INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF MB

MARCH 2018

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1. INTRODUCTION

1.1 Gemma Simpson was 23 when she was last seen in Leeds on 5 May 2000. She told a friend that she was on her way to Huddersfield. She was not seen again. Shortly after, Gemma was reported as missing by members of her family.

1.2 Gemma's disappearance remained unexplained until 2014. On 8 July 2014, MB confessed to killing Gemma. Following information provided by MB, her body was found in North Yorkshire.

1.3 MB subsequently pleaded guilty to the manslaughter of Gemma Simpson by reason of diminished responsibility. MB was found to be fit to stand trial and was sentenced to imprisonment for life. The judge specified the period of 12 years as being the minimum term MB must serve.

1.4 Little information is known about the circumstances surrounding the death of Gemma, save for information given to the Court by MB himself which is largely unsubstantiated.

1.5 According to evidence submitted to the Court on MB's behalf, on the day of her death, Gemma and MB were in MB's flat. MB stated that he had smoked cannabis that day. He told Gemma '*God wants me to kill you'*. He then struck her repeatedly with a hammer and stabbed her before leaving her body in a bath for several days.

1.6 During the course of the criminal proceedings relating to Gemma's death the Judge stated the following in relation to whether this account of why MB attacked Gemma was accurate:

'[The] *prosecution accept that there is no good reason to reject your account of the circumstances of the killing whilst accepting your account of the manner of the killing which has been corroborated by the evidence now discovered as a result of your admissions. For all those reasons and I agree with them they have concluded that there would be no proper basis for a jury to reject your account of the circumstances of the killing and therefore to reject the basis of your plea to manslaughter on the grounds of Diminished Responsibility*.'

1.7 At the time of the offence MB was 30 years old. He had initially come to the attention of mental health services on 1 November 1982, when he was assessed by a Consultant in Child and Adolescent Psychiatry because of concerns about his behaviour, in particular, stealing. No evidence of psychiatric illness was found.

1.8 On or around the 22 June 1992 MB took an overdose of paracetamol. He was seen by a Registrar in Liaison Psychiatry '*…who felt this was an impulsive overdose due to relationship difficulties and he did not require further psychiatric follow up'*.

1.9 In the period between 17 August 1999 and 13 March 2000, MB received care from Grovelands Priory Hospital, London ('Grovelands') and from Harrogate District Hospital Mental Health Services ('Harrogate'). This was MB's only admission to hospital as an in-patient.

1.10 Approximately two months after discharge from Harrogate, whilst MB was in receipt of out-patient care in Harrogate, on or around 5 May 2000, MB was responsible for the death of Gemma Simpson.

1.11 Following his discharge from Harrogate, MB moved around the country. There were no reported incidents of violent acts having been committed by MB during this time.

1.12 Following MB's confession in 2014, it was identified that he had been in receipt of NHS mental health services in the six months preceding the offence. Subsequently the case was presented at the NHS England North Independent Investigations Review Group and it was agreed that this case would have satisfied the Health Service Guidelines criteria at the time of the incident, had the NHS been aware of the incident, and therefore an Independent Investigation was commissioned.

2. INVESTIGATIVE APPROACH AND METHODOLOGY

2.1 NHS England's Serious Incident Framework 2015 states that:

'*Serious incidents in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again*'.

2.2 Due to the fact that MB did not disclose details of his offence until 8 July 2014, the organisations which provided his care in the period 17 August 1999 to 12 April 2001 were unaware of his actions. Consequently, they were unable to conduct an internal investigation to identify where learning could be garnered in relation to MB's care. Indeed, some of the organisations which delivered care no longer exist and professionals involved in his care are no longer in practice.

2.3 During the course of the Independent Investigation, the Independent Investigation Team has liaised with members of Gemma Simpson's family. The Independent Investigation Team hopes that the family and friends of Gemma will find this report helpful in addressing their questions and concerns in relation to the care of MB.

2.4 The Terms of Reference of the Investigation, Chronology, Team Membership and Glossary can be found at Appendices 1 to 4.

2.5 MB's records were obtained by NHS England (North) pursuant to the Caldicott process as MB did not consent to disclosure of his medical records.

3. EXECUTIVE SUMMARY

3.1 The Independent Investigation Team has been significantly hampered in its investigation of MB's care owing to the quality of the copy set of records which have been made available to it.

3.2 There are three issues which are associated with MB's records. Firstly, it appears that the copy set of records was incomplete; the notes which did exist were illegible in parts, and the content of the records in terms of depth of clinical information was, in parts, very poor. These deficiencies are particularly apparent in the period following MB's discharge from hospital on 13 March 2000, and include the period when MB was responsible for the death of Gemma Simpson.

3.3 The impact which this had upon the Independent Investigation was significant. The absence of a complete and legible set of medical records means that it has not been possible to establish a secure factual foundation upon which a detailed analysis can be constructed in order to identify learning.

3.4 On 17 August 1999, MB was admitted to Grovelands in London for assessment of his mental state. There were elements of good practice in relation to MB's care in London. In particular, clinically significant information was highlighted in a comprehensive discharge note which was provided to Harrogate upon MB's transfer.

3.5 MB was subsequently transferred to be nearer his home and was cared for in Harrogate on 26 August 1999. MB's initial detention in hospital in London and, indeed, the treatment provided to him in Harrogate was in accordance with the provisions of the Mental Health Act 1983 ('the MHA 1983'). However, as MB's condition improved he remained in hospital as a voluntary patient until 13 March 2000.

3.6 During his admission to hospital in Harrogate, clinicians found it difficult to engage with MB. However, it was established that MB suffered from either schizophrenia or a delusional disorder. It was also likely that he suffered from a personality disorder.

3.7 A Forensic Report dated 17 September 1999 was obtained in order to assist clinicians in understanding MB's illness, and the issue of the risk which MB posed to himself and others when he was unwell. This report raised a concern that MB would not reliably take his medication if he was to be discharged from hospital.

3.8 The Forensic Report agreed with the referring Consultant's opinion that MB was suffering from a mental illness (either schizophrenia or delusional disorder) and recommended that he be detained for treatment under the Mental Health Act, considering that there were adequate grounds for detention.

3.9 In the opinion of the Independent Investigating Team, the treating forensic (Consultant) appeared to link the grounds for detention to his suffering as a result of his mental illness. He states (in his report dated 17 Sept 1999):

'…. Nevertheless, he continues to suffer as a result of his mental illness, and therefore there are adequate grounds to detain him in hospital'. Addressing the potential risk to others, in particular, his brother,

'…from his answers, there is no good reason to suspect that his brother is in danger from him. He appears to have actively taken steps to avoid hurting his brother'.

3.10 In her report for the Mental Health Review Tribunal (dated 25 Oct 1999), the treating consultant reiterated the forensic consultant's opinion about the potential risk to MB's brother (see above). She stated her concerns as being *'if he was confronted by somebody that he thought was one of his persecutors, then he could be violent to that person'*. In the Tribunal decision to uphold the detention (19 Nov 1999), the President states;

'if discharged now, his health would be likely to deteriorate rapidly, if he perceived that others might try to abduct him, they would be at risk'.

3.11 The President does not refer to a risk to his brother as being a factor in the Tribunal's decision to uphold the detention. The main danger to others would be if MB were confronted by someone whom he thought was one of his persecutors. As MB carried a knife for his own protection (based on the delusional belief that he was at risk from others), there was likely to be a degree of risk to others, but this does not seem to be judged by clinicians as being at the level of a serious risk of fatal harm to others.

3.12 A Mental Health Tribunal decision on 19 Nov 1999 upheld MB's detention; their opinion being that, if he were to be discharged at that time, his health would deteriorate rapidly, and others would be at risk. The report prepared by his treating consultant for the Tribunal on 25 October 1999, refers to the risk of violence to a person if the patient thought that person was one of his persecutors.

3.13 By the time MB came to be discharged from Harrogate, an improvement in his mental state had been observed. The Independent Investigation Team accordingly reached the view that it would not have been appropriate for MB to remain in hospital in order to receive treatment. However, the discharge summary which was sent to MB's GP clearly highlighted areas of concern as MB moved to live in the community.

3.14 In particular, it states that MB was:

'*…* [Suffering] *from a severe mental illness… evidence of a personality disorder…whilst psychotic…a real threat to any perceived persecutors 'Progress': slow and steady ...no insight and was convinced that the persecutory ideas were real…was not agreeable to taking medication reliably…he showed no violence towards others and his behaviour was acceptable…complied with episodes of leave…Although not acknowledging any illness, he did eventually agree to take medication…affect gradually improved…capable of being somewhat cold and distant at times…intensity of his delusions became less prominent, though he continued to believe that his persecutors still existed. The fact that he has little insight into his illness, and that the delusions have not completely disappeared, are a cause for some concern*.'

'*There is a risk that* [MB] *will stop taking his medication and also a possibility that he will use cannabis again. Hence he will be monitored closely with the following package of care: Key worker; Out patients; Drop In Centre; possibility of a community care grant; Medication – Olanzapine 15mg nocte*'.

3.15 However, it appears that at the time of his discharge from hospital there was:

a) No review of the risks that had been identified at the time of his admission, nor in the Forensic Report.

b) The Independent Investigation Team could not find evidence of any discussion as to the extent to which those risks had reduced.

c) There appeared to be no discussion of MB's relapse warning signs.

d) There is no evidence of any discussion with MB about the risks associated with cannabis misuse, nor any consideration of referral to addiction services (or dual diagnosis service, if such a service existed).

e) Significantly, there was no discussion or, indeed, any planning as to any possible course of action that may be taken in the likely eventuality of MB's becoming non-compliant or starting to misuse cannabis (or other illicit substances) again.

3.16 The discharge summary makes it clear that the clinical team considered that non-compliance and cannabis misuse were risks that they had foreseen. Whilst clinicians are limited in the actions that can be taken when a patient in a community setting becomes non-compliant or resumes misuse of illicit substances, the apparent lack of any discussion about these risks and resultant crisis planning before discharge indicates a failure of comprehensive discharge planning.

3.17 There is a significant lack of information relating to the care which MB received in the period following MB's discharge from hospital. However, MB did appear to receive the following:

a) A key worker was appointed to monitor MB's mental state.

b) It was arranged for MB to have out-patient follow up with the psychiatrist who was responsible for his care as an in-patient.

3.18 It is clear that, whilst MB met with his key worker (who was a Forensic Mental Health nurse in the community) following his discharge, no records of these interactions have been provided to the Independent Investigation Team. MB also attended a drop-in centre at this time. Once again, it has not been possible to obtain the records of these attendances.

3.19 However, it is clear that MB did see his GP on 14 April 2000 requesting circumcision. A surgeon who reviewed this request was not prepared to undertake the procedure. It is not clear whether this information was passed to those providing psychiatric care to MB, or whether this could have been considered to be a sign that MB's condition was deteriorating, as MB's relapse signatures had not been identified as part of the discharge planning for MB.

3.20 Had there been a more systematic and detailed approach to discharge planning, with a repeat risk assessment, a more detailed exploration with MB of the risks of cannabis misuse, a discussion of his relapse signatures, and a contingency plan, then those caring for MB in the community, such as his General Practitioner and Community Forensic Nurse, may have been in a better position to assess whether MB required a mental health assessment.

3.21 Was the death of Gemma Simpson predictable?

3.22 The Independent Investigation Team has highlighted several areas of concern regarding the identification of risk, the understanding of MB's presentation, and the management of risk by the teams involved in his care.

3.23 The risk that was predicted was of a risk to others in cases where MB may perceive other people as one or more of the persecutors from whom he believed he would have had to protect himself. Gemma could not have been seen in that light by clinicians and, therefore, her death could not be seen to have been predictable by clinicians.

3.24 Was the death of Gemma Simpson preventable?

3.25 From the limited evidence which was available to the Independent Investigation Team, it appears possible that, if MB had been fully compliant with anti-psychotic medication and had refrained from misuse of cannabis, then he may not have suffered from a relapse of his psychotic illness. In these circumstances, the death of Gemma Simpson might have been prevented.

3.26 At the point of discharge, staff were aware that MB's delusions had not fully remitted; that he lacked insight; that there was a risk of non-compliance with prescribed medication, and; of a return to substance misuse. There was, therefore, a risk of a significant exacerbation of his delusional thinking because of these factors, and a return to the level of risk seen at the time of his initial admission, even if the risk to Gemma could not reasonably have been foreseen.

3.27 However, notwithstanding the failures in service provision outlined in this report, there were no actions that clinicians could have specifically taken to enforce the continuation of medication given MB's presentation in May 2000, nor to enforce his abstinence from cannabis.

3.28 In 1999/2000 there was provision within the Mental Health Act 1983 for aftercare under supervision. The relevant provisions are set out in Section 25A of the Act (as was). These provisions were repealed by the 2007 Act and replaced with Community Treatment provisions. The Act provided as follows;

'(4) A supervision application may be made in respect of a patient only on the grounds that—

(a) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment;

(b) there would be a substantial risk of serious harm to the health or safety of the patient or the safety of other persons, or of the patient being seriously exploited, if he were not to receive the after-care services to be provided for him under section 117 below after he leaves hospital; and

(c) his being subject to after-care under supervision is likely to help to secure that he receives the after-care services to be so provided.'

3.29 However, the powers of section 25A were limited, which is one of the reasons that this section was replaced by Community Treatment Orders (see comment 8). CTOs allow a clinician to recall a patient to hospital to receive treatment, which was not possible under section 25A. Individuals subject to the former were liable to be conveyed to a suitable place where a formal Mental Health Act assessment could be undertaken to determine whether they needed to be detained once more. However, they were not subject to the possibility of formal recall to the same section of the Act under which they were previously detained, without the need for a full new assessment, as are those now placed on a CTO.

3.30 <u>Changes in service delivery since 2000:</u>

3.31 A significant amount of learning which has been identified in relation to the care of MB has already been addressed in the considerable legislative changes and changes in the structure and manner in which care is now delivered by the NHS.

3.32 The Independent Investigation Team is of the view that the following changes in practice may reduce the risk of a similar tragic outcome such as the death of Gemma Simpson occurring in the future:

- Introduction of Crisis Resolution Home Treatment ('CRHT') teams - Such teams, if properly constituted, can provide a 7-day week/24-hour service to patients at the time of discharge. Staff can visit patients in their homes and put in place systems to monitor and encourage compliance. This would have made a difference in MB's care, as any signs of a possible relapse could have been monitored and, if necessary, actioned.

- Dual diagnosis service - There was no evidence that staff attempted to influence MB's propensity to misuse cannabis. The availability of trained staff, or a specific service for patients with mental illness and substance misuse, would have enabled this problem to receive much more attention than it did.

- Personality Disorder service - Whilst the risk which MB posed was driven primarily by the psychotic process, a more rigorous approach to the diagnosis and management of a potential co-morbid personality disorder may have informed MB's discharge plan and subsequent care following his discharge from hospital.

- A more systematic and comprehensive approach to risk assessment and management, including the development of the Care Programme Approach.

- The amendment of the MHA 1983 to provide a vehicle for clinicians to recall patients to hospital in certain circumstances should they cease taking medication.

- Clinical guidance issued by NICE to inform and support clinicians to deliver evidence-based care.

