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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of a mental health service user Mr W in Sussex

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

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Contents

1 Executive Summary

1.1 NHS England, South commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr W. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

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

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

1.5 Mr W killed Mr Lock on 16 July 2015 after a minor collision between their cars. Mr W stabbed Mr Lock nearly 40 times and then left the scene. Mr W was arrested the following day and charged with the murder of Mr Lock.

1.6 We would like to express our condolences to all the families affected by this incident. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr W.

Mental health history

1.7 Mr W was first referred to one of Sussex Partnership NHS Foundation Trust's (to be referred to as the Trust hereafter) early intervention services in January 2008. He was referred by his GP because Mr W had become increasingly reclusive, abusive and had a poor appetite. Mr W's GP prescribed a "small dose" of olanzapine pending an appointment with the early intervention team.

1.8 The early intervention team in Worthing initially saw Mr W in late February 2008. Following this appointment Dr M, the psychiatrist, noted his "likely diagnosis" as schizophrenia and asked the GP to increase the dose of olanzapine from 5mg to 10mg.

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[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-*

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

1.9 Mr W was allocated a care coordinator, Ms N, who met with Mr W and separately with his parents, Mr Y and Mrs Y, who were separated.

1.10 In March 2008 Mrs Y advised that Mr W would be resuming his job as a lifeguard and would be moving to Brighton. Ms N advised that she would be able to refer Mr W to the early intervention team in Brighton.

1.11 Shortly after this information was received, Mrs Y reported that Mr W had been abusive towards her and had talked about shaving his head. An emergency meeting was therefore arranged with Mrs Y three days later. On the day of the appointment with Mrs Y, Mr W arrived at the clinic base unannounced and asked to see Dr M because he wanted to cease contact with the service. Mr W reported that he wanted to stop taking his medication and that he was feeling better. Dr M noted that Mr W's insight into his illness and treatment was poor and, concerned about a relapse if Mr W were to return to work, arranged a further appointment for three weeks later.

1.12 Mr W did move to Brighton in April 2008 and Ms N made a referral to the Brighton team and informed Mr W's GP of the plans for the Brighton team to take over responsibility for Mr W's care and treatment. Mr I from the Brighton team wrote to Mr W at the end of the month and invited Mr W to make contact with him by email or phone.

1.13 There is no evidence that Mr W responded to this letter, nor that there was any follow up made by Mr I until late June 2008 when Mrs Y made contact expressing concerns about Mr W. Mr I made an unsuccessful attempt to contact Mr W at home, and left a note asking him to make contact.

1.14 There were no further attempts made by the service to contact either Mr W or his parents in 2008. However at the end of December 2008 Mr Y emailed Mr I to let him know that Mr W would be returning to Worthing to live with his mother in the new year.

1.15 In January 2009 Mrs Y also made contact with Mr I to advise that Mr W was planning to return to Worthing. Mr I subsequently advised the Worthing team of this information and Mr W was seen, albeit very briefly because Mr W left the house, by the Worthing team within 24 hours. At this time there were significant concerns being expressed by Mr W's family about his wellbeing. Mrs Y reported obsessive behaviour and arguments between Mr W and family members. On one occasion, Mr W had thrown a glass that had smashed near his mother's head. Although a decision was made to offer to see Mr W at his home, Mr W did not respond and in fact Mrs Y reported that Mr W had shredded the letter without even opening it.

1.16 The early intervention service had further contact with Mrs Y and Mr W's uncle and a decision was made to make a referral to the autistic spectrum disorder service for guidance on meeting Mr W's needs after assessing whether he fitted the criteria for Asperger's Syndrome.

1.17 There was no direct contact between the early intervention service and Mr W until April 2009. However during February and March Mr Y, Mrs Y and her

brother had either spoken or met with early intervention staff on five occasions. Mrs Y reported that Mr W often appeared anxious and had continued to burn documents in the garden, rearrange ornaments and shred photographs of himself that he considered unflattering. Mr Y later reported an improvement in Mr W's mental state.

1.18 When Mr W met with his care coordinator in April 2009 he reported that he found engaging with others "less stressful" and that he was learning his tasks for his job in a fast food cafe but that he found busy times confusing and difficult. Mr W met with his care coordinator Mr T and his consultant psychiatrist Dr E in May when Dr E noted a likely psychotic illness and "query" Asperger's. Dr E indicated that Mr W would benefit from treatment but that his risks were not sufficient to warrant use of the Mental Health Act. Around this time Mr Y and Mrs Y were reporting confusing communications with Mr W and that Mr W had said he did not want to take medication. Mr Y later reported feeling overwhelmed by Mr W's behaviour.

1.19 Mr T met with Mr W on four occasions in June 2009. Towards the end of the month Mr T reported that a violent incident had taken place at Mrs Y's home resulting from Mr W's incorrect belief that his mother had called him a paedophile. There was an argument that escalated and the police were called to de-escalate the situation. Mr W did not attend the subsequent meeting with his parents and Mr T.

1.20 During July and August 2009 there were a number of contacts with Mr W and Mrs Y. It appeared that Mr W's presentation was more stable and that there had been only a couple of incidents when he had been abusive towards his mother.

1.21 In September 2009 Mrs Y reported having found crude drawings of Mr W with derogatory sexualised comments. Mrs Y reported that she did not believe that these had been drawn by Mr W and consequently wondered if Mr W was being bullied at work. Mr W continued to hear voices but was described as rejecting any psychotic diagnosis and refusing to consider any medication. Mr W was having financial difficulties and was supported by his care coordinator to attend appointments at the Citizen's Advice Bureau to access advice and support in managing his debts and benefit applications. Mr W was concerned that he would be labelled as "mad" by support services.

1.22 In November 2009 Mr W disengaged with the early intervention team and advised Signposts[3] that they were not to share any information about him with the early intervention team. A decision was made that the team would stay in touch with Mrs Y and Mr Y. Following this Mrs Y reported that she remained fearful of Mr W and his potential to explode, however this information did not change the chosen approach by the team. Mrs Y was in contact with the service about twice a month, and in April she reported that Mr W had become very angry, had swung the fridge doors off the hinges, had threatened to hit Mrs Y and had said "he might as well kill himself". Mrs Y later reported a

[3] Signposts is a charity that supports people with learning difficulties to live independent and fulfilling lives in the community

further aggressive incident. It appears that no action was taken by the service in response to this information.

1.23 In July 2010 Mrs Y made contact with the service again to report a series of events the previous evening. Mr W had been lying in the garden in his underwear complaining of feeling sick and stating he wanted to go to Brighton to have sex with his girlfriend for money. It was agreed that the need for an appointment was not urgent and that Mrs Y would wait for Mr W's care coordinator to return two days later. Mr Y later reported that Mr W was not hearing voices and that he felt "okay". However Mrs Y made further reports of strange behaviour by Mr W and in August Mr Y reported that Mr W had lost his job and that he (Mr Y) believed it was because Mr W had been rude to a customer. Around this time it was also reported that Mr W had been visiting a prostitute in Brighton.

1.24 It was not until September 2010 that an urgent appointment was arranged for Mr W to see Mr A. By this time it had been three months since staff had made face-to-face contact with Mr W because in July Mr W's parents had reported that Mr W would not agree to have contact with the service. The appointment was arranged after Mr W's parents had made contact to report an incident that led to Mrs Y calling the police. Mr W had woken his mother in the middle of the night and thrown a glass jug at her, blaming her for "many things". A plan was made for Mr W to see Dr R and for Mr A to contact Mr and Mrs Y, however it was noted that Mr W was not considered a risk to himself or others. Mr W's behaviour towards his parents continued to present as bizarre and aggressive and Dr R prescribed quetiapine[4]. Later in the month Mr Y reported to Mr A that in his opinion Mr W's issues were mostly associated with autistic spectrum disorder. Although a diagnosis of autistic spectrum disorder had not been made, staff continued to work with Mr W as if this were the case.

1.25 During October 2010 discussions took place about Mr W moving to independent accommodation. Mr W reported that he had been compliant with the medication and that he would prefer to live with his mother. However shortly afterwards Mr W told his father that he had decided to stop taking his medication and Mr Y was advised to monitor Mr W for signs of any deterioration. Mr W made contact with the early intervention team to advise that he was considering disengaging with the service. He also reported to Mr A that he had stopped taking his medication. An arrangement was made for Mr W to see Dr R and again Mr W reported that he was not taking the medication, and had never done so. It was agreed that the early intervention team would work with Mr W on psychosocial issues and continue to monitor Mr W's mental state.

1.26 Mr W appeared to engage, at least on a superficial level, with the service for the next couple of months with little incident taking place at home. However in December 2010 Mr W refused to attend an appointment with Mr A because

[4] *Quetiapine is an antipsychotic and belongs to a group of drugs used to treat certain mental illnesses. It affects how chemical messengers in the brain, known as neurotransmitters, are able to direct brain activity. In general this drug is used to treat schizophrenia, as well as manic or depression episodes associated with bipolar disorder. drugs.webmd.boots.com*

he was being encouraged to discuss personal things, which he (Mr W) did not like. Around this time Mr W's care coordinator spoke to the autistic spectrum disorder service lead who advised that Mr W had only attended one appointment and therefore the assessment was not complete. Following this a clinical discussion took place and Mr W's level of risk was increased.

1.27 In early 2011 it was reported that Mr W had started a relationship with an older woman and that it appeared to be having a positive impact on Mr W. Around this time it was agreed that because Mr W had been in the care of an early intervention service for nearly three years, it was time to start planning for his discharge from the service. Mr W was continuing to display obsessional behaviour (now towards his girlfriend too), showing signs of anxiety and hearing voices. However within a couple of months it was reported that Mr W was doing well and that Mr W remained unwilling to engage with the early intervention service. Information continued to be sought from Mr Y and Mrs Y and it was felt that Mr W should see Dr R prior to discharge for a final medical review.

1.28 However in April 2011 Mrs Y called Mr A to inform him that Mr W had told her he was hearing voices telling him to do inappropriate things. This including Mr W saying he wanted to "shoot out the part of his brain that was causing the voices". There were differing views from Mr Y, Mrs Y and Mr W's care coordinator about the reason for Mr W's behaviour.

1.29 Over the following few months Mr W moved into his own flat and reports indicated that he appeared to be functioning better. However, he continued to miss appointments including his medical review at the end of June.

1.30 Mr W did attend two appointments during July 2011 and reported that he had received a letter from the autistic spectrum disorder service and that he didn't want to keep the appointment because he didn't feel the service was right for him. At the discharge Care Programme Approach meeting at the end of the month Dr R noted that he thought that Mr W had "autism with episodes of psychotic symptoms when under stress". At this time Dr R had discounted a primary psychotic diagnosis such as schizophrenia. It was planned to refer Mr W to a community mental health team because he was about to move to a new area. This referral was made in October.

1.31 In late October 2011 Mr W and his parents met with Ms S an autism spectrum disorder practitioner, who noted that neither Mr W nor his parents were aware of his diagnosis of autism (which of course they would not have been because Mr W had not been diagnosed with autism). By this time Mr W was being prescribed pregabalin[5] to help with anxiety and in November the dose was increased to 150 mg daily and Mr W was provided with a medical certificate for two months.

1.32 In December 2011 Mr W saw Dr O who noted that Mr W had been diagnosed with psychosis but that an assessment for autistic spectrum disorder was in

[5] *Pregabalin can be helpful in treating the symptoms of generalised anxiety disorder (GAD), particularly if other medicines which are more often prescribed for people with this condition are not suitable. https://patient.info/medicine/pregabalin-lyrica*

progress. Mr W told Dr O that he had stopped taking pregabalin and that although he had been prescribed quetiapine, he had never taken it. Dr O's view was that he wanted to see Mr W a couple of times before coming to a conclusion about his diagnosis.

1.33 In early 2012 Mr W presented at the community mental health team base complaining of being unwell. It transpired that he had taken three times the dose of pregabalin over the previous six days.

1.34 In March 2012 Mr Y wrote to Dr O to express his concerns about the lack of support he felt Mr W was receiving. Mr Y asked for an urgent meeting and confirmation that a care plan was in place. Dr O responded to say that he had been seeing Mr W regularly and that a care coordinator would be allocated to him. Dr O also advised that Mr W had "consistently refused permission" for Dr O to contact either Mr Y or Mrs Y.

1.35 The following month, following a medical review meeting Dr O wrote to Mr W's GP and noted Mr W's diagnosis as Asperger's Disorder.

1.36 During June 2012 it was reported that Mr W had been hearing voices and had gone to the house of a family friend with a hammer. Mr W had smashed a car window and threatened the family friend. The police were called and Mr W told his father that he had to do it because of the voices. At a follow up medical appointment Mr W reported doing irresponsible things and that he was hearing voices.

1.37 The following month Mr W had a meeting with a new care coordinator, Mr F. During this meeting Mr W was still agitated following the incident with the hammer and Mr Y stated that he felt Mr W needed to be detained under the Mental Health Act. Both Mr W and his girlfriend reported that he was compliant with his medication and in light of this information Mr F advised that he did not consider that Mr W needed to be assessed under the Mental Health Act, but he would refer Mr W to the autistic spectrum disorder service.

1.38 In August 2012 Mr F attempted to meet with Mr W as arranged but Mr W was not at home and Mr F was unable to contact him. Mr F did contact Mr Y who reported that Mr W was doing well and that he was not concerned about him. However a few days later Mrs Y contacted Mr F and reported that she was unsure whether Mr W was taking his medication. Mr W had appeared anxious and rude when she had seen him a day or so earlier. Mr W did admit to hearing voices but refused to discuss the matter in any detail with Mr F.

1.39 In October Mr Y reported that Mr W had confronted a member of the public in the street and had attempted to grab him but he had run off. Mr F explained it was his view that Mr W's confrontation was directly related to his mental health problems and that if the behaviour continued Mr W could be arrested, resulting in either a criminal record or formal detention in a psychiatric unit.

1.40 Mr W was seen by Dr O in November 2012 when he reported that he had been taking the olanzapine regularly and the pregabalin when he felt he

needed it. Mr W said the voices continued and that the content was distressing for him.

1.41 In January 2013 Mr W reported that he had removed and thrown away the storage heaters from the walls in his rented property because his new pet rabbit had chewed through the wires. Mr W had caused damage to the flooring in doing so and consequently the landlord had refused to renew the tenancy agreement so Mr W had to find somewhere else to live by the end of March.

1.42 Mr W did not attend his medical appointment later that month, but was seen once in February and once in April 2013 by Mr F.

1.43 In June 2013 Dr O saw Mr W who reported that he had put on weight and wanted to decrease his medication. Dr O suggested alternative medications but Mr W was not keen.

1.44 Mr W's mental state started to decline and he reported hearing voices and accused his father of calling him a paedophile. Mr F agreed to arrange an appointment with Dr O, however despite a follow up letter from Mr Y, Dr O did not see Mr W until mid-November 2013, more than three months later. The letter from Mr Y expressed significant concerns about Mr W's behaviours. Mr Y noted that Mr W "could end up seriously injuring someone or worse" unless he received proper medication and treatment. There is no indication that Dr O ever responded to this letter.

1.45 Mr W was not seen again by the service until 5 November 2013 but it is unclear why there was such a long period of time with no contact. At this meeting Mr Y reported another incident when Mr W had confronted a member of the public and that he had followed somebody else. Again Mr F told Mr W that the police would detain him if the behaviour continued. At the medical review two weeks later Mr W's parents met with Dr O. They expressed concern about Mr W's mental state, medication compliance and lack of psychological therapy. Mr W reported that he had not taken any medication at all for the previous nine months (contrary to a number of other reports he had made previously). Although Mr W agreed to try a different medication the clinical team felt it was unlikely he would comply with the treatment.

1.46 Mr W was not seen again by the clinical team in 2013 for reasons that we have not been able to establish.

1.47 In January 2014 Mr W again presented at his father's home with unusual behaviour. By this time Mr W had disengaged with the housing support provider. When Mr F met with Mr W he reported that he had started some voluntary work at a stables and that he had not been taking his medication, neither was he experiencing any hallucinations. Shortly afterwards Mr W's girlfriend contacted Mr F and reported that Mr W had been sexually demanding, controlling and jealous, regularly insinuating that she had been unfaithful to him. Mr F organised a medical review that took place in early February. Mr W again reported that he had not taken his medication and that he would not do so.

1.48 In mid-March 2014 Mr Y contacted the community mental health team to express concern about Mr W's welfare because of his behaviour over the previous weekend. Mrs Y then called Mr F to report that Mr W had attended his girlfriend's work place and assaulted a customer, who then assaulted Mr W in response. Records from Mr Y show that he emailed Dr O to remind him of the concerns that he (Mr Y) had raised the previous September, there is no evidence that Dr O responded to Mr Y. Mr W was not seen by clinical staff until the beginning of April when he stated he did not want Mr F to report any information to the police.

1.49 A multi-agency meeting took place at the end of April 2014 when Mr W's behaviours over the previous few years were noted. The agreed plan was for Trust staff and Mr W's family to report any violent incidents to the police, the police to place a tag on Mr W's property so that other officers would be aware of his history, and the police community support officer would remain the point of contact for the police.

1.50 At the end of May 2014 Mr F received an email from Mr W's girlfriend who advised that Mr W had confessed to her that he had been visiting brothels since the start of their relationship. Despite this, Mr W was still accusing his girlfriend of cheating on him saying that King Henry VIII beheaded his wives because they cheated on him. Mr W's girlfriend expressed significant concern about Mr W's risks saying "what's to say he won't kill someone if he goes into one of these out of control body experiences". Mr F encouraged her to report the incident to the police and later emailed a summary of the information to the police expressing his concern for Mr W's girlfriend and her 17-year-old daughter. However there is no indication of any action taken in relation to Mr W's mental state.

1.51 Within a few days Mr W's girlfriend again contacted Mr F to say that Mr W had "turned nasty" again and accused her of being a prostitute and saying he wanted her to die. Again there is no indication of any action taken by Mr F in relation to Mr W's mental state. However five days later Mr F met Mr W in a coffee shop. Mr W reported that he had assaulted two members of the public because he felt they were being abusive towards him. Mr F reported this information to the police community support officer and asked if any reports had been made to the police.

1.52 At the end of June 2014 Mr F contacted Mr W to inform him that he would be leaving and that Mr W would have a new care coordinator, Mr J.

1.53 At the beginning of July Mr R, a service manager, attended a MARAC meeting that had been arranged regarding Mr W's behaviour towards his girlfriend. Later that month Mr W attended A&E complaining of paranoid delusions. He was assessed and prescribed some olanzapine. Mr W was seen by Mr J who noted that Mr W was describing hearing voices and the presence of other people. A discussion took place about prescribing olanzapine on an 'as required' basis and Mr J agreed to follow it up with Dr O. Despite contacting Dr O on three occasions Mr J did not receive a response until mid-September, following which Mr J was unable to contact Mr W.

1.54 At the end of September 2014 Mr J asked for a complex case formulation meeting to be held to discuss Mr W's case. Dr O was invited but was unable to attend and by the time the meeting took place in mid November Mr W had assaulted his brother in their mother's home.

1.55 In October 2014 Mr J meet with Mr W and discussed the impact of olanzapine on Mr W's ability to drive. Mr J sought advice from Dr O who indicated that Mr W could continue to drive provided that Mr W was aware of the risks when taking it. Dr O also suggested that Mr W be encouraged to inform the DVLA of his diagnoses and prescription. Mr W heeded this information and provided the relevant advice to the DVLA who later wrote to Dr O. Dr O informed the DVLA that although Mr W experienced auditory hallucinations they "had not had an impact on behaviours such as self-care, instructions or aggression".

1.56 In early 2015 Mr W purchased a number of goats and a foal and it was reported that he was not being entirely truthful with staff. Mr W was allocated another new care coordinator, Mr E, in February who made a number of unsuccessful attempts to meet with Mr W. Eventually in March Mr E did meet with Mr W and noted that some of his behaviours appeared to be due to paranoia rather than anger. Mr W was still being prescribed olanzapine on an 'as required' basis at this time but he reported that he was taking it more often. At the end of March Mr Y reported that Mr W had been feeling anxious and paranoid and had not been able to attend appointments with Mr E. By mid-April it appeared that Mr W's anxiety and paranoia had improved, apparently having taken medication.

1.57 Towards the end of May 2015 Mr W reported that he was taking the medication occasionally to manage his anxiety but agreed that he needed to take it more regularly.

1.58 Throughout May and June 2015 the issue of Mr W's finances were problematic and a number of appointments were arranged to support him with this issue.

1.59 In early July 2015 Mr W reported that he was sleeping well and not experiencing any persecution in the street. A further appointment was arranged with a finance support worker because Mr W had a significant amount of unopened post.

1.60 Shortly afterwards Mrs Y reported that Mr W had fallen out with his girlfriend because he had been physically abusive towards her. Mrs Y expressed concern at Mr W's mental state and said that he had stopped taking his medication. Within two days of this report Mr W attacked and killed Mr Lock.

Relationship with the victim

1.61 There is no evidence that Mr W knew or had any contact with Mr Lock prior to minor collision between their vehicles on 16 July 2015.

Offence

1.62 On 16 July 2015 Mr W killed Mr Lock after a minor collision between their cars which took place on the A24 in West Sussex. Mr W had braked suddenly and Mr Lock's car bumped into the back of Mr W's car. Mr Lock left his vehicle and asked Mr W why he had stopped. Mr W then stabbed Mr Lock.

1.63 On 16 May 2016 a jury acquitted Mr W of murder but found him guilty of manslaughter.

Sentence

1.64 On 8 July 2016 Mr Justice Singh sentenced Mr W to life, with a minimum term to serve of 10 years. Mr W was detained to a secure mental health hospital under Section 45a[6] of the Mental Health Act.

1.65 In sentencing Mr Justice Singh said:

> "It is clear from the evidence which was given at the trial that for many years the Defendant was either wrongly diagnosed or under-treated. His parents had tried valiantly to get help for him from at least 2008. Although this is not a straightforward case even for the medical professionals, it has now become clear, consistent with evidence which the jury must have accepted at the trial, that the Defendant suffers from paranoid schizophrenia. He has suffered for many years from delusions and auditory hallucinations. It is only recently, while he has been detained in a medium secure unit at [*], that he has received the therapeutic anti-psychotic medication which he needs for that psychosis. In the view of the treating clinician, [Dr L], the Defendant has begun to improve his mental health as a result of that treatment."

Internal investigation

1.66 The Trust undertook an internal investigation that was led by a service manager and a consultant psychiatrist.

1.67 The report identified eight care or service delivery problems. They were:

- Unclear diagnosis;
- Incomplete risk assessment;
- Poor risk management;
- Ineffective treatment;
- Inappropriate response to concerns raised 48 hours prior to the incident;

[6] *Section 45a is an order which the Crown Court can make at the same time as imposing a prison sentence (except where the sentence is fixed by law, i.e. murder) upon an offender who suffers from mental disorder: s45A(1),(2). A "limitation direction" must also be given: s45A(3). A hospital direction has the same effect as a transfer direction under s47; a limitation direction has the same effect as a restriction direction under s49. The sentenced person goes straight to hospital but is treated as if he had been transferred to hospital from prison under s47/49. Before the end of the sentence he can be transferred "back" to prison to serve the remainder of the sentence. At his release date the restrictions cease; however, for convenience, in these notes s45A patients are always treated as restricted.*

- Lack of longitudinal clinical review of the patient's presentation and management;
- Lack of appropriate family engagement;
- Inconsistent inter-agency communication and incident reporting.

1.68 Nine recommendations were made:

1. The team (and wider service) should introduce peer review mechanisms for patients who have received care and treatment for longer than two years.
2. The Trust should develop electronic risk assessment tools which "pull through" previous risk events in a historically based way.
3. Ensure risk assessment training delivers a clear understanding of risk markers in dual diagnosed patients and an understanding of the need to reformulate risks when new risk events occur.
4. Review carer engagement methods and processes within the team and ensure all staff understand the need to document written communication with carers and to provide and document response to such communication.
5. All teams to have representation at Triangle of Care Meetings to further inform and support carer engagement.
6. Review the benefits of specialist outpatient (OP) clinics where the allocated consultant does not work alongside the local team. Where such clinics exist communication processes and systems should be agreed and documented.
7. Ensure all staff within the team understand the importance of accurate record keeping and the need to complete care plans and risk assessments to an agreed standard.
8. Ensure Trustwide all practitioners are aware of formal and informal referral methods to obtain a forensic opinion.
9. To ensure training of dual diagnosis in the context of Psychosis and Autistic Spectrum Disorder becomes an essential aspect of training

1.69 An additional recommendation was added to the action plan, related to the practice of a psychiatrist. This was:

"Commence review of professional practice and identify appropriate actions as indicated".

1.70 The Trust developed an associated action plan and both documents (the investigation report and the action plan) were scrutinised internally and externally by Coastal West Sussex Clinical Commissioning Group. There were two recommendations that were not explicitly referenced in the action plan (recommendations 5 and 8) however there was evidence within the monitoring report that recommendation 5 had been addressed.

1.71 Coastal West Sussex Clinical Commissioning Group has provided us with limited evidence to indicate the actions they took in scrutinising the report and action plan and monitoring progress of the action plan.

Independent investigation

1.72 This independent investigation has reviewed the internal process and has studied clinical information, witness statements, interview transcripts and policies. The team has also interviewed staff who had been responsible for Mr W's care and treatment and spoken with Mr W, his family, and Mr Lock's family.

1.73 We have provided an assessment of the internal investigation and associated action plan, including oversight by Coastal West Sussex Clinical Commissioning Group of the improvements required.

1.74 We have also reviewed the communication between the Trust and Mr W's family and the Trust and Mr Lock's family and provide comment on the timeliness and appropriateness of those communications.

Conclusions

1.75 Mr W had been under the care of the Trust for more than seven years at the time of Mr Lock's death. We can see that Trust staff did make efforts to engage Mr W. However, because the Trust had failed to undertake robust assessments in relation to psychosis and autism, this led to a flawed set of assumptions about how to manage Mr W.

1.76 Added to this was the fact that staff considered his violent behaviours as matters for the criminal justice system, and not directly related to Mr W's mental illness. This position denied Mr W the opportunity to receive appropriate treatment and consequently resulted in Mr W's behaviours gradually escalating over time.

1.77 It is our view that there was clear evidence that Mr W's levels of violence had increased such that serious harm to others was increasingly likely. However, we acknowledge that staff could not have predicted that Mr W would have killed Mr Lock in the way that he did in July 2015.

1.78 It is our view that had Mr W been in receipt of effective therapy starting at any stage between 2008 and 2015 the tragic death of Mr Lock may have been avoided.

1.79 It is our opinion that the root cause of this incident lies in the Trust's failure to ensure that robust assessments were undertaken, in accordance with NICE guidelines.

Recommendations

1.80 This independent investigation has made 21 recommendations for the Trust to address in order to further improve learning from this event. We have also made one recommendation for the Clinical Commissioning Group.

1.81 The recommendations have been given one of three levels of priority:

- **Priority One:** the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.
- **Priority Two:** the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients but identifies important improvement in the delivery of care required.
- **Priority Three:** the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Priority One

Recommendation 4

The Trust must ensure that the effectiveness of the training in dual diagnosis of psychosis and autism is assessed and monitored.

Recommendation 6

The Trust must seek further assurance that the liaison between stand-alone specialist consultants and teams responsible for the care coordination of clients has sufficiently mitigated the risk of the more remote way of working.

Recommendation 7

The Trust must assure itself and its commissioner that when investigations into concerns about medical staff are commissioned, the Trust policy is followed.

Recommendation 9

The Trust must undertake an audit of all clients with a diagnosis of autism to ensure that appropriate evidence is present to support the diagnosis. Where the required evidence is not present appropriate remedial action must be taken.

Recommendation 11

The Trust must ensure that processes are in place for effective multi-disciplinary review of clients who present with recurring or escalating risks.

Recommendation 12

The Trust must ensure that the benefits of informal admission are properly considered and documented. If a client is not compliant with their treatment plan consideration is given and documented for assessment under the Mental Health Act.

Recommendation 14

The Trust must ensure that a documented multi-disciplinary discussion takes place when there has been no face to face contact with a client for more than six months.

Recommendation 15

The Trust must properly consider and document risks, and take appropriate action where children and young people are having contact with a vulnerable adult.

Recommendation 16

The Trust must ensure that actions from a MARAC are clearly recorded in relevant clinical records so that all staff can take appropriate and timely action where necessary.

Recommendation 17

The Trust must ensure that information provided to the DVLA is complete, follows the DVLA guidance, and adequately represents all the available information available about the client including multidisciplinary records.

Recommendation 18

When staff are in receipt of information about a possible offence the Trust must ensure that there is a process for relevant information to be shared with police in a timely fashion and that staff follow the relevant risk assessment policy.

Recommendation 19

When managing the oversight of serious incidents, the Clinical Commissioning Groups must ensure that their own policies are fit for purpose and that relevant staff understand and adhere to those policies. The Clinical Commissioning Groups must also ensure that the effectiveness of new arrangements is monitored and that appropriate responses are in place to remedy non-compliance.

Priority Two

Recommendation 1

The Trust must ensure that communications with families use plain English and that when information cannot be provided there is an honest and clear rationale.

Recommendation 2

The Trust must ensure that there is a defined process for ensuring that the Family Liaison Lead keeps affected parties up to date regarding progress of serious incident investigations.

Recommendation 5

The Trust must gain assurance that the appointment of the carer lead in Coastal West Sussex is making a difference to carers.

Recommendation 10

The Trust must ensure that proper consideration is given and information provided when suggesting medication to clients.

Recommendation 13

The Trust must ensure that communication from families is logged appropriately and that a timely response is given. The Trust must also ensure that information is given to carers indicating what other routes are available to them if they are not satisfied that their concerns are being taken seriously.

Recommendation 20

The Trust must ensure that all recommendations presented in a serious incident report are reflected in the associated action plan. The Trust must also ensure that if additional recommendations not presented in the serious incident report are added to the action plan there is a clearly stated rationale.

Recommendation 21

The Trust must assure itself and commissioners that all actions within serious incident reports and associated action plans are completed within an appropriate timeframe.

Priority Three

Recommendation 3

The Trust must assess the effectiveness of the peer review process and make any necessary adjustments if the effectiveness is unsatisfactory.

Recommendation 8

The Trust must ensure that guidance is in place for staff completing serious incident investigation reports that they use plain English and that the templates include section numbering, page numbering and a table of contents.

Good practice

1.82 Clinical entries made by care coordinators were very detailed and provided a significant amount of information about the content of interactions with Mr W, his parents and his girlfriend.

1.83 The Trust has developed a process to prepare and support staff who are required to provide evidence to independent investigations. This has been developed in response to a criticism in an earlier investigation. The process

has been described and is shared with staff in a briefing meeting prior to their interview with the independent team. Staff are also offered the opportunity for a de-briefing meeting once all the interviews have taken place.

1.84 The Trust has introduced a new role of Family Liaison Lead. This new role aims to provide additional support to affected families and carers following a significant serious incident such as a homicide, inpatient suicide or where someone has very complex care needs. This role is provided in addition to the allocation of a serious incident investigation team. This is the first time we have encountered this approach and it is to be commended. We have shared high-level information about this new role with another NHS Trust that has already expressed interest in developing a similar role.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework[7] (March 2015) and Department of Health guidance[8] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

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

2.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.

2.4 The investigation was carried out by Naomi Ibbs, Senior Associate for Niche, with expert advice provided by Dr Ian Davidson, Consultant Psychiatrist.

2.5 The investigation team will be referred to in the first person plural in the report.

2.6 The report was peer reviewed by Carol Rooney, Deputy Director, Niche.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[9]

2.8 NHS England contacted Mr W at the start of the investigation, explained the purpose of the investigation and sought his consent to access to relevant records. Mr W gave his consent and this was used to obtain all information used in relation to him.

2.9 We used information from the Trust, Mr W's GP surgery, Mr W and Mr W's father (Mr Y) to complete this investigation.

2.10 As part of our investigation we interviewed:

- Lead Investigator for the serious incident (internal) investigation;
- Clinical Advisor to the serious incident (internal) investigation;
- Consultant Psychiatrist for the early intervention service, Worthing;

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[7] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

[8] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

[9] *National Patient Safety Agency (2008) Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

- Care coordinator for the early intervention service, Worthing;
- Care coordinator for the early intervention service, Brighton;
- Consultant Psychiatrist for the early intervention service, Brighton;
- Specialist Nurse Practitioner for the autistic spectrum conditions service;
- Specialist Practitioner and Team Leader for the autistic spectrum conditions service;
- Consultant Psychiatrist for the community mental health team and latterly the neurodevelopmental disorders clinic;
- Care coordinator for the community mental health team, Worthing;
- Care coordinator for the community mental health team, Worthing.

2.11 The Trust provided a briefing session to staff participating in the interviews with us. In this session the advice to staff included:

- to read and familiarise themselves with the internal investigation report;
- to read their notes and their clinical contacts.

2.12 All interviews were digitally recorded and interviewees were subsequently provided with a transcript of their interview. Interviewees were invited to review the transcript and to "add or amend it as necessary, then sign it to signify that you agree to its accuracy and return it to Niche". Interviewees were further advised that if we did not receive the signed transcript within two weeks, we would assume that the interviewee accepted the contents as accurate. We undertook twelve interviews and nine transcripts were returned to us.

2.13 A full list of all documents we referenced is at Appendix B, and an anonymised list of all professionals is at Appendix C.

2.14 We have adhered to the Salmon and Scott principles as outlined below:

"The Salmon Process' is used by a public Inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1966 Royal Commission on Tribunals of Inquiry. The Salmon Report set out general principles of an adversarial process for conducting an inquiry, similar, in essence, to what may be expected in a court of law. However it was recognised by Lord Justice Scott, during his 1992 inquiry into the sale of arms to Iraq, that it is not practicable or appropriate in all cases to conduct an inquiry with a full adversarial process. Whilst recognising that it is proper that all witnesses must be able to adequately present their evidence, and have access to legal advice if required, it is not necessary to allow a full process of examination and cross-examination by legal counsel in order to achieve fairness in the course of proceedings. In many cases, the financial and logistical implications of such a process would have a significant detrimental impact on the ultimate aim of the inquiry; to reach conclusions on the issue under consideration."

2.15 The draft report was shared with NHS England, the Trust, the GP surgery and Sussex West Coastal Clinical Commissioning Group. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with the victim's family

2.16 Contact for the victim's family was with Mr Lock's son and daughter-in-law. We met with them at the start of the investigation to explain the investigation process and invited them to contribute to the terms of reference.

2.17 Mr Lock (junior) was understandably still distressed about what had happened to his father. Mr Lock had a number of questions that he wanted our investigation to address; most of which were already included within the draft terms of reference. However a key question for him was the issue of whether Mr W's diagnosis and details of his medication had been reported to the DVLA. We have addressed this issue later in the report.

2.18 We met with Mr Lock's family prior to the publication of the report and shared the key findings. We explained why we had made our recommendations and what action the Trust would now have to take.

2.19 They were particularly concerned that the lessons identified from this investigation should be picked up by other organisations. The Lock family sought confirmation from NHS England regarding the processes within the NHS for learning lessons across organisations.

2.20 The Lock family were also concerned about the role of the DVLA in withdrawing driving licences where it is appropriate to do so. Our review within this report was focussed on the inputs and decisions of health and social care services and therefore we have not sought further information from the DVLA on this matter.

2.21 Mr Lock (junior) asked that our use of the term "affected families" be amended to "affected parties" in order to allow for lessons learned to be applied more broadly when appropriate to do so. We have made this amendment.

Contact with the perpetrator's family

2.22 Contact with the perpetrator's family was with Mr W's father, mother and brother. We wrote to them at the start of the investigation with the offer to meet with us so that we could explain the process of the investigation and invite them to share any specific concerns about Mr W's care and treatment.

2.23 We met with Mr W's father, Mr Y and then separately with Mr W's mother and brother, Mrs Y and Mr G.

2.24 When we met with Mr Y, he provided a large number of documents in both hard copy and electronically. This information gave an overview of the family's intervention with Mr W over a number of years. Nearly all of the

information provided in the sections about Mr W's childhood and family background, training and employment, relationships, and history of violence comes from Mr Y's summary and associated documents. We have therefore not repeated the information provided by Mr Y here.

2.25 We met with Mr Y and Mrs Y prior to the publication of the report and shared the key findings. We explained why we had made our recommendations and what action the Trust would now have to take. Mr Y provided us with a detailed response to the report and asked for further clarification on some aspects of our findings. We provided the clarity on our findings and made some minor appropriate amendments in response to his letter.

Contact with the perpetrator's ex-girlfriend

2.26 It became clear that Mr W's girlfriend at the time of the incident might have helpful information to provide context to Mr W's behaviours as described to clinical staff. We therefore asked the Trust to forward a letter from us to her inviting her to meet with us. We did not receive a response and because of the sensitive nature of her involvement with Trust staff we felt it would be insensitive to make contact a second time.

Contact with the perpetrator

2.27 We met with Mr W after we had interviewed staff. Mr W was pleased to meet us and was happy to share information about his perceptions about his care and treatment.

2.28 Mr W told us that his parents had first contacted mental health services after he had become physically unwell. He had become bed-ridden with an allergy to penicillin that had been prescribed. This was around 2007.

2.29 Mr W told us that he had worked as a lifeguard and had completed a rescue in Eastbourne that had left him "traumatised". After this he was hearing voices and mental health services diagnosed this as psychosis.

2.30 Mr W appeared not to be fully aware of the roles of some of the staff that he had spoken with, for example he told us that he couldn't remember talking to a psychologist but that he found Ms L (the team clinical psychologist) helpful. Mr W said that he was able to talk to Ms L in a way that he was unable to talk to his care coordinator.

2.31 We asked Mr W what his views were about how a hospital admission could have helped him when he was still living in the community. Mr W told us that he now believes hospital would have been good for him but that he did not believe that to be the case at the time.

2.32 Mr W told us that he was not truthful with staff and that he put on a brave face because he did not want to lose his freedom. Mr W could not recall why he did not want clinical staff to go to his flat, in retrospect he wondered if it was because he would have to wait outside because his doorbell didn't work. Mr W did not like having to wait around outside his flat.

2.33 Mr W found Mr A and Mr F were good listeners, but found it difficult to relate to Mr J and Mr E because they were "students".

2.34 Mr W was vague when we talked about his medication. He talked about taking too much pregabalin, although if he had taken the correct amount he thought it would have been helpful for him. He also said that olanzapine made him drowsy and that he did not think he had ever taken aripiprazole.

2.35 Mr W's passion for animals was very evident when we met him, he told us that when he was arrested he was very worried about who would look after his horses and goats.

2.36 Mr W told us that he has found it helpful to be in hospital because there is always someone available for him to talk to if he is having a bad day. He told us that he still hears voices, although it was happening less when we met him than 18 months previously.

2.37 Mr W knew that his father thought something was going to go wrong, but he (Mr W) did not believe that anything bad would happen. He said that he had told his mother that he had killed someone and that he had agreed to meet the police. He was glad that he had done this because he was very frightened at the police machine guns that were pointing at him when he was arrested.

2.38 Mr W said that his father had been worried because of the fights that Mr W had been involved with and that the confidence his mother has in him has kept him strong.

2.39 We met with Mr W prior to the publication of the report and shared the key findings. We explained why we had made our recommendations and what action the Trust would now have to take. Mr W thanked us for sharing the information with him.

Structure of the report

2.40 Section 3 provides detail of Mr W's background; Section 4 sets out the details of the care and treatment provided to Mr W. There is a significant amount of detail in this section and we are mindful that the volume can appear overwhelming. It is important to note that this section is a summary of Mr W's care and treatment and the actual records contain information in even greater detail. There is information within this section that refers to Mr W's numerous purchases of animals, which we have included because his actions were indicative of quite how unwell Mr W was at the time.

2.41 We have also included an anonymised summary of those staff involved in Mr W's care for ease of reference for the reader.

2.42 Section 5 examines the communication the Trust had with Mr W's family after the death of Mr Lock.

2.43 Section 6 examines the communication the Trust had with Mr Lock's family.

2.44 Section 7 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.45 Section 8 examines the issues arising from the care and treatment provided to Mr W and includes comment and analysis.

2.46 Section 9 sets out our overall conclusions and recommendations.

3 Background of Mr W

Childhood and family background

3.1 Mr W is one of three children born to Mr Y and Mrs Y. Mr W has two younger siblings, a brother Mr G and a sister Miss C.

3.2 Mr Y described Mr W as being:

> "a well-behaved boy, but very shy and not willing to put himself forward. Mr W is polite and did very well at school, but is always shy, he had a few close friends. In doing his homework, he always had to have things just right, he would rather tear up two pages of writing rather than just correct a minor error."

3.3 Mr W left secondary school with "very good CGSE results".

3.4 In April 2003 Mr W was told that his parents were planning to divorce. Shortly afterwards the family home was sold and Mr W's parents lived separately in rented property pending the divorce settlement. The divorce was settled in March 2004 at which time Mr Y and Mrs Y bought separate properties. Mr W and his sister lived with Mrs Y and Mr G was away at college.

3.5 At Christmas 2004 Mr Y described that Mr W had the "first of many rows with his mother and sister" and went to live with his father on a temporary basis.

3.6 In spring 2005 Mr W moved into a bed-sit flat and subsequently told his parents of problems with neighbours and noise. Mr Y later wondered whether this was the first indication of Mr W hearing voices. Mr W then took two holidays by himself in the USA, "looking at baseball matches". Mr Y has told us that Mr W got into debt by spending money on computers.

3.7 In August 2006 Mr W moved out of his bed-sit flat to live with his father as he had resigned his position as a trainee architect and planned to return to his architecture studies in Brighton.

3.8 In 2007 Mr W moved into a rented flat in Worthing. Whilst he was living there he complained to his family about people talking about him in the street. On one occasion Mr W unplugged his fridge and turned it around so that the door was facing the wall. He also moved most of the furniture into the attic space and lived out of just one room. Mr W told his family that the fridge and furniture were "disturbing him", that he did not like his family visiting him at the flat and he would not allow his possessions to be touched.

3.9 In early 2008 Mr W appeared very unwell to his family. At a very low point Mr W admitted to his family that he had a problem in his head and asked them to get formal help for him. Mr Y and Mrs Y realised at this point that Mr W was seriously ill and agreed to work together to support Mr W.

3.10 In April 2008 Mr W decided to leave Worthing and move into a flat with two female work colleagues.

3.11 In December 2008 Mr W decided to leave his job as a lifeguard at the swimming pool and returned to live with his mother. Mr Y told us that at this time Mr W became unwell again.

3.12 During 2009 Mr W worked part time at a fast food café and alternated between living with his father and mother. Mr Y told us that Mr W was inconsiderate towards his mother and destroyed some of her belongings.

3.13 Mr W returned to live with his father in September 2010, after an altercation with his mother during which the police were called to his mother's property. Mr Y had a "persistent battle" with Mr W over his unwillingness to ventilate his room.

3.14 In November 2010 Mr Y moved to Goring and Mr W moved with him. Mr Y described Mr W as being "very excited and slightly disturbed, clearly hearing voices".

3.15 During Christmas 2010 Mr W's brother and sister returned home but Mr W was not very interested in them. Mr W was verbally aggressive to Mr Y in demanding some money, which Mr Y refused to give to him.

3.16 In spring 2011 Mr W was claiming job seeker's allowance and his parents were providing all his meals and paying for his gym membership.

3.17 In July 2011 Mr W moved into his own flat in Worthing. Mr W expected Mr Y to fund the deposit, first month's rent and act as guarantor. Mr Y told us that Mr W was "certain that with state allowances" he would able to afford the rent. However, this was not the case and after many months of Mr W's parents supporting him to pay his rent, buying his food and feeding him at their own homes Mr W told Mr Y that unless he sought help he would be made homeless.

3.18 In April 2013 Mr W received a court order to vacate his flat. It is not clear where Mr W went to live at this point.

