weekend of 1-2 December 2012 P took, he said later, two boxes of co-codamol, two boxes of paracetamol and a box of amitriptyline⁶ at a friend's house, with alcohol. He said he attempted to harm himself with a razor blade before blacking out and "*sleeping it off*". He did not seek medical help.
- 4.19 P attended the KAT assessment on 5 December 2012, with his mother. He was assessed by a single Senior Nurse Practitioner, SNP1, who had twenty years of experience of working in acute and community-based mental health services. At interview she told us that she was probably working alone due to workload pressures. Other staff would, she said, have been aware of where she was and she had access to a portable alarm system. Had she felt at risk at any point in the assessment, she told us, she would have ended it.
- 4.20 SNP1 told us she had assessed P with reference to the Maudsley Assessment Tool. She did not use the assessment proforma because she found it restrictive. A full risk assessment was documented as well as a Payment by Results (PbR) clustering summary⁷. The PbR summary graded P's presentation under the following categories:

- Non-psychotic

⁶ Amitriptyline belongs to a group of medicines called tricyclic antidepressant drugs. These medicines alter the levels of chemicals in the brain to relieve the symptoms of depression.

<https://www.medicines.org.uk/emc/medicine/18030>

⁷ PbR is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. In mental health, patients are allocated to one of 21 separately priced treatment clusters. Within each cluster, a 1-4 scale denotes severity. Maximum review periods from four weeks to annual are applied. Or the person may be discharged immediately after the assessment.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/232162/Mental_Health_PbR_Guidance_for_2013-14.pdf

- Cluster number 0002 - Common Mental Health Problems (Low Severity)
- Discharged from service (non-CPA⁸).

4.21 SNP1 also completed a Health of the Nation Outcome Scale (HoNOS⁹) scoresheet. P was graded 3 (in a scale of 4, denoting moderately severe problems) in the following areas:

- Overactive, aggressive, disruptive or agitated behaviour
- Non accidental self-injury
- Problem drinking or drug taking.

He was graded 0 (no problem) for *“Problems with hallucinations & delusions”* and *“Other mental & behavioural problems”*. And 1 (minor problem requiring no action) for *“Problems with depressed mood”*.

4.22 P linked his mood disturbances and high risk behaviour with alcohol abuse. He said that when abstinent he did not experience depression or any thoughts of harm to himself or others. He described his steadily increasing alcohol and drug use of the past six years. His mental state had been a lot better when he was imprisoned and substance-free, he said. Since his release P said he had been drinking heavily every day and this would spill into cocaine and pill use.

4.23 P told SNP1 about his overdose and self-harm of the weekend. SNP1 could see no evidence of after effects and therefore continued with the assessment.

4.24 In the assessment P’s mother stated that P was physically aggressive when under the influence of substances. SNP1 noted: *“mum appears supportive but does not know how to help”*. His mother felt P might have Asperger’s syndrome but SNP1 saw no evidence to support this.

4.25 P did not disclose any other psychiatric symptoms other than depression linked to substance misuse. He denied hallucinations and abuse experiences within his family. He also denied thoughts of harming himself or others.

4.26 P was not assessed as needing mental health services. He was not therefore referred for an extended assessment to encompass his full forensic history. SNP1 was sure that no clear signs or symptoms of mental illness were evident. Her assessment summary sent to P’s GP concluded:

“Formulation - This 19 year old gentleman presents with predominantly with alcohol and poly drug use which when intoxicated leads him to perform risk

⁸ The Care Programme Approach (CPA) is a process for the assessment, planning and reviewing of someone’s mental health care needs. CPA is for someone who has a diagnosis of severe mental disorder. There will normally be a care co-ordinator who co-ordinates the input of the multi-disciplinary team and the team will hold regular review meetings. P was assessed at this stage as not needing CPA.

⁹ HoNOS provides 12 scales on which service users with mental illness are rated. <http://www.rcpsych.ac.uk/training/honos/generalinformation/faq.aspx>

taking behaviour such as being aggressive and taking overdoses. He reports that when he was not under the influence he was not aggressive and does not have any thoughts to self-harm/suicide. There was no evidence of mental health problems at this time, P states he was depressed however there was no evidence of this today, and the alcohol and substances obviously impact on his mental state”

- 4.27 P was advised to attend A&E in Whiston Hospital, which was adjacent, for medical checks and blood tests, given the recent overdose. He told us he did this. SNP1, who was not aware that P had recently been referred to Addaction by PO1, referred him to Addaction to address his substance misuse problems. She advised him to deal with his substance problems before considering bereavement therapy. There was no record of Trust 1 communicating the outcome of this assessment to the referrer, PO1.

Panel comments

- 4.28 *We agree with Trust 1’s serious incident (SI) report finding that the seven week interval between the probation referral and P being seen was too long. The target was 10 days. P contributed to the delay by cancelling an appointment.*
- 4.29 *In this time Trust 1 undertook a timely screening assessment by telephone and kept in contact with P. It is unfortunate that the KAT did not speak to the referrer, PO1, in this time as she could have provided more information, including that P had already been referred to Addaction.*
- 4.30 *P was assessed as requiring two staff to be present in the assessment given his offending history. In the event, SNP1 had no anxieties about seeing P with his mother there, staff nearby and access to an alarm system. This seems to reflect the operational pressure we were told the KAT was experiencing at the time. In our view, SNP1, who seemed to us an experienced and capable practitioner, made a reasonable judgment to continue the assessment.*
- 4.31 *SNP1 documented a detailed assessment and risk screening. P denied the psychotic symptoms he would later describe as originating around this time. It should be remembered that, unlike assessments where he said more about familial abuse, his mother was present. All other aspects of the history taken would be repeated in later assessments. P’s account of impulsive harmful behaviour following alcohol and drug use was in line with the referral information. P’s mother corroborated P’s own account that alcohol was his main problem. P’s need to control his drinking was reasonably assessed as the priority, before further exploration of the option of talk therapy would take place.*
- 4.32 *In our view, the decision that P was not a candidate for therapy or specialist mental health services at that time was appropriate. We are reinforced in this view by the similar outcome of Trust 2’s assessment five weeks later. However, we do think that the outcome of this assessment should have been communicated to PO1, the referrer, by Trust 1.*

- 4.33 *We consider some of Trust 1's criticisms of SNP1's practice in the SI report unfair and we will address them in section 6 of this report.*
- 4.34 *In our view, the assessment was of a good standard. Had P presented without current alcohol problems, he might have been referred to bereavement counselling at most. But in the absence of symptoms of mental illness, he would not have met the threshold for referral to specialist mental health services.*
- 4.35 *P disclosed a recent overdose. We think that SNP1 was correct to continue with the appointment on the basis of her assessment of P's physical and mental state.*

Further referrals to Addaction and for mental health assessment

- 4.36 Two days later, on 7 December 2012, PO1 warned P that further bingeing would result in his order being returned to court with a recommendation for custody as she could not manage his risk in the community. Later that day P and his mother attended a GP appointment and described the overdose and self-harm. P was given a low (10mg) dose of amitriptyline to be supervised by his mother and a plan was documented to re-refer him to Addaction and to Open Mind, a service run by Bridgewater Community Healthcare NHS Trust (Trust 2)¹⁰. Trust 2's services included screening assessments for mental health services run by Trust 1.
- 4.37 On 19 December 2012, the GP referred P to Trust 2 for an assessment, referring to the recent history. Bereavement counselling was also mentioned. A routine appointment was offered by Trust 2 for 16 January 2013. With it, P was sent questionnaires for depression (PHQ-9¹¹), anxiety (GAD-7¹²) and work and other activities (WSAS¹³).
- 4.38 Around this time P commenced a relationship with Ms Y.
- 4.39 On 14 January 2013 P disclosed to PO1 that he had been involved in an assault against a 16 year old male having consumed a litre of gin. In addition,

¹⁰ <http://www.bridgewater.nhs.uk/haltonsthelens/openmindmentalhealthservice/> ¹⁰ Please refer to Appendix D for more information about this service which offered assessments by mental health nurses leading to access to therapies and referrals to secondary mental health services. It was available in the area of the former Halton and St Helens Primary Care Trust. Open Mind was heavily used by local GPs until its closure in October 2015.

¹¹ The Patient Health Questionnaire, a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.

¹² A screening tool and severity measure for generalised anxiety disorder (GAD).

¹³ The Work and Social Adjustment Scale, a five question measure of functional impairment, i.e. ability to undertake work, domestic, social and leisure tasks and maintain relationships.

four males had attended his mother's home looking for him as he had been accused of being a "grass".

Panel comments

4.40 *In our view PO1 should be commended for her strenuous efforts at engaging P with substance misuse and mental health services. She correctly assessed P as at high risk of alcohol and/or drug related crime. She also had concerns about his mental health and the safety of his mother which she acted on. The probation provider notes show that she repeatedly took on a bridging role, attending services with P in an effort to support and encourage him in the engagement process.*

First assessment by Trust 2

4.41 On 16 January 2013, P attended Trust 2 with PO1 for the assessment and was seen by a Mental Health Practitioner (MHP1), a mental health nurse. He disclosed low mood, depression, poor sleep, poor motivation and not wanting to live because of the bad things he had done. He gave a history of violence from his father and his own increasing substance dependence. P's increased involvement in criminal activity and his avoidance of the town centre to preserve his own safety were mentioned. The assessment included:

"Sometimes [P] describes hearing bangs and doors slamming, but this appears to be in line with his increased paranoia at people coming for him. [P] also feels people [are] in the room with him when no one was there. [P] feels depressed, he knows he must make changes in his life ..."

As before, P did not disclose hearing voices.

4.42 P was told by MHP1 that mental health services could not help him until his drug and alcohol problems were under control. It was noted that PO1 was taking this forward. MHP1 made the following recommendations to the GP:

- Full blood count including liver function tests
- Start mirtazapine¹⁴ 15mg increasing to 30mg after two weeks and stop amitriptyline.

She also recommended that P should work with probation *"in changing his life around"* and that probation should facilitate a forensic psychology appointment. This suggestion was not taken forward.

¹⁴ Mirtazapine is an antidepressant. It affects chemicals in the brain that may be unbalanced in people with depression. <http://www.drugs.com/mirtazapine.html>

Panel comments

- 4.43 *Trust 2 screened the referral within 24 hours of receiving it, in line with its service specification. It allocated “routine primary care screening” status to it. This was appropriate given the information provided, which indicated no immediate risks. As with Trust 1, pressures on the service meant that Trust 2 did not achieve its target of seeing P within 10 days. However, the 17 working day interval was reasonable, particularly given the non-urgent content of the referral and its timing, just before the Christmas holiday period.*
- 4.44 *It is difficult to discern the impact of the questionnaires provided prior to the assessment on the outcome, if they were completed. MHP1 documented a reasonable history which appropriately highlighted criminality related to alcohol and drug use. PO1 was present and contributed. The mental health problems disclosed included reactive low mood and remorse. P’s references to paranoia and hearing noises were not conclusive symptoms of mental illness.*
- 4.45 *MHP1 knew that PO1 was trying help P to engage with alcohol services and made no referral herself. Sensibly, MHP1 recommended that the GP commence the antidepressant mirtazapine which is less toxic in overdose than the amitriptyline P was taking and had already overdosed on. A referral for a forensic psychology report was also recommended somewhat unrealistically at that stage. We agree with the decision not to refer P to secondary mental health services.*
- 4.46 *Of all the services which P would see, Trust 2 appeared to offer the widest range of therapies. Its specification provided that the “use of drugs and alcohol will not be used as an exclusion criterion”¹⁵. Perhaps more consideration might have been given to addressing the difficulties P had experienced over the previous three months engaging with Addaction, in particular his aversion to group work. It appears from the records that P was controlling his drinking at this time. An opportunity for a referral for therapy might therefore have been taken forward given the difficulties with anger and bereavement he described. But in our view, this assessment was of a reasonable standard with the outcome in line with the main presenting problem, alcohol use, and the low level mental health symptoms disclosed.*

4.47 On 21 January 2013, P was seen by his GP and commenced on mirtazapine. Full bloods were taken and a three month sick note was issued for depression. On 6 March 2013, the GP increased the mirtazapine to 45mg and sent a work capability assessment for P to Jobcentreplus.

4.48 On 7 March 2013, Jobcentreplus wrote to P’s GP to say that P was now able to work and sick notes would no longer be required for him. On 26 March 2013, P told PO1 that he was having “visions” of shooting his father and two police officers. He did not mention hearing voices. P also expressed anxiety

¹⁵ Please refer to Appendix D for more information about this service.

about the Court requirement that he should attend the TSP (see paragraph 4.10 - the Thinking Skills Group programme aimed at reducing criminality). P also told PO1 he was looking for work.

- 4.49 On 16 April 2013, P reported “visions of killing his father” to his GP (no record of visions of killing police officers was made, if it was mentioned). He was started on a trial of hydroxyzine hydrochloride¹⁶ for insomnia. He was re-referred by the GP to Trust 2 that day with a summary of his latest presentation.
- 4.50 On 18 April 2013, Trust 2 offered P an appointment on 4 June 2013 (33 working days’ time compared to its target of 10 working days), and sent him the three mental health questionnaires.