- The implementation of the Care Programme Approach.

3.33 Recommendations:

3.34 The Independent Investigation Team has made two recommendations. These relate to the difficulties which the Independent Investigation Team and NHS England had in locating MB's original records.

3.35 Recommendation One:

The Tees, Esk and Wear Valleys NHS Foundation Trust ('TEWV') reviews its procedures concerning the provision of medical records to investigative and regulatory bodies including the Police, General Medical Council and Nursing and Midwifery Council, with a view to being able to ensure the return of any original records provided to such bodies at the end of those proceedings.

3.36 Recommendation Two

3.37 Given the considerable impact which the absence of a legible and complete set of records relating to MB's care has had upon the Independent Investigation into his care and treatment, the Independent Investigation Team is of the view that MB's case raises a significant issue for all NHS Trusts.

3.38 There are a number of organisations with statutory responsibility to investigate specific types of incidents which may involve the delivery of healthcare and therefore can coincide with serious incident investigations led

by the health service. It is essential that the interfaces between these organisations do not create a barrier to the investigation of serious incidents due to the loss of records or key information contained within those records.

3.39 *Accordingly, it is recommended that NHS England issue guidance to Trusts to highlight that Trusts comply with their legal duties and internal policies relating to records management to ensure that the whereabouts of original NHS records are known and that upon completion of investigations carried out by other statutory bodies, that the notes are tracked and returned to the NHS.*

3.40 The Trust which provided care to MB is no longer in existence. Therefore, any recommendations regarding the delivery of care by it would appear to be redundant. TEWV, the Trust which would now be responsible for MB's care, were not involved in MB's discharge from Harrogate. However, the Independent Investigation Team recognises that discharge planning which is the subject of criticism in this report remains an issue of concern highlighted in the CQC despite a number of initiatives. These initiatives are discussed in Sections 8 and 10 of this Report.

4. FAMILY STATEMENT

4.1 In order to give Gemma Simpson a voice in this investigation and to allow members of Gemma's family to express how her death has had an impact upon their lives, the Independent Investigation Team asked Gemma's family to explain their loss. They responded as follows:

'*This statement is an attempt to quantify the massive amount of damage, hurt and distress caused to our family by the loss of Gemma*.

'*Our Gemma raised a smile in every room she entered, she was a young woman in the prime of life with decades in front of her. She was a daughter, sister, aunt, cousin to us and a true and loyal friend to so many, we are left with broken hearts feeling that we would be better off had MB not come forward and we were still living in hope that she was still alive*.

'*When a loved one is missing, no matter for how long, a family is left in a state of uncertainty and worry. MB left our family in complete limbo for 14 years - 4,980 days, almost 5,000 days of pain, worrying and fear for Gemma and her well-being. Not knowing the whereabouts of a loved one isn't something that a person thinks about once or twice a day, it becomes an integral part of their whole life, it is a constant shadow and a chill in the heart that never leaves and is with them from waking in the morning to closing their eyes at night*.

'*As a grieving and stunned family, we were deeply hurt further by the tactics of Gemma's killer in an attempt to evade the sentence that we believe he truly, deserves. We are not stupid people. Please consider that MB was in control of himself enough to carry on, for 14 years, with his own life and the building of a family. His family are also his victims*'.

5. QUALITY OF MEDICAL RECORDS

5.1 The Independent Investigation Team's primary source of information about MB's care was the copy set of medical records which was provided to it by TEWV, and MB's GP.

5.2 The main purpose of any clinical record is to provide continuity of care, but medical records also form the basis of investigations into the standard and quality of care provided to an individual such as MB. This is particularly the case where the events which are the subject of investigation took place some years ago.

5.3 As a result of the passage of time, individuals' recollections of events will be diminished or cannot be relied upon accurately without recourse to the contemporaneous notes which they made at the time that care was delivered. If this information is missing as an aide memoire, the value of individuals' recollections of events which took place more than 16 years ago is called into question.

5.4 MB's care took place at a time when electronic records were being gradually adopted across the NHS. As is typical of the period when MB received care, MB's records consisted of paper records.

5.5 <u>Original records:</u>

5.6 Whilst NHS England North made significant efforts to obtain MB's original paper records in an attempt to improve the quality of information available to the Independent Investigation Team, the original notes could not be located.

5.7 As a result, the Independent Investigation Team has been significantly hampered in their investigation of MB's care by the quality of the copy set of MB's records which were made available to it. The copy records appear to be incomplete in that numerous episodes of interactions by clinicians with MB appear to be undocumented or indeed are missing and there are difficulties with legibility due in part to fading of entries, resulting in poor or illegible photocopies being produced.

5.8 This has particularly impacted upon the Independent Investigation Team's consideration of MB's care following his admission to Harrogate during the eight-month period between 26 August 1999 and 13 March 2000.

5.9 Content of available records:

5.10 A further issue relates to the quality of the content of the records which do exist. For example, nursing records in relation to MB's admission to Harrogate are of poor quality in terms of their content. There are many dates when there appear to be no nursing entries at all (for example 3-8 September 1999, 18-22 September 1999, 2-8 October 1999, 13-18 October 1999, 12-18 November 1999, 22 November-2 December 1999, 9-15 December 1999, 16-23 December 1999, 17-27 February 2000). In addition, the nursing notes which do exist are consistently poor in terms of the information which they record and also in terms of the level of detail which is included, even if judged by the standard of records which were maintained at the time.

5.11 Crucially, following MB's discharge from hospital, there is very little information available concerning his ongoing care as an out-patient at Harrogate. It is unclear whether this is a feature of the original records being of poor quality and so relevant clinical information simply was not recorded or whether an incomplete copy set of records was provided to the Independent Investigation Team. Without access to the original records, this cannot be clarified.

5.12 Whichever explanation is accurate, the outcome is that limited information outside that which was contained in MB's GP records was available to the Independent Investigation Team concerning this crucial time period.

5.13 This is clearly not ideal as it does not allow a full picture of MB or his care and treatment to be obtained in relation to the time immediately preceding the death of Gemma Simpson.

5.14 As a direct result of the poor quality of medical records, it has not been possible for the Independent Investigation Team to establish a secure factual basis for the investigation. Without a secure factual basis to the investigation, the depth of analysis which can be undertaken is impeded and the resultant learning is therefore diminished.

5.15 Data loss has significant consequences within the healthcare system; not only is this a breach of security, it can also affect an individual's healthcare by providing incorrect information and can affect the accessibility of information which may be vital to the management of ongoing healthcare needs.

5.16 The Serious Incident Framework states;

"Serious Incidents in the NHS include:

- *… An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:*

- *Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues...*[1]*"*

Comment 1:

The Independent Investigation Team has identified significant issues in relation to records which have been provided to it in relation to MB's care.

As a direct result of the poor quality of medical records, it has not been possible for the Independent Investigation Team to establish a secure factual basis for the investigation. The lack of information available to the Independent Investigation Team has also had a direct impact up the consideration of the issue of whether the death of Gemma Simpson was predictable or preventable.

Good clinical records are essential if good quality evidence-based healthcare is to be delivered, particularly where a multi-disciplinary team of clinicians is responsible for delivering patient centred care. Unless everyone involved in clinical management has access to the information they require, duplication of work, delays and mistakes are inevitable.

The main purpose of any clinical record is to provide continuity of care, but medical records are also used for other important purposes including:

- Assisting in clinical audit in order to promote learning.
- Administrative and managerial decision-making within the NHS.
- Supporting improvements in clinical effectiveness through research.
- Responding to legal bodies including coroners and other investigative bodies.

Significant practical, legislative and regulatory changes have been made to enhance and improve the nature and content of medical records since 2000.

There have been a number of initiatives both at a national level aimed at NHS organisations and at an individual level through the various regulatory bodies which are involved with healthcare professionals to improve the quality of medical records and the ease by which they can be retrieved.

Records may now be held electronically or manually, or a mixture of both. Records must be retained securely and must be capable of being located at all times.

The Department of Health defines a care record as *'a paper or electronic-based record which contains information or personal data relating to a person's care.'*

1. [1] *Serious Incident Framework, NHS England 2015 p.15*

There have been a number of initiatives by the NHS to improve record keeping at an organisational level. For example, the Essence of Care[2] (first published by the Department of Health in 2010) aimed to ensure that:

- Patients were able to access their care records in a format that meets their needs.
- Patients are able to have a single, life-long multi-professional and multi-agency (where appropriate) care record which supports integrated care.
- Patient care records demonstrate that their care is evidence-based.
- Patient care records are safeguarded.

The introduction of electronic record systems will also be of benefit in this regard. A number of initiatives have been undertaken with regard to electronic records. For example, NHS England now requires hospitals to send in-patient and day case discharge summaries to GP practices electronically. As of 1 October 2015, discharge summaries can no longer be sent by post or fax.

As part of enabling information sharing across care settings, the 2016/17 NHS England Standard Contract required providers to implement the Academy of Medical Royal Colleges ('AoMRC') headings by 1 December 2016 when sharing in-patient and day case eDischarge summaries. The AoMRC headings describe standards for the structure and content of patient records. The headings have been developed using published evidence and consultation with doctors, patients, nurses and allied health professionals.

In addition to the responsibility of organisations, healthcare regulators have taken steps to address the individual responsibility of healthcare professionals with regard to healthcare records.

This view is supported by the Nursing and Midwifery Council ('NMC'). The NMC was established under the Nursing and Midwifery Order 2001 and came into being on 1 April 2002.

The NMC regulates nurses and midwives in England, Wales, Scotland and Northern Ireland. It sets standards of education, training, conduct and performance for nurses and midwives.

The NMC has been active in setting the guidelines for nurses in relation to the standard of record keeping. Guidelines such as Nursing and Midwifery Council guidelines for records and record keeping 2009, for example, have been issued and updated.

Allied professions, and indeed the General Medical Council have also been active in issuing guidance to professionals and working to enforce a higher standard of record keeping amongst healthcare professionals.

[2] Department of Health. Essence of Care 2010; Ref 14641

Record Management:

Given the significant practical, legislative and regulatory changes have been made to enhance and improve the nature and content of medical records, the Independent Investigation Team believes that the NHS and the professionals working in it have already made changes at an individual and organisational level to improve the quality of medical records.

Record keeping is distinct from records management. Records management is the process by which an organisation manages all the activities associated with records.

All NHS Trusts have a legal duty to make sure records are managed from the moment they are created, to the moment they are destroyed or placed in special deposit for permanent archive. In this case, MB's records were not created by TEWV, but were transferred to the Trust following mergers between Trusts actively involved in his care and treatment. Due to the passage of time since MB's care, his records were held in paper format.

All NHS records are public records under the terms of the Public Records Act 1958 and as such all Trusts have a duty to make arrangements for the safe keeping, maintenance, archiving and eventual disposal of all types of records.

MB confessed to the killing of Gemma Simpson on 8 July 2014. At the time of MB's arrest, TEWV provided the Police with the original set of MB's paper records. Whilst the Trust retained a copy set of the records, the copy set was of poor quality due in part to the manner in which the photocopying process had been conducted. It has not been possible to locate MB's original records resulting in a loss of 'personal data' as defined by the Data Protection Act 1998 and with a potential impact upon MB's ongoing care.

TEWV had in place at the time of MB's arrest a policy entitled 'Records Management Policy' dated March 2014. The TEWV Records Management Policy states

'*Records must be managed throughout their lifecycle: from the moment they are created to the moment they are destroyed. The main elements of records management are:*

•*They must be kept secure at all times to prevent breaches of confidentiality;*

•*They must be managed so they are always available when needed*'

TEWV Records Management Policy provides the following advice with regard to the disclosure of records and information:

• Original records must never be released unless exceptional circumstances exist and then they must be tracked and their return ensured.

• The steps to be followed when moving records are documented in the Trust's records management procedures.

The Trust has sought to enforce adherence to this policy by the inclusion of the following disciplinary measure:

'*Breaches of this policy will be investigated and may result in the matter being treated as a disciplinary offence under the Trust's disciplinary procedure'.*

Given the lack of clarity surrounding the current location of MB's original records together with the significant impact which the loss of information has had on the ability of the Independent Investigation Team to investigate this matter potentially leading to a loss in public confidence in the lack of scrutiny which has resulted following a serious incident, the Independent Investigation Team would recommend that:

TEWV reviews its procedures concerning the provision of medical records to investigative and regulatory bodies, with a view to being able to ensure the return of any original records provided to such bodies at the end of those proceedings.

6. MB - BACKGROUND

6.1 This section of the Independent Investigation Report is intended to provide background information about MB. It is compiled from information contained within his GP Records.

6.2 MB was born in Harrogate on 28 July 1969.

6.3 MB was raised by his mother who was of Irish descent. MB said that his father would beat his mother. MB's parents divorced before he was born. MB was the youngest of three male siblings. MB has said that he had experienced abuse from his mother. His mother is now dead, and he lost contact with his brothers around the time of her death which was in 2012 when MB was 43.

6.4 MB said that he started being *'naughty*' around the age of eight. He said he would steal and would smoke cigarettes.

6.5 On 1 November 1982 when MB was 13 years old, following concerns that his mother had raised as a result of a two-year period in which MB had been stealing, MB's GP made a referral for him to Child and Adolescent Psychiatry. According to the GP's referral letter, other than MB stealing and expressing '*…little or no remorse…*' MB's GP knew of '*… no predisposing factors from the past and he is normally quite healthy*'.

6.6 Following a consultation with MB on 20 December 1982, a report to MB's GP by Child and Adolescent Psychiatry, stated that '*Apart from the stealing…*' MB '*…presents with no other problems*'. The diagnosis made was one of '*Disocial* (sic) *behaviour without manifest psychiatric disturbance*'. MB's mother was reassured by the Consultant who reviewed MB that he '*…did not feel MB was psychiatrically ill…*'

6.7 Following a period of follow-up care, MB was discharged by Child and Adolescent Psychiatry services back to the care of his GP owing to '*…no further stealing episodes…nothing new had come to light… the absence of other disturbance*'.

6.8 When he was 14, in or around 1983, MB was involved in glue sniffing had '*few friends*' and he was '*Unable to mix with fellow pupils…rejected and isolated*' and held '*generally poor relationships*'.

6.9 In July 1984, when he was 15, MB spent time at a Community Home which housed boys with '*behavioural*' problems. MB was discharged from the Community Home to the care of his mother in 1985. Unfortunately, the referral sheet for the Community Home does not document the issue which led to his referral. Similarly, the admission and the discharge sheet do not record the reason for admission, or the '*status*' of MB on discharge.

6.10 MB left school aged 15 with one GCSE. After leaving school MB attended Technical College. He left without completing his course.

6.11 MB moved in with his brother who lived in Leeds when he was 16. He undertook a number of unskilled jobs. At around the age of 18, MB moved back to Harrogate and worked in an Italian restaurant for a two-year period. He also developed an interest in the occult.

6.12 Between 1985 and 1999, MB did not come to the attention of secondary mental health services apart from a single assessment by a Registrar in Liaison Psychiatry on 22 June 1992, when MB was 23. This assessment arose following an overdose of paracetamol taken by MB.