3.19 In November 2013 Mr W moved into an alternative flat in Worthing; it is not clear how this tenancy was funded.

3.20 In June 2014 Mr W bought a car on finance, despite not being in paid employment at the time. Mr Y told us that Mr W was a vulnerable person who had never managed money and that when he received state funding in large chunks he was unable to resist the temptation to spend it (usually on items that Mr Y considered inappropriate), resulting in Mr W having no money for most of the time.

3.21 In August 2014 Mr W asked his parents to help him buy 11 hectares of pastureland. Mr W also suggested that his "sister could get a mortgage" to help fund it.

3.22 In November 2014 Mr W had a minor accident in his car with another driver. Mr Y told us that two cars were wedged together but nobody was injured and

the police were not called. Mr W was able to exchange details with the other driver and had to negotiate the claims process himself.

3.23 Shortly after this incident, Mr W decided to rent a field from a local landowner and purchased two horses from a farm in Cornwall. As soon as Mr W's parents were aware of his plans, they tried to dissuade him. Mrs Y contacted the vendor of the horses and negotiated that only one foal would be sent. Mr Y described Mr W as "being ecstatic" when the foal arrived. Mr W later bought three pygmy goats from a farm in Surrey with the intention of keeping them on the same land as the foal. The landowner would not allow Mr W to keep the goats on the same land as his own horses so Mr W persuaded the owner of the stables where he did voluntary work to allow him to keep the goats there.

3.24 In early 2015 Mr W drove to Norfolk to put a £250 deposit down on a £1000 horse. He was unable to pay the balance and asked Mr Y to help him recover his deposit.

3.25 In summer 2015 after it had been agreed that Mr W should not buy any more animals, Mr W bought a male goat and asked his father if he had any equipment to remove an ear tag. Mr Y informed Mr W that ear tags must remain on animals and at this point Mr Y discovered that goats are subject to strict government restrictions relating to ownership and transport. Mr Y later challenged Mr W about the DEFRA (Department for Environment, Food and Rural Affairs) regulations, Mr W told him that he had all the necessary authorisations from DEFRA in place. However it subsequently transpired that this was not the case.

Training and employment

3.26 Mr W started a two-year building studies course at Chichester in 1997 and his father told us that Mr W "seemed to enjoy the course" but "didn't make many friends". Mr W completed the course in 1999 and was prepared for a place at university to study architecture.

3.27 Between 1999 and 2003 Mr W studied architecture at Portsmouth University. He took accommodation in the university halls of residence in his first year. Mr W failed his first year of studies but wanted to continue with his degree so started year one again. For his repeat year he moved into a flat with three other young men who were studying year two.

3.28 At some point during his repeat year Mr W disappeared during term time to visit Argentina. It seems that he travelled alone and did not tell "anyone, except a flat mate". Mr Y was concerned about Mr W so made enquiries with Mr W's housemate who told Mr Y where Mr W had gone. It is reported that later Mr W had a tattoo that covered all of his back. Mr Y noted that that Mr W was not communicating well about his decisions and actions and that he was sufficiently concerned about Mr W that he visited the university to discuss Mr W's problems. Mr Y told us that Mr W was having problems understanding requirements for his work and that he (Mr Y) was concerned about the lack of

pastoral care and the unwillingness of the university to share Mr W's difficulties with his family.

3.29 In 2002 Mr W started the final year of his degree and had to move into a flat on his own as his previous house-mates had graduated. Mr Y described Mr W as being "unhappy and withdrawn" and "unable to communicate" with Mr Y in a meaningful way. However Mr W graduated from Portsmouth University in 2003 with a Bachelor of Arts degree in architecture.

3.30 In January 2004 Mr W started work as a trainee architect in East Sussex. In August 2006 it is reported by Mr Y that Mr W was upset at the way he was being treated at work and that "they don't understand him". Mr Y felt that Mr W was being bullied. Mr W resigned and enrolled in further architecture studies in Brighton, however he failed to turn up on the first day of the course.

3.31 During 2007 Mr W worked at a petrol station, trained as a lifeguard and started a job as a qualified lifeguard in Brighton. It is reported by Mr Y that Mr W found the work very stressful because he was required to rescue noisy children who were in difficulty, which caused him "great anxiety".

3.32 During 2009 Mr W started working part time at a fast food café, Mr W continued working there until August 2010 when he lost his job, it is thought the reason was because he was rude to a customer.

3.33 At various points between September 2011 and spring 2011 Mr W claimed job seekers allowance, after which he returned to work at the petrol station but had constant difficulties dealing with other staff and the public. In late 2011 Mr W resigned and tried to return to the job a few days later but the manager would not have him back.

3.34 Mr W was out of work and claiming benefits until March 2014 when he secured voluntary work at a stable. He continued working here until he killed Mr Lock in July 2015. He was living in his own flat during this period.

Relationships

3.35 Around Christmas/New Year 2010/2011, it is reported that Mr W found his first real girlfriend, someone who was in her forties with two daughters, although it appears that only one daughter still lived with her. At this time Mr W would have been around 30 years old. Mr Y described Mr W as being "besotted" with her and that they went swimming, running and to yoga classes together. However, by February 2011 Mr Y told us that Mr W's girlfriend wanted to "cool things down" but Mr W was making it difficult for her to have "peace and time alone".

3.36 Mr Y told us that in March 2014 Mr W "dumped his girlfriend" but was back with her within a few days. Mr Y described this on/off approach as characterising their relationship. Mr W was still seeing his girlfriend in July 2015.

History of violence

3.37 Mr W had no prior forensic history because his actions did not come to the attention of the courts. Mr W's family has noted a number of occasions when Mr W had violent outbursts.

3.38 In September 2006 having failed to turn up on the first day of an architecture course, Mr W appeared very disturbed about something and smashed up his father's flat. He broke internal doors and the family rocking horse. Mr W would not discuss his behaviour with his father and returned to live with his mother. Mr Y recognised that Mr W had problems and suggested that Mr W had a course of Cognitive Behavioural Therapy, funded privately. Mr Y told us that Mr W "took fright" and would not engage with the private therapy.

3.39 In September 2010 the relationship between Mr W and his mother became very difficult and the police were called to Mrs Y's property after Mr W had threatened her. The outcome was that Mr W returned to live with Mr Y. Although no MARAC referral was made at the time, it is clear from the records that Mrs Y was the victim of domestic violence

3.40 In June 2012 Mr W took a hammer from his mother's house and cycled to the home of a family friend. Mr W smashed the window of the family's car and stood at their front door with the hammer in his hand. The incident was reported to the police who visited Mrs Y's property looking for Mr W.

3.41 On 14 March 2014 Mr W had a fight outside a pub where his girlfriend was working. It is reported that Mr W accused a stranger of looking at his girlfriend and started the fight. The police were called but it appears that no further action was taken.

3.42 In July 2014 a MARAC meeting was held in response to Mr W's behaviour towards his girlfriend. The actions agreed from the meeting were:

- Trust staff to discuss boundaries and consequences of his actions with Mr W;
- WORTH staff to encourage Mr W's girlfriend to report incidents in order to set boundaries for Mr W;
- on-going support to be available to Mr W's girlfriend from WORTH;
- on-going support to be available to Mr W from mental health services.

3.43 In September 2014 Mr W had an altercation with his brother at Mrs Y's home, whilst Mrs Y was away. Mr W had been "fiddling around with things and generally making a lot of noise" and his brother had asked him to leave the house. Mr W held his brother against the wall and threatened to hit him.

4 Care and treatment of Mr W

4.1 The vast majority of information in this section has been drawn from clinical records held by the Trust and the GP. The Trust records were very detailed and captured significant amounts of information shared by Mr W, Mr Y and Mrs Y. Consequently it may appear that we have obtained the information from Mr W or his family; this is rarely the case. Where we have provided additional contextual information provided to us directly by Mr Y we have indicated as such.

2008

4.2 In January (age 26 years) Mr W had a chest infection and was prescribed antibiotics. However, he refused to take the medication and threw the tablets away. Mrs Y was concerned about Mr W's behaviour because he was becoming violent and abusive towards her, the details are not available in the clinical records. Mrs Y contacted the GP out of hours service and was advised to take Mr W to A&E.

4.3 On 29 January Mr W's GP, Dr H wrote to the community mental health team requesting an urgent appointment because Mr W had become increasingly reclusive, abusive and had a poor appetite. Mr W had lost in excess of three stone over the previous year that had been associated with bloody diarrhoea, for which a gastroenterology referral had also been made. Mr W had recently reported that he had been hearing voices that were derogatory and abusive and this caused him a great deal of distress. Dr H had prescribed 5mg of olanzapine[10] daily.

4.4 Two days later a file note was created by the Trust that indicated that Dr H had called to inform community mental health team staff that Mr W was "much improved" following the "small dose" of olanzapine.

4.5 Mr Y's records indicate that in early 2008 Mr W was very unwell and he had admitted this to his family who had agreed to work together to support Mr W.

4.6 On 19 February Dr H received a letter from the gastroenterology team advising that they had seen Mr W who had appeared very anxious but otherwise looked fit and well, despite noting that he had lost half a stone in two months and had been suffering auditory hallucinations. Diagnoses considered were "IBS, colitis" and "C.Diff". The letter further advised that an urgent colonoscopy and more biopsies had been arranged and that Mr W had been prescribed metronidazole[11] 400mg three times daily for ten days.

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[10] *Olanzapine belongs to a group of medicines called antipsychotics. https://patient.info/medicine/olanzapine-arkolamyl-zalasta-zyprexa*

[11] *Metronidazole is used to treat a wide variety of infections caused by certain types of germ (anaerobic bacteria) and types of microorganisms called protozoa. These types of organisms often cause infections in areas of the body such as the gums, pelvic cavity (stomach or intestines) because they do not need oxygen to grow and multiply. https://patient.info/medicine/metronidazole-for-infection-flagyl*

4.7 On 21 February Mr W attended an appointment with the early intervention in psychosis team. He was seen by Ms N, an early intervention practitioner, and Dr M who noted that Mr W was expressing high levels of anxiety, helplessness and hopelessness. Mr W was having difficulty managing his physical health and had been aggressive and violent towards his parents. It was recorded that Mr W had struggled with derogatory voices for four years and believed that he could transmit thoughts and hear others' thoughts. These experiences had left him isolated and distressed. Dr M noted a risk of deterioration with increased risk of self harm. Dr M noted that Mr W was already compliant with 5mg olanzapine daily and therefore the plan was for Ms N to meet Mr W weekly for six weeks to offer support for stress management and explore Mr W's psychotic symptoms. A care co-ordinator was to be allocated for Mr W and Dr M planned to review Mr W on 4 April to assess his on-going risk factors and identify a future plan.

4.8 On 26 February Mr W's GP, Dr H, received a detailed letter from Dr M summarising the appointment with Mr W on 21 February. It was reported that Mr W found his job as a lifeguard stressful and that he been hearing voices intermittently over the last two years. These were related to females he worked with. Mr W had described these voices as pleasant, non-intrusive and non-threatening whilst he worked at a petrol station, but the voices had stopped when he changed jobs and became a lifeguard in summer 2007. Since working as a lifeguard the voices Mr W heard were male and he identified these voices as external and talking to him. Mr W had stated that there were approximately five voices all of which would appear aggressive and unpleasant, making him feel very low. Mr W had described four or five stressful incidents involving children as his role as a lifeguard, all rescues had been successful however Mr W found them very upsetting and had only recently been able to discuss them with his grandmother, which had made him tearful. The stress of the lifeguard role caused him to resign however Mr W was clear he would like to continue being involved with swimming. Mr W had described himself as a "sociable, tactile young man until half way through university". He had a longstanding girlfriend with whom he would hold hands, however he had never had a sexual relationship and that since leaving university he had far fewer girlfriends. There was no clear family history of poor mental health, however Mr W had been informed that his great-uncle had a learning disability and spent most of his life in a nursing home. Prior to attending university, Mr W described himself as light-hearted, sporty, fit, although shy. However now, he stated he was more of a loner and someone who found "physical communication with people much harder" than previously. Mr W had described feeling disillusioned by friendships because he was being taken advantage of by friends, who also did not provide support, however he had some support from his family. Mr W reported that he had liked things to be simple with minimal clothes and possessions. He had poor concentration skills, he liked organisation and to be in control. Mr W suggested that he felt at his lowest when the sun was at its lowest in the dark evenings. Mr W described the lowest points in his life: in the first year of university when his grandfather died; and in his final year when his parents divorced and his grandmother died. Mr W lived alone which he enjoyed. Dr M noted Mr W's likely diagnosis as "schizophrenia" and indicated that the

olanzapine that the GP had started prescribing two weeks' previously should be increased from 5mg to 10mg daily.

4.9 On 27 February Mr W did not attend his appointment with Ms N.

4.10 On 3 March Ms N wrote to Mr W offering a home visit appointment on 5 March, which was attended by Ms N and Ms K (role unknown). Mr W presented with an improved mood and spoke of plans to improve his physical health. Mr W said that he was still hearing voices but this had lessened, however he was keen to continue with his appointments with Ms N. Ms N noted that Mr W had run out of medication. Ms N arranged a further appointment for 10 March and it was agreed that contact would be agreed via Mr W's parents.

4.11 On 7 March Mr W's mother, Mrs Y spoke to Ms N. Mrs Y said that her son had had difficulties connecting with others; he was obsessional and had been taken advantage of in the past. However he had a supportive landlord at that time. Mrs Y said that Mr W found it difficult to cope with stress and would get anxious, frustrated, and angry at times but was never violent. Mrs Y told Ms N that Mr W would be seeing his father at the weekend, and that Mr Y would discuss medication with Mr W. Ms N agreed to remain in contact and provided emergency contact details.

4.12 On 10 March Ms N met with Mr W in a local café. Mr W told Ms N that he had been offered his old job at a garage and that he was looking forward to starting again. Mr W agreed to see his GP as he told Ms N that he was having problems sleeping. Mr W said that he had been contacted by an old girlfriend and consequently might visit Glasgow. Ms N advised Mr W about his diet (he did not like hot food or drink), he thought this was unusual but could not say why he had adopted the habit. Ms N noted that Mr W engaged well and that she planned to arrange a visit for the following week. Ms N recorded that Mr W appeared in "brighter mood, and more relaxed despite twitching at times".

4.13 The following day Mrs Y texted Ms N expressing concerns as Mr W had told Mrs Y that he would be moving to Brighton to resume his job as a lifeguard. Ms N advised Mrs Y that Mr W could be referred to Brighton early intervention service if he did move. Mr Y also spoke to Ms N expressing his concerns and told Ms N that he managed Mr W's finances by paying Mr W's rent and taking him shopping. Mrs Y later called Ms N stating that the family had had concerns about Mr W for a number of years, he was anxious, had fixed ideas, had threatened and assaulted his siblings, and was difficult to calm down. Mr W was verbally abusive when Mrs Y suggested seeing a doctor and Mr W had spoken of shaving his head when stressed as a form of self-clean. Ms N spoke to Dr M about the concerns from Mr W's parents and an emergency meeting was arranged with Mrs Y for 14 March (three days later).

4.14 On 12 March Ms N called Mr Y to inform him of the appointment arranged with Mrs Y. Mr Y expressed disappointment that he would not be involved and so Ms N agreed to arrange a separate time to meet with Mr Y.

4.15 On 14 March Mr W had an unscheduled meeting with Dr M and Dr I, an associate specialist. Mr W said he did not have an appointment but he wanted to discuss stopping contact with the service. Mr W was due to meet Ms N with his mother that day, however his mother was unable to attend. Mr W reported that he felt much better physically and mentally and was planning to return to work the following week in Brighton as a lifeguard. Dr M noted in her subsequent letter to Mr W's GP that since she had last seen Mr W, contact with him had been difficult to achieve because Mr W had not always wanted to engage with the team. Mr W informed Dr M that he had been taking olanzapine 5mg for a month and that when the dose was increased to 10mg he became drowsy. Consequently he now wanted to stop taking the medication completely. Mr W attributed his change in mental health to a healthy diet and exercise. Upon reflection Mr W was able to report that the voices were not real and therefore he did not wish to have any further appointments with Dr M or Ms N, as he would be able to speak to work colleagues if he had any problems. Dr M advised Mr W that the medication would also have contributed to the improvement in his mental health however Mr W did not agree. Dr M suggested changing the medication to risperidone,[12] but Mr W refused. Dr M noted that Mr W was well-dressed although he was restless whilst in his seat, "moving his fingers up and down his legs". Mr W attributed this to picking up "habits" from other people. Dr M recorded that Mr W's rapport and eye contact were good, his speech was a more normal volume in comparison with previous meetings, and his mood was anxious. Mr W denied any abnormal perceptions however Dr M felt that Mr W's insight into his illness and treatment was poor. Mr W was certain that he wanted to stop taking his medication, however Dr M felt that a relapse was possible and therefore arranged an appointment for 4 April. Dr M sent a detailed letter about the appointment to Dr H, which was received on 17 March.

4.16 On 19 March Ms N wrote to Mr W inviting him to make an appointment with her.

4.17 On 27 March Mr Y reported to Ms K, an early intervention practitioner, that Mr W appeared tired and "in another world". Ms K noted "no obvious safety risks"; Mr W was polite but was not taking his medication, however he was still going to work and appeared to be managing this. Mr Y said that Mr W was ripping up letters from mental health services prior to reading them. Ms K advised that she was aware of the review due to take place that week and said that Mr Y would be updated following the appointment. Mr Y said that Mr W had not seen his mother for two weeks due to a falling out and that Mr W had broken a picture frame at his father's home.

4.18 On 31 March Ms N met with Mr W who stated he would be moving to Brighton in April to stay in a flat with two girls he knew. Mr W said that his father would meet them the following weekend and that moving would reduce Mr W's stress. Ms N noted that Mr W was upbeat and hopeful, he denied hearing voices and his explanation of the broken picture indicated that it was

[12] *Risperidone belongs to a group of medicines called antipsychotics. https://patient.info/medicine/risperidone-risperdal*

accidental. Ms N also noted that Mr W's landlord had offered a solution if the move did not work. Ms N planned to meet with Mr Y and to discuss a referral to Brighton early intervention service. Ms N also planned to discuss Mr W's claims of "no further physical tests" from his GP and to update Dr M.

4.19 On 2 April Ms N spoke to Mrs Y who stated that Mr W wanted her (Mrs Y) to move him to Brighton because his father was a "control freak". Ms N again advised onward referral to Brighton early intervention service and Mrs Y agreed to confirm Mr W's new address. Mrs Y said that Mr W had put on weight and his hair had grown. Mrs Y took this be a good sign and said that she was less concerned.

4.20 Two days later Mr W did not attend his appointment with Dr M and Brighton early intervention service was updated on contact with Mr W and his family to date.

4.21 On 11 April Mr W was discharged to the care of his GP.

4.22 On 21 April Ms N sent a letter to Mr W's GP, Dr H advising that Mr W's case had been closed because of his recent move to Brighton. Ms N enclosed a copy of the referral to Brighton early intervention service for Dr H's records and advised that Mr and Mrs Y had been made aware of the support available to Mr W. Ms N's referral to the Brighton team stated that Mr W had been having difficulties with derogatory voices over the last four years and had only recently shared this information with his GP, the community mental health team and the early intervention service. Mr W believed he could transmit thoughts and hear what others were thinking however he denied hearing any commands to harm himself or others. Mr W had reported he was socially isolated and was distressed by his experiences and Ms N advised that he required support to prevent further deterioration.

4.23 Mr I, an early intervention worker from Brighton, wrote to Mr W on 30 April to introduce himself because Ms N had asked him to offer some support to Mr W. Mr I provided some information about the service his team offered and noted that Mr W had been prescribed 10mg olanzapine daily. Mr I invited Mr W to contact him by email or mobile.

4.24 On 7 May Mr W's GP surgery received a letter from the gastroenterology department advising that Mr W did not attend the scheduled appointment on 25 April and that there were concerns that Mr W had some form of irritable bowel disease that was affected by his mental state. A follow up appointment had not been arranged.

4.25 On 23 June (a Monday) Mrs Y called Mr I expressing concern that Mr W was twitching, occasionally doubling over and his eyes were rolling back. Mrs Y wanted advice about how to discuss this with Mr W; Mr I stated he would attempt contact with Mr W later that afternoon. Mr I then attempted to visit Mr W at home, but Mr W was not at home. Mr I left a note for Mr W to contact Mr I, who would attempt another visit the following week and liaise with Mrs Y.

4.26 It is unclear why the team would leave it a week before following up on Mr W's wellbeing. In addition there is no evidence of any follow up after this entry until 2009.

January to June 2009

4.27 On 12 January Mrs Y spoke to Mr I and informed him that Mr W was planning to return to Worthing. Mr I notified Worthing early intervention service of this information.

4.28 The following day an initial assessment by Worthing early intervention team took place at Mr W's home. It had been arranged by Mrs Y and was attended by Mr T, Mr W's new care coordinator. Mr W had not been made aware of the visit, as he had refused contact with the early intervention service, however Mr W's family expressed concern about his wellbeing in light of his bizarre behaviour and aggressive outbursts. Mr W was asked to come in and talk to Mr T and upon entry to the room became very anxious and agitated. Mr W left the house shortly afterwards without any discussion other than identifying he did not wish to see any of the mental health team. Mrs Y described some of Mr W's recent behaviour and her concerns about his rigid opinions and inability of others to reason with him. Mrs Y talked about Mr W's recent obsession with exercise and often excessively staring at himself in the mirror. Mrs Y also reported several arguments between Mr W and his family and one occasion where Mr W threw a glass, which had smashed by her head. Mrs Y was advised about her safety and strategies to contact the police should Mr W become aggressive. The early intervention service later contacted the police to inform them of the incident. Mr T stated that their intervention with Mr W needed to be at a slow pace to prevent increasing Mr W's anxiety and possibly disengaging with his support network entirely. Mr W's previous episode was discussed and it was noted how well he initially engaged until he took exception to a clinic letter from the early intervention service stating he had schizophrenia, consequently rejecting the service's support. Mr T's entry states "discussed issue that the schizophrenia diagnosis was premature and the need for diagnostic ambiguity when undergoing assessment by early intervention services". It was agreed that the early intervention service would write to Mr W inviting him to arrange a home visit and that Mrs Y would remain in contact with the service. Following this meeting Mr T wrote to Dr H, Mr W's GP to provide an update and advised that a further meeting had been arranged for 30 January.

4.29 Mrs Y later contacted Mr T to advise that Mr W had received the letter inviting him to a meeting, but he had shredded it without reading it. Mrs Y reported that Mr W appeared to be calmer and there had been no further aggressive outbursts. Mr T agreed with Mrs Y that Mr W and his uncle would meet Mr T on 30 January. It is unclear why this meeting was planned with Mr W's uncle, or whether he was Mr or Mrs Y's brother.

4.30 On 30 January Mr W's uncle met Mr T at a local coffee shop. Mr W declined to attend the meeting. Mr W's uncle reported that Mr W had obsessive thoughts and behaviours but this was not unusual for him. Mr W was described as not mixing well with other people, often preferring his own

company and found it difficult to alter plans or adapt to lifestyle or circumstance changes; his parents' divorce was given as an example of this. Mr W's uncle was not aware of any reports Mr W had made about hearing voices however Mr T and Mr W's uncle discussed Mr W's previous psychotic episode which had been triggered by being physically unwell. Mr W was adamant that he would not engage with the mental health service however Mr T said he would maintain contact with Mr W's mother and uncle. Mr T noted he planned to liaise with the autistic spectrum disorder service to discuss a possible investigation of Asperger's Syndrome. It is unclear why a doctor did not lead the discussion about autistic spectrum disorder. We have not seen any evidence that the referral followed a multi-disciplinary discussion about the likelihood of such a diagnosis or the value in a referral to the autistic spectrum disorder service.

4.31 On the same day Mr T completed a referral to the county wide autistic spectrum disorder service, noting "it is hoped that your team could provide guidance about meeting Mr W's need after assessing whether he fits criteria for Asperger's Syndrome". The reason for referral was identified as pre-screening by a clinical nurse specialist, prior to referral to assessment and diagnostic clinic. Dr R was noted as Mr W's consultant psychiatrist but the diagnosis is illegible, other than "on-going assessment". However in the text of the document it states that Mr W "was given a diagnosis of schizophrenia by a medic" at the community mental health team.

4.32 On 2 February Mr T contacted Mrs Y to update her on the outcome of the meeting with Mr W's uncle. Mrs Y reported that Mr W had not displayed any disruptive behaviour over the weekend. She also advised that she had learned that Mr Y had re-married two weeks previously; Mr W and his siblings were informed of the news but had been instructed not to tell their mother. Mrs Y stated that Mr W did not like his new step-mother and the timing of the news coincided with his unsettled behaviour, therefore the combination of Mr W's confusion and having to avoid talking about it caused him to be upset. Mr T agreed that continuous encouragement for Mr W to engage with the service could cause him to completely disconnect from all support. Therefore it was agreed Mr T would periodically contact Mrs Y to be updated on Mr W's presentation and to provide support to Mrs Y on managing Mr W's needs. Mrs Y asked for the referral to the autistic spectrum disorder service to be postponed; it was agreed that it was unlikely that Mr W would engage with the service. Mr T noted he would discuss a provisional plan in the clinical meeting and potentially place Mr W on "watching brief".

4.33 On 6 February a risk assessment was completed. This noted Mr W's current suicide risks as "expression of suicidal ideas, believes no control over life, expression of high distress levels, helplessness/hopelessness, relevant significant life events, unemployed". It was noted that Mr W felt unable to adequately manage his difficulties and he could become impulsive and rigid in his thinking. He was unlikely to accept support from services. Mr W had recently moved back to live with his mother, but Mr T had been unable to establish Mr W's attitude towards this. Mr W's "neglect risk indicators" were noted as a lack of positive social contacts, and difficulty communicating his

needs, he preferred his own company and found socialising difficult. Current aggression and violence risks were noted as "dangerous impulsive acts, signs of anger and frustration". An example given was when Mr W thought he heard his mother call him a paedophile which led to an argument where Mr W poured hot tea on his mother, also given as evidence that Mr W was being influenced by voices. Other risks were noted as damage to property, periods of not eating properly, compulsive exercising, and little remorse shown for damage when his "mother expressed sadness". The early intervention service had been unable to complete an assessment because Mr W had refused to meet with staff. It was agreed that the service would remain in contact with Mrs Y and that a referral would be made to the autistic spectrum disorder service.

4.34 On 5 March Mrs Y spoke to Mr T and reported that there had been no further aggression from Mr W since she last spoke to him (Mr T). Mr W continued to have rigid thoughts and was "unappreciative of others' needs". Mr W was often anxious about how the household was run and would demand to know how his mother spent her time. Mrs Y said that Mr W continued to burn documents in the garden, rearrange ornaments and shred unflattering photographs of himself. Mrs Y did not confront Mr W's behaviour or assert her own needs, in order to avoid an argument, and she was therefore unable to control events in her own home. Mrs Y would second-guess Mr W's actions and often ask herself what she had done to have caused Mr W to act in such a way. Mr T discussed the burden this added to Mrs Y and suggested ways to alleviate the pressure. Mrs Y was keen to avoid further difficulties and would "gently encourage" Mr W to consider other people's needs. Mrs Y said that she had support from her brother and Mr W's brother who would keep Mr W occupied. She also said that Mr W was not keen on the idea of spending a few nights with his father, to provide her with some respite, due to his dislike of his stepmother. Mr T said that he would write to Mr W to invite him to attend an appointment. It is worth noting that at this time Mr W is approaching his 28th birthday.

4.35 On 17 March Mr T met with Mr Y who reported an improvement in Mr W's mental state with fewer incidents. Mr W had been spending a lot of time with his father who was trying to support him without being overly assertive. The benefits of this approach and the importance of Mr W's trust with his family was noted during the meeting. Mr Y said that Mr W recently disclosed to his father feelings of "worthlessness". The significance of this disclosure was discussed. Mr Y advised that Mr W was due to start work at a fast food restaurant and that he still continued to burn documents. Mr Y reported that Mr W did little around the house and was rude to his mother. Mr T advised about the importance of boundaries and gently challenging unacceptable behaviour. Mr Y was reminded of the role of the autistic spectrum disorder service and what benefits they had to offer. It was noted that Mr W had difficulty relating to others, reading social cues and found social gatherings overwhelming and was unable to process information during this time. Mr Y reported that Mr W thrived when things were ordered and controlled and struggled most during times of change. Mr Y agreed to continue to support Mr W and was advised of the importance of respite for Mr W's mother.

4.36 On 7 April Mr T met with Mr W and his father and noted that Mr W "engaged well in conversation". Mr W reported an improvement in his mood and that he found it less stressful engaging with others. He was learning his new job role however he "found busy times confusing and difficult". Mr T explored Mr W's sense of being "influenced" by other people; it seemed Mr W meant that people were intentionally controlling him. It appeared that combination of Mr W's anxiety about being judged, people and Mr W's sense of norms influenced how comfortable he felt and how he behaved. Mr W reported he had difficulty concentrating in crowded places, which "stopped him from prioritising leading him to feel physical pain in his head". In order to refocus, Mr W would ignore everything around him and stop his task or conversation for a few seconds. Mr W noticed he had greater difficulty concentrating when he was stressed or worried. When Mr W was asked about hearing voices, he was vague in his response. Mr T discussed Mr W's tendencies to throw away paperwork and possessions, both his and his mother's. Mr W explained his need to reduce possessions in order to start building a new life in an ordered fashion. Mr W said that he viewed the communal areas of his mother's home as cluttered and his "need to reorganise superseded the feelings of others". Mr W reported that the arguments had diminished but continued to occur when Mr W was tired. Mr W was exercising however there was a concern that this was excessive. A further appointment was arranged for 5 May and a PANSS[13] assessment was organised for 20 May. It appears that the PANSS assessment did not take place until 10 July, but we have not been able to establish why there was a delay.

4.37 On 5 May Mr T met with Mr W and his parents. Prior to the session Mrs Y had contacted Mr T and reported that Mr W had recently been unsettled and had been sleeping poorly. Mr W was moving around the house had woken her in the early hours on the Saturday morning. Mr W had told his mother that he was hearing voices and demanded that his mother stop them, when she could not, he became aggressive and started to throw and smash items. Mrs Y asked Mr W to stay with his father and since then the voices had stopped. Mr W reported that the voices belonged to people he grew up with however he no longer had contact with them. Mr W described the voices as "persistent" and that he could not get them to stop, but said they were not derogatory. Mr W was not clear if the people were actively communicating with him and controlling the voices however he did not describe any other view of the origin, such as mental health. Mr T noted that Mr W was not fully forthcoming but Mrs Y reported recent experiences of Mr W being bullied at work and said that she and Mr Y were working with him to settle the matter. In addition Mr W's employer had not been giving him full time hours therefore leaving him with little money and lots of spare time, resulting in Mr W feeling lost. Mr T advised about the role of "CAB" and suggested Mr W sought their advice to identify his rights under his contract. It was noted that Mr W was staying with his father to allow his great-aunt to use his bedroom at his mother's home. Mr W was protective over his space and may have felt unsettled about the idea of someone staying there. Mr T discussed the

[13] *Positive and Negative Syndrome Scale for schizophrenia – this is a well validated scale for the assessment of psychotic and allied symptoms (Kay, et al, 1987)*

options to help Mr W manage the voices. Mr W refused medication although agreed to consider it before the next meeting. Mr W was also informed about medication he could take as and when he needed it, and how it could have improved the situation from the weekend by making him feel calmer. It was agreed that Mr T would explore other options to help Mr W to manage his needs and that a further appointment would be offered on 11 May. Mr T noted that he would arrange an appointment with Dr E to explore the role of medication further.

4.38 On 7 May Mr T and Dr E, consultant psychiatrist met with Mr W. Dr E described Mr W as having "a very rigid posture, with extremely unusual hand movements" and appeared "ill at ease during the interview". Dr E noted that Mr W appeared thought disordered at times when discussing his symptoms and therefore it was difficult for Dr E to decide if Mr W was describing symptoms of control and reference. Dr E noted that Mr W had been teaching swimming and working as a lifeguard the previous year and that he had felt an "incredibly strong bond" with the children that he found difficult to explain. Mr W described hearing voices of the children, in particular one boy who lived close to him and they would therefore often share a lift home from the pool. Dr E described that he felt that Mr W "had a likely psychotic illness given his positive symptoms and poor social functioning in someone who has previously got an architecture degree". Mr W had refused the option of medication and would only consider vitamins and minerals, therefore Dr E had discussed the benefits of fish oils. Dr E offered Mr W some blood tests given the "slightly atypical presentation and the onset of symptoms shortly after a period of gastrointestinal disturbance and weight loss". Dr E also noted that whilst Mr W would "clearly benefit from treatment, risks are not at a level currently such that use of the Mental Health Act is appropriate". This appointment was summarised in a letter that was sent to Dr H, Mr W's GP, on 28 May. In the letter Dr E noted the diagnosis as "probable psychotic illness" and that no medication was being prescribed. We can see no evidence of a risk assessment being completed or reviewed at this point.

4.39 The following day (8 May) Mr Y spoke to Mr T and reported that Mr W had seen the appointment with Dr E as positive and that Mr W was in good spirits. Since the appointment, Mr W had decided to move back in with his mother and had asked his father not to contact him. Both Mr and Mrs Y found this confusing and had been unable to obtain a coherent explanation from Mr W. Mr T contacted Mrs Y who stated that Mr W returned to her in an anxious state, he was not open to reason when discussing his accommodation arrangements but was not aggressive. Mr T then had a conversation with Mr W who stated that his father's behaviour was intolerable and *"perverted"* and stated his father had thrust his hips, which "made him feel sick". Mr W stated he was too embarrassed to mention other incidents. It was established that Mr W's father was joking however Mr W did not appreciate the humour, and therefore wanted to avoid contact for a few days. Mr W stated he found the appointment with Dr E useful but that he did not want to use medication. Mr T spoke to Mrs Y again, who was doubtful about the report Mr W had made about his father, and suggested Mr W was keen to spend time with his family members that were currently staying at his mother's home.

4.40 On 11 May Mrs Y telephoned Mr T prior to the scheduled appointment and stated that there had been no incidents during the weekend, however earlier that day Mr W had become distressed when his mother attempted to leave the house for a social event. Mr W had been tearful, so much so that he vomited. Mrs Y had encouraged Mr W to attend his appointment, however he told her he was too unwell. Mr Y attended the appointment without Mr W and Mr T noted that Mr Y appeared "dismayed" with Mr W's behaviour and the "abrupt nature" in which Mr W left his father's home. Mr Y was also upset about being called a "pervert'" and not having had an opportunity to discuss this with Mr W. Mr T advised Mr Y that Mrs Y had suggested that Mr W felt a strong need to be at his mother's home whilst family were visiting and the accusation was a way of Mr W's being able to justify being with his mother. Mr T advised Mr Y of Mr W's difficulty to express how he felt. Mr Y stated he was overwhelmed by Mr W's behaviour and had concerns about Mr W's lack of sustained progress. Mr T advised Mr Y about Mr W's difficulty with adapting to change and perhaps moving between the two homes regularly was causing more issues. Mr T noted that Mr W had been provisionally diagnosed with psychosis and discussed with Mr Y the aspects of Mr W's presentation that led to that diagnosis (however this diagnosis had not been formally made at this point). Mr T also talked about the significance of any autistic disorder on Mr W's interpretation of events and his environment.

4.41 A further appointment was arranged for 18 May but Mr W did not attend this appointment and did not answer any telephone calls from Mr T. Mrs Y sent a text to Mr T stating that Mr W was unlikely to attend the appointment because he was tired, and advised that there had been no bizarre or aggressive incidents from Mr W. However Mr Y did attend the appointment with Mr T, who explored strategies in order to approach Mr W about his recent behaviour. It was agreed that soft encouragement had previously enabled Mr W to come to his own decision to engage with the service over time. Mr T called Mrs Y and spoke to Mr W who stated he was too tired to talk on the telephone. A provisional appointment was made for Mr W's mother on 26 May.

4.42 On 28 May Dr E wrote to Dr H, Mr W's GP. Although Dr E dictated the letter on 7 May, it was not sent for another three weeks. Dr E noted that Mr W's diagnosis was "probable psychotic illness" and indicated that he had not prescribed any medication. No formal diagnosis was noted. The plan was for Mr W to remain under the care of the early intervention service and Dr E advised that Mr W's care co-ordinator was Mr T. Dr E advised that Mr W had reported that when he used to teach groups of 13-16 year olds he felt an incredibly strong bond, which he found difficult to explain. Mr W described the group as his friends; something that Dr E found odd given (a) the age gap and (b) that Mr W did not see the group outside of classes. Mr W had described feeling separated from the young people when they were not together and after an onset of vomiting and diarrhoea when he lost a lot of weight, he started to hear voices and that they were of the teenage children he was teaching to swim. Mr W heard the voice of one particular boy, who lived close to him and used to share a lift with Mr W on the way home from the swimming pool. Mr W had informed Dr E that the voices were quite scary and described

the feeling of being so close to the swimming group that they were inside his mind and was able to communicate with them through mental gestures. Mr W had denied any improper relationships with any of the teenagers and had no contact with them since he had left that employment a year previously. Mr W was at that time working in a fast food café and living with his mother. Dr E indicated that Mr W had appeared thought disordered when discussing his symptoms and it was therefore difficult to identify if he was experiencing auditory hallucinations. Mr W had refused to take medication. Dr E told us in interview that Mr W was "very clear that he didn't have any attraction to children, physical or sexual". It appears on the basis of this information potential safeguarding concerns were not escalated. However this does not explain why treatment under the Mental Health Act was not explicitly considered. There were known risks and Mr W was considered to be so thought disordered that a proper assessment could not take place. In addition Mr W was refusing to take medication.

4.43 On 5 June Mr T saw Mr W at home and reported that Mr W had engaged well in conversation, with no evidence of anxiety or agitation. All risks appeared low at that time. Mr W reported that there had been no significant problems over the previous few weeks and that the issues at his workplace were less of a problem as Mr W was able to avoid confrontation and concentrate on doing his job well. Mr W stated that the irregular routine of his mother's social life was difficult for him to adapt to and that he immediately became unsettled when she was not home when he expected. There had been a few arguments between Mr W and his mother due to Mr W being tired. Mrs Y advised that Mr W had not been sleeping and that she had concerns it was related to hearing voices. Mr W stated he did not hear voices but acknowledged there were times when he would wake up in the night however was able to go back to sleep straight away. Mr W reported that the boundaries that had recently been set helped keep the house calm and Mr W was happy to continue to pay rent and contribute to food costs. It was agreed that the next appointment would be on 16 June when Mr W's care plan would be finalised.

4.44 A few days later Mr T contacted Mrs Y who stated that she had discovered a smashed dinner set in her cupboard. Mr W had been confronted and he had admitted to breaking it a few months previously. Despite this finding, Mrs Y stated that Mr W was less disruptive and continued to respond well to boundaries.

4.45 On 11 June the records indicate that Mr W did not attend an appointment, however we cannot find any information to indicate that one had been arranged.

4.46 On 17 June Mr T was due to see Mr W at home. Prior to the visit Mr T had received a text message from Mrs Y who had stated that Mr W had not presented any management problems. However Mr W had not been able to sleep one night and had been pacing around the house in the early hours of the morning. When Mr T arrived Mr W was in his bedclothes because he had forgotten about the appointment. Mr T noted that Mr W had engaged well in conversation and had been open about his mental state. No risks or concerns

were identified. Mr W attributed a recent sleepless night to hearing voices, described as his neighbours and those living nearby. The voices had said "disgusting things" and had told him to "do stuff". Mr W did not want to disclose what they said and denied following their instructions. Mr W stated that on occasions when he ignored the voices, they would disappear but generally they did not. Mr T advised Mr W of the impact medication would have to help manage his difficulties, however Mr W said he would rather manage them through a good diet and exercise. Mr W denied wanting to confront the people he believed to be the source of the voices and said that he did not feel hopeless about hearing them. Mr W said that he was struggling to make monthly payments for a loan and agreed to attend the Citizens Advice Bureau in accordance with Mr T's advice. A further appointment was planned for 24 June.

4.47 On 22 June Mr Y telephoned Mr T prior to the home visit and reported that the previous Friday Mr W had "accused his mother of calling him a paedophile", because she had refused to apologise for something she had not done. An argument had broken out between Mr W and Mrs Y and Mr W had telephoned his father to ask him to intervene. Mr W had spilled a cup of tea over his mother during the argument but it was not clear if this was intentional. Mr Y had not supported Mr W during the argument which had caused a further disagreement and the police were called to de-escalate the situation. Mr W was asked to leave his mother's home (it is not clear by whom), which he did however he returned the following day. During the home visit Mr W did not want his father present and it was agreed Mr W would see Mr T alone. Mr W described the incident to Mr T and said that he had been sitting at his computer and had heard his mother say '"I know you're a paedophile because you act like it". Mr W was unsure whether these words were said or projected. He further explained that he would often hear other people's thoughts whilst working as a lifeguard and had been "reprimanded for reporting that others" had called him a "paedophile". Mr W had no insight about the possibility of his experiences being linked to a mental illness and was reluctant to consider medication, but did agree to try a choice of medication on the basis it might dampen the voices. Mr T discussed the medication options with Dr E and advised Mr W that he would have the choice of aripiprazole,[14] risperidone[15] and quetiapine[16]. It was agreed that Mr T would liaise with Mrs Y to share the content of the meeting and that Mr T would contact Dr E to organise a prescription.

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[14] *Aripiprazole is used to treat the psychiatric disorders schizophrenia and mania. It is an atypical antipsychotic.*

[15] *Risperidone is used to treat schizophrenia and manic episodes in people with bipolar disorder. Risperidone is also used to control persistent aggression. It is an atypical antipsychotic, sometimes known as a neuroleptic. Atypical antipsychotics may be better tolerated than other antipsychotics with fewer side effects of abnormal movements. Risperidone is also an antimanic and mood stabilising agent. It is used to control symptoms of agitation and disturbing behaviour associated with mania and schizophrenia. The symptoms of mania include feeling high, having excessive amounts of energy and sometimes being very irritable. Symptoms of schizophrenia include hallucinations (hearing, seeing or sensing things which are not there), abnormal thoughts (mistaken beliefs, unusual suspiciousness) and becoming withdrawn. It is also used on a short-term basis to control aggression when people may harm themselves or others. drugs.webmd.boots.com*

[16] *Quetiapine is an antipsychotic and belongs to a group of drugs used to treat certain mental illnesses. It affects how chemical messengers in the brain, known as neurotransmitters, are able to direct brain activity. In general this drug is used to treat schizophrenia, as well as manic or depression episodes associated with bipolar disorder. drugs.webmd.boots.com*

4.48 In a care plan dated 23 June Mr W's crisis plan indicated that if a dispute arose and Mr W were to become aggressive, the police were to be called. If the incident took place during office hours, the early intervention service should be notified, if out of office hours the family GP should be contacted or Mr W should attend A&E. The care plan also noted that Mr T was still getting to know Mr W so Mr T would continue to review Mr W on a regular basis. Also on this day, Mr T contacted Mr W regarding his medication. Mr W advised Mr T that he did not want to trial any medication.

4.49 The following day Mr T accompanied Mr W to his appointment with the Citizen's Advice Bureau. Mr W was advised to complete an income and expenditure form and that the Citizen's Advice Bureau would arrange a payment plan for Mr W's creditors. Mr T noted that Mr W did not appear anxious or agitated and that he engaged well in conversation and had good insight. Mr T later called Mrs Y to discuss Mr W's reluctance to take medication. Mrs Y had concerns about Mr W's compliance and therefore it was suggested that it (taking medication) was made a house rule if Mr W were to continue to live with her. Mr T advised Mrs Y of the alternative techniques Mr W could use to manage the voices and said that Mr C (clinical psychologist) would explore this further with Mr W in the appointment planned for 10 July. Mrs Y was advised of the actions to take in emergencies and Mr T agreed to meet with Mr W and Mrs Y to discuss the impact of Mr W's behaviour.

4.50 A meeting took place on 30 June but Mr W did not respond to any of Mr T's messages and did not attend the meeting. Mr T and Mrs Y spent time discussing the impact of Mr W's behaviour and how Mrs Y tried to second-guess what Mr W was going to do because he was unable to articulate himself well. Medication and psychological treatment options were discussed and Mr T again advised about out of hours arrangements in emergencies. A provisional appointment was agreed for the Friday (three days later).