Panel comments

- 4.51 *The GP referral of 16 April 2013 referred to P’s prison sentence for assaulting his father and current “visions of killing his father”. It was screened by Trust 2 within its 24 hour target time and graded appropriately as “Complex Primary Care appointment – Grade 3”. It is of concern that this referral was then allocated an appointment 33 working days hence, far outside the 10 day target. In our view, given the risks referred to, the “Step 4” screening option available to the service of immediate referral to secondary mental health services for assessment should have been implemented.*
- 4.52 *Trust 2 has acknowledged that P’s wait was too long. Trust 2 told us that in all likelihood “the delay would have been due to the pressures of the significant amount of referrals received by the service at the time”, in the order of 800-900 GP referrals per month. In our view, this underlines the point that a timely re-routing of a potentially high risk referral to Trust 1 was needed.*

- 4.53 During May 2013, PO1 and her colleagues attempted to reassure P who was anxious about attending the TSP course. It was agreed that P could postpone it until he had completed his mental health assessment. Meanwhile P’s relationship with his mother deteriorated. Between May 2013 and March 2014 when he took up his own tenancy, P would be largely based at Ms Y’s family home.

Second assessment by Trust 2

- 4.54 On 4 June 2013, P was reassessed by Trust 2, this time by MHP2. For the first time, P disclosed hearing voices. The “visions” mentioned in the GP referral were documented as repetitive, fleeting thoughts of harming his father. MHP2 referred to P’s disclosure on the pre-assessment questionnaire

¹⁶ Hydroxyzine is used as a sedative to treat anxiety and tension.
<http://www.drugs.com/hydroxyzine.html> .

of occasional thoughts of being “*better off dead*”. The risks highlighted in the referral were mitigated by P’s statement that he had no plans to harm his father and did not know where he lived.

- 4.55 P reported a long and worsening history of disturbed sleep with nightmares about his father hitting his mother. He also disclosed low motivation and difficulty concentrating. P discussed anger towards his father and said he had been hearing two voices in the back of his head for approximately eight months which at times he had been unable to distract himself from. This had caused him distress. P, who attended by himself, denied any command hallucinations and said it sounded like the voices were having a conversation. However, he was unsure what was being said. In the assessment P reiterated the history of physical abuse from his father and his own substance misuse and overdose history.
- 4.56 On 6 June 2013, Trust 2 referred P to Trust 1’s Early Intervention Team (EIT) with an overview of the presenting history. P was also informed about the local voluntary sector support service, the Hope Centre. The GP was asked to continue monitoring and reviewing him.

Panel comments

- 4.57 *In the assessment MHP2 documented a detailed history. The immediate referral to Trust 1’s Early Intervention Team was appropriate, in our view, given the disclosure of seemingly psychotic symptoms with violent content concerning a specific individual.*

Trust 1’s Early Intervention Team engagement

Assessment, June-December 2013

- 4.58 P was telephoned on 13 June 2013 by a Senior Nurse Practitioner in the EIT, SNP2, and an appointment was arranged with her for 24 June. Meanwhile, plans were being put in place by PO1 and her colleagues for P to attend the TSP in July.
- 4.59 On 24 June 2013, P attended initial screening with SNP2 and a student nurse. Standardised assessment tools were used including the Positive and Negative Syndrome Scale (PANSS) and the Mental Health Clustering Tool. The core assessment document recorded P’s recent disclosure of an eight-month history of hearing voices along with the established history of mood and sleep disturbances with alcohol and drug misuse. The mental health problems, P stated, had emerged since December 2012 when he had stopped using alcohol. He stated that he had been experiencing visions since December and hearing two different unintelligible voices in the back of his head in the form of a whisper or mumble as if they were sat on his shoulder. This occurred more frequently when he was low in mood. He rationalised the voices as his grandmother telling him to behave and stated that he was able to distract himself by keeping busy.

4.60 As far as the visions were concerned, P reported that he had the same frightening and unwelcome “*daydream*” of killing his father which lasted for about 20 minutes and occurred three to four times per week, more often when he was in a bad mood. SNP2 noted:

“[P] feels that he can hear voices in the back of his head; however upon exploration it appears that [P] actually hears the voices coming from behind his head, although he attempts to rationalise this as his own thoughts coming from inside his head. It appears that he does experience visual hallucinations in the form of a 'daydream' of killing his father, which he states are not his own thoughts and that they frighten him. Despite reporting that he has disorganised thinking, [P] was able to hold a conversation without disruption in pace and flow. He has also reported problems with agitation and aggression, however this was not evident during the assessment.”

4.61 P once again disclosed the history of familial abuse, his bereavement and history of alcohol and drug use. He said he felt nervous in town because he thought people were out to harm him or even kill him.

4.62 SNP2 graded P’s delusions as “*moderate*” on the PANSS (a score of 4 with a maximum of 7) and moderate/severe hallucinatory behaviour (5 on the PANSS). He was assessed as having moderate ideas of persecution and minimal signs of thought disorder. SNP2 documented a detailed risk assessment. Overdose and self-harm risks were associated with P’s use of substances and his violent history and visions concerning his father were highlighted. P was noted not to have access to a gun and not to be in contact with his father.

4.63 On the Mental Health Clustering Tool P’s assessments included:

- Agitated behaviour / expansive mood - severe (4)
- Problems drinking or drug taking – moderately severe (3)
- Repeat self-harm – moderately severe (3)
- Overactive, aggressive, disruptive or agitated behaviour – mild (2)
- Problems associated with hallucinations & delusions – mild (2)
- Other mental & behavioural problems – mild (2)
- Problems with occupation and activities – No problem (0)
- Care cluster – First episode psychosis.

4.64 P was seen by SNP2 and a student on 1 and 8 July and a more detailed assessment of his hallucinations was undertaken using the Auditory Hallucination Rating Scale. P said that the voices caused minimal disruption to his life but were always extremely distressing.

Panel comments

- 4.65 *SNP2's contact with P was timely. In her initial assessments a detailed history was documented and a range of objective tools were used. This was a thorough, well-documented assessment congruent with the diagnosis of first episode psychosis, a diagnosis which was still in place when we met P in November 2015.*
- 4.66 *In the risk assessment, dual diagnosis, overdoses, the history of assault and the hallucinations were highlighted. The standardised risk screening and assessment tools on Trust 1's "Otter"¹⁷ system were used. P's own account of his offending history was detailed as was the fact that he was on probation. Again, a thorough and authoritative risk assessment was documented which met the standards provided in the Trust's policy.*
- 4.67 *There is no record of the EIT discussing P's December 2012 assessment at Trust 1 with him. In that appointment he had denied hearing voices and ascribed his problems to bereavement and alcohol abuse. In contrast, from June 2013 he would state that he had been hearing voices regularly from December 2012.*
- 4.68 *EIT practitioners would at times suggest that P's reported voices were not hallucinations as the engagement progressed. A fuller assessment might have looked harder at the context of the change in P's account of his symptoms. The voices and visions P described from March 2013, for example, had followed Jobcentreplus adjudging him fit to work.*

4.69 On 12 July 2013, P was assessed by a psychiatrist for the first time, a junior EIT doctor, ST5. ST5 recorded P's history and account of his intermittent use of alcohol, cannabis, cocaine and ecstasy. P reported a significant improvement in his mood following mirtazapine treatment. As would be the case in each assessment, his consistent account of his forensic history and the fact that he was on probation was recorded along with his propensity for violence and history of contact with the criminal justice system.

4.70 P once again described hearing voices from the back of his head which seemed to be internal. He described them as intermittently loud and soft, and unrecognisable, taking the form of whispers. P did not identify trigger factors but linked the voices to his mood. P described having three episodes of intrusive daydreams about killing his father but denied any thoughts of harming himself or anybody in particular. ST5 concluded:

"IMPRESSION:

This was a 20-year old man with a history of depression, harmful use of polysubstances (he reports current abstinence) and antisocial traits, who has had multiple confrontations with the law. He currently describes what appear

¹⁷ Trust 1's electronic mental health service database.

to be auditory pseudo-hallucinations. No other clear psychotic symptoms are currently evident. He described a troubled background characterised by mainly domestic abuse in the home environment for which he has not had help over the years.”

- 4.71 The plan put in place by ST5 was psycho-education for drug and alcohol use and to obtain collateral information from P’s mother. P was to continue on mirtazapine 45mg nocte. Further exploration of P’s childhood issues was also recommended with the possibility of therapy in the near future. Bloods and an ECG¹⁸ were requested in preparation for probable antipsychotic treatment and SNP2 was to take on the role of care coordinator. A further clinic appointment was to occur in six to eight weeks’ time. In the meantime the EIT would continue assessing the frequency and duration of the symptoms of psychosis.

Panel comments

- 4.72 *In clinic, ST5 also took a very detailed history, summarising the basis of the diagnosis succinctly “as pseudo auditory hallucinations which are mostly mood congruent, intermittent in nature and non persistent”. The question mark in the mind of ST5 about the nature of the auditory experiences described by P would be echoed in successive assessments. The “Antisocial traits” and polysubstance abuse highlighted by ST5 would also be reprised although the diagnosis of First Episode Psychosis would remain in place.*
- 4.73 *A proportionate plan of psycho-education around substance misuse, obtaining further information from P’s mother and “exploring childhood issues” was proposed. Assessment would continue, in our view appropriately, without the introduction of anti-psychotic medication at this stage. P was allocated SNP2 as care co-ordinator and accepted onto the care programme approach (CPA). In our view the working diagnosis and decision to offer the EIT’s services to P through CPA was correct given his age and presentation.*

- 4.74 From mid-July to mid-August 2013, P disengaged from the EIT despite SNP2’s repeated attempts to contact him. He was noted by probation provider staff to have failed to present for the TSP. Ms Y told us that in this time he was staying with his family while she and her family had a fortnight’s holiday abroad. Up to this point, P had not disclosed any voice hearing to Ms Y.
- 4.75 On 18 August 2013, while Ms Y and her family were still away, P attended A&E after an impulsive overdose of alcohol and 17 mirtazapine tablets. This had followed a social drinking session in a pub the night before. He told us that while Ms Y was away the voices had felt like “madness in my head”, telling him to drink. He told us “the voices were getting on my nerves that

¹⁸ An ECG (electrocardiogram) is a test which measures the electrical activity of the heart to show whether or not it is working normally.

much I was punching the doors in my mum's house, and I just got all my medication and took it" before falling asleep. He was later, he said, discovered by family members asleep with a suicide note. P was seen in hospital by an A&E psychiatric liaison nurse and then he returned home. He did not have any ongoing thoughts of harming himself and at the time he could not say what his motives had been.

- 4.76 On 21 August 2013, SNP2 rang P having noted his A&E attendance on the system. She arranged a home visit with a junior doctor, ST6/1, that afternoon. In his assessment ST6/1 noted that P had discontinued his mirtazapine. He recorded P's account of his overdose. P continued to describe auditory hallucinations. ST6 decided to commence aripiprazole¹⁹ 5mg for generalised paranoia and auditory hallucinations and to discontinue mirtazapine. The first episode psychosis diagnosis was confirmed. P was once again advised that he should be abstinent. Further review in four to six weeks' time was planned.

Panel comments

- 4.77 *We commend SNP2 for her efforts at maintaining contact with P and for her detection of and response to P's A&E attendance. In our view, the timely medical review and introduction of low dose antipsychotic medication was a reasonable response to the evolving presentation.*

Summary of EIT involvement with P

- 4.78 The EIT then monitored P closely for symptoms of mental illness and medication side-effects. He reported only one instance of hearing voices in the weeks which followed. He would also later disclose on/off consumption of prescribed antipsychotic medication in this time and throughout his EIT engagement. He told us the visions of killing his father "*just went*".
- 4.79 During September and October 2013, P attended half of his weekly appointments with SNP2, and this pattern broadly applied to the remaining year of his EIT community engagement. The emphasis in his sessions with SNP2 was anxiety and stress management and reducing his alcohol and substance intake. Anger management became another focus for her work as P disclosed more incidences of rows with Ms Y over the year.
- 4.80 On 18 September 2013, P was reviewed by ST6/1 who noted a significant improvement with reduced paranoia, depressive symptoms and hallucinatory experiences (the voices were now described as two male voices mumbling). The plan was to continue with the current management and to then review P again in three months or sooner if required.
- 4.81 On 7 October 2013, P told SNP2 that he had had a heated discussion with his partner after he heard a voice telling him she was cheating on him. Cognitive

¹⁹ Aripiprazole is an atypical antipsychotic. Exactly how it works is not known. It affects certain substances in the brain. <http://www.drugs.com/cdi/aripiprazole.html>

behavioural therapy principles were discussed in relation to managing voice hearing experiences. P failed to attend his remaining appointments that month.

- 4.82 Meanwhile, P had been allocated a new probation officer, PO2, who noted on 9 October 2013 that he had failed to attend a rescheduled TSP the day before, citing his mental health issues. When challenged, P claimed that he had been attending a mental health appointment and would be doing so the following day (the EIT records do not support this statement). Efforts were made by probation staff to look at how to progress the situation but P would continue to resist attending the TSP. No communication had occurred between probation and the EIT at this stage.