6.13 The Registrar who reviewed MB's presentation at this time concluded that this was:

'[An] *impulsive overdose of 92 paracetamol. The circumstances of this episode were that he was having problems with his girlfriend, and was worried about imminent court appearances…He did not have any psychiatric illness and we agreed that there was no need for psychiatric follow up'*.

6.14 When MB was about 21 and Gemma Simpson was 15, they met for the first time. They started spending time together. MB stated that he engaged in crime to impress Gemma. He said he would steal cars, burgle houses, and that he engaged in credit card fraud. He said that he and Gemma had a '*spiritual connection*'. He admitted to being attracted to her.

6.15 MB has said that as a consequence of the crimes he had committed in order to impress Gemma, he went to prison at the age of 21 for approximately 10 months. He stated that he was convicted of burglary, deception (credit card fraud), and stealing cars. The Independent Investigation Team has not been able to verify the accuracy of this information which was provided to the Court during MB's trial.

6.16 Following his release from prison, MB attempted to start a career in catering. When he was 25, he got married. The marriage broke down and there were suggestions that the relationship became violent. After the marriage ended MB moved back to Leeds, living in bedsits.

6.17 When he was 30, MB said that he started to believe that people were trying to find him in order to attack him. He referred to these people as '*gangsters*'. He said he started moving around the country to different places but that each time he felt that his 'pursuers' would find him

6.18 After a period of doing this, MB handed himself into the police. MB was in London at the time and was carrying a knife for his own protection. Following mental state assessment in Holborn police station, MB was detained for further assessment at Grovelands Priory Hospital, London. MB was then transferred to Harrogate for continuation of his treatment.

7 ADMISSION TO HOSPITAL IN LONDON 17 AUGUST 1999

7.1 On 17 August 1999 MB presented at Holborn Police Station ('Holborn') in London. Concerns were raised about his mental health. The Independent Investigation Team does not have access to police records relating to MB's attendance at Holborn. However, it appears that officers were sufficiently concerned about his presentation to request mental health assessment.

7.2 An application by an approved social worker for admission for assessment was completed. A mental health assessment by two medical practitioners approved under section 12 of the MHA 1983 was also carried out. Both concluded that:

'*He presents with persecutory delusions, delusional perception, paranoia, disturbed sleep and lack of insight. He is carrying a knife for fear of his safety. He tries to rationalise his behaviour but his explanation lacks coherence & consistency. He needs full assessment in hospital which he refuses*'.

7.3 MB was formally detained for assessment under section 2 of the MHA 1983, at the Grovelands Priory Hospital, London.

7.4 At the time of MB's assessment, the test which was applicable for detention in hospital in accordance with section 2 of the MHA 1983 was:

a) The patient is suffering from a mental disorder of a nature or degree which warrants detention of the patient in a hospital for assessment (or assessment followed by medical treatment) for at least a limited period, and;

b) He ought to be so detained in the interests of his own health and safety or with a view to the protection of other persons.

7.5 An order made under section 2 of the MHA 1983 lasts for a period of 28 days. Accordingly, MB's section 2 order would have expired on 14 September 1999[3].

7.6 <u>Initial assessment:</u>

7.7 During his initial assessment upon admission to hospital, it was noted that MB had no forensic history of violence, or violent crimes, or that he had any ideation of harming others – unless in self-defence, and that his thoughts were of a persecutory delusional nature. There was acknowledgement of dissocial personality traits, possibly a dissocial personality.

[3] Section 2 of MHA 1983 is set out in Appendix 5.

7.8 Clinical records made during admission record MB's reasoning for the circumstances which led to his admission:

'*…13 years ago went to the pub in Leeds…approached by 4 black men who "pulled knives" & threatened to rape him if he did not leave his GF* (sic)*. He left the pub…3 years ago met this girl again and started relationship "didn't remember her…she didn't remember me at first" She remembered me when she saw me with my brother. She told some local lads and they came around with baseball bats to do me over but I knew she knew more so as she remembered more I did…she told them I tried to help her and they left me..*(sic) *they said someone had to pay & gave me a year to do over my brother…started seeing people outside my* [mother's] *house – believed they were after him…wouldn't go out of house…went to Edinburgh…gang member returned to* [mother's]*…came to London, stayed in hostel – 4 men watching hostel, tried to escape from them on tube…presented…to police station had 6" blade on* (sic) *possession "for self defence"* (sic)*…*'

7.9 Clinicians made the observation that '*…The possibility of a drug induced psychosis is high. He has no Schneiderian symptoms suggestive of Schizophrenia*'.

7.10 Following MB's initial examination on 17 August 1999, a provisional diagnosis was recorded as '*…acute psychotic episode*'. However, it is clear that staff were concerned about the relevance of MB's cannabis misuse to his presentation. Cannabis use is recorded as '*not really*' and then '*sometimes 2-3 joints daily*'. There is a separate note, recorded after this examination which appears to have obtained collateral information which indicates that MB was smoking '*skunk*' around the time of his admission.

7.11 The possibility of a drug induced psychosis was mooted, a drug screen was ordered, and regular anti-psychotic medication was not prescribed. Instead, MB was prescribed droperidol and lorazepam. These are short acting anti-psychotic (droperidol) and anti-anxiety (lorazepam) medications that were to be used '*as required*' in the case of acute disturbance or severe anxiety, but the care plan was that MB was to be observed medication-free if possible.

7.12 A plan was formulated: '*1 to carry out random drug screens until MB is drug free (MB to be fully informed of this) 2 for further psychiatric assessment when he's drug free … 1900hrs… He agrees to random drug screens*'.

7.13 A drug-induced psychosis may persist for many months, usually influenced by the duration and frequency of abuse and the type of substance(s) abused. The use of cannabis, especially '*skunk*', is particularly associated with the development of psychosis – MB admitted to smoking skunk, see above.

7.14 In everyday clinical practice, it can be difficult to distinguish between:

a) Psychosis induced by drugs (psychosis would not have occurred but for the use of the substance, and will remit and not recur when the patient stops using the substance);

b) Drug precipitated psychosis (the person would have developed psychosis even in the absence of drug use, but the actual psychotic episode was precipitated by an episode of drug misuse), and;

c) Psychosis exacerbated by drug misuse (the person has a diagnosis of psychosis, but episodes are made more severe, more frequent and longer-lasting by the concurrent misuse of the illicit substance).

7.15 The approach taken on 17 August 1999 when assessing what treatment MB would require, was to attempt to exclude a drug induced psychosis as the cause of his presentation.

7.16 It appears that those responsible for MB's care were initially optimistic that his psychotic symptoms would remit quickly in the absence of illicit substance misuse and that anti-psychotic medication would not be required.

7.17 <u>Ongoing care in Grovelands:</u>

7.18 Consistent with this approach, on 18 August 1999, it was decided to conduct a fuller assessment of MB in a drug free state following MB's confirmation that he smoked cannabis. His use had been discussed and it was found that '*…depends on finances will not quantify can use 1/8 ounce in a week. Can have weeks when he has none. Experimented* [with] *drugs in youth. None for 7 years – LSD; cocaine; speed; ecstacy (sic) but claims there were all 'one offs' Never IVI Heroine* (sic)'.

7.19 However, during his admission to Grovelands, MB refused all but one Urine Drug Assessment. This test appears to have been conducted on 17 August 1999 and proved positive for cannabis.

7.20 On 19 August 1999, it was said of MB that he '*… does feel well, his thoughts are clearer…prior to his admission he took drugs which made him feel the way he felt on admission…*'

7.21 However, on 20 August 1999, MB was re-assessed because he was very agitated and appeared to be actively psychotic. Following discussions by clinicians, he was prescribed the anti-psychotic medication olanzapine. Whilst it is not explicitly stated in the records, it appears that MB's delusional beliefs at this time led clinicians to believe that MB had an underlying psychotic illness: (schizophrenia or delusional disorder), and that his symptoms were not solely due to his misuse of cannabis.

7.22 Whilst admitted to Grovelands, MB presented as polite but guarded. It is recorded that he did not make any attempts to leave. MB occasionally interacted with other patients but was reluctant to fully engage with staff. Indeed, he would be talkative and friendly one minute, but quiet and reclusive the next. MB appeared to be isolative and spent a lot of time sleeping.

7.23 MB underwent a detailed mental state examination on 22 August 1999, when a number of paranoid and grandiose delusions were elicited, including the delusion that he would be made to kill his brother by his persecutors.

7.24 During the course of his admission to Grovelands it was noted that MB was:

'*…*[Holding] *his persecutory delusions with less rigidity'* although he consistently remarked that he felt unsafe in Grovelands and that he believed his *'persecutors'* knew of his admission, and that *'…Re plot to kill brother still feels that his killing of his brother will not be his decision. Will do it of own volition but after being directed by his persecutors*'.

7.25 On 26 August 1999 MB was transferred to Harrogate where he could receive care and treatment nearer his home.

7.26 In a note of 26 August 1999 relating to the transfer of MB from Grovelands to Harrogate, MB's medication is recorded as '*Olanzapine 10mg nocte*' and his diagnosis was '*…persistent delusional disorder …*'. MB was stated to be detained in accordance with section 2 of the MHA 1983 but it was suggested '*…possibly conversion to section III …*' The issue of MB's misuse of illegal substances is not mentioned, although it is recorded that '*…He has consistently refused blood testing, urine testing and physical examination…*'

7.27 The note also states that MB presented with:

'*…*[Complex] *delusional system involving a plot to kill his brother in order to prevent a bounty killing of himself by his 4 persecutors. He remains guarded and paranoid…He will need forensic opinion re his plot to kill brother…his mental state has remained unchanged. In view of his delusions, the fact that he was armed with a knife…I feel that* [MB] *is a high risk of harm to others…*'

7.28 This '*handover*' provides crucial information for the continuation of care, treatment and management of a patient when their care is transferred.

Comment 2:

MB was admitted to Grovelands for a period of nine days. During this time, care was arranged for MB closer to his home. At the time of transfer, clinicians in London '*flagged*' information which had been elicited from MB during his admission and which was of clinical relevance in order that it could be explored in order to determine its relevance to MB's presentation and ongoing care.

The discharge note was detailed and provided suggestions for MB's ongoing care including a suggestion that ongoing detention might be necessary and that a forensic psychiatric opinion would be of value. In addition, clinicians '*flagged*' that there was a risk to others in MB's presentation at that time. MB's GP was also told this information in a Discharge Summary date 4 October 1999. This represents evidence of good practice.

8. HARROGATE DISTRICT HOSPITAL

8.1 MB received in-patient care in Harrogate between 26 August 1999 and 13 March 2000. He continued to receive out-patient care until approximately 12 April 2001.

8.2 At the time of MB's care in the Briary Wing at Harrogate, Harrogate Health Care NHS Trust was responsible for the Briary Wing.

8.3 The Briary Wing continues to provide mental health services within Harrogate. There have been significant reconfigurations of mental health services in the Harrogate area since 2000. The Briary Wing has been managed by more than one Trust since this time.

8.4 TEWV provides a range of mental health, learning disability and eating disorder services across a large geographical area including the Tees Valley, Scarborough, Harrogate, Hambleton, Richmondshire and the Vale of York.

8.5 In June 2011, TEWV took over the contract to provide mental health and learning disability services to Harrogate.

8.6 TEWV now have responsibility for the management of the Briary Wing in Harrogate. However, TEWV do not have responsibility for the management of Harrogate, despite providing mental health services in the Briary Wing. Harrogate is in fact managed by Harrogate and District NHS Foundation Trust.

8.7 TEWV were not responsible for mental health services in Harrogate at the time of MB's care.

Comment 3:

Due to substantial service reorganisation and configuration, the Trust which provided care and treatment to MB, no longer exists and therefore any recommendations which the Independent Investigation has made cannot impact upon the delivery of care by that Trust.

9. ADMISSION TO HARROGATE

9.1 MB was admitted to Harrogate on 26 August 1999. Upon arrival at Harrogate, MB remained unwell and was noted to be floridly psychotic. He did not actively attempt to leave hospital. On 1 September 1999, he was noted to be delusional and had no insight.

9.2 On 6 September 1999, it was noted that:

'*He's stopped medication…Needs to make sure he is safe. Denies that he may be a risk to anyone. Does not feel frightened here in Harrogate. Feels staff are overconcerned* (sic) *Refuses to take medication. Referred to Forensic Consultant Psychiatrist for forensic assessment*'.

9.3 MB's section 2 order expired on 14 September 1999. At this point, he would have been free to leave hospital. However, on 21 September 1999, MB was detained for treatment under section 3[4] of the MHA 1983. The factors precipitating MB's detention under section 3 on the 21 September 1999 were the fact that when admitted to Harrogate, MB's persecutory delusions continued and he '*…denied he was ill, did not want to take medication, and wished to leave the Hospital*'.

9.4 An indication of the concerns about the risks posed by MB at this time was that an assessment by a Forensic Consultant Psychiatrist was requested.

9.5 The Forensic Consultant Psychiatrist concluded that MB was:

'[Clearly] *suffering from a mental illness, either schizophrenia or delusional disorder…*

'…*recommended that MB be detained under s3 Mental Health Act 1983 as he would be unlikely to accept treatment voluntarily*…

'*…it is likely that he also suffers a personality disorder*'.

9.6 The criteria which had to be met in relation to a section 3 detention at the time was:

a) Suffering from a mental illness and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; and,

b) In the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition; and,

c) It is necessary for the health or safety of the patient or for the protection of other persons that should receive such treatment and it cannot be provided unless he is detained under this section.

[4] Section 3 of the Mental Health Act 1983 is set out in Appendix 5.

9.7 An individual can be detained for up to 6 months under section 3 of the MHA 1983. Detention under section 3 can subsequently be renewed for a further 6 months. After that, detention can be renewed for further periods of one year at a time provided detention is justified.

9.8 The individual has the right to appeal against detention to a Tribunal once within each detention or renewal period, i.e. once during the first six months of detention, once during the next six (if renewed) and once a year if detention is renewed. The individual has the right to apply for discharge to the Hospital Managers at any time whilst they are detained.

9.9 In addition, once a patient has been detained, it is important to remember that their detention must continue to be justified by their condition. The validity of continued confinement is contingent upon the mental disorder's persistence.

9.10 From the records which are available to the Independent Investigation Team, it appears that MB challenged his detention on the following occasions:

a) 8 October 1999 Hospital Manager's Review of Detention.
b) 19 November 1999 Mental Health Review Tribunal (appeal against detention for treatment under section 3.

9.11 The Independent Investigation Team understands that the Tribunal agreed with the reports compiled by clinicians in relation to the 19 November 1999 Tribunal hearing and in particular that MB was:

'*…*[Suffering] *from mental illness, characterised by delusional beliefs…his perception & interpretation of the events have been distorted by his illness…the use of illicit drugs has exacerbated his condition…we are not convinced that he would accept medication if discharged…we agree that the section should continue so that the trial of medication & his reaction from* (sic) *be monitored…if discharged now, his health would be likely to deteriorate rapidly & if he perceived that others might try to abduct him, they would be at risk*'.

9.12 Consequently, the decision of the Tribunal was that MB's detention was upheld.

Comment 4:

MB's detention under section 3 of the MHA 1983 demonstrates that at the time, those involved in MB's care were concerned that MB should remain in hospital until he responded to treatment.