July to December 2009

4.51 On 2 July Mr T, a care coordinator with the early intervention service, met with Mr W and Mrs Y. Mr W reported that he had no mood disturbance; Mr T noted that Mr W engaged well and was open to answering questions, however Mr W had fairly fixed views about the incident two weeks previously, but Mr W was prepared to consider the voice originated from elsewhere. House rules for Mr W to follow were outlined during the meeting: aggression would not be tolerated and Mr W must consult his mother before he burned or disposed of any items. Mr W was able to identify elements of other people's behaviour that upset him, and described how he felt during a funeral where his mother was speaking and he had interpreted her looking at him to check if he was okay, as blaming him for the person's death. Mrs Y was shocked that Mr W had held onto this view for so long and had not disclosed his feelings. This led to a conversation about Mr W's ability to approach people to express his concerns.

4.52 On 7 July Mrs Y contacted Mr T to discuss their previous meeting. Mr T advised on ways to enable Mr W to express himself when he was distressed.

Mrs Y noted that Mr W had been quiet and avoidant since the appointment but had not displayed any aggression and had been able to interact with his family. On one occasion Mrs Y had witnessed Mr W pacing with his hands over his ears however he would not disclose the reason for this.

4.53 Three days later Mr W attended an assessment with Mr T. Mr W advised that he had heard several voices, some good and some bad. Mr W admitted he would occasionally follow good commands however he would ignore the bad ones. Mr W was unable to determine the origination of the voices and denied they were linked to a mental health issue. Mr W thought they could be a projection of people's thoughts, he reported he would hear the voice of a woman he was attracted to, which he found comforting, but he wanted to get rid of the negative voices, which he thought could be done by altering his state of mind. Mr T telephoned Mrs Y who stated that Mr W had told her he could hear voices, and that usually he would deal with the issue on his own in his bedroom. When Mrs Y asked if medication would help, Mr W had responded with "medications are for sick people" and that he did not need them. Mrs Y offered to spend some time with him and said that she expected Mr W would have a sleepless night and be distressed for the remainder of the day however this did not happen. The PANNS assessment noted:

- moderate and moderate/severe problems in conceptual disorganisation and hallucinatory behaviour respectively;
- moderate problems in lack of spontaneity and flow of conversation;
- moderate problems in mannerisms and posturing and lack of judgement and insight.

4.54 On 13 July Mr T accompanied Mr W to his appointment at the Citizen's Advice Bureau and reported that Mr W engaged well with the advisor, however he had been uncomfortable discussing his mental health. Mr W agreed to a general letter being sent to the bank stating he was supported by mental health services but declined to state he had a mental health problem. Mr W did not take his bank statements and therefore the advisor came to the conclusion Mr W had adequate funds. Mr W agreed to calculate his earnings with his mother when he returned home.

4.55 Mr W texted Mr T prior to the planned appointment on 20 July to say that he would not be able to attend due to work commitments. It was agreed that Mr T would call Mr W the following day. We can find no evidence of a telephone call or any other follow up.

4.56 There is a record of an appointment, undated (but filed between July 2009 and August 2009) and unclear with whom the appointment was. The record states "Voices did not affect Mr W's employment. Earns £300/week. No benefits. No ambition and happy where he was. Swimming daily. Things were okay with his parents. Stated he had not binned stuff- reminded that documents were burnt, denied any photos binned. Previously lived alone for two years but ran out of money." The record also indicates that Mr W had been glancing around the room, his speech was vague and that Mr W had stated "girls sleep with him at night" but he had refused to discuss this further.

Mr W stated an ex-girlfriend had taken advantage of him; she had taken his money and that she had a split personality. Mr W had emailed her the other day because "she shouted abuse at him".

4.57 On 14 August Mrs Y spoke to Ms G (role unclear) and reported that Mr W had shouted and sworn at her during the weekend however subsequently had been settled and pleasant. Mr W had made kind gestures of buying dinner and had accompanied Mrs Y during a visit to his grandmother. Mr W had been given more work hours, which sometimes caused him stress, but he had coped well. Mrs Y stated she had not heard Mr W getting up during the night and that he had been sleeping well. Mr W remained underweight but was eating well. Mr W reported he had been power swimming and still wanted to lose weight.

4.58 Four days later Mr T visited Mr W at home. Mr W reported that he had found working the extra hours a useful distraction. Mr W had no significant problems to report however had recently sworn at his mother whilst trying to read an email. Mr W said that his mother's presence was a distraction whilst trying to concentrate and likened this to busy periods at work. Mr T advised of appropriate ways of Mr W asserting himself. Mr W mentioned he continued to have periods when he did not sleep and paced the house at night, sometimes he would hear his neighbours speaking about him and also the voice of a woman he found attractive. Mr W said that he found the voices difficult to block. Mr W continued to exercise daily and was keen to lose weight, despite already being very slim. Mr W reported "losing more weight would help him become streamlined". Mr W was advised of nutritional requirements of competitive swimmers however Mr W did not see the need for a physical health check-up.

4.59 On 25 August, prior to a meeting at a community team base, Mr W's mother called Mr T to inform him that Mr W had been well, however Mr W had shouted and sworn at her when she was in his bedroom. During the meeting Mr T noted that Mr W engaged well in conversation and reported he was coping well at work. Mr W vaguely acknowledged an argument with his mother but stated it was insignificant. Mr W spoke of occasional sleeping difficulties and being woken at night by "a woman he was attracted to". Mr Y reported this woman took advantage of Mr W financially and for car journeys. Mr W stated he liked hearing her voice but it was sometimes accompanied by an aggressive voice. Mr W interpreted the voices as a kind of telepathy and dealt with them by getting out of bed and reading or getting a drink. Mr W disclosed that he had heard a voice inside his head talking to him when he got into bed that was not like the other voices. Mr W was due to see the early intervention service psychiatrist on 3 September and he would be discussed at an early intervention service meeting on 2 September.

4.60 However, on 1 September Mr W was discharged from the Brighton & Hove service and the Worthing early intervention service took over Mr W's care and treatment. This was because Mr W returned to live in Worthing.

4.61 On 3 September Mr T met with Ms N. Mr T advised that Mr W remained a risk, (the precise risk is not described) he was psychotic and had admitted

hearing voices of two females from his past, usually in the early hours of the morning. Mr T noted that Mr W was an "amber risk"[17] and that the on-going plan would be to continue to arrange regular appointments. It was agreed Mr T would introduce Mr W to Mr A, his new care coordinator. The risk assessment completed on this date noted that Mr W's current suicide risks were "major psychiatric diagnosis, expression of suicidal ideas, believes no control over life, expression of high distress levels". It was noted that Mr W was, on occasion, hostile at home and had periods of shouting with no apparent trigger. It was also noted that Mr W was rejecting any psychotic diagnosis and associated medication, despite frequently hearing voices and misinterpreting events that had led to him displaying aggression. The plan was for the early intervention service to monitor his risk, liaise regularly with his parents and explore options to help Mr W manage the voices.

4.62 On 7 September Mrs Y called prior to Mr W's appointment to inform the team that he had burned 30 of her books because he deemed them worthless and not needed. Mr W had not been aggressive, however he had been unable to understand his mother's concern. It was reported Mr W had been settled however Mrs Y had found crude drawings of Mr W with derogatory, sexualised comments, which she did not think had been drawn by Mr W. Mrs Y had not approached Mr W about these and Mr W had not mentioned them. Mrs Y said that she suspected Mr W was being subjected to bullying at work, which was impacting on his behaviour. It was noted that both Mr W's parents had approached him about being independent and Mr W was open to finding his own flat. During the appointment with Mr T, Mr W was asked about his weekend. Mr W did not mention the incident with his mother's books or any other difficulties. It was noted that Mr W engaged well and his speech was coherent and appropriate. Mr W reported that he was keen to have his own flat and Mr T advised Mr W about his options. Mr W continued to hear voices however it was hard to determine whether these were auditory hallucinations, intense thoughts or voices from the street outside. He dealt with this by shutting his window and getting a drink of water. Mr T noted that Mr W was reporting events from months ago as if they were just days previous. Mr W stated he had emailed one of the women whose voice he would hear at night to ask her to stop contacting him, but he had had no response from her. Dr E wrote to Dr H, Mr W's GP, with a summary of the meeting and advised that although Mr W had refused to consider any medication, his level of risk at that time was insufficient to consider a Mental Health Act assessment. Dr E had not made any plans to see Mr W again, however Mr T was able to arrange an appointment with Dr E if it was required.

4.63 On 10 September Mr T met with Ms N and advised that Mr W continued to display odd behaviour at home and was still hearing voices. Mr T and Ms N discussed Mr W's risk and need for an assessment; Mr W's risk was noted as amber.

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[17] *An amber risk is described in the operational policy as someone who is "mentally unwell but not in immediate crisis. Changing needs not met by the current care plan and requiring increased input from the team and the patient's resource network. Review should occur regularly to discuss ways in which the care plan can be altered to meet the patient's needs and hence move towards green".*

4.64 Mr T made a home visit on 16 September. Mr W was present along with both of his parents. Mr W appeared uncomfortable at the start of the meeting and refused to sit down. Mr W explained separately that he didn't want to spend time with his father that day as he felt that too much time with him would lead to Mr W "adopting some of his father's traits" which he didn't want to do, however Mr W found it difficult to explain this. Mr Y therefore agreed to leave the meeting. Mr T discussed Mr W's progress, securing stable employment, the recent decision to explore independent living and the options available to Mr W by declaring he had a mental health issue. Mr W agreed to amend the housing application to reflect his needs. Mr T saw that Mr W made an average income of £500 per month and that £200 of that went towards his graduate loan. Mr T noted the plan to be to contact the housing department to amend the application and make an appointment to seek advice. Mr W also needed to visit the Citizen's Advice Bureau to obtain financial advice regarding his entitlements. Mr W's parents would also explore the private rental options.

4.65 Two days later Mr T accompanied Mr W to the housing department to amend the housing application. Mr W engaged well in conversation and did not appear anxious. Mr T informed Mr W that he would be leaving and that Mr W would have a new worker, Mr A, a psychiatric nurse, who would visit jointly with Mr T on 25 September.

4.66 However on 25 September Mr W was not at home when Mr T and Mr A visited. Mr T left a telephone message and a note asking Mr W to contact him.

4.67 On 30 September Mr W attended an appointment at the Citizen's Advice Bureau accompanied by Mr T and Mr A. The advisor agreed to contact Mr W's creditor to negotiate reduced payments. Following a discussion regarding Mr W's income, it was identified that Mr W's income would not cover his outgoings without additional support. Mr W was advised to meet with Signposts[18] to discuss housing support. Mr W presented as mildly anxious but engaged well and reported he was getting on well with his mother and swimming regularly. Mr W stated he was eating plenty when asked about his diet. A further appointment was arranged for 9 October.

4.68 This next meeting took place with Mr T who recorded that Mr W was "euthymic and engaged well in conversation". Mr W reported hearing no voices over the previous two weeks; his stress levels had reduced and he was coping well at work. However, Mr W had become concerned when staff from Signposts contacted him, because he did not want people knowing his difficulties and labelling him "mad". Mr W refused further support from mental health services, however following a discussion with his mother, decided to continue to engage with the early intervention service. Mr T called Signposts and asked that Mr W be reinstated; an assessment was arranged for 19 October.

[18] *Signposts is a charity that supports people with learning difficulties to live independent and fulfilling lives in the community.*

4.69 On 19 October Mr T accompanied Mr W for his assessment at Signposts. It was noted that Mr W engaged well during the assessment and that Mr W said that he had no significant difficulties since the last visit. Signposts agreed to contact Mr W to arrange an appointment at the housing department to confirm his entitlements and assist with the working tax credit application. Mr W agreed to take his payslips to the Citizen's Advice Bureau office in order for the advisor to continue negotiations with his bank.

4.70 On 4 November the early intervention service received a letter from Mr W stating that he didn't want to continue to engage with the service. He asked that all contact with him and his family be ceased. The same day Mr A returned Mrs Y's telephone call from the previous day. Mrs Y reiterated what Mr W had put in his letter and said that Mr W was not good with change or dealing with new people. Mrs Y felt that Mr W had "lost" Mr T who had been a stable feature and from whom Mr W had benefitted a great deal. Mrs Y also expressed concern that Mr W had mentioned leaving his job. Mr A agreed to take a step back to allow Mr W some space and Mrs Y agreed to keep Mr A informed of any changes or concerns.

4.71 The following day Mr A met with Ms N and updated her on Mr W's letter and telephone call with Mrs Y. Mr W's level of risk continued to be noted as "amber". It is unclear from the records what would have changed this level of risk.

4.72 On 10 November Mr A contacted Signposts who had been informed by Mr W that he didn't want any further engagement with the early intervention service and therefore refused to allow Signposts to share any information with Mr A. Signposts agreed to share any concerns with Mr A but otherwise would respect Mr W's request. Mr A noted he would remain in contact with Mrs Y and planned to re-establish contact with Mr W in the near future.

4.73 On 1 December Mr Y contacted Mr A and reported that there were no issues and that Mr W had continued working, part-time in a garage. Mr W had told his parents that he didn't want to live on his own and had therefore stopped involvement with Signposts. Mr A agreed to contact Mrs Y prior to calling Mr W later that week.

4.74 Mr A attempted to contact Mr W, without success and therefore arranged an appointment on 8 December with Mrs Y. Mrs Y reported that she remained fearful of her son and his potential to explode, although he mostly avoided contact with her. Mrs Y described a time that she had been sitting in the living room with her son, who without warning had stood up and said "you're an annoying b***h". Although Mr W had been friendlier since, he "was not back to his old-self" prior to the aggression. Mrs Y repeated the information that Mr Y had given about the contact with Signposts and added that Mr W had said he wished to remain living with his mother. Mrs Y indicated she felt her son needed to move on however there was no rush, and was also fearful about discussing such a difficult subject. Mrs Y agreed to think about a carer's assessment. Mr W arrived home as Mr A was leaving, he was polite but annoyed by Mr A's presence, Mr W asked Mr A to leave and stated he did not want to have contact with the early intervention service.

January to June 2010

4.75 On 12 January Mrs Y contacted the service to arrange a telephone call for that day. Mrs Y reported that Mr W had been behaving unusually; moving things out of his room into the loft, "looking through" his mother and on one occasion invited his father over, then questioned why Mr Y was at Mrs Y's home and asked him to leave. Mr W's mother did not think Mr W was hearing voices and had not been aggressive, however Mr W had left this job at the petrol station because "someone was aggressive towards him". Mrs Y felt it was more likely that it was either because he was doing two jobs or that his father had approached him about moving out. Mr A advised about supported housing for Mr W and offered to investigate the options. Mr A asked Mrs Y to think about boundaries whilst Mr W was living with her and discussed the idea of Mr and Mrs Y spending more time with Mr W to allow him to feel more comfortable talking about difficult issues. Mrs Y said that she felt Mr W's aggression would reduce because his brother was going to be home for a few months. Mr A provided Mrs Y with details of a website about hearing voices to pass to Mr W who was currently spending a lot of time on the internet.

4.76 Later that month Mrs Y contacted Mr A to report paranoid behaviour by Mr W; he would go into town to get money for his mother and say that people were watching him. Mr Y had indicated he thought this could be an excuse to not pay what he owed his mother. Mrs Y also reported an argument with Mr W, during which Mr W was informed he needed to re-engage with Signposts and continue looking for his own place. Mrs Y stated that Mr W had reacted better than she had expected and had since been nicer towards her. Mr A advised how this could be followed up with boundary setting. Mrs Y also stated she would inform Mr W that he needed to re-engage with the early intervention service. Two days after this Mrs Y sent a text to Mr A stating that there had been an improvement between Mr W and her; Mr W had given her some money and they had gone shopping together.

4.77 On 17 February Mr A met with Mrs Y to complete a carer's assessment. A referral and carer's assessment had been sent to the Carer's Support Service and Mrs Y had also obtained details for the Sussex Autistic Society who organise support groups. The carer's assessment noted that Mrs Y's "brother and partner are around at weekends and my brother will sit and talk" to Mr W. Mr A contacted the benefits office to obtain the relevant forms to claim disability living allowance. Mr A intended to complete the forms on Mr W's behalf should he not agree to do it himself. Mrs Y stated she "needed a break" so she and Mr A spoke about the options to follow this through to support Mr W with his "OCD-like tendencies" regarding his environment. Mrs Y reported that she felt more in control at home, although some of Mr W's more difficult behaviours persisted, he was more responsive when asked not to do things.

4.78 About two weeks later Mrs Y contacted Mr A to let him know that Mr W had contacted the police to report that some money had been stolen from the house. Mr W had invited a group of 15 year olds to the house for pizza, he stated he knew them however could not provide their details. Mrs Y said that

the police had contacted her because they were aware that Mr W was vulnerable. Mrs Y had talked to Mr W to explain that that there was little point in following the case through as there was little information, however Mr W felt they should be punished therefore would provide a statement for the police. Mrs Y reported that Mr W had also knocked on someone's door (a woman he used to know) whilst with his brother stating the person owed him money. Mrs Y confirmed Mr W did lend someone money and that it had not been returned. Mr W had told his brother that this woman would speak to him, asking him to do things and he was unable to always say no. Mrs Y said that Mr W's brother would try and identify more information about the voices. Mr A noted that Mr W would be discussed in the clinical team meeting two days later and that he would maintain contact with Mrs Y. We have not seen evidence of any records of the clinical discussion. There is no indication that Trust staff considered the safeguarding risks associated with Mr W's behaviour, either to the teenage boys or to Mr W.

4.79 On 10 March Mrs Y contacted Mr A to let him know that she and Mr W had met with the police so that Mr W could provide a statement regarding the stolen money. It appeared that Mr W knew the teenagers from the local area. The police had given Mr W some advice about (a) the risks involved in inviting relative strangers to his home and (b) not taking matters into his own hands if he were to see the teenagers again. Mr W agreed to contact the police if he did see them again. Mrs Y also reported that Mr W had agreed to see someone, arranged by Mr Y, to look at coping strategies.

4.80 The following day Mr W's case was discussed in a clinical review meeting; it was noted that he was not engaged with the service and there was on-going friction at home. Mr W's risk was noted as amber and it was agreed that Mr W's risk assessment would be updated and that status of the referral to the autistic spectrum disorder service would be checked. It appears that the risk assessment was not updated until 29 April, nearly six weeks later.

4.81 On 29 April Mr A called Mrs Y who reported that Mr W had been "up and down". Mr W had not made it to see the speech and language therapist that Mr Y had contacted because he was very anxious about seeing her and had not been sleeping well. Mr Y told us that he had organised this because Mr W needed help with his communication. Mrs Y said that recently Mr W had been violent after she had accidentally woken him after he had been working until 4am. Mr W became very angry, swung the fridge doors off the hinges and shouted at Mrs Y, threatening to hit her and that he "might as well kill himself". Mrs Y told Mr A that Mr W had said this on a previous occasion when he was anxious and worked up about something. Mrs Y had asked Mr W's brother to come to the house and Mr W stated, "might as well kill himself". Since the incident Mr W had been better and cooked dinner for his mother which he had never done before. He had also reconnected with some old friends whilst seeing a band. Mr W's mother did not feel there were any signs of her son hearing voices. She had been seeing someone from the carer's service and had been exploring claiming Disability Living Allowance, however Mr W was required to sign the forms. Neither Mr W nor his mother had heard from the Autistic Spectrum Disorders service so Mr A agreed to follow this up.

However we can find no evidence of any associated actions in the following few weeks.

4.82 In May Mrs Y was sent some information about the Family Nights (a carer support group) sessions. This was followed up by a call from Mr A to Mrs Y to let her know that the autistic spectrum disorder service would soon be writing to Mr W to send some information and offer him an assessment. Mrs Y reported a further aggressive incident with Mr W, following a night shift, however on that occasion she had felt able to stand up to him and had left him a note saying that his behaviour would not be tolerated. The letter to Mr W was sent on 27 May, it was from Ms P.

July to December 2010

4.83 On 5 July Mrs Y contacted Mr C, a duty worker. Mrs Y was very tearful following a series of events the previous evening. Mr W had been lying in the garden in his pants at 11:00 pm saying he was feeling sick and wanted to go to Brighton to "see his girlfriend and have sex with her for £60". Mr and Mrs Y had persuaded him not to go. Mr W had not seemed paranoid or frightened but had reported hearing a voice from the person who owed him money. Mrs Y also said that Mr W had wanted to see his father for the first time in a while and had asked him (Mr Y) to contact the early intervention service to arrange to see Mr A. Mrs Y agreed with Mr C that the appointment was not urgent and that she would arrange for Mr W to see Mr A when he returned from his course. This was later arranged for 7 July.

4.84 On the day of the appointment on 7 July Mr A tried a number of times to contact Mr W, however he did not answer any calls. Mr A then spoke to Mr Y who reported that Mr W was with him. Mr Y reported that Mr W held a good conversation, was rational and able to have a discussion. Mr W had told his father that he was not hearing voices and felt okay at that time, although he said there was nobody there to help him when he needed it. Mr A gave his mobile phone number to Mr Y for Mr W to be able to call him when he needed to. Mr A then contacted Mr W's mother who reported that Mr W had been moving furniture and taking items apart in his bedroom during the night. Mr W had told her that he did not need to see Mr A because he was seeing someone in Brighton about psychosis. Mr A advised Mrs Y to suggest that Mr W call Mr A.

4.85 Five days later Mr A contacted Mrs Y who reported that Mr W had thrown some things out and had made other changes to the house whilst she had been away. She also said that Mr W was refusing to have contact with the early intervention service. Mr A then contacted Mr Y who reported he had recently seen his son and had gone for a drive and walk in the country; things had gone reasonably well. Mr Y reported that he was working with Mr W on the idea of him moving to live with him (Mr Y) because Mrs Y was not coping well. Mr A advised that Mr and Mrs Y needed to think about strategies to manage this. Mr Y said he would continue to encourage Mr W to engage with the early intervention service and other services.

4.86 On 14 July the Trust sent a letter to Mrs Y asking for feedback from the Family Nights group session she had attended.

4.87 During August Mr A received a telephone call from Mr Y who stated that Mr W had lost his job, Mr Y suspected it was because Mr W had been rude to a customer. Mr Y said that Mr W was living with Mrs Y full time and that Mrs Y was struggling. Mr Y had therefore agreed to pay for Mr W to have his own flat; Mr W had agreed to this and said he wanted to live in Broadwater close to his mother. Mr Y asked to meet with Mr A to identify other methods of help. Following this call Mr W was discussed in a clinical review meeting when the situation at that time was noted. It was agreed that Mr A would meet with Mr Y and that the autistic spectrum disorder service would initiate engagement with Mr W. Later in the month, Mr Y met with Mr A, who advised about strategies to help him and others whilst Mr W was not engaging with their service. Mr Y had agreed to pay for his son's private rent for six months and to encourage Mr W to apply for housing benefit thereafter. Mr A advised how to manage Mr W's expectations to ensure he was fully aware of the arrangements. Mr Y reported that Mr W was looking for a new job and Mr A advised that Southdown[19] could support Mr W with housing and job seeking. Mr A discussed how Mr and Mrs Y could approach their son and encourage him to accept help by highlighting the impact on others' feelings and identify what motivated him. It was reported that Mr W had been seeing a prostitute in Brighton and had spoken about his difficulties with relationships and confidence. Mr A advised that Mr W should engage with someone to help with his confidence/skills.

4.88 On 6 September Mr A arranged an urgent appointment for Mr W after receiving a text from Mr or Mrs Y during the weekend reporting an incident that had led to Mrs Y calling the police. (We have no information about action that the police took at this time.) Mr W had woken his mother in her bedroom at night, angry and blaming her for many things. He had thrown a glass jug at her and also smashed some christening plates. Mrs Y had called the police and Mr Y and had asked Mr W to leave the house and not return from his father's until things had changed. When Mr A met with Mr W he presented a little anxious with some unusual gesturing and facial grimacing, however he was pleasant and engaged well. Mr A noted that Mr W had been distracted; this indicated auditory hallucinations that Mr W admitted. Mr W reported mainly hearing one male, high-pitched voice that he found annoying. The voices were company for Mr W however they became distressing when he felt stressed, they provided a running commentary and would comment on what he was doing and make commands. Mr W stated that he would never harm anyone and that the voices never commanded him to harm himself or others. Mr A tried to explore some the voices further, however it was unclear how well Mr W was following the conversation. Mr W believed the voices belonged to real people and was frustrated that he did not know who they were. He also stated he could read people's minds and was drawn to famous people who were distressed and he would try to contact them via the internet. Mr W stated he saw Rebecca Adlington mouth his name whilst he was watching her

[19] *Southdown is a not-for-profit specialist provider of care, support and housing services for vulnerable people in Sussex.*

on television. Trust records indicate that Mr W's traffic light status was moved to "red"[20]. A risk assessment completed on 8 September noted that Mr W was expressing intent to harm others, displaying dangerous impulsive acts and showing signs of anger and frustration. Mr W had slept poorly over the previous four to five days and he associated this with his stress and his mum snoring. Mr W said that he was able to manage the voices better when he was busy, otherwise they become intrusive. Mr A noted that "it was clear Mr W was keen to move back with his mother" and despite numerous occasions of Mr A stating it would take some time, Mr W thought that by engaging with the early intervention service, he would be able to move home. Mr W thought that his mother had overreacted about the incident at the weekend and although he admitted to throwing the jug and smashing the plates, he minimised the incident. Mr W felt his mother was upset for no reason and calling the police was unnecessary. Mr A discussed how Mr W could reduce his stress and voices however Mr W was still not keen on taking medication. The plan was for Mr W to see Dr R and for Mr A to contact Mr and Mrs Y.

4.89 A couple of hours later Mr A called Mr Y who reported that he had just seen Mr W who believed he was going to move back in with his mother. Mr A and Mr Y agreed that Mr Y would contact Mrs Y to clarify the situation and Mr A advised that Mrs Y should not go home on her own. Mr A then spoke to Mrs Y who advised that Mr W would not be able to get into her home as he didn't have a key. Mr A noted that during the conversation "some safety planning took place" because of Mr W's unpredictability, however he was not considered a risk to himself or others. Mrs Y agreed to contact the police in the event of any further incidents. Mr A recommended that Mr W should have a psychiatric assessment and agreed to contact the police to "put a marker next to Mr W's name". Later still Mrs Y contacted Mr A to advise that Mr W had been sitting outside of her flat when she had returned home. Mrs Y had been clear that Mr W could not move back in, she had told him that he was unwell and needed treatment, and that he had to agree to everything suggested by the early intervention service if he were to have any chance of moving back in the future. Mr A noted that Mrs Y had been upset when she had called him.

4.90 Mr A contacted Mr and Mrs Y the following day and was told that Mr W had attempted to get back into his mother's house at 11:00 pm the previous night. Mr Y had heard him leave and had called Mrs Y to warn her. Mrs Y had not responded to Mr W and he had then returned to his father's address. Mr Y reported that when Mr W returned home, he was making bizarre comments and asked his father to "not make his d*** small" and that "his d*** was small at his Dad's but big at his Mum's'". Mr W had told his father that he had heard him and his (Mr Y's) wife talking about it. Mr Y had asked if Mr W could hear his father's thoughts, and Mr W confirmed he could.

[20] *The operational policy describes a red status as someone who is "currently assessed at significant risk that may exceed the resources available within the team and the patient's support network. Review should occur at every zoning meeting and discussion focused on changes required to move that patient towards amber then green – i.e. manage and hence reduce the risk."*

4.91 On 8 September Mr W met with Mr R and Mr A. Recent events were discussed and it was noted that Mr W had been under the care of the early intervention service for 18 months but had refused proper treatment. Dr R recorded that the deterioration of Mr W's mental state was likely to have occurred because of the loss of his job, but the recent episode had provided the early intervention service with the means of initiating treatment. At this time it appears that Mr W was placed back in the red zone, having been moved to amber in March and then to green at an unknown point in between. Mr W was prescribed with quetiapine 100mgs, to increase to 200mgs if it was tolerated, routine blood tests needed to be arranged and the service would continue to support Mr W and his family, with a review arranged for two weeks later. A summary of this meeting was sent to Mr W's GP, Dr H. Dr R also provided feedback about the meeting to Mr Y, who reported a notable improvement in Mr W and stated that he appeared more relaxed. Mr Y has told us he has no recollection of speaking to Dr R on this occasion.

4.92 On 14 September, Mr W called Mr A to cancel his appointment because he had a job interview. Mr Y also called to advise that Mr W had continued to have some sleep problems and had broken a picture frame, however he had generally been better. Mr Y stated that Mr W did not have an interview, he had an appointment with the job centre and in Mr Y's opinion Mr W could have attended the appointment with Mr A. Mr W had told his father that he did not want to engage with the early intervention service, however both Mr and Mrs Y had maintained that Mr W had to remain engaged with the service. Mr Y said that he believed that Mr W was taking the medication, however he had only seen him take it on one occasion.

4.93 On 20 September Mr A met with Mr W and Mr Y at Mr Y's home. Mr W was still in bed when Mr A arrived. Mr Y reported significant improvements in Mr W over the previous week that Mr Y attributed to the medication. Mr Y reported that in his opinion Mr W's issues were "mostly associated with autistic spectrum disorders, he liked things a certain way and would become frustrated when they were not the way he wanted them". (Mr Y has told us that this has been wrongly recorded and that this was not his view.) Mr Y and his wife had spent time with Mr W drawing clear boundaries and explaining the rationale for them. Mr Y also reported that Mr W lacked empathy unless in extreme situations and had difficulty communicating with people. Mr A met with Mr W who engaged well, however he avoided conversations about his mental health. Mr A noted that it was unclear if Mr W recognised the benefits of his medication in relation to not hearing voices over the last week, however he did recognise the benefits of living with his father, with reduced stress. Mr W said that he was applying for jobs and pursuing those with minimal stress and public contact. It was noted that Mr W had an appointment with Dr R the following day. There is no record of that appointment taking place however Dr R did meet with Mr W on 24 September.

4.94 On 24 September Dr R met with Mr W who reported that he was more relaxed, sleeping better and said he had not heard voices for the previous ten days. Mr W stated he was happy to continue with his medication and was feeling more comfortable living with his father. Mr W agreed to explore the

diagnosis of autistic spectrum disorder and receive support from the service once a specialist had been appointed. Mr W asked Dr R to talk with his father about his next prescription because Mr W was unsure when it was due. Mr W said he would like some practical support around employment and at the right time, housing. Dr R planned to meet with Mr W the following Monday (three days later). Dr R then spoke with Mr Y who reported that he was happy with Mr W's progress, and Mr Y concurred with Mr W's progress report. Mr Y agreed to contact Mr W's GP regarding his prescription.

4.95 On 27 September Mr A met with Mr W in a café. Mr W reported on-going issues with hearing a female voice who instructed him to visit her. Mr W denied ever following the command and said he did not find the voices distressing but that they had been consistent since his initial referral to the service. Mr W believed the voices originated from real people that were trying to communicate with him. It was difficult for Mr A to identify what was real and what was not because Mr W would "discuss meeting an old friend in Brighton and the voices within the same breath". Mr A recommended Mr W have a further assessment regarding the voices and also for autistic spectrum disorder. Mr W said he was uncomfortable when new people entered the cafe, but was said it was not in relation to paranoia but more the "hustle and bustle" and he was concerned about being overheard. Mr W said he had not yet had a job interview however he continued to apply for jobs.

4.96 At the beginning of October Mr W was discussed in a clinical review meeting. His risk was noted as amber (although it appears he was still in the green zone) and it was agreed that if Mr W's aggression worsened, the dose of quetiapine should be increased. The engagement with Mr A should continue and the team would consider what independent accommodation might be appropriate for Mr W.

4.97 On 4 October Mr A met with Mr W and Mr Y. Mr Y reported continued improvement in Mr W's mental state and that Mr W had coped well when he had met his mother in a busy space the previous weekend. It was noted that Mr Y agreed to pay for private support for Mr W to help with his understanding of his social difficulties, "until the vacancy in the Trust had been filled". We have not been able to establish precisely what vacancy this was or what the specific impact of it was. Mr A recorded that Mr W appeared stressed by the long discussion and was vague when Mr A asked if Mr W had been hearing voices. Mr W reported that he had been taking 100mg of quetiapine, although he should have been taking 200mg. When Mr A explored the reason for this, he established that the reduced dose was the result of a communication error between Mr W's father and the GP surgery. Mr A advised that he would arrange for Dr R to write to the surgery to request that Mr W be prescribed 200mg of quetiapine.

4.98 On 12 October Mr A met with Mr W and they went to the sea front. Mr W denied hearing voices and was not keen to discuss the issue. Mr A recorded that Mr W was distracted at times and his eyes would dart around, Mr W also mentioned that his father had been talking to himself in his sleep. Mr W told Mr A that he was compliant with his medication however had missed a couple of doses recently. Mr A indicated that it was unclear to him whether Mr W

understood his difficulties because he would not talk about them. Mr W stated he had visited old friends recently and his relationship with his mother was improving, he stated he would prefer to live with her rather than his father. Following the appointment, Mr A telephoned Mr W's father who reported he was happy with how Mr W was progressing. Mr W's father had contacted the Speech and Language therapist and was awaiting a response. Mr W had had a few issues regarding house rules however there were no problems within the home. Although Mr W sometimes complained about the behaviour of others outside his father's home which would lead him to become frustrated.

4.99 On 15 October Mr A telephoned Mr Y following receipt of a text message the previous day stating that Mr W had decided he no longer wished to take his medication. Mr W's father stated this had not led to any friction within the home and Mr W had been honest about not taking his medication for about a week. Mr W did not appear to be sleeping well, however Mr Y had not noticed any other negative effects. Mr A advised that Mr W would require monitoring for any deterioration.

4.100 On 19 October Mr A met with Mr W who stated he would prefer to meet at the team office because "it was quieter". Mr A allowed Mr W to lead the discussion as Mr W was considering not meeting with the service any longer. Mr W stated he had not been taking his medication and had been sleeping well and Mr A noted Mr W appeared relaxed. Mr W also stated he was not hearing voices but wanted to understand his experiences and would figure it out for himself. Mr A provided some useful websites to Mr W to obtain a better understanding via the internet and talk about this further at a later point. Mr W spoke about finding it difficult to cope with noise and chaos as well as people talking to him for too long about personal things. Mr A was informed of an incident where people who had a learning disability approached Mr W whilst he was working as a lifeguard. Mr W said he had found this difficult because they created noise and mess however Mr W said that he remained professional. Mr W agreed to think about how to manage similar situations in future. Mr W also asked to reduce the meetings with Mr A from weekly to fortnightly. Mr A advised that Mr W should be signed off sick during this difficult period. Mr W said he would think about being signed off and asked to see Dr R about his medication. Mr A arranged for Dr R to see Mr W the following day.

4.101 The following day Dr R and Mr A met with Mr W. It was reported that Mr W was stable and that he had denied any psychotic or depressive symptoms, and no further reported episodes of aggression since living with his father. Mr W stated that he had never taken the medication that was prescribed to him (quetiapine 200mg) due to his concern that they would interfere with his sports activities. He said that the change of environment had reduced his stress that he had not heard any voices since moving in with his father. Dr R noted that Mr W's "first psychotic episode had resolved without medication" (it would actually have been unclear whether this statement is true, because over time Mr W gave varying responses about taking medication). Given that Mr W had declined medication to prevent future relapse, the plan was for the early intervention service to work with Mr W on psychosocial issues and

support him with vocational and financial aspects of life. The team would continue to monitor Mr W's mental state, and Mr W agreed to try medication should he deteriorate. Mr W would remain living at his father's address. Dr R issued a sick note for one month. A summary of the meeting was sent to Mr W's GP.

4.102 On 2 November Mr A met with Mr W who reported no significant issues since the previous appointment, however he was disappointed that he had not secured a job yet. Mr W stated he had been seeing his mum more frequently and their relationship was going well. Mr A recorded that Mr W was "a little paranoid and uneasy during the appointment" due to a viewing window in the room. Mr W was shown the other side of the window during his appointment, which appeared to relax him. Mr W was unable to think of a topic focus therefore Mr A suggested that they explore Mr W's social difficulties. Mr W stated there had been issues whilst he was swimming however found it difficult to explain the issues. After some time it became apparent that the difficulties were in relation to feeling overwhelmed due to external stimulus. Mr W described needing to focus on swimming but was unable to do so due to the noise and movement of others, distracting him and leading him to over stimulation. Mr A advised of some coping strategies such as ear plugs (which Mr W would try) and withdrawing to the side of the pool, which Mr W already did. Mr W stated that he had been to a small venue music concert and despite the room being busy and loud, he managed the situation well because he could "connect" to the music and exclude what else was going on. Mr A gave positive feedback and advised using an MP3 player when Mr W had to go into town during busy shopping times.

4.103 On 10 November Mr A telephoned Mrs Y who reported that she was pleased with Mr W's progress. Mr W had been well behaved and polite to his mother however had still been asking when he could "return home". Mrs Y told Mr A that she found it difficult to repeat "it would not be any time soon". Mrs Y said that Mr W was beginning to arrive at her home unannounced, therefore Mr A advised about boundary setting. Mrs Y stated that her son was not showing any psychotic symptoms and said she felt that hearing voices was in relation to acute stress. Mr A updated Mrs Y about how the meetings were progressing.

4.104 On 16 November Mr W's care plan was reviewed. It was noted that "up until recently", he engaged well with the early intervention service. Mr W had been resistant to taking medication so it was agreed that Mr W would inform his care coordinator of any distress. Mr W's parents should continue to be involved with his care. Mr W found his own and others' behaviour confusing, resulting in finding relationships difficult. Mr W was sensitive to stimulation, making him anxious, frustrated or angry if he were unable to avoid it. Mr W was aware that some of his characteristics were sometimes associated with those with autistic spectrum disorders. However he had refused to have information about autistic spectrum disorders. The early intervention team would continue to review Mr W regularly, and it was noted that the team was still getting to know him and how best to manage his needs. The next review

was due on 13 May 2011. A copy of the care plan was sent to Mr W's GP who received it in early December.

4.105 On 1 December Mr A met with Mr W and reviewed the care plan together. Mr W stated the report was "pretty accurate" and signed the document. Mr W highlighted that he would benefit from support with communication issues from his first appointment with his speech therapist. Mr W described an incident where he had invited another lifeguard back to his home for a sleep over. Mr W had worked out that he did not know her very well and reported she was embarrassed and upset. Mr A advised about social rules and boundaries and how Mr W may have benefitted from getting to know her first. Mr A talked about the differences between acquaintances, being friendly and friends. Mr W confirmed he understood the consenting age for sexual encounters and that "no" means "no".

4.106 On 13 December Mr Y telephoned Mr A to report that Mr W had met with the speech and language therapist, Ms R, that Mr Y organised, however Mr W did not want to see Ms R again nor meet with Mr A again following the previous meeting. It was reported that Mr W felt that Mr A was discussing personal things about Mr W, which he did not like. Mr A advised that difficult content had been covered during the meeting in relation to Mr W's attitude towards young females. Mr A noted that this would have been particularly difficult for Mr W because he had been called a "paedo" previously and this word was also in the content of the voices that he heard. Mr Y said that Mr W would not attend the next appointment.

4.107 As expected, the following day Mr W did not attend his appointment with Mr A, however Mr A spoke to Mr W on the phone. Mr W was polite and said that he had emailed the team to say that the sessions had been helpful however he had what he needed from them and would like to keep things more private. Mr A offered fewer visits however Mr W declined. Mr A noted that he would discuss Mr W's case at a clinical meeting and recorded that Mr W appeared to be well with no risk, therefore engaging with him against his wishes would not be necessary. Mr W was aware his parents would contact the service if anything changed. Later that day Mr A spoke with Ms R who stated that Mr W had only attended one appointment and therefore she had been unable to complete the autistic spectrum disorder assessment. It was reported that Mr W had described pronounced language and communication difficulties associated with autistic spectrum disorders. This could lead to Mr W's responses appearing irrelevant on occasions because he was slow to process information and his response was linked to the previous question. Ms R had suggested coping strategies to Mr A and had also emailed Mr W. Ms R had also spoken to Mr Y who would encourage Mr W to attend appointments with the early intervention team and Ms R.

4.108 Mr W was moved from green to amber on the team traffic light status on 15 December, however we have not seen any records of the associated clinical discussion.

4.109 On 17 December Mr D, an employment advisor, received a referral for Mr W to access to employment support. Mr D forwarded the relevant paperwork to Mr W to sign and return if he wished to access employment advice.

January to June 2011

4.110 On 5 January Mr D telephoned Mr W who reported that he did not wish to look for paid or voluntary work. Mr D advised that Mr W could be re-referred at any time.

4.111 On 27 January Mr A telephoned Mr Y who reported that Mr W had started a relationship with a woman in her forties who was currently going through a divorce. Mr Y thought that this was Mr W's first sexual relationship. Mr Y had met Mr W's girlfriend and reported that the relationship seemed to be having a positive effect on Mr W, who was happier and more confident. Mr W and his girlfriend would swim and jog together but Mr Y expressed concern regarding the effect on Mr W should they split up. Mr Y reported that Mr W had not found employment however he had applied for a catering course and was due to attend an induction later that week. Mr Y was informed that Mr W's discharge plan would begin shortly because he had been under the care of the early intervention service for three years. Mr A planned to inform Mr W of this and to offer to meet him for a discharge planning meeting.

4.112 During February 2011 Mr Y recorded that Mr W was displaying obsessional behaviour, and showing signs of anxiety and hearing voices. Mr W had been persistently trying to maintain contact with his girlfriend, despite her wanting to cool things down. Mr Y noted that Mr W was "making it difficult for her to have peace and time alone". If this information was shared with the clinical team, we have not found any evidence that it was recorded.

4.113 On 13 February Mr A received a letter from Mr W stating that he was having difficulty paying a bank loan and asked Mr A to complete the Debt and Mental Health evidence form in order for Mr W to access the necessary support. The form was later sent to Mr W and later completed by Mr W and Mr A, indicating that Mr W had psychosis and autistic spectrum disorder.

4.114 On 10 March Mr A called Mr Y who reported that Mr W was doing well and still in a relationship. Mr W was open to the idea of finding his own place and had met with Signposts for support. Mr W did not want to engage with the early intervention service despite encouragement however Mr Y said he would like to meet with the service before Mr W was discharged. Mr A agreed to meet with Mr Y and Mrs Y on 21 March. This appointment was later changed to 28 March at the request of Mr W's family.

4.115 On 25 March a risk assessment was signed by Mr A. This is the risk assessment that was started on 8 September 2010. It is not clear why there was a delay in signing off the risk assessment. The document indicated that Mr W was unemployed at that time and that he was under threat of eviction, had a lack of positive social contacts, was experiencing financial difficulties, and was denying problems in himself that were observed by others. Mr W would binge eat and had been given advice about the diet he should follow

when he was exercising excessively. He was not engaging with the service and had expressed an intention to harm others, displaying dangerous impulsive acts, including damaging property. It was felt that Mr W had engaged well at some points and had made some progress with developing his understanding of his presentation, however following an increase in his symptoms he refused to engage with the service. It appears that Mr W was in the green zone at this time.

4.116 On 28 March Mr A met with Mr W's parents who reported that Mr W had started working for a petrol station, but Mr Y believed this was causing Mr W a degree of stress. It was reported that Mr W's girlfriend had needed to lay down some rules due to Mr W's jealousy, needing reassurance and wanting to see her every day, they had nearly split up three weeks previously however it seemed that they had worked through their issues. There was concern about the effect on Mr W should they split however he was philosophical about it. Mr A noted that Mr W's "autistic spectrum disorder traits remain" however he was more active. It was recorded that Mr Y and Mrs Y were aware of the autistic spectrum disorder services that could be accessed via adult social services should Mr W wish to engage with them. Mr Y and Mrs Y were informed that the team planned to discharge Mr W back into the care of his GP because he was not engaging with the community team. It was noted that Mr W was on the housing list register and had been invited to attend an assessment. Mr W had been engaging with Signposts and was due to attend an appointment with them later that day. Mr Y said that Mr W had told him he would have attended the appointment with Mr A if he had not already had another commitment. Mr A recommended that Mr W had a review with Dr R prior to discharge and suggested that Mr W should attend the meeting.