Panel comments

- 4.83 *It is clear from the probation notes that PO1 had developed a good rapport with P in the 15 month span of her work with him. She was able to combine both challenging and supportive interventions. Her notes record her understanding of how P's lifestyle, accommodation and associations affected his risks of violent reoffending. And she made strenuous efforts at linking him with services which could help to reduce what probation termed his "pro-criminal attitudes"²⁰. This included the repeated suggestion that he should address his substance misuse and alcohol problems and that he should seek bereavement counselling. PO1 also actively involved P's mother in her work.*
- 4.84 *In the month after her departure in early September 2013, the probation provider's records tell us little about the handover to PO2. In this time P was again supposed to attend the TSP but again did not do so. It appears that he was rescheduled for the TSP for a third time in October 2013 after PO2 had been assigned his case, but again did not attend.*

- 4.85 On 7 November 2013, P was told by PO2 that he would need a sick note to justify his not attending the TSP.
- 4.86 On 17 November 2013, P consumed alcohol and had an argument with Ms Y culminating in his staying with his own family. He went to bed ruminating over this, got up and struck himself in the head with a bottle. Family members intervened but P put his right fist through a window. He later said he had been upset after talking about his grandmother. He attended A&E but did not disclose the source of his injuries and was not referred to the mental health liaison team. He was treated for superficial cuts.
- 4.87 On 18 November 2013, P told SNP2 about the events of the night before and that he had not been taking his aripiprazole for the past two weeks. He had,

²⁰ An attitude that supports crime, such as anticipating and evaluating crime as worthwhile, which has been found to link to reoffending.

he stated, recently become engaged to Ms Y. P was given a contact number for the home treatment team (HTT) in the event that he needed out of hours support and an approach to dealing with the voices was agreed with him and his mother. SNP2 arranged to see P the following day and an outpatient appointment was made for the day after. P did not appear distracted or suffering from low mood to SNP2. She noted that he appeared relaxed and smiling at appropriate points. When reviewed the following day, SNP2 suggested that P should think about psychological therapy to explore his emotional difficulties in more depth.

Panel comments

4.88 *ST6/1's description of the EIT as holistic and client-focused is reflected in SNP2's work with P. In line with Trust 1's applicable policies²¹, SNP2 as care co-ordinator established regular (weekly) appointments with P. Her work with him focused on addressing his identified risk factors - substance misuse, strategies for managing his voice hearing and his anxiety. His own perception of his problems was the starting point for interventions. SNP2 was flexible and client-centred, for example seeing P at Ms Y's family home, at his mother's house and occasionally in clinic. On some occasions she would attend multiple sites to locate him. She maintained contact by telephone when he missed or cancelled appointments. His accounts of difficulties, including in his relationship, were the foci of interventions. Commendably, SNP2's approach had features of assertive outreach practice. Her documentation was meticulous.*

4.89 On 20 November 2013, P attended an outpatient EIT appointment with his mother. He saw a staff grade psychiatrist²², SG1, who added depression and antisocial personality traits to the diagnosis of first episode psychosis. P said that he had stopped taking the aripiprazole on instructions from the voices. He reported critical comments belonging to a male and female seeming to emanate from the back of his head. He claimed to have recommenced aripiprazole. P also disclosed taking mephedrone²³.

4.90 SG1 concluded that continued use of alcohol and illicit substances could significantly impact on P's mental health given his tendency to act impulsively. P again said he would stop taking alcohol and street drugs and stick with the treatment plan. This was to increase the aripiprazole to 10mg in two days under the supervision of Ms Y and to continue the current approach. Details of out-of-hours services were again made available should P need them.

²¹ In particular, its Care Programme Approach (CPA) and Clinical Risk Assessment policies

²² A "staff grade" doctor is permanently employed as a middle grade doctor rather than progressing to consultant.

²³ Mephedrone (sometimes called 'meow meow') is a powerful stimulant and is part of a group of drugs that are closely related to the amphetamines, like speed and ecstasy.
<http://www.talktofrank.com/drug/mephedrone>

Panel comments

- 4.91 *Trust 1's CPA policy states that "Carers form a vital part of support to aid a person's recovery. Their own needs must be recognised and supported." P saw the EIT with his mother in November 2013 after the incident. Although P did not live with his mother for much of the time he was seeing the EIT, we agree with Trust 1's SI report that the involvement and support of P's mother was not given sufficient priority in the EIT's care of P. And the July 2013 plan to incorporate information from P's mother into the assessment was not apparently followed up.*
- 4.92 *We balance that comment with the observation that P had been to a large extent based at Ms Y's family home since May 2013. Ms Y and her mother told us that SNP2's visits had been short and her communications with P superficial. He had not, they felt, been able to open up to SNP2. That assessment is not corroborated by the evidence of SNP2's contact with P in the records. P would attend approximately half of his scheduled appointments.*
- 4.93 *SG1 was the third of four junior EIT doctors who reviewed P between July 2013 and July 2014. P's self-reports of his family background, offending history and drug and alcohol use would be consistent in each of the six EIT psychiatric assessments which occurred over this period. The junior doctors he saw provided care of a good quality and consistency while the EIT's Consultant was on sabbatical. However, while it would not have affected the outcome, consultant-level review early in the EIT engagement would have been of assistance. In reaching that view, we highlight the variation in P's accounts of his symptomatology (see Appendix C). Other complicating factors were his forensic history and his drug and alcohol use.*
- 4.94 *The EIT assessments were thorough and accurately identified the main problem as unpredictable, impulsive drug and alcohol-related violent behaviour. The EIT would rely almost exclusively in the first year of P's engagement on information provided by P. Our review of the probation file has shown that information from the probation provider would have improved the effectiveness of the EIT's assessment and management of risk in the first months of the service's engagement with P. We also think that the fact that reducing domestic violence was an aim of probation's work with P might have alerted the EIT to the possibility that Ms Y might be at risk. In our view, given P's known history, this risk should have been part of his risk assessment and management plan.*
- 4.95 *At the initial EIT contact stage, PO1 had been working closely with P for a year in an effort to mitigate the high risk of violent reoffending she had identified. This was also a risk Trust 1 sought to reduce. The EIT's failure to make contact with PO1, consent from P permitting, was a missed opportunity. Had contact been made, P's disclosure of visions of shooting police officers would also have been known by the EIT. And the Court's requirement for P to address his history of domestic violence in a structured way through the TSP would have been understood by the EIT. Probation and the EIT worked commendably hard*

to reduce the risks associated with P's decision-making and behaviour. But they unfortunately did not communicate until the final months of his probation order.

- 4.96 *Trust 1's SI report recommended that, where a significant forensic history is apparent, all assessments should record a full forensic history secured from all possible sources. Having reviewed the EIT's engagement with P, we endorse that recommendation²⁴.*
- 4.97 *It would not be until November 2014 when P was in prison that the Trust's Criminal Justice Liaison Team²⁵ was approached by the EIT. This was the first step in obtaining a definitive forensic history for P from the police. We agree with Trust 1 that P's known violent offending should have prompted an earlier approach, certainly no later than at the stage that the need for a pre-birth assessment was identified (January 2014). And we consider that earlier contact with probation would also have contributed to a fuller risk assessment and management plan. However, that comment should be balanced with the evidence that from January 2014, the probation provider was less than responsive to the EIT's attempts at joint working to protect P's and Ms Y's child.*
- 4.98 *Finally, we consider that P's history of domestic violence towards his father might have been linked explicitly to a risk of his directing domestic violence towards Ms Y in the EIT's November 2013 risk assessment. The risks associated with domestic violence changed during the pregnancy but were not formally assessed until just before Ms Y gave birth.*

- 4.99 On 17 December 2013, P told SNP2 that his partner was six weeks' pregnant and they were planning to get a flat together. More psycho-education in relation to alcohol was provided by SNP2 with an emphasis on P staying safe over the festive period.

Panel comments

- 4.100 *Trust 1's Safeguarding Policy is clear that its statutory duty extends to the care of the unborn child. All staff are expected to be alert to potential safeguarding issues and to share concerns with their line manager and Trust 1's Safeguarding Team. Liaison with other agencies is also expected.*
- 4.101 *P had a history of domestic violence growing up and had directed it at his father. It is a well-established fact that children brought up in such*

²⁴ However, as Trust 1 later reflected itself, we do not think that the recommendation should apply to every assessment. Clearly P was not displaying signs or symptoms of mental illness commensurate with a forensic assessment during Trust 1's December 2012 assessment of him

²⁵ <http://www.5boroughspartnership.nhs.uk/base-page.aspx?ID=4767>

environments are at risk, emotionally and physically²⁶. We reiterate that P's risk of perpetrating domestic violence should have been considered as part of his risk assessment. While SNP2 recorded the fact that Ms Y was pregnant, contrary to policy she would not start to implement the safeguarding process for another six weeks.

- 4.102 After an apparently uneventful Christmas, P saw SNP2 three times in January 2014. Of note were (on 7 January) his second account of his partner annoying him. And (on 30 January) his agreement for SNP2 to contact probation to discuss safeguarding, given the fact that his partner was now 11 weeks' pregnant. P also informed PO2 of the pregnancy and she wished him luck. No record of a pre-birth assessment referral being made was ever made in the probation provider's notes.
- 4.103 On 10 February 2014, SNP2 rang PO2, telling her that she had no mental health-related concerns about the welfare of P's child. However, SNP2 stated that she was aware of P's history of aggressive and assaultive behaviour. SNP2 documented that PO2 agreed to refer P's partner to social services for a pre-birth assessment. She asked PO2 to tell her when she had done so. There was no note of the call in PO2's records. The following day, 11 February 2014, SNP2 informed P that there could be a social services referral given his offences. P could not understand why as his last offence had been two years previously.
- 4.104 On 3 March 2014, P informed PO2 that he was moving into his own flat that day. PO2 informed him that she would need to inform social services of his partner's pregnancy, given his record. She noted that *"he appeared OK with this"*. P was again asked by PO2 for medical evidence that the TSP should be removed from his order. On 19 March 2014, SNP2 wrote to PO2 to say that P felt anxious about group work due to the risk of meeting people from his past and was committed to working with her (SNP2) on anxiety management techniques. P did not attend the TSP.

Panel Comments

- 4.105 *In our view, the EIT's understanding of the psycho-social dimension of P's risk profile is not fully reflected in the risk assessments and records. His acquisition of his own tenancy in March 2014 represented a significant if general increase in the identified risks in the form of more opportunity for drug and alcohol-related activity. This development was not reflected in the risk assessment and received scant coverage in the notes although it had particular relevance to the safety of the staff seeing P. The risk assessment plan would remain unchanged between the overdose of August 2013 and the June 2014 pre-birth*

²⁶ <https://www.gov.uk/guidance/domestic-violence-and-abuse>

assessment. In our view, the risk of domestic violence in particular increased in this time.

4.106 *Several people we spoke to described P as a “follower”. Away from Ms Y’s family home, he had more opportunity to drink and take drugs to excess. Although difficulties in his relationship with Ms Y were documented repeatedly in this time with associated violence to property²⁷ it would take the impetus of the pre-birth assessment in June 2014 for the risk of domestic violence to enter the formal risk assessment. We think the move to the flat should have triggered a re-assessment of all risks.*

4.107 *The requirement for P to attend the TSP seems to have been dropped by the probation provider although the records are not conclusive. Meanwhile SNP2’s concerns about the risk of domestic violence were justifiably increasing. We think it unfortunate that SNP2 did not fully understand that the TSP course which she had helped P to avoid was aimed at one of the foci of her work with P - preventing criminal behaviour including domestic violence.*

4.108 On 27 March 2014, PO2 saw P for the last time before she went on maternity leave. The 20 week scan of P’s and his partner’s baby was mentioned in the notes but the plan to refer Ms Y for a pre-birth assessment was not taken forward.

Panel Comment

4.109 *It is of concern to us that no evidence exists in the probation provider’s notes of its staff informing the EIT of the changes in allocated officer. Nor is there evidence of a handover of the pre-birth assessment referral within the probation provider’s records.*

4.110 On 15 April 2014, P was assessed in clinic by the fourth junior doctor from Trust 1 to see him, ST6/2. SNP2 explained that P and his partner had argued, he had used alcohol, cocaine and ecstasy and omitted his medication for nine days. He reported that the hallucinations had become louder with unspecific content, sounding like people “*sitting on his shoulder*”. P also reported worsening temper but denied depression. P described suffering panic attacks in large groups, citing this as a reason for his avoidance of Addaction (ST6/2 did not therefore refer him to Addaction).

²⁷ 9/9/13: Paranoia and jealousy expressed about Ms Y. 3/10/13 & 7/10/13: Arguments with Ms Y. 18/11/13: Argument, fist through window. 7/1/14: Annoyed by Ms Y’s “sarcasm”. 11/2/14: Reports arguments with mother & Ms Y. 25/3/14: Tells SNP2 “*All women are bitches*”. 8/4/14: Argument with Ms Y.

4.111 ST6/2's plan was to increase aripiprazole to 15mg daily for a fortnight and then to increase it to 20mg per day and to commence sertraline²⁸ 50mg. SNP2 was to continue weekly input and liaise with probation with a view to linking P with anger management. A Support Time Recovery (STR) worker was suggested to help with social activities but in the event this resource was not required by P. Once again P was advised to stay off alcohol and illicit substances. He was for review in six to eight weeks.

Panel comments

4.112 *ST6/2's management plan was reasonable. While we have found that a definitive forensic history should have been sought, it would not in all likelihood have affected P's management significantly as his own account of his offending history was reasonably accurate.*

4.113 On 25 April 2014, SNP2 rang PO2 to find out if the pre-birth assessment referral had been made only to discover that she was on maternity leave.

4.114 On 30 April 2014, SNP2 spoke to PO3, P's new probation officer. PO3 told SNP2 that the pre-birth assessment referral had not been made but that she would make it that week or the next. SNP2 explained that she was about to go on annual leave but would assist on her return. That day, SNP2 visited P at home with a student nurse to learn that he had been on an alcohol binge in his flat the previous week. The focus of SNP2's intervention was once again on anxiety management. His mood was normal. SNP2 noted that P's presentation might be related to a paranoid personality rather than psychosis.