It also demonstrates that those caring for MB were confident that criteria for detention were, at that time, satisfied.

10. PROGRESS IN HARROGATE HOSPITAL

10.1 Psychiatric diagnosis is an active process in which history, symptoms and behaviours are evaluated against standard criteria.

10.2 MB's records make reference to a number of diagnoses indicating that an active review process was being adopted by clinicians in Harrogate.

10.3 There was a consistency of opinion that MB had symptoms of psychosis. At different stages of the in-patient admission, the psychotic symptoms were attributed to:

a) Drug induced psychosis;

b) Schizophrenia; and/or,

c) Delusional disorder.

10.4 However, MB's presentation appears to have proved problematic for those responsible for his care. He consistently presented as guarded, and frequently refused to agree to be interviewed. This would have presented clinicians with significant difficulties in establishing a therapeutic relationship and potentially denied them access to clinically relevant information about MB.

10.5 The table below illustrates the difficulties which clinicians encountered in establishing a therapeutic relationship and obtaining clinically relevant information due to his non-engagement:

Date	**Remarks**
26 August 1999	*Mental State Examination* *Dressed casually, leather jacket. Good level of hygiene. Appeared guarded, suspicious illegible* *obtuse and difficult but good illegible…* *……content illegible belief of persecution* *Does not believe he has any illegible* *Understands he is undersection of MHA … Not actively trying to leave* *Plan 1.Olanzapne 10mg illegible* *2 to be reviewed by …tomorrow*
1 September 1999	*…Still delusional…No insight remainder of entry illegible*
8 September 1999	*He's stopped his medication. Does not require them Need to make sure he is safe Denies that he may be a risk to anyone. Does not feel frightened here in Harrogate. Denies "Four men from Leeds" Feels staff are overconcerned (sic)Refuses to take medication* *Plan after …illegible…escorted leave with staff only* *Refer to …Forensics*

21 September 1999	*Mental Health Act Assessment* *Detained under Section 3 of the Mental Health Act for treatment of his psychiatric illness…remainder of entry illegible*
23 September 1999	*…Section III appealed…Refuses to take medication states he is well & does not require medication. States he has co-operated fully apart from with medication I/V refused* *Plan if refuses oral medicine then needs im*
27 September 1999	*Not well…refuses to take medication…Upset cannot get off ward. Refused to attend ward round* *Plan s17escorted leave with staff 1 hour*
30 September 1999	*refused Haloperiodol ?reaction* *Also refused Zuclopenthixol. Still thinks he is well and does not require. Refuses to be seen.*
4 October 1999	*Taking medication now for 4 days* *Olanzapine 10mg… looking for flat in Harrogate . To see solicitor today. Illegible Plan … 30min unescorted leave per day + 1 hour escorted leave Section III upheld*
11 October 1999	*Management review declined* *More relaxed … Tribunal 19/11/99* *Taking medication* *No fixed abode at present* *Asleep* *Remaining entry illegible*
14 October 1999	*Spending a lot of time illegible Eating sleeping… A little guarded at times… States no longer illegible … and plans to go to New Zealand after discharge. .Refuses to be seen this morning*
18 October 199	*Sense of humour returning more relaxed … refuses to get up illegible …..refuses to be seen*
21 October 1999	*… Much warmer in his affect…* *Still maintaining that the girl was raped ……. illegible* *…Says he feels comfortable out with staff now*
28 October 1999	*Illegible …..* *… Feels safer in hospital … illegible* *Now more open….illegible ……. for years* *Agreed …illegible* *Wants to start back at the …illegible*

1 November 1999	*Feels ok - … Felt comfortable in town "because I haven't seen anyone" Still believes "they" must know he's been here but may be leaving him alone now because he went to the police and if anything should happen to him in Harrogate the police will know who is to blame…Still convinced he saw the gang members in Edinburgh* *Continue illegible meds Section 17 illegible*
8 November 1999	*… quiet not as forthcoming … ↑ [increase] Olanzapine to 20mg … 'seen alright'…still believes that people wanted to abduct him 'fed up of this place' … needs to use 2hr (sic) leave appropriately*
11 November 1999	*Took meds (sic) last night without any problem. Still maintains not ill* *Section 17 Rescinded … i/v refused* *Plan continue*
15 November 1999	*Has been complying…medication* *Back in illegible using his computer* *i/v refused* *Seen alone 'alright' …* *Sleeping well* *Spending a lot of time ….illegible…. computer* *taking medication regularly though he believes that it's not having any effect* *To continue*
18 November 1999	*Now taking medication regularly … Is more open today… illegible….* *Illegible* *'Just remembered the illegible…his life when he was …Harrogate just before fleeing to London in fear of his life…* *Says he now feels safer because the police are aware of the names of the 4 persons in Harrogate who were a threat to his life* *He believes these 4 persons …illegible threat police are aware and …..remainder of entry illegible*
22 November 1999	*…much the same cold to staff …spending time on his computer keeps to himself. Not seen his door is locked*
25 November 1999	*Continues … on 20 mg Olanzapine* *Goes to bed …illegible* *… keeps himself to himself* *Plays on computer* *…Locks his door. Little interaction* *i/v refused*

29 November 1999	*The same has been complying illegible … medication & section 17…illegible…….Allow overnight leave…illegible* *'I feel fine' No problem … with medication appears to be improving.* *No alcohol illegible …advised continue*
2 December 1999	*Same complying* *Overnight leave today continue*
6 December 1999	*… Leave went well. Kept to s17 restrictions … Attending the gym and illegible* *i/v would like u/n no side effects from meds …not interest=ted in gaining access to child* *ex girlfriends partner knows 4 people who have threatened him … O/N leave Thurs*
9 December 1999	*… A bit more friendly 'Alright' …* *Wants tonight out* *In right direction* *To get in touch xxx* *Allow home tonight after tea and come back tomorrow tea time after gym review Monday*
16 December 1999	*… As usual cold, not unpleasant* *Talking to student nurse illegible* *Does his own thing basically* *…seen 'alright' going to mums house* *Did not sleep well illegible* *Disturbance last night* *continue*
20 December 1999	*… much the same i/v alright consenting to medication…. Illegible…* *Leave Friday – Monday. Planning to illegible* *Form 38 completed….illegible*
29 December 1999	*Interacting …..illegible…Looks good, relaxed, enjoyed Christmas…illegible to go on leave*
6 January 1999	*… More relaxed…illegible* *stubborn at times. Leave has gone well* *I/V fairly happy* *Discussed accommodation* *S17 leave 7/01/99 ……..13 illegible… says will avoid people… no longer carrying knife*
10 January 2000	*… [CPN] present getting towards discharge much warmer…more illegible…..appears to be complying … medication No insight needs to be ….remainder of note illegible*

13 January 2000	*… I/V looks & feel well taking meds* *Discussed possibility of xx House* *Advised one pint of beer only* *Plan weekend leave Fri 1300 Sun 1800*
17 January 2000	*Feels well Out and about* *Remainder of entry illegible*
20 January 2000	*Seems settled* *Would like some leave* *Illegible …..feels comfortable* *Illegible seen alleged attackers* *Enjoying gym* *Continue* *leave* *illegible*
24 January 2000	*… Well … … awaiting offer of suitable accommodation* *Now on top of list* *…asleep* *Feels well enjoyed leave spent illegible* *Plan continue… Olanzapine ↓[decreased]Thursday*
31 January 2000	*Good leave…Still not giving much away. This seems to be his personality… illegible* *awaiting accommodation … reduce Olanzapine to 15mg*
3 February 2000	*Awaiting housing illegible* *… Mood fluctuates…illegible* *Plan w/e leave*
7 February 2000	*Has 117 meeting Thurs* *Leave continue* *S3 commenced 21/9/99* *… At iv (sic) Looks tired stay up till 2am watching tv attends gym… Denies any paranoid ideas but says that he would be forthcoming if …illegible..… concerns* *Plan for further leave* *S17*

10 February 2000	*(Section 117 Aftercare meeting)…* *Illegible* *Attends gym at illegible* *Has responded well to w/e [weekend] leave.* *F/U (follow up) will be in OPD* *Attends xxx as often as possible -drop in basis* *Insight …"I guess I've been ill"… illegible…* *Plan* *Day Leave s(3) will not be renewed if making progress*
17 February 2000	*Flat available from 2/3/00…* *At IV feels well…Looking forward to flat* *Could scrape funds together ifnecessary illegible* *Plan w/e leve 2/7 s17*
21 February 2000	*Accom has been arranged. W/e leave has gone well. More settled … Appears illegible* *… More settled … At IV leave went well spends most of time on internet playing games. Sleeps from 1 /2 … 9/noon… Reluctant to discuss any thought re beliefs+ persecution …remainder of entry illegible*
13 March 2000	*Illegible …Settled … No problems…illegible OP [Out-patient] appointment in 3 weeks* *Discharge 13/3/00*

10.6 In complex cases such as MB's, the information needed to make a diagnosis is often incomplete or requires a period of longitudinal evaluation and information from multiple sources. Further, a service user's symptoms or presentation may change over time. Diagnosis, therefore, should be dynamic and be regularly reflected upon, reviewed, and refined.

10.7 As part of this period of longitudinal evaluation and information from multiple sources particularly in the case of an individual such as MB who was guarded and unforthcoming, it is common practice to contact the family of the patient to obtain '*collateral*' information to assist in the diagnostic process. Collateral information is information that accompanies or confirms information already obtained.

10.8 The following paragraphs set out the opportunities which could have been utilised by clinicians to attempt to obtain further clinically relevant information.

10.9 Attempts to gain further Information to assist in MB's evaluation and care – Involvement of MB's Mother:

10.10 Families provide a resource to clinicians and a means of significant knowledge in relation to the individual who is ill that can be exploited. Families can often be part of the solution to understanding aspects of a patient's presentation.

10.11 MB's nearest relative was interviewed as part of the legal process attached to MB's detention in hospital under section 3 of the MHA 1983. The following information was provided at this time:

'*…rather vague about precise dates of MB's history and had not really known where he was living in Harrogate until he had turned up in June this year "all skin and bone" and terrified. He was hiding in the attic and talking of a gang trying to get him to murder his brother...*

'*He believes there was an incident when a girl was raped some years ago and the gang of perpetrators are now trying to kill him and his brother. There is no evidence of this. He also has memories of his mother trying to drown him and his brother trying to suffocate him as a child and other incidents with which he confronts his mother and she denies. He has also been reading and interpreting the Book of Revelation. MB got into trouble whist at…School and went to an approved school at Scarborough. He also has a prison record from his early 20's for burglery* (sic)*, car theft and deception…describes him as an open child but does not really know what he has been thinking or doing as an adult.*

'*MB was given money to go to Edinburgh to get away and stayed one week only, he returned to Mum* (sic) *for another week or so before setting off for Italy to get away from his persecutors and presented himself to the Police in London*'.

10.12 MB's mother remained in contact with her son and indeed provided accommodation for him during periods of leave from hospital.

10.13 Attempts to gain further information to assist in MB's evaluation and care – Information gained about MB's periods of leave:

10.14 During his time in hospital MB underwent a number of periods of '*leave*', some of which involved him staying at his mother's home

10.15 Section 17(1) of the MHA 1983 allows a patient's '*Responsible Clinician*' to grant leave with any conditions that may be necessary '*in the interests of the patient or for the protection of other persons*'.

10.16 It is important that the process of transition from inpatient to community care is carefully planned (see NICE guidance CG 136). It is necessary to ensure that the patient has maintained their daily living and social skills, and his social connections, during the inpatient admission.

10.17 The longer the period of inpatient stay, the more important it is to plan and phase the discharge. The use of periods of leave to a community environment while still an inpatient is seen as an important part of discharge planning. The use of leave under the 1983 MHA is discussed in sections 20.3 and 20.4 of the MHA code of practice (1999).

10.18 NICE guidance CG 136 states *'Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people using mental health services. Ensure that:*

- *such changes, especially discharge, are discussed and planned carefully beforehand with the service user and are structured and phased*
- *the care plan supports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis*
- *when referring a service user for an assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.'*

10.19 Section 17 leave is used to grant short periods of leave from hospital in the build up to discharge to allow patients an opportunity to rebuild life skills and regain control of their life. Periods of leave are also important to '*test*' the sustainability of a patient's recovery out of a supervised assessment, such as a hospital ward. It would not be considered good practice for clinicians to admit an individual with an acute mental health condition and then keep them detained in hospital without periods of leave until their point of discharge. Section 17 leave is used for patients who are detained under sections 2 and 3 of the MHA 1983 in the same manner.

10.20 The process by which MB was initially considered for leave by the clinical team in Harrogate is not clear as the section 17 leave forms are illegible. In particular, it is unclear how information from MB's family was included in the decision-making process surrounding his leave. In addition, it is not clear from the records whether or not MB's mother was contacted after periods of leave to determine whether that leave had gone well.

10.21 Therefore, collateral information about MB including information which could have been useful in determining his potential relapse signatures, drug use etc. does not appear to have been gathered. This information could have been very useful in assessing the level of risk which MB posed to himself and others. It should also be mentioned that MB's mother does not appear to have contacted the ward about concerns which she had about her son or his presentation whilst on leave.

10.22 Failure to obtain further information to assist in MB's evaluation and care by following up information previously obtained:

10.23 MB had originally presented in London appearing to be floridly psychotic with a complex delusional system. Clinicians therefore had to make immediate decisions about his treatment and managing his immediate risk and in particular, the potential harm to others that MB may consider to be his persecutors.

10.24 However, during the course of his admission in London, clinicians elicited that MB had taken an overdose of paracetamol on or around 22 June 1992. Clinicians in London were, in the first instance, trying to make decisions about MB's ongoing care and treatment, including whether MB satisfied the criteria for detention and where it was best for him to receive care. However, they did obtain a good history and highlighted some important information in their discharge note provided to Harrogate on 26 August 1999.

10.25 The Independent Investigation Team could not find any evidence that this information was followed up with members of MB's family during MB's admission in Harrogate. However, there is reference to MB's brother being contacted regarding MB's statement about his alleged persecutors, in a report for the hospital managers prepared on 5 October 1999. MB's brother was part of a complex delusional system involving MB, his brother and a gang. The delusion was that he had to kill his brother by a certain date, but that MB was determined not to harm his brother and was therefore himself at risk from this gang. It appears that MB had taken specific steps not to harm his brother.

10.26 During his admission to Harrogate, it does not appear as though MB was tested or re-tested on his return from leave in respect of his possible use of illicit substances whilst he had been on leave, except on one occasion on 12 October 1999. On MB's section 17 leave forms is the condition of '*No use of illicit substances' and 'to use no alcohol or illicit substances*', indicating that the clinicians were concerned about the possible misuse by MB of illicit substances, with adverse consequences for his mental health.

10.27 Lack of evidence concerning MB's substance use/misuse during periods of leave:

10.28 A common issue throughout MB's admission to Harrogate is that there is a lack of evidence as to whether or not MB engaged in illicit substance misuse when on leave from the hospital. Because MB's mental state improved, with no evidence of deterioration following periods of leave, the clinical view appears to have been that he did not abuse illicit substances either in hospital or during periods of leave.