4.117 On 5 April Mrs Y called Mr A to advise that Mr W attended her home the previous night and said that he was hearing voices telling him to do inappropriate things. There was no indication that Mr W would do anything and Mrs Y reminded him that he had to make his own decisions (and not listen to the voices). Mrs Y said that Mr W had told her he wanted to "shoot out the part of his brain that was causing the voices". Mr A noted this appeared to be an indication of stress rather than intention. Mr Y had told Mrs Y that he believed that Mr W had made this up to try and get back into his mother's home. Mrs Y said that she had suggested that Mr W to go to A&E the previous evening however he had refused. Although the previous day Mr W had agreed to see Mr A, Mrs Y had received a text from him to say that he was at home and might meet with Mr A later in the day. Mr A reminded Mrs Y of the options should the concerns for Mr W increase. Mrs Y said she suspected things were not going well with Mr W's relationship and that he and his girlfriend may have split up. Later that day Mr W made an unplanned visit to the team office. Mr A spent about an hour with him and noted that he appeared "quite relaxed and engaged well". Mr W reported that he heard the voice of his girlfriend and her children and described them as "largely comforting". Mr A noted that he was on leave the following week, but that Mr W had agreed to see him on 21 April. We can see no evidence that any action was taken in respect of Mr W's statement to his mother, nor any

consideration of the potential risks to the children of Mr W's girlfriend at this time.

4.118 Three days later at a clinical review meeting, it was recorded that Mr W had re-engaged with the service because he had been hearing voices. It was also noted that Mr Y had asked Mr W to move into his own accommodation and that Mr W was in a relationship. The review recorded Mr W as being "amber" and recommended referral to the autistic spectrum disorder service.

4.119 At the end of April Mr W did not attend his planned appointment but arrived at the community mental health team base and asked to see Mr A. Mr A was unable to spend very much time with Mr W so arranged to see him on 4 May. Mr A also made contact with Mrs Y who reported that Mr W was doing well and was working regular hours. Mrs Y was not aware of the situation with Mr W's girlfriend however said he could appear "stressed and over-excited at times".

4.120 Mr W attended the planned appointment on 4 May and reported that things were going well at that time and that he had "no major stressors", he also said that things were going well with his girlfriend. Mr A talked to Mr W about the voices and Mr W said that he related them to times of stress. Mr W did not appear to be comfortable talking about the voices so Mr A did not go into any depth. Mr A talked about Mr W's need to focus on one thing and how others might perceive things. Mr A noted that Mr W struggled with this but that they spent some time helping Mr W to see things from others' perspectives. A further meeting was arranged for 19 May.

4.121 On 16 May Mr A received a telephone message from Mrs Y to advise that Mr W had told her that he was moving into a flat the following week. It appeared that Mr W had not told his father and had pleaded with his mother not to share the information. Mr A noted that he would be unable to return Mrs Y's call as she was going abroad for a few days and had been about to board a plane when she left the message. Mr A therefore called Mr Y who said that he wasn't aware that Mr W had started seeing Mr A again. Mr Y said that he was aware of Mr W's impending move and described things as being good.

4.122 Mr A next met with Mr W on 25 May (it is not clear why the appointment on 19 May did not take place). Mr W reported that things were generally going well but described some issues with colleagues: (a) that they were more tactile than him and he didn't feel it was okay to touch anybody else, even on their arm; and (b) that newer people had been asking him a lot of questions when he was trying to focus on other things, and he found this frustrating and unreasonable. Mr W said that he often chose to ignore people when they were talking to him. Mr A discussed how others might perceive this and that this might exacerbate Mr W's frustration. Mr A arranged to meet again on 13 June.

4.123 The Care Programme Approach review due in May 2011 did not take place, but it is not clear why.

4.124 The meeting on 13 June did not take place (it is unclear why) but Mr W dropped into the mental health community team base on 15 June to see Mr A. Mr W reported some stress and said that his girlfriend had upset him recently. Mr A offered to see Mr W the following week but he didn't attend the appointment.

4.125 Mr W did not attend his medical review on 24 June so on 28 June Mr A called him and arranged to meet on 12 July.

July to December 2011

4.126 Mr W attended the appointment on 12 July and said that he had received a letter from Ms S regarding the autistic spectrum disorder service appointment. Mr W had written a letter to Ms S prior to his meeting with Mr A to say that he didn't think the service was right for him so he didn't want to keep the appointment. Mr A spent some time talking to Mr W about this but was unable to persuade him to attend the appointment. Mr A noted that Mr W was aware that the period of three years with the early intervention service was coming to an end and that Mr W had indicated he didn't want any input from other services. Mr A also noted that they had discussed the "psychotic part of his presentation". Mr W had said that he was "not really" hearing any voices and that he was aware that the source of the voices was his own mind. Mr W said that he had never received commands from the voices and that even if he had, they would not influence him as he was "strong enough to make up his own mind". Another appointment with Mr A was arranged for 9 August and an appointment with the doctor arranged for 9 July.

4.127 On 29 July Mr W attended a discharge Care Programme Approach appointment with Mr A and Dr R, Mrs Y accompanied Mr W. In a letter to Mr W's GP summarising the meeting, it noted that Mr W had been seen by the service for three years and it was reported that Dr R thought Mr W had "autism with episodes of psychotic symptoms when under stress". Dr R did not record any formal diagnoses. Although medication had been discussed, Mr W was not taking any medication at that time and appeared to be ambivalent about the idea of an autism diagnosis, despite his mother's agreement with the formulation. Dr R recorded his impression as autistic spectrum disorder "with discrete episodes of psychotic symptoms; paranoia and auditory hallucinations". Dr R had discounted a primary psychotic diagnosis such as schizophrenia. Although Mr W had social needs in relation to his autism he was not willing to engage with the autism practitioner (Ms S) and he did not want to see the community mental health team. Dr R noted that Mr W could access antipsychotic medication that had previously been prescribed (quetiapine). Dr R asked that Mr W's GP arrange a physical health check because Mr W had reported some weight loss. Dr R advised that he planned to refer Mr W to the community mental health team as Mr W was about to move to a new area and would need to register with a new GP.

4.128 In early August Dr R met with Mr W and Mrs Y because Mr W had had a panic attack the previous day. Mr W had experienced chest pain for 20-30 minutes and had found it difficult to de-escalate himself. Dr R found no evidence of psychosis but noted that Mr W was anxious because he had

recently moved into his own flat and was finding this difficult. Dr R contacted Mr W's GP surgery and asked that an ECG be arranged and advised Mr W to go to his GP or A&E if the pain recurred before meeting with Mr A the following week.

4.129 Mr W contacted Mr A on the day of his appointment to suggest that they met at Mr W's new flat. Mr A noted that the flat was sparsely furnished but that it appeared to have everything that Mr W needed. Mr A and Mr W discussed his finances which were "very tight". Mr A indicated that Mr W could try applying for Disability Living Allowance (DLA) but that to do so he would need to accept his mental health diagnosis. Mr W agreed to meet with a worker to explore his benefit entitlements.

4.130 On 22 September Mr A met with Mr W who reported that things were going reasonably well, that he was considering returning to architecture and he was being active. Mr A agreed to meet with Mr W once more before discharge and an appointment was arranged for 5 October. Mr W attended this appointment and he and Mr A went through the discharge plan, which Mr W signed. Mr W agreed that this plan could be shared with his parents and he thanked Mr A for his help.

4.131 On 12 October Mr A met with Mr W, Mr Y and Mr Y's partner. Mr Y reported that Mr W had been struggling over the previous week and had admitted to hearing voices that he had found distressing. Mr W had said that he had heard people at work calling him a paedophile and his girlfriend's voice suggesting that he should call or visit her. Mr W reported that he thought the voices were real, but Mr A recorded that Mr W accepted that this was probably not the case. Mr W said he had attended on that day because he now wanted help with hearing the voices as they had become difficult to tolerate. Mr A noted that although Mr W had actually been discharged, he had worked with Mr W and his father to identify a new plan for Mr W. Mr W agreed to see his GP to obtain some medication and to take the medication. Mr A reminded Mr W of some strategies to help him when he was stressed and suggested that Mr W might benefit from an appointment with Ms S, the autism practitioner. Mr A also said that he would contact the community mental health team to make them aware that he would be making a referral to their service. Later that day Mr A discussed Mr W's case with Ms S. Ms S indicated that Mr W was still open to her service and offered to send Mr W an appointment. Ms S also suggested that Mr Y sought some support from the National Autistic Society or other private sources. Mr A arranged an urgent appointment for Mr W to see Dr R two days later, just in case the GP (with whom Mr W was newly registered) would prefer any medication to be prescribed by the early intervention service.

4.132 The following day Mr A spoke to Mr Y who reported that Mr W had seen his GP the previous day but had not been prescribed any medication because the GP was aware that Mr W had an appointment the following day with Dr R. Mr A noted that the GP would make a referral to the community mental health team.

4.133 On 14 October Dr R and Mr A met with Mr W and Mr Y. Mr A noted that it was unclear whether the voices Mr W described were "psychotic in nature and may be intrusive thoughts, misinterpretations related to ASD". Mr W had agreed to a prescription of pregabalin[21] to help with anxiety (previously reported in August and two days previously) and reported that he had handed in his notice at work. Mr A noted he would meet with Mr W the following week.

4.134 On 20 October Mr A again met with Mr W and his father, Mr Y. It was reported that things had been more settled over the previous week, but some stressors remained that Mr W was struggling with. Mr W had applied for some benefits but was unclear about what he should do so agreed that his father could be involved to ensure that things happen as they should. Mr W reported that he had tried to manage his anxiety by listening to music through headphones and said that he tried to hear his girlfriend's voice as found that reassuring. Mr A reminded Mr W and Mr Y of the appointment with the autistic spectrum disorder service the following week and the assessment with the community mental health team on 4 November.

4.135 On 27 October Ms S met with separately with Mr W, and then Mrs Y and Mr Y to discuss Mr W's diagnosis and identify his support needs. Ms S noted that neither Mr W nor his parents were aware that Dr R had diagnosed Mr W as being on the autistic spectrum. It is of note that Mr W had never been diagnosed as being on the autistic spectrum, so it is not surprising that Mr W's family was unaware of the 'diagnosis'. Mr W told Ms S that he had found working with Mr A very helpful. Mr W described a number of difficulties that Ms S told him were not unusual for people on the autistic spectrum, such as sensitive hearing, his eyes being sensitive to colour changes, and difficulties sleeping and with touch sensation. Mr W also talked about the difficulties adjusting to his parents separating and seeing them both in "two separate worlds". Ms S suggested that Mr W might find it helpful to put together a visual schedule of his week and identify a purpose for visiting his parents. Ms S noted that Mr and Mrs Y were not aware of Mr W's diagnosis of autism and that she had discussed with them how autism affects someone. Ms S noted that Mr W's parents appeared relieved because they thought the picture fitted Mr W really well. Ms S provided Mr and Mrs Y with some strategies to be used when interacting with Mr W and offered to provide some information about support networks, specific approaches and other reading material.

4.136 Ms S met with Mr W again on 10 November when she discussed Mr W's need for predictability and the use of autistic spectrum condition alert cards. Mr W said that he felt it would be useful to carry these so that he could give relevant information to people that he trusted (e.g. police or other emergency services). Ms S agreed to produce a sample card with information that Mr W wanted included.

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[21] *Pregabalin belongs to a group of medicines known as anti-epileptic medicines, although it is prescribed for the treatment of several different conditions. Pregabalin can also be helpful in treating the symptoms of generalised anxiety disorder (GAD), particularly if other medicines, which are more often prescribed for people with this condition, are not suitable. https://patient.info/medicine/pregabalin-lyrica*

4.137 On 15 November Dr R and Mr A met with Mr W who reported that he had seen Dr O from the community mental health team on 4 November. Mr A noted that no information was available from that meeting and that Mr W had a further appointment arranged on 19 November. It was agreed to continue to prescribe pregabalin, increasing the dose to 150mg. Dr R provided a medical certificate for two months and noted that although no further appointment would be arranged with the early intervention service, Mr W would be followed up by Ms S and the community mental health team.

4.138 Ms S met with Mr W on 17 November when they discussed the information in the alert cards. Mr W described sometimes feeling as though he were drowning when there was too much noise, and that his breathing and feeling of his feet were "lost" when other people looked at him. Mr W also talked about his relationship with his girlfriend and said that he could never make the first move in a conversation.

4.139 On 22 November Mr Y emailed Ms S asking for an update about Mr W's assessment for autistic spectrum disorder. Mr Y advised that he had been informed that there was no longer a need for Ms S to see Mr W, and that he felt this must be a misunderstanding because both he and his son needed support. There is no indication that Mr Y received a response to this email.

4.140 On 9 December Mr W's GP received a letter from Dr O following Mr W's appointment with him on 4 November. The letter provided a summary of Mr W's personal and mental health history and indicated that Mr W had been diagnosed with psychosis, but that an assessment for autistic spectrum disorder was in progress. Dr O noted that Mr W had initially indicated it was okay for his father to be present for the appointment, but "after about ten minutes he asked his dad to leave since he said he could not be speaking to two people at the same time". Dr O advised that Mr W was not keen to discuss the voices he had heard and reported that he did not hear the voices at that time, but that they had been distressing. Dr O noted that Mr W had told him he had tried taking pregabalin for a while but was not taking it at that time. Mr W also told Dr O that he had been prescribed quetiapine, but that he didn't take it and was not keen to try any medication at that time. Dr O advised that he would "like to see Mr W a couple of times before coming to a conclusion about his current diagnosis". There is no summary of this appointment in the electronic case notes, or any indication that the appointment took place. Dr O's entry was made in paper records held at the community mental health team base.

4.141 On 19 December Dr O saw Mr W and Mr Y when again Mr W asked his father to leave the room after five minutes. Dr O discussed allocating a care co-ordinator for Mr W, who said he would be willing to be supported. Dr O discussed "the voices" with Mr W who spoke about the streets being noisy, especially at night. Mr W was concerned about people who might be aggressive and was hearing voices inside his head although he felt that they might be actual sounds from the streets. Although Dr O wrote a summary letter to Mr W's GP, this was not received until 13 January when the GP surgery contacted the community mental health team enquiring about medication (see paragraph 4.143 below).

4.142 On 30 December a duty worker received a telephone call from Mrs Y to say that Mr W wanted to take his medication but his GP had refused to prescribe pregabalin 250mg. The duty worker contacted Dr O to ask if he could organise the prescription and liaise with the GP.

January to June 2012

4.143 On 13 January Mr W called Dr O to say that he had run out of medication. Mr W said that the medication was working well and he had felt quite relaxed over the previous week. Mr W agreed to visit his GP to obtain more medication. Shortly afterwards a duty worker was contacted by the GP surgery seeking clarification of the prescription requirements.

4.144 Six days later Mr W and Mr Y arrived at the mental health community team base asking for support because Mr W was feeling unwell. Initially it was unclear whether Mr W was physically or mentally unwell because he had poor eye contact and minimal speech. Mr W asked to be seen without Mr Y present. Ms C, the duty worker, noted that Mr W appeared generally uncomfortable but responded well to her and relaxed easily. It transpired that Mr W had misunderstood his medication regime and had used all of the pregabalin that had been dispensed six days earlier. Mr W reported that he had taken 300mg three times a day, rather than 150mg twice a day. Ms C checked Mr W's physical observations which appeared normal. Having discussed the issue with a doctor, Ms C said it was safe for Mr W to return home and that she would discuss a further plan with Dr O the following day.

4.145 On 23 January Mr W met with Mr D, a vocational specialist. Mr W told Mr D that he felt he should still be employed by his previous employer and that he wanted help to apply to the Royal Air Force. Mr W said he "believes he does not have Asperger's Syndrome" and therefore could continue with the application. Mr D noted that Mr W needed to have a care coordinator allocated and that he would discuss the matter of Mr W's understanding of his diagnosis with Dr O because Mr W's previous case notes indicated that he was aware of his diagnosis. Mr D followed this up with Dr O on 30 January when it was agreed that Dr O would discuss the matter with Ms S.

4.146 Mr Y arrived at the community mental health team base on 20 February asking to talk to someone about Mr W because his son appeared confused about who was involved in his care. The duty worker confirmed that Dr O was currently involved and that Mr W was waiting for a care coordinator to be allocated. The duty worker also confirmed that Ms S was due to see Mr W soon regarding the autistic spectrum disorder diagnosis. The duty worker noted that Mr Y planned to write to Dr O and that Mr Y appeared happier about the situation after speaking with her.

4.147 Four days later Mr D recorded that he planned to discharge Mr W from his caseload and that he could be referred again in the future if necessary.

4.148 On 12 March Mr Y wrote to Dr O to express his concern at the lack of support he felt Mr W was receiving. Mr Y notes that he has told Mr W that Dr O would not speak to him (Mr Y) because of patient confidentiality, but that Mr W had

disputed this and had said there was no reason that Dr O could not talk to Mr Y. Mr Y sought confirmation that a care plan was actually in place and asked for an urgent meeting so that he and Mrs Y could see the care plan and share their concerns with "someone in authority". Dr O responded on the same day and advised that he had been seeing Mr W regularly for scheduled appointments and had also seen him when he had arrived unannounced. Dr O said that he agreed that Mr W needed more help than just being seen in outpatient clinics and that a care coordinator would be allocated. Dr O also advised that Mr W had consistently refused permission for contact with Mr Y or Mrs Y, however he suggested that Mr Y attend Mr W's next outpatient appointment so that the issue could be discussed again.

4.149 On 26 March Ms C (Mr W's new care coordinator) noted that she had contacted Mr Y to arrange an appointment for 30 March, however there is no indication that this appointment went ahead. Three days later Mr Y noted that he had shared a copy of the journal he had prepared with Ms C. We have not found a copy of this journal in any of the records we received from the Trust.

4.150 On 13 April Dr O and Ms C met with Mr W for a review. Dr O provided a summary of this meeting in a letter to Mr W's GP that was received on 27 April. Dr O noted Mr W's diagnosis as Asperger's Disorder and that Mr W was being prescribed pregabalin 150mg to take as required. Dr O advised that he had received a letter from Mr W's father asking that he be kept informed of the care that Mr W received, and that Ms C had been in touch with Mr W's father in response to this request. Mr W had told Dr O that he didn't want to take regular medication; he only wanted to have medication to take as and when he needed it.

4.151 On 18 June Mr Y contacted a duty worker to say that Mr W had been hearing voices about a family friend having a relationship with his girlfriend. Mr W had taken a hammer to the home of the family friend and had smashed a window in the car and threatened the family friend. Mr Y reported that the police had been called but that they had not interviewed Mr W yet. Mr Y reported that Mr W had told him that he had had "to do it because of the voices". Ms C asked if Mr W was taking his medication but Mr Y was unsure. Ms C advised that she would arrange an appointment with a doctor for four days later.

4.152 The appointment on 22 June was with Dr J who provided a summary of the meeting to Mr W's GP, but this was not typed until 12 days later and not received by the GP surgery until six days after that; three weeks after the violent incident. Mr W (who was accompanied by his girlfriend and Mr Y) told Dr J that he had started feeling very protective of his girlfriend and that he sometimes did irresponsible things such as turning up at her house at 4:00 am. He also said that he had become suspicious of other people and that he heard voices "like listening to another person's conversation". Mr W said that he heard a particular voice that talked about sex and that this had prompted his visit to the home of the family friend. Mr W admitted smashing the car window and knocking on the front door and told Dr J that he knew it was ridiculous but that he had been "not able to contain his emotion that day because he had brandy". Mr W's girlfriend reported that when Mr W was taking his tablets (pregabalin) he was okay but that sometimes he took too

many which meant he had none left and that this was when he started to hear voices. Dr J noted that it was "obvious that compliance with medication is an issue" and that Mr Y had asked that Mr W be admitted to a psychiatric unit. Dr J had discussed this with the crisis team who felt that Mr W's presentation could be managed in the community by a care coordinator. Dr J then "discussed the issue with [Dr O] who advised to give olanzapine 5mg at night to get rid of the voices and to refer to the community mental health team for a care coordinator".

4.153 Mr Y made notes from the meeting and his record shows that Dr J's view was that if the police thought the matter was sufficiently serious they would have dealt with it at the weekend, and that crisis staff would not enter Mr W's property because of the risk to staff, given the incident with the hammer. We have not been able to triangulate the detail of this exchange with Trust records because there is no record of the information that Dr J gave to Mr W, his girlfriend or Mr Y.

4.154 Mr W contacted a duty worker on 25 June to express concern that he had been prescribed five days of medication (pregabalin and olanzapine) and that he was already on day three. It was agreed that the duty worker would contact him the following day. The duty worker did contact Mr W the following day and Mr W asked to see Dr J because she was the person that knew him and was dealing with his care. The duty worker offered him an appointment and said that she would organise another prescription for his medication. The duty worker then spoke with Dr J who advised that she was unable to offer Mr W an appointment that day; it was agreed that the duty worker would contact Mr W's GP to request that a prescription for seven days of olanzapine 5 mgs be prescribed as an interim measure. Mr W met with the duty worker later that day, his girlfriend and Mr Y accompanied him. Mr W reported that he was not hearing voices any more but that he had not been on his own for the previous week. Mr Y asked when the follow up appointment with Dr J would take place so the duty worker offered to arrange an appointment. Both Mr W and Mr Y were concerned about the dose of the pregabalin and wanted clarification about this, and Mr W wanted to know why he was being treated with anti-epileptic medication. The duty worker offered to send some further information about pregabalin. (Pregabalin is an antiepileptic medication but it can also be prescribed for generalised anxiety disorder.) The duty worker also advised that she would be in touch with Mr W's new care coordinator Mr F who would be in touch with Mr W when he returned from holiday.

July to December 2012

4.155 On 6 July Mr W had his first meeting with his new care coordinator Mr F. Mr F met Mr W at Mr Y's home, who was also present, along with Mr W's girlfriend. Mr W said that his main preoccupation was the negative voices that he heard, he believed that the family friend was talking directly to his mind in order to upset and distress him. It was because of this belief that Mr W had threatened to "sort him out" the previous day. Mr Y explained the incident that happened three weeks previously and expressed concern that Mr W would act similarly that day. Because of this concern Mr Y had decided to take the

family friend away for a brief holiday. Mr F noted that during this discussion Mr W became "highly agitated" because he strongly believed that the family friend was a "bad person". Mr Y stated that he believed Mr W needed to be detained under the Mental Health Act, but Mr W said he had no intention of having any contact with the family friend. Mr W's girlfriend said that she did not feel threatened by Mr W, but that she found it difficult to deal with his anxiety, mental distress and constant demands for contact. Both Mr W and his girlfriend said that he was compliant with his medication. In light of this information Mr F noted that he did not feel that Mr W needed to be assessed under the Mental Health Act, but that he needed enhanced support from mental health services. Mr F noted that he would refer Mr W to the autistic spectrum disorder service, consider a referral to psychology, and refer to a financial support service. A medical appointment was arranged for 13 July and a further appointment with Mr F arranged for 10 July. Mr F noted that he advised Mr W and his family that Mr W had "control over his actions, and that in the future if he became threatening or aggressive the police had to be contacted".

4.156 Mr F met with Mr W on 11 July at his home where his girlfriend was also present. Mr W said that he had been feeling better since the family friend had gone on holiday with Mr Y. Mr W "held the idea that because the family friend was abroad he would not be able to hear his derogative voice talking to him". Mr F discussed Mr W's finances and noted that Mr W was not receiving Disability Living Allowance so it would not be possible to use some of this income to pay for 1:1 support. Mr F agreed to speak to the psychologist to see whether the Trust could provide psychology therapy for "voice hearers". A further appointment with Mr F was arranged for 25 July.

4.157 Two days later Mr F received a text message from Mrs Y to say that Mr W had been to her work place the previous day, and had become anxious because she had not been there. Mrs Y reported that Mr W was hungry and had no money. Mrs Y had arranged to meet Mr W later the previous day and had given him £20 but Mr W would not listen to Mrs Y. Mrs Y expressed concern because she had not heard from him since and he had very quickly deteriorated into an agitated state. There is no indication that any action was taken following receipt of this text message. However, the same day Mr W attended a medical review meeting with Dr J, he was accompanied by his girlfriend. Mr W reported that he was doing well; sleeping better, improved mood and normal appetite. Mr W said that he had had two episodes of hallucinations that were relieved by his girlfriend's reassurance. Dr J noted "no remarkable findings", when examining Mr W's mental state and indicated that she would review him with his care coordinator six months later. Mr W's diagnosis was noted as "Asperger's Disorder" and his medication was continued as pregabalin 150mg, five tablets per week and olanzapine 5mg at night. It is unclear from the records whether Mr F was present at this review meeting or whether the text message from Mrs Y was received before or after the meeting. Regardless, the letter to Mr W's GP summarising the appointment was not sent until 30 July.

4.158 On 17 August Mr F attempted to meet with Mr W as arranged, however Mr W was not at home and Mr F could not get hold of him. Mr F spoke with Mr W's girlfriend who reported that she and Mr W had recently fallen out and that Mr W could be upset by this, she was also concerned that he could have stopped taking his medication. Mr F then called Mr Y who said that Mr W knew about the meeting with him and that he was surprised Mr W had missed it. Mr Y reported that Mr W had been doing well and that he was not concerned about Mr W's welfare. Mr F sent a message to Mr W asking him to make contact.

4.159 Five days later Mr F received a text message from Mrs Y who reported that she was unsure whether Mr W was taking his medication. Mrs Y said that she had seen Mr W at the weekend and he had been very anxious and rude. He had been trying to contact his girlfriend and had not listened to Mrs Y. Mrs Y advised that the previous day Mr W had appeared dazed and very unsettled and during the previous week he had been very agitated.

4.160 The following day (23 August) Mr F met Mr W at home. Mr W appeared tired and slightly sedated and said that he had taken his olanzapine medication that morning because he had forgotten to take it the previous night. Mr W said that this was unusual as he was good at remembering to take his medication before going to bed. Mr F attempted to explore the content and frequency of the auditory hallucinations but Mr W said he did not want to discuss it, although he did say that he regularly heard derogatory voices, particularly when he was on his own. Mr F noted he would discuss the possibility of psychological therapy, although this might not be suitable because of Mr W's reluctance to talk about the voices. Mr F again noted he would refer Mr W to the autistic spectrum conditions service.

4.161 In September Mr F met with Mr W twice. On the first occasion they discussed Mr W's finances and Mr F helped Mr W to apply for Disability Living Allowance. Mr W reported that he was compliant with his medication and that his girlfriend was helping him to ensure that he did not take more pregabalin than he should. On the second occasion Mr F suggested that Mr W request a blister pack to help him to manage the medication himself, rather than relying on his girlfriend. Mr W reported that as his landlord did not know he was in receipt of benefits, he did not want his housing benefit to be paid directly to his landlord. Mr W said that he found his medication helpful in managing the auditory hallucinations, along with regular exercise and a good diet.

4.162 Mr F next saw Mr W on 5 October when he was at home with his father, Mr Y. Mr W stated that the previous week he had confronted someone on the street whom he felt was being abusive towards him. The individual had been talking on the phone and Mr W "misinterpreted the conversation". Mr W had moved to grab the individual but they had run off. Mr W admitted that this was not the first incident he had had with a member of the public and Mr F noted that Mr W "clearly lacked insight into the link between his mental health problems and these incidents". Mr F also noted that Mr Y had become emotional at his son's disclosure but "very positively he did not request a hospital detention". Mr F advised that he had already referred Mr W for psychological therapy, which Mr Y supported. Mr F explained that it was his view that Mr W's

confrontation was directly related to his mental health problems and that if the behaviour continued he could be arrested, resulting in either a criminal record or formal detention in a psychiatric unit. It appears that Mr F took no other action to manage Mr W's risks. Mr Y has

4.163 Five days later Mr F met with the team psychologist, Ms S2 who advised that Mr F should ask Mr W to write down the thoughts he had prior to becoming aggressive, as well as recording the content and frequency of the auditory hallucinations.

4.164 Mr F met with Mr W again on 19 October. Mr W was accompanied by his girlfriend and a support worker from the housing association. Mr W reported that he had been awarded the highest level of Disability Living Allowance and the support worker explained that this meant that Mr W was entitled to full housing benefit. Mr F discussed strategies that Mr W could use to control his anger and noted that Mr W would start recording his feelings and the most distressing of the auditory hallucinations.

4.165 Ms S2 emailed Mr F on 25 October and advised that she had discussed Mr W's case with Mr A from the early intervention team. Mr A had reported that Mr W had been hard to engage but the issues with aggression had been the same.

4.166 On 1 November Mr W attended a medical appointment with Dr O and Mr F. Mr W, who was accompanied by his girlfriend and Mr Y, reported that he had been taking the olanzapine regularly and the pregabalin when he needed it. Mr W said that the voices occurred "regularly and in many contexts" and that the content was quite distressing. Dr O suggested that the dose of olanzapine be increased to 10mg every night. A summary of the appointment was sent to Mr W's GP in a letter dated 15 November that was not received until 13 December. The letter informed the GP that Mr W's diagnoses were Asperger's Syndrome and Psychosis (not otherwise specified).

4.167 The following day Mr F accompanied Mr W to the Citizen's Advice Bureau to ask for support in appealing a decision to terminate his Employment Support Allowance. However no appointment was available until after the time limit for an appeal had expired. Mr F therefore wrote to Mr W's housing support worker to ask whether he would be able to provide the necessary support.

4.168 Ten days later Mr F also emailed the housing benefit office to enquire about the impact of the decision regarding Employment Support Allowance on Mr W's housing benefit.

4.169 On 26 November Mr F met Mr W at his home; Mr W had bought a pet rabbit. Mr W reported that he was managing the voices better and that he was compliant with his medication. He also said that he had not experienced any violent or distressing thoughts. Mr F contacted the relevant benefits agencies because Mr W had not received a response. Mr F was informed that the appeal regarding the Employment Support Allowance had been received and that although it could be up to a year for the appeal to be heard, in the meantime the benefit would continue to be paid.

January to June 2013

4.170 On 3 January Mr F saw Mr W at home along with his girlfriend and Mrs Y. Mr W had removed the storage heaters from the wall and thrown them away because his new rabbit had chewed through the wires. In removing one of the heaters he had caused significant damage to the carpet and consequently his landlord had refused to renew the tenancy agreement. Mr W had to leave on 31 March. Mr F provided details of MyKey, a new housing support service. Following the meeting Mr F also contacted MyKey to inform them of Mr W's situation and then spoke with Mr Y who said that he would be able to help Mr W to arrange an assessment with MyKey.

4.171 Mr W did not attend his appointment with Dr J on 25 January.

4.172 Mr F next saw Mr W on 31 January. Mr W had been allocated a worker from MyKey and was hopeful that she would be able to support him to secure alternative accommodation. Following the meeting Mr F noted that he had updated Mr W's care plan. There is no record of any discussion about why Mr W didn't attend the appointment with Dr J the previous week.

4.173 On 22 February Mr F saw Mr W at home. Mr W reported that he was being supported by MyKey to secure alternative accommodation, but he had to wait until the managing agency had issued a possession notice and he had been taken to court. Mr F advised Mr W to continue paying his rent and to get some legal advice from Shelter.

4.174 Mr W was not at home for his appointment with Mr F on 21 March.

4.175 On 11 April Mr F visited Mr W at home. Mr W had moved the majority of his belongings to his mother's home and was waiting confirmation of the eviction date when he will have to present himself as homeless at the council offices. Mr W said he was compliant with his medication and that he was not experiencing any psychotic symptoms, despite the degree of stress he was under.

4.176 A week later Mr F saw Mr W again at home. Mr F noted that Mr W remained stable and that he was receiving weekly housing support from MyKey. Mr W reported that he was paying his rent but was very guarded about discussing his finances which led Mr F to believe that he had not been making payments in accordance with the debt management plans agreed with water and electricity suppliers.

4.177 Mr F next saw Mr W on 13 May at Mr Y's home. Mr W had been evicted at the beginning of May and Mr Y had offered for Mr W to stay with him until he had successfully bid for a council tenancy. Mr F noted that Mr W's psychotic symptoms were being well managed with medication and although there was no evidence of auditory hallucinations, Mr W had previously been reluctant to discuss his symptoms. Mr W reported that he had gained weight since the dose of olanzapine had increased and wanted to change his medication. Mr F therefore arranged an appointment with Dr O on 27 June.

4.178 Mr W attended the appointment with Dr O and Mr F as planned and stated that he had put on weight and felt sedated since the increase in his medication. Mr W asked that the medication be reduced to 5mg. Dr O suggested that Mr W try another antipsychotic medication such as aripiprazole, but Mr W said he wanted more information about the drug before making a decision. Dr O agreed to send this to Mr W. Mr F discussed the lack of psychological therapies for people with Asperger's and it was agreed that Mr F would refer Mr W to the mindfulness group that was due to start. Dr O dictated a letter to Mr W's GP on the same day, but the letter was not typed until 19 July.

July to December 2013

4.179 On 25 July Mr F saw Mr W at Mr Y's home, Mr Y was also present. Mr Y explained that Mr W had been distressed that morning and had asked his father if he had called him a paedophile. Mr Y said that he had remained calm and had told Mr W that he would never say something like that. Mr F noted that Mr W quickly became aware that his father would never use language like that against him and tried to minimise the incident. Mr F indicated that he felt that Mr W was hearing voices again and strongly suggested that he increase the olanzapine. Mr W said he was finding it difficult to cope with the side effects of olanzapine so Mr F offered to arrange another appointment with Dr O to explore alternatives. Mr W said he did not want to increase the olanzapine at that time but said he would consider increasing it if he heard distressing voices frequently.

4.180 On 5 August Mr F spoke with Mr W on the phone. Mr W said that he would be unable to meet with Mr F that week as he was going on holiday with his girlfriend. Mr W explained that the previous week, whilst on the bus, he thought that somebody outside was calling him names, so he left the bus and assaulted the person. The police had not been involved, but Mr W was concerned he could be arrested. Mr F noted that Mr W was aware that this incident was related to the reduction of olanzapine and agreed to increase the dose to 10mg as previously advised by Dr O. Mr F agreed to arrange an appointment with Dr O and said he would meet Mr W after his holiday. However despite a letter from Mr Y to Dr O in September asking for an urgent appointment with Dr O (see paragraph 4.183), Mr W did not see Dr O until 14 November more than three months later.

4.181 On 29 August Mr W was not at home for his appointment with Mr F.

4.182 Mr F next saw Mr W on 12 September at his father's home. Mr Y remained concerned about the lack of psychological therapy input provided to Mr W. Mr F noted that it was his view that rather than psychological therapies, Mr W needed to start to engage with his housing support worker as his major difficulty was managing his finances. It was agreed that Mr Y would attend the next medical review meeting. Mr F also noted that Mr W was back on 10mg olanzapine which appeared to be the right dose for him to manage his symptoms.

4.183 On 23 September Mr Y wrote to Dr O to express his concerns about Mr W. Mr Y said that he had urged Mr W to meet with Dr O to discuss his desire to reduce the dose of olanzapine, and that Dr O had agreed to the reduction in dose. This concerned Mr Y because in his view the reduction was not properly monitored and the result was that the voices returned and Mr W had been involved in a street fight. Mr Y expressed further concern that Mr W "could end up seriously injuring someone or worse" unless he received proper medication and treatment. Mr Y reported that Mr W was now taking 10mg olanzapine but that he was not receiving any help with his behavioural problems. Mr Y pointed out that Mr W's most recent care plan included psychological therapy that Mr W had never received. Mr Y asked that he and Mrs Y had the opportunity to meet with Dr O in advance of his appointment with Mr W on 14 November so that they could share first-hand accounts of their daily experiences of Mr W. There is no indication that Dr O ever responded to this letter, however Dr O did meet with Mr W's parents on 14 November.

4.184 Mr F did not see Mr W again until 5 November when he met him at home, along with Mr Y. It is not clear why there was such a long period of time when Mr W was not seen. Mr Y explained that there had been another incident of Mr W confronting a member of the public in an aggressive manner (the same incident that Mr Y referred to in his letter to Dr O). Mr W also admitted that he had recently followed someone he had seen at the gym and had also confronted them, but had not assaulted them. Mr F again told Mr W that it was likely he would soon be detained by the police. Mr F noted that he did not believe that Mr W was fully compliant with his medication. When Mr F assessed Mr W he did not appear to be responding to voices, his thoughts did not appear disordered and he was able to remember and provide an explanation for the incidents. Mr F noted that he considered that Mr W had a level of control over his behaviours, but that he did not consider that Mr W was detainable under the Mental Health Act and that his anti-social behaviour should be dealt with through the courts. Mr F recorded that if the level of aggression continued to escalate in the context of poor compliance with the treatment programme, the team might need to breach his confidentiality and report the incidents to the police to protect public safety. It is not clear whether the team considered moving Mr W into the amber or red zone at this point. A review meeting with Dr O had been arranged for 14 November; it is also unclear why this was not arranged earlier.

4.185 Prior to the appointment on 14 November with Mr W, Dr O met with Mr W's parents. They expressed their concerns about Mr W's mental state, compliance with his medication and lack of psychological therapies. From the information that Mr Y provided to us we can see that he had sent an agenda to Dr O and specifically requested to see the Asperger's assessment. However there is no reference to this in Dr O's entry or follow up letter. Dr O then met with Mr W who reported that he had not taken any medication for the previous nine months. Mr W said that he believed medication changed his character and made him put on weight, making him less attractive to his girlfriend. Dr O noted that Mr W had been involved in another recent assault and that he had been hearing voices. Dr O discussed an alternative

antipsychotic medication and Mr W agreed to take aripiprazole, although Mr F had noted that he felt it was unlikely that Mr W would comply with the treatment. Dr O provided a summary of the appointment to Mr W's GP within two weeks of the appointment. In the letter Dr O advised that Mr W had asked for psychological therapy and that Mr F had been tasked with organising this, with the focus being on the symptoms of psychosis rather than Asperger's.

4.186 On 18 November staff from MyKey raised a safeguarding alert citing financial and emotional/psychological concerns in relation to Mr W's girlfriend. Mr W had reported to his support worker from MyKey that he had a girlfriend who claimed carer's allowance for him and that he had been giving his girlfriend £50 per week from his benefits. Mr W reported that he did not eat or stay at his girlfriend's house and that he usually saw her once a week. Mr W's support worker had previously advised Mr W that he could claim severe disability premium but he said he would rather his girlfriend claimed the carer's allowance. Mr W told his support worker that he did not feel that he was being taken advantage of and said that the £50 per week was for his uses of water, food and laundry at her home, and the purchase of clothes for him. Mr W also spoke of paying for his girlfriend (the same girlfriend as referred to previously) and him to visit Slovakia to see her mother. Mr W's support worker discussed counselling; Mr W said he would like to see someone twice a week, he had been looking at cognitive behavioural therapy the previous evening and had found somewhere that charged £40. The support worker later contacted Mr F to find out what action was being taken. Mr F asked that further concerns were passed directly to him so that he could maintain a record of any increasing concerns.

4.187 On 25 November Mr W's support worker from MyKey, Ms W, informed Mr F that Mr W had chosen his accommodation, and that it did not come with any additional support, therefore once Mr W was settled his case would be closed. Ms W advised that she had met with Mr W and his girlfriend to discuss what support she was providing to Mr W. Ms W said that it appeared that Mr W was receiving advice with budgeting but not being encouraged to save for the things he needs for his new home. Ms W was concerned that saving for items for his new home had been on Mr W's action list since February but no progress had been made. Ms W pointed out that Mr W's girlfriend received carer's allowance which meant that she should be providing 35 hours of support per week to help Mr W budget and eat well. Ms W said that under his girlfriend's guidance, Mr W should not get into difficulties that he did with his previous accommodation i.e. breaching his tenancy by keeping a pet and causing damage. It seemed that Mr W planned to make some structural changes to his new accommodation before moving in and Ms W had advised him to speak to his landlord before starting any such work.

4.188 The following day Mr W did not attend the scheduled appointment with Mr F.

January to June 2014

4.189 On 5 January Mr W went to Mr Y's house and appeared "delusional" believing that Mr Y's guests had used foul language in describing him (Mr W).

4.190 On 9 January Dr O sent a letter to a psychologist in the community mental health team that he had dictated on 26 November 2013. Dr O advised that he had been seeing Mr W in the neurodevelopmental clinic for over a year and that Mr W had a diagnosis of Asperger's Syndrome with psychosis. Dr O further advised that Mr W's mental health was stable but his compliance with medication was irregular. Dr O said that he felt that Mr W would benefit from psychological therapy and that he was in a situation where he would be able to engage with such therapies.

4.191 The same day Mr F received an email from the team manager at MyKey who asked for some advice in dealing with Mr W. Mr W was not engaging with his support worker, Ms W, and she had therefore contacted Mr Y who had concerns about Mr W's mental state and medication compliance. The team manager asked if Mr F could facilitate a meeting between Mr W and Ms W as MyKey were concerned that Mr W was at risk of losing his new accommodation. Mr F responded to advise that he was next due to see Mr W on 15 January and that he would arrange a three way meeting for the following week.

4.192 Mr F actually saw Mr W on 16 January as Mr W did not want to meet Mr F at Mr Y's house or in his new home. Mr W reported that he had started voluntary work in a stable and this was helping him to feel well and manage his anxiety. Mr W had not been taking his medication and said he had not had any auditory hallucinations, nor did he require housing support. Mr W said that his housing benefit was paid directly to his landlord and that he was on top of his utility bills.

4.193 On 28 January Mr F received a call from Mr W's girlfriend, Ms A, who said she was concerned about Mr W's deteriorating presentation. Mr W had accused her of entering his home without his consent and requested she returned her key to him. Ms A had told Mr W that she was unsure whether she wanted to continue their relationship and told Mr F that she was not concerned about her safety. It was reported that Mr W had been sexually demanding, controlling and jealous, regularly insinuating she had been unfaithful. Despite this, Ms A said that Mr W had never forced her to have sex against her will or been physically aggressive towards her. Ms A said she was no longer claiming carer's allowance because Mr W regularly stated he was financially worse off because he could not claim Severe Disability Premium. Ms A also said she thought he wanted the extra money to pay for a sex worker. Ms A reported that Mr W had gradually reduced contact with his family and disengaged with MyKey since moving into his new property in January. Mr F noted that he had spoken to Dr O and that he would arrange a review in the following few days.

4.194 Following this conversation Mr F emailed the team manager at MyKey to say that he did not think that Mr W would respond to their attempts at contact because he had seen Mr W a fortnight previously when Mr W had reported that he was managing everything okay. MyKey subsequently closed Mr W's case.

4.195 On 30 January Mr F contacted Mr W's landlord, Worthing Homes, who reported that the rent was paid directly to them and that they had no concerns at that time about Mr W's tenancy.

4.196 Mr W attended an urgent review with Dr O and Mr F on 6 February. Mr W reported that he had not taken the aripiprazole because of the side effects that he had read about (weight gain and depression). Dr O showed Mr W the website that had evidence to show that weight gain had not been a significant issue with aripiprazole and at that point Mr W admitted that he was reluctant to take medication because he would not feel in control of his own emotions. Mr W said that he had not been hearing voices for some time but that there had been two incidents of altercations with people over the previous three months. Mr W said he felt he could control his aggression by being aware of the risks, not interacting with others and controlling his diet. Mr W refused to take medication and both Dr O and Mr F felt he had mental capacity to make this decision, however they told Mr W that they disagreed with his decision. We cannot see any evidence of a formal mental capacity assessment being undertaken or recorded at this time. Dr O noted that a referral for psychological therapy had been made and that Mr W's diagnoses were Asperger's Syndrome and Psychosis (not otherwise specified).

4.197 On 11 February a psychologist in the community mental health team, Ms L emailed Mr F and Dr O to advise that she had been allocated to work with Mr W.