4.115 SNP2 kept in contact with P during the first three weeks of May by telephone. On 23 May 2014 he was seen at home by SNP2 and a male senior nurse practitioner, SNP3. SNP3 told us that SNP2 had some concerns that P might be abusive to Ms Y. That day P reported reduced voice hearing and no issues in relation to anxiety. He was noted to be refusing to access any counselling services related to his childhood trauma and anger towards his father. P reported better relations with Ms Y although they were prone to arguing leading to him on occasion punching the wall and the door in frustration. According to the notes, P reported that he had convictions for 10 violent offences (this exaggerated his history of violent offending) and SNP2 documented a plan to liaise with probation about anger management.

4.116 On 30 May 2014, during case supervision with SNP2, the EIT Team Leader rang PO3 who again confirmed that a pre-birth assessment referral would be made.

²⁸ Sertraline is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). <http://www.drugs.com/sertraline.html>

Panel comments

4.117 *Over the previous four and a half months, PO2 followed by PO3, failed to refer Ms Y as they repeatedly assured SNP2 they would. While SNP2 should be commended for her persistence in following up the referral up, we think that some effort should also have been made to escalate the matter up the probation provider's hierarchy. We agree with Trust 1's SI report that the matter should have been referred to Trust 1's specialist safeguarding team when the lack of progress from the probation provider became apparent.*

4.118 *Ms Y and P told us that the probation officers saw no need for a pre-birth assessment and were only involved in the referral at SNP2's insistence. That perception is not wholly reflected in the probation provider's records, which contain a clear undertaking to make the referral. However, Ms Y's and P's account is supported by the fact that no referral was ever made by the probation provider despite repeated references to Ms Y's pregnancy.*

4.119 On 11 June 2014, SNP2 spoke to PO3 having left a message the previous day. PO3 said she had made a referral to children's services for a pre-birth assessment and that P was aware of this and had accepted the rationale. SNP2 was told that no anger management courses were available in St Helens unless a court order was in place or a £80 fee was paid. The probation notes record that SNP2 rang the probation provider and left messages for PO3 on 10, 11 and 19 June and that PO3 returned the call on 20 June 2014 when SNP2 was not available.

4.120 Meanwhile on 17 June 2014, P denied to SNP2 that he had spoken to PO3 about a pre-birth assessment. He also stated that PO2 had told him that she would only make the pre-birth assessment referral if SNP2 had concerns. At this stage SNP2 thought that the probation provider had made the referral. P again expressed surprise and claimed that he had never assaulted a minor. SNP2 explained that although she did not have any concerns related to his mental health she would be referring information about his drug use and his punching the walls and doors in anger. On 19 June 2014, SNP2 contacted social services and discovered that no referral had been made for a pre-birth assessment. The following day SNP2 sought advice from Trust 1's Safeguarding Team.

Panel comments

4.121 It is of some concern to us that the probation provider gave a false assurance to SNP2 that the referral had been made. We commend SNP2 for checking this out for herself and for taking advice as to next steps from Trust 1's expert safeguarding resource. We found no evidence on file of EIT concerns about this being escalated within the management of *the probation provider* by Trust 1.

4.122 *The week before his daughter's birth when he saw SNP2, P had flatly contradicted PO3's account that he was aware of, and content with, the pre-birth assessment referral. Whatever PO3 said to P, poor communications from the probation provider would set the scene for a very difficult assessment completed in the face of understandable concern from both P's and Ms Y's families, a short time before the baby was born.*

4.123 On 23 June 2014, SNP2 was advised by Trust 1's safeguarding team to make the referral herself. She rang P in order to get the necessary information about his partner. P, meanwhile, was with Ms Y in hospital given complications which would lead to a Caesarean delivery seven weeks early.

4.124 On the social services First Response Service Request Form, SNP2 gave an account of P's aggressive behaviour in relation to alcohol and drug use including his response to arguments with his partner which included punching walls and doors. He was noted to have no history of domestic violence towards Ms Y; a history of 10 violent offences was given.

Panel comments

4.125 *The exaggeration of P's violent offending history seems to have originated in P's own accounts. This underlines our point and the finding of Trust 1's SI investigation that a definitive forensic history should have been obtained sooner.*

4.126 On 24 June 2014, P's community order expired. Given the imminent pre-birth assessment, SNP2 completed a risk screening which set out P's known risk history including his substance misuse and related impulsive overdoes and arguments with his girlfriend. P's account of his history of assault, criminal behaviour and his four-month prison term were summarised. His reports of experiencing hallucinations and thoughts of hurting his father were included along with his statement that the voices did not influence his behaviour.

Panel comments

4.127 *P's known risks and history were communicated effectively to social services in line with Trust 1's Safeguarding Children and Risk Assessment and Management policies.*

The birth of P's and Ms Y's daughter, 24 June 2014

4.128 On 24 June, SNP2 liaised with social services' first response team and arranged to attend hospital to conduct the assessment with a social worker. P expressed concern about the additional stress this would place upon Ms Y as the Caesarean was to occur that evening. The assessment occurred in hospital just before the Caesarean. P made his displeasure towards SNP2

apparent by staring at her. The risks associated with P's presence on the neonatal unit were also discussed. The social worker told SNP2 that PO3 had said she thought that the assessment had been arranged by PO2 before she went on maternity leave. Social services had recorded a list of risks including high risk to self and to others and medium risk to children. SNP2 insisted that the risks she was aware of concerned her knowledge of P's anger following an argument with his girlfriend and his history of assaultive behaviour including to family members. She did not regard him as presenting a high risk to himself. Shortly after the assessment a baby girl weighing under 3lbs was delivered.

4.129 The following day, 25 June 2014, SNP2 liaised with the safeguarding midwife about access to the risk assessment given P's visits to his daughter on the neonatal unit. A similar approach was made to probation. SNP2, who was liaising closely with Trust 1's safeguarding team, rang P and agreed to meet him the following morning to discuss the risk assessment. On 27 June 2014, the risk assessment was revised to reflect the birth of P's daughter and P's comments. It highlighted that P had punched walls and doors after having arguments with his partner. The lack of any history of domestic violence in the relationship with Ms Y and the role of alcohol were highlighted.

4.130 SNP2 and SNP3 saw P at his mother's home on 1 July 2014 with his mother and latterly his partner present. The rationale for the referral was explained and the risk assessment and plan was read to P who agreed that the safeguarding midwife team could have a copy. P expressed concern about social services' involvement. The baby meanwhile was to remain in hospital for another four weeks. That evening SNP2 took advice on the conditions which would apply to the midwifery team in terms of keeping the risk assessment secure and confidential.

Panel comments

4.131 *SNP2's records document the considerable care she exercised in ensuring that sensitive information about P was protected.*

4.132 P and his partner remained aggrieved at SNP2's involvement in the pre-birth assessment when we spoke to them in November 2015.

4.133 On 28 July 2014, at the initial child protection conference²⁹, P's daughter, who was due for discharge that week, become subject to a Child Protection Plan (CPP) under the category of emotional abuse. The conference outcomes included the following recommendations:

- Ms Y was not to stay overnight in his flat with their daughter

²⁹ A child protection conference under the Children Act 2004 is convened where the agencies most involved with a child think the child to have suffered, or at risk of suffering, significant harm. In the conference, professionals and the family assess all relevant information and plan how best to safeguard and promote the welfare of the child.

- P's contact with his daughter was to be supervised by Ms Y's or his own mother
- further risk and parenting assessments were to be undertaken
- P was to engage with SNP2 and Addaction
- P's orientation to anger management was to be explored with probation; SNP2 was also to look at anger management options and obtain an advocate for P
- core group³⁰ meetings were to occur every 28 days, starting in 10 days.

- 4.134 The conference triggered a re-assessment of P's risks by the EIT resulting in practitioners not visiting him singly. This was reflected in a revised risk assessment dated 4 August 2014.
- 4.135 Meanwhile on 31 July 2014, ST6/2 reviewed P with Ms Y. Ms Y gave an account of good progress with, in ST6/2's words, "*no anger outburst*" for a number of months. A psychological assessment to address past childhood difficulties and anger problems was suggested again. No symptoms of mental ill health were evident. The plan was to continue aripiprazole 20mg and sertraline 50mg. P was to be referred to psychology for an assessment for treatment for anger problems. He was to continue contact with SNP2 and SNP3 and to undertake routine blood tests and an ECG. SNP3 was allocated as an additional care co-ordinator to work jointly with SNP2 as a risk management measure.
- 4.136 The psychology referral was made on 4 August 2014. The plan for P's contact with his child to be supervised was kept in place following the core group meeting on 6 August.
- 4.137 When P was seen in his flat by SNP2 and SNP3 on 12 August, Ms Y was present with her nephew, aged four years. SNP2 rang P after the visit to tell him that she would need to check with social services if any restrictions existed on other children visiting him at the flat. Two days later social services confirmed that this was acceptable as long as P's partner was present. Meanwhile the psychology appointment remained on hold pending the imminent arrival of a psychologist available to the EIT. P, who was being seen one-to-one by Addaction staff as a result of social services' involvement, again rejected the option of attending Addaction's Recovery Centre.
- 4.138 P's and Ms Y's account was that after an initial period of settled and responsible behaviour, P's behaviour deteriorated as a result of the restrictions imposed by social services. P spent more time in his flat drinking and associating with other drinkers and drug takers. Ms Y became depressed and fearful of her child being taken into care and the couple argued more. Both she and P lost faith in the EIT.

³⁰ The core group is responsible for developing and implementing the child protection plan put in place by the child protection conference.

Panel comments

- 4.139 *We commend SNP2 for ensuring that the pre-birth assessment took place. Her records of her communications with all parties are meticulous and underline the comments of SNP3 at interview that safeguarding was an activity understood and prioritised by the EIT. SNP2 and SNP3 contributed fully to the child protection process which followed. In particular, they ensured that confidential information was afforded a high degree of protection while information was released appropriately to those that needed to know it. In addition, they remained alive to the broader implications of the CPP, for example by reporting the presence of Ms Y's four year old nephew in P's flat.*
- 4.140 *According to Ms Y, this process signalled the end of any remaining trust P and she had in SNP2 and the EIT. We understand their view that the restrictions brought in by the child protection process intensified the pressure on them as a new family. However, there is evidence that other people were using P's flat as a venue to consume drink and drugs from when he took on the tenancy in March. In August and September 2014 in particular the reports of incidents there increased. In our view P's inability to manage his flat safely, as well as his own history of impulsive violence and criminal associations, completely justified the measures put in place by social services in liaison with the EIT.*
- 4.141 *We also distinguish here between the CPP requirement that P's access to his child was supervised by a grandmother and the conditions of bail which came into effect after he assaulted Ms Y on 26 August. It seems to us that the most significant limits affecting P's ability to function as a father followed his violence towards Ms Y.*

P's first assault on Ms Y, 26 August 2014

- 4.142 P was seen on the morning of 26 August 2014 by SNP2 and SNP3 and appeared relaxed. He reported feeling less anxious in social situations. No psychiatric symptoms were evident. Later that day an argument broke out between him and Ms Y, she told us concerning his decision to buy alcohol. This resumed later on the doorstep of her family home where P grabbed her by the throat, threw her against a car and spat at her. Ms Y's mother rang the police and P was put on police bail and banned from any contact with Ms Y. From this point onwards, P spent more time based at his flat drinking and taking drugs. No link was established between the assault and P's mental health which he had described as stable for some time. A court date of 29 September 2014 was set.

Panel comments

4.143 *This incident underlines the lack of apparent correlation evident throughout the care episode between P's violent behaviour and his reports of mental health problems. However, Ms Y told us that after the pre-birth assessment P stopped disclosing any information to the EIT which he thought might be used to restrict his access to his daughter, including about his mental health.*

4.144 SNP2's and SNP3's continued work with P aimed to help him identify triggers to aggressive behaviour and to develop cognitive behavioural approaches. On 1 September 2014 he reported being unable to identify thoughts leading to violence due to the speed of his reactions. He denied that alcohol was a problem but, as directed by social services, saw Addaction for a preliminary assessment. The following day a fight broke out amongst P's friends outside his flat involving an assault with a hammer. P sustained two broken fingers. Meanwhile P, who had access to his daughter via her grandmothers, had met Ms Y which represented a breach of his bail conditions.

4.145 On 4 September 2014, Addaction visited P at home with one of his sisters present. P explained the events of the recent fight. P saw SNP2 and told her he had had a meal with Ms Y, another breach of his bail conditions. SNP2 reported this to Ms Y's social worker for referral of the matter to the police.

4.146 On 8 September 2014, SNP2 and SNP3 noted that red paint had been thrown over the exterior and interior of P's flat and there were signs of alcohol and cannabis consumption inside. They reported this to social services that day.

Panel comments

4.147 *Once again, we commend SNP2 for implementing the CPP by ensuring that information was shared with the relevant agency.*

4.148 On 10 September 2014, P was seen for the first time by the psychologist. A 10 session contract to work on "increasing distress tolerance and emotional regulation skills" was agreed. Meanwhile the EIT practitioners in conjunction with Addaction maintained their focus on P reducing his drinking and drug consumption.

P's inpatient admission, 12-15 September 2014

4.149 That Friday, 12 September 2014, P took an overdose and cut himself after consuming alcohol. He then attended A&E where he was joined by Ms Y, a sister and his mother. He told the assessing A&E doctor that he was hearing voices telling him to self-harm. He demanded a mental health hospital admission and threatened to harm himself again. He was admitted that evening to Taylor Ward, a male acute unit run by Trust 1 where he remained for the weekend on 15 minute (level 2) checks. He tested positive for cocaine

there. P reported a recent increase in voice hearing (he was, he claimed, told he was a bad father and would lose access to his daughter). He told us that Ms Y was restricting his access to his daughter at the time. No evidence of voice hearing or any other mental illness symptom was observed or elicited by staff during the admission. An acute stress reaction with co-morbid psychotic symptoms with drug and alcohol misuse was diagnosed.