10.29 Those caring for MB appear to have been appropriately concerned that, whatever his diagnosis, the misuse of cannabis was likely to be a significant factor in causing an exacerbation of his psychosis. This may have been behind the rationale for granting so many periods of section 17 leave.

10.30 It is clear from the Harrogate discharge summary and from the stipulations on the forms authorising section 17 leave that the clinicians viewed with concern the possibility that MB would return to the misuse of illicit substances, especially cannabis. Whilst MB may have been reluctant to consider that cannabis was harmful, the Independent Investigation Team could not find any evidence of how this issue was addressed or managed. The Independent Investigation Team could not find any references in MB's records of discussions with MB about the adverse effects of cannabis, nor consideration of a referral to drug/alcohol treatment services.

10.31 Notwithstanding the apparent lack of testing or re-testing at Harrogate, the Investigation Team understands that with a patient whose symptoms are thought to be precipitated or exacerbated by the misuse of illicit substances, staff would probably see a deterioration in his mental state if the patient had been misusing illicit substances whilst on leave, or unsupervised.

Comment 5:

MB was an in-patient in Harrogate between 26 August 1999 and 13 March 2000.

MB's presentation appears to have proved problematic for those responsible for his care. He consistently presented as guarded, and frequently refused to agree to be interviewed. This would have presented clinicians with significant difficulties in establishing a therapeutic relationship and potentially denied them access to clinically relevant information about MB.

During this time, the opportunity to gather collateral information about MB concerning his past history, his presentation, his use of illicit substances and the quality of his leave do not appear to have been explored with key individuals involved with MB, including his mother in order that they could be factored into how MB's care was planned and delivered.

Information highlighted in the discharge note and subsequent discharge summary from Grovelands in London does not appear to have been the subject of further investigation (for example, information concerning a possible previous admission to hospital in Harrogate).

This could have elicited information which would have given individuals involved in MB's care a better understanding of MB's presentation including the risk which he posed to others.

Family and carers:

Family members can play an essential role in planning treatment and care. They can also give mental health professionals a history of their relative's problems when an assessment is being made.

The National Institute for Health and Care Excellence ("NICE") 2014 clinical guideline about the treatment of psychosis and schizophrenia recommends that mental health professionals give family members and other carers written and verbal information about their relative's diagnosis, about the role of different mental health teams and different services, and about how to get help in a crisis.

NICE recommends that health and social care should offer family members and other carers '*education and support*' to help them in a caring role.

MB was an in-patient in Harrogate between 26 August 1999 and 13 March 2000. The Trust which delivered his care is no longer in existence.

The CQC was established in order to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. Their findings are published.

The CQC has a duty under the MHA 1983 to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship.

The CQC produces an annual report on the use of the MHA 1983 called '*Monitoring the Mental Health Act'* in 2015/16. The report states:

'*In 2015/16, we have found little or no improvement in some areas that directly affect patients, their families and carers and that we have raised as concerns in previous years. This includes*:

There was no evidence of patient involvement in care planning in 29% (1,214 out of 4,226) of records that we examined. Similarly, 10% (452 out of 4,407) of care plans showed that patients' needs had not been considered'.

This suggests that despite a series of NHS initiatives, the involvement of patients and carers in care planning remains an issue at national level.

11. UNDERSTANDING OF MB'S ILLNESS AND RISK DURING ADMISSION TO HARROGATE

11.1 Psychosis is a general term used to describe a group of disorders including schizophrenia in which people experience hallucinations, delusions, and changes in mood and behaviour. Patients with psychosis generally lack insight i.e. do not recognise that their experiences are secondary to an illness.

11.2 The use of the generic term *'psychosis*' rather than specific diagnoses (such as schizophrenia) in part recognises that diagnostic uncertainty is common, especially early in the course of psychotic illness.

11.3 As previously stated, there was a consistency of opinion that MB had symptoms of psychosis. At different stages of his in-patient admission, the psychotic symptoms were attributed to:

a) Delusional disorder;

b) Schizophrenia; or,

c) Drug induced psychosis.

11.4 The question of personality disorder as a co-morbid diagnosis was raised at various times during MB's treatment. At the age of 13, a Consultant in child and adolescent psychiatry attributed MB's difficulties to *'dissocial behaviour'*.

11.5 A Forensic Consultant Psychiatrist who assessed MB on 17 September 1999 stated:

'*His history reveals antsocial* (sic) *traits from a young age, and it is likely that he also suffers from a personality disorder. I am not sure what, if anything can be done about this…'*

11.6 In addition, that MB:

'*…* [Is] *clearly suffering from a mental illness…likely to be either schizophrenia or delusional disorder. Either way* [MB] *requires treatment for his mental illness*' and that the '*…main danger would be if he was confronted by somebody that he thought was one of his persecutors*'.

11.7 The final diagnosis recorded on the discharge summary on 22 March 2000 was of paranoid schizophrenia and probable personality disorder. Although not explicitly stated, there appears to have been a clear recognition by clinicians that any return to cannabis misuse would be very likely to exacerbate the symptoms of the underlying psychosis.

11.8 The Independent Investigation Team considers that the clinical team was appropriately focused on the assessment and management of the risks driven by schizophrenia or delusional disorder and that the dissocial traits were not the primary concern.

11.9 The primary concern was that it was MB's delusional system that was driving the risk which he posed. Whilst carrying a knife may be associated with MB's dissocial personality traits, the risk in MB's case was driven by his delusional thinking rather than by any possible personality disorder.

11.10 MB's delusional thinking was the '*mental disorder*' that required admission and/or detention for treatment that would be '*likely to alleviate or prevent a deterioration of his condition*'.

11.11 Notwithstanding that personality disorders were viewed as '*untreatable*' at the time, assessment of MB's personality could have been valuable. Such an evaluation would have allowed clinicians a better understanding of the relationship between MB's personality issues and its impact upon his psychotic illness. In turn, this would have provided a better understanding of how that risk if indeed any, could be better managed.

11.12 Once a diagnosis has been reached, an appropriate management plan can be formulated to deliver patient centred care.

11.13 It is unclear to the Investigation Team what, if any, specialist services were available at the time in Harrogate that would have allowed for a more formal assessment and diagnosis of possible personality disorder in MB's case or indeed into the management of his issues with substances.

Comment 6:

The assessment of the forensic psychiatrist that MB suffers from a psychotic illness, most likely schizophrenia, and that his mental state is highly sensitive to the effects of illicit substances appears to the Independent Investigation Team to have a secure basis.

The treating team did appear to have been concerned that (whatever the diagnosis) MB's misuse of cannabis was likely to be a significant factor in causing an exacerbation of his psychosis.

In addition, MB was noted to have a co-morbid diagnosis of personality disorder which was considered '*untreatable*'.

Improvements in care since 2009:

The NHS has undergone substantial re-configuration since 1999.

Care is now increasingly delivered in accordance with '*care pathways*'. There are care pathways in relation to psychosis, personality disorder and individuals with a dual diagnosis such as MB.

A care pathway is a type of template, or map, that sets out what should happen and what sort of treatment and care a person should be offered when they are given a diagnosis of a particular mental health problem or physical health problem.

Care pathways are designed for health professionals to follow and are supported by national guidelines and research highlighting the best possible treatment. They are often presented as '*flow charts*' that prompt health professionals to make assessments and take decisions at particular times and in different circumstances.

NICE creates pathways that demonstrate what should happen and which evidence-based guidance health professionals should follow for different conditions.

Through a number of key policies, the Government and NICE set out clear aims and standards for clinicians to have regard to which are intended to improve the standard of care which is delivered, particularly for those with a Personality Disorder which as has been stated was considered by many to have been untreatable.

For example, in relation to personality disorder the following initiatives have led to better standards of practice:

'*Managing Dangerous People with Severe Personality Disorder*' (1999) which sought to remedy the lack of treatment available for those people with severe personality disorder who present a danger to the public.

'*Personality Disorder: No longer a diagnosis of exclusion*' (2003). This was aimed at remedying the exclusion experienced by people with personality disorder and confirmed that personality disorder services should be part of the core business of mental health trusts.

'*Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework*' (2003) sought to improve the capabilities of staff in health and social care in relation to personality disorder.

The *Personality Disorder Knowledge and Understanding Framework* provides a new national education and training package for staff across health, social care and criminal justice, and high-quality education for all staff who come into contact with people with personality disorder.

Dedicated personality disorder services have now been established across the country.

NICE was originally set up in 1999 as the National Institute for Clinical Excellence, a special health authority, to reduce variation in the availability and quality of NHS treatments and care.

NICE Clinical Guideline (CG) 1 on the management of schizophrenia was the first guideline to be published by NICE in 2002 and there have been two updates since, the latest (CG178) in 2014.

NICE Quality Standard (QS) 80 on Psychosis and schizophrenia in adults was published in February 2015. It covers the treatment and management of psychosis and schizophrenia in adults aged 18–60 years in primary, secondary, and community care.

It has eight quality statements aimed at bringing about improvements in treatment and better outcomes for those experiencing a psychotic illness, including an increase in the use of crisis resolution and home treatment teams and reduction of hospital admissions, including those under the MHA 1983.

NICE places an explicit emphasis on increasing the use of evidence-based treatments. It does this in part by publishing clinical guidelines to assist in the '*management*' of conditions such as psychosis. The potential benefits of the use of clinical guidelines include provision of a robust management strategy for patients, and maintenance of consistency and quality in healthcare.

The Mental Health Act 2007 made several key changes to the MHA 1983, which laid down provision for the compulsory detention and treatment of people with mental health problems in England and Wales.

The changes brought in a single definition of mental disorder, replacing the categories of disorder found in the MHA 1983. The definition for the first time allowed a diagnosis of personality disorder to be considered a mental disorder in accordance with the terms of the MHA 1983.

The initiatives and policies discussed above have transformed service provision for individuals with personality disorder and co-morbid diagnosis. MB's admission to hospital and his subsequent treatment took place prior to these initiatives being put in place.

12. DISCHARGE AND AFTERCARE

12.1 When a patient begins to show signs of recovery, clinicians must consider whether their continued detention in hospital is justified.

12.2 When MB was initially detained in hospital, the risk that he presented to others, secondary to his psychotic illness at that time, had been the reason for his detention and indeed his continued detention following appeal. The subsequent MHRT accepted that the patient met the grounds for detention for treatment under the MHA. These are:

(a) *'They are suffering from [mental disorder] of a nature or degree which makes it appropriate for them to receive medical treatment in a hospital; and*

(b) *it is necessary for the health or safety of the patient or for the protection of other persons that they should receive such treatment and it cannot be provided unless they are detained under this section; and*

(c) *appropriate medical treatment is available for him.'*

12.3 The reasons for MB's detention are set out in section 9 of the decision paper. The MHRT agreed that the patient was suffering from a mental illness characterised by delusional beliefs. It noted that he had improved since starting medication and agreed that the section should continue so the trial of medication and his reaction to it may be monitored, and a care package put in place. The MHRT stated that, if he were discharged now, his health would be likely to deteriorate rapidly, and if he perceived that others might try to abduct him, they would be at risk.

12.4 MB's clinical condition improved with treatment in hospital. By 10 February 2000, there was objective evidence of improvement in his mental state. There had been no episodes of acute disturbance and MB had had several periods of leave from hospital. Although he remained guarded and did not appear to gain full insight, a clinical decision was made that there would not be grounds to renew his treatment section when the time came to do so on 13 March 2000.

12.5 Under section 117 of the MHA 1983, local health and social services authorities have a legal duty to provide aftercare for patients who have been detained in hospital under section 3 of the MHA 1983.

12.6 As a result, a discussion would normally take place to establish a care plan. According to the Code of Practice and the MHA 1983 which was applicable at the time, those who should be involved in those discussions are the patient's clinician, a nurse involved in caring for the patient in hospital, a social worker specialising in mental health work, the GP, a community psychiatric nurse, representatives of any relevant voluntary organisation involved with the patient together with the patient, and their representative.

12.7 The purpose of aftercare is to enable patients to return to their home or accommodation other than a hospital, and to minimise the need for future in patient care.

12.8 MB's section 117 meeting was held on 10 February 2000, around a month prior to his discharge. This appears to have been a multidisciplinary meeting, with hospital and community staff being present, as well as the patient himself. The Community Forensic Psychiatric Nurse who would be involved in MB's care following his discharge from hospital was also present at this meeting.

12.9 By the time MB came to be discharged from Harrogate, his improvement in mental state can be seen in the discharge summary which was passed to MB's GP. The discharge summary clearly highlights areas of concern as MB moved to live in the community:

'*…* [Suffering] *from a severe mental illness… evidence of a personality disorder…whilst psychotic…a real threat to any perceived persecutors 'Progress': slow and steady ...no insight and was convinced that the persecutory ideas were real…was not agreeable to taking medication reliably…he showed no violence towards others and his behaviour was acceptable…complied with episodes of leave…Although not acknowledging any illness, he did eventually agree to take medication…affect gradually improved…capable of being somewhat cold and distant at times…intensity of his delusions became less prominent, though he continued to believe that his persecutors still existed. The fact that he has little insight into his illness, and that the delusions have not completely disappeared, are a cause for some concern.*'

'*There is a risk that* [MB] *will stop taking his medication and also a possibility that he will use cannabis again. Hence he will be monitored closely with the following package of care: Key worker; Out patients; Drop In Centre; possibility of a community care grant; Medication – Olanzapine 15mg nocte*'.

12.10 At the time of his discharge on 13 March 2000, MB had been detained in hospital for approximately 8 months and had been receiving active treatment in the form of anti-psychotic medication for approximately five and a half months.

12.11 As stated above, the validity of continued detention is dependent on the criteria for continued detention being met. This is an extremely high threshold to meet as this decision impacts upon a person's liberty. As can be seen from the discharge summary above, MB's mental disorder did persist, but the clinical opinion was that it did not persist to the extent that he met criteria for renewal of detention or that he required ongoing hospital treatment as a voluntary patient:

'*…he showed no violence towards others and his behaviour was acceptable…he did eventually agree to take medication…affect gradually improved…intensity of his delusions became less prominent…*'

12.12 During MB's admission to Harrogate, from the records which have been made available to the Independent Investigation Team, consistent treatment with anti-psychotic medication, together with the avoidance of cannabis misuse, led to a significant recovery in MB's mental illness. However, the records indicate that this was not complete.

12.13 The discharge summary highlights a number of potential causes for concern for the Independent Investigation Team at the point of discharge. It was noted clearly that '*he has little insight into his illness and that his delusions have not completely disappeared*'. The summary points to the risks that he would stop taking medication and to the possibility that he would use cannabis again.

12.14 Consequently, the Independent Investigation Team was of the view that the following factors were relevant to the aftercare arrangements relating to MB:

- The severity of MB's psychosis on admission to the Grovelands and Harrogate.
- MB's probable dissocial personality disorder (as identified in the forensic report).
- His tendency to be self-isolating and not forthcoming, often refusing to attend for interview with mental health staff, and evidence that he minimised his psychotic symptoms.
- MB's intermittent compliance with medication.
- MB's propensity to misuse illicit substances and the precipitating or exacerbating consequence of this.
- MB's delusional thinking regarding alleged perpetrators and the risk posed to them
- MB's lack of insight of his mental state.