4.198 On 17 March the duty community mental health team worker received a call from Mr Y who expressed concern for Mr W's welfare and that of the public because of Mr W's behaviour over the weekend. The duty worker said she would pass the message on to Mr F. Within an hour of this call being logged, Mrs Y called Mr F to say she had noticed a deterioration in Mr W's mental state the previous week, but had not been able to speak to Mr F because he had been on leave. The previous Friday Mr W had gone to Ms A's work place (a bar/restaurant) where Mr W had "misinterpreted" a communication that Ms A had with a customer and Mr W subsequently assaulted them. The individual was with a group of friends who then hit Mr W who sustained an ankle injury. Mr F noted that Mrs Y was informed of the next appointment two days later. Records from Mr Y show that he emailed Dr O reminding him that he had written to him (Dr O) the previous September outlining concerns regarding Mr W. Mr Y stated that it appeared that Dr O was still not treating Mr W properly as he was continuing to carry out unprovoked attacks on members of the public, the most recent event being the previous Friday when the police had been called. (We do not have the police perspective on this incident). Mr Y expressed his worry that a fatal incident would happen unless Mr W got the appropriate help. Mr Y asked that Dr O urgently review the situation, and that he (Dr O) was "probably aware that Mr W was not taking his medication". There is no evidence of this email in the clinical records and no indication that Dr O responded to Mr Y. We obtained this email from the evidence provided to us by Mr Y.

4.199 On 19 March Mr F noted a conversation that he had with Dr O. Dr O was of the view that due to the apparent escalation of Mr W's altercations with

members of the public, the team need to arrange a level two risk assessment[22] involving the police. Mr F noted that the team believed that the assaults were in direct connection with his jealousy, inflexibility and misinterpretation of social interaction, rather than fluctuating psychotic symptoms. Mr F noted "our view is that his antisocial behaviour is a criminal matter, rather than something that could be treated with medication or by arranging a hospital admission under the MHA". We have not seen evidence of a team discussion that came to this view. Mr F then contacted Mr Y to inform him of this decision and recorded that Mr Y agreed with the course of action. The same day Mr W did not attend his appointment with Mr F who noted that he would try to reschedule the meeting through the family because of the difficulty contacting Mr W by telephone.

4.200 The following day the community mental health team manager contacted the local police sergeant who asked that the relevant details about Mr W were shared in order that the police could identify the most appropriate person to attend a professionals meeting.

4.201 On 24 March Ms L, the psychologist, emailed Mr F and Dr O as she had noted the recent entries on Mr W's clinical record and felt it would be helpful to have a briefing meeting with them. There is no indication in the records that Mr F or Dr O responded to Ms L's request, however Ms L did attend a multi-agency professionals meeting the following month and met separately with Mr F and Dr O afterwards.

4.202 On the same day Mr F attempted to speak to Mr W to reschedule the appointment and to let him know that the police needed to be informed of the incident the previous week. Mr W's phone was switched off and he was unable to leave a message. Therefore Mr F wrote to Mr W. Shortly afterwards Mr F emailed the police with a summary of Mr W's diagnoses, presentation, medication and engagement history. Mr F indicated that the community mental health team did not think that "medication could play a substantial part as the assaults are not always related to psychotic symptoms, but problems with social interaction" and that Mr W was not detainable or treatable under the Mental Health Act at that time. There is no record of Dr O recording his opinion of the appropriateness of the Mental Health Act at this time.

4.203 On 3 April Mr F met with Mr W in a coffee shop and went for a walk in the park. Mr W stated he would prefer the appointments to take place in the community, near to where he lived because he felt safer in areas with which he was familiar. Mr W was advised that Mr F was in the process of arranging a meeting with Sussex Police and would report any incidents that Mr W was involved in. Mr W said he did not want the information about incidents during the previous year disclosed, however Mr F reminded him that Dr O had informed him that the police would need to be informed if his aggressive behaviour continued.

[22] *A level two risk assessment is undertaken when service users with identified high-risk behaviours require further assessment to ensure effective management. A multi-disciplinary/multi-agency review of their risks will lead to a multi-disciplinary/multi-agency risk management plan.*

4.204 A multi-agency professionals meeting was held on 28 April when Dr O, Mr F and Ms L met with the police. Trust staff provided an overview of Mr W's presentation and advised that he was not compliant with the recommended treatment programme, however Dr O noted that it was his view that the violent incidents were related to Mr W's diagnosis of Asperger's rather than psychotic symptoms that would respond to medication. The police advised that Mr W did not have a criminal record and the only incident they had on record was involving a family friend being threatened two years previously. However, Mr W had started to call the police to complain that there was a men's group next to his home, where they were calling him a paedophile. The police stated that there were no concerns for that particular property at present however it had historically been problematic and advised it was not the most suitable accommodation for Mr W. The agreed plan was for Trust staff and Mr W's family to report any violent incidents to the police, the police agreed to place a tag on Mr W's property so that other officers could be aware of his history, and the PCSO would remain the main point of contact for the police.

4.205 On 1 May Mr F met with Mr W in a coffee shop. Mr F told Mr W about the outcome of the professionals meeting and that the community mental health team would be working with the police now. Mr F explained that "this type of behaviour would cause that he is eventually arrested and given a custodial sentence or a hospital order". Mr W said that he was trying to stay healthy and in control of his finances. Mr W said that he didn't have any credit cards or other debts.

4.206 Five days later Ms L wrote to Mr W inviting him to attend an appointment with her on 19 May. Mr W responded two days later via email to a generic Trust address to ask that their meeting is held in a coffee shop rather than at Ms L's base, however Ms L did not receive the email until the day of their scheduled appointment because she had been out of the office. Mr W did not attend for the appointment. Ms L discussed the situation with Mr F who suggested that he speak to Mr W about the fact that psychology appointments needed to take place on Trust premises.

4.207 On 20 May Mr F received an email from Ms A. About two months previously Mr W had confessed to Ms A that he had been visiting brothels since the start of their relationship. Mr W appeared to believe that because he had confessed, everything between them would then be okay. Ms A told Mr F that Mr W was still accusing her of cheating on him, saying "King Henry VIII beheaded his wives because they cheated on him". Mr W had also been saying that he felt possessed and overtaken by another person. Ms A was concerned about the risks that Mr W posed saying "what's to say he won't kill someone if he goes into one of these out of control body experiences". Ms A reported that Mr W had appeared proud of himself when he spoke about almost killing people he had assaulted. Ms A told Mr F that Mr W was lying a great deal and that she had lost her job as a result of Mr W's actions at her workplace. Ms A said that she had got another job but that Mr W did not know where she worked. Ms A told Mr F that in her view Mr W should not live alone, that it was a "disaster, he hears voices all the time which is driving him over the edge". Mr F responded to Ms A the same day and reassured her

that she was not responsible for Mr W's complex mental health difficulties. Mr F said that neither he nor MyKey were aware that Mr W had been spending his money on sex workers and that he was concerned about Ms A's safety and health, because nobody knew whether Mr W had used appropriate protection when having sex with sex workers, and because Mr W's reaction to Ms A ending their relationship could not be predicted. Mr F told Ms A that the assault incident she mentioned needed to be reported to the police in accordance with the decision taken at the multi-agency professionals meeting. Mr F also urged Ms A to report the threats Mr W had made to her, to the police.

4.208 Ms A responded the following day to say that she did not know the details of the incident because Mr Y had told her about it, and she had then spoken to Mr W about it. However Mr W had said that during the incident he had held a man down by his throat and that he wanted to grab a rock close by and kill him, but he couldn't reach the rock. Ms A told Mr F that the incident happened before Mr W had attacked somebody at a pub and that she had been at the same pub some time afterwards when one of the men who had witnessed Mr W's assault had commented "…if a guy like that had a knife, he'd kill someone, he's dangerous…". Ms A reiterated that Mr W had never actually threatened her, but was convinced that she had cheated on him when he was delusional. Mr W had told her that he needed to have sex at least four times a week and that if Ms A would not give it to him then he had to find it elsewhere. Mr W had also told Ms A that he had spoken to Mr F about it and that Mr F had agreed it was normal for a man to have those kind of needs. Ms A asked that Mr F did not let Mr W know what she had told him.

4.209 On 23 May Mr F emailed a summary of Ms A's emails to the police and expressed his concern for Ms A and her 17 year old daughter (the daughter that lived with Ms A), explaining that Ms A was reluctant to report anything because she did not know how Mr W would react.

4.210 On 25 May Ms A emailed Mr F again to give an update on the previous few days. Mr W had 'turned nasty" again and had turned up at her home unannounced, accused her of being a prostitute and said that he wanted her to die. Ms A said that Mr W had never spoken to her in this way before but he had been getting progressively worse. Ms A said that she had decided to end the relationship. Mr F advised Ms A to report the matter to the police so that the appropriate action could be taken. Mr F also gave Ms A details of an organisation providing confidential support and advice for women suffering from domestic abuse.

4.211 On 30 May Mr F met Mr W in a coffee shop because Mr W refused to meet in any NHS premises or at his home. Mr W reported that he was having problems with his neighbours calling him names and said he wanted to write to Worthing Homes to complain about the abuse. Mr F suggested that they meet at Mr W's home so that he could see if he could hear the abuse. Mr W reported that he had assaulted two members of the public in Brighton because he was under the impression they were being offensive towards him. Mr F said he would inform Sussex Police and advised Mr W to call the police in the future to avoid violent confrontations. Mr W stated he would like to

rearrange the appointment he missed with the psychologist and now felt secure in the town centre.

4.212 On 2 June Mr F emailed the police contact (the police community support officer) to inform her that Mr W had assaulted two members of the public on 26 May. Mr W had said that they were swearing at him and was "surprised by how scared they looked" when he confronted them. Mr F asked if any reports had been made to the police.

4.213 The following day Mr F received an email from the police community support officer to say that a colleague had visited Mr W at home and that he had been very upset and agitated. Members of the working men's club were outside his property smoking and laughing when the police arrived and Mr W believed their behaviour was targeted at him. The police officer had offered to take Mr W to a family member so that he could get away from the situation but Mr W said that his parents treated him "like the black sheep of the family" and that he had nobody to turn to. The police officer felt that because of Mr W's mental health problems it would be helpful to have a meeting with the mental health team to see whether Mr W could be re-housed.

4.214 On 9 June Ms L sent a discharge letter to Mr W because he no longer wished to pursue psychological therapies at that point. This, despite the fact that just ten days earlier Mr W had said that he did want to pursue psychological therapy.

4.215 Mr F emailed PCSO Ms D on 11 June to ask her to call Ms A, because she was concerned about her discussions with authorities not remaining confidential.

4.216 On 23 June PSCO Ms D emailed Mr F to ask whether it would be possible for Mr W to be rehoused because he was continuing to call the police with complaints about behaviour at the working men's club. Mr F responded by saying that Mr F had just moved in and it would take some time to secure an alternative flat for him. Mr F also advised that he would be leaving his job and that Mr W's new care coordinator would be Mr J.

4.217 Two days later Mr F and Mr J met with Mr W at a local park due to Mr W's reluctance to meet at NHS facilities. Mr J introduced himself and an informal conversation took place, without addressing any difficult topics. Mr W appeared anxious which Mr F thought was due to working with a new person. Mr F received a call from Mr W following the appointment stating he would rather work with a female coordinator because he had a bad feeling working with another male. Mr F suggested that Mr W gave Mr J some time to get used to him because he had requested a male worker of a similar age. Mr F spoke to a team leader about Mr W's request, who agreed that a reallocation was not justified.

July to December 2014

4.218 On 3 July Mr R, a service manager, attended a MARAC meeting regarding Mr W and Ms A. Mr R noted that he would upload and share the action plan

when it was received. Mr Y later asked for a copy of the minutes and action plan from this meeting and was unhappy that these were not received until June 2016. The reason for this delay is explored in section 5.

4.219 On 9 and 11 July Mr J attempted to contact Mr W to arrange an appointment. He was not able to speak to Mr W so sent a text message asking him to make contact.

4.220 On 13 July Mr W attended A&E complaining of paranoid delusions, accompanied by Mr Y. Mr W had been experiencing delusional thoughts about a man's presence in his girlfriend's body and car. This caused him to feel that his girlfriend had been unfaithful and therefore wanted to confront this man, who lived opposite his mother. Mr W was concerned that the situation would escalate if he were to do so had contacted his father for support, who had taken him to A&E. Mr W was assessed by Mr S, a senior nurse practitioner who described Mr W's mood as "stable with no suicidal thoughts or intent". Mr W expressed paranoid thoughts about his partner and another man, who was unlikely to have known his girlfriend. Mr Y said that he had concerns that Mr W had no money for food. Mr S indicated his impression was that Mr W was suffering a relapse of his psychotic illness and that the risks to himself and others was low at that time because he had sought help, however Mr S also noted that Mr W's risk of aggression towards others was likely to increase with further deterioration of his mental state. Mr W agreed to take olanzapine 10mg.

4.221 The following day Mr J attempted to call Mr W but was unable to get a response so sent a text message. Mr W responded and Mr J arranged to visit him at home later that day.

4.222 On 15 July Mr J visited Mr W at his home and suggested they met in his garden. Mr W stated the weekend had been difficult because he had "hugged his girlfriend" and had had been in her car when he "felt the presence of another man" that he thought was involved with his girlfriend. Mr W had became upset and Mr W's girlfriend attended his flat the previous day, he had asked her to leave because he felt they were spending too much time together. Mr J probed Mr W further about the other man he felt had been involved and Mr W stated that somehow he knew it was the man across the road from his mother's address, however his explanation was confused. Mr W stated the relationship with his girlfriend was going well and both had apologised to each other. Mr J reflected on Mr W's actions and suggested that he had done well to avoid confrontation and that it was positive that Mr W had gone to his father for help. Mr W stated he avoided speaking to his mother on this occasion due to the man living opposite to her and avoiding conflict. Mr J noted that Mr W appeared to understand the consequences of his anger when this was explored with him. Mr W stated he did not have plans to act upon anything against the man opposite his mother's address and appeared calm and engaged during the conversation. Mr J noted that Mr W did not appear as tired in comparison to the last time they met. Mr W explained he had slept until 3pm that day which was due to the medication, the main reason he did not like taking it as he led an active life. Mr J advised about medication that Mr W could take when he felt he was getting too angry

or upset. Mr W "appeared to consider this and agreed it as a possibility". Mr J informed Mr W that he had been told that Mr W was purchasing a car on finance, they discussed the implications and Mr W assured Mr J that he had worked out the budget. Mr W planned not to use buses or taxis and would be able to visit his family more frequently. Mr W agreed for Mr J to feedback the content of the meeting to his father, however stated that his father would want to "make an impression" and would talk about Mr W a lot. Mr J noted he would call Mr Y and would also discuss with the doctor whether 'as required' medication was a "possibility for anti-psychotics".

4.223 On 17 July Mr W sent a text to Mr J to request some 'as required' olanzapine to help him sleep after intense exercise. Mr J agreed to speak to a consultant and feedback to Mr W. Mr J then received a call from Mr W's father stating he wanted to meet to discuss his son because he was concerned that he had not seen him that week. Mr J provided some feedback about his meeting earlier that week and also the text message he had received from Mr W, and noted this seemed to reassure Mr Y. Mr Y stated he was about to go on holiday but would liaise with Mr J when he had returned. Mr J then emailed Dr O to update him on Mr W's recent presentation. Mr J described that Mr W had reported that he had been given some olanzapine whilst at A&E and this had helped him to sleep. This led Mr W to ask for olanzapine to be prescribed as an 'as required' medication, however Mr J was unsure how effective olanzapine was when prescribed in this way.

4.224 Mr J followed up his email to Dr O on 6 August and again on 21 August but did not receive a response. We have been unable to identify why Dr O did not respond.

4.225 On 16 September Mr J entered a record indicating that Dr O had agreed to an 'as required' prescription of olanzapine for Mr W and that he had left a message for Dr O to pass the prescription to him so that he could give it to Mr W. Mr J also left a message for Mr W to ask him to make contact so that they could discuss the prescription.

4.226 On 25 September Mr J visited Mr Y because he had been unable to get hold of Mr W. Mr Y provided some background information about Mr W that Mr J noted he would scan and upload to the electronic record. Mr Y explained that he continued to worry about Mr W and the on-going plan for him. Mr W had obtained a car on finance that Mr Y said he would not be able to afford. Mr Y explained that Mr W was not good with his finances and although he received a reasonable amount of money from benefits he frequently spent it all and had no money left for food. Mr Y commented that CBT had been mentioned previously but that this therapy had not materialised. Mr J noted that the following plan had been agreed:

- Mr J to chase Dr O regarding the prescription for 'as required' olanzapine;
- Mr J to discuss the possibility of a complex case formulation;
- Mr J to speak to Ms S to establish if there were any other Asperger's services that could be offered;

- Mr Y would arrange for Mr J to meet with Mr W at Mr Y's home to discuss support (including financial).

4.227 Mr J sent an email on 29 September asking for a complex case formulation to be arranged, suggesting that Dr O and Ms S, the Autistic Spectrum Conditions Specialist nurse) should also be present. Later that day Mr J received a call from Mr Y confirming arrangements for a meeting at his home on 7 October. Mr Y stated that Mr W had been to his mother's house earlier that day. Mrs Y was away and Mr W's brother was at the house. Mr W had apparently been fiddling with lots of things and generally making a lot of noise so Mr W's brother had asked him to leave. Mr W had held his brother against the wall and threatened to hit him. Eventually Mr W had left and his brother had got the house key back from him. Mr Y explained that he had spoken to Mr W on the phone. Mr W had gone for a long walk and Mr Y had suggested that Mr W go to Mr Y's house afterwards. Mr Y said that if Mr W was prepared to take some medication later he would go to A&E. Mr W did indeed go to A&E and was seen by Mr S. Mr S noted that although Dr O had agreed to prescribe olanzapine as an 'as required' medication, Mr W did not actually have the prescription. Mr S therefore provided four days' supply of 10mg olanzapine, with a further week's supply on prescription.

4.228 The meeting between Mr J, Mr W and Mr Y took place as planned on 7 October. Mr J advised that Dr O had agreed to prescribing olanzapine as 'as required' medication and that he (Mr J) would arrange for Mr W's GP to prescribe this for him. Mr J stated that he would need to speak to Dr O again because he was unsure whether the olanzapine prescription would impact on Mr W's ability to drive. Mr J discussed Mr W's frequency and type of driving and Mr W explained that he always drove slowly and not very far. Mr J asked whether Mr W ever found the voices distracting, but Mr W said not as he felt "contained and calm" inside the car. Mr W described an incident where a car was following him very closely and getting frustrated with him. Mr W explained that he had pulled over slightly because he was looking for a landmark; the car was able to get past him and he was able to calm down afterwards. Mr W also described a time when children outside of his flat were shouting his name; Mr J was unable to establish whether this was a real event or Mr W's hallucinations. Mr J asked Mr W whether he would have taken olanzapine if he had had the medication at the time. Mr W responded that he did not think if it, but he could have done. Mr W reported that when he did take olanzapine he found the effects positive and that he felt calmer, but drowsy for the next day or so. Mr Y explained later that after Mr W took olanzapine he was much calmer and more engaging for the following few days. Mr W described when he had completed an advanced driving test, however Mr Y later clarified that Mr W had driven round the Brands Hatch circuit when he was age 14. Mr J explained that he was organising a complex case discussion and how other services would be able to help Mr W manage his finances. Mr Y stated that since the incident with Mr W's brother, his brother had been scared of Mr W and did not know how to support him. Mr Y asked whether there was any information available to help with this.

4.229 Later that day Mr J noted that Mr W's prescription was on hold after he had contacted Mr W's GP surgery asking them not to act on the earlier letter until

Mr J had sought advice regarding driving. Mr J then emailed Dr O to advise that Mr W had been driving for a few months and that he (Mr J) had done some online research that indicated Mr W should not be driving whilst taking olanzapine, and that if someone had a diagnosis of psychosis then the DVLA should be informed. Mr J asked Dr O to advise on the issue of the prescription and whether any action needed to be taken regarding Mr W driving.

4.230 On 8 October Mr J spoke with Dr O regarding Mr W. Dr O advised that he was unable to attend the complex case formulation meeting but advised that the prescription for olanzapine could go ahead as long as staff were clear with Mr W about the risks for driving when taking it. Dr O also told Mr J that Mr W should be advised to inform the DVLA, but that if he did not the Trust would have a duty to do so because of his diagnosis and medication. Mr J then spoke with Mr Y to establish the most appropriate way of communicating this information to Mr W. It was agreed that letters would be sent to Mr W and Mr Y. The letters were sent the same day in which Mr J advised that Dr O had agreed to prescribe ten tablets of 10mg olanzapine each month so that Mr W could take one per day when he felt he needed to. Mr J stressed the importance of not driving when taking the medication and that Mr W needed to inform the DVLA of his diagnosis (Asperger's and psychotic disorder) and the medication being prescribed. Mr J advised that should Mr W not inform the DVLA then Dr O would do so. Mr J also stated that the letter was being copied to Mr Y so that everyone was kept informed.

4.231 On 23 October Mr J received a text from Mr Y stating that Mr W had informed the DVLA as required; Mr Y had seen Mr W completed the form and post it. Mr Y reported that Mr W had been taking the medication occasionally and seemed better for doing so, but Mr W's finances remained "not good".

4.232 On 11 November a multi-disciplinary formulation meeting took place; present were Mr J, Ms S and Dr L who was facilitating the discussion. The group discussed Mr W's history noting that he had no issues during schooling other than difficulties in social interaction. Mr W's relationships were discussed and it was again noted that Mr W experienced significant jealousy about his girlfriend however his girlfriend had been upset to learn that Mr W had been unfaithful and had regularly been spending money on prostitutes. Mr W had been emotionally and physically abusive towards his girlfriend and she had been offered support from WORTH[23] but so far had not taken this up. Mr W's diagnosis and consequential behaviours were also discussed and it was noted that Mr W experienced paranoia that resulted in him sometimes assuming that others were "out to criticise him". Staff felt that there was a sense that Mr W was "holding himself in and frustrated when in contact with services". Next steps were agreed as:

- Mr J to discuss Mr W's current presentation with Mr A to see how it compared to previous presentation;

[23] *WORTH Services is an Independent Domestic (IDVA) Service here to support people affected by domestic abuse in West Sussex.*

- Mr J to discuss expectations of his role with Mr W;
- A consistent approach to the timings of appointments (both in terms of day of the week and time of the day);
- Mr J to explore carer's support services for Mr Y and Mrs Y.
- Not to pursue psychological therapy because Mr W was "unlikely to engage in, be open and receptive to, or benefit from it" at that time
- Mr J to attempt to conduct a capacity assessment regarding Mr W's ability to manage his finances.

4.233 Three days later Mr J met with Mr W, Mrs Y and Mr Y at Mr Y's home. Mr J explained that he wanted to talk about the complex case formulation meeting and to find out how Mr W was managing at that time. Mr W said he felt things were going well and spoke about volunteering at the stables and running. He also said that he was managing his money and that he found the medication helpful. Mr J explained that he had discussed with his colleagues ways in which to better understand Mr W and asked some questions of Mr W. Mr W said he did not feel he had any difficulties in relation to his mental health and was unable to identify any past difficulties. Mr J then spoke to Mr W's parents in front of Mr W. Mr and Mrs Y explained their significant concerns about Mr W's ability to manage his finances, self care and his honesty about how he manages day to day. Mr W disputed these concerns and said that he felt he did eat well and Mr J noted that he did not appear malnourished. Mr W also mentioned that he had bought two foals and was paying about £20 per week for them. Mr and Mrs Y tried to push Mr W to talk more about his spending but he became "quite verbally aggressive" and stated that "they did not know what they were talking about". Mr W left shortly afterwards. Mr J then took the opportunity to talk to Mr and Mrs Y who expressed concern about people taking advantage of Mr W, the possibility of Mr W losing his tenancy because he had remodelled public areas and replaced his intercom without the permission of his landlord. They also reported that Mr W had no cooking utensils at his flat and no microwave in order to heat ready meals. Mrs Y reported that Mr W had started seeing his girlfriend again; she had gone to Mr W's home on his birthday and had been contacting Mrs Y to try and get in contact with Mr W. Mr J noted that he would discuss possible safeguarding concerns with his manager and follow up on what support could be put in place to minimise Mr W's financial risks. Mr J also noted he would find out when Mr W's last appointment with Dr O was because the DVLA had sent Mr W some questions following receipt of his letter. Mr J later advised Mr Y that the last appointment had been on 25 February and that another appointment needed to be arranged. Following discussion with his manager, Mr J established that more information was required in relation to safeguarding concerns, so that the team had a better understanding.

4.234 On 26 November Mr J discussed Mr W's case with Mr A. The conclusion was that Mr W appeared to have the same difficulties at that time as he had had a few years previously, particularly in relation to fixed beliefs, black and white views, lack of insight or ability to empathise, and difficulty engaging with services.

4.235 Two days later Mr J visited Mr W at his flat. Mr J noted that the flat appeared neat and tidy and there were food items in the kitchen. Mr W said that he had been okay over the previous few weeks and that he had been running and spending time in the stables. Mr W also said that he was okay financially, however he mentioned that the gas and electricity companies were taking £100 per month to pay off arrears. Mr J commented about the large amount and asked Mr W if he needed help to renegotiate the payments, but Mr W declined. Mr J asked how Mr W was managing with people outside of his flat; Mr W said it was quiet and that if he did become upset with other people he would go and talk to his father. Mr J asked more about Mr W's finances because he was trying to assess Mr W's capacity. Mr W explained that he received severe disability allowance and employment support allowance and that his rent and debts were paid automatically. He was also aware of how much he was spending on his car and other items and was clear that he didn't want help with budgeting.

4.236 On 1 December Mr W arrived at the community mental health team base unannounced and asked to meet with Ms L. Mr W explained to Ms L that he wanted a change in life, to be more motivated and that he felt bored. He had woken that morning and wanted a break from his routine of running and working at the stables so had gone into town. This was significant because Mr W usually avoided going into town because he "typically gets into arguments". Mr W said he had decided to go and see Ms L because he kept hearing her name and knew he had been due to meet her. Mr W told Ms L that he had written to his girlfriend to end their relationship; he had decided that the age gap was too big and that he did not love her. He said that he had left the letter for his grandparents to post and Ms L noted he appeared clear about his decision. Mr W spoke about being unpleasant to his girlfriend and it being a way of making her leave, but that he had decided to make it more directly clear that he wanted their relationship to end. Mr W talked about his work at the stables and expressed a desire to be more involved in caring for the horses and less involved with the public and lessons, because he found that more stressful. Mr W also talked about his financial difficulties and being aware that he could get some help, but being reluctant to lose all control over how he spent his money. Mr W said he was clear that if he thought psychological therapy could help he should discuss this with Mr J. Ms L noted that she would email Mr J to let him know about her meeting with Mr W and stress the importance of meeting that day in order to "demystify" herself and psychology.

4.237 On 12 December Mr J attempted to visit Mr W as planned, but could not get any answer from Mr W's door and his car was not visible.

4.238 On 17 December Mr J spoke with Mr Y and discussed Mr W's visit to Ms L and not being able to contact Mr W. Mr Y said that Mr W had not paid his phone bill so his phone wasn't working. Mr J agreed a provisional date of 5 January to meet with Mr W at Mr Y's home. Mr Y agreed to try and arrange this with Mr W.

4.239 On 22 December Mr W arrived at the community mental health team base unannounced and asked to speak to Mr J. Mr W said that he was just

passing and wanted to pop in because he wasn't sure when he was next due to see Mr J. Mr J arranged a time to meet the following week. Mr W said that he was getting tired of the stables and was looking at others where he could work with different horses. Mr W reported that he had made up with his brother a little and that he planned to spend Christmas at his mother's house.

4.240 On 31 December Mr J visited Mr W at home as planned. Mr W did not answer the door so Mr J tried to call but got no response. Mr J left a message, waited for 20 minutes then left.

January to June 2015

4.241 On 5 January Mr W arrived at Mr J's office unexpectedly. Mr J had earlier texted Mr Y to confirm arrangements to meet that afternoon but had not received a reply. Mr W explained that he thought the appointment was for 1:00 pm at the office. Mr J responded by saying that he was not aware of that arrangement and Mr W said that his mother would also be attending. However Mrs Y did not arrive. Mr W explained that he continued to run and work at the stables, which he still enjoyed. He had gone to his mother's at Christmas and that there had been some disappointment in relation to the weather. Mr W said that he had called the police a few days previously because he thought someone was being murdered in the flat below him. However, when the police arrived he explained that it was the person downstairs being noisy. Mr W said that he generally felt okay but talked of some difficulty associated with Goring at that time and described it as a "block in his thought process" rather than anything specifically to do with Goring. Mr W said he didn't think there were any concerns his parents wanted to discuss with Mr J and commented that he had joined the working men's club across the road. Mr W appeared to feel that going in there at times would help his relationship with them, because he would still get frustrated when customers were outside making a noise. Mr J discussed Mr W's financial situation and asked whether he would agree to complete a budget plan and let Mr J see it (for the continued capacity assessment). Mr W did agree to this and said it would give him a project for the evening. Mr J agreed to text Mr W with another appointment to review his budget plan and reminded him that he would be leaving at the end of January.

4.242 Later that day Mr J received a number of texts all at once from Mr Y who explained that Mr W had told him that he was meeting Mr J at the office and that Mr W had bought a horse and some goats. Mr W was refusing to talk about the animals with Mr Y.

4.243 On 6 January Mr J called Mr Y in response to the text messages received the previous day and explained what had happened regarding Mr W's appointment. Mr Y expressed concern that nothing appeared to be moving on with Mr W, that although he had seen a psychologist the previous year, nothing had happened regarding CBT. Mr J explained that he had met with Ms S and Ms L and that he had intended to provide some feedback at the appointment with Mr W and his family the previous day, however, Mr W appeared to have prevented this by telling Mr J that the plan had changed and they were to meet at the office rather than Mr Y's home. Mr J said that he

was continuing to assess Mr W's capacity regarding his finances and that attempts to maintain clear appointments with Mr W had been thwarted because Mr W had changed the arrangements or not been at home when agreed. Mr J advised that following discussion with colleagues, it was felt that Mr W would not engage with psychology and that Mr J would continue to speak to Mr W about this. Mr Y confirmed that he had previously received information about carers support services and that he had decided not to progress this in the past, however he did not know what Mrs Y's view was. Mr Y said he was very aware that Mr W did not like to discuss details of his life and felt that he did not tell lies, but would omit certain information (e.g. not telling Mr J about the purchase of the horse and goats or driving to Norfolk at 3:00am). Mr Y said that he felt that Mr W tried to manipulate situations to avoid being challenged and that he was worried about Mr W's chaotic life and poor decision making; Mr W had been caught speeding and would have to do a speed awareness course. (We have not seen any information to substantiate this statement.) Mr J agreed that he would meet with Mr W again two weeks later and that before meeting him, he would call Mr Y to get an update.

4.244 On 14 January the DVLA wrote to Dr O asking him to complete a medical questionnaire. It appears that Dr O completed and returned this form on 28 January when he indicated that Mr W was adequately engaged with treatment and experienced "auditory hallucinations regularly and has done so for three years. They have not had an impact on behaviours such as self care, instructions or aggression". It is of concern to us that these statements were made by Mr W's responsible clinician, because the clinical record to date clearly does not support Dr O's statement that the auditory hallucinations/delusions had not impacted on Mr W's self care, instructions or aggression.

4.245 As agreed on 20 January Mr J contacted Mr Y to get an update on Mr W. Mr Y explained that Mr W had purchased three goats and a foal and that initially Mr W had kept the goats at his flat but had since found somewhere else to keep them. Mr W had no money at that time and had been eating at Mr Y's home, he was also not using the medication that had been organised. Mr Y said that he felt Mr W would benefit from psychological therapy and that he didn't think Mr W would be able to cope with the animals. Mr Y also felt that not much was being done to support Mr W regarding treatment or finances. Mr J explained that Mr W had to want to engage with the team and advised that he was in the process of completing a capacity assessment. Mr J agreed to ask Mr W again that day about meeting with Ms L.

4.246 Mr J then met with Mr W and discussed his finances in order to complete the capacity assessment. Mr J noted that Mr W understood where his money came from, what his outgoings were (although also noting that Mr W was not always complete in his disclosures to Mr J) and reported no debt. Mr J indicated he felt that Mr W did not plan for contingencies as his back up was to rely on support from his parents. Mr J's conclusion was that he could find no evidence to suggest that Mr W lacked capacity to manage his finances. Whilst Mr W was making unwise choices, he had demonstrated an awareness

of the consequences of experiencing financial difficulties. Mr W confirmed he had split up with his girlfriend because he felt they could not give each other what they wanted. Mr J discussed the option of psychology again and how it might help him to understand his difficulties better. Mr W agreed to do so and so Mr J said he would contact Ms L. Mr W reported no concerns as regards psychosis and said he had been keeping himself busy with his animals. Mr W said he had no money concerns and that he had bought some fast food on the way to the meeting. Mr J noted that this was at odds with Mr Y's reports and noted that Mr W might be choosing to save his money and tell his father what he (Mr W) thinks he (Mr Y) wants to hear.

4.247 Following the appointment Mr J emailed Ms L to let her know that Mr W had expressed an interest in psychology and that it might take some time to engage with him.

4.248 On 16 February Mr E (Mr W's new care coordinator) received a message to call Mr W because he thought he had an appointment that week. Mr E made several attempts to contact Mr W but was unsuccessful. Mr E therefore contacted Mr Y to arrange an appointment on 25 February. Mr W did not attend this appointment.

4.249 On 2 March Mr E did meet with Mr W who had been at the stables during the day. Mr W reported that he had been completing the WRAP (Wellness Recovery Action Plan)[24] that he had picked up independently. Mr E and Mr W looked through what Mr W had completed and discussed some more productive ways for Mr W to manage his anger. Mr E noted that his interpretation of some of Mr W's behaviour was paranoia not anger. When considering what support would be helpful to Mr W, he said that he found it helpful to discuss his thoughts and feelings when anxious.

4.250 On 10 March Ms L discussed Mr W's case with Mr E, advising that Mr W had gone to her office base to see her again on a day when she had not been working. Ms L noted that she had previously offered appointments to Mr W but he had not attended. Mr E advised that Mr W's psychotic symptoms had reduced and that he was happier with his medication and taking it more regularly. Mr E advised that he did not see a role for psychology, which Ms L agreed with. It was agreed that Mr E would advise Mr W of the outcome of the discussion and obtain his view. Ms L noted that Mr E felt that Mr W did not want psychological intervention at that time because he considered that his issues related more to the Asperger's than any mental health problems.

4.251 On 25 March Mr E sent a text to Mr W to remind him of the appointment the following day. Mr E also spoke to Mr Y who advised that he felt that Mr W was taking his medication and had calmed down a lot. Mr E reviewed Mr W's records and noted that Mr W had been prescribed olanzapine to take on an 'as required' basis but Mr Y indicated Mr W had been taking it more regularly. Mr E agreed to speak to Mr W to arrange a Care Programme Approach review. Mr Y indicated that he felt Mr W's care plan was out of date and that it

[24] *Wellness Recovery Action Plan.*
http://www.sussexpartnership.nhs.uk/sites/default/files/documents/the_care_programme_approach.pdf

needed to include his views. Mr E offered to discuss with Mr W the possibility of Mr and Mrs Y attending the Care Programme Approach review meeting.

4.252 The following day Mr E attempted to meet with Mr W at the stables as arranged, however Mr W did not arrive. Mr E tried to call him but his phone was switched off. Staff at the stables told Mr E that it was likely that Mr W would be out for over an hour. Mr E noted he planned to write to Mr W to offer to visit him on 30 March and that Mr Y had also agreed to pass the message on to Mr W. Mr W did not attend this appointment either.

4.253 On 31 March Mr E received a call from Mr Y who advised that Mr W had been feeling anxious and paranoid and had not felt able to attend appointments with Mr E. Mr E agreed to see Mr W later that day to discuss a Care Programme Approach review meeting, general care planning and medication as it appeared Mr W was now keen to take medication more regularly. Mr W advised that he had been at the stables for eight hours a day every day of the week (Mr Y also confirmed this information) and had not been sleeping. Mr W had been prescribed 28 olanzapine 10mg tablets by his GP so that he could take them every day, rather than 'as required' Mr W did not feel that he had any psychosis or paranoid thoughts. Mr E noted that he found it difficult to assess Mr W because he was so sedated. Mr W reported he had gone to his father's home due to feeling stressed, which was confirmed by Mr Y who also stated he had restarted his relationship with his ex-girlfriend and that he had become anxious about his car which needed to be repaired. Mr Y indicated that he needed to provide some support to Mr W to enable the problems to be resolved. Mr E suggested that Mr Y would benefit from having a carer's assessment and noted that he was keen to see what support was available. Mr E suggested that Mr W should take his medication at 9pm rather than 3pm and get up only when he felt rested and then volunteer for as long as he felt able rather than an entire day. Mr E advised that it was important to balance meaningful activity with relaxation.

4.254 On 15 April Mr E met Mr W at home and Mr W stated that since taking his medication he had been a lot calmer. He reported being less anxious and said that there were no issues with his neighbours or when he was out and about. Mr W said that he had been using a WRAP timetable to make sure he had a healthy mix of exercise and relaxation. Mr E noted that Mr W was not over-sedated by the medication but had not been taking it every day. Mr E discussed the possibility of paid work at the stables, but Mr W was unsure how to approach this and therefore Mr E agreed to seek options for support for Mr W. Mr E enquired about Mr W's debt; he had about £500 debt on his gas and electricity and a further £170 for water. Mr W advised he was liaising with the creditors about an affordable repayment rate and Mr E reminded him of support that was available if Mr W felt that dealing with the issues became too stressful.

4.255 The following day Mr Y called Mr E to advise that in addition to the debts Mr W had described the previous day, he also had about £700 of debt in relation to his car. Mr Y also said that Mr J had offered funds to Mr W from the Money Carer Foundation in the past, but he had been reluctant to take up that support. Mr Y explained that he was concerned that the reason Mr W

didn't want help with his finances was because he was unsure of how to ask for help. Both Mr E and Mr Y felt Mr W would benefit from some additional support and Mr E offered to discuss it with Mr W when he next met with him.

4.256 On 19 May Mr W met with a support worker to discuss his finances. The support worker contacted the energy and water companies and arranged for Mr W to sign a consent form to enable her to act on his behalf. The gas company noted that Mr W's case had already gone to court but unusually they were prepared to consider a payment plan. The water debt would be dealt with after the gas debt had been settled, in accordance with "their policy". (We assume this is the water company's policy). A further appointment was made for 29 May to deal with Mr W's other debts.

4.257 On 21 May Dr O met with Mr W, Mr Y and Mrs Y for a Care Programme Approach review meeting. Mr W reported that he had been taking olanzapine irregularly because he felt quite sedated by it, and that he only took it when the noises outside his flat got too much, or he was getting more anxious. Mr W agreed that he needed to take his medication regularly and Dr O discussed the advantages of this. Dr O noted that Mr W had "not been very good on psychological therapy" but that he would be willing to look at this again in the future. Dr O indicated that he had not made any changes to Mr W's medication and that he had not seen any "definite evidence" of psychotic features during the appointment.

4.258 The financial support worker met with Mr W again on 29 May to finalise the arrangements for installation of gas and electricity meters and repayment plans. Mr Y was informed of the arrangements so that he could remind Mr W of when the engineer would be coming. A further appointment was made for 1 June.

4.259 On 1 June Mr Y called the financial support worker expressing concern about another debt of £130 for Mr W's mobile phone. Mr Y was informed that there was another meeting with Mr W that day and that it would be discussed, along with payments for his car. However, Mr W did not attend the appointment.

4.260 Mr W did not attend the appointment with Mr E on 9 June either.

4.261 On 22 June the financial support worker met with Mr W again. Mr W did not have the money to pay his debts and therefore more time was agreed with the relevant companies before they would take the matter further.

July 2015

4.262 On 7 July Mr E visited Mr W at home to discuss his debts and review the capacity decision completed by Mr W's previous care coordinator, Mr J. Mr E found no changes since the last review. Mr W appeared to understand the consequences of not paying his bills and believed that Mr Y or Mrs Y would continue to bail him out. Mr E noted that Mr W reported that he was sleeping well and not experiencing persecution from people in the street, despite not taking his medication. However Mr W had accumulated a significant amount

of unopened post to do with his finances, so Mr E helped him to sort this in advance of Mr W's meeting with the financial support worker on 14 July.

4.263 On 14 July Mrs Y had arranged to attend Mr W's appointment with him but Mr W didn't arrive. Mr W had sent a text to Mrs Y to say he "was unable to make it into town" that day, but didn't give a reason. Mrs Y told the support worker that Mr W had fallen out with his girlfriend because he had been physically violent with her, which had really frightened her. Mrs Y thought that Mr W didn't attend the meeting that day because he was worried about the consequences of that incident. Mrs Y reported more problems with Mr W's car payments because he had missed some payments to the credit company.

4.264 The following day Mr E received a call from Mrs Y expressing concerns about Mr W's relationship with his girlfriend. Mr E noted that it appeared that Mr W had again been threatening Ms A and pressuring her into having sex. There had been an incident when Mr W had become angry and had forced Ms A down by her chest. Mrs Y reported that Mr W became frustrated with the side effects of his medication and had therefore stopped taking it; the side effects had also caused him to become angry with his girlfriend. Mr E noted that there did not appear to be any indicators of a psychotic relapse. Mrs Y also expressed concern that Mr W had possibly been drink driving because Mr W had been driving a colleague around to buy alcohol, and this person had been banned from driving. Mr E noted that he would advise the police of the situation and obtain the registration number of the car from Mr W or from Mr Y. We can find no evidence that Mr E made any contact with the police until after Mrs Y reported her suspicions that Mr W was involved in the death of Mr Lock. Mr E also noted from the review of historical records and the MARAC document, that domestic violence incidents should be reported to the police.

4.265 On 16 July Mr E discussed the situation with his manager, Mr R. It was noted that Mr R had attended the MARAC meeting and had discussed the possible options for Mr W. Mr R advised Mr E that Ms A (Mr W's girlfriend) was not a service user but that she had been in contact with WORTH. Mr E was advised to contact WORTH to share the information with them so that they could consider whether to make contact with Ms A and the police.

4.266 At about 9:45 am the following day Mr E contacted WORTH regarding Mr W's case. The person Mr E spoke to advised that WORTH was a consent based service only and that Ms A would need to contact them. Mr E was advised to contact Mrs Y who was in contact with Ms A to suggest that Ms A contact WORTH. Mr E was further advised that the police rarely prosecuted without the consent of the victim, but a third party report could be logged with Sussex police.

4.267 At about 11:40 the same day Mr E received a telephone call from Mrs Y who expressed concern that Mr W might be a suspect in a murder investigation. Mr W had sent a text to Ms A late the previous night and that his car had been abandoned at the stables with damage to the back of it. Mrs Y was also concerned that Mr W fitted the description of the person the police were

looking for. Mr E contacted Sussex police to inform them of this information and to raise concerns about Mr W's behaviour towards his girlfriend.

4.268 Following Mr W's arrest, he was assessed by a forensic consultant psychiatrist who found that Mr W was not acutely unwell in terms of a psychotic illness, however it appeared to the doctor that Mr W was suffering from mental disorder in the form of an Autistic Spectrum Condition. Mr W was found to be fit to be interviewed, charged and detained without transfer to hospital for psychiatric treatment.

5 Communication with Mr W's family

5.1 We have received copies of communication between the Trust and Mr W's family from Mr Y and the Trust. There were a number of gaps in the information provided by the Trust. Details of all the communication we have reviewed can be found at Appendix D.

5.2 It should be noted that all references to the Chief Executive and Director of Nursing Standards and Safety refer to individuals no longer employed by the Trust.

2015

5.3 The Trust wrote to Mr W's family on 21 July offering support, expressed concern and advised that a member of the investigation team would be in contact in "in the next week or so". The letter was sent in the Chief Executive's name but signed by someone on his behalf. In Mr Y's response dated 4 August he expressed disappointment that the Chief Executive had not signed the letter and that his assistant had called Mr Y to obtain his postal address, rather than source it from information already held by the Trust. Mr Y also advised that Mrs Y had not received any contact from the Trust. Mr Y asked for a number of pieces of information and included a signed authority from Mr W to enable the Chief Executive to be able to respond.