- 4.150 On Monday 15 September 2014, in the ward review P told the consultant, CP1, that the increase in volume of the voices had preceded his use of alcohol and cocaine. He did not, he said, inform SNP2 because he was afraid the information would be used to restrict his access to his daughter. The diagnosis was recorded as "*Still under assessment for ? episode of psychosis*". The plan was for the EIT to continue working with P in the established way. In addition, an ECG and blood tests were to be arranged. P was discharged that day and SNP2 updated the risk assessment documentation. Social services were updated.
- 4.151 In the week that followed P had his second psychology appointment and intensive follow-up from the EIT. In discussion with SNP2, P attributed his behaviour to not taking his medication rather than to his substance misuse.
- 4.152 On 26 September 2014, the CPP was confirmed in the second case conference given recent events and P's alcohol and drug misuse and mental health. Given the information that P and Ms Y were no longer in a relationship, P's future contact with his daughter was to occur at a contact centre.

P's second and third assaults on Ms Y, 27 September 2014

- 4.153 On Saturday 27 September 2014, two days before he was due to appear in court for his 26 August assault on his partner, P assaulted Ms Y again. This took the form of verbal abuse and head-butting followed by a second assault after she had left the scene and P had followed her. P then attended A&E having taken, he would say, a month's supply of antipsychotic and antidepressant medication. He was admitted to a medical ward and seen by SNP3 and another EIT practitioner, SNP4, on 29 September. P told them that he had been drinking alcohol and using cocaine. He said he had not experienced voice hearing but had suicidal thoughts based on the breakdown of his relationship. The new requirement for contact with his child to take place at a contact centre was also, he said, a contributory factor. P associated contact centres with paedophiles.
- 4.154 P discharged himself on Tuesday 30 September after being assessed as medically fit but before a psychiatric assessment could be completed. An arrangement was made by SNP3 to see him the following day. P stated that he had no intention of self-harm and had no medication left following the overdose. When seen on 1 October 2014 at his mother's house he reported that he had drunk four litres of vodka following his discharge. P expressed considerable bitterness towards Ms Y who he made various allegations against. He agreed to be seen by an EIT doctor and cover for SNP3's

forthcoming annual leave was discussed. SNP3 informed social services of the situation. That evening P was placed in police custody.

- 4.155 On 3 October 2014, P pleaded guilty to three counts of battery and was sentenced to six months' imprisonment consisting of two months (and a restraining order) for the assault of 26 August and four months for each of the assaults of 27 September, to be served concurrently, but consecutively to the two months.

Care by Trust 3, 3 October 2014 – 31 December 2014

- 4.156 On 3 October 2014, P was imprisoned in HMP Liverpool. He arrived with documentation flagging he was potentially at risk of self-harm or suicide (a SASH – suicide and self-harm - form). The prison mental health services were managed by Trust 3, Mersey Care NHS Trust (and since 1 June 2015 have been run by Lancashire Care NHS Foundation Trust)³¹.

- 4.157 A primary care health screen was undertaken which flagged P's drug and alcohol use and his medication regime was noted. P stated that he had no thoughts of self-harm or suicide. Details of his recent mental health service use were taken. No current signs of mental ill health were noted or disclosed. He was not placed on the Assessment, Care in Custody and Teamwork programme (ACCT³²). Given P's high alcohol consumption, a benzodiazepine³³ detoxification was prescribed along with vitamins. He was referred for a mental health assessment.

Panel comments

- 4.158 *The benzodiazepine detoxification was necessary and implemented without delay. In our view, the decision not to place P on ACCT was correct as he did not present with a heightened or exceptional risk of harm.*

- 4.159 On 6 October 2014, the EIT faxed P's recent discharge summary and his most recent risk screening to Trust 3. For some reason this information was not matched with P's file and would not be available to inform his assessment by the prison consultant psychiatrist, CP2, the following month.

³¹ Please refer to Appendix D for more information about the provision of medical and mental health care at HMP Liverpool. During P's imprisonment, primary health care services in the prison were run by Liverpool Community Health NHS Trust.

³² ACCT includes close supervision for prisoners with heightened or exceptional risk of harm. <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc>

³³ Benzodiazepines are similar in pharmacological action but have different potencies, and some benzodiazepine work better in treatment of particular conditions. Benzodiazepines are used as sedatives, hypnotics, anxiolytics, anticonvulsants and muscle relaxants. <http://www.drugs.com/drug-class/benzodiazepines.html>

Panel comments

4.160 *A theme in Trust 3's documentation was the lack of information about P provided by Trust 1. However, when we examined Trust 3's records we discovered the 6 October fax. It is unfortunate that this information did not seem to inform Trust 3's assessment of P by his primary nurse, SNP5, or by CP2 who would see P two months after his prison admission. CP2 would comment in his assessment specifically on the lack of information provided by Trust 1.*

4.161 On 15 October 2014, P was assessed as his diazepam³⁴ detoxification was complete. He reported that he had not experienced any withdrawal symptoms or nausea. No other concerns or issues were raised.

4.162 Also that day in St Helens a child protection conference occurred which recommended that the CPP should remain in place with P to have no contact with Ms Y post-release. Clarification of P's release date was to be obtained. He was also to engage with Addaction and the EIT on his release.

4.163 On 27 October 2014, Trust 3's mental health team made contact with P and obtained his permission to contact his GP.

4.164 On 28 October 2014 P was discussed in Trust 3's mental health inreach team allocation meeting.

Panel comments

4.165 *The Trust 3 policies available to us do not provide for a clear target time between the arrival of a prisoner subject to CPA and their assessment by the prison mental health team. Trust 3's mental health team would not contact P for over three weeks. It would be a full month into his three month sentence before he was seen by a practitioner from Trust 3, SNP5. This was in our view too long a wait.*

4.166 On 3 November 2014, P was seen by a Senior Nurse Practitioner from Trust 3, SNP5, and an assessment was documented. P gave a history of hearing voices "whining" at him and telling him to harm himself. P stated that he used alcohol to try and "knock out" the voices. He was encouraged to make contact with SNP5 or the prison's crisis service if he had suicidal thoughts.

4.167 On 10 November 2014, SNP5 contacted SNP2 and agreed that information about P would be provided on receipt of a fax from the EIT (as we have noted, it would appear that the fax sent on 6 October 2014 was still not accessible to SNP5). SNP5 agreed to keep SNP2 informed of developments including P's release date so that a release plan could be made. P was also seen and

³⁴ Diazepam is used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms. Diazepam is sometimes used with other medications to treat seizures.
<http://www.drugs.com/diazepam.html>

reported hearing no voices and looking forward to his release before the New Year. He reported no suicidal thoughts and did not appear distressed.

- 4.168 Also on 10 November 2014, SNP2 requested information from Trust 1's Criminal Justice Liaison Team about P's assault offences in preparation for a forensic assessment.
- 4.169 On 11 November 2014, the core group overseeing the CPP met and noted that Ms Y's mother would be taking P's daughter to see him in prison the following day.
- 4.170 On 13 November 2014, SNP5 completed his assessment and risk assessment of P. Substance misuse and physical violence were the only two risks ranked under "*Current Concern*". The plan was for other services to manage these risks on release by re-referral to Addaction and resumption of EIT contact. P was to be assessed by CP2, Trust 3's prison psychiatrist. P, who continued to take aripiprazole 20mg once daily and sertraline 50mg daily, reported no mental health symptoms in prison and showed no signs of mental illness.
- 4.171 SNP5 told us that P's psychotic symptoms were well controlled by medication. He assessed P as presenting: "*evidently as a first episode, psychosis. There's been episodes of depression. We have episodes of self-harm. There's some suicide attempts. Obviously a lot of instability there, and then anti-social personality traits, lot of aggression and violence, and that's how I saw [P]. In this environment, always a model prisoner.*"
- 4.172 SNP5 told us that although psychology services had been available at the time of P's detention, the shortness of his sentence meant that he was not referred. While SNP5 expected P to get into trouble in the future, and possibly commit further acts of domestic violence, he told us he had been deeply shocked and surprised by the circumstances of the homicide which followed his release. Given P's offending history and calm presentation in prison, he had absolutely no inkling that P would commit a crime of that magnitude.
- 4.173 In the assessment P once again stated that he had used alcohol to cut out the voices. SNP5 concluded:

"[P] acknowledges potential problems which appear to be exacerbated with alcohol and drug use. He remains somewhat dismissive about his need for support but has been informed that if his behaviour does not change then there was a high likelihood he will return to prison in the near future."

SNP5 sent a fax that day to the EIT requesting further information.

Panel comments

4.174 SNP5 documented a full assessment in the first half of November 2014. Although Trust 1's records had not been found, SNP5 echoed earlier assessments in correctly identifying substance misuse-related violence as the main issue of concern.

4.175 Also on 13 November 2014, SNP3 visited P in prison and discussed the fact that alcohol had contributed to the assaults which had led to his prison sentence. P disclosed that he intended to drink alcohol on his release as it would be New Year's Eve.³⁵ He then planned to stop drinking alcohol from New Year's Day onwards. SNP3 noted that he "encouraged [P] to reflect upon this as once he starts drinking it may be difficult to stop, and he identified that alcohol affects his behaviour. Plan to discuss key points of the appointment with [Ms Y's social worker]."

4.176 On 14 November 2014, P was seen for a third time by SNP5 who concluded that he had significant problems with alcohol and long term mental health needs requiring future support from community health team services. P acknowledged that he needed to address unresolved issues relating to the death of his grandmother and that he needed future support concerning his alcohol use. Bereavement counselling after his release was discussed.

Panel comments

4.177 P's enforced sobriety offered a potential window for therapeutic work and he was described by SNP5 as a "model prisoner". However, Trust 3's plan was for therapeutic work on bereavement and substance misuse to be undertaken by other services after P was released. The rationales we were given when we interviewed SNP5 were that his sentence was too short for psychological work and he showed no apparent interest. However, both SNP5 and CP2 would suggest therapeutic work with P in the community so our view is that there were clear indications to offer it to him in prison even though the late contact with P meant that time was limited.

4.178 P was seen on 26 November 2014 by SNP5 and appeared calm but subdued. He was noted to be coping well on the wing with no significant difficulties. A second fax was sent to the EIT that day asking for "information [which] has previously been requested but not sent".

³⁵ P's actual release date should have been 1 January 2015. However, the Prison Service's sentence calculation rules state: "5.1.6 [...] In the case of prisoners whose release dates fall on weekends or Bank Holidays (except those serving 5 days or less who will be released on the Saturday) release dates must be brought forward to the immediately preceding weekday which is not a Bank Holiday." http://www.justice.gov.uk/downloads/offenders/psipso/ps0/PSO_6650_sentence_calculation.doc

4.179 P was reviewed by CP2 on 27 November 2014. CP2 noted “*Unfortunately we have not been able to receive any clinical information from his Community Psychiatric Team*”. P was noted to be flat in mood with little “[affective] reactivity”, in other words he appeared unresponsive. No psychotic symptoms or thoughts of self-harm were elicited. P indicated that he was keen to re-engage with the EIT, with psychology and with Addaction. CP2 suggested that P was suffering from recurrent depressive disorder following the death of his grandmother complicated by harmful use of alcohol and illicit drugs. Like Trust 1’s medical staff, he identified underlying antisocial personality traits and noted P’s reports of auditory hallucinations. Like the EIT practitioners, CP2 was unclear as to whether the reported hallucinations were related to P’s personality structure, intermittent drug use or part of an independent psychotic illness. A recommendation was made to reintroduce mirtazapine 30 mg in the evening and to stop sertraline as P reported that mirtazapine had worked better. No change was made to the aripiprazole.

Panel comments

4.180 *We note that the delay in P’s assessment by the mental health team meant that CP2 did not see him until 27 November 2014 when he was in the latter stage of his sentence. This was another factor limiting the opportunity for meaningful changes to be made to P’s treatment. In the event, CP2’s assessment was similar to that of the medical staff who had assessed P at Trust 1. The main difference was that CP2 posited depressive disorder as the primary diagnosis and flagged a more explicit question mark as to the basis of the reported hallucinations.*

4.181 On 5 December 2014, the EIT supplied 18 pages of information by fax to Trust 3. This included the full risk assessment of 29 September 2014 and the care plan covering P’s recent admission to Taylor Ward.

4.182 On 8 December 2014 the core group overseeing the CPP met. The possibility of visits at P’s flat supervised by Ms Y’s mother were discussed. The next meeting was planned for the New Year.

4.183 On 17 December 2014, SNP5 rang SNP2 and updated her. He told her that P was stable, on a different antidepressant, and would be released on 31 December 2014. He updated her about CP2’s assessment and CP2’s question as to whether the psychotic symptoms might relate to a personality disorder or an actual psychosis. The recommendation was again made that P should receive psychological help around the loss of his grandmother. An undertaking was given to forward copies of CP2’s assessment and other CPA documentation. SNP2 told SNP5 that a visit to P in the first week of January was planned.

4.184 On 18 December 2014, SNP2 completed a comprehensive re-assessment of P’s risks, taking in the assaults and recent overdose. As before, priority was given to clinical indicators of risk rather than psychosocial factors even though

no clear correlation between P's reports of mental illness symptoms and risk behaviour had been established.