12.15 The after-care plan appears to have been as follows:

1. Keyworker.
2. Out patients.
3. Drop In Centre.
4. Community care grant.
5. Medication – Olanzapine 15mg nocte section 3 not to be renewed in March.
6. Section 3 not to be renewed.

12.16 The plan lacks any detail about what is to be delivered by who and when. There is no mention as to what should be done in a crisis. In addition, there does not appear to have been consideration of his being discharged under supervised discharge arrangements as a means of managing the risks which MB posed when discharged from hospital.

12.17 The Independent Investigation Team is concerned that the discharge plan does not appear to accurately identify all the risks posed by MB, the reason for the need for MB to be closely monitored and most importantly, the mechanism through which these risks would be addressed.

12.18 In addition, the section 117 aftercare planning meeting does not refer to the Forensic Report or provide an updated risk assessment. There is little in the way of identification of relapse signatures, or a contingency plan in the case of non-compliance with medication, MB's disengagement from services, or evidence of deterioration in severity of psychosis. It is unclear whether the outcome of the section 117 meeting was shared with MB's GP.

12.19 It is apparent from the legible records that those managing MB did not take an overview of MB's care and review his history as they began discharge planning; they do not appear to have fully reviewed and measured progress against the extent of his psychosis at initial presentation and the risks identified in the forensic report.

12.20 This would have systematically identified the risks and determined if there were any other courses of action that could have been taken. At the very least it would have been an opportunity to share with MB's GP a plan for identifying possible signs of relapse and a means of planning for a rapid access back into services.

Comment 7:

<u>Decision to discharge MB:</u>

Given that MB had a prolonged admission with some evidence of improvement in mental state, no episodes of aggression or violence and several periods of leave with no deterioration in mental state, it is difficult to argue that the decision to discharge at that time was incorrect.

It is also the case that once a patient is discharged, it is not possible for mental health staff to ensure that they continue to take medication and do not misuse illicit substances.

However, the discharge planning process which was applied to MB did not systematically review the risks identified and attempt to develop a contingency plan for the identification and management of those risks in a community setting.

Given the risks identified, the level of engagement with, and monitoring of, MB in the community should have been more comprehensive.

Discharge planning was weak. There was a lack of clarity surrounding actions to be taken should MB fail to engage. Further, there was no crisis planning or identification of MB's relapse indicators.

Discharge Planning:

The section 117 aftercare planning meeting does not refer to the forensic report or provide an updated risk assessment. It does not discuss relapse signatures or draw up a contingency plan in the case of non-compliance with medication, disengagement from services, or evidence of deterioration in severity of psychosis.

Given that it was clearly recognised that MB's risk to others could increase significantly at times of relapse, and that relapse could be precipitated by cannabis misuse, the discharge planning shows a lack of a systematic approach to the recognition of relapse signatures, and the development of a contingency plan to manage relapse. Whilst MB may have been reluctant to consider that cannabis was harmful, there appears to have been no effort to assess or manage his cannabis misuse.

There is evidence of only one risk assessment completed when MB was admitted to Harrogate, carried out on 10 December 1999. The writing is difficult to read, and it is very brief. It is more properly characterised as a risk screening tool. It is also inaccurate in that the box '*no*' is ticked beside the question '*Is there a history of substance/alcohol misuse?*' There does not appear to have been consideration of his being discharged under supervised discharge.

Supervised discharge was introduced in 1995 in response to a series of incidents involving violent acts committed by patients with a mental disorder living in the community (Eastman 1995).

The aim was to help break the cycle of repeated admissions, relapses, and readmissions of '*revolving door patients*'. Like an order made in accordance with section 3, section 25A MHA 1983 order initially lasted for 6 months, could be renewed for a further 6-month period and then annually thereafter.

Supervised discharge allowed conditions to be imposed on patients in the community and provided a power to recall a non-compliant patient to hospital. Crucially, it did not give professionals the power to treat a patient who had been returned to hospital without that patient's consent unless they were subjected to a formal compulsory re-admission process in accordance with the MHA 1983.

Supervised discharge was therefore not widely used as it was considered by many professionals to be ineffective when faced with a non-compliant patient (Franklin et al 2000)[5].

Improvements in discharge planning since 2000

The Care Program Approach ('the CPA') describes a framework originally introduced in the 1990s to ensure that the care of people with severe mental health problems was co-ordinated within secondary mental health services.

The CPA was introduced in 1991 [HC(90)23/LASSL(90)11] to provide a framework for effective mental health care. Its four main elements are:

1. Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
2. The formation of a care plan which identifies the health and social care required from a variety of providers;
3. The appointment of a key worker to keep in close touch with the service user and to monitor and co-ordinate care; and
4. Regular review and, where necessary, agreed changes to the care plan.

The CPA model was reviewed in 1999 with the publication of the Mental Health National Service Framework and to incorporate lessons learned about its use since its introduction.

In March 2008, the Department of Health issued updated guidance called '*Refocusing the Care Program Approach Policy and Positive Practice Guidance*' Gateway (ref 9148), which took account of the move towards a '*personalised*' approach to community mental health services. The CPA provides an approach to working in situations where more than one professional or agency is involved, and clarity is therefore needed about who does what.

The Care Program Approach is now used in secondary mental health care to assess, plan, review, and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics.

As has already been mentioned, individuals who have been detained on section 3 of the MHA 1983 have rights under section 117 to aftercare services. However, everyone discharged from hospital, whether or not they have section 117 rights, must have a discharge plan.

[5] Franklin D, Pinfold V, Bindman J, Thornicroft G (2000). *'Consultant Psychiatrists' experiences of using supervised discharge: results of a national survey'*. Psychiatric Bulletin, vol24, pp 412-15.

When leaving hospital, all those involved in a person's care (including informal carers) should be aware of their role and what is expected of them. It is unclear in MB's care who was responsible for what.

Discharge plans should include information on everyone involved in a person's care and should be clear about who the care co-ordinator will be. The care co-ordinator is now the person responsible for coordinating between all the professionals involved.

Plans should include explicit outcomes or expectations, and it must be clear how help will be available in a crisis. All discharge plans should include a risk assessment and information on how risks will be managed.

Code of Practice:

Code of Practice: Mental Health Act 1983 was published in March 1999, pursuant to section 118 of the Act.

The Code of Practice gives guidance on how the MHA 1983 should be applied. The Code provides guidance to registered medical practitioners, managers and staff of hospitals and mental nursing homes and approved social workers (who have defined responsibilities under the provisions of the Act), on how they should proceed when undertaking duties under the Act.

The Code has been amended on a number of occasions. It includes provisions relating to the discharge of patients in order to improve care.

Introduction of crisis resolution services:

In recent years CRHT services have been developed to provide acute care and treatment for mental health service users living in the community and experiencing an episode of illness that requires intensive treatment. Previously, such treatment could only have been provided by admitting the service user to an in-patient ward.

The introduction of CRHT services was one of the key elements in the 1999 *National Service Framework for mental health; the NHS Plan* (2000) made the provision of CRHT services a national priority; and the Department of Health's 2002 Public Service Agreement included targets both for the number of teams and the number of people treated.

A key function of CRHT teams is the assessment of treatment required by a service user, made in the early stages of an acute psychiatric crisis, which considers whether CRHT would be a safe and clinically beneficial alternative to admission for the person concerned.

Often, CRHT will work intensively with people to allow them to leave hospital more quickly than might have been the case in the past. CRHTs should, according to best practice guidelines, operate 24 hours a day and have dedicated consultant psychiatrist time; such teams allow for facilitated early discharge from in-patient units and intensive monitoring of mental state and risk in the days and weeks following discharge, in addition to avoiding admissions.

It is expected that a person discharged from a mental health in-patient ward will be seen at home at least once in the 7 days after discharge.

CRHT would have been able to work with MB in the community following his release from hospital to monitor his compliance with medication and to identify whether changes in his presentation warranted a mental health assessment.

<u>Discharge planning:</u>

The CQC annual report '*Monitoring the Mental Health Act in 2015/16*' states:

'*The Code and Care Programme Approach expect service providers to begin discharge planning as soon as the patient is admitted. Services also need to ensure that patients are clear about plans and goals for their recovery and discharge*.

'*...examples of good practice include a particular focus on engaging with and supporting carers and family members, both in understanding the patient's care and treatment in hospital, and in developing skills to help them after the patient's discharge*.

'*…However, 32% (1,324 out of 4,086) of care plans we reviewed during 2015/16 showed no evidence of discharge planning. This is a slightly larger proportion than 2014/15, when the equivalent measure showed 29% of records had no evidence of discharge planning*'.

Consequently, despite the initiatives which aim to improve the quality of discharge planning there remains some work to be done.

13. CARE FOLLOWING DISCHARGE FROM HOSPITAL

13.1 Following his discharge from hospital on 13 March 2000, MB was allocated a Forensic Community Psychiatric Nurse ('FCPN'). It appears that the Consultant responsible for MB's care whilst in Harrogate remained involved in his ongoing care and maintained their involvement with him as an out-patient.

13.2 There is very limited information available to the Independent Investigation Team about the interaction which MB had with the FCPN following discharge on 13 March 2000.

13.3 In particular, it is unclear how often MB met with the FCPN or what the FCPN's observations were. This lack of information is a significant impediment to the Independent Investigation Team's consideration of MB's care and treatment during this critical period. In addition, it appears that MB also attended the Acorn Centre which was a '*Drop in Centre*' two or three times a week. The Independent Investigation Team was unable to access any records relating to MB's attendance at the Acorn Centre which was not an NHS service.

13.4 It appears that once in the community, MB began to disengage with services. It is not clear when this began. Notwithstanding MB's lack of engagement, several attempts to engage MB in order to review his mental state were made. It appears that whilst at the Acorn Centre, he chose not to participate in any group therapy and there were doubts that he was not compliant with his medication.

13.5 On the 14 April 2000, MB attended his GP and requested a circumcision. MB's GP referred MB to a surgeon in connection with this procedure. The GP's referral letter stated:

'*Thank you for seeing this 30 year old…He does have a diagnosis of schizophrenia and currently takes Olanzapine 15 mg at night…He is under the care of* [Consultant Psychiatrist] *and has close contact with forensic CPN. He is currently very well mentally and although I can find no medical indication he has requested referral to yourself* (sic) *to discuss this request*'.

13.6 MB attended an appointment with a surgeon. The surgeon declined to perform circumcision. In a letter to MB's GP dated 26 April 2000, the Surgeon stated:

'*… I felt very uncomfortable about his reasons for wanting a circumcision. Basically he told me that he had done a lot of bad things in his life and he felt that being circumcised would make it up to God. I declined to arrange circumcision…*

'*I do not feel ethically that it is correct for me to go ahead to circumcise him in his particular circumstances. He left a very angry young man in the certain knowledge that God would punish me'.*

13.7 Although the phenomenon of genital self-mutilation is rare, it is commonly associated with psychotic illness. The request for a circumcision could be seen as a form of genital mutilation and should have been an alert to the possibility of a relapse of psychotic illness, leading to a request for urgent psychiatric assessment. It is the opinion of the Independent Investigation Team that MB's request for a circumcision is a cause for concern.

13.8 The Independent Investigation Team has not been able to establish from the copy set of medical records with which it was provided whether the request made by MB for circumcision was brought to the attention of secondary mental health services by MB's GP.

13.9 The discharge planning process in relation to MB's ongoing care, in the opinion of the Independent Investigation Team, is poor. In particular, there is a lack of information relating to MB's relapse indicators and instructions for the GP about the pattern of MB's illness. Such instructions would have provided MB's GP with valuable guidance concerning whether any requests made by MB could be indicative of deterioration in his mental health. Consequently, there was a risk that the significance of information about MB's presentation would not be fully appreciated and steps would not be taken to pass it on.

13.10 The information which the Independent Investigation Team had available regarding MB's contact with his FCPN in respect of this period is included in the table below:

Date	Source	Remarks
22 March 2000	Correspondence: CP 2 to GP	Discharge Letter: *"Progress* *This was slow and steady. MB had no insight into his illness and was convinced that the persecutory ideas were real. Hence he was not agreeable to taking medication reliably in the early weeks of his admission. Although unco-operative, he showed no violence towards others and his behaviour was acceptable. He made no attempts to leave the ward and latterly complied with episodes of leave. Although not acknowledging any illness, he did eventually agree to take medication. His affect gradually improved, though it was observed that he was still capable of being somewhat cold and distant at times. Generally he did resent the fact that his liberty was restricted.* *The intensity of his delusions became less prominent, though he continued to believe that his persecutors still existed. He denied being concerned about them because he believed that the police were watching them and hence they were too frightened to seek him out.* *During the latter stages of his admission he spent his time attending the gym and playing games on his computer.* *The fact that he has little insight into his illness, and that the delusions have not completely disappeared, are a cause for some concern. There is a risk that MB will stop taking his medication and also a possibility that he will use cannabis again.* *Hence, he will be monitored closely with the following package of care:* 1. *Key worker, Forensic CPN* 2. *Out patients …. on the 20 April 2000* 3. *Acorn Drop In Centre* 4. *… to advise regarding the possibility of a community care grant* 5. *Medication – Olanzapine 15mg nocte".*
14 April 2000	Correspondence: GP to Surgeon	*"Thank you for seeing this 30 year old chap with a request for circumcision. He says he wishes this doing for reasons of hygiene. He does have a diagnosis of schizophrenia and currently takes Olanzapine 15 mg at night. He is under the care of* [CP 1] *and has close contact with forensic CPN. He is currently very well*

		mentally and although I can find no medical indication he has requested referral to yourself to discuss this request".
25 April 2000	Correspondence: CP 2 to GP	*"I saw MB in clinic on the 20 April 2000. He has commenced work in a takeaway establishment and would admit to only fifteen hours, though I am sure he is doing many more hours than this. This is shift work and he finishes in the early hours of the morning. He looked quite tired in clinic, but said he had not been up long. He assures me that this is not due to his medication.* *He told me that he has seen his alleged persecutors and spoken to him. Fortunately there was no confrontation. He went on to say that they do not share his own memories of events. He does not accept that he has had a mental illness, though interestingly he does insist that he has been taking his Olanzapine. It would seem that his delusions are not as intense as they had been and I would like to think that he has perhaps developed sufficient insight to appreciate that his medication is preventing a relapse. I have asked him to continue with Olanzapine 15mg daily and we will see him again in four weeks time".*
26 April 2000	Correspondence: Surgeon to GP	*"Thank you for referring this gentleman. He came to see me today. I felt very uncomfortable about his reasons for wanting a circumcision. Basically he told me that he had done a lot of bad things in his life and he felt that being circumcised would make it up to God. I declined to arrange circumcision for him as I believe that he is almost bound to regret the decision at a later date or things are bound to go wrong. I do not feel ethically that it is correct for me to go ahead to circumcise him in his particular circumstances. He left a very angry young man in the certain knowledge that God would punish me".*
26 May 2000	Correspondence: Consultant to GP	*"I reviewed [MB] on the 25th May 2000. Since I last saw him he has stopped his work in a take away as he found it too "boring". When I last saw him he appeared quite tired which I assumed was due to his nocturnal work. However, today he looked equally tired, though insists he is sleeping from midnight until eight or nine in the morning. His appetite is intact. He spends his days either with friends or attending the Acorn centre perhaps twice weekly. The latter is to socialise with friends as he is not interested in participating in any group work. Generally he complains of boredom, though does say he enjoys reading the author, Brian*

		Green. He had not shaven and as I have already stated looked tired. However, I was not able to elicit any psychotic symptoms and he denied have any concerns about his previous perceived persecutors. He is reluctant to talk about these past events and I suspect that deep down he still has some concerns about what happened at the time. There has been no further contact with these people and he does not feel the need to protect himself or carry a weapon. *He tells me that he is no longer smoking cannabis, drinking or even using caffeine.* *He says that he does take his Olanzapine (mostly) though conceded that he misses it perhaps up to one third of the time. On questioning him, he says he is just tired when he has not taken it. The Olanzapine is sedative and this is something we will have to bear in mind.* *I am aware that [FCPN] has been a little concerned about [MB] of late, though today there was no evidence of psychosis. Nonetheless, we will need to monitor his closely. He is not interested in any other form of structured activity other than popping into the Acorn Centre from time to time. We will review him again in four weeks time".*

13.11 The request for circumcision appears to have been made at a time when the FCPN and Consultant Psychiatrist had been in contact with MB and had appeared to have reached the view that MB was not exhibiting signs of psychosis.