5.4 The Chief Executive responded promptly and asked if Mr Y would consider a telephone conversation with him. The Chief Executive also apologised for the frustration his letter had caused and indicated that this was not his intention, and stated that the Trust would be in contact the following week regarding the information requested.

5.5 The Chief Executive followed up this letter on 14 August and assured Mr Y that information about Mr W's diagnosis and treatment had been shared with the team at the prison where Mr W was being held on remand. The Chief Executive provided an update on the information Mr Y had requested:

- Meeting held with the police: this had been a MARAC meeting that was led by the police, and the Trust had requested copies of the minutes from the police.
- Records of communication between Mr Y and Mr W's treating team: the Chief Executive had been advised that these had been documented in Mr W's clinical record and would be reviewed by the investigation team.
- Information about Mr W's attendances at A&E: two occasions had been identified when Mr Y had taken Mr W to A&E. A check of A&E records found no other attendances.
- Copy of the (autism) assessment undertaken by Ms S: this would be sent to Mr W the following week.

- Contact with Mrs Y: the Chief Executive apologised if Mrs Y did not have the Trust's contact details and advised that Mr E had spoken with her on the day of the incident.

5.6 Mr Y responded on 23 August indicating that he found the contents of the letter helpful and that he looked forward to further updates. Mr Y indicated that he had understood that the meeting with the police had been held in response to the concerns he had raised with Dr O regarding Mr W's assault on the member of the public. Mr Y also expressed concern that the Trust did not already have a copy of the minutes of the MARAC meeting and asked to see a copy of the risk management plan that had been produced following the meeting. Mr Y advised that he had expressed his concerns in writing on at least nine occasions, but that Dr O had only responded once, and that none of his concerns had been escalated to the Chief Executive's office was a matter for the Trust, not himself.

5.7 On 28 August Mr Y forwarded a note from Mr W saying that being in London made him feel "frail" and that he wanted the Trust to go and see him and take him home if they could. Mr Y asked the Chief Executive to confirm that someone from the Trust would be visiting Mr W.

5.8 On 1 September the Chief Executive wrote to Mr Y to advise that the MARAC minutes had been requested from the police on two occasions and that the Trust had been advised that the minutes could not be shared at that time, because they formed evidence as part of the police investigation. In addition, the Chief Executive advised that he had been informed that Ms S had not completed an assessment on Mr W, because Dr R had already given the diagnosis. Ms S had confirmed that she had met with Mr W in October 2011 to offer him support. Three potential dates for a meeting with the Chief Executive over the following 16 days were provided.

5.9 Mr Y responded to this letter on 3 September and stated that he was grateful that a meeting had been organised with the Chief Executive for 14 September. Mr Y indicated that he wanted the Chief Executive to "definitively state" his position on four items:

- What support the Trust gave to Mr W whilst in custody at Worthing;
- What support the Trust had been given to Mr W since being detained on remand in prison;
- The circumstances around the non-existent Asperger's Syndrome assessment;
- Trust notes on the meeting with Sussex police on 28 April 2014.

5.10 The following day the Trust wrote again to Mr Y in response to his letter of 28 August and confirmed that the Trust would be arranging contact with Mr W. And on 9 August the Chief Executive advised that he had asked a senior member of staff to provide a response to the points in Mr Y's letter of 3 September so that he was in a position to respond at the meeting on 14 September.

5.11 Mr Y attended the meeting on 14 September and had prepared 14 pages of questions and indicated that any questions that did not receive a response during the meeting, be responded to in writing. In this document, Mr Y expressed concern that Mr W had received no further contact from the Trust and that the Trust should not be waiting for Mr W to contact them, as he had limited access to methods of communication.

5.12 On 17 September Mr Y received an email from the Lead Investigator inviting him to contribute to the internal investigation. Mr Y responded the same day indicating two dates on 29 September or 1 October and stated that he and Mrs Y were quite busy dealing with the Trust on three fronts. Mr Y asked for written clarification of the process so that he and Mrs Y were able to contribute properly, Mr Y also asked that Mrs Y be included in all communication.

5.13 On the same day the Clinical Academic Director, who had been present at the meeting with Mr and Mrs Y and the Chief Executive on 14 September, wrote to Mr Y and Mrs Y to summarise the meeting. The letter was addressed to both parents, but apparently sent only to Mr Y. The Clinical Academic Director advised that the helpful document provided by Mr Y would form the basis of the discussion with the investigation team. The letter provided email contact details for the healthcare team at the prison and advised that Mr W would be assessed by the Trust's secure and forensic service for possible transfer from prison to a secure psychiatric unit. The Clinical Academic Director provided a copy of the terms of reference for the internal investigation and invited Mr and Mrs Y to advise on the best method of contact.

5.14 Mr Y responded on 20 September indicating that he was happy to receive communication via email. Mr Y also asked that occasional formal communication be sent via letter but that he was happy to receive as a pdf attachment to an email.

5.15 On 29 September Mr Y received an email from the Lead Investigator apologising for the delay in responding (to Mr Y's email of 17 September). The Lead Investigator provided an overview of the roles of the staff involved in the investigation and advised that he and the Clinical Director were preparing responses to the questions raised in the document Mr Y had given to the Chief Executive. The Lead Investigator offered a meeting with Mr and Mrs Y the following week, however subsequently withdrew this offer due to the clinical commitments of his colleague. A further date to meet was offered for 16 October. The meeting went ahead on this date and Mr Y subsequently emailed a copy of the journal about Mr W to the Lead Investigator and Clinical Director. On the same day Mr Y wrote to the Clinical Academic Director to request support from the Trust in eliciting answers to questions in three emails he had sent to the psychiatrist caring for Mr W in prison. At this time, it appears Mr Y believes that the Trust was still responsible for Mr W's on-going treatment.

5.16 On 20 October Mr Y wrote to the Clinical Academic Director advising that in the meeting with the internal investigation team he had learned that the Trust had held two meetings with the police, rather than just one, as Mr Y initially

believed. Mr Y advised that he understood that the Trust did have information about the second multi-agency meeting and requested that the Trust provide that information to him:

- The names of everyone who attended the meeting;
- What was discussed at the meeting;
- What action plan was agreed upon;
- Who was responsible for carrying out the action plan on both sides;
- What the outcome was of a follow up review.

5.17 On 21 October Mr Y emailed the Lead Investigator and the Clinical Director regarding the correspondence between the Trust and Mr Y that they had been unable to locate. Mr Y provided a list of 16 documents and asked that the Trust should indicate which files the investigation team did not have. The Lead Investigator responded the following day and advised that the investigation team had been able to locate only one of the sixteen documents Mr Y had listed and asked that Mr Y provide copies of all the other correspondence to aid the investigation. Mr Y did so on 23 October.

5.18 On 27 October Dr L responded to an email exchange with Mr Y regarding Mr W's transfer from prison to hospital, which had been prompted by Mr Y's email to the Clinical Academic Director on 16 October. Dr L advised that the Ministry of Justice was waiting receipt of the assessment that had been undertaken by Broadmoor Hospital.

5.19 On 17 November Mr Y prepared some notes for a meeting with the Trust. In the notes Mr Y expressed concern that nobody in the Trust appeared to be taking responsibility for Mr W's treatment. Mr Y wanted three urgent issues addressed:

- Mr W's on-going treatment: Mr W's family remained concerned at Mr W's lack of mental health treatment in prison and referenced a letter they had received from Mr W that he had asked was passed on to the Trust.
- Serious incident investigation: Mr Y wanted to know how the investigation was progressing, why progress had not been shared with the family and when the family were going to get answers to the questions they had submitted in September.
- Trust's Duty of Candour: Mr Y referenced the Duty of Candour responsibilities and the fact that the Chief Executive had advised that no record was available of an important meeting with the police, but the investigation team had in fact found a record of the meeting. Mr Y stated that he had written to the Clinical Academic Director four weeks previously but had not had a response, and asked when a response would be provided.

5.20 It is not clear from Trust records who was present at the meeting on 17 November, whether it actually took place or what the outcome was. However, Mr Y's notes indicate that the meeting did take place with the Chief Executive and Director of Nursing Standards and Safety. Mr Y's notes also indicate he

was increasingly concerned about the serious incident investigation, the Trust's response as regards Duty of Candour and that "vague verbal assurances" were given at the meeting.

5.21 On 30 November Mr Y emailed (on behalf of himself and Mrs Y) all members of the Serious Incident Investigation Panel, having had an opportunity to read the draft investigation report. Mr Y cited the concept of "groupthink" and indicated that he and his family felt they were in the "outgroup" at times.

> **"Groupthink** is a psychological phenomenon that occurs within a group of people, in which the desire for harmony or conformity in the group results in an irrational or dysfunctional decision-making outcome. Group members try to minimise conflict and reach a consensus decision without critical evaluation of alternative viewpoints, by actively suppressing dissenting viewpoints, and by isolating themselves from outside influences.
>
> Loyalty to the group requires individuals to avoid raising controversial issues or alternative solutions, and there is loss of individual creativity, uniqueness and independent thinking. The dysfunctional group dynamics of the "ingroup" produces an "illusion of invulnerability" (an inflated certainty that the right decision has been made). Thus the "ingroup" significantly overrates its own abilities in decision-making, and significantly underrates the abilities of its opponents (the "outgroup")."[25]

5.22 Mr Y included a copy of a letter sent to the Chief Executive that provided feedback on the draft report. The family had been given a couple of hours to read and assimilate 50 pages of text and had found this quite difficult, particularly because of the style, unfamiliar jargon and some of the findings. The family had been able to make only a few minor comments because of this and felt they had been unable to give the document a thorough critique, although they understood why they had been unable to take copies away with them. Mr Y stated that the family had had time to consider the draft report and wanted opportunity to comment further. Mr Y highlighted that the family had provided a number of documents to the investigation team and felt that these should appear in the appendix and timeline, as they were opportunities missed by the Trust. Mr Y indicated that the family wanted to see the report produced using Plain English and would not consider the report to be complete unless 13 bullet points were included. The family felt that there had been many opportunities lost by the Trust to acknowledge Mr W's illness and treat his condition properly and that the Trust had been unable to provide any evidence that Mr W's condition was ever treated, except for prescribing medication that the Trust knew Mr W was not taking. Mr Y highlighted that his family still did not have any information about the multi-agency meeting despite requesting it in writing on four occasions.

5.23 The Clinical Academic Director responded on behalf of the Chief Executive and the investigation panel on 11 December. She stated she had reviewed Mr Y's letters dated 4 August, 3 September, 20 November and 30 November

[25] *Email from Mr Y to members of the Serious Incident Panel 30 November 2015*

and the 14-page document handed over at the meeting on 14 September. She stated that she felt the report addressed the major themes that Mr and Mrs Y had raised and that the consistent high level themes were:

- Unclear diagnosis and treatment plan;
- Lack of comprehensive risk assessment and management;
- Inconsistent and responsive carer engagement.

5.24 The Clinical Academic Director asked to meet with Mr and Mrs Y in the new year, indicating that because the report could not include all of the detailed points this might enable the family to have assurance that the Trust had listened to their concerns.

5.25 On 17 December Mr Y emailed the Director of Nursing Standards and Safety to advise that the family had learned that the Trust had shared a copy of the internal investigation report with the victim's family and asked that a copy be shared with Mr W's family also. The Director of Nursing Standards and Safety responded the following day and said that the police had specifically advised the Trust not to share a paper copy of the report with Mr W's family at that time. She further advised that the report had been updated since the family had met with the Lead Investigator and offered to arrange a meeting to discuss the report contents.

5.26 The following day Mr Y wrote to the Chief Executive in response to the letter sent by the Clinical Academic Director on 11 December. Mr Y expressed disappointment that a paper copy of the letter was sent only to him, not to Mrs Y. Mr Y also indicated that he was writing to the Chief Executive because he felt it was inappropriate for the Trust to expect the family to deal with four different senior officers. Mr Y expressed frustration at the evasive responses the family had received from the Trust and lack of use of Plain English. Mr Y stated he felt there was little to be gained from meeting with Mr W's previous care team and stated the family had already met with Mr W's new care team (also Trust staff) with whom they were full of praise for their professionalism and commitment.

5.27 The Clinical Academic Director responded to this letter on 22 December and stated that the Chief Executive had suggested that she and the Director of Nursing Standards and Safety were the key points of contact for the family. She suggested a meeting in early January 2016, stating it was "so important to address the issues you raise to help us in our learning".

5.28 The following day the Director of Nursing Standards and Safety emailed Mr and Mrs Y to inform them that the Trust had submitted the final draft of the investigation report to the Clinical Commissioning Group. She advised that the Clinical Commissioning Group would scrutinise the report and associated action plan early in 2016 and that they may request further amendments. She advised that she would be on annual leave until the new year and would not be in touch again until then.

2016

5.29 Mr Y prepared a document for a meeting with the Trust on 11 January. In the document Mr Y listed 18 questions for which he was seeking answers. Following the meeting the Director of Nursing Standards and Safety sent an email in which she stated that she had agreed to follow up the questions that Mr Y had raised. She advised that she had contacted the police to request that the Trust be able to approach Mr W, with the consent of his treating clinician, to listen to his views about his care and treatment and to share the report. The Director of Nursing Standards and Safety provided a copy of the front sheet of the report that was submitted to the Clinical Commissioning Group that set out the requests for the deadline to be extended and the reasons why. She also provided contact details for the independent advocacy service providers in West Sussex.

5.30 On the same day Mr and Mrs Y received an email with a reworded letter from the Clinical Academic Director. The letter reworded the third bullet point of the high level themes set out in the original letter dated 11 December. The new wording read:

- The response to concerns for carers was inconsistent and at times did not show due regard to their concerns.

5.31 Mr Y responded by return and stated that the alteration was "slightly less confusing".

5.32 On 4 February the Director of Nursing Standards and Safety emailed Mr and Mrs Y to let them know that Mr W had been seen by the Lead Investigator and the Clinical Director and that he had been able to share his view of the care he had received from the Trust prior to the incident. She advised that the report had been updated to reflect that his views had been considered and that the updated report would be scrutinised by the Clinical Commissioning Group. She also provided contact details of Hundred Families.[26]

5.33 The following day Mr Y wrote to the Chief Executive to express disappointment that the Trust had not taken on board the feedback from the family following their opportunity to read the draft report in November 2015. Mr Y stated that (in his view) the common themes in the treatment of Mr W and engagement with his parents were incompetence, arrogance, deceit and dishonesty. Mr Y further stated that he would be writing to the Trust again following the trial to request further information.

5.34 On 12 February the Director of Nursing Standards and Safety emailed Mr and Mrs Y to inform them that the serious incident report had been scrutinised by the Clinical Commissioning Group that day and that no further amendments to the report had been requested. She also advised that the Clinical Commissioning Group would be reviewing Trust progress the following month.

[26] *Hundred Families is a charity that provides practical information for families affected by mental health homicides in Britain.*

5.35 The same day the Chief Executive responded to Mr Y and Mrs Y. He stated that the Trust would provide them with a paper copy of the report once they had been advised that this was possible. He also stated that as Mr Y had indicated his intention to write again after the trial, he would respond in detail at that time.

5.36 The Director of Nursing Standards and Safety wrote to Mr Y and Mrs Y (letter undated, but saved by Mr Y as dated 7 March) providing copies of the serious incident report. Mr Y subsequently prepared a number of questions in readiness for a telephone conversation on 14 March, however it is unclear what answers Mr Y received during the telephone call.

5.37 On 4 April Mr Y wrote (on behalf of himself and Mrs Y) to the Chief Executive and indicated that the serious incident report raised further questions and concerns for the family. Mr Y set out two immediate issues that he wanted answered:

- The name and GMC number of the individual who diagnosed Mr W with Asperger's Syndrome and when the diagnosis was made.
- Confirmation of when the Trust was going to share the care plan that was produced in May 2015.

5.38 Mr Y further asked that the Chief Executive provide a full response to the letter of 5 February and that answers were provided to all questions posed previously:

- Letter of 4 August 2015
- Letter of 3 September 2015
- Meeting of 14 September and supporting 14 page document
- Letter of 20 October 2015
- Letter of 30 November 2015

5.39 Mr Y asked that if the response to the question could be found in the serious incident report, that the relevant text be included in the Trust's written response, rather than simply referring to the report.

5.40 The Chief Executive responded on 12 April apologising that the information provided was not satisfactory and advising that the Trust was making every effort to ensure that all Mr Y's requests were clearly identified and communicated. The Chief Executive invited Mr and Mrs Y to meet with him to discuss their concerns and advised that his office would contact them to arrange a suitable time.

5.41 Mr Y responded the following day to advise that he would prefer to wait for a meeting until the family had received written answers to the questions posed over several months. Mr Y stated that three most important pieces of information the family were seeking were:

- All the information surrounding the meeting held with Sussex police on 28 April 2012, specifically: the names of all who attended; what was discussed (i.e. a copy of the meeting notes); what action plan was agreed; who was responsible for carrying out the action on both sides; the outcome of a follow up review.
- The name and GMC number of the clinician who diagnosed Mr W's with Asperger's Syndrome and the date of the diagnosis.
- A copy of Mr W's care plan from May 2015.

5.42 On 15 April Mr Y wrote to the Chairman of the Trust to make her and the Trust Board aware of the "bad experiences" he and Mrs Y had had with the Chief Executive. Mr Y asked that the Chairman remind the Chief Executive of the responsibilities under the Duty of Candour and suggested that the Chief Executive was in danger of bringing the Trust into disrepute.

5.43 On 26 April the Chief Executive wrote to Mr Y and Mrs Y to apologise for providing responses previously that did not provide sufficient clarity or detail for the family. Included with the letter was a 14-page document that set out responses to all the questions posed by Mr Y.

5.44 On 7 May Mr Y wrote (on behalf of himself and Mrs Y) to the Chairman to express thanks for taking the time to talk to Mr Y. Mr Y indicated the family's gratitude to receive the "fulsome letter of apology" from the Chief Executive and that they accepted that apology. Mr Y asked that the family's thanks were passed to staff caring for Mr W in the secure psychiatric unit and that the family remained committed to supporting the Trust to implement lessons learned.

5.45 The Chairman acknowledged this letter on 13 May and thanked Mr and Mrs Y for their comments regarding the staff at the secure psychiatric unit. She stated it would be helpful to meet as planned on 24 June and again expressed sorrow that Mr W did not receive the level of care that he deserved.

5.46 On 19 May the Chief Executive wrote to Mr and Mrs Y to inform them that the Trust had commissioned an independent review of homicides involving patients known to the Trust. He advised that the review period covered 2006 to 2016 and included the care provided to Mr W, and that it was in addition to the review that would be commissioned by NHS England (which is this investigation). The Chief Executive apologised for any further distress this might cause Mr and Mrs Y and offered the Director of Nursing Standards and Safety as a point of contact if they required any further information.

5.47 On the same day Mr Y emailed the Director of Nursing Standards and Safety following a verdict being reached in Mr W's trial. Mr Y thanked the Director of Nursing Standards and Safety for her help and cooperation but highlighted that one issue remained outstanding. Mr Y referred to obtaining minutes of the multi-disciplinary meeting held on 28 April 2014 with Sussex police and that in a letter dated 14 August 2015 the Chief Executive had said:

"We have requested minutes of the meeting from the DCI leading the Police Investigation on 23rd July, and have been advised that these will be shared with us so we can pass a copy on. We have not received these to date but will ensure we get these".

5.48 Mr Y requested that now the trial had concluded, the Director of Nursing Standards and Safety obtain those minutes on his behalf.

5.49 The following day (20 May) the Director of Nursing Standards and Safety responded indicating that there had been some confusion that the Trust had inadvertently added to. She stated that there were no formal minutes from the meeting held with the police on 28 April and that the only records the Trust had ever held were within Mr W's clinical record and had already been shared with the family. She advised that the MARAC minutes from July 2014 had still not been shared by Sussex police and that she would again request them now that the trial had ended. Mr Y responded on 24 May indicating that he felt there was little he could contribute to the thematic review of ten homicides and thanked the Director of Nursing Standards and Safety for the support given to his daughter (Mr W's sister).

5.50 On 10 June 2016 the Director of Nursing Standards and Safety sent a copy of the MARAC minutes from July 2014 to Mr Y and Mrs Y. She highlighted that the information relating to the victim had been removed in order to maintain confidentiality.

5.51 Mr Y prepared notes for the meeting with the Trust Chairman on 24 June highlighting three significant areas:

- Concern at the lack of proper care and treatment given to Mr W since he was first diagnosed with paranoid schizophrenia in 2008;
- Disappointment with the way in which the serious incident report was carried out and the way the family were treated in the process;
- Disappointment with the way in which the Chief Executive had handled things.

5.52 On 27 June the Director of Nursing Standards and Safety wrote to Mr Y to apologise again for the events that happened the previous year and to acknowledge that times remained difficult for him and his family. She provided a copy of the serious incident report and summarised the eight problems identified in relation to the care and service the Trust offered to Mr W. She further highlighted five key actions that the Trust had already taken and invited Mr Y to make contact should he have further questions.

5.53 On 6 July the Chair wrote to Mr Y to thank him and Mrs Y for meeting with her. It appears that the letter was sent only to Mr Y. The letter provided a summary of the key points discussed at the meeting on 24 June.

Analysis of Trust communication

5.54 The Trust did not use information already available in order to communicate with Mr W's family. The Chief Executive's office telephoned Mr Y in order to obtain his address, which caused Mr Y unnecessary distress and could easily have been avoided.

5.55 The initial letter from the Chief Executive to Mr Y was not signed by him, but pp'd[27] by someone else. This led Mr Y to feel disappointment, which he communicated to the Chief Executive in a response. Again this caused Mr Y unnecessary further distress and could very easily have been avoided.

5.56 No contact was made by the Chief Executive's office to Mrs Y. When responding to this issue being highlighted by Mr Y the Chief Executive stated that contact had been made with Mrs Y by the care coordinator the day after the incident. This was a poor and misguided response and the criticism should have been dealt with by an apology and commitment to ensure that all communication was sent to both parties in the future.

5.57 The Chief Executive assigned a number of key contact persons to Mr W's family for a variety of different purposes. Whilst we can see the intention was to ensure that from the Trust's perspective there was a clear purpose to each of the contact individuals, this clarity was not shared by Mr W's family and they were left feeling that they had to chase four individuals for information. It appears from the review of correspondence from Mr Y that he did not know whom he should contact for which purpose. The Trust later rectified this by assigning a single point of contact but by this time many weeks had passed and unnecessary frustration had set in.

5.58 On numerous occasions Mr Y asked that the Trust provide clear written responses to questions that he and Mrs Y had. These were not forthcoming in a timely fashion and led to heightened feelings of frustration by Mr W's family. We recognise that there was some information requested that the Trust was unable to provide at certain points, however Trust responses could have been clearer about what information could and could not have been provided and the reasons why. See recommendation 1.

5.59 The Lead Investigator made contact with Mr W's family two months after the incident and then took nearly two weeks to respond to Mr Y's subsequent response. This meant that the first date that the Lead Investigator had offered to Mr and Mrs Y had already passed. It took a further 17 days to organise a meeting between the investigation team and Mr and Mrs Y, meaning three months had already passed since the homicide. The Trust should ensure that families have information early on about when to expect contact from internal investigation teams and be clear about in what circumstances this contact might be delayed, such as when there is an on-going criminal investigation. See recommendation 2.

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[27] *PP - per procurationem means 'through the agency of'.*

5.60 The internal investigation team did not have access to a large number of documents that Mr Y had previously sent to Mr W's treatment teams. This led to further frustration on Mr Y's part and understandably a lack of confidence that the concerns he had previously raised about Mr W had been taken seriously. It is of concern to us that the detailed chronology we have been able to create in relation to the communication between the Trust and Mr Y after the incident is only because Mr Y kept detailed records of each communication. Mr Y provided us with in excess of 60 documents pertaining to his communication with the Trust after the incident. In contrast the Trust provided us with 18 documents; 16 of which appear to be the documents Mr Y provided to the internal investigation team.

5.61 Some letters from the Trust were not written in Plain English and contain passages that we cannot interpret. The Trust must consider the way in which staff communicate more carefully to ensure that service users and families do not feel unnecessarily isolated. See recommendation 1.

5.62 It remains unclear what document was shared with the victim's family in late 2015 and why the police had advised that the serious incident report should not be shared with Mr W's family.

5.63 We deal with associated recommendations for the Trust later in Section 9.

5.64 Following the circulation of the first draft of this report the Trust considered its initial response to a formal complaint received from Mr Y and Mrs Y regarding the way the organisation dealt with the concerns raised about Dr O's clinical practice. The Trust sought external support from the former medical director of another mental health trust and one of the Trust's own non-executive directors to consider the Trust response to the complaint and the decision-making in relation to concerns about clinical staff involved in the care of Mr W. The findings of that review are consistent with our own findings and the Trust has confirmed that the issues will be dealt within the action plan responding to this report.

Duty of Candour

5.65 We have reviewed the Trust's recording of its actions under the Care Quality Commission Regulation 20: Duty of Candour. Regulation 20 was introduced in April 2015 and is also a contractual requirement in the NHS Standard Contract. In interpreting the regulation on the duty of candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- **"Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."

5.66 To meet the requirements of Regulation 20, a registered provider has to:

- "Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person."

5.67 It is our view that the Trust met most of its requirements under Regulation 20. However there was considerable delay before a face-to-face meeting took place with Mr Y and Mrs Y, and no evidence that a face-to-face meeting took place with the Lock family.

5.68 There was confusion about specific details that Mr Y and Mrs Y were seeking answers to and even now we have not been able to clarify some issues.

5.69 It appears that in this case the Duty of Candour responsibility was taken forward initially by the Chief Executive, and then passed to the Director of Nursing Standards and Safety. However, in early communication the Chief Executive indicated that no further communication had been sent to Mrs Y because Mr W's care coordinator had made telephone contact with her. It would have been helpful for the Trust to have been clear about who was leading on fulfilling Duty of Candour responsibilities.

6 Communication with Mr Lock's family

6.1 We have been provided with copies of two letters that were sent to Mr Lock's wife. An initial letter dated 30 July 2015 was sent by the Chief Executive that expressed the Trust's condolences, shock and confirmed cooperation with the police investigation. The letter also indicated that it was important to include any questions from the family in the investigation and to offer an opportunity for them to hear the findings at the conclusion of the internal investigation. The Trust arranged for the letter to be delivered by hand via the police Family Liaison Officer.

6.2 On 27 June 2016 the Director of Nursing Standards and Safety wrote to Mrs Lock to provide a summary of the issues identified in the serious incident investigation. The letter also provided a summary of five key actions that the Trust had taken in response to the findings of the serious incident investigation. The Director of Nursing Standards and Safety also offered the opportunity for a telephone or face to face discussion and again apologised for the loss that Mr Lock's family had experienced.

6.3 We have not seen any indication that Mr Lock's family responded to the letters either directly or via their Family Liaison Officer. This is not at all a criticism of Mr Lock's family; merely we wish to make the point that there is no further communication for us to review.

7 Internal investigation and action plan

7.1 The Trust was first alerted to the potential involvement of Mr W in the incident when on 17 July Mrs Y contacted Mr E. The Trust completed an incident report and commissioned an investigation team to undertake the internal investigation.

7.2 The Lead Investigator was allocated to the investigation on 22 July 2015, within five days of the Trust being aware of the incident. The Lead investigator is experienced in undertaking serious incident investigations, completing approximately 12 investigations per year.

7.3 The internal investigation team comprised:

- General Manager, East Sussex Community Services (Lead Investigator)
- Clinical Director, North West Sussex (Clinical Advisor)
- Service Director, Secure and Forensic Services (Investigation Supervisor)

7.4 Although the internal investigation team was identified promptly, the Lead Investigator told us that within about two weeks of the investigation being commissioned it was clear that it was going to be a more complex investigation than initially thought. We understand that it was at that point that the Investigation Supervisor was asked to provide some support to the team.

7.5 The initial timeline was completed on 7 August 2015 and on 11 August the investigation team was advised by the police not to contact Mr W, due to the criminal investigation that was underway. On 17 August Trust staff were advised that the investigation team would be looking to interview them.

7.6 The internal investigation team interviewed seven members of staff and received written communication from two further members of staff. Notes were retained from these interviews and we have had access to these.

7.7 The first panel meeting took place on 25 September 2015 at which there were discussions about sharing the MARAC minutes so that more information could be included in the report. The Clinical Advisor told us that this was an area where the investigation team did not have the appropriate level of access to information from the start.

7.8 The Lead Investigator told us that on 23 October he contacted the Director of Nursing Standards and Safety to inform her that the investigation would not be completed within the required timeframe and requested an extension. At that time, he believed another month would be required. By this time the investigation team had met with Mr W's family and that meeting had identified a significant new line of enquiry, specifically, communication between Mr W's family and the team providing his care. The Lead Investigator told us that although the 60-day deadline had passed by 23 October, it was very hard to hit that target when an investigation is as complex as this one was. He suggested that the Trust needs to mobilise resources differently in order to achieve this deadline for similar cases in the future. He noted that "the major

negative effect of not delivering within the 60 day timeline is exactly what we encountered here – a very unhappy family". We agree with this statement.

7.9 The Lead Investigator also stated that he felt more guidance is needed within relevant policies for staff that are conducting a serious incident investigation that relates to a homicide. He felt this was because the report is often much more lengthy than in other circumstances (because the period of time being reviewed is significantly longer) and there are a range of other complex issues to consider such as media interest, and (sometimes) two affected families.

7.10 The Lead Investigator told us that there is a new willingness within the Trust to consider the experience of staff conducting serious incident investigations relating to homicides. He also told us that the Trust was looking at developing a process to help staff to manage such investigations better in the future.

7.11 We note that there were revisions to the serious incident report, however the Trust template does not include an element of version control. This means that anyone viewing the document cannot be sure which version they are reading or whether any further versions exist.

7.12 The internal investigation report identified a number of care or service delivery problems and recommendations.

Care or service delivery problems

- Unclear diagnosis;
- Incomplete risk assessment;
- Risk management problems;
- Ineffective treatment;
- Inappropriate response to concerns raised 48 hours prior to the incident;
- Lack of longitudinal clinical review of the patient's presentation and management;
- Lack of appropriate family engagement;
- Inconsistent inter-agency communication and incident reporting.

Recommendations

1. The team (and wider service) should introduce peer review mechanisms for patients who have received care and treatment for longer than two years.
2. The Trust should develop electronic risk assessment tools which "pull through" previous risk events in a historically based way.
3. Ensure risk assessment training delivers a clear understanding of risk markers in dual diagnosed patients and an understanding of the need to reformulate risks when new risk events occur.

4. Review carer engagement methods and processes within the team and ensure all staff understand the need to document written communication with carers and to provide and document response to such communication.
5. All teams to have representation at Triangle of Care Meetings to further inform and support carer engagement.
6. Review the benefits of specialist outpatient (OP) clinics where the allocated consultant does not work alongside the local team. Where such clinics exist communication processes and systems should be agreed and documented.
7. Ensure all staff within the team understand the importance of accurate record keeping and the need to complete care plans and risk assessments to an agreed standard.
8. Ensure Trustwide all practitioners are aware of formal and informal referral methods to obtain a forensic opinion.
9. To ensure training of dual diagnosis in the context of Psychosis and Autistic Spectrum Disorder becomes an essential aspect of training.

7.13 We support the recommendations made by the internal investigation team.

7.14 An additional recommendation was present in the action plan: "Commence review of professional practice and identify appropriate actions as indicated".

7.15 Although this recommendation was not present in the serious incident report, only in the associated action plan, we also support this recommendation.

Analysis of Trust action plan

7.16 **Recommendation 1**. The Trust has implemented a new Care Programme Approach policy that includes the requirement for teams to complete peer reviews for patients who have received care and treatment for over two years. The actions are audited through review of subsequent peer review notes that are held on the relevant clinical record. This audit process has identified that peer review meetings are being held as required. The evidence provided by the Trust focuses on ensuring that the required actions have been completed. We suggest that the Trust could provide further assurance to themselves if they undertake a review of the effectiveness of the peer review process. See our recommendation 3.

7.17 **Recommendations 2 and 3**. The Trust has provided extensive information about the new risk assessment tools and the associated training provided in January and February 2016. We can see that 124 staff have received additional face-to-face training in risk assessment and that the Trust will continue to provide this as part of the annual training offer.

7.18 We have seen the supporting slides for the training that is provided by a clinical psychologist and a practitioner who specialises in autistic spectrum conditions. This training was delivered in January and May 2016, however there is no indication that the training forms part of any rolling programme and

therefore there is the risk that the knowledge is lost over time as staff move on. See our recommendation 4.

7.19 There is no indication in the information provided by the Trust of the effectiveness of the training in ensuring that staff understand the risk markers in patients who have a diagnosis of autism and psychosis. See our recommendation 4.

7.20 **Recommendations 4 and 5**. The Care Programme Approach paperwork now includes a section for carers. We have been advised that carers have been involved in service developments via cluster working groups in Coastal West Sussex. The Trust has implemented the triangle of care principles that include learning and actions being fed back to teams when required. The Trust has appointed a carer lead and the Coastal West Sussex services are working with this member of staff to deliver locally based training. Triangle of Care training was provided to staff in the Coastal Community in February 2017 with further training for other staff in April 2017. We have not seen evidence to indicate that the Trust has sought assurance that the actions are making a difference to carers. See our recommendation 5.

7.21 **Recommendation 6**. The Trust has advised that the issue has been discussed with specialist consultants and that they have reported having regular contact with local teams. A process is in place to access a peer review in complex cases (as discussed for Recommendation 1). The Trust has completed a review of the neurodevelopmental clinic and an audit of the neurodevelopmental clinic that "demonstrated positive results and good compliance to NICE ADHD guidelines". The focus of the work in the neurodevelopmental clinic is ADHD in adults, not autism, which is the diagnostic reason Mr W was being seen by Dr O in this clinic. The Trust has noted:

"There is a significant difference between the two audits (2014 and 2015). In 2014 there were several patients referred for an assessment of Autism and Asperger's Syndrome (27%). This reduced to 16% in 2015 indicating that the focus of the clinic is now on assessment and treatment of neurodevelopmental disorders other than Asperger's Syndrome."

7.22 The review paper notes that liaison with community teams was an issue raised in this serious incident investigation. One slot per week has been set-aside for members of the community team and mental health liaison practitioners to have telephone or face-to-face discussions with Dr O. Dr O has also been invited to attend complex case discussions of patients shared between the clinic and community mental health teams. The paper does not indicate what the outcome of the weekly slot has been, nor does it state how frequently Dr O attends complex case discussions of patients.

7.23 We suggest that the Trust should seek further assurance that this process has sufficiently mitigated the risk of specialist consultants working in a more remote way than consultants embedded within local teams. Having regular contact with a team does not bring as much added value as being part of

weekly multi-disciplinary discussions about clients. See our recommendation 6.

7.24 **Recommendation 7.** The Trust undertook an audit in 2016 that demonstrated 90% compliance with accurate record keeping and appropriately completed care plans and risk assessments. The audit made recommendations for Coastal West Sussex adult services to focus improvements on:

- Documenting carer involvement in the Risk Assessment and Management process and if collaboration is not possible, documenting the reason for this on the risk assessment form.
- Documenting that risk assessments have been reviewed at CPA (Care Programme Approach) milestones, whenever a service-user's circumstances or presentation changes, and within seven days of discharge from an inpatient unit.

7.25 The audit has been incorporated into the annual audit programme for the Trust. We have not seen any further audits in response to these additional recommendations because they were scheduled to take place after we conducted the review.

7.26 **Recommendation 8.** This recommendation is listed within the final internal report but does not appear in the associated action log. Consequently there is no evidence available to confirm what actions the Trust took. We have been informed that the Trust is confident "services were informed" as part of the recommendation but that there is no evidence available to support this. The Trust has provided a copy of the Referral Protocol for the Secure and Forensic Service. The stated principles include:

"This referral process will allow for joint assessment, consultancy/advice, shared care arrangements and networking between services."

7.27 The protocol sets out the secure and forensic service community team process for managing referrals and the different functions provided by the team. However, we have seen no evidence to indicate that across the Trust all practitioners are aware of formal and informal methods to obtain a forensic opinion. We suggest that the Trust assures itself and commissioners that the recommendation from the internal investigation report has been fully implemented. See our recommendation 21.

7.28 **Recommendation 9.** In February 2016 a Senior Clinical Director wrote to all Service Directors and Clinical Directors requesting that all clients who had a dual diagnosis of Asperger's and psychosis had a Level 2 risk assessment completed. Additional support was offered and directors provided information confirming this had been completed by the end of April 2016.

7.29 **Additional action: Commence review of professional practice and identify appropriate actions as indicated.** This additional action was included in the action plan but was not listed as a recommendation in the internal serious incident report.

7.30 The Trust policy 'Managing Concerns about Medical Staff' sets out the process to follow when concerns are raised or identified about a doctor. The procedure covers five key elements:

- Action when a concern arises (Part 1)
- Restriction from practice and exclusion from work (Part 2)
- Conduct and disciplinary matters (Part 3)
- Procedure for dealing with issues of capability (Part 4)
- Handling concerns about a practitioner's health (Part 5)

7.31 The policy states that a case manager should be appointed to "identify the nature of the problem" and "assess the seriousness of the issue". The policy also states that root cause analyses should be conducted and that the case should be discussed with NCAS (National Clinical Assessment Service)[28] before deciding whether a formal or informal approach can be taken. Should a formal route be followed the Medical Director or Associate Medical Director must appoint an appropriately experienced or trained person as case investigator. The role of the case investigator is also set out:

- "Is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings;
- Must formally involve a senior member of the medical staff nominated by the medical staff committee chair [or equivalent] where a question of clinical judgement is raised during the investigation process. (Where no other suitable senior doctor is employed by the Trust a senior doctor from another NHS body should be approached);
- Must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but any disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how - within the boundaries of the law - that information should be gathered. The investigator will approach the practitioner concerned to seek views on information that should be collected;
- Must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene any disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report;
- Must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Director of Workforce and OD with the Medical Director/Associate Medical Director;

[28] *National Clinical Assessment Service (NCAS) NCAS contributes to patient safety by helping to resolve concerns about the professional practice of doctors, dentists and pharmacists. http://www.ncas.nhs.uk/*

- Must assist the designated Board member in reviewing the progress of the case."

7.32 The policy states that the case investigator should complete the investigation within four weeks of being appointed and submit their report to the case manager within a further five days.

"The report should give the case manager sufficient information to make a decision whether:

- There is a case of misconduct that should be put to a conduct panel;
- There are concerns about the practitioner's health that should be considered by the NHS body's occupational health service;
- There are concerns about the practitioner's performance that should be further explored by the NCAS;
- Restrictions on practice or exclusion from work should be considered;
- There are serious concerns that should be referred to the GMC;
- There are intractable problems and the matter should be put before a capability panel;
- No further action is needed.

7.33 Involving NCAS assumes commitment by all parties to participate constructively and its assessors work to formal terms of reference, decided upon after input from the doctor and the referring body.

7.34 When considering how to manage the potential or risks to patients the policy states "…the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice…. Exclusion will be considered as a last resort of alternative courses of action are not feasible."

7.35 Matters which fall under the Trust's capability procedures include:

- Out of date clinical practice;
- Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
- Incompetent clinical practice;
- Inability to communicate effectively with colleagues and/or patients;
- Inappropriate delegation of clinical responsibility;
- Inadequate supervision of delegated clinical tasks;

- Ineffective clinical team working skills.

7.36 The Trust has advised that there were two processes in place in relation to managing the concerns about Dr O's practice:

- a clinical capability review undertaken by NCAS;
- a GMC investigation as a result of a letter of complaint by Mr Y to the GMC.

7.37 Our analysis deals only with the clinical capability review.

7.38 The Trust communicated with and sought advice from:

- the GMC (General Medical Council) "shortly after the incident";
- NCAS (National Clinical Assessment Service) "from receipt of the first draft of the internal investigation report".

7.39 It appears that the internal serious incident report fulfilled the requirement for a root cause analysis of the issues. This is unusual and not best practice, as serious incident investigations are not designed to form the basis of a disciplinary investigation. However it did provide a root cause analysis.

7.40 The Trust confirmed to Dr O on 21 September 2015 the intention to request an external review of his clinical work. Although the internal serious incident report had not been finalised, the Responsible Officer[29] spoke to NCAS the following day.

7.41 A planned review discussion between the Responsible Officer and NCAS took place on 12 November 2015. At this point the internal report still had not been finalised and the Responsible Officer was awaiting this before considering what action it might be appropriate to take.

7.42 On 1 February 2016 the Responsible Officer liaised with NCAS. By this time the internal investigation report had been finalised. The Responsible Officer advised NCAS that a preliminary audit of the Autistic Spectrum Disorder clinic had not identified any immediate concerns and the Responsible Officer had not placed any restrictions on Dr O's practise. The Responsible Officer sent the internal investigation report to NCAS for their review and consideration of the issues discussed with them. The referral of Dr O to NCAS was completed on 26 February 2016.

7.43 It is of concern to us that the formal referral to NCAS was not made until February 2016 – six months after the concerns about clinical practice were first identified and five months after the Trust indicated their intention to commission an NCAS review. We acknowledge that this delay was as a result of the delays in finalising the internal serious incident investigation report, however it is our view that the Trust should not have relied upon the serious incident report to fulfil the requirements within Part 1 of the policy.

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29 *Responsible Officers have an important, wider role in medical regulation, helping to make sure a doctor who has restrictions on their practice is appropriately and safely managed. https://www.gmc-uk.org/doctors/revalidation/12385.asp*

Had the Trust commissioned a discrete investigation in line with the policy the report into concerns about Dr O's practice should have been available by the end of October 2015.

7.44 It took NCAS seven weeks (until 12 April 2016) to make the decision that they would carry out an assessment. Their report was completed on 10 May 2017.

7.45 Following completion of the NCAS report the Trust met with NCAS, Dr O and his legal team on 26 June 2017. An action plan was "agreed, shared with the GMC and is in place".

7.46 During the period between the NCAS decision to conduct an assessment and the completion of their report Mr Y submitted a complaint about Dr O to the GMC. This was submitted in late June 2016 and in mid August the GMC advised Dr O of their intention to investigate the concerns. The GMC requested information from the Trust to inform their review, "including the outcome of the NCAS investigation if available".

7.47 In September 2017 the GMC made a recommendation that the case should be concluded with a schedule of undertakings. Those undertakings include:

- "To design a personal development plan (PDP), approved by my responsible officer (or their nominated deputy), with specific aims to address the deficiencies in the following areas of my practice:
- assessment of the patient's condition;
- record keeping;
- communication and practitioner-patient relationship;
- working in teams (leadership and management);
- written communication.
- To undertake an assessment of my performance, on a date given by the GMC, unless notified by the GMC that this assessment is not necessary."

7.48 The Trust has advised us that had Mr Y not made a referral to the GMC, then the Trust would have done so at the conclusion of the NCAS assessment.

7.49 To conclude, the way that the Trust dealt with concerns about Dr O's practice appears not to have followed the 'Managing Concerns about Medical Staff Policy'. The consequence of that was that the formal referral to NCAS, and subsequent assessment outcome were delayed by five months. It is our view that the Trust seeks assurance that the relevant policy is always followed when managing concerns about medical staff. See our recommendation 7.

7.50 Following the circulation of the first draft of this report the Trust considered its initial response to a formal complaint received from Mr Y and Mrs Y regarding the way the organisation dealt with the concerns raised about Dr O's clinical

practice. The Trust sought external support from the former medical director of another mental health trust and one of the Trust's own non-executive directors to consider the Trust response to the complaint and the decision-making in relation to concerns about clinical staff involved in the care of Mr W. The findings of that review are consistent with our own findings and the Trust has confirmed that the issues will be dealt within the action plan responding to this report.