- 4.185 On 19 December 2014, P was seen by SNP5 and noted to appear healthy, mentally stable and to be coping well. P was updated about after-care arrangements and told that he would be seen prior to his release. He was noted to be "*nonchalant*" when asked about how he would cope.
- 4.186 On 24 December 2014, SNP2 rang SNP5 to discuss P's medication. She was told that P would be released with a week's supply and the GP would be informed. SNP2 undertook to ask the GP to issue weekly prescriptions pending review by an EIT doctor.
- 4.187 On 29 December 2014, SNP2 left a message with P's mother who she wished to inform about the hours during which the EIT would be available over New Year and how to access out of hours services. On 30 December 2014 SNP2 called at P's mother's address and left her a letter with information including out of hours contact details on it.
- 4.188 On 31 December 2014, P was visited in reception by SNP5 prior to his release. As had been the case throughout his imprisonment, he appeared mentally stable and symptomless. He was advised to visit his GP for a prescription and was told that a letter would be faxed to confirm his current medication. He was advised not to break his restraining order and to go through legal procedures if he wanted access to his daughter. P expressed some animosity towards Ms Y and appeared "*somewhat indifferent*" to abstaining from alcohol when advised to engage with Addaction. SNP5 contacted the EIT and updated SNP4. SNP4 asked SNP5 to contact social services to report the current situation which SNP5 did that afternoon.
- 4.189 That afternoon SNP4 rang P's mobile but was unable to make contact. SNP4 rang P's mother who told her that P was at the shops and had received a week's supply of medication but not mirtazapine. P's mother confirmed she had received SNP2's hand delivered letter with EIT and out of hours services information on it. SNP4 rang social services to let them know that P had been released.
- 4.190 Also on 31 December 2014, SNP5 wrote to P's GP with details of his new medication regime and the information that he had been referred back to the EIT. SNP5 sent the EIT a copy of the recent assessment by CP2. He described P's voice hearing as well controlled with medication. He described P's motivation to deal with his substance misuse as indifferent and flagged ongoing animosity towards Ms Y. CPA documentation was provided

Panel comments

- 4.191 *Discharge planning intensified in the final fortnight of P's detention with information shared appropriately and robust plans put in place for P's EIT care to resume. SNP2 went to some effort to ensure that P's mother was aware of the plan for discharge and of out of hours resources. P was seen by SNP5 just before his discharge and reminded of next steps and in particular of the need to avoid alcohol.*
- 4.192 *While he was in prison P's risks had been comprehensively re-assessed by SNP2 with further violence towards Ms Y being rightly highlighted. At SNP4's suggestion, SNP5 updated social services on the day of P's release. This was particularly important as P had expressed continued anger towards Ms Y in relation to the conditions applying to access to his daughter. After P's release SNP4 attempted to contact him but he did not want contact with the EIT that day.*
- 4.193 *Concluding, both Trust 1 and Trust 3 collaborated effectively to ensure as seamless as possible a transition from prison to community-based mental health care. Both services knew that the risk of alcohol and/or drug-related violent crime was high. And both risk-managed effectively around the main known risk, further violence from P towards Ms Y. Our review has confirmed that none of the NHS services working with P had any reason to think that the shocking and tragic events of 1 January 2015 would unfold as they did. We conclude that those events could not have been predicted or averted by NHS care.*

5 Arising issues, comment and analysis

- 5.1 In this section we will summarise our findings with reference to our terms of reference (Appendix A).

Assessment, care and treatment

- 5.2 P was consistent in his accounts of lowered mood, bereavement and substance misuse. But what he said to professionals about experiencing visions and voices varied. It was not until March 2013 at his third assessment that he started to disclose symptoms in line with a diagnosis of psychotic mental illness. His accounts of his psychotic symptoms then varied over the following year and a half. We have summarised P's presentations in Appendix C of this report. We have found in general that P's assessments by all three trusts were of a good standard and conducted with reference to appropriate tools.

5 Boroughs Partnership NHS Foundation Trust

- 5.3 The initial Assessment Team and EIT assessments of P were conducted with reference to an array of recognised tools. Documentation was of a high standard.
- 5.4 We consider that the EIT diagnosis of first episode psychosis with elements of depression and anti-social traits was reasonable. Medical and nursing interventions were of a high standard and consistent with the diagnosis. The GP was provided with detailed and regular updates. Prescribing was cautious and potential side effects were closely monitored.
- 5.5 The uneventful nature of P's presentation and disclosures in hospital and prison perhaps explains why the consultants who saw him, CP1 and CP2, gave much less weight to psychotic features. We are of the view that more consultant involvement in P's EIT care would have been of benefit given the complexities in his presentation. This might have included a more robust exploration of why P's account of his symptoms changed. But we do not consider that more consultant involvement would have had a significant impact on care. It certainly could not have changed the outcome.
- 5.6 To implement care 5 Boroughs allocated P to a skilled care co-ordinator, SNP2, who worked in a team designed for presentations like his of an apparent first episode psychosis in a young person. P's own perceptions of his problems were given prominence in the documented care plans and activity sheets and the starting point for interventions was usually his own perception of his needs.
- 5.7 Anti-social traits were formally added to the diagnosis in November 2013 and in our view the EIT's work with P addressed the key areas identified in the

relevant NICE guidance³⁶ (which was introduced mid-way through P's engagement with the team). These included detailed assessment of antisocial behaviours, a focus on strengths and vulnerabilities and risk assessment and management in the area of domestic violence and abuse. P's related disorders of depression, insomnia, anxiety and substance misuse were also addressed through medication and therapeutic input from SNP2 and SNP3.

- 5.8 SNP2 documented a consistent and high standard of community nursing care throughout P's year and a half of EIT engagement. We wish to commend SNP2 for her determined efforts to maintain a therapeutic relationship with P under often challenging circumstances. The aim of her therapeutic work was helping him manage his anxiety, his drug and alcohol use and his related impulsive behaviour. These were all correctly assessed as risks to P's main aim, of establishing himself as a father within his new family. These foci were in line with P's own expressed concerns, his diagnosis and aimed squarely at reducing risk.
- 5.9 We understand the basis of 5 Boroughs' SI report conclusion that access to dual diagnosis and psychology expertise should have been more available. However, we also note the extensive evidence of different professionals trying to link P with drug and alcohol services, and counselling, between 2012 and his imprisonment in 2014. His two appointments with the EIT's psychologist were inconclusive. Overall, in the community context, we found scant evidence that P had the commitment to change his behaviour which is needed for therapy to work.
- 5.10 Finally, we are of the view that more could have been done to involve P's mother in the assessment process in line with 5 Boroughs' CPA Policy. While P had ceased to live with her permanently during his period of EIT engagement, a clear plan to involve her in the assessment was documented but not implemented.

Bridgewater Community Healthcare NHS Foundation Trust

- 5.11 Open Mind's assessments were of a good standard but the second was considerably delayed. It should, in our view, have been routed direct to the EIT given the violent "visions" the GP highlighted.

Mersey Care NHS Trust³⁷

- 5.12 While P's primary care assessment and benzodiazepine detoxification in HMP Liverpool was reasonable and timely, a month of the three month sentence

³⁶ The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE (2014) Assessment and risk management for antisocial personality disorder - <http://pathways.nice.org.uk/pathways/personality-disorders>

³⁷ HMP Liverpool's mental health service has been provided by Lancashire Care NHS Foundation Trust since 1 June 2015. Our recommendations therefore are directed towards Lancashire Care NHS Foundation Trust.

would pass before the mental health team became involved. This is of concern given the fact that P was on CPA and being administered anti-psychotic medication on admission. This reduced the opportunity to use the enforced alcohol and drug-free episode to make any improvements to his care. In the event, no new interventions were made in the three month period other than a reversion to the former antidepressant regime.

Recommendation 1:

Lancashire Care NHS Foundation Trust should ensure that prisoners with known mental health problems are fully reviewed no later than in the first weekly mental health service allocation meeting following their primary care assessment in the prison.

- 5.13 That said, our overall assessment of P's care in prison is positive. In line with Mersey Care's CPA Policy he was allocated a care co-ordinator, SNP5. SNP5 conducted a detailed assessment spanning multiple interviews with P and produced a thorough CPA plan and risk assessment. He also liaised with 5 Boroughs and ensured P received a consultant review. At interview we were particularly impressed by the evidence of thoroughness and commitment in SNP5's approach to his role.
- 5.14 Both SNP5 and CP2 would suggest that P would benefit from therapeutic work on bereavement and drug and alcohol misuse. We have suggested that the opportunity to initiate this while he was stable and sober in prison was not taken by Mersey Care, perhaps due to the lateness of his assessment.
- 5.15 For some reason 5 Boroughs' records were not available to Mersey Care until late in the sentence despite 5 Boroughs' timely provision of key documents. This meant that up to date assessments were not available to the prison mental health team during their own assessment of P.

Recommendation 2:

Lancashire Care NHS Foundation Trust and Mersey Care NHS Trust should review the effectiveness of their systems for receiving information about prisoners from external agencies and entering it into the health care record. The aim should be to ensure that information from other agencies, while subject to the required protection, is made available quickly to the staff that need it.

- 5.16 On a positive note, both 5 Boroughs' and Mersey Care's records evidence a good standard of communication between clinical staff in the two services. And SNP3 is to be commended for visiting P at the mid-point of his sentence and reinforcing the message that avoiding alcohol post-discharge was key. SNP3 reported back the outcome to social services.

Risk assessment and management

5 Boroughs Partnership NHS Foundation Trust

- 5.17 Our overall conclusion is that 5 Boroughs produced accurate and appropriate risk assessment and management plans based on P's known risks throughout his engagement. Risk assessments were initiated within initial assessments. The EIT risk assessments were updated in dated log format following significant events. The Trust's standard screening and assessment tools were used. The overdoses, P's impending fatherhood and the assaults on Ms Y were, rightly, triggers for re-assessment. This dynamic risk assessment process was in line with 5 Boroughs' policy and the NICE guidance on anti-social personality disorder.
- 5.18 A slight criticism is that we found an over-reliance on information provided by P. This meant that a definitive forensic history was not available even by June 2014 when P's risks as a parent were assessed as commensurate with a Child Protection Plan. We think that the EIT should have sought P's full forensic history through the Trust's Criminal Justice Liaison Team by January 2014 at the latest when safeguarding was being initiated. That said, P himself gave a consistent and reasonably accurate account of his offending history. We therefore do not consider that the lack of a formal forensic assessment had a significant impact on events. And we regard this deficit to have been addressed by the action plan resulting from 5 Boroughs' SI investigation.
- 5.19 We felt that 5 Boroughs should have, at Assessment Team and EIT stages, communicated with the probation provider which was working closely with P to reduce the risk of reoffending, particularly while PO1 was involved. We highlighted P's referral by the Court to the TSP as an example of an area where better communications with the probation provider by the EIT might have made a difference. Had the EIT understood that the TSP was aimed at reducing the risk of domestic violence, the EIT might have thought twice about assisting P in his efforts to avoid attending. P had also disclosed to PO1 a vision of killing police officers, an account which never entered the mental health assessments. However, we also note the probation provider's poor contribution from 2014 despite the EIT's strenuous attempts at joint working on the pre-birth assessment.

Recommendation 3:

5 Boroughs Partnership NHS Foundation Trust should review the effectiveness of its policies and procedures for working in partnership with other agencies, including local probation providers³⁸, where a service user has a known risk of domestic violence.

- 5.20 We have been assured by the current probation provider that the principal learning for the organisation relating to the timeliness of referrals for pre-birth

³⁸ This should include the National Probation Service which works with high risk offenders and the Merseyside Community Rehabilitation Company which works with low and medium risk offenders.

assessments in appropriate cases is being taken forward across the organisation.

- 5.21 Returning to 5 Boroughs, we would also suggest that the risk of domestic violence might have been assessed sooner than June 2014, particularly as it brought with it dangers to Ms Y's unborn child.
- 5.22 In our view, psycho-social factors, in particular P's acquisition of his own tenancy, increased the general risk of violence related to his alcohol and drug use. We cannot see that the EIT could have done much more to manage those general risks. But we think that the increased risk to staff attending P's flat rather than Ms Y's family home should have been fully assessed and managed sooner. However, we commend EIT staff for their vigilance in their management of the risk of further domestic violence to Ms Y. They reported breaches of bail and ensured that SNP5 informed social services of P's attitude towards Ms Y at the point of his release.

Mersey Care NHS Trust

- 5.23 We found that Mersey Care's risk assessment was thorough, well documented and consistent with P's community presentation. Like the general assessment, it lacked information from 5 Boroughs until late in the sentence because the information provided by 5 Boroughs was not made available to the prison mental health team. Inside prison P appears to have been free of mental health symptoms and displaying no risks in the areas of self-harm or violence to others. While the low level input of the prison mental health team was in line with that presentation, our view is that an opportunity to address the risks which had brought him into prison through focused therapeutic work was missed.

Safeguarding

5 Boroughs Partnership NHS Foundation Trust

- 5.24 Our overall positive assessment of the EIT's performance in the safeguarding process is in line with the outcome of the SI investigation. We commend SNP2 in particular for taking over the lead role by insisting on the pre-birth assessment referral after the probation provider had failed in its undertaking to make the referral. And we note her meticulous record keeping, her effective communication with P and other agencies and her consistent follow-up of issues related to the Child Protection Plan.
- 5.25 Inaction and poor communications from the probation provider meant that the pre-birth assessment nearly did not happen. These failings also made the tense circumstances of the assessment much more difficult for all parties. We feel that the probation provider's poor contribution to such an important area of joint working should have been escalated by 5 Boroughs.
- 5.26 Following the pre-birth assessment, the EIT staff played active and effective roles in the multi-agency delivery of the Child Protection Plan.