13.12 If the Consultant and/or the FCPN had been made aware of the unusual reasoning behind the request (as detailed in the surgeon's letter) it may have raised their index of suspicion and perhaps prompted a more detailed and rigorous mental state examination. This would have allowed the relevance of this information to be explored in order to determine whether it was a possible indication of delusional thinking which warranted further exploration. Nevertheless, it is still possible that MB would not have disclosed any delusional ideas to them.

13.13 When MB was discharged from hospital, he was prescribed oral olanzapine. Given that this was a first episode of psychosis, the Independent Investigation Team believes that attempts to treat him with oral medication in the first instance were not unreasonable. However, his compliance with medication required monitoring. It was not clear to the Independent Investigation Team what plans were in place with regard to monitoring MB's medication compliance, and what plans had been drawn up in the event of staff becoming aware on non-compliance. Although doubts about MB's compliance on or around 7 June 2000 were raised, no specific action appears to have been taken by mental health services with regards to this information.

13.14 It is clear that by 23 November 2000, there were significant doubts about MB's compliance with his medication. Indeed, MB's GP was contacted to confirm whether MB was obtaining his prescription for Olanzapine. However, those treating MB did not find overt evidence of psychosis, or a breakdown in MB's mental state during their assessment at out-patient clinics.

13.15 On 1 December 2000, MB's GP indicated that MB had not been collecting his prescriptions for Olanzapine.

13.16 Those managing MB were aware that he was not compliant with medication. Under the MHA 1983 at that time, mental health services were limited in what they could do in terms of a voluntary patient living in the community. MB was not presenting as floridly psychotic nor with any persecutory delusions. Consequently, there was no evidence of increase in risk. Accordingly, section 2 criteria for detention under the MHA 1983 were not made out and there would have been no grounds to detain MB were he not to consent to admission to hospital. Equally, there was nothing to suggest that MB did not have capacity to choose whether to take medication or not.

13.17 In recognising the fact that staff are limited in the actions they could take, there is no evidence of a systematic review of the original care plan which was drawn up on discharge, to reflect the information concerning his non-compliance.

13.18 MB's mental state appeared to be stable despite being medication free, and he told the consultant on 25 May 2000 that he was '*…no longer smoking , using cannabis, drinking or even using caffeine'* and on the 12 April 2001 that he '*…is keeping well away from illict (sic) substances…as he knows that his use of cannabis was instrumental in at least precipitating his severe psychotic episode'*.

13.19 On both occasions, the Consultant reviewing MB provided that there was no evidence of psychosis.

13.20 Notwithstanding concerns about relapse at the time of discharge, MB appeared to be free from symptoms of psychosis one year later, despite having been non-compliant with medication for at least five months of this period.

13.21 In a letter from MB's treating Consultant to his GP dated 23 April 2001, after which he was discharged from psychiatric follow up into the care of his GP states

'he is keeping well away from illicit substances as he knows that his use of cannabis was instrumental in at least precipitating his severe psychotic episode.'

13.22 Whilst it is difficult to be certain due to the issues surrounding the quality of medical records which have already been mentioned, it is possible that MB's diagnosis was revised to a drug-induced psychosis, and therefore it was considered that MB would remain well, despite non-compliance with medication as long as he did not take drugs. The use of the words 'at least' indicate that the consultant had in mind the possibility that the use of cannabis may have been entirely responsible for the psychotic episode**.**

Comment 8:

Following discharge from hospital, MB appeared to those involved in his care to not be exhibiting any signs of florid psychosis which would warrant an assessment under the MHA 1983.

However, MB attempted to undergo circumcision on or around 26 April 2000. He consulted a surgeon who refused to carry out this request.

Due to the poor quality of records which were made available to the Independent Investigation Team, it is not clear if this information was brought to the attention of mental health services.

By 23 November 2000, there were significant doubts about MB's compliance with his medication. However, due to MB not displaying overt symptoms of psychosis, the options available to clinicians with regard to ensuring MB's compliance with his medication were limited. In particular, there is no information available to the Independent Investigation Team which would suggest that MB lacked the capacity to make a decision to not take his medication. Equally, there is no information which would suggest that a mental health assessment was indicated at this time as clinicians believed that MB was presenting as being well.

Improvements in practice (changes made since the incident):

<u>Introduction of Supervised Community Treatment ('SCT'):</u>

The Mental Health Act 2007 ('the MHA 2007') made several key changes to the MHA 1983, which laid down provision for the compulsory detention and treatment of people with mental health problems in England and Wales.

Community treatment orders (CTOs) were introduced under the Mental Health Act 2007. A key aim of the introduction of CTO's was to improve the care and support of some individuals with severe mental health problems in the community following their discharge from hospital.

CTOs give clinicians powers to recall individuals following their discharge from detention in hospital if they relapse or have a change of circumstances and pose a high risk to themselves or others on account of their mental disorder. Individuals can be placed on a CTO if they are at the time detained in hospital under a s3 treatment order of the Mental Health Act 1983 such as that which was imposed upon MB.

Individuals can, at their clinicians' discretion based on CTO criteria, be returned to hospital for compulsory treatment for their mental disorder if they stop taking their medication and/or they disengage with services. They can be recalled for treatment for up to 72 hours, after which they must return to the community, or the CTO may be revoked, which means they will be placed on a new treatment order.

CTO's may be used where:

• the individual is suffering from a mental disorder such that they need medical treatment

• it is necessary for the individual's health or safety or the protection of others that they should receive such treatment

• treatment can be provided without the individual being detained in hospital, provided there are powers to recall the individual to hospital for medical treatment and

• appropriate medical treatment is available.

CTOs do not give clinicians powers to force individuals to take medication outside a hospital or clinic setting. A clinician may only enforce treatment by recalling the individual to hospital if they think this is necessary. However, being the subject of a recall to hospital detention is in the opinion of the Independent Investigations Team, a form of compulsion.

The Independent Investigation Team is of the view that the introduction of a SCT would have been beneficial in the care of MB following his discharge from hospital. In particular, the power to recall MB to hospital in the event that he failed to take his medication would have been beneficial had this legislation been in place at the time of MB's treatment.

14. PREDICTABLE / PREVENTABLE

14.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether Gemma Simpson's death was predictable or preventable

14.2 Many Independent Investigations identify failings, missed opportunities, or gaps in the care which was provided to an individual. However, this does not mean that a homicide could have been either predicted or prevented.

14.3 The Independent Investigation Team has applied the following tests to determine whether a homicide could have been predicted or prevented:

14.4 Predictable:

14.5 A homicide is 'predictable' if there was evidence from the perpetrator's words, actions, or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had been un-noticed or misunderstood at the time it occurred.

14.6 Preventable:

14.7 A homicide could have been 'prevented' if there were actions that healthcare professionals should have taken, which they did not take, that could in all probability have made a difference to the outcome. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done better.

14.8 The Independent Investigation Team has applied the tests of predictability and preventability to the events up to and including 5 May 2000, and has reached a view that Gemma Simpson's death was not predictable nor preventable

14.9 Was Gemma Simpson's death predictable?

14.10 In sentencing MB, the Judge referred to the following extracts from psychiatric reports disclosed to the Court:

'*MB has a psychotic mental illness. The course of his illness has been fluctuated with relapse and remission, and for large parts of his life he has been able to lead an independent life managing to greater or lesser degree all the opportunities available to him without the need for treatment. The more florid manifestations of his illness have been precipitated or worsened most probably by drug misuse. As he has an inherent illness he is also vulnerable to spontaneous relapse as well as deterioration in the face of stressful life events*.'

'*He has a highly unusual personality structure amounting to a personality disorder. He has antisocial traits, as well as schizotypal abnormalities which mark him out as somewhat of a loner and eccentric.'*

'His mental illness is not currently active and for this he does not require treatment in hospital, however the situation may change in the future. He will require monitoring by prison mental health services and in the event of relapse there are mechanisms to transfer to secure hospital care via section 47 Mental Health Act. His personality disorder is lifelong and probably not amenable to treatment nor does it require in patient management'.

14.11 The National Patient Safety Agency '*Guide to investigation report writing following Root Cause Analysis of patient safety incidents*' contains the following warning with regard to the issue of hindsight and outcome bias:

'It is important when analysing investigation findings to be aware of, and try to avoid, hindsight and outcome bias.

'Hindsight bias is the tendency for people with the 'benefit of hindsight' to falsely believe, once all the facts become clear, that the actions that should have been taken to prevent an incident seem obvious, or that they could have predicted the outcome of an event'.

'…*failure to recognise hindsight bias in incident investigation can result in misinterpretation of findings and may ultimately mask the real lessons to be learne*d.'

14.12 Hindsight bias is a cause for concern for those engaged in healthcare investigations. Put simply, hindsight does not equal foresight.

14.13 Investigations that focus upon the outcome run the risk of failing to recognise the complexities and uncertainties facing front end carers and why their actions made sense at the time. This may cause important lessons to be lost. Outcome knowledge may also distort our thinking on the quality of the processes that led to the outcome

14.14 Prior to the death of Gemma Simpson MB did not have a significant history of violence or aggression towards others. The death of Gemma constituted a significant escalation in the level of violence exhibited by MB.

14.15 The Independent Investigation Team has had access to a limited amount of information relating to the criminal proceedings arising out of Gemma Simpson's death. The Independent Investigation Team understand that the reason that MB gave for killing Gemma during the course of criminal proceedings was that he had been told by God to kill a witch and he believed that Gemma was a witch '*because he had been able to talk to her with her mind'*.

14.16 On the day of her death, Gemma Simpson and MB had, according to MB, been smoking cannabis in his flat. Evidence given to the Court by MB suggested that he had told Gemma to leave because he had been told by God to kill her. MB says that Gemma started to get angry and said that she would get people in Leeds to beat him up and allegedly asked where MB's children lived. MB states that he perceived this to be a threat. In sentencing MB, the Judge stated the following in relation to whether this account of why MB attacked Gemma was accurate:

'[The] *prosecution accept that there is no good reason to reject your account of the circumstances of the killing whilst accepting your account of the manner of the killing which has been corroborated by the evidence now discovered as a result of your admissions. For all those reasons and I agree with them they have concluded that there would be no proper basis for a jury to reject your account of the circumstances of the killing*.'

14.17 However, the delusions which MB had previously divulged to clinicians whilst in hospital had revolved around a 'gang' which were pursuing him. For example, and as previously mentioned, in a Report by a Forensic Psychiatrist dated 17 September 1999 it was said:

'*His history reveals antisocial* (sic) *traits from a young age, and it is likely that he also suffers from a personality disorder… Fortunately, there does not seem to be much of a history of violence to others. Although he carried a knife, this has been for his own protection. The main danger would be if he was confronted by somebody that he thought was one of his persecutors*'.

14.18 The following comments were made by medical experts at MB's trial:

'*Risks. This is difficult to judge. He has committed a homicide in unusual circumstances but over a decade ago without evidence of reoffending. However, given that in my view mental illness and personality disorder were significant factors he must still be regarded as presenting substantial risk of serious harm to the public. This relates to the view that he has a lifelong personality disorder and he has a relapsing mental illness which has been an important contributory factor in this offence. In addition, his illness has had as one characteristic homicidal ideas*'.

14.19 However, these comments were made with the knowledge that MB had been responsible for the death of Gemma Simpson. There was nothing in the content of MB's previously stated delusions which could have alerted professionals prior to the death of Gemma that Gemma was at a real risk of significant violence exhibited by MB in May 2000. In addition, MB's brother had been part of a complex delusional system involving MB, his brother and a gang. The delusion was that he had to kill his brother by a certain date, but he was determined not to harm him and was therefore at risk from this gang. However, it is important to bear in mind that a Forensic Report dated 17 September 1999 indicated that MB himself had taken steps so as not to harm his brother despite him being part of the delusional system.

14.20 Whilst it could potentially be argued that anyone who became enveloped in MB's delusional system could be at risk, there was no evidence contained in MB's medical records that such a delusional system was present when he was discharged from hospital nor indeed was there any suggestion that Gemma Simpson could have been a part of MB's delusional belief system.

14.21 Preventable:

14.22 From the limited evidence which was available to the Independent Investigation Team, it appears possible that if MB had been fully compliant with anti-psychotic medication and had refrained from misuse of cannabis, then he may not have suffered from a relapse of his psychotic illness. In these circumstances, the death of Gemma Simpson might have been prevented.

14.23 However, notwithstanding the failures in service provision outlined in this report, there were no actions that clinicians could have specifically taken to enforce the continuation of medication given MB's presentation in May 2000 nor indeed enforce his abstinence from cannabis.

14.24 At the point of discharge, staff were aware that MB's delusions had not fully remitted; that he lacked insight; that there was a risk of non-compliance with prescribed medication and of a return to substance misuse. There was therefore a risk of a significant exacerbation of his delusional thinking because of these factors, and a return to the level of risk seen at the time of admission, even if the risk to Gemma Simpson could not reasonably have been foreseen.

14.25 Gemma Simpson's death was not preventable because, at the time of MB's discharge from hospital, MB's mental state appeared, to the treating clinicians to be stable, MB was compliant with leave and there was no evidence that he was misusing cannabis (either on the ward or during periods of leave). Accordingly, there was nothing to indicate that he posed a significant risk to others and certainly not to a particular individual such as Gemma.

14.26 Paragraphs 14.23 and 14.24 refer to aspects of MB's care that could have been done better but this is not to say that Gemma's death was preventable. In particular, there should have been a more systematic and detailed approach to discharge planning, with a repeat risk assessment, a more detailed exploration with MB of the risks of cannabis misuse, a discussion of relapse signatures, and a contingency plan outlining possible courses of action in the event of non-compliance, a return to cannabis misuse or evidence of relapse, notwithstanding the absence of any such eventuality.