Conclusions of review of internal investigation and action plan

7.51 It is our view that the internal investigation did meet the terms of reference set, however there were some issues that we have identified in our independent investigation that were not identified in the internal investigation. We address these in Section 8.

7.52 The Trust has completed most actions within the plan in a timely fashion. However we have highlighted our concerns above where we consider that more action or assurance is required.

7.53 The Trust appointed a panel to review the action plan that was chaired by executive leads, the purpose of this was to ensure that the organisation was able to respond to immediate learning needs. As a consequence some actions were implemented within weeks of the incident including:

- an alert was sent to all consultants requiring them to review those clients with dual diagnoses of autism and psychosis;
- peer reviews were implemented for all clients who had been on caseload of a team for two years.

7.54 The Trust has made significant changes to the Serious Incident Policy and Procedure. The Serious Incident policy follows the NHSE Serious Incident Framework (March 2015) guidance and was ratified by the Clinical Practice/Policy Forum on 11 May 2017. The Clinical Practice/Policy has delegated responsibility from the Quality Committee for consultation and ratification of the Serious Incident Policy.

7.55 The new Trust templates for serious incident reports are included within the policy but they are also being built electronically as part of the Trust electronic safeguarding reporting system. The Trust is exploring whether the electronic templates can have a version tracker included. It is unclear whether the template has section and page numbers and it appears not to have a table of contents. Whilst these are relatively minor issues, they do help a reader who is unfamiliar with such reports (affected families for example) to understand the flow and where to find relevant information. In addition there is no guidance to staff within the policy and procedure about ensuring that the investigation reports are written in plain English with any abbreviations properly explained. This is essential in ensuring that affected families are not alienated by unfamiliar language. To aid transparency it would also be helpful to include a section to indicate the process undertaken for requesting any extensions to the 60-day timeframe, and the process and dates for the

relevant Clinical Commissioning Group approval of the report. See our recommendation 8.

7.56 The Trust has introduced a new role of Family Liaison Lead. This is a new role that aims to provide additional support to affected families and carers following a significant serious incident such as a homicide, inpatient suicide or where someone has very complex care. This is in addition to the support the family will receive as part of the serious incident investigation process. The Trust has completed a leaflet to explain the Family Liaison Role and is developing a leaflet for affected families and carers outlining the serious incident investigation process and support. This is the first time we have encountered this approach and it is to be commended.

7.57 We would recommend that the Trust ensures that there are clear links between the recommendations in serious incident reports and the actions listed in associated action plans. See our recommendation 20.

7.58 Serious incident reports and associated plans are overseen by the Quality Improvement Group. The duties of this group include:

- For reviewing the recommendations which arise from Serious Incidents*, and using the Quality and Safety Report to recommend necessary trust wide actions.
- The group will focus on clinical risk issues, raised by care and professional groups and highlighted through submitted reports.
- Learn from the Serious Incident reports of all homicides and 'near miss' homicides involving people known to the Trust and ensure that any lessons learned are disseminated within the Trust. To identify any trends arising from these incidents and take action as appropriate.
- To review national suicide data to determine trends and highlight differences.
- Promote safer practices through assisting in the implementation of service improvement related to the Quality and Safety Report.
- To promote a positive learning culture to ensure incidents are reported through the Trust Incident Reporting System by ensuring staff recognise improvements resulting from the use of the reporting system.
- Make recommendations to the Clinical Audit and Effectiveness Committee on audits required to enable audit to be used as a tool to confirm the implementation of changes when lessons are learnt from incidents.

7.59 In addition the Quality Committee receives reports and action plans for serious incidents in the cases of homicide. This committee also reviews and monitors the actions plans arising from independent inquiries.

7.60 On a quarterly basis the committee receives reports that consider trends and associated recommended actions.

Clinical Commissioning Group monitoring of action plan

7.61 Coastal West Sussex Clinical Commissioning Group was responsible for approving the internal investigation report and action plan, and monitoring progress of Trust actions.

7.62 The relevant documents in place at the time were:

- Policy and Procedures for all services commissioned by Coastal West Sussex Clinical Commissioning Group on the reporting of Patient Safety Incidents and Serious Incidents;
- Pan-Sussex Clinical Commissioning Groups - Serious Incidents Scrutiny Group Terms of Reference 2015/16;
- Sussex & East Surrey Serious Incidents submission and closure process;
- Contract Performance and Quality Review Meeting Terms of Reference (used in 2015/2016)

7.63 The policy covering the reporting of serious incidents states at paragraph 9.4:

"The Brighton and Hove CCG Patient Safety Team will monitor that investigations of serious incidents are completed and submitted to the pan Sussex Serious Incident Scrutiny Panel within the agreed timescale of 60 working days.

Request for extensions to report submission deadline will be considered, but the rationale for this must be clearly outlined e.g. new information relevant to the investigation that requires consideration and further investigation."

7.64 Paragraph 9.6 further clarifies:

"In the event of a formal request to suspend the investigation from the Police or Coroner, Commissioners can apply a 'Stop the clock' process. The date for completion of the investigation and submission of the final report will be reviewed and agreed once the investigation can be recommenced."

7.65 This policy describes the process for reviewing serious incidents reported by NHS commissioned providers. Specifically, that the pan Sussex Serious Incident Scrutiny Panel is responsible for ensuring that the relevant organisation has:

- identified a root cause to the incident;
- demonstrated that they have been open with the patient and/or relative;
- identified learning from the incident;
- developed recommendations to prevent recurrence with a robust action plan to demonstrate how the recommendations will be embedded in the organisation.

7.66 At 10.2 of the policy it states "Written feedback from the pan Sussex Serious Incident Scrutiny Panel will be provided to the relevant organisation".

7.67 In the case of the internal investigation into Mr W's care and treatment there was an active police investigation. This did not prevent the Trust from commencing their investigation, however it did impact on their ability to interview some key staff at the beginning of the investigation. We have seen evidence that the Trust requested extensions to the 60-day timeframe on:

- 7 October (83 days after the incident) – requesting an extension from 15 to 29 October because the internal investigators were due to meet with Mr W's family on 16 October and they wanted to ensure that any feedback was noted in their final report;
- 26 October (102 days after the incident) – requesting another extension to 13 November because there had been further contact with Mr W's family that needed to be included and additional work on the action plan was required;
- 12 November (119 days after the incident) – requesting a further extension to 27 November because new information had come to light and therefore further time was required to complete the report, and that an external panel member had to "comment and approve the report" but had not yet done so.

7.68 On each occasion the Clinical Commissioning Group approved the request for the extension. We have seen the final report submitted to StEIS[30] that indicates that report was closed by the commissioner on 20 April 2017 and the internal investigation report and action plan were submitted on 2 May 2017. We have asked for clarification of why the report was not closed until 2017 (but seemingly before receipt of the final internal investigation report and action plan were received) and received the following comments from the Clinical Commissioning Group:

- "10 June 2016 from [lead commissioner for Coastal West Sussex at the time]: not closed and has to come back to panel with completed/updated action plan";
- 9 December 2016 from [Patient Safety Officer, Brighton and Hove Clinical Commissioning Group] to [serious incident administrator at the Trust]: "they were waiting for the conclusion of the court case and are looking for an updated action plan, probably including any lessons that arose during the court case";
- March 2017 from the Trust: "this has been submitted previously however was not signed off as required an up to date action plan".

7.69 The final StEIS report that we have seen also indicates that in order to address national learning the "key learning points to be shared via Mental Health Nurse Directors Forum". We have clarified with the clinical

[30] *Strategic Executive Information System (StEIS) is NHS England's serious incident management system.*

commissioning group that the expectation was that this would be an action taken forward by the Trust and not the clinical commissioning group. We have therefore raised the issues with the Trust and understand that this action was not undertaken at the time. We believe that it is possible that the Executive Director of Nursing who was in post at the time, shared the learning in accordance with the action in the StEIS report, however we have been unable to access anything to evidence that this took place.

7.70 It is unclear why it took so long for the clinical commissioning group to close the report. The NHS England Serious Incident Framework states:

"Serious Incidents should be closed by the relevant commissioner when they are satisfied that the investigation report and action plan meets the required standard. Incidents can be closed before all actions are complete but there must be mechanisms in place for monitoring on-going implementation. This ensures that the fundamental purpose of investigation (i.e. to ensure that lessons can be learnt to prevent similar incidents recurring) is realised."

7.71 We asked Coastal West Sussex Clinical Commissioning Group to provide us with a copy of the feedback that was provided to the Trust (as per the requirement in the policy highlighted in paragraph 7.66 above). We were advised that at the time the "…panel didn't supply notes, and there was no patient safety team representative. The [Director of Nursing Safety and Standards for the Trust] was in attendance and took notes and comments directly from [Heads of Quality]". We therefore consider it is reasonable to determine that the clinical commissioning group provided no formal response to the Trust.

7.72 Coastal West Sussex Clinical Commissioning Group has told us that there is very limited documented evidence that reflects robust monitoring of the Trust's action plan. The organisation recognises that this is not satisfactory and is in the process of developing and implementing robust arrangements to ensure that this does not happen in future. Specifically the plans include staff working in the contracts team and the quality team working in a more collaborative way to support the contract, performance and quality review meetings with providers.

7.73 To summarise, in managing oversight of this serious incident the clinical commissioning groups did not wholly follow the NHS England Serious Incident Framework or their own policy. See Recommendation 19.

8 Discussion and analysis of Mr W's care and treatment

8.1 Our findings about the care and treatment provided to Mr W are broadly aligned with the findings of internal investigation team. It is our view that the care and treatment provided to Mr W was inconsistent and did not respond to his clinical need or level of risk.

8.2 Mr W is now being cared for by the Trust in a secure psychiatric hospital. Dr L, the forensic consultant psychiatrist responsible for Mr W's care and treatment, has made a diagnosis of paranoid schizophrenia. We did not meet with Dr L as part of this investigation, however we have seen some of his reports on Mr W. From these reports we can see that it is Dr L's opinion that "during childhood and adolescence, Mr W demonstrated some traits associated with an autistic spectrum disorder, but these were not to a degree that would meet the threshold for a full diagnosis". Dr L further reported that Mr W "presents as though he suffers from an Autistic Spectrum Disorder but this diagnosis requires the onset to be in childhood whereas Mr [W] does not appear to have developed these marked difficulties until his early adult life. It is likely these deficits in social communication which are unusually severe are a consequence of his schizophrenic illness".

8.3 It is the view of Dr L that Mr W's illness onset was when he was aged between 19 and 23 years old and that this onset "appears to have led to a gross exacerbation of autistic traits".

8.4 Dr L also notes that since Mr W's time in the secure unit it has become apparent that he is "an unreliable historian" and that as at July 2016 he had shown only a partial response to treatment.

8.5 We recognise that the views we have reported above have been formed after the death of Mr Lock, however we have referenced them here because it formed a line of questioning during our interviews with staff.

8.6 Our findings are broadly consistent with that of the internal investigation team, however we have identified nine themes that we explore in more detail below.

Diagnosis of autistic spectrum disorder/condition

8.7 The internal investigation team reported:

> "The formulation of Asperger's syndrome was developed based on MDT discussions and meetings with family members. There is no evidence that [the teams] had formalised this specific diagnosis assuming that a diagnosis of autistic spectrum disorder had been made by the specialist autistic spectrum disorder service…"

8.8 From our review of Mr W's records and interviews with staff who were responsible for his care and treatment, it is clear that no formal assessments were ever undertaken in order to inform the possible diagnosis of autistic spectrum disorder/condition. In January 2009 a referral was made to the autistic spectrum disorders/conditions service for "guidance about meeting Mr

W's needs after assessing whether he fits the criteria for Asperger's syndrome". There was never any assessment undertaken or diagnosis made and for reasons that we have been unable to identify, clinicians started to act as though Mr W had been assessed and diagnosis with autism.

8.9 Mr W was referred to the autistic spectrum disorders/conditions service twice; once in 2009 and again in 2011. Ms S told us that in 2011 she had a waiting list but that she would also prioritise any referral that seemed urgent. Ms S used the approach of screening referrals and if the client was known to the Trust she would use information already held on the electronic patient record to get a better picture. Specifically she would look for diagnostic and assessment information, however for reasons that are not clear, in the case of Mr W, Ms S did not take this approach.

8.10 Ms S recalled that in Mr W's case he did not want to be seen by her service initially (July 2011) but that later in October 2011 he did agree to attend an appointment with his parents. Ms S told us that she understood he had been given a diagnosis of autism spectrum condition by the early intervention psychiatrist and therefore she planned to undertake some psycho-educational work with Mr W; this meant helping him to understanding his diagnosis, put his behaviours into context and provide some help and guidance to his parents.

8.11 Ms S was clear that had she been aware that a full diagnostic assessment had not been undertaken she would have taken a very different approach with Mr W. This would have included a semi-structured diagnostic interview and obtaining an early developmental history.

8.12 There are two key documents that are relevant to services being provided:

- Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy – published by the Department of Health
- Autistic spectrum disorder in adults: diagnosis and management – published by the National Institute for Health and Clinical Excellence (NICE)

8.13 In March 2015 the government published new statutory guidance (that replaced existing guidance from 2010). The new guidance placed a legal responsibility on local councils and NHS organisations in implementing the Adult Autism Strategy. Of particular relevance is Section 2: Identification and diagnosis of autism in adults, leading to assessment of needs for relevant services. Paragraph 2.3 of this section states:

"A diagnosis represents the formal clinical confirmation of autism and the clear elimination of an alternative diagnostic explanation for an individual, based on all the available information – including patient experience, carer reports, direct observation and special interview schedules, to find out if characteristic behaviour was present during childhood and has continued to

adulthood. A diagnosis of autism is therefore usually made by a specially trained health professional, working as part of a multi-disciplinary team. For adults, this is most commonly led by a psychiatrist, or by a clinical psychologist, or speech and language therapists who also has had sufficient training and clinical experience in diagnosing a wide range of other mental and behavioural disorders frequently found in people with autism."

8.14 In June 2012 NICE published Clinical guidance 142: Autistic spectrum disorder in adults: diagnosis and management. This guidance sets out when identification and initial assessment of possible autism should be considered:

"Consider assessment for possible autism when a person has:

- one or more of the following:
  - persistent difficulties in social interaction
  - persistent difficulties in social communication
  - stereotypic (rigid and repetitive) behaviours, resistance to change or restricted interests, **and**
- one or more of the following:
- problems in obtaining or sustaining employment or education
- difficulties in initiating or sustaining social relationships
- previous or current contact with mental health or learning disability services
- a history of a neurodevelopmental condition (including learning disabilities and attention deficit hyperactivity disorder) or mental disorder."

8.15 The NICE guidance provides guidance on diagnostic processes and states that a "comprehensive assessment" should:

- Be undertaken by professionals who are trained and competent
- Be team-based and draw on a range of professions and skills
- Where possible involve a family member, partner, carer or other informant, or use documentary evidence (such as school reports) of current and past behaviour and early development.

8.16 Ms N told us that when Mr W returned to the care of her team (Early Intervention Team) in 2009 it was her impression that the diagnosis of autism had not been achieved. She recalled that several attempts to secure a proper assessment but that the service provided by the Trust at that point was "extremely limited". However she confirmed that if the question of autism had

never arisen the care and treatment Mr W received from her team would have been no different. Ms N was clear that the focus of her team's work with Mr W was on trying to work with Mr W so that he could understand his diagnosis of schizophrenia and engage with the team to successfully manage his treatment in an appropriate way. Ms N did tell us that she felt that as a team they had not been able to help Mr W to fully understand his difficulties.

8.17 Dr R's view was that when he saw Mr W his only symptom of psychosis was voice hearing and that he was "struck by the characteristics of an autistic spectrum condition", but that he was aware that it was sometimes difficult to differentiate between the causes of the presentation.

8.18 Whilst the teams responsible for Mr W's care and treatment had access to his family in order to obtain a detailed history, this was not done but a diagnosis of autistic spectrum disorder/condition was later recorded. At no point after this happened did any clinician responsible for Mr W's care and treatment attempt to read any assessment documents. Had they done so, the lack of said assessment would have become apparent.

8.19 Mr F told us that had he known that Mr W did not have autism it would have made a difference to how he and the rest of his team (community mental health team) managed Mr W. Mr F felt that there would probably have been more evidence that the incidents were related to psychosis, rather than a difficulty with social interaction. However it would not have changed his view about the appropriateness of a Mental Health Act assessment. We discuss this in more detail later on.

8.20 Mr J told us that the only difference in the care and treatment he provided to Mr W would have been that he (Mr J) would not have received the support from Ms S. Otherwise his presentation and behaviour would have been the same and it is these aspects that Mr J worked with.

8.21 The consequences of not undertaking a detailed assessment include an over-reliance upon behaviours reported by Mr W, his family and his girlfriend being attributed to an autism diagnosis.

8.22 It appears that clinicians believed that Mr W had autism with intermittent psychosis, but no assessment of autism was ever undertaken. Even if he did have autism, overlaid with psychosis, the team should have properly assessed and treated the psychosis as well as treating the symptoms of autism (anxiety).

8.23 The Trust has a service that responds to referrals from GPs and other Trust clinicians that provides a diagnostic service for adults with suspected autistic spectrum conditions. The service commissioned provides a limited offer to adults comprising a diagnostic assessment with the offer of some support sessions specifically aimed at helping adults to understand and manage their condition.

8.24 We have not reviewed this pathway in detail because he was not formally assessed. Although Mr W was referred to this service the diagnostic

assessment was not completed in Mr W's case because the clinician believed that the assessment had already been conducted.

Diagnosis and treatment of psychosis

8.25 The internal investigation team reported:

> "The team provided care to [Mr W] believed that the antipsychotic treatment that they provided to him for his psychosis had been ineffective. The review team could not find any evidence that the efficacy of treatment with medication had been assessed by close monitoring of medication compliance at a therapeutic dosage for any meaningful period of time. There was a lack of timely assessment to determine the impact of medication and the relationship between compliance and the severity of [Mr W's] symptom profile and risk"

8.26 The diagnosis of psychosis was present throughout Mr W's clinical records from 2008 onwards. In a document dated September 2009 the Trust recorded that:

> "…it is thought that [Mr W] has undergone a prolonged period of untreated psychosis and is not showing any signs of excepting [sic] pharmacological interventions…"

8.27 For long periods of time the team relied upon Mr W's parents' assessment of his mental state, without any direct professional assessment. We would have expected the team to make more assertive attempts to engage with Mr W and actively assess him. If he refused to engage, then the team should have made a judgement about whether the long-term impact of the risks of untreated psychosis outweighed the need for Mr W to remain in the community. This consideration should have been revisited on an ongoing basis and if the risks started to increase, or kept recurring, then the clinical decision should have been revisited. We provide further narrative on this aspect in the next section.

8.28 It is our view that Mr W was experiencing a relapsing/remitting course of psychosis. There is nothing in the Trust records to indicate that the early intervention team decided that he didn't have a psychotic illness, therefore the team must have at least highly suspected that Mr W had a psychotic illness. Given this we would expect to have seen proactive steps to try to engage with him more in order to undertake an assessment of his mental state.

8.29 Mr W was discharged from the early intervention in psychosis service after three years with no clear diagnosis.

8.30 Early intervention (in psychosis) teams were established to ensure that services were able to respond in a timely and appropriately focussed way when someone experiences psychosis for the first time. By minimising the time between onset of symptoms and the start of appropriate and effective treatment (commonly referred to as the duration of untreated psychosis, or

DUP), outcomes for individuals are markedly improved. Longer periods of untreated psychosis is associated with:

- Psychosocial decline
- Prolonged morbidity
- Increased treatment costs
- Worse course and outcome
- Increased duration of the acute phase

8.31 The NICE guidance on the management of schizophrenia, first published in March 2009 indicates that the following psychological and psychosocial interventions should be offered and started during the acute phase or later:

- Cognitive Behavioural Therapy;
- family intervention to families living with or in close contact with the service user;
- consider offering arts therapies;

8.32 Mr W was offered psychological therapy and it is recorded that he refused to take this up. However in May 2013 Mr W did indicate that he would like to engage in psychological therapy, but his referral to psychology was closed just ten days later.

8.33 Mr W was referred in 2008 and in late 2009 staff were still noting that the psychosis remained untreated. Psychological therapy was offered but not taken up and the view of staff was that to take an assertive approach to treatment would be counter-productive. It appears that this view was maintained throughout Mr W's time with the early intervention team and the community mental health team, a total period of six years.

8.34 Mr W was prescribed pregabalin on a number of occasions. Pregabalin can reduce anxiety in generalised anxiety disorder, and can be used as an adjunctive treatment in psychosis; it is not an antipsychotic medication. Therefore it will not help to address a psychotic illness; it will simply reduce any anxiety symptoms associated with the psychotic illness. The consequence of this treatment was that it simply extended the period of untreated psychosis, therefore increasing the harmful effects arising from an increased duration of untreated psychosis.

8.35 In June 2009 Dr E advised Mr T to offer Mr W the choice of aripiprazole, risperidone or quetiapine. These medications all have slightly different effects and we can find no evidence that these differing effects and associated side effects were properly explained to Mr W in order for him to make an informed decision. We can see no evidence that Mr W was provided with full information about the effects and side effects of these medications and therefore he would not have been in a position to make an informed decision.

8.36 Mr A told us that Mr W was "open, to a point, about the voices he heard, but he didn't want to talk in real depth about them". Mr A was clear that because

Mr W was not open he felt he needed to check what Mr W's reactions were to some of the voices. Therefore Mr A asked Mr W "will you respond if they tell you do to x?" to which Mr W said that he would not respond in any way. Despite this Mr A told us "it was always a concern and we never felt there were any guarantees that that was the case".

8.37 When Mr W was first transferred to Dr O's team in 2011, Dr O told us "what was clear was that he was diagnosed with a first episode psychosis…termed as a psychosis not otherwise specified". Dr O stated that it was his view that Mr W needed both medication, and "wider care and support" from the team which is why he asked for a care coordinator to be allocated.

8.38 Ms S was clear that if a client in their twenties had experienced an on-going psychosis since their mid or early teens, this would change their social interactions. Meaning that behaviours that could have been interpreted as autistic tendencies could actually be driven by psychosis.

8.39 Dr O told us that during the period November 2011 to June 2012 the focus was "more around anxiety because Mr W was not reporting psychotic symptoms at that time". However later on in November 2012 Dr O told us that his advice to the community mental health team was that Mr W's presentation was "a psychotic experience and needs to be dealt with by antipsychotics". Despite this and despite the view that Dr O held in early 2013 that Mr W would have agreed to an informal admission, this was not offered because he wanted to "get Mr W to comply with his medication in the community, because when he presented…, the risks weren't evident".

8.40 Dr O told us that he prescribed pregabalin in 2011/2012 in order to address the anxiety that Mr W had reported experiencing when he was in social situations.

8.41 Dr O told us that later in 2012 he gave advice to a specialty doctor and suggested that Mr W be prescribed olanzapine to help manage the symptoms of psychosis. Later still Dr O prescribed olanzapine as an 'as required' medication. In our opinion the use of 'as required' olanzapine to treat on-going psychosis (in Mr W's case) does not fit with best practice.

8.42 Mr W was frequently non compliant with his medication, most often not taking it at all, but on one occasion reportedly taking too much over a few days. Mr W reported inconsistent information to clinical staff about whether he was, or was not taking his medication. At various points and at time he reported different information to clinical staff about the same time period, but we can find no evidence that clinical staff identified and acted upon these discrepancies. Dr L, Mr W's current responsible clinician, has described Mr W as "a poor historian… likely to re-construct events to sustain a view of himself as virtuous and admirable". As we have indicated previously, we recognised that this view has been obtained since the offence was committed. We include this information here to highlight the fact that it is clear in the records prior to the offence that Mr W was inconsistent in his accounts and that staff were not sufficiently curious in understanding why this was, or in determining the true facts.

8.43 The Trust describes the view of team being that "the instances of assault related to morbid jealousy". Morbid jealousy is a form of psychosis and a dangerous condition that usually requires admission to hospital for assessment.

8.44 Mr W presented with hearing voices, risks of violence to others that were chronic and ongoing. An inpatient stay, earlier in Mr W's treatment pathway, would have been helpful to clarify his diagnosis and identify an appropriate treatment regime.

Use of the Mental Health Act

8.45 The internal investigation team reported:

> "The suitability of treatment in acute inpatient setting or in an acute community setting (CRHT) had not been considered by the team in the last three years of Mr W's treatment. SW 2 & 3 did not believe that [Mr W] would have met the criteria for detention under the Mental Health Act (MHA). However, the review team felt that this was poorly considered as both care co-ordinators (SW 2 & 3) failed to combine and collate previous risk information around risk to others in a cohesive risk assessment and risk management plan."

8.46 We share this view. We found no evidence that a reasonable assessment was undertaken in considering whether the use of the Mental Health Act could have been a useful tool to manage Mr W's psychosis. In light of his continuing difficulties, it is our opinion that Mr W did need a period of inpatient assessment to fully understand the frequency and severity of his periods of psychosis.

8.47 Given that the teams had been unable to conduct an adequate community assessment, best practice is to offer an informal inpatient assessment. This was never offered. Had this been done and Mr W had refused, then staff could have formally considered use of the Mental Health Act and made a decision about detention. In addition non compliance with treatment is one of the criteria for detention under the Mental Health Act.

8.48 It is well documented that a diagnosis of autism is not a reason to exclude admission to an inpatient unit simply because of the autism diagnosis.

8.49 Recommendation 12 deals with this issue.

8.50 At interview we asked staff responsible for Mr W's care and treatment whether they had considered use of the Mental Health Act but not documented it. All said that they had not. We also asked staff whether, if Mr W had not had a diagnosis of autism, their view about the appropriateness of the use of the Mental Health Act in Mr W's treatment would be different. Even with the benefit of hindsight, nearly all said that it would not.

8.51 Ms N told us that she felt the team had exhausted virtually all routes with Mr W, with the exception of a Mental Health Act Assessment and that things might have been different if they had considered this early on. However,

Ms N was clear that at no point did any member of staff in the Worthing early intervention team feel that a Mental Health Act assessment was needed and was overruled.

8.52 Ms N felt that Mr W was probably someone who would have benefitted from input from the assertive outreach team, but he didn't meet the criteria, as he had never been admitted to a psychiatric ward.

8.53 Dr E told us that he had worked in an assertive outreach team and that in 2009 Mr W would have been a long way off the threshold for being taken onto the caseload of an assertive outreach team. In May 2009 the Mental Health Act was not explicitly considered despite Mr W being so thought disordered that Dr E was unable to conduct a proper assessment.

8.54 This concerns us greatly. Over a number of months staff received reports of Mr W threatening a family friend with a hammer; attacking a stranger as he got off a bus; attacking a customer in the café where his girlfriend worked; repeated episodes of domestic violence. All of these actions should have caused significant concern and generated discussion about whether Mr W's treatment plan was effective. A more assertive approach should have been taken but this did not happen, despite pleas from Mr W's family to consider this.

8.55 We asked Dr O, if Mr W didn't have autism, what would have been different in the way he managed Mr W's care and treatment. Dr O told us that he didn't think the approach would have been different, "he would have received the same treatment or care and the same amount of discussions around whether he needed care under the Mental Health Act…I don't think that would have changed in any sense".

8.56 In October 2012, November 2013 and March 2014 Mr W's care coordinator specifically recorded that it was his view that Mr W's antisocial behaviour was a matter for the police and the criminal justice system and was not an issue that would respond to medication. On these occasions the care coordinator said that Mr W would not have been detainable under the Mental Health Act. We have found no evidence of a team discussion that led to this conclusion. Additionally, at those times it was unclear whether Mr W was actually taking any medication so it would have been impossible for any member of staff to have stated with certainty what effect medication would have had on Mr W's presentation.

8.57 Dr O told us in 2014 Mr W's behaviour worsened and that the information received at that time did change the team's view about Mental Health Act assessment, medication and other treatments. Dr O told us that the team discussed use of the Mental Health Act but that there was a united view that they could get Mr W to comply with his medication. This was echoed by Mr F who told us that when the team discussed Mr W there were no conflicting views.

8.58 By this time various teams had been trying for six years to get Mr W to comply with his medication and to date it had not been successful. There is nothing

in the records at that time that indicate a significant change in Mr W's willingness to cooperate with clinical staff.

8.59 Mr F told us that following the multi-agency (level two) risk assessment meeting in 2014 there was a discussion about a Mental Health Act assessment but the "team and Dr O" felt that the criteria were not met and it was Mr F's view that Mr W would not have agreed to an informal admission and therefore "it could not have been explored".

8.60 Even in the two days prior to the death of Mr Lock, Trust staff were alerted to Mr W assaulting his girlfriend, being non-compliant with his medication, concerns about his driving and taking reckless decisions. The Trust had opportunity to undertake an urgent clinical discussion and review and to instigate a Mental Health Act assessment.

8.61 Dr O told us that he believed that Mr W would have agreed to an informal admission but that it was never offered to Mr W. Dr O's reason for this was that at that point the team was focussed on getting Mr W to comply with his medication in the community. Dr O also told us that the risks were not "evident" when Mr W presented to the team and that the information the team received was more "retrospective".

8.62 This was a lost opportunity with serious and tragic consequences for Mr W, Mr Lock and the families of both men.

Communication with Mr W's family

8.63 Although they were separated Mr W's parents, Mr Y and Mrs Y, were very proactively involved in supporting Mr W and made frequent contact with the various care coordinators. We have seen evidence that on several occasions Mr Y wrote to Dr O to express his concern about the treatment plan for Mr W and to ask Dr O to consider alternative treatment pathways. Mr Y only received one written response from Dr O (12 March 2012) and that was to state that he was unable to share any information with Mr Y because Mr W had "consistently refused permission to contact [Mr Y] or [Mrs Y]".

8.64 Dr O asserts that "the response to a letter need not take the form of a written response" and that when he received Mr Y's letter of September 2013 he (Dr O) believes that he spoke with the care coordinator to ask him to liaise with Mr Y to arrange an outpatient appointment for Mr W. We can find no evidence that the subsequent meeting on 5 November between the care coordinator (Mr F), Mr W and Mr Y was in any way a response to the request that Dr O believes he made. The subsequent meeting (on 14 November) between Dr O and Mr and Mrs Y had already been arranged at the time that Mr Y had written his letter and did not deal with Mr Y's request for a separate, earlier meeting with Dr O.

8.65 Mr W's consent to share information with his parents fluctuated greatly. At times he was very happy for his parents to be involved, at other times he tried to keep them at arm's length and was reluctant to share any information with his care team in the presence of his parents. Given this pattern, it would have

been appropriate for the care team to check and formally record Mr W's consent at regular intervals.

8.66 However, regardless of the status of Mr W's consent at any given time, Dr O should have given Mr W's parents (and Mr Y in particular) time to share their views about Mr W's presentation and to hear their experiences of Mr W's behaviour over long periods of time, rather than the hour or so that Dr O assessed Mr W in clinic. Had Dr O taken this approach, and recorded the information received, it is possible that the care team may have considered Mr W's risk differently.

8.67 Whilst the level of engagement with Mr and Mrs Y by care coordinators was very high, the lack of face-to-face contact with Mr W meant that Trust staff meant that this was the only information they had at times. It is possible that when Mr or Mrs Y reported things as "going well" or "going okay", it may not have been the view of the other parent at that time.

Consideration of risks

8.68 Mr W was frequently threatening or violent towards his family, girlfriend, family friends and members of the public.

8.69 Mr W's risks to his mother included:

- throwing a glass at her in January 2009;
- throwing hot tea over her in June 2009;
- burning her belongings in September 2009;
- throwing a vase at her in September 2010;
- regularly threatening her;
- regularly being verbally abusive.

8.70 Mrs Y had cause to call the police to intervene in Mr W's threatening behaviour towards her on three occasions: January 2009, June 2009 and September 2010. Mrs Y also sometimes made calls to Mr Y to provide help and support to manage Mr W's behaviour.

8.71 Mr W's risks to his father were less obvious and there is little evidence of Mr W being particularly abusive. However Mr W had a greater tendency to withdraw from Mr Y's support and would withhold information from him. This appears to have been an alternative management strategy on Mr W's part, usually at the point at which Mr Y's desire to help and support his son was seen as too intrusive by Mr W.

8.72 Mr W's girlfriend reported abusive and violent behaviour towards her on a number of occasions. There was a MARAC referral in 2014 however the response by the clinical team to the outcome of the meeting was limited to informing the police if they became aware of any further abuse or assaults. There is little evidence that the Trust assertively managed the risk that Mr W presented to his girlfriend.

8.73 At the time of the multi-agency meeting in April 2014, it is reported that the only incident the police had on record was when they were called to deal with the attack involving a hammer in June 2012. There was no mention of them being called to Mrs Y's property in June 2009 or September 2010, or indeed the fight at the pub in March 2014. We have not seen the police records so are unable to clarify whether this report is correct.

8.74 A risk assessment dated 15 April 2015 stated that Mr W had not taken antipsychotic medication for the previous year, despite telling his care team that he had been doing so. An update noted on the same date stated that Mr W was compliant with his medication. There appears to have been no consideration of how much validity the care team was placing on the information being reported by Mr W. The safety plan within the risk assessment stated:

"…may be detained at some point by the police due to his recurrent violent incidents with members of the public….stronger case is slowly building up for assessing [Mr W] under the MHA [Mental Health Act] if the problems in the community continue escalating."

8.75 This statement was present in the risk assessments completed in April 2015, November 2014, June 2014 and January 2014 and should have prompted a multi-disciplinary clinical discussion. It is clear from staff interviews that the clinical team felt there was no place for the use of the Mental Health Act in managing Mr W's treatment.

8.76 A risk assessment completed in April 2010 stated:

"…more assertive attempts at treating [Mr W], for instance, use of the Mental Health Act, would result in future engagement and support being even more unlikely though this would need to be considered if his mental state appears to be deteriorating."

8.77 Despite this statement, and despite the community mental health team being advised by Mr A (Mr W's care coordinator from the early intervention team) that it appeared Mr W's presentation was deteriorating, use of the Mental Health Act was not actively considered.

8.78 In March 2014 Mr F noted a conversation that had taken place with Dr O, in which Dr O had been of the view that a Level 2 risk assessment should be completed, and that the police should be involved in the risk assessment discussion. The Trust policy in place at the time covering clinical risk assessment identifies a Level 2 risk assessment as being required when service users have "identified high risk behaviours requiring further assessment to ensure effective management". A Level 2 risk assessment requires that a multi-disciplinary review of the service user's risks be undertaken. A multi-disciplinary meeting was held on 28 April however we can find no evidence that such a risk assessment was ever completed. The agreed plan from that meeting was that Trust staff and Mr W's family would report any violent incidents to the police and the police agreed to place a 'tag' on Mr W's property so that other officers were aware of Mr W's history should

they be called to his address. None of these actions addressed Mr W's clinical risk and there was no change to the clinical plan at that point. It appears that his risk to others was seen as separate to his mental illness.

The Clinical Risk Assessment and Risk Management Safety Planning Policy in place at the time states that risk assessments

"…must be reviewed whenever there is new information, or a change in clinical presentation or circumstances. This includes:

- admission, discharge or leave for a detained patient from inpatient care;
- transition between services or for onward referral;
- change of lead practitioner or other key staffing change;
- significant life changes or events;
- change in clinical presentation".

8.79 We do not consider that the actions taken by the clinical team properly executed the expectations outlined in the policy.

8.80 Mr F told us that he found working with Mr W "quite challenging, dealing with the gravity of the violence episodes and how to manage them". We discussed with Mr F whether he had considered an assertive outreach approach for Mr W, however Mr F said that Mr W would not have met the criteria at any point and it therefore had not been in his consideration.

8.81 Following the multi-agency (level two) risk assessment meeting held in 2014 Trust staff agreed with the police that the family and clinical staff would forward any reports of violence to the police, and would encourage Mr W's family to do the same. Mr F told us that there was also an agreement about the police sharing information with clinical staff so that both agencies would have a clear picture. We asked what difference this risk management plan made to the level of information the Trust had about Mr W's violence. Mr F told us that it made little difference because the only incident the police had recorded was the incident with the hammer two years previously.

8.82 We asked Mr F about how Mr W responded when he discussed the issue of using sex workers. Mr F told us that he did not discuss the issue with Mr W because he had received the information in confidence from Mr W's girlfriend and Mr F did not want to "antagonise things with her". Mr F was clear that he felt he couldn't "betray" Mr W's girlfriend and it appears he did not consider the fact that Mr W was a vulnerable adult who was often placing himself in a risky situation.

8.83 Mr J took over as care coordinator from Mr F, but had been working in the same team beforehand. We asked whether Mr J recalled any team discussions about Mr W's care and treatment, but he said he could not recall

any. Mr J told us that he did not take Mr W's case to a team discussion whilst he was care coordinator, however he did take him forward to a case formulation discussion to try to identify a better way to work with him. Mr J clarified that case formulation is not a team meeting, but organised separately, and that relevant clinicians who can contribute are invited. Mr J told us that he invited Dr O to the meeting, but he wasn't available, so those present were Ms S, the autism practitioner and Ms L, a psychologist.

Gaps in care and treatment and non attendance at appointments

8.84 Mr W had no contact with services between June 2008 and January 2009. Just prior to this gap in care and treatment, Mr W's mother had contacted the early intervention team to report concerns about Mr W's presentation and to seek advice about how to discuss managing it with him. Following this telephone call Mr W's care coordinator (Mr I) attempted to visit Mr W at home. Mr W was not home so Mr I arranged to see him the following week.

8.85 There is no plan going forward and there are no more entries for more than six months. Given that Mr W was under the care of an early intervention in psychosis team we would have expected to see a period of active watchful waiting as a minimum. We accept there is a balance between attempts to engage a client and harassment, however there were no attempts to conduct an assessment between June 2008 and January 2009, despite concerns being raised by Mrs Y in June 2008. It is our view that this was not sufficient or appropriate.

8.86 In November 2009 Mr W told the early intervention service that he no longer wanted to engage with them and asked that all contact with him and his family should stop. The team did cease contact with Mr W but continued to remain in contact with Mr Y and Mrs Y. A month later Mrs Y reported that she remained fearful of Mr W and his potential to explode. Similar reports continued throughout January, February, March, April, May, July, and August. However Mr W had no contact with the team during this time. Although staff continued to maintain contact only with Mr W's parents, Mr W was not seen for an appointment until September 2010 – nearly ten months after staff last saw him face to face. During this period of time both Mrs Y and Mr Y had contacted staff to express concerns about Mr W's wellbeing and behaviour.

8.87 There were similar gaps in contact by staff between June and November 2013 and again in March 2014, a time when Mr Y again emailed Dr O expressing concern about Mr W's unprovoked attacks on members of the public and fear that a fatal incident would happen unless Mr W received appropriate help.

8.88 During the period January 2008 to July 2015 (seven and a half years, or 90 months) it appears that Mr W did not attend appointments with the Trust on 17 occasions. It is reassuring to us that at no point did the Trust attempt to discharge him from services as a result of these non-attendances.

8.89 The Active Engagement incorporating Did Not Attend (DNA) Policy and Procedure (Replaces Policy Number Clinical 179) is incomplete and under review. It is our understanding that this policy is being reviewed in response

to a recommendation made by an independent investigation. The relevant investigation report was published in 2013 and in the follow up review completed in March 2016 the reviewer was informed that the project to complete the policy review was underway. It is of concern to us that it appears that this work is still not completed two years later.

8.90 However, the policy states that "if a person does not attend an appointment the professional involved must make a decision about what to do". That decision must be based on all of the evidence available and must consider the risk the person may post to themselves or others and the right of the person to refuse to see the professional. The policy further clarifies that in making this judgement the professional must "consider whether they are competent to make this decision alone or if they need to refer to their supervisor and/or other members of the multi-disciplinary team".

8.91 The policy also refers to persistent non-engagement and clarifies that every effort should be made to engage with service users and their families and that it must be recognised that any person who has capacity and whose mental illness does not warrant detention under the Mental Health Act has the right to refuse mental health services.

8.92 On the basis that the clinical team did not consider that Mr W met the criteria for detention under the Mental Health Act, we consider that the team was compliant with the policy regarding non-engagement. However we do not consider that the team properly assessed whether Mr W met the criteria for detention and we deal with this in paragraphs 8.45 to 8.62.

Transfer of care between Trust services

8.93 Mr W's care and treatment was formally transferred between services on the following occasions:

- 2008 – to Brighton early intervention team;
- 2009 – to Worthing early intervention team;
- 2011 – to Dr O's specialist clinic and co-worked with a community mental health team care coordinator

8.94 The Care Programme Approach policy details the actions to be taken when transferring responsibility for a client's care to another Trust team. The policy sets out the minimum information that should be provided by the transferring team and states:

"In order to comply with these information requirements, fully completed CPA documentation (see Appendix 8) comprising of assessment, risk assessment, care plan and review summary documentation should be sent to the receiving team within 5 working days of the review meeting at which the decision to transfer was agreed."

8.95 We can see that this was done in the case of transfer in 2008, however no up to date care plans or risk assessments were completed in 2009.

Safeguarding concerns

8.96 The Trust were aware of two referrals relating to safeguarding concerns; one concerning Mr W as a victim (the Safeguarding Vulnerable Adults referral) and one concerning Mr W as a perpetrator (the MARAC referral).

8.97 Staff from MyKey made the Safeguarding Vulnerable Adults referral in November 2013. The focus of their concerns were financial and physical/emotional:

- that (in their view) Mr W's girlfriend was inappropriately claiming carer's allowance, thereby depriving Mr W of the opportunity to claim additional benefits for himself;
- in addition to Mr W's girlfriend receiving carer's allowance, Mr W would give her £50 per week and pay for their horse riding sessions every month.

8.98 There is no indication that the alert resulted in a safeguarding strategy meeting. Follow up email communication between MyKey staff and Mr F indicated that Mr W's girlfriend was considered a positive influence in supporting Mr W to budget properly.

8.99 The MARAC referral was made and a meeting held in July 2014. The concerns were that Mr W had been verbally abusive towards his girlfriend throughout their relationship, he was excessively jealous and constantly put her down. Mr W's girlfriend reported that she was feeling increasingly isolated and had recently given up her job. She had recently discovered that Mr W was having sex with prostitutes and that Mr W had been putting "constant pressure" on her for sex, and had even offered to pay her for more regular sex. It was reported that Mr W's girlfriend had tried to end the relationship six times but that each time Mr W harassed her and pressurised her to resume the relationship and he continued to send her sexually explicit text messages.

8.100 The actions agreed from the meeting were:

- Trust staff to discuss boundaries and consequences of his actions with Mr W;
- WORTH staff to encourage Mr W's girlfriend to report incidents in order to set boundaries for Mr W;
- on-going support to be available to Mr W's girlfriend from WORTH;
- on-going support to be available to Mr W from mental health services.

8.101 When there were further concerns about Mr W's behaviour towards his girlfriend the MARAC action plan was sometimes referenced by staff, but the response was not consistent and at times staff did not take immediate action to inform police. The Operating Protocol for the West Sussex Multi-Agency Risk Assessment Conference (MARAC) for high risk victims of domestic abuse defines domestic abuse as:

"any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have

been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, and emotional."

8.102 The same document states that Sussex Police data from 2010 indicated that 74% of repeat victims had experienced three or more acts of domestic violence in the previous year. It appears from the information within Mr W's clinical records that his girlfriend experienced at least three acts in a twelve-month period. The operating protocol clearly states that the responsibility to take appropriate action rests with individual agencies and no responsibility is transferred to the MARAC. The role of the MARAC is to "facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety".

8.103 The operating protocol states that a summary of actions agreed at a MARAC meeting will be circulated within one working day of the meeting and minutes will be circulated within two working days. We have not been able to identify at what point the MARAC notes were circulated, however they are present in the clinical records. It is unclear to us why the Trust was not able to access actions and minutes from the meeting held on 3 July 2014 when conducting the internal investigation and liaising with Mr Y, particularly as Mr E had reviewed the action plan in order to determine relevant actions in July 2015.

8.104 There is no indication that clinical staff fully considered the risks that Mr W could pose to:

- the children he was responsible for whilst working as a lifeguard;
- the teenagers he invited into his flat;
- his girlfriend's teenage daughter.