Mersey Care NHS Trust

- 5.27 The records show that SNP5 was alive to the possibility of domestic abuse on P's discharge and ensured that social services, the GP and 5 Boroughs had the information necessary to manage the community risks. This was in line with Mersey Care's Safeguarding Children Policy.

Release from prison

5 Boroughs Partnership NHS Foundation Trust

- 5.28 5 Boroughs worked closely with Mersey Care from the outset of P's imprisonment by providing documentation of his recent presentation and a full risk assessment on two occasions. EIT staff established the exact date of release at an early stage and planned appropriately. They kept in close communications with SNP5. The risk assessment was updated. SNP3 visited P in prison in the mid-point of his sentence and reinforced the message that he needed to address his alcohol and drug problems. Social services and P's mother were kept informed and EIT staff went to some lengths to ensure that P's mother was aware of the discharge plan – timely EIT follow-up – and of out of hours arrangements in the event of a crisis over the Bank Holiday period. P's mother was contacted on the afternoon of his discharge and P, who did not want contact with EIT staff that day, was also telephoned.

Mersey Care NHS Trust

- 5.29 Mersey Care ensured that, in line with national guidance and its CPA policy, P left prison with care coordination in place. Full CPA documentation including the outcome of the CP2 assessment was referred to the EIT with whom SNP5 had been in regular contact throughout the period of imprisonment. The GP was informed of discharge arrangements and of the change in antidepressant medication. And social services were telephoned and told of P's hostile attitude to Ms Y and the likelihood of his resuming drinking. This information was based on a re-assessment undertaken by SNP5 immediately before P's release on New Year's Eve.

6 Internal investigation and action plan

6.1 In this section we examine 5 Boroughs Partnership NHS Foundation Trust's serious incident (SI) investigation and consider if:

- it satisfied the terms of reference (ToR)
- all key issues and lessons were identified
- recommendations are appropriate and outcome focussed
- affected families were appropriately engaged with during the investigation process
- the Trust can evidence implementation of the internal action plan and improved outcomes

Terms of reference and overall conclusion

6.2 In our view the SI report addressed the key aspects of P's care and treatment from his 2012 contact with the Assessment Team to his release from prison on 31 December 2014. Key staff involved in P's care were interviewed namely SNP1, SNP2, CP1 and SNP5. P himself as well as his ex-partner and his mother were interviewed. The quality of care was clearly referenced to relevant local and national guidelines. Significantly, our own investigation has confirmed the SI investigation's over-arching conclusion that the incident could not have been predicted, or prevented by care from the Trust.

6.3 The lack of contact between 5 Boroughs' services and the probation provider before 2014 was not commented on by the SI report despite its ToR to evaluate inter-agency communication. In our view the opportunity to broaden the assessment and collaborate more actively with the probation provider on reducing the risk of P re-offending was not considered. And CP2's clear if inaccurate statement in his assessment that information from the Trust had not been available was not referred to.

Key issues and lessons

6.4 We conclude that the SI investigation identified the key issues, particularly concerning the breadth of the risk assessment and the timeliness of the pre-birth assessment. While we place less emphasis on the findings relating to dual diagnosis and psychological therapy, we regard them as appropriate and reasonable (although the issue of EIT access to psychological therapy had been addressed during P's engagement). We also agree with the finding about data quality given the change in P's recorded date of birth which occurred shortly after his engagement with the EIT began.

6.5 The SI report's overall conclusion was that inter-agency communication was of a high standard. It referred justifiably to comprehensive communications with the GP, Mersey Care and the probation service. We would regard most of those communications as a standard baseline for community mental health services. We agree that the applicable standards were met.

- 6.6 In particular, our investigation has corroborated the SI investigation's conclusion that the Trust's communications with the prison in preparation for P's release were of a good standard. And our scrutiny of the probation records fully corroborates the Trust's conclusion that responsibility for the late implementation of the pre-birth assessment resided largely with the probation provider. We are of the view that the probation provider's poor handling should have been escalated by Trust management.

Fairness

- 6.7 We think the SI investigation was unfair in its assessment of SNP1. First, we do not agree that a presentation where minimal psychiatric symptoms were elicited warranted a referral for a full forensic history³⁹. Second, we would question the suggestion that P's mother should have been referred for a carer's assessment when there was scant evidence that her son suffered from mental illness. Third, at interview SNP1 pointed to clear evidence in her assessment record that she had asked questions about relationships. However, the SI report stated that no such questions were asked. It is true that P would disclose more about the physical abuse from his father in other assessments. However, the SI report does not seem to consider that the presence of his mother in the assessment with SNP2 might have affected what he said.
- 6.8 SNP1's assessment was adjudged to be "biased" towards drugs and alcohol in the presentation but these were the features highlighted in the referral and in the assessment itself. In fact, with hindsight SNP1's emphasis on the effects of drugs and alcohol appears to have been further validated. SNP1 was also found to have failed to make it clear to P that he needed to address his substance misuse problems before he could access counselling. In reality, this advice was clearly documented by SNP1 and understood by P. SNP1 was also criticised for not following up the assessment given the "*reported large and potentially fatal overdose*". However, the purpose of follow-up from or through the Assessment Team was not clear to us. The priority was to complete a very overdue assessment and to advise P to seek medical help, which he did.
- 6.9 Our final concern about this part of the SI investigation is that SNP1 was not offered an opportunity to comment on the summary of her own evidence (which was inaccurate, for example in describing P as self-referred) or on the criticisms of her practice. Like the other witnesses interviewed, she had not seen the SI report prior to our investigation. This resulted in unfairness towards her. It also meant that recommendations which actually applied to the EIT's involvement in CPA over a period of a year and a half appeared to be

³⁹ This was not a finding of the SI investigation but we will say anyway that we did not consider that the fact that P did not tell SNP1 that he was hearing voices was attributable to any deficiency in her approach. For unknown reasons, he would not start saying this to any professional, including PO1 who worked very closely with him, for a further three months.

attached to a single hour-long assessment episode. This was disproportionate and limiting.

Recommendation 4:

Clear procedures should be built into 5 Boroughs Partnership NHS Foundation Trust's Incident Management Policy to ensure that staff whose practice is subject to criticism have an opportunity to comment before the investigation is finalised. The policy should also provide clear procedures for confirming the accuracy of witness evidence before it is incorporated into an investigation report.

Engagement with P's family

- 6.10 As far as the ToR to engage the mother of P in the SI process is concerned, we note that she was interviewed by 5 Boroughs as part of the investigation. We understand that the joint interview during the investigation with her and Ms Y was not planned.
- 6.11 Although P's mother asked for a copy of the SI report, it had not been provided to her four months after its publication (in June 2015) when we contacted her in October 2015. Although 5 Boroughs has now shared its SI report with P's mother, we remain concerned that SNP1 and SNP3 had not been given a chance to see the report.

Recommendation 5:

5 Boroughs Partnership NHS Foundation Trust's implementation of its Incident Management Policy should ensure that the outcome of an SI investigation is shared where possible and appropriate with all parties to the investigation.

SI report recommendations

- 6.12 We next consider the SI report's recommendations in turn.

Recommendation 1: *Where a significant forensic history is apparent, all assessments to record a full forensic history with details of risks posed to others, secured from all possible sources, to support a risk management care plan.*

- 6.13 Recommendation 1's broad reach was, correctly in our view, adjusted after consideration in the local leadership team on 20 August 2015. Implementation consisted of the Criminal Justice Liaison Team reminding 5 Boroughs' teams in St Helens and Knowsley of its remit and how to refer to it. We regard this as a proportionate and reasonable outcome.

Recommendation 2: *Involvement and support for informal carers to be considered at all assessments. Carers/relatives to be offered an assessment of their needs as required and/or given information on how to access further support by the assessment team.*

- 6.14 We considered that Recommendation 2 was disproportionate in the circumstances of P's December 2012 assessment where few symptoms of mental illness were elicited. Had it been applied to that assessment P would have been discharged while his mother was offered further support. However, the outcome of providing written information to all carers who attend assessments can only be positive and we have been provided with adequate evidence of implementation.

Recommendation 3: *To consult the Nurse Consultant for Dual Diagnosis in complex cases where substance misuse and alcohol consumption impact on the service user's mental health or a lack of engagement with 3rd sector drug and alcohol services.*

- 6.15 The implementation of Recommendation 3 consisted of the Nurse Consultant for dual diagnosis visiting the St Helens and Knowsley teams to explain his role. Again, this seems to us sensible and proportionate and 5 Boroughs has provided us with adequate evidence of implementation in the form of meeting minutes.

Recommendation 4: *When records are updated regarding demographics, an entry in the clinical records to identify the rationale and date of change should be made using the Data Quality Policy as a reference.*

- 6.16 Recommendation 4 was implemented by being shared and discussed in the local leadership meeting, with the message being cascaded to local teams, but 5 Boroughs has provided us with evidence of this and with evidence that its revised Data Quality Procedure addresses the SI report recommendation.

Recommendation 5: *EIT to review access to dedicated psychology input to meet NICE guidance. When an intervention is identified as needed for a service user but cannot be provided within a team, this should be reported to line manager to discuss alternate options to meet this need.*

- 6.17 Recommendation 5 had been implemented during P's engagement with the EIT, as far as providing access to psychology for EIT clients is concerned. Our overall assessment is that access to the psychology service for EIT is to be welcomed and no further action is required on the basis of this case.

Recommendation 6: *Advice must be sought immediately from the Trust Safeguarding Department as soon as it is known that a partner agency has not enacted a safeguarding referral.*

- 6.18 As far as Recommendation 6 is required, implementation consisted of discussion in the local leadership meeting and in the Early Intervention Team. 5 Boroughs has provided us with adequate evidence of this. We also note that

5 Boroughs' revised Domestic Abuse Policy & Procedure highlights joint working and risks to the unborn child.

- 6.19 Concluding, we have highlighted some points of departure from the methodology and conclusions of the SI investigation. However, we emphasise that we agree to a significant extent with the overall analysis and recommendations which have been largely validated by our own investigation.

7 Overall analysis and recommendations

- 7.1 P had a history of petty crime and domestic violence, and he harboured pro-criminal attitudes. However, in our review of the records and in the interviews that we have carried out, no signs came to light that could have alerted any professional in contact with P that he would commit a homicide within hours of being released from prison in 2014. The homicide represented a sudden unpredictable escalation in P's criminal behaviour.
- 7.2 5 Boroughs' SI investigation into P's care concluded that while P's tendency to violence was predictable, the homicide was not preventable through NHS care. That is the same conclusion which we have reached through our independent investigation.
- 7.3 The records show that staff repeatedly looked for links between P's anti-social behaviour and his reports of mental illness symptoms. No such links were ever found nor claimed by P at any stage, including after his arrest for murder. For P, a clear link did exist between violence and drug and alcohol use but P could not reduce his intake even when access to his daughter was at stake. We conclude that none of the services which started to work with P following his release from prison in June 2012 could have prevented the tragic event which occurred hours after his release from prison in 2014.
- 7.4 We have found much to praise in the work of the staff who tried to help P and to keep his partner and child safe.
- 7.5 Although this independent investigation has highlighted some service delivery problems (please also refer to the fishbone diagram in Appendix B), these are not felt to be causal or contributory factors to the homicide. Where they are not already addressed by the SI investigation action plan we have made recommendations which are set out below.

Recommendation 1:

Lancashire Care NHS Foundation Trust should ensure that prisoners with known mental health problems are fully reviewed no later than in the first weekly mental health service allocation meeting following their primary care assessment in the prison.

Recommendation 2:

Lancashire Care NHS Foundation Trust and Mersey Care NHS Trust should review the effectiveness of their systems for receiving information about prisoners from external agencies and entering it into the health care record. The aim should be to ensure that information from other agencies, while subject to the required protection, is made available quickly to the staff that need it.

Recommendation 3:

5 Boroughs Partnership NHS Foundation Trust should review the effectiveness of its policies and procedures for working in partnership with other agencies, including probation, where a service user has a known risk of domestic violence.

Recommendation 4:

Clear procedures should be built into 5 Boroughs Partnership NHS Foundation Trust's Incident Management Policy to ensure that staff whose practice is subject to criticism have an opportunity to comment before the investigation is finalised. The policy should also provide clear procedures for confirming the accuracy of witness evidence before it is incorporated into an investigation report.

Recommendation 5:

5 Boroughs Partnership NHS Foundation Trust's implementation of its Incident Management Policy should ensure that the outcome of an SI investigation is shared where possible and appropriate with all parties to the investigation.