Chronology

Date	Event
28 Jul 1969	MB born
1 Nov 1982	MB stealing over a two-year period - referral from GP to Child and Adolescent Psychiatry.
20 Dec 1982	Child and Adolescent Psychiatry Report - “Dissocial behaviour without manifest psychiatric disturbance”.
18 Jan 1983	MB seen by Consultant in Child and Adolescent Psychiatry
19 Jan 1983	Discharged from Child and Adolescent Psychiatry
5 Jul 1984	Admitted to Community Home - No clinical information noted
20 Nov 1985	Discharged from Community Home - No clinical information noted
22 Jun 1992	MB attempted suicide.
17 Aug1999	Presented at Holborn police station, assessed by mental health services, recommended for admission to hospital for assessment under section 2 Mental Health Act 1983 - admitted to Grovelands Priory Hospital, London. Recorded as presenting with an “*acute psychotic episode*”, prescribed Droperidol and Lorazepam, drug screen returned positive for cannabis. Plan formulated – random drug screens until he is drug free, further psychiatric assessment, attend activity and support groups, consider s3 if delusions persist beyond 2 weeks.
18 Aug 1999	Fuller assessment of MB in drug free state following MB’s confirmation that he smoked Cannabis.
19 Aug 1999	Ward round interview – MB said he does feel well, his thoughts are clearer.
20 Aug 1999	Ward round interview - agitated and told mother by telephone would be leaving the hospital. Claimed he was a psychic with telepathic abilities, started upon Olanzapine 5mg at night and Melleril for night sedation.
22 Aug 1999	Ward round; detailed mental state examination – holding delusions less rigidly though some remain, claims to maintain psychic abilities, remains unwell, has given one urine sample, night sedation decreased as unable able to get up for breakfast.
23 Aug 1999	Olanzapine increased to 10mg at night
25 Aug 1999	Ward round interview - Persistent delusional disorder, consider section III. Admits to ongoing delusions, Continue 10mg Olanzapine.
26 Aug 1999	MB transferred to Harrogate District Hospital, discharge note of psychiatrist registrar provided continue Olanzapine 10mg at night, persistent delusional disorder. Psychiatrist felt MB high risk of harm to others.
27 Aug 1999	Letter informing MB’s mother of his transfer to Harrogate and was detained under section 2 MHA 1983.
1 Sep 1999	Ward round interview - noted to be delusional and lacking insight into his illness.
1 Sep 99 – 6 Mar 00	MB granted escorted and unescorted leave, varying in length from 1 hour to (from 2 December 1999) full weekends.
3 Sep 1999	Nursing report prepared for hospital managers - MB electing not to take oral medication.

6 Sep 1999	Ward round interview – stopped medication, needs to ensure safety, denies risk to anyone, not frightened in Harrogate. Request for Consultant Forensic Psychiatrist opinion – MB claims not ill, was never ill, does not need medication. He claims no longer at risk and wishes to leave. Psychiatrist unwilling to allow as full assessment not completed. Requested forensic assessment of "the dangerousness of this man".
8 Sep 1999	Refuses to take medication
13 Sep 1999	MB discharged from section 2 MHA 1983.He remained in hospital as an informal patient.
15 Sep 1999	Correspondence from Harrogate to MB's mother informing her of MB's discharge from section 2 MHA 1983
16 Sep 1999	Consultant Forensic Psychiatrist assessment of MB – clearly suffering from a mental illness, likely schizophrenia or delusional disorder, requires treatment, obvious will not accept voluntarily, recommended s3 MHA 1983 detention. Psychiatrist did not believe would take medication if out of hospital, history reveals antisocial traits from an early age, likely suffers personality disorder – main danger would be if confronted by someone he thought was a persecutor.
21 Sep 1999	Social Assessment Report of MB – Gemma Simpson interviewed at her home and did not want MB to know of her involvement. Informed social assessor of MB's belief in incident after which persecutors began to pursue him, no evidence of this. MB detained under section 3 MHA 1983.
22 Sep 1999	MB appealed section 3 - applied to the Mental Health Review Tribunal.
23 Sep 1999	Refuses to take medication
26 Sep 1999	*Confirmed his continued rejection of oral medication*
27 Sep 1999	*Refuses to take medication…Prescribed medication oral or IM if refused. Medication to be given.*
30 Sep 1999	Date set for MB's appeal to the Mental Health Review Tribunal: Friday 19 November Refused medication
4 Oct 1999	Had been compliant with medication for 4 days. Discharge summary sent from Grovelands Hospital to MB's GP in Harrogate.
5 Oct 1999	Nursing report provides that MB's brother has been contacted at some point regarding MB's recollection of events leading up to his presenting at Holborn police station
8 Oct 1999	Hospital managers' review of detention: section 3 upheld
12 Oct 1999	Drug screen conducted, results indecipherable.
8 Nov 1999	Olanzapine increased to 20mg
9 Nov 1999	MB refused to take increased dosage. Accepted 15mg only

10 Nov 1999	MB refused medication
11 Nov 1999	Recorded as complying with medication
15 Nov 1999	Recorded as complying with medication
19 Nov 1999	Mental Health Review Tribunal in respect of MB's appeal against detention for treatment under section 3 MHA 1983 Outcome: section 3 upheld
2 Dec 1999	First period of overnight leave granted (mother's house)
10 Dec 1999	Risk assessment carried out
20 Dec 1999	Recorded as complying with medication
10 Feb 2000	Section 117 aftercare meeting - key worker in community was appointed, decided he would have outpatient follow up and be prescribed antipsychotic medication. Arrangements made for housing needs to be addressed.
13 Mar 2000	Discharged from Harrogate (and section 3 detention) under section 117. Diagnosis - Paranoid schizophrenia and 'probable' personality disorder.
14 Apr 2000	Circumcision requested.
20 Apr 2000	Harrogate Hospital Out-patient clinic – MB allegedly seen his persecutors, no confrontation, cannot accept this is part of his mental illness, delusions not as intense as previously, felt medication (Olanzapine 15 mg daily) was preventing relapse, to be seen again in 4 weeks' time.
26 Apr 1999	Circumcision request denied by surgeon – "uncomfortable about his reasons for wanting a circumcision… he told me had done a lot of bad things in his life and he felt that being circumcised would make it up to God. I declined to arrange a circumcision"
5 May 2000	Gemma Simpson last seen in Harehills by friend.
18 May 2000	MB visited by FCPN – tired, poor conversation, flat mood, little interest, denied paranoid thoughts, not easy to engage and can be quite cold and dismissive, unlikely taking medication as prescribed.
25 May 2000	Harrogate Hospital Out-patient clinic – stopped work as found it boring, appeared tired, unshaven, not able to elicit psychotic symptoms, informed no longer using illicit substances and uses Olanzapine two thirds of the time.
30 May 2000	MB visited by FCPN – in better sprits and more reactive.
22 Jun 2000	Failed to attend Harrogate Hospital Out-patient clinic.
6 Jul 2000	Harrogate Hospital Out-patient clinic – initially unforthcoming, warmed a little, seems to be drifting and not motivated to find work or daily structure, prefers own company – unable to elicit any psychotic symptoms, denied previous concerns re perceived persecutors, said felt safe and did not need protection with a weapon – did not "like" suggestion he attend day unit. Informed he took the Olanzapine "quite often".
2 Aug 2000	FCPN saw MB at a drop-in centre – seemed responsive but quite guarded…. does not like to discuss his illness.

3 Aug 2000	MB failed to attend outpatient appointment at Harrogate Hospital Out-patient clinic.
4 Aug 2000	FCPN letter to consultant – MB proving a “difficult” participant of services. No reply to numerous visits. Apparently was presenting relatively well, mood reasonable and self-care adequate.
16 Nov 2000	Consultant letter to GP – MB says he feels well, not “overtly psychotic”, seems of normal mood. Continues Olanzapine. Consultant requested GP inform as to whether MB is obtaining a prescription from the surgery.
1 Dec 2000	GP note to Consultant - surgery had no record of prescribing Olanzapine for MB
12 Apr 2001	Consultant letter to GP informing MB admits to not having taken medication for many months, showed no evidence of psychosis, keeping away from illicit substances. Consultant informed care was to be passed back to GP but would see MB again at GP request.
10 Feb 2003	MB registers with GP in Harrogate, informs practice of history of paranoid schizophrenia and no use of medication for almost 2 years, recently feeling paranoid, suspicious of people around him. GP suggests MB restart medication and MB apparently agreeable.
13 Mar 2003	Consultant letter to GP in Harrogate – last seen in April 2001, been prior suffering severe paranoid illness which responded well to medication. Has had none for 2 years. Consultant felt little else to offer MB and discharged to GP
8 Jul 2014	MB confessed to murder of Gemma Simpson.
15 Dec 2014	MB trial at Leeds Crown Court - pleaded guilty to the manslaughter of Gemma Simpson on diminished responsibility.

Glossary

1) **Activated Charcoal** - “Activated charcoal” is similar to common charcoal, but is made especially for use as a medicine. Manufacturers heat common charcoal to develop lots of internal spaces or “pores”. Activated charcoal is used to treat poisonings amongst other uses.

2) **Co-morbidity** - the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder

3) **Deliberate Self-harm/Parasuicide**: Any attempt at self-injury or self-poisoning, which often occurs in the context of acute stress, personality disorder, depression, and alcoholism. The patient is considered to have performed a suicidal act but without the intention to kill him – or her – self. Treatment consists of various forms of psychotherapy, a psychological assessment, and occasionally antipsychotic medication.

4) **DNA** – Did Not Attend

5) **Droperidol** - a drug of the butyrophenone series, used for its antianxiety, sedative, and antiemetic effects as a premedication prior to surgery and during induction and maintenance of anesthesia, as a postanesthesia antiemetic, and to produce conscious sedation; administered intravenously or intramuscularly.

6) **Emetic** - a medicine or other substance which causes vomiting

7) **FCPN** – Forensic Community Psychiatric Nurse: Forensic psychiatry is a specialised branch of psychiatry which deals with the assessment and treatment of mentally disordered offenders in prisons, secure hospitals and the community. It requires sophisticated understanding of the interface between mental health and the law.

8) **Ipecac** - Ipecac has been used as an emetic and treatment for dysentery. It has amebicidal components. It currently is not recommended as an emetic for childhood poisonings. Activated charcoal now is the treatment of choice. Always consult a health care professional or poison control center when an accidental poisoning occurs.

9) **Lorazepam** – This is an antianxiety agent. It is a benzodiazepine and mild tranquilizer, anxiolytic, sedative, anticonvulsant and central nervous system (CNS) depressant.

10) **Melleril** – A typical antipsychotic, it blocks receptors for the chemical dopamine in the brain. At low to medium dosage, Melleril is used to treat tension and anxiety, and it acts against several symptoms of non-psychotic mental disorders such as agitation, depression, and sleep disturbances. At higher doses, Melleril is used to treat disorganised and psychotic thinking. It is also used to help treat false perceptions such as hallucinations or delusions.

11) **Olanzapine** - Olanzapine is considered an "atypical" antipsychotic. This drug blocks multiple receptors, including dopamine and serotonin in the brain.

    This medication is more effective against negative symptoms of schizophrenia than the other classes of antipsychotic medications, though it improves both positive and negative symptoms.

12) **Personality Disorder/Traits** - described in the *International Classification of Mental and Behavioural Disorders* (ICD-10 2002) as 'deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations'; they represent 'either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and particularly relates to others' and are 'developmental conditions, which appear in childhood or adolescence and continue into adulthood' (**World Health Organization, 1992*a***).

    "*a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct*"

13) **Pravolex** - is indicated for the treatment of paracetamol overdose in patients

14) **Schneiderian symptoms**

    - Hearing voices conversing with one another.
    - Voices heard commenting on one's actions (hallucination of running commentary)
    - Thought echo (a form of auditory hallucination in which the patient hears his/her thoughts spoken aloud)

15) **Terms of Reference -**Terms of Reference are the areas of the 'patient's' care that the Independent Investigations Review Group, following liaison with the families of both the perpetrator and the victim and all appropriate stakeholders, deem necessary to investigate.

Panel Membership

Janet Hawthorne LLB (Hons)

Janet Hawthorne is an experienced regulatory lawyer. She has held the position of Legal Director of a national regulator and has represented a variety of regulatory bodies in front of disciplinary tribunals such as the General Medical Council and HPC regulated individuals. She has extensive experience of the practice and procedure relating to performance management and investigation, and has extensive risk management experience gained in the insurance and healthcare sectors. She is a former head of the Investigations Department of Lloyds of London.

Janet has experience of performing NHS Investigations, including Mental Health Homicide reviews, and insight into the unique legal issues, such as whistle-blower protection, and confidentiality. On a practical level, Janet has undertaken a number of complex investigations within the NHS, and is able to put her risk management and governance experience to good use in the healthcare investigations which she performs. As an accredited mediator, Janet is able to work with clinicians to facilitate investigations which deliver a transparent audit trail, and which can sustain public and legal security.

Janet's role would be restricted to providing ad hoc advice where necessary, on issues such as scope of the terms of reference, legal issues relating to confidentiality, evidence gathering, or securing the audit trail of information supporting the Report produced by Iodem.

Dr Gerard Lynch MD FRCPsych

Dr Lynch has held the post of consultant psychiatrist since 1994. During this time he has worked throughout the Northern Health and Social Care Trust based in Belfast in Northern Ireland. Dr Lynch's specialism is in general adult psychiatry with additional experience in community psychiatry, PICU and liaison psychiatry. Dr Lynch has been a consultant in the 'Crisis Resolution Home Treatment Team' since 2009, his contributions were essential to the establishment of this service.

Dr Lynch's role as a clinical director, which he gained in 2003, has allowed him extensive involvement in developments and changes to this service. As part of this role, Dr Lynch conducts appraisals for consultants and speciality doctors; he is also involved in the investigation of complaints and untoward events. On two occasions Dr Lynch acted as a case investigator within the 'Maintaining High Professional Standards' structure when concerns have been raised regarding the performance or conduct of a member of medical staff. Dr Lynch is also a member of the Royal College of Psychiatrists panel and is used in its Independent Review Mechanism. Dr Lynch would perform all of the clinical review aspects of the project plan

Terms of Reference for Independent Investigations under HSG (94) 27/NHS England's Serious Incident Framework 2015

The Individual Terms of Reference for independent investigation 2015/MB are set by NHS England North. These terms of reference will be developed further in collaboration with the offeror and affected family members. However the following terms of reference will apply in the first instance.

Core Terms of Reference

- In the absence of an internal investigation of the incident, review the content of the prepared chronology.

- Conduct a proportionate investigation given the historical nature of the incident which satisfies HSG (94) 27/NHS England's Serious Incident Framework 2015.

- 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 in 2000 (albeit unknown at the time) and in the subsequent period 2000 – 2014.

- Review 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.

- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others

- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.

- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

- Establish contact with both the families of those affected as fully as is considered appropriate, in liaison with the police and other support organisations.

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

- Provide a written report to the NHS England North that includes measurable and sustainable recommendations.

- Assist NHS England in undertaking a brief post investigation evaluation.

Supplemental to Core Terms of Reference

- Support the commissioners to develop a structured plan to review implementation of the resultant action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.

- Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CGG and Trust and feedback the outcome of the assessment to NHS England, North.