8.105 Neither is there any indication that clinical staff fully considered the risks that Mr W could have been in as a vulnerable adult by inviting teenagers into his home.

Notifying the DVLA

8.106 One of the concerns raised by Mr Lock's family was that of notification to the DVLA of Mr W's diagnosis and medication (olanzapine). We have seen documentary evidence and heard from Dr O that the DVLA were notified.

8.107 On 7 October 2014 Mr J identified that Mr W should not be driving if he was taking olanzapine. Mr J told us that a discussion arose with Mr W about him continuing to drive whilst taking olanzapine. Mr J then discussed the issue with Dr O and raised the concern that Mr W needed to inform the DVLA. Mr J told us that the reason for this was that the olanzapine could impact on Mr W's ability to drive. However Mr J told us he had no cause for concern about Mr W's safety whilst driving.

8.108 Mr J suspended the request for Mr W's GP to prescribe the medication whilst he sought advice from Dr O. Dr O's advice was that the prescription could be

written out provided that staff were clear with Mr W about the associated risks as regards to driving. Dr O also indicated that Mr W should be advised to inform the DVLA.

8.109 Mr W did indeed inform the DVLA of his diagnoses of Asperger's and psychotic disorder, and the medication he was being prescribed. Mr W later reported that the DVLA had contacted him to ask some supplementary questions.

8.110 On 14 January 2015 the DVLA wrote to Dr O asking him to complete a medical questionnaire relating to Mr W. Dr O completed the form and indicated that it was his view that Mr W was sufficiently well and stable to drive and had been so for one year. In the year prior to Dr O indicating this view Mr W had:

- January – been sexually abusive towards his girlfriend;
- February – reported that he had not been compliant with the prescription for aripiprazole and had refused to take any other medication;
- March – assaulted a member of the public in his girlfriend's workplace;
- April – stated he did not want the police to be informed of his aggressive behaviour;
- May – reported to his girlfriend that he had "almost killed" people that he had assaulted. His girlfriend reported that the voices were "driving him over the edge". Mr W accused his girlfriend of being a prostitute and said that he wanted her to die;
- June – reported that men from the working men's club were outside his flat smoking and laughing at him;
- July – attended A&E complaining of paranoid delusions and reported to be hearing voices;
- September – threatened his brother and was later seen at A&E where he was given 11 days' supply of olanzapine;
- October – described an incident where a car was following him closely and getting frustrated with him, and described children outside his flat shouting his name;
- November – been unable to manage his finances, presented with fixed ideas and poor engagement with services;
- December – told staff he avoided going into town because he "typically gets into arguments", was not available for planned appointments with his care coordinator.

8.111 We acknowledge that there is no clinical definition of "stable" in terms of mental health. However it is most reasonably used to convey that someone has reached a point where the plan is clear, is being adhered to and risks are minimised or being clearly addressed without significant flare ups. We fail to see how any such view or label could be applied to Mr W at that time, given the known events in the preceding year. It may well be that Dr O did not feel

that detention under the Mental Health Act was appropriate during that time, however that is very different to describing a client as stable.

8.112 Dr O advised that Mr W was being prescribed olanzapine 10mg 'as required' and that Mr W did not want to take this regularly and that Mr W was adequately engaged with treatment.

8.113 Dr O indicated that Mr W did not "continue to experience hallucinations/ delusions likely to distract attention from driving" but noted that Mr W regularly experienced auditory hallucinations and had done so for three years. Dr O noted "they have not had an impact on behaviours such as self care, instructions or aggression". This statement was not supported by the very many entries in Mr W's clinical record by Dr O's colleagues. Dr O had access to those entries, and had received reports directly from Mr W about his aggression.

8.114 Indeed Dr O himself told us that he believed that Mr W's aggressive behaviours were directly related to his psychosis. Dr O later asserted that this belief (that the aggressive behaviours were directly related to Mr W's psychosis) was "affected by the benefit of hindsight and it is with hindsight that [Dr O] attributes the episodes more directly to the psychosis". Regardless of the cause of Mr W's "episodes", the behaviours were present, had been noted in Mr W's clinical record and were therefore known.

8.115 We therefore do not accept that Dr O's report to the DVLA accurately reflected the known facts at the time the report was written.

8.116 We have not seen any further correspondence between Dr O and the DVLA, or the DVLA and Mr W.

8.117 Dr O's response to the DVLA was not a full and accurate picture of Mr W's presentation over the stated time period. We cannot say whether a more full response would have resulted in a different decision by the DVLA regarding the status of Mr W's driving licence, but the DVLA would at least have been in receipt of all the salient facts.

8.118 The DVLA guidance on medical standards of fitness to drive in place at the time indicated that when a client presented with a psychotic disorder in an acute phase the DVLA should be notified and the client should "cease driving during acute illness". The client "can be licensed if he/she has remained well and stable for ≥3 months, if necessary criteria met".

8.119 The same DVLA guidance indicated that when a client presented with a chronic psychotic disorder the DVLA should again be notified and the client should cease driving unless they have had "stable behaviour for ≥3 months, adequate treatment adherence and no adverse effects of medication (subject to favourable specialist report)".

8.120 The DVLA guidance has since been updated and now includes guidance for pervasive developmental disorders including Asperger's disorder, autistic spectrum disorders and severe communication disorders.

Other driving concerns

8.121 The day before Mr Lock's death (15 July 2015) Mrs Y informed Mr E of concerns she had that Mr W was driving whilst drunk. Mr E recorded that he would advise the police of the situation and obtain the registration number of the car Mr W was driving. We can see no evidence that the police were informed of this information. It was only after Mrs Y contacted Mr E on 17 July that Mr E informed the police of the information of Mr W's whereabouts and his behaviour towards his girlfriend.

8.122 It is entirely reasonable that Mr E sought advice from his manager (Mr R) about what action to take regarding Mr W's behaviour towards his girlfriend; however there is nothing in the records to indicate that there was any discussion about the drink driving concerns.

8.123 Mr E should have escalated this in his discussion with Mr R and the police should have been contacted that day.

9 Conclusions and recommendations

9.1 Mr W had been under the care of the Trust for more than seven years at the time of Mr Lock's death. During that period of time he was under the care of a number of different teams including two early intervention in psychosis teams and a community mental health team.

9.2 Trust staff did make efforts to engage Mr W. However because the Trust had failed to undertake robust assessments in relation to psychosis and autism, this led to a flawed set of assumptions about how to manage Mr W.

9.3 Added to this staff considered his violent behaviours as matters for the criminal justice system, and not directly related to Mr W's mental illness. This position denied Mr W the opportunity to receive appropriate treatment and consequently resulted in Mr W's behaviours gradually escalating over time.

9.4 All mental health care and treatment should be based upon a robust assessment in accordance with best practice and NICE guidelines. The root cause of this incident lies in the Trust's failure to ensure that this was implemented in Mr W's case.

9.5 As we have stated earlier, given the teams had been unable to conduct an adequate community assessment, best practice is to offer an informal assessment. This was never done. We can see one occasion when staff considered a referral to the crisis team (June 2012) but there are no other records of a discussion where inpatient treatment was considered by the multi-disciplinary team.

9.6 As part of our terms of reference we have been asked to consider whether this incident could have been predictable or preventable.

Predictability

9.7 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[31] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[32]

9.8 Trust staff had received information over a long period of time about Mr W's threats and assaults towards his girlfriend, a family friend, and members of the public. The level of Mr W's risk behaviour showed a step-wise progression from verbal abuse, smashing objects, targeting others' belongings, to the point where he was getting into fights with people who were not known to him. Once Mr W was harming others the risk of killing someone was increased.

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[31] *http://dictionary.reference.com/browse/predictability*

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

9.9 Each time one of these escalation thresholds is breached, it is more likely that the individual will breach the next threshold. It is our opinion that had the clinical team undertaken a full review of Mr W's presentation over time his risks would have become more apparent to staff.

9.10 We recognise that the clinical team appeared to hold the view that Mr W's violence was not attributable to his psychosis, and should have been dealt with by the police.

9.11 On 14 July, just two days before Mr W killed Mr Lock, Mr W's mother called his care coordinator reporting that Mr W had again been threatening his girlfriend and pressuring her to have sex. Mr W's mother also reported that Mr W had stopped taking his medication because of the negative side effects. Finally, Mr W's mother reported that she was concerned that Mr W had been drink driving.

9.12 In response, two days later the care coordinator spoke to his manager regarding the risk to Mr W's girlfriend. It was determined that the information should be shared with WORTH, rather than reported to the police directly. It appears that this decision was taken because Mr W's girlfriend was not a service user of the Trust.

9.13 It is our view that there was clear evidence that Mr W's levels of violence had increased such that serious harm to others was increasingly likely. However we acknowledge that staff could not have predicted that Mr W would have killed Mr Lock in the way that he did in July 2015.

Preventability

9.14 Prevention[33] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

9.15 There were missed opportunities to engage Mr W in active, effective therapy. Mr W did not accept robust community assessment or treatment and it is therefore our opinion that admission to hospital should have formed part of Mr W's treatment programme, where his medication could have been titrated.

9.16 In the period of time leading up to the incident he was not being offered effective treatment for the management of his psychosis. We recognise that the clinical team was proactively trying to maintain contact, however they were not proactively trying to initiate interventions to manage his presentation. The clinical team were not sure whether they were treating autism or psychosis and the result was that neither condition was treated effectively.

9.17 Adequate treatment of Mr W's psychosis was never implemented. Had this been done it would have significantly reduced all of the psychosis-related risks to himself and other people. Most people with psychosis, treated

[33] http://www.thefreedictionary.com/prevent

effectively, are less likely to get into relapse and therefore less likely to get into situations that are dangerous to themselves or others. A diagnosis of autism is not a reason for under-treating psychosis, which is what we consider to have been the case for Mr W.

9.18 The view held by the team was that Mr W's violent episodes were not as a consequence of psychosis and attributed it to his autism, citing that Mr W would end up in prison if he continued behaving as he was.

9.19 It is our view that had Mr W been in receipt of effective therapy starting at any stage between 2008 and 2015 the tragic death of Mr Lock may have been avoided.

Recommendations

9.20 This independent investigation has made 20 recommendations for the Trust to address in order to further improve learning from this event. We have also made one recommendation for the Clinical Commissioning Group.

9.21 The recommendations have been given one of three levels of priority:

- **Priority One:** the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.
- **Priority Two:** the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients, but identifies important improvement in the delivery of care required.
- **Priority Three:** the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Priority One

Recommendation 4

The Trust must ensure that the effectiveness of the training in dual diagnosis of psychosis and autism is assessed and monitored.

Recommendation 6

The Trust must seek further assurance that the liaison between stand-alone specialist consultants and teams responsible for the care coordination of clients has sufficiently mitigated the risk of the more remote way of working.

Recommendation 7

The Trust must assure itself and its commissioner that when investigations into concerns about medical staff are commissioned, the Trust policy is followed.

Recommendation 9

The Trust must undertake an audit of all clients with a diagnosis of autism to ensure that appropriate evidence is present to support the diagnosis. Where the required evidence is not present appropriate remedial action must be taken.

Recommendation 11

The Trust must ensure that processes are in place for effective multi-disciplinary review of clients who present with recurring or escalating risks.

Recommendation 12

The Trust must ensure that the benefits of informal admission are properly considered and documented. If a client is not compliant with their treatment plan consideration is given and documented for assessment under the Mental Health Act.

Recommendation 14

The Trust must ensure that a documented multi-disciplinary discussion takes place when there has been no face to face contact with a client for more than six months.

Recommendation 15

The Trust must properly consider and document risks, and take appropriate actions where children and young people are having contact with a vulnerable adult.

Recommendation 16

The Trust must ensure that actions from a MARAC are clearly recorded in relevant clinical records so that all staff can take appropriate and timely action where necessary.

Recommendation 17

The Trust must ensure that information provided to the DVLA is complete, follows the DVLA guidance, and adequately represents all the available information available about the client including multidisciplinary records.

Recommendation 18

When staff are in receipt of information about a possible offence the Trust must ensure that there is a process for relevant information to be shared with police in a timely fashion and that staff follow the relevant risk assessment policy.

Recommendation 19

When managing the oversight of serious incidents, the Clinical Commissioning Groups must ensure that their own policies are fit for purpose and that relevant staff understand and adhere to those policies. The Clinical Commissioning Groups must also ensure that the effectiveness of new arrangements is monitored and that appropriate responses are in place to remedy non-compliance.

Priority Two

Recommendation 1

The Trust must ensure that communications with families use plain English and that when information cannot be provided there is an honest and clear rationale.

Recommendation 2

The Trust must ensure that there is a defined process for ensuring that the Family Liaison Lead keeps affected parties up to date regarding progress of serious incident investigations.

Recommendation 5

The Trust must gain assurance that the appointment of the carer lead in Coastal West Sussex is making a difference to carers.

Recommendation 10

The Trust must ensure that proper consideration is given and information provided when suggesting medication to clients.

Recommendation 13

The Trust must ensure that communication from families is logged appropriately and that a timely response is given. The Trust must also ensure that information is given to carers indicating what other routes are available to them if they are not satisfied that their concerns are being taken seriously.

Recommendation 20

The Trust must ensure that all recommendations presented in a serious incident report are reflected in the associated action plan. The Trust must also ensure that if additional recommendations not presented in the serious incident report are added to the action plan there is a clearly stated rationale.

Recommendation 21

The Trust must assure itself and commissioners that all actions within serious incident reports and associated action plans are completed within an appropriate timeframe.

Priority Three

Recommendation 3

The Trust must assess the effectiveness of the peer review process and make any necessary adjustments if the effectiveness is unsatisfactory.

Recommendation 8

The Trust must ensure that guidance is in place for staff completing serious incident investigation reports that they use plain English and that the templates include section numbering, page numbering and a table of contents.

Good practice

9.22 Clinical entries made by care coordinators were very detailed and provided a significant amount of information about the content of interactions with Mr W, his parents and his girlfriend.

9.23 The Trust has developed a process to prepare and support staff who are required to provide evidence to independent investigations. This has been developed in response to a criticism in an earlier (but not yet published) investigation. The process has been described and is shared with staff in a briefing meeting prior to their interview with the independent team. Staff are also offered the opportunity for a de-briefing meeting once all the interviews have taken place.

9.24 The Trust has introduced a new role of Family Liaison Lead. This new role aims to provide additional support to affected families and carers following a significant serious incident such as a homicide, inpatient suicide or where someone has very complex care needs. This role is provided in addition to the allocation of a serious incident investigation team. This is the first time we have encountered this approach and it is to be commended. We have shared high-level information about this new role with another NHS Trust that has already expressed interest in developing a similar role.

Appendix A - Terms of reference

Purpose of the investigation

1. To identify whether there were any gaps, deficiencies or omissions in the care and treatment that [Mr W] received, which could have predicted or prevented the incident on 16th July 2015.
2. The investigation will identify any areas of best practice, opportunities for learning and areas where improvements to services are required in order to prevent similar incidents from occurring.
3. The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and/or the provider's formal Board sub-committees.

Main Objectives

4. Review the assessment, treatment and care that [Mr W] received from Sussex Partnership Foundation Trust from 2011 up to the time of the incident.
5. The report will include a review of the communication between agencies, services, friends and family including the transfer of relevant information to inform clinical risk assessments and care planning.
6. Identify any care or service delivery issues that may have contributed to the incident or affected its preventability/predictability

Terms of Reference

7. Review the care pathways and information sharing processes in place at the time.
8. Review the application of the Trusts care planning, clinical risk assessment, non-attendance and transfer of care policy and procedures in relation to [Mr W's] treatment.
9. To establish if the risk assessment and risk management (including any multi agency risk management plans) of [Mr W] was sufficient in relation to his needs including the risk of [Mr W] harming himself or others.
10. Review and comment on the involvement of the perpetrators family/carers in relation to care plans, risk assessment and subsequent management plans.
11. To evaluate and comment on the mental health care and treatment [Mr W] received at each stage of his treatment with particular reference to the treatment of co morbid ASD and psychosis.
12. To review the local care pathways in relation to support for adults with Autistic Spectrum Disorder.
13. Establish appropriate contacts and communications with families/carers to ensure appropriate engagement with the independent investigation process.
14. Review the both Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan and identify:

- If the internal investigation satisfied its own terms of reference
- If all key issues and lessons have been identified and shared.
- Whether recommendations are appropriate and comprehensive and flow from the lessons learnt.
- Review and comment on progress made against the action plans.
- Review processes and comment on in place to embed any lessons learnt.
- Review and comment on the efficiency of monitoring of the action plans by the trust internal governance structures

15. Review and comment on any communication and involvement with families of the victim and perpetrator before and after the incident.
16. To identify key issues, lessons learnt, recommendations and subsequent actions for local healthcare providers, commissioners and NHS England
17. To independently assess and provide assurance on the progress made on the delivery of action plans following the internal Trust(s)investigations
18. To independently assess and provide assurance that the monitoring of the relevant Trusts action plans by the commissioning CCGs is adequate.
19. To identify any lessons and/or recommendations that have implications for all social and healthcare providers both locally and nationally.
20. Review and comment on the trust(s) recording of its undertaking of its Duty of Candour.
21. Consider if this incident was either predictable or preventable.

Level of investigation

22. **Type**: An investigation by a team examining a single case.
23. **Timescale:** It is envisaged that the investigation process should be completed within six months of receipt of all clinical and social care records up to the time of the incident.

Initial steps and stages

NHS England will:

24. Arrange an initiation meeting between the Trust(s) and commissioners.
25. Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved.
26. Seek full disclosure of the perpetrator's medical records to the investigation team and with a view that the report will be published in the public interest.

Outputs

27. A clear chronology of the events leading up to the incident

28. A clear and up to date description of the incident and any Court outcomes (e.g. sentence given or Mental Health Act disposals)

29. A final report that is easy to read (and meets the NHS England accessible information standards) and follow with a set of measurable and meaningful recommendations, having been legally checked, proof read and shared and agreed with participating organisations and families

30. Meetings with victim and perpetrator families and perpetrator to explain the findings of the investigation

31. A concise and easy to follow presentation for families

32. A final presentation of the investigation to NHS England and/or Clinical Commissioning Group as required

33. We would encourage the investigators to include a lay/family member on the panel to bring an independent voice to the investigation

34. An assurance visit follow up and review by the independent investigator, six months after the report has been published, to assess if the report's recommendations have been fully implemented and adequately monitored by the relevant CCG. Then produce a short report for NHS England, families and the commissioners which should be made public

Appendix B – Documents reviewed

Sussex Partnership NHS Foundation Trust documents

- Risk: Autism Spectrum Condition and Psychosis Module
- Risk Training November 2016

  Serious Incident (SI) Policy and Procedure, ratified 29 October 2012, review date 31 October 2015
- Clinical Risk Assessment & Management Policy and Procedure, ratified 24 January 2012, review date 24 January 2014
- Serious Incident Action Log
- West Sussex Specialist Clinical Assessment Team Operational Policy, ratified July 2013, review date April 2016
- Adults – Risk Assessment/Screening (combined) Form (Carenotes – as of: 09/03/2017)
- Care Delivery units- discussion paper February 2015
- Clinical Risk Assessment and Safety Management [3 Years]
- Clinical risk assessment and safety planning /risk management policy and procedure, undated, to be reviewed in September 2017. (One of two documents labelled with the same name but different content.)
- Clinical risk assessment and safety planning /risk management policy and procedure, undated, to be reviewed in September 2017. (Two of two documents labelled with the same name but different content)
- Clinical Risk Assessment and Safety Planning/Risk Management – Essential Training 2017
- Clinical Risk Assessment and Safety Planning/Risk Management October 2014
- Audit of completed clinical risk assessments
- Care Programme Approach Policy, ratified 26 October 2010, review date June 2014
- Identifying and Responding to Domestic and Sexual Abuse, ratified 22 December 2015, review date October 2017
- Care Programme Approach Policy (including standard care), ratified January 2016, review date March 2017
- Service user and carer involvement guidance, ratified 1 September 2014, review date September 2015
- Description of the Neurobehavioral Clinic – Adur, Arun and Worthing. April 2017
- Working Protocol for assessing and working with At Risk Mental States in Sussex EIP, 23 March 2016

- West Sussex Modified Early Intervention in Psychosis Service, Operations Manual, working draft 2013
- Clinical Risk Assessment & Management Policy and Procedure, ratified 24 January 2012, review date January 2014
- WSCC Information Sharing Framework. Level 2: Information Sharing Agreement Adult Mental Health
- The NICE ADHD audit tool and the Neurodevelopmental clinic
- Review of the Neurodevelopmental clinic at Worthing
- Incident & Serious Incident Reporting Policy & Procedure, ratified October 2015, review date October 2017
- West Sussex Safeguarding Adults Board Information Sharing Protocol, Effective from 1 April 2015
- SCAS Updated referral pathway
- Operational Policy, Adult Community Mental Health Services, ratified 9 June 2011, review date October 2011
- Summary of differences between old and revised Clinical risk assessment & safety planning/risk management policy and procedure and eLearning. April 2017
- Clinical Risk Assessment and Safety Planning/Risk Management Policy and Procedure, Report Q2-3, 2015/16
- Information Sharing Protocol for the West Sussex Multi-Agency Risk Assessment Conference (MARAC) for high risk victims of domestic abuse, undated, review date March 2011
- Operating Protocol for the West Sussex Multi-Agency Risk Assessment Conference (MARAC) for high risk victims of domestic abuse, version 1 October 2009, review date March 2011
- Managing Concerns about Medical Staff Policy, ratified September 2015
- Referrals Protocol Secure and Forensic Service, no ratification date provided

Other documents

- Broadwater Medical Centre clinical records

Appendix C – Professionals involved

Pseudonym	Role and organisation
Dr A	GP, Broadwater Medical Centre
Dr B	Internal investigation team
Dr C	GP, Broadwater Medical Centre
Dr D	West Sussex EIS
Dr E	Consultant Psychiatrist, Early Intervention Service
Dr H	GP, Seldon Medical Centre
Dr I	Associate Specialist, CMHT
Dr J	Specialty Doctor, Working Age Mental Health Services
Dr J2	Consultant Psychiatrist, HMP Belmarsh
Dr O	Consultant Psychiatrist, Assessment and Treatment Service, Sussex Partnership NHS Foundation Trust
Dr L	Forensic Consultant Psychiatrist, Sussex Partnership NHS Foundation Trust
Dr M	Senior House Officer to Dr O
Dr M2	Internal investigation team
Dr N	Internal investigation team
Dr R	Consultant Psychiatrist, Early Intervention Service
Dr S	GP, Broadwater Medical Centre
DS G	APT, Sussex Police
Mr A	EIS Psychosis Worker, Early Intervention Service
Mr C	Clinical Psychologist, Early Intervention Team, Sussex Partnership NHS Foundation Trust
Mr D	Vocational Specialist
Mr E	Care Coordinator
Mr F	Care Coordinator
Mr I	Early Intervention in Psychosis Worker, Brighton
Mr J	Social Worker, Assessment and Treatment Service, Sussex Partnership NHS Foundation Trust
Mr L	Internal investigation team
Mr M	Team Leader, CMHT
Mr P	Duty Worker, CMHT
Mr R	Service Manager, SPFT
Mr S	Senior Nurse Practitioner, Mental Health Liaison Service, Worthing Hospital
Mr T	Care Coordinator, Early Intervention Service
Mr V	Housing Officer, Worthing Homes
Mr W	Perpetrator
Ms B	Query Duty Worker
Ms C	Community Psychiatric Nurse, Working Age Mental Health Services

Pseudonym	Role and organisation
Ms E	Social worker
Ms N	Care Co-ordinator, Early Intervention Service
Ms G	Early Intervention Service
Ms H	Occupational Therapist, Working Age Mental Health Services
Ms I	Team Manager, Team Manager, MyKey, Southdown Housing Association
Ms J	Head of Quality and Nursing, Coastal West Sussex CCG
Ms K	Early Intervention Service
Ms L	Clinical Psychologist, Assessment and Treatment Service, Sussex Partnership NHS Foundation Trust
Ms M	Recovery Duty Worker, CMHT
Ms P	Specialist Nurse Practitioner, ASD Service
Ms R	Speech and Language Therapist
Ms R2	Service Director
Ms S	ASC Specialist Practitioner and Team Leader, Autistic Spectrum Conditions Service
Ms S2	Psychologist, CMHT
Ms U	Duty Worker, CMHT
Ms W	Support Worker, My Key
PCSO Ms D	PCSO, Sussex Police

Appendix D – Summary of communications with Mr W's family

Date	Source	Event	Information
21/07/15	Mr Y	Letter	Letter from CEO to Mr Y confirming their support for the family, Mr Y's son and the police enquiry. Internal investigation to be led by Dr O where the family would be offered the opportunity to contribute.
22/07/15	Mr Y	Letter	Letter from Director of Nursing to Mr Y's son stating the Trust's support of his care despite the incident. Confirmed a review would be led by Dr N. Contact had been made from the Trust to his family to identify any help they may need.
26/07/15	Mr Y	Statement	Mr Y provided a statement Re: the day of the incident.
26/07/15	Mr Y	Chronology	Mr Y provided a chronology of his son's life, including treatment, milestones and concerns.
04/08/15	Mr Y	Letter	Letter from Mr Y to CEO highlighting his disappointment re: the CEO's candour. Information request for Ms S's assessment, Worthing A&E admissions, minutes from the multi agency meeting with Sussex Police on 24/04/2015. Stated SPFT had not listened to the family to date.
06/08/15	Mr Y	Letter	CEO wrote to Mr Y thanking him for his response to his letter dated 21/07/2015 and apologised for the frustration it caused. The Trust would be in contact re: information requests.
14/08/15	Mr Y	Letter	CEO wrote to Mr Y to answer queries and provided responses to Mr Y's letter dated 06/08/2015
23/08/15	Mr Y	Letter	Letter from Mr Y to CEO requesting clarification re: reason behind meeting between SPFT and Sussex Police. ?? Direct result of Mr Y's warning letter re: son's unprovoked attacked on member of public. Concerns re: lack of document retention within the Trust for such an important meeting. Worthing A&E visits were incomplete. Family wrote to the Trust on nine occasions with only one response letter- confirming the Dr in question could not speak to him. Ms S's assessment was requested from CEO and opportunity to discuss concerns further.
28/08/15	Mr Y	Letter	Letter from Mr Y to CEO attaching letter received from Mr Y's son re: lack of visit from SPFT at Belmarsh
01/09/15	Mr Y	Letter	Letter from CEO to Mr Y confirming that MARAC minutes could not be provided due to forming evidence for the police enquiry. Ms S did not complete the assessment on Mr Y's son due to diagnosis from Dr R. Appointment times offered for Mr Y to meet with CEO and Dr N

Date	Source	Event	Information
02/09/15	Mr Y	Letter	Letter from Mr Y to Head of Healthcare Belmarsh stating his concerns re: Son's MH. A recent visit indicated Mr Y's son was hearing voices and also confirmed he was not taking medication. Mr Y stated his son had MH issues which led to his arrest. Offered availability to meet on 17/09/2015 to obtain insight into his condition.
03/09/15	Mr Y	Letter	Mr Y wrote to CEO and requested definitive update regarding: Support from SPFT for Mr Y's son whilst in custody, support from SPFT since he had been in HMP Belmarsh, the circumstances around non existent Asperger's Syndrome Assessment, SPFT notes on meeting with the police on 28/04/2014
04/09/15	Mr Y	Letter	Letter from CEO to Mr Y confirming the Trust would be contacting Mr Y's son and ask the mental health team at Belmarsh to confirm arrangements with him directly.
09/09/15	Mr Y	Letter	Letter from CEO to Mr Y acknowledging his letter dated 03/09/2015 and confirming that a response would be given in person on 14/09/2015
14/09/15	Mr Y	Meeting preparation	Mr Y prepared a 14 page list of questions at a meeting in Swandean.
15/09/15	Mr Y	Letter	Letter from Belmarsh to Mr Y acknowledging his concern re: his son and confirmed a referral had been made for transfer to a psychiatry hospital under Section 38 MHA. Psychiatric report would be submitted to the Admissions Panel.
17/09/15	Mr Y	Email	Mr L emailed Mr Y requesting a meeting re: SII
17/09/15	Mr Y	Email	Mr Y emailed Mr L requesting Mrs Y be included in any correspondence. Requested clarity regarding SII process as the family had three points of contact; Dr N, Ms R2 and Mr L.
17/09/15	Mr Y	Letter	Dr N wrote to Mr Y and Mrs Y summarising the content of the meeting on 14/09/2015. Contact names and their role was provided.
17/09/15	Mr Y	Document	Investigation Terms of Reference
20/09/15	Mr Y	Email	Email from Mr Y to Dr J2 requesting a telephone call with her. Mr Y had written to Belmarsh a number of time re: worrying signs Mr Y's son was presenting with no response. A male nurse had contacted Mr Y to put his mind at ease.
20/09/15	Mr Y	Email	Email from Mr Y to Dr N requesting information relating to the liaison with Sussex Police for Mr Y's son's forthcoming trial. Requested any formal information that was sent via email to be attached as PDF
20/09/15	Mr Y	Email	Mr Y emailed CEO and Dr N to thank them for their time on 14/09/2015 although many questions could not be answered.

Date	Source	Event	Information
21/09/15	Mr Y	Email	Mr Y emailed Dr L requesting an explanation of the assessment that Dr Y would carry out on his son and possible outcomes.
21/09/15	Mr Y	Email	Dr L emailed Mr Y offering availability later that day for discussion.
29/09/15	Mr Y	Email	Mr L emailed Mr Y outlining the roles of the three contact points. Mr L and Dr B were preparing answers for the questions Mr Y had recently sent.
09/10/15	Mr Y	Email	Email from Mr Y to Dr J2 stating the police had been in contact re: transfer to Broadmoor. Mr Y requested clarity re: decision and who had had input into the decision to move Mr Y's son and if Mr Y's son had been made aware.
16/10/15	Mr Y	Email	Email from Mr Y to Dr N requesting her to prompt a response from Dr J re: Mr Y's son's transfer. Mr Y had not been directed or informed who was responsible for his son's care.
16/10/15	Mr Y	Email	As per previous email entry.
16/10/15	Mr Y	Email	Mr Y emailed Mr L attaching document '20150726 [Mr W] the story so far' for the purpose of the enquiry.
20/10/15	Mr Y	Letter	Letter from Mr Y to Dr N requesting information from the meeting with the police following Mr Y's son's violent behaviour in the pub at Broadwater: Names of those attending, discussion content, agreed action plan, who was accountable for the action plan, outcome of the follow up review.
21/10/15	SPFT	Email	Email from Mr Y to Mr L and Dr B providing a list of letters for the Trust. Trust to respond to confirm which letters were missing from their system
21/10/15	Mr Y	Email	As per Trust records.
22/10/15	SPFT	Email	Email from Mr L to Mr Y confirming the Trust only had one letter from Mr Y on their system date 23/09/2014
22/10/15	SPFT	Email	Email from Mr Y to Mr L stating concerns re: lack of retention of his letters regarding his son. 16 documents provided to the trust, blue watermark to aid investigation and signify they were provided by the family.
22/10/15	Mr Y	Email	As per Trust records.
23/10/15	Mr Y	Email	As per Trust records.
27/10/15	Mr Y	Email	Email from Mr Y to Dr L re: hospital transfer. Following a complaint Mr Y's son had made, he had been put on 'duty of care'- Mr Y stated the complaint was manifested from his son's illness and would like to share this information with someone. It had been impossible to obtain a response from anyone at Belmarsh
27/10/15	Mr Y	Email	Dr L emailed Mr Y stating he was on leave and not received any update since he last spoke to Mr Y however had contacted colleagues at Belmarsh to prompt a response.

Date	Source	Event	Information
29/10/15	Mr Y	Email	Email from Dr L to Mr Y stating that the MOJ were awaiting receipt of Broadmoor's assessment.
08/11/15	Mr Y	Letter	Letter from Mr Y's son to Mr Y highlighting his issues during prison and the need for talking therapy. Requested the note was given to Mr Y's wife and Dr N.
17/11/15	Mr Y	Meeting preparation	Mr Y requested a meeting because the Trust had not identified who was responsible for Mr Y's son's care. Meeting called to address: on going treatment of Mr Y's son, the Serious Incident Investigation and Sussex Partnership's Duty of Candour. Mr Y had concerns RE: his son's state of mind in Belmarsh and not coping well. 'No one seems to be listening'... Dr L has been proactive but that was about the Hospital Admissions Process'. Requesting confirmation that Dr L would be responsible for Mr Y's son's care. Requesting adequate answers from the long list of questions provided previously. Concerns RE: trust's controls of documentation. 15 warning letters from the family had been lost. Poor quality care plan in place. Requesting an update regarding the progression of the investigation and when answers would be provided. The Trust informed the family that there was no record of an important meeting with the police, however the investigation team found evidence of one taking place. Family wrote to Dr N urgently requesting details of the Trust's engagement with the police. No acknowledgement or reply.
30/11/15	SPFT	Letter	Letter from Mr Y to Mr D providing further input to the Serious Incident Investigation having considered the report content, listing bullet points that were to be included in the incident report else the family would deem it unfit for purpose. Mr Y provided dates he written to the trust to obtain information re: MDT meeting on 28/04/2015
30/11/15	Mr Y	Letter	As per Trust records.
30/11/15	Mr Y	Letter	Letter from Mr Y to SII Panel members stating that the family have felt like the 'outgroup' and the Trust being the 'in-group' when referring to groupthink. Letter attached that was sent to the CEO regarding report feedback. (dated 30112015) requesting observations to be included in the report.
01/12/15	Mr Y	Letter	Letter from Mr Y to Ms J requesting to meet RE: SI process and framework. Mr Y outlined the lack of answers provided from CEO at SPFT.
11/12/15	Mr Y	Letter	Letter from Dr N to Mr Y responding on behalf of CEO. The report could not conclude all the detailed points raised from the family, therefore would like to meet to assure they had been listened to and discuss the action plan from the report.

Date	Source	Event	Information
14/12/15	Mr Y	Meeting preparation	Chronology of communication to date. Questions and concerns of the family raised. Following documents provided to the CCG: 20151130 E mail to SII Panel Members 20151130 Letter to SPFT with report feedback 20151211 Letter from SPFT final non answers
17/12/15	Mr Y	Email	Email from Mr Y to Director of Nursing Standards and Safety requesting copies of documents shared with the victim's family to also be shared with himself and Mrs Y.
18/12/15	Mr Y	Letter	Letter from Mr Y and Mrs Y to the CEO stating their frustration with the Trust's evasiveness with answering the family's questions. The paper copy of the letter dated 11/12/15 only went to Mr Y's address not Mrs Y's. Mr Y confirmed CEO was deemed their point of contact due to dealing with four individuals up until that point. Requested clarification regarding points re: inconsistent and responsive carer engagement. Requested the opportunity to read the 72 hour and 60 Day Report. Little benefit had come from meeting with Mr Y's son's previous care team.
18/12/15	Mr Y	Email	Email from Director of Nursing Standards and Safety stating the police specifically advised that no paper copies were to be shared with Mr Y and his family. Suggested a meeting to discuss the report and the subsequent changes.
22/12/15	Mr Y	Letter	Letter from Dr N to Mr Y and Mrs Y confirming receipt of letter dated 18/12/2015 and that Director of Nursing Standards and Safety and Dr N would be the family's point of contact. Suggested that they met in January 2016.
23/12/15	Mr Y	Email	Email from Director of Nursing Standards and Safety to Mr Y and Mrs Y to confirm the Final SI draft report had been submitted to the Clinical Commissioning Group. The family would have opportunity to read the report in the New Year.
27/12/15	Mr Y	Email	Email from Director of Nursing Standards and Safety to Mr Y and Mrs Y stating that the agreed changed that they had requested would be made and the report would move to the next stage- to be sent to the CCG for scrutiny, also shared with the victim's family and Mr Y's son's clinical team in Worthing.
04/01/16	Mr Y	Letter	Letter from Ms J to Mr Y and Mrs Y summarising the content of their meeting with Senior Communications Manager on 14/12/2015
11/01/16	Mr Y	Meeting preparation	A list of 18 questions to be answered by SPFT. No answers documented.

Date	Source	Event	Information
15/01/16	Mr Y	Email	Director of Nursing Standards and Safety confirmed that Mr Y's son would be contacted re: view on his treatment. Information for support from ICAS provided. Director of Nursing Standards and Safety confirmed she would bring a copy of the 72 hour report at their next meeting.
15/01/16	Mr Y	Email	Email from Executive Assistant to Dr N to Mr Y with attachment of re-worded letter.
15/01/16	Mr Y	Email	Mr Y responded with further suggestions for the amended letter.
25/01/16	Mr Y	Letter	Mr Y wrote to Ms J confirming he was satisfied that any learning points would be translated into an action plan for SPFT to deliver. Mr Y would be writing to CEO re: view on the final SI report. Thanks given re: open and honest treatment from Ms J.
25/01/16	Mr Y	Email	Mr Y emailed Ms L consenting for his details to be shared with NHS England Homicide Investigation Team.
04/02/16	Mr Y	Email	Director of Nursing Standards and Safety emailed Mr Y and Mrs Y confirming their son had been seen by Mr B and Dr M2 and his view's re: care received up until the date of the incident had been added to the report. Report to be shared with the CCG for scrutiny. NHS England would be in touch re: independent review.
05/02/16	Mr Y	Letter	Mr Y and Mrs Y wrote to CEO requesting to see the SI report. It was noted re: CEO not taking on board their feedback from the draft document in November. No root cause for Mr Y's son had been found nor any common theme documented; incompetence, arrogance, deceit and dishonesty. Examples were provided. The family had been open with the Trust however this was not returned.
05/02/16	Mr Y	Letter	Letter to Ms J from Mr Y enclosing letter to CEO date 05/02/2016. The SI report, in Mr Y's opinion fails on many levels.
12/02/16	Mr Y	Letter	Letter from CEO to Mr Y and Mrs Y confirming that he would respond to the letter dated 05/02/2016 after the trial. Mr Y and Mrs Y stated they would write to CEO after the trial, therefore CEO would provide a detailed response upon receipt. Paper copy of the SI report could not yet be provided.
12/02/16	Mr Y	Email	Director of Nursing Standards and Safety emailed Mr Y and Mrs Y confirming that the SI report had been scrutinised by the CCG who had requested an update on the action plan in one month's time.
07/03/16	Mr Y	Letter	Letter from Director of Nursing Standards and Safety to Mr Y and Mrs Y enclosing copies of requested documentation.

Date	Source	Event	Information
14/03/16	Mr Y	Meeting preparation	A list of questions provided to Director of Nursing Standards and Safety during their telephone call-responses not documented.
04/04/16	Mr Y	Letter	Letter from Mr Y to CEO requesting a full response to their questions from 05/02/2016 and all other questions up until the date of 04/04/2016
12/04/16	Mr Y	Letter	Letter from CEO to Mr Y requesting a conversation following the unsatisfactory answers CEO had provided the family.
13/04/16	Mr Y	Letter	Letter from Mr Y and Mrs Y to CEO requesting more adequate responses to their questions
13/04/16	Mr Y	Letter	Letter to Ms J re: allegations relating to SPFT and Mr Y's son's treatment. No acknowledgement or response had been received from later date 05/02/2016 by Mr Y
15/04/16	Mr Y	Letter	Letter from Ms J to Mr Y summarising the content of their conversation from 'Friday', Ms J encouraged Mr Y to meet with CEO to discuss his dissatisfactions regarding issues the family had raised with him. Ms J reconfirmed the role of the CCG in the scrutiny and management of the SI report and confirmed that the panel had agreed that a comprehensive action plan would be added to the investigation report upon conclusion of the trial. Mr Y's concerns re: 'Version control' of the report had been highlighted to SPFT Director of Nursing Standard and Safety.
15/04/16	Mr Y	Letter	Letter from Mr Y and Mrs Y raising concern's re: CEO's obstructive behaviour and lack of communication, highlighting the bad experience Mr Y and his family had when dealing with the CEO.
22/04/16	Mr Y	Letter	Letter from Mr Y to Ms J stating that many of his questions would not prejudice Mr Y's son's trial and thought it was a reason for delay. Mr Y had prepared a critique of the 60 day report would share with Ms J.
26/04/16	Mr Y	Letter	Letter of apology from CEO to Mr Y and Mrs Y.
26/04/16	Mr Y	Letter	CEO provided answers to 106 questions from Mr Y and Mrs Y.
07/05/16	Mr Y	Letter	Letter from Mr Y and Mrs Y thanking the Chairman of SPFT formally writing a letter of thanks to all staff at the Hellingly Centre.
09/05/16	Mr Y	Letter	Letter from Ms J to Mr Y acknowledging receipt of his letter dated 15/04/2016. Mr Y was awaiting formal written response from Ms C regarding the content of the SI report. Ms J offered availability to receive critique and or discuss the SPFT report.
13/05/16	Mr Y	Letter	Letter from Chair of Trust to Mr Y and Mrs Y acknowledging their letter and apologised that their son did not receive the level of care deserved from the Trust.

Date	Source	Event	Information
19/05/16	Mr Y	Letter	Letter from CEO to Mr Y apologising that the family learnt about the external review via the media and explained the reason behind the conduction of an external review. Any further information to be requested from Director of Nursing Standards and Safety.
19/05/16	Mr Y	Email	Mr Y emailed Director of Nursing Standards and Safety requesting the minutes from the 'Multi-agency meeting dated 10.00 on 28th April 2014'
20/05/16	Mr Y	Email	Director of Nursing Standards and Safety emailed Mr Y clarifying that it was the MARAC minutes that had not been shared with Sussex Police. Director of Nursing Standards and Safety agreed to request this information. Confirmed Mr Y would receive a letter re: 10 case review
24/05/16	Mr Y	Email	Mr Y emailed Director of Nursing Standards and Safety stating there was little more he could contribute to the 10 cases for review other than the comments in the letter to the CEO dated 05/02/2016
10/06/16	Mr Y	Email	Email from Director of Nursing Standards and Safety to Mr Y and Mrs Y attaching the minutes from the MARAC meeting from July 2014
10/06/16	Mr Y	Email	Email from Director of Nursing Standards and Safety to Mr Y and Mrs Y attaching the minutes from the MARAC meeting from July 2014
24/06/16	Mr Y	Notes	Concerns regarding Mr Y's son's treatment, disappointment with the conduction of the 60 day SI report and how the CEO of SPFT had dealt with matters, concern re: clinicians involved and lack of professionalism, concerns re: lack of line management of care co-ordinators, no one had taken responsibility for Mr Y's son's mental well-being prior to arriving at Hellingly.
27/06/16	Mr Y	Letter	Letter from Director of Nursing Standards and Safety to Mr Y stating that she would like to provide Mr Y with a copy of the Serious Incident Report. Director of Nursing Standards and Safety confirmed 8 problems identified in the report relating to the care Sussex Partnership provided and also highlighted the action the Trust had taken in response to those issues.
27/06/16	Mr Y	Letter	Letter from Ms J to Mr Y confirming she had met with NHS England who had appointed Niche Patient Safety Limited to conduct the investigation. Requesting consent to share correspondence exchange.
29/06/16	Mr Y	Email	Email from Director of Nursing Standards and Safety to Mr Y and Mrs Y requesting consent to share all email correspondence as part of NHS England's review.
29/06/16	Mr Y	Email	Mr Y emailed Director of Nursing Standards and Safety consenting for correspondence to be shared for the purpose of the NICHE investigation.

Date	Source	Event	Information
01/07/16	Mr Y	Email	Mr Y emailed Ms J consenting for correspondence to be share for the purpose of the NICHE investigation
06/07/16	Mr Y	Letter	Letter from Chair of Trust to Mr Y and Mrs Y capturing the key elements of their meeting on 24/06/2016. The Chair highlighted the improvements and action that had been taken as a result of the Serious Case Review and addressed Mr Y's concerns re: Mr Y's son's treatment, care planning, the serious case review, difficulty communicating with the trust and disappointment with how the case was handled. The Chair confirmed Director of Nursing Standards and Safety would be the main point of contact regarding the case.