Appendix A – Terms of Reference

1. Review 5 Boroughs Partnership NHS Foundation Trusts internal investigation of the incident, to include timeliness and methodology, to identify if:

- the internal investigation satisfied the terms of reference
- all key issues and lessons were identified
- recommendations are appropriate and outcome focussed
- the Trust can evidence implementation of the internal action plan and improved outcomes
- affected families were appropriately engaged with during the investigation process

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

- The care and treatment received whilst the service user was in prison from prison health services including their involvement in discharge planning and risk assessment and management prior to release
- the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern
- the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others (including risks associated with domestic violence)
- compliance with local policies, national guidance and relevant statutory obligations
- the effectiveness of the service user's care plan including the involvement of the service user and the family

3. Based on overall investigative findings, constructively review any gaps in the interface between NHS services and also external agencies, identify potential opportunities for improvement

4. Involve the affected families as fully as considered appropriate, in liaison with Victim Support, police and other support organisations

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

6. Provide a written report to NHS England North that includes outcome focussed measurable recommendations

7. Assist NHS England, North in undertaking a brief post investigation evaluation

Supplemental to Core Terms of reference:

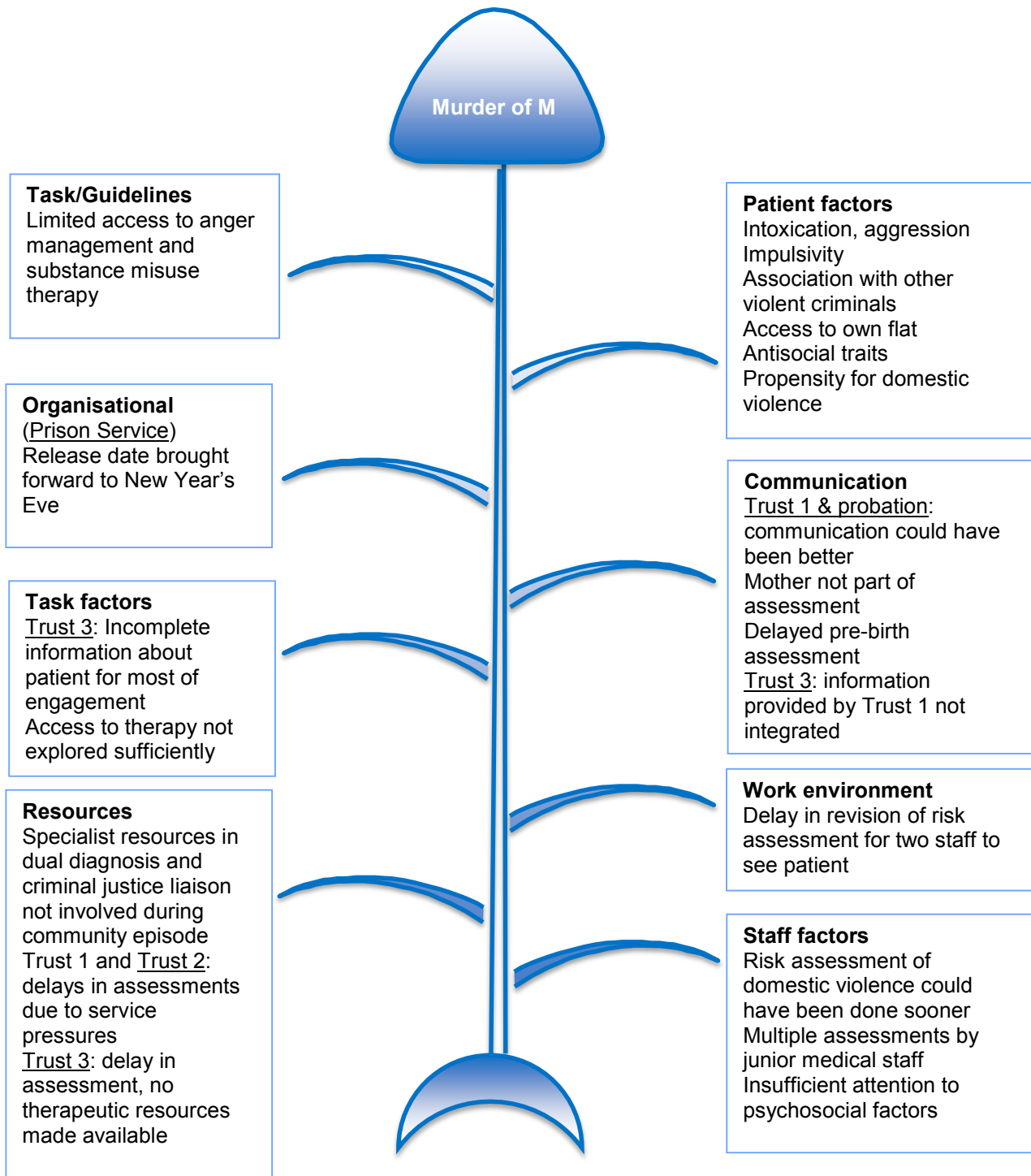
8. Review the effectiveness of:

- the discharge from prison services to health services including if CPA requirements were fully met
- safeguarding processes in relation to this investigation

9. Provide the Trust with support to develop an outcome based implementation plan.

Appendix B – Fishbone analysis

The Fishbone Analysis below sets out the key issues we have identified and refers to 5 Boroughs unless otherwise stated.



Appendix C – P’s presentation of psychotic symptoms

June 2012-February 2013 (Probation & GP). No reference to voices or visions.

5 December 2012 (Trust 1, SNP1 assessment). Voices and hallucinations denied.

16 January 2013 (Trust 2, MHP1 assessment). Hearing bangs and doors slamming but ascribed to paranoia. No voices.

26 March 2013 (Probation). “Visions” of shooting father and two police officers, no reference to voices.

16 April 2013 (GP). “Visions of killing his father”, no reference to visions of killing police officers.

4 June 2013 (Trust 2, MHP2 assessment). Hearing indistinct voices for about eight months. Repetitive thoughts of harming father (no reference to visions or police officers).

24 June 2013 (Trust 1, SNP2 assessment). Two unintelligible voices since December 2012 when alcohol use dropped. Visions or “daydreams” of harming father 3-4 times per week, 20 minutes duration, since December 2012. Paranoia and feeling people could hear thoughts. Voices behind or in head.

1 July 2013 (Trust 1, SNP2 assessment). Voices a few times per day, last at least an hour, close to ears, outside head, quiet, believes due to drug use and internal, one low pitch one high, content unclear, always very distressing, minimal disruption to life.

12 July 2013 (Trust 1, ST5/1 assessment). Voices/whispers since December 2012, loud, soft, unrecognisable, internal. Variable, every other day to begin with. Mood related. Three episodes of intrusive images of harming father while day dreaming, last occasion 2 months ago. [P told us the visions stopped and did not recur after four occasions.]

21 August 2013 (Trust 1, ST6/1, post-overdose assessment). Two voices mumbling since December 2012, becoming clear, gender unknown. From behind head. Critical. Mood-related. Episodic. Speaking to him. No commentary or commands. [Aripiprazole commenced, not always taken.]

18 September 2013 (Trust 1, ST6/1, clinic). Two male voices mumbling, transient, lower volume. Improved mood.

7 October 2013 (Trust 1, SNP2): Voice told him Ms Y was cheating (led to row). This account would be questioned by staff.

4 November 2013 (Trust 1, SNP2): No voices during holiday with Ms Y’s family.

18 November 2013 (Trust 1, SNP2), Voice every day telling him nobody wants him.

December 2013-January 2014 (Trust 1, SNP2). Muffled voice.

8 April 2014 (Trust 1, SNP2). Increase in voices after not taking medication.

15 April 2014 (Trust 1, ST6/2 assessment). Voices worse after cocaine and ecstasy. Two voices, like people "sitting on shoulder", louder, mumbling, content unclear.

30 April 2014 (Trust 1, SNP2). Mumbling voices up to three times per day.

May-June 2014 (Trust 1, SNP2). Reduced and declining incidents of voices, muffled when heard.

In weeks after birth of child (24/6/2014) and inception of Child Protection Plan, voice hearing denied.

31 July 2014 (Trust 1, ST6/2, clinic). No voices reported.

12 September 2014 (Trust 1, SNP3, post-overdose). Hearing voices commanding him to harm self, saying he is bad father and daughter will be taken away by social services. Two clear voices, one male, one female. Also mumbling. [Admitted to mental health ward for weekend.]

15 September 2014 (Trust 1, CP1, discharge). Inconsistent account of voices admitted, now saying voices preceded overdose. Mumbling voice.

17 September 2014 (Trust 1, SNP3). Voices saying he is better off dead.

24 September 2014 (Trust 1, Psychologist). Muffled voices inside head.

29-30 September 2014 (Trust 1 SNP3, SNP4). No voices. [Prison from 3 October 2014.]

27 November 2014 (Trust 3, CP2 prison assessment). Voices since 2010. Has often acted on critical voices by overdosing and/or harming himself. No current signs or symptoms of hallucinations.

October-December 2014 (Trust 3, SNP5, prison). No voices.

(No voices since, according to P who we saw on 18 November 2015).

Appendix D – Profile of the Trusts involved

5 Boroughs Partnership NHS Foundation Trust (Trust 1)

This trust provides mental health, learning disability and community health services across five geographical boroughs, Warrington, Wigan, St Helens and Knowsley and Halton.

In 2012-2014 drug and alcohol services were provided by independent organisations; for St Helens and Knowsley drug and alcohol services were provided by Addaction, a charitable organisation. The service was commissioned by Public Health Commissioning at St Helens Council. The same arrangements are in place currently.

Assessment Teams

Trust 1's assessment teams provide a single point of access into secondary services for people referred by GPs, probation and other services. They provide specialist mental health assessment, advice and signposting for adults with moderate to severe symptoms of mental illness.

The Early Intervention Team

Trust 1's Early Intervention Team (EIT) provides people Aged 14 to 35 in St Helens, Warrington, Halton and Knowsley with first episode psychosis with intensive case management for up to three years. The service accepts people without a firm diagnosis and does not exclude people using substances and/or alcohol. It espouses a person rather than diagnosis-led philosophy. The EIT is based on the principles of the Early Psychosis (or Newcastle) Declaration which in 2002 included the following values:

- *“Support young people with psychosis and their families to achieve an ordinary life - move beyond illness to health improvement*
- *Raise expectations for users and family members as a key driver of service improvement*
- *Act as an attractor of good practice”.*⁴⁰

Taylor Ward

Taylor ward is a 17-bed male acute admission ward at Peasley Cross Hospital in St Helens.

⁴⁰ More information about the early Intervention model is available on the iris website <http://www.iris-initiative.org.uk/iris/>

Psychiatric Liaison Team

Trust 1's 24-hour a day Psychiatric Liaison Team is based in Whiston Hospital Accident and Emergency Department, providing an assessment of mental health needs to all adults aged 16 to 65.

Bridgewater Community Healthcare NHS Foundation Trust (Trust 2)

Trust 2 provides NHS community health services in Bolton, Halton, St Helens, Warrington and Wigan as well as community dental services.

Trust 2 ran a service called "Open Mind" between 1 April 2010 and 30 October 2015 in the area formerly covered by Halton and St Helens Primary Care Trust (now St Helens Clinical Commission Group and Halton Clinical Commission Group). Any health professional could refer people to Open Mind and people could also self-refer. It set out to "*challenge traditional thinking around a purely medical model*".

Open Mind aimed to:

"co-operate with the Mental Health Single Point of Access to facilitate clinical assessments for those people requiring psychological therapies and where necessary, risk assessments for people who are suffering mild to severe mental health problems.

Following assessment the Service will provide case formulations. Interventions to be brief to medium term in accordance with Steps 2, 3, and 4 of NICE guidance and using a range of psychological therapies and/or signposting on to other services, where appropriate."

Open Mind provided a range of therapies⁴¹ as well as referrals to secondary mental health services for people not already engaged with those services. Open Mind was used heavily by Halton and St Helens GPs who by 2014 were referring 800-900 patients per month.

Open Mind's assessments were undertaken by mental health nurses. After an initial screening of each incoming referral (within 24 hours), it had provision to refer referrals it classed as urgent direct to secondary mental health services. It aimed to see non-urgent patients within 10 working days of referral and to match people with services within 13 days of assessment.

⁴¹ Its specification referred to an integrated therapeutic approach with seamless access to "Self help and bibliotherapy, Computerised CBT, Cognitive Behavioural Therapy, Interpersonal Psychotherapy, Cognitive therapy, Generic Counselling, Integrated therapy, Eye Movement Desensitisation and Reprocessing, Problem solving therapy [and] Group Work".

Its specification included:

“Service users who present with alcohol or drugs as the primary issue must be referred directly to the available specialist substance misuse services. However, we anticipate that a significant number of service users will have an alcohol problem often alongside mental health difficulties, therefore use of drugs and alcohol will not be used as an exclusion criterion for those experiencing mental health problems. The new service will ensure that strong links are established with Substance Misuse Services and that, where appropriate, brief interventions around safe use of alcohol are available.”

Mersey Care NHS Trust (Trust 3)

Mersey Care NHS Trust provided mental health services at HMP Liverpool until 1 June 2015 at which point Lancashire Care NHS Foundation Trust took over.

Other providers of healthcare in HMP Liverpool

Liverpool Community Health NHS Trust provided primary health care services at Walton Prison during P’s 2014 sentence. In July 2014 it reported concerns about quality of care and the workforce to the Care Quality Commission (CQC) which undertook an inspection on 31 October and 1 November 2014. The CQC published a report in December 2014⁴² which was very critical of HMP Liverpool’s primary care services in particular.

In January 2015 primary care services at the prison were transferred to Lancashire Care NHS Foundation Trust on a temporary basis by NHS England due to significant concerns about the safety of the service.

Lancashire Care NHS Foundation Trust took over as the substantive provider of both primary and mental health care services in HMP Liverpool on 1 June 2015. Where we make recommendations for Trust 3 concerning prison mental health care, they are directed to Lancashire Care NHS Foundation Trust.

⁴² http://www.cqc.org.uk/sites/default/files/Ry1X1_Health_Suite_INS1-1755953626_Responsive_-_Concerning_Info_01-01-2015.pdf